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There is a strong relationship between alcohol and crime - the higher the alcohol consumption, the higher the crime rate - only 50% of offenders have been convicted at the time of commission of the offense
Alcohol and the Alaskan Offender

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This report has been prepared for use by the Standards and Goals Task Forces of the Division of Corrections and the Alaska Court System. It is an attempt to integrate material from several reports, and to isolate information concerning the impact of alcohol abuse on the correctional system.

Our data spans the five-year period from 1969 through 1974, permitting observations concerning the effects of the Uniform Alcoholism and Intoxication Act, which was passed in October, 1972. It also addresses the relationships between race, alcohol use and crime, and the relationship between alcohol use and violent crime.

The reports which have been reviewed are: Survey of Public Offenders: A Comparison of Ethnic Groups, published by the Office of Alcoholism in 1970; Misdemeanant Probation Project: Evaluation of First Year (1974); Sentencing Data, 1974; Recidivism, 1971-1974; and data from the population of the Eagle River Correctional Center (1975). Unfortunately, each of the reports employs a different data base, because they were prepared for specific administrative purposes. Taken together, however, they permit some inferences concerning the impact of alcohol abuse on the criminal justice system.

OVR/Office of Alcoholism Study (1969)

Data Base: In 1969, OVR conducted an interview survey of Alaskan offenders. Their sample included one-half of the total inmate population in 12 Alaskan state and city jails, and 3 federal prisons (Alaskan inmates only).

In 1970, the OVR data was re-analyzed by the Office of Alcoholism, with emphasis on questions regarding alcohol use. The Office of Alcoholism study included only sentenced Caucasian and Native adult males. In the sample of 173 who met these criteria, 99 (57%) were Native. Distribution of the various Native racial subgroups was similar to their distribution in the population of the state.

Results: Drunk in Public was the most frequent charge (36% of the total), accounting for 30% of Native and 16% of Caucasian charges. Natives accounted for 76% of Drunk in Public charges. Violent crimes accounted for 20% of Native and 36% of Caucasian sentences. The study did not investigate the relationship between drinking and violence. However, all respondents were asked whether they had been drinking at the time of their offense. Responses are shown in Table 1.

Table 1
Use of Alcohol at Time of Offense

	<u>Caucasian</u>	<u>Native</u>	<u>Total</u>
Drinking	64%	92%	80%
Not Drinking	36%	8%	20%

The difference between the two groups was statistically significant, with Natives highly more likely to have been drinking at time of offense ($\chi^2 = 19.34$, $p < .001$).

DOC Misdemeanant Probation Project (1975)

Data Base: As part of the evaluation of the LEAA funded Misdemeanant Probation Project, the DOC compared 152 Anchorage misdemeanants assigned by judges to probation, with 148 cases not assigned to the project. The comparison group consisted of the docket following each case assigned to the project; the comparison group was drawn to determine whether those assigned to probation were representative of the population of misdemeanants appearing in District Court.

Results: Table 2 shows type of offense for the Probation referrals and the Comparison group.

Table 2
Misdemeanant Offenses

	Probation Referrals		Comparison Group	
	<u>N</u>	<u>%</u>	<u>N</u>	<u>%</u>
Harm to Person	7	5	12	8
Property Theft/Damage	79	52	22	15
OMVI	14	9	33	22
Other Alcohol	11	7	30	20
Drugs (Sales, Posses.)	14	9	15	10
Traffic	7	5	16	11
Firearms	18	12	7	5
Other	<u>2</u>	<u>1</u>	<u>13</u>	<u>9</u>
	152	100	148	100

Table 2 shows that there are distinct differences in types of offense between those who are, and are not, referred to Probation. Most striking is the fact that 52% of Probation referrals are for offenses involving property theft or damage, while this category makes up only 15% of the Comparison group. Conversely, 42% of the Comparison group have charges of OMVI or other alcohol offenses, as compared to 16% of those assigned to Probation. This finding suggests efficient use of referral resources by District Court judges. The Borough Health Department DWI Program is designed to accept referrals from District Court. In fact, 34 clients (23%) of the Comparison group were referred to the Borough program.

The Comparison group is, in effect, a random sample of cases appearing in District Court; 42% of the offenses are alcohol-related. The dockets do not provide information concerning race of offenders, and there was no way to determine race. Those cases referred to Probation were, however, 74% Caucasian, 20% Native, and 6% Black.⁽¹⁾ If they are representative of the Comparison group, it appears that, as an offender population approaches the racial distribution of the state population, drunken driving assumes an important picture in contribution to total offenses. Data from a sentencing study (see below) support this finding.

(1) A study of sentencing in Alaska published by the Alaska Judicial Council (Cutler, 1975) shows that among 567 felony defendants appearing in Anchorage courts, 66% were Caucasian, 15% Native, 6% Black, and 13% Other or Unknown. Comparable information is not available for District Court, which is served by the Misdemeanant Probation project.

Statewide, 1973 felony defendants were 60% Caucasian, 17% Native, 6% Black, and 16% Other or Unknown.

DOC Sentencing Study (1974)

Data Base: In Fairbanks, Juneau and Ketchikan, data was recorded for all offenders sentenced to time in jail during the final six months of 1974. Information included race, age, sex, type of charge, and time to be served.

In Anchorage, the same information was obtained from Commitment and Release cards, for calendar year 1974.

Number of cases were: Fairbanks, 270; Juneau, 41; Ketchikan, 38; Anchorage (six months), 497, (full year) 1038.

Results: Table 3 shows selected characteristics of offenders included in this survey. The statewide population includes Anchorage sentences; the same group is included in the Anchorage one-year survey. Thus, the two groups overlap and cannot be compared; both populations are shown simply to demonstrate the similarity between sentencing for Anchorage and for Alaska (a similarity caused by the fact that Anchorage accounts for 59% of the statewide sample).

Table 3
 Characteristics of Statewide and Anchorage
 Sentenced Offenders

	Statewide* 6 mo. Sample (N= 846)	Anchorage 12 Months (N=1031)
<u>Race</u>		
% Caucasian	44%	48%
% Native	50%	46%
% Black	5%	6%
<u>Offense</u>		
% Alcohol-Related Charges	41%	37%
% Part I Offenses	20%	23%
<u>Length of Sentence</u>		
% 1-10 days	65%	60%
% 1 day to 1 yr.	95%	93%
More than 1 yr.	5%	7%

(*Includes 497 in Anchorage 6-month sample.)

In the statewide six-month sample, Natives received 50% of all sentences; Caucasians received 44%, and Blacks, 5%.

Alcohol-related charges (D.W.I., Drunk on a Roadway and Disorderly Conduct) accounted for 41% of all sentences. Within the alcohol-related group, Natives received 58% of the sentences, and 57% of the sentences for Part I crimes (those which the FBI describes as most serious, including all violent crime).

The cut-off point of one year sentences provides a rough approximation of the distinction between misdemeanors and felonies (although some plea-bargained felonies are included as misdemeanors when this classification is employed).

In the statewide sample, 6% of the Caucasians, 2% of the Natives and 9% of the Blacks received sentences of more than one year. The total number was 39, or 5% of the population.

In Anchorage, during the calendar year 1974, DWI was the most frequent offense (17% of all charges), followed by Drunk on a Roadway (10%) and Disorderly Conduct (10%). Twenty-three percent of all sentences were for Part I offenses.

For the purposes of this report, we looked more closely at three offense categories within the Anchorage data--OMVI, Drunk on a Roadway, and Disorderly Conduct. Table 4 shows incidence of each type of offense by race.

Table 4
Racial Distribution of Alcohol-Related Offenses

	Caucasian		Native		Total*	
	<u>N</u>	<u>%</u>	<u>N</u>	<u>%</u>	<u>N</u>	<u>%</u>
OMVI, DWI	137	67	66	20	203	38
Drunk on Roadway, Disorderly Conduct	<u>67</u>	<u>33</u>	<u>265</u>	<u>80</u>	<u>332</u>	<u>62</u>
	204	100	331	100	535	100

*11 Blacks have been omitted.

Natives account for 62% of alcohol-related⁽¹⁾ offenses; however, 80% of the alcohol charges against Natives were nuisance offenses (Disorderly Conduct, Drunk on a Roadway). Coincidentally, Natives committed 80% of the nuisance offenses. Two-thirds of the alcohol charges against Caucasians were for OMVI, and Caucasians committed two-thirds of the OMVI offenses⁽²⁾.

(1) The term "alcohol-related" refers to charges directly involving alcohol use, but does not include other offenses committed while drinking.

(2) Perhaps it will help in understanding this statement if the reader notes that the number of Caucasians and the number of OMVIs is the same, and that the number of Natives and the number of nuisance charges is the same. Pure coincidence, but very confusing.

An Alaska Supreme Court ruling in early 1975 indicates that the charge of Drunk on a Roadway may no longer be used to subvert the intention of the Uniform Alcoholism Act. We may therefore expect that, in the future, either fewer Natives will be sentenced, or there will be an increase in Disorderly Conduct charges.

DOC Recidivism Study (1975)

Data Base: In 1975, the Division of Corrections published its first recidivism study meeting standards set by the National Advisory Commission on Criminal Justice Standards and Goals.⁽¹⁾

Recidivism statistics are up-dated annually, and consist of a follow-up on all offenders who are released after serving 10 days or longer in custody of the Division of Corrections.⁽²⁾ Data is reported as cases; thus each release from correctional custody is counted as a "case", and a single individual may account for a number of cases.

(1) "Recidivism is measured by (1) criminal acts that resulted in conviction by a court, when committed by individuals who are under correctional supervision or who have been released from correctional supervision within the previous three years, and by (2) technical violations of probation or parole in which a sentencing or paroling authority took action that resulted in an adverse change in the offender's legal status."

Our data differs from these standards in that we can provide only corrections-to-corrections data. Thus, recidivism is measured from time of release to time of sentencing to Corrections custody. Suspended sentences, fines and court probation are not included.

The data does not include recidivism taking place outside Alaska.

(2) Data from the 1974 Sentencing Study, cited previously, indicates that those serving more than 10 days compose from 35-40% of total sentenced intake.

The base year for the recidivism study is 1971. In the process of conducting the study, data has been collected on a total of 4,314 adults released (after serving ten days or more) during the period 1971-1974.

Results:

a. Recidivism: The three year follow-up of adults released in 1971 showed a recidivism rate of 36%. Despite the decriminalization of Drunk in Public (in October 1972), 50% of recidivism was accounted for by those with alcohol-related charges. Within this group, 78% committed another alcohol-related offense.

Fifty-two percent of offenders released in 1971 were Natives; however, when compared with other racial groups, Natives accounted for 72% of recidivism.

Eighty percent of cases released from Corrections custody during 1971 had served short jail sentences only, without probation/parole services after release. This 80% of the population accounted for 98% of recidivism among 1971 releases.

b. Description of population: A side-product of the recidivism study was the collection of information on cases released from custody during the years 1971 through 1974. These data clearly demonstrate the impact of the Uniform Alcoholism Act (October 1972) on characteristics of those receiving sentences of ten days or longer.

Table 5 shows percentage of all cases which were alcohol-related over the four year period.

Table 5
Proportion of Offenses
Which Were Alcohol-Related

<u>Year</u>	<u>Alcohol Related</u>
1971	34%
1972	25%
1973	13%
1974	7%

There was a 38% decrease in number of alcohol-related offenses between 1971 and '72, a 49% decrease between '72 and '73, and a 1% decrease from 1973 to '74. (This suggests that the impact of the Uniform Alcoholism Act may have stabilized, and that we may expect to see around 120 cases annually sentenced to ten days or more for alcohol-related crimes.)

At the time of passage of the Uniform Alcoholism Act, it was widely observed that the charge of Drunk in Public was, de facto, discriminatory against the Native population. With passage of the Act, in 1972, it was anticipated that both numbers and proportion of Natives in correctional custody would decrease.

Table 6 addresses alcohol-related offenses only, showing distribution by race.

Table 6
Alcohol-Related Offenses by Race

	1971		1972		1973		1974	
	<u>N</u>	<u>%</u>	<u>N</u>	<u>%</u>	<u>N</u>	<u>%</u>	<u>N</u>	<u>%</u>
Native	310	81	190	79	100	81	84	69
Caucasian	73	19	49	21	22	18	37	30
Black	1	0	0	0	1	1	1	1
	<u>384</u>	<u>100</u>	<u>239</u>	<u>100</u>	<u>123</u>	<u>100</u>	<u>122</u>	<u>100</u>

In numbers, there has been a 68% decrease in alcohol-related offenses over the four year period. (A 73% decrease for Natives, and a 49% decrease for Caucasians.) The contribution of each racial group to total alcohol offenses remained steady until 1974, when there was a decrease in the proportion committed by Natives, and a corresponding increase for Caucasians.

Table 7 shows racial characteristics of all cases released from 1971 through 1974, in percentages.

	Table 7 Race			
	1971 %	1972 %	1973 %	1974 %
Native	52	53	48	37
Caucasian	43	43	45	56
Black	4	3	6	5
Other, Unknown	<u>1</u>	<u>1</u>	<u>1</u>	<u>2</u>
	100	100	100	100

Since passage of the Uniform Alcoholism Act, the proportion of Natives has decreased, with a corresponding increase in proportion of Caucasians. It would be in error, however, to attribute this change entirely to the Uniform Act. As Table 8 makes clear, there has been an even more dramatic impact from the population influx which the state is experiencing.

Table 8
Race by Year for Sentenced Releases

	1971		1972		1973		1974	
	<u>N</u>	<u>%</u>	<u>N</u>	<u>%</u>	<u>N</u>	<u>%</u>	<u>N</u>	<u>%</u>
Native	584	52	506	53	468	48	462	37
Caucasian	483	43	408	43	444	45	704	56
Black	41	4	33	3	55	6	64	5
Other, Unknown	<u>15</u>	<u>1</u>	<u>8</u>	<u>1</u>	<u>14</u>	<u>1</u>	<u>25</u>	<u>2</u>
	1123	100	955	100	981	100	1255	100

Clearly, the change in racial proportions which took place in 1974 is due largely to an increase in number of Caucasians in corrections custody.

Figure 1 portrays the percentage change in numbers of Caucasians and Natives released, using 1971 as a baseline year (zero on the scale).

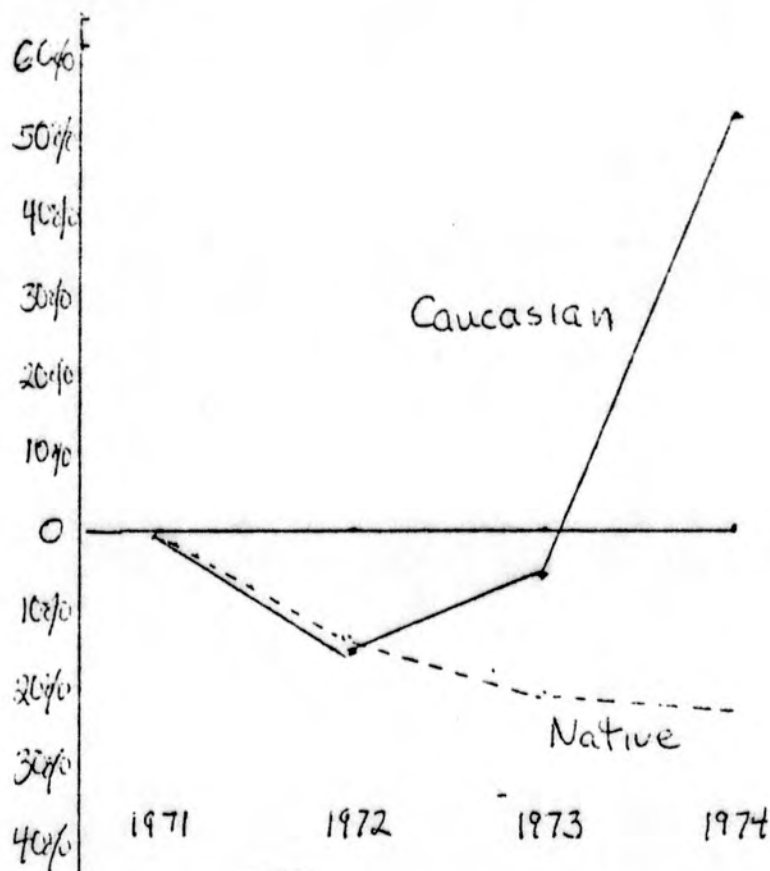


Figure 1: Annual percentage change in number of releases.

Table 9 shows the percentage change figures on which Figure 1 is based.

Table 9
Annual Percentage Change

<u>Time Period</u>	<u>Native</u>	<u>Caucasian</u>	<u>Total</u>
1971 to 1972	13% decrease	16% decrease	15% decrease
1972 to 1973	8% decrease	9% increase	3% increase
1973 to 1974	1% decrease	59% increase	28% increase

Figure 1 and Table 9 show that changes in racial composition of releases are the product of an interaction between the Uniform Alcoholism Act, and the pipeline-generated population increase.

DOC Base Expectancy Data (1975)

Data Base: Anchorage area offenders are presently housed in the Annex prior to sentencing. Those receiving sentences of six months or less are sent to either the Third Avenue facility or to the Palmer Correctional Center. Those with longer sentences are held in the Special Treatment unit (maximum security) at Eagle River, pending classification to another institution or into the Eagle River Correctional Center program.

The Self Administered Base Expectancy is a modified version of an instrument found to predict parole outcome in California. It consists of a number of questions concerning the offender's criminal and social history, as well as questions involving drug and alcohol use. The questionnaires are anonymous; we have no way of verifying

information provided by inmates. The results, however, seem reasonable in the light of other data regarding alcohol use.

During the first year of operation of the Eagle River Correctional Center, 103⁽¹⁾ inmates in Special Treatment have completed the Base Expectancy. These offenders were grouped in terms of whether or not their crimes had involved violence.

Results: Of the 103 who completed the Base Expectancy, 56% were Caucasian, 27% Native and 17% Black.

Fifty-two percent had committed violent crimes; 84% reported that they had been drinking at the time of their most recent offense.

Tables 10 and 11 show the relationship of alcohol use and violent crime, according to racial distribution of offenders.

Table 10
Numbers Committing Violent and
Nonviolent Crimes, and Number Drinking

	Caucasian		Native		Black		Total	
	V. -	Nonv.	V. -	Nonv.	V. -	Nonv.	V. -	Nonv.
	<u>N</u>	<u>N</u>	<u>N</u>	<u>N</u>	<u>N</u>	<u>N</u>	<u>N</u>	<u>N</u>
Drinking	25	22	13	12	8	7	46	41
Not Drinking	3	5	0	1	0	2	3	8
Unknown	<u>2</u>	<u>0</u>	<u>2</u>	<u>0</u>	<u>1</u>	<u>0</u>	<u>5</u>	<u>0</u>
	30	27	15	13	9	9	54	49

(1) Most of this group were Anchorage-area offenders. Eighteen, or 14% had been classified for the Eagle River program by institutions in other parts of the state, and were in Special Treatment awaiting acceptance by the Eagle River Classification Committee.

Table 11
Relationship of Alcohol Use
and Violence (Percent)

	<u>Caucasian</u>	<u>Native</u>	<u>Black</u>	<u>Total</u>
Violence, Alcohol	44%	46%	44%	44%
Violence, No Alcohol	5%	0%	0%	3%
Alcohol, No Violence	39%	43%	39%	40%
No Alcohol, No Violence	9%	4%	11%	8%
Unknown	3%	7%	6%	5%
	100%	100%	100%	100%

Tables 10 and 11 show that approximately half the crimes committed by Caucasians were violent; of the violent crimes, 89% were accompanied by alcohol use. Among Natives and Blacks, violence accounts for 46% and 44%, respectively, of crimes committed by each group. In these groups, 100% of violent crime took place when the offender had been drinking.

Table 12 summarizes the above data by showing the proportion of total offenses involving either violence or alcohol.

Table 12
Percentage of Offenses Involving
Violence or Alcohol Use

	<u>Caucasian</u>	<u>Native</u>	<u>Black</u>	<u>Total</u>
Violence	53%	54%	50%	52%
Alcohol Use	82%	89%	83%	84%

Tables 10, 11 and 12 show a clear relationship between alcohol use and crime -- both violent and nonviolent. They also show that the relationship is virtually independent of race.

The 103 Eagle River inmates were asked whether or not they had ever had a "serious" drinking problem. Responses are shown in Table 13.

Table 13
"Have you ever had a serious drinking problem?"

	Caucasian		Native		Black		Total	
	<u>N</u>	<u>%</u>	<u>N</u>	<u>%</u>	<u>N</u>	<u>%</u>	<u>N</u>	<u>%</u>
Yes	27	47	21	75	3	17	51	50
No	<u>30</u>	<u>53</u>	<u>7</u>	<u>25</u>	<u>15</u>	<u>83</u>	<u>52</u>	<u>50</u>
	57	100	28	100	18	100	103	100

In the total population, there is a 50-50 split between those reporting a "serious" drinking problem and no problem. There are marked racial differences, however: 75% of Natives, 47% of Caucasians and 17% of Blacks report having had an alcohol problem.

When the Base Expectancy had been in use for some time, we added a question concerning drug use; responses are available from 64 offenders. Table 14 shows violent and nonviolent crimes, distributed according to both alcohol and drug use.

Table 14
Alcohol and Drug Use on Day of Offense
by Type of Crime

	Violent		Nonviolent		Total	
	<u>N</u>	<u>%</u>	<u>N</u>	<u>%</u>	<u>N</u>	<u>%</u>
Alcohol only	19	58	8	26	27	42
Drugs only	1	3	13	42	14	22
Alcohol and Drugs	5	15	4	13	9	14
Neither	<u>8</u>	<u>24</u>	<u>6</u>	<u>19</u>	<u>14</u>	<u>22</u>
	33	100	31	100	64	100

Drug use figured in 36% of the offenses, and alcohol in 56%. (It has been suggested that there may be a tendency to under-report drug use, or to substitute alcohol use for drug use in reporting. There is no way to verify this suspicion.)

If our responses are accurate, there is a striking difference between alcohol and drug use in relation to violent crime. Alcohol use had occurred on the day of 73% of all violent crime, and 39% of nonviolent crime. Drug use had taken place in only 18% of violent crime, and in 55% of nonviolent crime. The use of both alcohol and drugs was equally associated with violent and nonviolent crime.

Twenty (31%) reported that they have, at some time, had a serious problem with drugs. Table 15 shows responses to this question, by race.

Table 15
"Have you ever had a serious problem with drugs?"

	Caucasian		Native		Black		Total	
	<u>N</u>	<u>%</u>	<u>N</u>	<u>%</u>	<u>N</u>	<u>%</u>	<u>N</u>	<u>%</u>
Yes	13	35	2	13	5	42	20	31
No	<u>24</u>	<u>65</u>	<u>13</u>	<u>87</u>	<u>7</u>	<u>58</u>	<u>44</u>	<u>69</u>
	37	100	15	100	12	100	64	100

The tendency for each group to report drug problems reverses the findings for alcohol problems: 42% of Blacks, 35% of Caucasians and 13% of the Natives had experienced serious problems with drugs.

Finally, Table 16 shows number and percent of individuals reporting problems with both drugs and alcohol.

Table 16
 Serious Drug and/or Alcohol Problem
 (Self Report)

	Caucasian		Native		Black		Total	
	<u>N</u>	<u>%</u>	<u>N</u>	<u>%</u>	<u>N</u>	<u>%</u>	<u>N</u>	<u>%</u>
Alcohol only	7	19	10	67	3	25	20	31
Drugs only	9	24	0	0	4	33	13	20
Alcohol <u>and</u> Drugs	4	11	2	13	1	8	7	11
Neither	<u>17</u>	<u>46</u>	<u>3</u>	<u>20</u>	<u>4</u>	<u>33</u>	<u>24</u>	<u>38</u>
	37	100	15	100	12	99	64	100

When reported alcohol and drug problems were combined, 11% of the group reported having had a problem with both alcohol and drugs; 31% with alcohol only, 20% with drugs only, and 38% reported that they had never had a problem with either. Two-thirds of the Natives, but a quarter or less of Caucasians and Blacks reported an alcohol problem: one-third of the Blacks, a quarter of the Caucasians and none of the Natives reported a drug problem. The three groups did not differ in terms of having had a problem with both alcohol and drugs. Almost half the Caucasians, one-third of the Blacks and one-fifth of the Natives reported no problems with either.

Summary and Conclusions:

In this paper, we have attempted to tie together a series of reports, all based on different population groups, but all dealing to some extent with the relationship between alcohol use and crime in Alaska.

I. Relationship between alcohol use and crime:

1. In a 1969 study of one-half the Alaskan residents in 15 state, city and federal jails, 80% reported that they had been drinking at the time of their offense; 36% had been charged with Drunk in Public.

2. In a 1974 random sample of District Court cases (misdemeanors), 42% of the charges were alcohol related (OMVI, Drunk on a Roadway, Disorderly Conduct).

3. In a 1974 study of all sentences received during a six-month period in major population centers, 41% of the sentences were for alcohol-related offenses. Thirty-seven percent of all sentences in Anchorage during 1974 were alcohol-related.

4. In a study completed in 1975, which traced recidivism in 1,123 individuals released from corrections custody in 1971, an overall recidivism rate of 36% was reported for the three-year period; 50% of recidivism was accounted for by those with alcohol-related offenses.

5. In a 1974-75 sample of 103 offenders with sentences of six months or more, 84% reported that they had been drinking on the day of the offense for which they were incarcerated. In a sub-sample of this group (the 64 who were tested after questions on drug use

had been added to the questionnaire), 42% reported that they had used alcohol on the day of the offense; 22% had used drugs, and 14% reported that they had used both alcohol and drugs.

II. Distribution of racial groups:

Table 17 shows racial distribution of five selected populations. The 1973 Alaska Workforce shows numbers of adults (age 16 and over) in the state population; 1973 statewide Felony Defendants represent the only data on race available from the Court System. The three remaining groups are from DOC data: the Sentencing, Recidivism and Base Expectancy Studies.

Table 17
Racial Distribution
of Selected Populations

	1. 1973 Alaska* Workforce (N=123,400)	2. Statewide** 1973 Felony Defendants (N=749)	3. July - Dec. 1974 Statewide Sentences (N=846)	4. 1974 Releases 10 days plus (N=1255)	5. 1974-1975 6 mo. plus (N=103)
Caucasian	84%	60%	44%	56%	55%
Native	11%	17%	50%	37%	27%
Black	2%	6%	5%	5%	17%
Other, Unknown	<u>3%</u>	<u>16%</u>	<u>1%</u>	<u>2%</u>	<u>0</u>
	100%	99%	100%	100%	99%

*1973 Alaska Workforce: Department of Labor, June, 1973.

**Alaska Judicial Council, Sentencing in Alaska (1975).

Although it includes both 1973 and 1974 data and several data bases, Table 17 permits some speculation regarding proportion of Natives within the system. Column 1 is an approximation of the adult population of the state, classified by race. Column 2 shows the percentage of each racial group represented among felony defendants, statewide, in 1973. (The relatively high rate of "unknowns" in this sample is unfortunate; however, the data indicates that Natives are over-represented in the felony defendant population. It is also unfortunate that similar data is not available from District Court, where most alcohol-related cases are processed.) Column 3 includes statewide sentences for 1974 (including all sentences, no matter how short), and the Native percentage increases markedly. Column 4, from the Recidivism study, includes only those with sentences of ten days or longer, and shows a reduction in proportion of Natives to total population. Column 5 is based on a group of offenders (mostly from the Anchorage area), with sentences of six months or more. Natives make up a still smaller proportion of this group, although the percentage of Natives is still more than twice the percentage in the adult population of the state.

This is very rough data; the groups are not strictly comparable, and our own data (see Table 8, this paper), indicates that 1973 Workforce figures may drastically underestimate the Caucasian population present in the state by 1974.

The data does suggest, however, that as sentence length increases (theoretically suggesting more serious offenses), the

proportion of Natives in the correctional population more closely approaches the proportion in the statewide population.

III. Impact of the Uniform Alcoholism Act (passed in October 1972):

The time span covered by this series of reports permits us to look at very similar populations before and after passage of the Uniform Act. In 1969, the decriminalization of Drunk-in-Public was only starting to be contemplated, but no changes had been made in the system. The OVR study conducted in that year consisted of a sample of one-half the sentenced adult male Alaskan offenders, including those serving only a day or two. At that time, 36% of all offenses were alcohol-related, and 57% of the offenders were Native.

In 1974, a DOC statewide survey of all sentences (one day or over) during a six month period showed that 41% of charges were alcohol-related, and 50% of offenders were Native.

Thus, when all sentences are considered, there is very little change in proportion of alcohol-related arrests, or of Natives in custody. This confirms the observations of booking officers in the jails, who have consistently claimed that, "Nothing has changed except that the people who used to be charged with Drunk in Public now come in for Disorderly Conduct or Drunk on a Roadway."

The Uniform Act has had an impact, however, and its effect is evident in data from the DOC Recidivism study, which includes only those sentenced for ten days or longer, thus eliminating approximately 60% of those booked into the jails. Within the longer-term group included in the Recidivism study, the percentage of offenses

which were alcohol-related was reduced from 34% of total 1971 offenses, to 25% of 1972, 13% of 1973, and 7% of 1974 offenses.

Among those with sentences of 10 days or more, the number of alcohol-related offenses decreased by 38% between 1971 and '72, 49% between 1972 and '73, and there was a 1% decrease between 1973 and '74, indicating that the number of alcohol-related charges may be stabilizing.

This data suggests that the major impact of the Uniform Alcoholism Act has been in reducing the number of offenders who receive sentences of more than ten days; there has been virtually no change in terms of alcohol-abusers serving very short sentences. Correctional centers are still serving as a primary resource for detoxification.

IV. Alcohol/Drug Use and Violent/Nonviolent Crime:

Data gathered as part of the program evaluation of the Eagle River Correctional Center provides further information concerning the relationship between alcohol use and crime. This is self-report data from a group of 103 inmates with sentences of six months or longer, awaiting classification in the maximum security unit of the Eagle River Correctional Center. These offenders completed a self-administered version of the California Base Expectancy, which includes items on alcohol and drug use. (Items concerning drug use were added after 39 individuals had already completed the Base Expectancy; drug use information is therefore available on 64 offenders.)

Of the sample of 103, 52% had committed violent crimes, and 84% reported that they had been drinking at the time of their offense. Among the 54 individuals who had committed violent offenses, 85% report that they had been drinking; among the 49 who had committed nonviolent offenses, 84% had been drinking. The data indicates that alcohol use is equally associated with violent and nonviolent crime; there was virtually no difference between racial groups in terms of either violence or alcohol use. Although the numbers are very small, there is a slight relationship between race and alcohol use on the day violent crimes are committed: 89% of violent crimes committed by Caucasians were accompanied by alcohol use, while 100% of violent crime by Natives and Blacks took place on a day when the offender had been drinking.

In the subgroup of 64 inmates who had answered questions concerning both alcohol and drug use, alcohol had figured in 56% of all offenses, and drug use in 36%. Alcohol use had occurred on the day of 73% of all violent crime, and 39% of nonviolent offenses. Drug use had taken place in only 18% of violent offenses, and in 55% of nonviolent crime. The use of both alcohol and drugs on the day of the offense was equally associated with violent and nonviolent crime. In this group, alcohol tended to be associated with violent crime, and drug use with crimes involving property theft.

The total group of 103 offenders were asked whether or not they had ever had a "serious" drinking problem. Answers were evenly divided, with 50% of the group reporting an alcohol problem. There

were striking racial differences, with 75% of the Natives, 47% of the Caucasians, and 17% of the Blacks reporting that they had had a serious problem.

Of the 64 who answered questions about drug use, 31% reported having experienced a serious problem with drugs. By race, 37% of the Caucasians, 42% of the Blacks and 13% (two individuals) among the Natives reported drug problems.

It is easy to question the veracity of responses to these questions, since the inmates' replies are not validated by other data. The racial differences, however, seem to confirm that the answers are truthful. Alcohol is much more available than drugs within the Native population of the state, and drinking is more socially acceptable than drug use. Further, alcoholism programming, education and interest has tended to focus on the highly visible Native alcoholic, with less impact on Caucasians and Blacks. On the other hand, drug use is more socially acceptable in the Black culture; as a Black inmate says, "It's considered cool to be on drugs."

In summary, our data supports the following conclusions concerning Alaskan offenders:

1. As expected, there is a strong relationship between alcohol use and crime.
2. The proportion of Native offenders in the correctional system far exceeds their presence in the general population of the state. The proportion decreases, however, in groups composed of those with progressively longer sentences. Natives are, thus, more involved in minor offenses than in more serious crime.

3. The major impact of the Uniform Alcoholism Act has been in reducing numbers of those with alcohol-related offenses serving sentences of ten days or longer. Corrections still plays a major role in detoxification, and in housing nuisance offenders.

4. When releases (of those with sentences of ten days or longer) are compared for the years 1971 through 1974, there is a striking decrease in proportion of Natives to Caucasians. Although this is partly due to the effects of the Uniform Act, the major cause can be attributed to a sharp rise in number of Caucasians.

5. In a sample of offenders with sentences of six months or longer, alcohol use was associated with 84% of all offenses, 85% of violent crime, and 84% of nonviolent crime. The relationship between drinking and violence did not differ among racial groups.

6. There are striking differences among racial groups in response to the question, "Have you ever had a serious alcohol problem?" Seventy-five percent of the Natives, 47% of Caucasians, and 17% of the Blacks reported a problem. In contrast, 42% of the Blacks, 37% of Caucasians and 13% of Natives reported having had a drug problem.

References

Office of Vocational Rehabilitation, Alaska Department of Education, A Survey of Public Offenders in Alaska, May, 1970.

Office of Alcoholism, Alaska Department of Health and Welfare, A Survey of Public Offenders II: A Comparison of Ethnic Groups, July, 1970.

Division of Corrections, Alaska Department of Health and Social Services:

- a. Misdemeanant Probation Project: Evaluation of First Project Year, February, 1975.
- b. Sentencing Study (1974).
- c. Recidivism, 1971-1974.

National Advisory Commission on Criminal Justice Standards and Goals, Corrections, Washington, D.C., 1973.

Alaska Judicial Council, Sentencing in Alaska, March, 1975.

CP-303

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19 V

THIS IS A DRAFT

CASE,

VILLAGE LAW

PROPOSALS

Prepared by: David S. Case
Staff Director
Bush Justice Implementation
Committee

Prepared for: Judge Roy Madsen
Judge Nora Guinn
Magistrate Sadie
Neakok
Magistrate Roswell
Schaeffer

Date: 1 July 1976

INTRODUCTION

On June 4, 1976, Judge Roy Madsen, Judge Nora Guinn and Magistrate Ross Schaeffer met in the chambers of the Alaska State Judicial Council for a conference on village law. The purpose of the conference was to develop proposals for administrative, judicial and legislative changes which would enable village governments to better enforce their own ordinances without unnecessary reliance on "outside" services. The conference was sponsored by the Bush Justice Implementation Committee of the Alaska Federation of Natives and grew out of a discussion members of the committee staff had early in 1976 with Robert Boocheever, Chief Justice of the Alaska Supreme Court. The conference was funded by a grant from the Alaska Humanities Forum.

The conferees met in the chambers of the Alaska Judicial Council in Anchorage, Alaska during the morning and afternoon of June 4, 1976. During the course of these discussions, the conferees covered a wide range of subjects including treatment of juveniles in the bush, development of local village ordinances, development of local alternatives to usual court processes, village recommendations on sentencing, establishment of municipal judges and a trial court administrator for rural areas. Specific proposals were developed for (1) Binding arbitration as an alternative to court process (2) Involvement of the village council in sentencing decisions (3) Development of municipal judge-ships in areas which are not served by magistrates and (4) Establishing a trial court administrator for rural courts. The conferees requested that these proposals be reworked in written form for their further consideration. That is the purpose of this paper.

I VILLAGE LEVEL ARBITRATION

This proposal is based on the Alaska Uniform Arbitration Act (AS 9.43.030) and would make binding arbitration an alternative to a court trial for violation of state misdemeanors or city ordinances.

Under this proposal, arbitration would occur after arrests for misdemeanors or violations of a city ordinance. The defendant would have to be brought before a magistrate or other judicial officer and advised of his rights--including the right to arbitration. If the defendant and the victim would both sign a consent to arbitration of the dispute, and if the local district attorney would also consent to the arbitration, then the defendant and the victim could arbitrate their dispute. If arbitration was available, up to three people could be selected (preferably from the village where the dispute arose) to arbitrate the problem. It was suggested that the arbitrators could also be members of a conciliation board.

After arbitration was complete, the arbitrator's decision would be referred back to the magistrate for approval and filing with the court. It was also suggested that the arbitrator could be appointed as a special master to the court with a magistrate or other judicial officer reviewing the arbitration finding much as is done in Superior Court today.

The arbitration could specify restitution or any of a wide variety of requirements for the victim and the defendant. Since the finding would be filed with court and become the subject of a court order, any violation of the arbitration agreement would be a violation of a court order. If the defendant repeated his conduct, the court would have a record of the previous arbitration and would be able to take that fact into consideration in future adjudication.

A. Rationale: The conferees see arbitration as a step between conciliation and full court proceedings. Conciliation (as in the court's conciliation board project) occurs prior to arrest and therefore there is no need to advise the potential defendant of any constitutional rights. Arbitration would be an alternative both to the conciliation board and full court proceedings. Arbitration would be used in the case of more serious misdemeanors and violations of city ordinances and would occur only after arrest. The conferees concluded that there had to be local alternatives to a full court proceeding after a village defendant was arrested. They also concluded that arbitration would put "more teeth" in the conciliation boards themselves.

B. Implementation: The conferees concluded that village level arbitration could only be implemented after amendments to municipal codes, state laws, and the criminal rules. It is possible that the Uniform Arbitration Act as it now stands is sufficient to permit arbitration as a matter of state law. However, it may be necessary to amend certain judicial jurisdictional statutes to permit magistrates to order binding arbitration. The arbitration process would have to be clarified through more specific court rules than now exist and would also have to be included within municipal statutes for the purposes of arbitrating violations of those local ordinances.

Payment of the arbitrators is another requirement for effective government implementation. It was suggested that either the state or the parties should pay for arbitration. State payment was favored as the conferees thought that arbitration would result in lower court case loads and therefore benefit the state court system.

It was also suggested that the summons or citation system could be used in lieu of arrest in cases where there was no need to take the offender into custody for his own or society's protection.

C. Remaining Questions: Whether or not juvenile matters could be fitted into the arbitration proposal seems to be an open question. The conferees felt there was a need for alternatives such as arbitration in the area of juvenile offenses.

Availability of magistrates might pose another problem. Some areas of the state (near Kotzebue, Kodiak, etc.) have ample numbers of magistrates for effective arbitration proceedings. Other areas (such as the lower Yukon-Kuskokwim) do not have magistrates in many of their villages. Absence of a magistrate means there is no decision making authority to send the case to arbitration even if the defendant and the victim wish it.

II SENTENCING PROPOSAL

Based on their own experiences as judicial officers, the conferees felt a need for more involvement of the village council in sentencing of village offenders. The feasibility of this proposal seems to rest on the wide discretion of a judge where sentencing matters are concerned. Judge Guinn noted that she relies on the village council all the time to make sentence recommendations. Magistrate Schaeffer indicated that one way to involve the council in sentencing was to suspend imposition of sentence contingent on the guilty party following the council's recommendations. It was also suggested that, if the defendant were found guilty by a magistrate or a judge it might be possible to return the defendant to the village council for sentencing.

The conferees concluded that valuable flexibility would be added to the system if a judge (in the absence of a presentence report) could impanel an advisory body to assist in sentence determination. The advisory body could be the village council or some other appropriate group of persons.

A. Implementation: Adoption by court rule of a procedure permitting impaneling of an advisory body to assist in sentence determination in the absence of a presentence report.

III MUNICIPAL JUDGE PROPOSAL

This proposal would create a lower level of judges (below present magistrate) who would hear only cases involving violations of village ordinances. The decisions of the municipal judge would be reviewable by either a district court judge or a magistrate. To satisfy certain due process requirements, the municipal judge's decisions would be reviewable by either a district court judge or a magistrate. To satisfy other due process requirements, the municipal judge would be able to impose only a minimum fine (perhaps limited to \$100) and would have no jurisdiction to impose jail sentences or to withdraw valuable licenses. The municipal judge, as with all state judges, would be required to abide by unified court-system rules, and would in fact be a part of the unified court system. The proposed municipal judgeships would be available to those communities which do not qualify for magistrate services. Alternatively, it was suggested that magistrate posts could be created in small villages wherein the magistrate would have power only to accept guilty pleas for violations of state statutes or to hold hearings on violations of municipal ordinances.

A. Rationale: The conferees thought that the municipal judgeships would fulfill the promise of administrative rule 41(b) which states that magistrates should fill the judicial needs of political subdivisions if no district judge is stationed in or near those subdivisions. The fact is, many of Alaska's second class cities are without any ongoing judicial presence. If these communities do not qualify for state supported magistrates, then the conferees believe the state has an obligation to at least support a local judicial presence in such villages. It was also felt that state recognized, local judicial officers would provide an education in self government to the communities in which they reside. Finally, the presence of a judicial officer to handle violations of local ordinances would save the exorbitant transportation costs now required to arraign people even for misdemeanors committed in remote villages. Judge Madsen recited one recent incident where two defendants were flown from Nulato to Kodiak for an arraignment and then had to be flown back to Nulato again.

B. Implementation: Implementation of the proposal would require an amendment to administrative rule 41 as well as to the statutory jurisdictional statutes in order to create a lower level judgeship. The conferees felt that the municipal judges would not have to be paid but would rather serve the village as council members serve the village. The municipal judge would, however, have certain fringe benefits including court sponsored training and the like. Finally, the conferees concluded that the municipal judge should be appointed only on recommendation of the involved city council to the appropriate presiding judge.

C. Remaining Problems: The power of the proposed municipal judge to handle juvenile matters needs to be more fully explored.

Since the municipal judge would serve only those communities that do not have magistrates, there would be no conflict or inconsistency between arbitration and the municipal judge's activities.

IV RURAL TRIAL COURT ADMINISTRATOR

The conferees recommended that a separate trial court administrator position be established to service only rural courts. The rural court administrator would be responsible for administration and development of all rural courts and would be subordinate to the Administrator of All Courts.

A. Rationale: Conferees believe that the three trial court administrators in Anchorage, Fairbanks and Juneau have their hands full with the problems of their immediate courts. The problems affecting bush courts are unique and demand the special attention of a full time administrator.

B. Implementation: Court administrative policy should be revised to include a position for a rural court administrator and funding sought from the Alaska legislature.

V POSSIBLE FUTURE TOPICS

A. What statutory, court rule or administrative changes must be implemented to permit greater village involvement in the disposition of juvenile matters?

B. What are the judicial service needs of Alaska's unincorporated communities and do these proposals meet those needs?

Drinking occurs in homes

Athabascan Drinking

The single largest problem that affects the health and well-being of Alaskans involves the use and abuse of beverage alcohol. In 1972, the per capita consumption for Alaskans 15 years of age or older was 5.06 gallons of distilled spirits, 2.93 gallons of wine and 27.87 gallons of beer. A recent study by the State Office of Alcoholism indicates that in fiscal year 1976 alcohol related costs accounted for \$17,807,200 in expenditures from the General Fund.

In the following article, Mr. Brelsford describes the systemic properties of alcohol distribution and consumption in an Alaskan Athabascan village. In so doing, he focuses on a cultural, as opposed to a medical or psychological, dimension of alcohol use in order to help us understand the social context in which drinking takes place. In most small scale societies or communities the ingestion of chemical substances, like alcohol, is used to expose tensions that grow slowly between individuals who live in close and constant contact. It also provides an occasion around which to establish, affirm, or break off social relationships. This article illustrates aspects of these processes as well as describing the economic network that exists to provide beverage alcohol to a "dry" community.

Gregg Brelsford is currently Health Director of the North Pacific Rim Native Corporation, the non-profit organization serving the Chugach Region Aleut people. Mr. Brelsford is a graduate of the University of Alaska, Anchorage, and is trained in both Community Mental Health and Cultural Anthropology. He trained at Adams County Community Mental Health Center and Fort Logan State Hospital in Denver, Colorado, and has done field work in New Mexico, Arizona, and Alaska. He has resided in Alaska for five years.



ng Behavior:

by Gregg Brelsford

A Preliminary Ethnography

This information was gathered in an Athabascan village in rural Alaska between April 1974 and June 1975. During this time I was employed by this village as a mental health worker, and spent an average of two days and nights per week in the village for the duration of a year.

The identity of the village in this paper will remain anonymous. Toward this end, the descriptive information concerning this village will be kept general, the behavioral information, however, will be specific.

The purpose of this paper is twofold: (1) to demonstrate the cultural dimension of drinking behavior, as illustrated in this particular village, and (2) to partially address what Dorothy Hones, in referring to the attitudes of "white run alcoholic rehabilitation centers," accurately describes as "little awareness of cultural differences in the meaning attributed to drinking... in many Native villages" (Jones 1976:40; see also Kunitz and Levy 1974a: 246). This cultural dimension is to be distinguished from the medical and psychological dimensions, i.e., the disease, and the stress-coping models of drinking behavior. This is not to repudiate the medical or psychological models, but rather to demonstrate the broader context within which they occur.

A quick review of the literature will place this research with the context of similar efforts of this kind. To my knowledge, there are only 3 articles published on the drinking behavior of Alaska Natives generally; none of which directly addresses Alaskan Athabascans. Two of these articles are statistical (Knisley 1972; Foulks and Katz 1973). The third (Berreman 1956) genuinely describes Aleut drinking behavior and dates from 1956. With regard to non-Alaskan Athabascan drinking behavior, Honigsmann and Honigsmann (1945) have written about Canadian Athabascan drinking, and recently, attention has been devoted to Mescalero Apache (Curley 1967), and Navaho (Kunitz 1970; Kunitz and Levy 1975a,b) drinking patterns.

To demonstrate the cultural dimension of drinking behavior, the following definitions will be used throughout this paper. My operational definition of culture is the system of rules by which behavior

is arranged and organized and the rules by which meaning (values and beliefs) is assigned to these arrangements of behavior. Ethnography simply means the description of a culture. A system is "a regularly interacting or interdependent group of items forming a unified whole" (Webster's 7th Collegiate). Drinking behavior is any behavior directly associated with the consumption of alcoholic beverages. This paper, then, will describe the system of drinking behavior present in this rural Alaskan Athabascan village. The three aspects of this system focused on here will be: (1) the source of alcohol; (2) the patterns of consumption, and; (3) the drinking behavior itself.



At the time this information was gathered, Village X had a population of approximately 270, an active Russian Orthodox Church, a K-12 school, a Native store, a community center, a youth recreation hall, and a medical-dental clinic. There was no liquor store or bar, and no police. The village is relatively isolated and can be reached primarily by charter plane. Internally, however, it does contain a number of automobiles and trucks, and a small road system.

Economic activity is primarily seasonal, with most of the village involved in commercial and subsistence fishing. Year round employment is available at a nearby industry to any who desire it, or who can endure the inequitable management practices. A few other jobs are available with the village itself, the recreation center, a community services organization, the store, a day care center, and the school.

It is not known how long alcohol has been present in Village X. The earliest recorded plausible reference I could locate is drawn from the report of the Russian Orthodox Missionary Hieromouk Nikita to Bishop Nestor, Number 7, April 27, 1882:

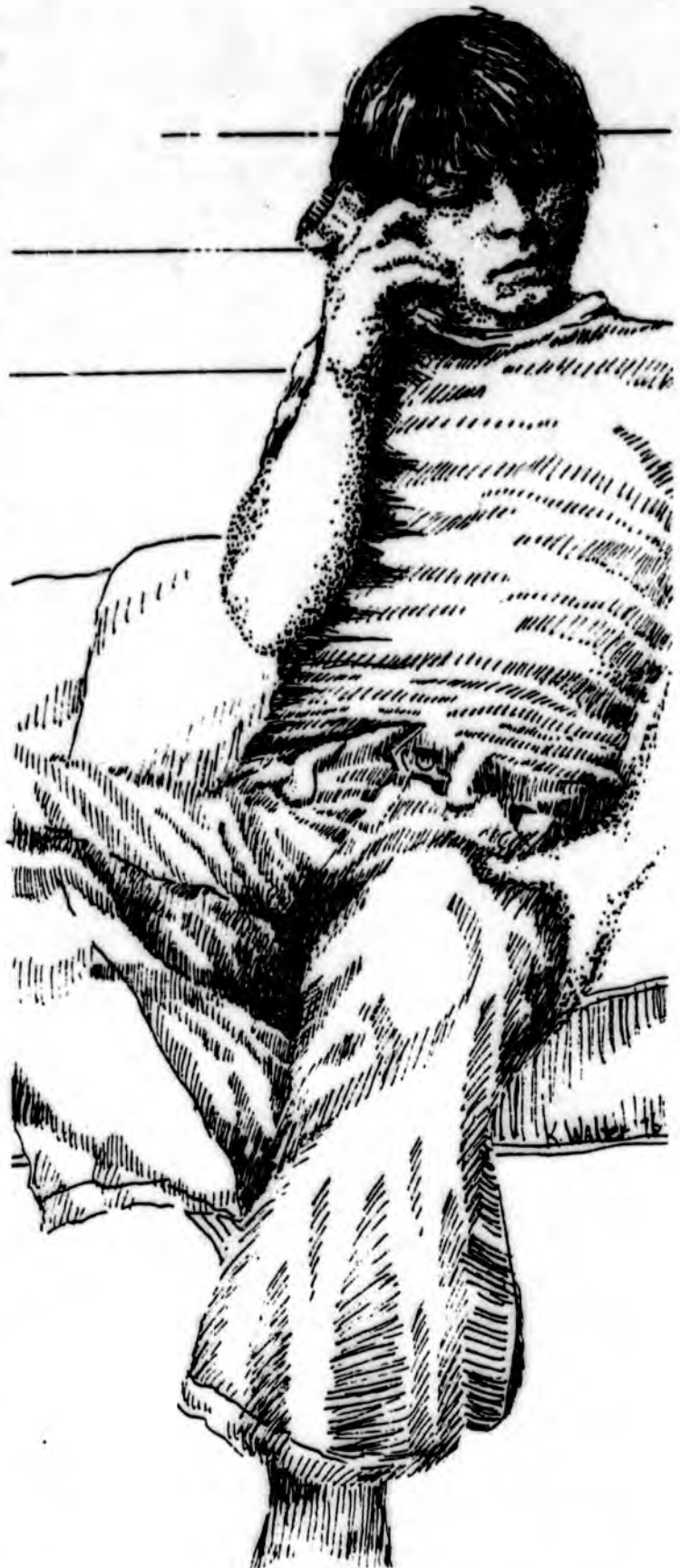
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top: Commissioner of Administration Andrew Warwick, a member of the Governor's Task Force on Corrections, delivering the commencement address.

center: Following the ceremony, the graduates received members of the Academy staff and visitors. There were a lot of smiles in that reception line; bottom left: Officer Michael Wehrer receives special awards for physical fitness and academic excellence from Director William Huston; bottom right: And yes, there was a party that night.



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It is not known how long alcohol has been present in Village X. The earliest recorded plausible reference I could locate is drawn from the report of the Russian Orthodox Missionary Hieromouk Nikita to Bishop Nestor, Number 7, April 27, 1882:

"Drunkenness is the chief vice of the aborigines. Because of the lack of good grain alcohol, they make their liquor from flour fermented with sugar in stills made of gasoline tins and distill it through a rusty gun barrel. The smell of such a drink is repelling." (Townsend 1974:13)

I am certain, however, that alcohol was present at least by the time of the first Russian contact over 100 years earlier (informant: 7-17-74).

Source of Alcohol

Because the village is legally dry, and relatively isolated, there are no commercial liquor outlets present or nearby. "Home brew" is virtually nonexistent. Only two elderly men brew their own, in spite of the fact that it is vastly cheaper. This means almost exclusively that alcohol arrives on the small planes that serve the village.

The primary air service serving Village X estimates that it transports minimally the following amounts of alcohol to the village every month (quantities shown are correlated with their costs as priced at an Anchorage retail liquor store): 15 cases of liquor (12 fifths per case; Calvert whiskey at \$63.48 per case), \$952.00; 4 cases Port Wine (12 fifths per case; Italian Swiss Colony Red Port at \$18.60 per case), \$75.00; and 10 cases of beer (Olympia, 12 ounces, at \$8.55 per case), \$85.00. This is a total of \$1,112.00 per month. These are minimal figures and are utilized merely to provide a point of reference. It is my impression, and that of many villagers, that alcohol consumption fluctuates in terms of this reference point at different times of the year (end of fishing season, Christmas, etc.). Also, in addition to the above carrier, there are three others that regularly serve Village X, and it must be assumed that they are also transporting alcohol to this village.

The act of flying to a liquor outlet and returning to the village with alcohol is known in the village as a "round trip" or "R.T." The air fare alone for this is \$72.00 total. Though I do not know the amount of alcohol generally purchased on a "round

trip", I have personally helped unload five cases of beer and two cases of whiskey from one "round trip" and had the impression that this was a large run.

"Round trips" tend to be spontaneous rather than planned or organized. A run is generally made only for enough liquor to satisfy immediate desires, requiring another run, plus air fare, when that supply is consumed. One individual made a "round trip" on three consecutive days. He purchased a total of \$216.00 in air fare, for a total expenditure of \$407.00. I do not imply that this individual drank all of this himself, or that this reflects the normal drinking pattern in this village. It does, however, indicate somewhat the degree of expenditure occasionally made.

It is easy to see why the primary air carrier for the village is just that, the primary carrier. Not only is its attitude regarding carrying alcohol very liberal, but it allows the air fare to be charged on account. The only cash required for a round trip, therefore, is money for the cab and the price of the liquor. For example, the cash required for the above mentioned three day expenditure was closer to \$190.00, rather than the entire amount of \$407.00. This is a key factor in this system. This "charge account" arrangement implicitly supports and maintains the system of drinking in this village by maintaining relatively easy access to alcohol. It also probably maintains the spontaneous nature of the "round trip" because the additional costs of plane fares are not immediately experienced in connection with the purchase and consumption of the liquor.

Patterns of Consumption

We turn now to the second element of the drinking system in Village X, the patterns of consumption. This discussion will include descriptions of the patterns themselves, the drinking group, and frequency and duration of consumption.

Description of Patterns

Once the alcohol arrives in the village, it is loaded

into cars or pick-ups. Rarely is it left to sit at the airstrip. This seems to be more due to concern for protecting one's goods than concern for getting caught.

The patterns of consumption of alcohol appear to be functions of 4 elements, and the relations between them. These elements are: (1) location; (2) time of day; (3) age; and (4) sex.

Alcohol consumption in Village X is essentially private in nature. It occurs primarily in private homes or private vehicles such as cars or trucks. No drinking was observed in fishing boats or on snow machines.

Drinking in vehicles occurs as early as late afternoon, but primarily in the evening and night. The vehicle may be parked in an isolated area, but for the most part is done while driving along the village roads, talking and listening to the radio. This is practiced only by the teenagers and young adults up to approximately age 30.

In private homes, drinking may occur during any time of the day or night. The kitchen and living room seem to be the location of most drinking activity (reinforcing the idea of the "social" nature of drinking in this system), with some drinking also occurring in bedrooms. All age groups engage in drinking in private homes. The pre-adolescents and early and middle teenagers drink covertly, as they are not explicitly allowed to drink by the adults. This restriction appeared not to be an issue of legality or morality, but an economic one, i.e., not "wasting" a valuable commodity on someone not likely to (be able to) reciprocate.

Age, therefore, is apparently a significant factor in determining the location of where alcohol is consumed. The young adults and late teens drink both in homes and vehicles, whereas the adults (approximately 30 years plus), middle-aged, and elderly drink exclusively in private homes.

As noted above, drinking activity is essentially private in nature. Alcohol is never consumed, as part of the group activity, at public gatherings, whether business or recreational. People may attend while intoxicated, withdraw temporarily to

drink and return, or occasionally even take quick, hidden, pulls on a bottle, but none of this is done as part of the group activity. The one exception to this which I observed was a religious activity—starring. Starring is a Russian Orthodox custom at Christmas in which the village gathers together (in this case, mostly small children up to older teenagers) and visits each house singing Christmas songs and prayers. As the group arrives at each house in turn, the host offers them refreshments, including alcoholic beverages. This is done in an atmosphere of festivity and celebration. Even the youngsters are allowed to participate in the drinking, though somewhat ambivalently, by the adults.

Another exception to the essentially private nature of drinking here, is the minor degree of drinking which occurs openly while the person is walking on the streets in the village. This is done only by the young men, approximately 19-27 years old. Walking the village streets while intoxicated (walking, but not consuming alcohol) occurs with low to moderate frequency, and is also done only by males. Someone will occasionally pass out on the side of the street, although this is very rare. This person is generally left where he is if he is in no danger. This also occurs only with males and is apparently nonexistent in winter.

The Drinking Group

Drinking in Village X is a social activity. It is the only time that as many people get together, as often as they do, for as long as they do. I did not hear of, or observe, a single instance of substantive drinking in isolation. Whether it occurs in a home or vehicle, whether the age of the person is 8 or 80, and whether the number of companions is one or ten, drinking occurs only with other people.

In the drinking group, no restrictions are placed on the amount of alcohol a person may consume, except as conditioned by the quantity available, and the person's credit. When the supply and credit are unlimited, so is the freedom, and expectation, to consume. Under these conditions, even persons known to become violent are allowed unlimited access to alcohol.

Though not documented, it appeared that membership in a specific drinking group was determined either by kinship or an individual's ability to reciprocate and contribute to the alcohol supply of the group. This reciprocity could extend over a long period of time and was not necessarily limited to the immediate moment. This is supported by my observation of the exclusion of some adults on the basis that they were consuming more than their share (3-14-74). This perspective would also explain the exclusion of children on an economic basis rather than a moral or legal one. The costs involved in obtaining liquor have already been demonstrated; it simply is not economically sensible to sacrifice your alcohol to someone who has little potential for, or history of, reciprocity.

Frequency and Duration

Though I have no empirical statistics in this area, I do have many references to individual drinking activity in my notes. These references cluster together in two ways: days of the month and months of the year. The first cluster occurs primarily between the 4th and 14th day of each month. This corresponds roughly with the arrival of various agency support checks. The second cluster occurs in June, July, and August, 1974, and January, February, and March, 1975. The summer cluster corresponds very roughly with fishing season, and the latter cluster included Russian Christmas, as well as the coldest months of the year. Drinking activity was high in May, 1975. This corresponds with Russian Easter (5-5-75) and tax refund checks.

Drinking is intense when it occurs but the duration is irregular. An individual may drink for one evening or for three weeks. The same person may evidence both of these extremes at different times, and apparently alcohol supply is not the only factor determining this range in duration.

Drinking Behavior

Drinking behavior itself is the third element in the drinking system of Village X. This discussion will include a description of concrete drinking behavior, intervention into this behavior, and the role of the young in the system of drinking behavior.

Description of Drinking Behavior

Drinking is a process of consuming cumulatively increasing amounts of alcohol. This results in an increasing degree of intoxication. The process of intoxication in Village X may best be conceptually represented by a continuum. This continuum ranges from sober to extremely or profoundly intoxicated. Movement along this continuum may be measured behaviorally, rather than chemically.

When sober, the person is circumspect. He or she is quiet, reserved and contained. He may be distantly friendly, polite, or cold, depending upon his relationship with you. Joking and card playing occur, but with indirectness and restraint. Personal appearance and home interiors are orderly and well kept.

When mildly to moderately intoxicated, composure "relaxes". The person may become warm, jovial, generous, affectionate, talkative, and expressive. People are quick to joke and laugh, and motor activity may become heightened; often there is much card playing, or walking or riding around the village. Homes and personal appearance are left unattended and become somewhat disheveled.

Extreme intoxication may be represented by violent, destructive, hostile, aggressive, or belligerent behavior. Threats and challenges may be exchanged. Withdrawal may substitute for violence or aggression in middle-aged to elderly males. Eventually, in every one, cognitive and motor ability becomes reduced, movement and speech become slow, and thoughts are difficult to organize. Personal appearance becomes very disheveled and home interiors become very disorderly and unkept.

Perhaps most characteristic of the Village X drinking process is that once begun, this process of intoxication is pursued to its full completion. Once drinking has started, it is not terminated until the person has moved through the entirety of the drinking behavior continuum, or the supply is exhausted. I have often observed people support another person's progress along this continuum

knowing that the outcome not only would be violence and aggression, but that they, themselves, may be the target.

Intervention

Intervention occurs into the drinking behavior as distinguished from the process of intoxication. Intervention was avoided and withheld as long as possible, and occurred only in the face of physical danger (this is consistent with the traditional Athabascan respect for the independence of the individual). When intervention did occur, the violent behavior was the focus of the intervention, not the drinking. Physical aggression was restricted, but not the drinking which preceded it. Even after a violent episode, once the violent person had calmed down, he was allowed to continue or resume drinking, until such time as he presented another unavoidable threat.

Intervention would occur when a person became so aggressive as to present an apparent serious threat either to his own safety or that of others. The form that this intervention took seemed to be determined by sex roles. Women would attempt to intervene if overt, physical aggression appeared imminent, but had not yet occurred (The aggressor referred to here is always a male. With the exception of two teenage girls, I never observed active physical aggression on the part of women.). Female intervention would take the form of reasoning, persuading, physical restraining efforts, and threats, both joking and serious. A male could respond to female intervention without losing face; whereas male intervention of this type would merely intensify the aggression, or cause the male intervenor to appear feminine. Males would intervene if actual physical aggression, beyond the limits tolerated by the group, was occurring. Male intervention took the form of physically separating the combatants and trying to persuade them to cool down. This type of intervention was the last resort and used only when a safety issue was involved; the degree to which safety was an issue determined the degree of intervention. Females, primarily, but males also, would remove the potential weapons (knives, guns, scissors, etc.) when it appeared that the safety of the individual or the group was at risk.

Role of the Young

Children are a significant factor in the drinking system in Village X. When the parent may become incapacitated through intoxication, the children maintain and manage the household. Older siblings feed, clothe, and care for younger siblings, protecting them from neglect. They possibly take care of the helpless parent (s), and occasionally protect the family from the violent outbursts of the drinking parent. Under drastic conditions the children may leave the home and stay with relatives or friends temporarily.

Children also occasionally assist with the preparations for drinking. I observed three boys, ages 10, 14, and 14, loading and unloading alcohol from a car trunk to a kitchen, and heard the owner instructing them as to where and how to hide and protect the liquor. Having assisted with, or observed, the preparations for a party, the youngsters then wait for the drinking activity to begin. When alcohol is left unattended, or the adults are too intoxicated to care, they take full advantage of their opportunity to indulge. When the party (and hang overs) is finished, the children also assist in the clean up of the house. This assistance is rendered whether or not the youngsters engaged in the drinking.

Effects of Drinking

While it is difficult to demonstrate cause-effect relationships between drinking and certain events, a number of correlations may be identified in which alcohol is a present factor. These correlations include employee turn over, family discord, aggression, and deaths.

Of the villagers that are employed, employee turn-over in which alcohol is believed to be a present factor is 80%. This figure is the estimate of various members of the village council and other members of the village. With regard to marital and family discord, I am aware of two young women, each having one child, who have left their husbands because of their drinking. There are other cases of family breakdown in the village in which alcohol is present.

Aggression was not always present with alcohol, but alcohol was always present with aggression. The only fighting among men that I observed always included the presence of alcohol, as did the one instance of fighting among two teenage girls.

As determined from conversations with two members of the village, alcohol is believed to be present in the majority of deaths occurring in the village. This particularly holds true for violent deaths, such as shootings, drownings or snowmobile accidents. Approximately 10% of the village population (about 27 people) have died in the past 13 years. Of these, 40% were violent and were known or strongly believed to have alcohol as a present factor. If the cases of violent death in which the presence of alcohol is questionable are included, the figure becomes 60%.

Conclusion

This paper has described social systemic aspects of drinking behavior in one rural Athabascan village in Alaska. It has shown that drinking behavior is patterned systemically; and that implicit rules (and values) prescribe how alcohol arrives, how it is managed, and when, where, and by whom it is consumed. Though touched on only slightly here, economic, social, and religious factors in the drinking system were also identified.

This system of drinking behavior is powerful and pervasive. It ranges from the socialization of children to expressions of what it means to be a man or woman in this village at this time. Additionally, this system is supported by economic, social, and religious factors. All of these aspects together constitute what I call the cultural dimension of drinking behavior. This cultural dimension must be acknowledged; particularly by alcohol rehabilitation programs that aspire to be seriously effective. And not only is acknowledgement necessary, but also integration of this perspective with the medical and psychological models of drinking if we are to achieve a genuinely adequate understanding of drinking behavior.

1. Berreman, G.D., *Drinking Patterns of the Aleuts*, *Quarterly Journal of Studies on Alcohol*, 17: 503-514, 1956.
2. Curley, R.T., *Drinking Patterns of the Mescalero Apache*, *Quarterly Journal of Studies on Alcohol*, 28:116-131, 1967.
3. Davis, N.Y., *Toward Understanding Cultural Diversity and Its Relation to Drinking Behavior*, Unpublished Manuscript, Anchorage, Alaska, 1973.
4. Foulks, E.F. and Katz, S.J., *The Mental Health of Alaskan Natives*, *Acta. Psychiat. Scand.*, 49: 91-96, 1973.
5. Honigmann, J.J. and Honigmann, I., *Drinking in an Indian-White Community*, *Quarterly Journal of Studies on Alcohol*, 5: 575-610, 1945.
6. Honigmann, J.J. and Honigmann, I., *Eskimo Townsmen*, Ottawa: Canadian Research Centre for Anthropology, 1965.
7. Horton, D., *The Function of Alcohol in Primitive Societies: A Cross Cultural Study*, *Quarterly Journal of Studies on Alcohol*, 4: 199-320, 1943.
8. Jones, D., *The Urban Native Encounters the Social Service System*, Institute of Social, Economic, and Government Research, Fairbanks: University of Alaska, 1974.
9. Knisley, E.R., *Native Alaskan Indians, Eskimos, and Aleuts, and Their Drinking Habits*, State Office of Alcoholism, Fairbanks, Alaska, Proc. 30th International Congress on Alcoholism and Drug Dependence, 1: 42, 1972.
10. Kunitz, S.J., *Navaho Drinking Patterns*, Ph.D. dissertation, Yale University, University Microfilms No. 70-26-174, 1970.
11. Kunitz, S.J. and Levy, J.E., *Changing Ideas of Alcohol Use Among Navaho Indians*, *Quarterly Journal of Studies on Alcohol*, 35: 243-259, 1974a.
12. Kunitz, S.J. and Levy, J.E., *Indian Drinking: Navaho Practices and Anglo-American Theories*, New York: Wiley, 1974b.
13. MacAndrew, Craig and Edgerton, *Drunken Comportment*, Chicago: Aldine Publishing Co., 1969.
14. Price, J., *An Applied Analysis of North American Indian Drinking Patterns*, *Human Organization*, 34:1: 17-26, 1975.
15. Shore, J., et. al., *Three Alcohol Programs for American Indians*, *American Journal of Psychiatry*, 128:11: 134-138, 1972.
16. *Medicine Column*, *Time Magazine*, January 19, 1976.
17. Townsend, H., *Journals of 19th Century Russian Priests....*, *Arctic Anthropology*, XI-1: 1-30, 1974.
18. VanStone, J.W., *Athapaskan Adaptations: Hunters and Fishermen of the Subarctic Forest*, Chicago: Aldine Publishing Co., 1974.
19. Wolff, P.H., *Ethnic Differences in Alcohol Sensitivity*, *Science*, 175: 449-450, 1972.

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DESCRIPTIVE ANALYSIS OF THE IMPACT OF ALCOHOLISM AND
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(FIVE VOLUMES)

Volume I

THE ECONOMIC IMPACT OF ALCOHOLISM AND ALCOHOL ABUSE
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Final Report

January, 1977

Prepared by

Analysis of Alcohol Problems Project
Dennis Kelso, Ph.D.
Project Director

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State Office of Alcoholism
Robert L. Cole, Coordinator
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- Volume III Alcoholism and Alcohol Abuse Programs, Services
 Delivery Systems, Alaska, 1975
- Volume IV Social Systems Indicators of Alcoholism and Alcohol
 Abuse in Alaska, 1975
- Volume V Executive Summary: Descriptive Analysis of the Impact
 of Alcoholism and Alcohol Abuse in Alaska, 1975

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FOREWORD

There is no topic in Alaska more familiar, more controversial, and simultaneously more opaque than alcoholism. Almost as if the problems and concerns associated with it were an intrinsic part of the Alaskan experience, everyone seems to have something to say about it. Newspaper articles and radio talk shows debate public drunkenness. Political campaigns are waged, promising greater priorities for the alcohol problem. Even the national wire services carry stories dubbing alcoholism "the bane of Alaska." From the person on the street, to merchants and city councils, to the most specialized of government and health officials--everyone seems to agree that alcoholism and alcohol abuse constitute the greatest human problem facing the state.

In short, there is no shortage of opinion in Alaska about alcoholism and alcohol abuse. In point of fact, however, there is precious little else except opinion. Theories abound as to the causes of problem drinking. Definitions of the very nature of the "problem" are as numerous as the dozens of State agencies, officials, organizations, and interest groups created (or simply compelled) to deal with it. Concerning what to do about it, feelings range all the way from simple apathy, to lip-service, to honest concern, to almost ideological fervor operating at the limits of reason. This is not to say that the public concern is in error: it is not. It is instead to say that, without foundation, not much can be done to seriously respond to that concern.

For so volatile and perduring a problem, there has been in Alaska virtually no significant statewide research to date. What research has

been conducted, has been fragmentary and poorly disseminated. Most often, as well, it has largely been based on concepts and models transplanted from other, inapplicable regions of the country. In all cases, such research has confined itself to a single problem or single aspect of a problem. Never, in other words, has an attempt been made to comprehensively conceptualize the problem in terms of all its major manifestations and attendant effects. By no means is this a denigration of any prior research efforts anywhere, for such was not their ambition. The time has simply come for a particular kind of undertaking: an integrated information and data base capable of addressing Alaska's alcoholism and alcohol abuse problems in all their important interrelationships.

The Analysis of Alcohol Problems Research Project, organized in September of 1975, began just such an undertaking. In response to the question of what (in its entirety) constitutes the problem of alcoholism and alcohol abuse in Alaska, the Project assumed as its province the full context of the intended and unintended consequences of the sale, distribution, and consumption of beverage alcohol in the state. Formally stated, the mission of the Project became the systematic collection of valid and reliable information for implementation of Alaska's Uniform Alcoholism and Intoxication Treatment Act. (The adoption of this act in 1972 essentially established policy for the State by decriminalizing public drunkenness and defining alcoholism as a public health problem.)

Throughout the Project, the nature of the research process was considerably less difficult to specify than the nature of the topic. With the health and medical services community exhibiting as much variance within its own ranks as between itself and the law enforcement or educational communities, little agreement existed as to how "alcoholism" and "alcohol abuse" should be defined. Considerable agreement existed, however, on the

fact that alcoholism and alcohol abuse impact the general public and the social system in a variety of ways. Alcoholism program client loads, child abuse, automobile accidents, alcohol-related crime, etc.--all became, from this perspective, equally valid and interconnected ways of looking at alcohol's impact on Alaskan society. In the same sense, they also thereby provided a composite basis for relating the many extant definitions of the problem (e.g., as a public health problem, mental health problem, criminal justice problem, child welfare problem, etc.).

For this reason, the Project took as its focus the measurable indicators of alcohol's impact on Alaska's social system, and on selected specific sub-systems: the economy, health and medical services delivery system, criminal justice system, et al.. The intention was not to be exhaustive, for such was impossible given the limitations of resources and time available for conduct of the study. Nor was the intention to be definitive, as the general paucity of useful information which plagues research efforts in Alaska made such a goal unrealistic. (In many cases, even basic information is not systematically reported or collected, nor kept in summary fashion.) Rather, the ambition was to develop a research methodology capable of being implemented at once, but also capable of being elaborated and refined on a continuing basis. Such an instrumentality, it was hoped, would serve the dual purpose of linking for the first time the several major areas (e.g., economic, legislative, programmatic, social, et al.) related to alcohol affairs in Alaska, and of constellating and grounding future alcohol-related research efforts in the state.

It should be said that such concentration on the collective effects of alcoholism and alcohol abuse was not intended to preclude genuine concern for the health and well being of individual alcohol abusers and their families. From the perspective taken, and because of the limitations

mentioned, it was not possible to address such highly relevant questions as whether alcoholism is a disease, addiction, defensive coping mechanism, etc.; or whether it derives from genetic transmission, learned behavior, cultural assimilation, or--in Alaska's case--a set of environmental factors so pervasive but elusive of description that it might quite unjokingly be called the "Arctic Factor". These remain, nonetheless, serious questions, and their omission had only to do with the fact that a need for the multiple-definition approach described above was considered more pressing.

The beginnings of this kind of multiple-definition approach are contained in the present report, Descriptive Analysis of the Impact of Alcoholism and Alcohol Abuse in Alaska, 1975. The title is preceded by the term "Working Papers" because this is the first time that alcohol-related information of this scope has been collected and put to use, and because a great deal more information is still missing. For these reasons, reaction to the content of the report is not only seriously invited, but regarded as indispensable. Only by such review and response, it is felt, will the efforts initiated by this project and report yield more complete and comprehensive information about the impact of alcoholism and alcohol abuse upon Alaskan society.

The five volumes of the report are described below:

VOLUME I : The Economic Impact of Alcoholism and Alcohol Abuse in Alaska, 1975

Volume I investigates and describes the economic impact on Alaska of alcoholism and alcohol abuse. Major goals of the volume include the identification and estimation of financial benefits deriving from the sale and consumption of beverage alcohol, and determination of the economic cost of alcoholism and alcohol abuse for the state as a whole. Findings and methodologies for each of the cost categories utilized are presented. Further, the absolute and relative magnitude of economic costs for each category are analyzed, then compared with corresponding estimates based on national findings. Finally, a separate part of the volume examines the fiscal revenues and expenditures for State government which are directly attributable to the sale and consumption of beverage alcohol.

VOLUME II : An Analysis of State Legislation Pertaining to Regulation and Control of Beverage Alcohol and Alcoholism and Alcohol Abuse, Alaska, 1975

Volume II identifies and analyzes all Alaskan legislative statutes and administrative codes which are in any way concerned with the sale and consumption of beverage alcohol, or with alcoholism or alcohol abuse problems. Analysis includes internal examination of all the statutes and codes, resulting in presentation of detailed summaries of each of the major provisions within a categorical structure developed in the process. (No such categorical listing or cross-reference system for alcohol-related legislation existed, previously.) Additionally, all identified statutes and codes are discussed and analyzed with respect to their consistency or inconsistency with policies and provisions set forth in the Uniform Alcoholism and Intoxication Treatment Act, the only available source of legislative policy for alcoholism and alcohol abuse. Throughout, analysis of the statutes and codes is cast within the context of existing, relevant federal legislation.

VOLUME III : Alcoholism and Alcohol Abuse Programs, Services Delivery System, Alaska, 1975

Volume III presents the findings of an analysis of the major elements of the alcohol services delivery system in Alaska. Based on a modified systems approach, the analysis employs nationally established alcohol program components promulgated by the Joint Committee on Accreditation of Hospitals for development of the concept of an appropriate statewide alcohol services delivery system. Statewide organizations providing direct and indirect alcoholism services are described with respect to their various administrative and programmatic dimensions. Local alcohol programs are similarly described and compared with respect to their various treatment or program components. Additionally, all organizations and programs are analyzed with regard to their participation in an emergent, comprehensive services delivery system at both the statewide and regional levels. Throughout, the focus of analysis is the nature of the overall delivery system itself (components, allocations, comprehensiveness, etc.), and not comparison or evaluation of individual programs.

VOLUME IV : Social Systems Indicators of Alcoholism and Alcohol Abuse in Alaska, 1975

Volume IV assembles and discusses a range of current data and information regarding the social impact on Alaska of alcoholism and alcohol abuse. The data compiled are regarded as conventional social system indicators, and discussed accordingly. Each part of the volume concentrates on a specific set of such indicators, with primary attention given to the prevalence of alcoholism in Alaska, the consumption of beverage alcohol, related mortalities, crime, and highway safety. A number of other, related indicators are also reviewed. Wherever possible, information is analyzed historically and compared with corresponding national (and, where applicable, international) information and research findings.

Volume V : Executive Summary: Descriptive Analysis of the Impact of
Alcoholism and Alcohol Abuse in Alaska, 1975

As an executive summary, Volume V synoptically treats the findings contained in the four primary volumes preceding it. Additionally, it integrates various portions of these findings to provide alternative descriptions of the impact on Alaska of alcoholism and alcohol abuse. The descriptions are not viewed as competitive, but as demonstrative of the various perspectives and approaches possible for description and analysis of the associated problems. Finally, overall policy-level recommendations extrapolated from the study's findings are suggested for more effective implementation of Alaska's Uniform Alcoholism and Intoxication Treatment Act.

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VOLUME I

THE ECONOMIC IMPACT OF ALCOHOLISM AND ALCOHOL ABUSE IN ALASKA, 1975

PART I. SUMMARY: INTRODUCTION AND OVERVIEW--THE ECONOMIC IMPACT OF
ALCOHOLISM AND ALCOHOL ABUSE, 1975

INTRODUCTION

That Alaskans drink a lot of beverage alcohol appears to be common knowledge within the State. Available consumption information supports this notion.* A frequent companion thought to this notion is that Alaska has a serious "alcohol problem". Most generally, the term, "alcohol problem", seems to refer to the prevalence of alcoholism and alcohol abuse. These terms themselves are elusive and confusing but generally serve as catch-all phrases for adverse personal or social events linked with alcohol consumption. Nearly everyone can recall and recite such unpleasant or undesired events related to alcohol consumption as auto/boating accidents, arrests, broken families, child abuse/neglect, mental anguish, work not done, jobs lost, personal degradation, and more. There is a common awareness that alcoholism and alcohol abuse are both pervasive and significant. This feeling seems particularly strong in Alaska but also characterizes national and international thought.

Although it is impossible to conclusively link alcohol to a certain portion of adverse personal or social events, association can often be inferred.** Many of these possible adverse social consequences also have economic consequences. The following Parts of this Volume examine the economic consequences of alcohol-related adverse events as well as the economic bene-

*See Volume IV for a detailed description and analysis of beverage alcohol consumption in Alaska.

**See Volumes IV and V for a detailed description and analysis of alcohol-related adverse events.

fits of the sale of beverage alcohol.

Particularly in view of the widespread societal feeling about the pervasiveness and significance of alcoholism and alcohol abuse, the economic magnitude of the cost of related adverse personal and social events provides an important point of reference from the standpoint of public policy.

STATEMENT OF PROBLEM

The intent of this volume is to provide an economic analysis of the sale and consumption of beverage alcohol in the state of Alaska. The analysis includes the determination of the economic benefit of the sale and consumption of beverage alcohol, as well as the economic cost associated with alcoholism and alcohol abuse. Further, the economic cost of alcoholism and alcohol abuse is compared with corresponding national findings for analysis of a possible differential configuration of the economic impact of alcoholism and alcohol abuse in Alaska.

In addition, a separate part of the investigation contains an examination of the impact of the sale and consumption of beverage alcohol on state government revenues and expenditures. Although these two areas are clearly interrelated, they logically and theoretically approach the subject from different perspectives. The extraction of state government expenditures and revenues from overall societal costs and benefits represents a more limited perspective, but one of direct interest for state government policy determination and budgeting and planning activities.

METHODOLOGY

The report for the National Institute on Alcohol Abuse and Alcoholism, DHEW, entitled, The Economic Cost of Alcohol Abuse and Alcoholism, 1971, March 1974, provided a general and constant reference for the basic design

and elements of this analysis. In the absence of any other comprehensive documents regarding the subject, this report provided both the prototype and also national results for purposes of comparisons. Certain adaptations and modifications were required due to problems of access and availability of data in Alaska. Each Part of this Volume will discuss the specific methodology used in arriving at cost and benefit estimates.*

SUMMARIES OF COST AND BENEFIT CATEGORIES AND MAJOR FINDINGS

A brief outline of cost estimation procedure and the results of the estimation of costs and benefits for each category considered is provided below.

PART II. Economic Benefit of Sale and Consumption of Beverage Alcohol

The estimation of economic benefit of the sale of beverage alcohol in the State of Alaska was calculated through the value added approach; that is, through determination of the total value added to state production by the beverage alcohol industry. This was approximated by the difference between sale (at both the wholesale and retail level) and the costs of the intermediate products. The estimated wholesale value added was computed to be \$8.7 million and the retail value added was \$83.0 million, for a total value added to state production of \$91.7 million in 1975.

Certain federal dollars that come into the state as a result of the sale and consumption of beverage alcohol may also be viewed as a benefit to the state. These funds totaled \$2.4 million in 1975. Thus the total economic benefit of the sale and consumption of beverage alcohol amounted to \$94.1 million in 1975.

*A general design and framework for estimation of economic costs and benefits was also suggested by economists Dona Lehr, Ph.D. and Ronald Lehr, Ph.D. However, all responsibility for methodology, data collection, and accuracy resides with the authors.

PART III. Economic Cost of Lost Production

The economic cost of production lost due to alcoholism and alcohol abuse was examined within three major considerations: (1) the diminished productivity of alcohol-troubled workers which results from the loss of efficiency and absenteeism due to alcohol; (2) the labor lost as a result of occupational injuries; and (3) the work not performed (foregone earnings) due to the premature death of the alcohol abuser.

Reduced productivity for men was determined through use of national sample studies on the effect on family income of alcohol abusers. Available data allowed the particularization of economic cost estimation according to male head of households, income differentials and prevalence of alcoholism/alcohol abuse by age groupings. The results were adjusted for inflation to produce a net loss of \$47.8 million in 1975 for reduced productivity for male alcohol abusers.

Reduced productivity for women was approached differently in that no similar study as that for males was available for analysis of female loss of income due to excess drinking. The prevalence of female alcohol abusers was determined by the Marden* procedure and a diminished productivity figure of 25% was used, as suggested by the National Council on Alcoholism. An economic cost of \$9.69 million was determined for diminished productivity for females in the 1975 work force in Alaska.

The economic cost of lost production due to occupational injuries resulting from alcohol abuse was determined by the analysis of costs incurred by the three plans providing compensation to employed workers in the state. This economic loss was estimated to be \$4.3 million after the costs due to mortality were excluded.

*A procedure for estimating prevalence of problem drinkers for a given population group developed by Parker G. Marden, Ph.D. See "A Procedure For Estimating the Potential Clientele of Alcoholism Service Programs", by Parker G. Marden. Reprint by National Institute on Alcohol Abuse and Alcoholism.

The economic cost of lost production due to excess mortality attributable to alcoholism and alcohol abuse was estimated separately for males and females. The estimation was based on national sampling information and applied within the income, age and sex differentials in Alaska. The economic cost was found to be \$2.8 million for females and \$21.8 million for males.

The total economic cost of lost production attributable to alcoholism and alcohol abuse is summarized in the chart below according to the major categories employed for analysis.

Diminished Productivity	-	\$ 57.5 million
Females--\$9.7 million		
Males--\$47.8 million		
Occupational Injuries	-	4.3 million
Excess Mortality	-	24.6 million
Females--\$2.8 million		
Males--\$21.8 million		
Total		\$ 86.4 million

PART IV. Economic Costs of Alcohol-Related Motor Vehicle Accidents

Alcohol abuse is often associated with traffic accidents; however, automobile accidents would occur even without alcohol abuse. The estimation of economic costs thus involved determination of excess costs, not just a percentage of total motor vehicle accident costs. Three types of accidents (fatalities, injuries, and property damage) were considered separately since costs differ substantially according to accident type. Excess economic cost for all accidents attributable to alcohol abuse amounted to \$19.7 million in 1975. In order to provide an economic cost figure not redundant with any other category of costs, the cost associated with loss of future earnings--\$10.7 million--was calculated and extracted to yield a fi-

gure of \$9.0 million.

PART V. The Economic Cost of Alcoholism and Alcohol Abuse to the Criminal Justice System

The overall economic cost of alcoholism and alcohol abuse for the criminal justice system was calculated for different categories of crime and for the separate components of the system--enforcement, courts, rehabilitation and "other" (essentially planning and support services). This cost estimate concerns the cost to the system rather than social cost of criminal acts to victims. In this economic sense, the resources used for alcohol-related crimes could have been utilized in alternative ways had these acts not taken place.

Total economic costs for all components of the system for all categories of offences amounted to \$15.3 million. Separate system component costs were: enforcement--\$7.95 million; court costs--\$1.97 million; corrections costs--\$3.78 million; and, other costs--\$1.56 million.

PART VI. Economic Costs of Health and Medical Care Associated with Alcoholism and Alcohol Abuse

In this Part, an estimate was made of the economic cost of the impact of alcoholism and alcohol abuse on the health and medical care system. Here again the estimated economic costs refer to system costs, the cost of providing the services to consumers. The primary interest was in estimation of excess economic costs, cost of services due to alcoholism and alcohol abuse that would not have been necessary without alcoholics or alcohol abusers.

Economic cost estimates were made for a variety of categories of health and medical care--hospital services, physicians' services, nursing care, drugs and other professional services.

In addition, non-institutional costs--administration and planning, health

care administration, research and training--were determined and discussed as much as available data would allow.

The total estimated economic cost for health and medical care services for alcoholics and alcohol abusers totalled \$13.3 million. Indirect costs associated with health and medical care users such as illness, disability and premature death attributable to alcoholism and alcohol abuse were estimated and reported in the part on Lost Production.

PART VII. Economic Cost of Alcoholism and Alcohol Abuse and Social Services and Public Assistance

Part of the pervasiveness of alcoholism and alcohol abuse includes generation of adverse individual and social events beyond the individual alcoholic and alcohol abuser. The economic consequence of this is the possible additional cost of public and private social services and assistance to others in addition to alcoholics and alcohol abusers, including foster care, daycare, homemaker services and social work services.

Economic cost estimates, based on actual expenditures, were made for provision of public social services and assistance attributable to alcoholism and alcohol abuse. The estimated economic cost for alcohol-related social services was found to be about \$3.5 million. In addition, public assistance payments, or alcohol-related transfer payments for AFDC, AD and Medicaid cases totaled \$3.1 million. In economic terms, the cost of social services is a true economic cost, but transfer payments are not. However, transfer payments do represent a transfer of part of the burden of reduced income due to alcoholism from the alcoholic and family to the taxpayer.

PART VIII. Economic Cost of Direct Program Services for Alcoholism and Alcohol Abuse

A variety of statewide administrative organizations in Alaska provide for direct alcoholism and alcohol services such as prevention, treatment, rehabilitation, training and research, as well as planning, coordination

and administration. Financial information regarding the operation of eleven primary statewide organizations was obtained and expenditures were analyzed for all alcohol-related components. The total cost for all programs for all alcohol-related components totaled almost \$3.7 million in 1975. This cost is independent of the costs in any other economic cost category considered. The program expenditures were distributed as follows: Treatment-rehabilitation--55%; prevention--32%; administration--7%; training--6%; and research--1%.

PART IX. Impact of Alcoholism and Alcohol Abuse on State Government Revenues and Expenditures

This Part of the Volume examined the expenditures and revenues of state government and identified amounts attributable to the sale and consumption of beverage alcohol and alcoholism and alcohol abuse. Revenues and expenditures were delineated by use and source of funds in order to more clearly separate the inflow and outflow of alcohol-related dollars.

Total state government expenditures attributable to alcoholism and alcohol abuse totaled about \$24.8 million in 1975. Total state government revenues amounted to about \$10.4 million.

PART X. Conclusion

This Part provided a summary of the total economic cost attributable to alcoholism and alcohol abuse for each category considered, and the total economic benefit for the entire state of Alaska. The absolute and relative magnitude of the economic cost for each and all categories was reviewed and compared with corresponding national information.

The total economic cost attributable to alcoholism and alcohol abuse amounted to \$131.2 million for the state of Alaska during 1975. The largest percentage of the total economic cost, 65 percent, was derived

from lost production due to alcoholism and alcohol abuse. This category itself is rather broad and includes costs associated with diminished productivity, occupational accidents and foregone earnings due to premature deaths.

Alcohol-related costs to the criminal justice system accounted for about 12 percent of the total and alcohol-related health and medical care costs contributed about 10 percent of the total cost. Motor vehicle accidents (excluding excess mortality costs) represented 7 percent of the total and social services and direct alcohol service programs each accounted for less than 3 percent of the total.

The total economic benefit to the state was calculated to be \$94.1 million.

In comparison with national findings, the total economic cost attributable to alcoholism and alcohol abuse, \$131.2 million for the state, was found to be 65 percent greater than a corresponding adjusted national estimate. The finding that the actual economic cost for alcoholism and alcohol abuse was greater than might be projected from national findings was not surprising, as discussed in this Part, but the magnitude of the difference is dramatic.

Further comparison of the distribution of the findings of this study with corresponding national findings for each of the categories studied indicated additional distinguishing characteristics of the economic cost of alcoholism and alcohol abuse in the state of Alaska. When adjusted for the overall difference in total economic cost, the categories of lost production and the criminal justice system contributed a disproportionately greater percentage of the total cost, compared to national findings. In addition, health and medical care costs and motor vehicle accidents were relatively less important in overall contribution to the total cost.

A summary of the total economic cost attributable to alcoholism and alcohol abuse for the state of Alaska in 1975 is provided below:

ECONOMIC COST OF ALCOHOLISM AND ALCOHOL ABUSE, 1975

Lost Production	\$ 86.4 million
Criminal Justice System	15.3 million
Health and Medical Care	13.3 million
Motor Vehicle Accidents (excluding mortality costs)	9.0 million
Direct Alcohol Services	3.7 million
Social Services	<u>3.5 million</u>
Total Cost	\$ 131.2 million

COMMENT

The final estimate of total cost of \$131.2 million is probably conservative. The estimate may contain some double counting, but if so, the effects are minimal. Also, as with most types of descriptive statistics, the total cost estimate is more reliable than any of the separate elements.

However, the conservative nature of the total estimate is primarily due to the inability to include all that could possibly be considered in this investigation, because of the lack of reliable data.

In addition, future estimates of the economic cost of alcoholism and alcohol abuse will probably increase considerably as more becomes known about the relationship of alcohol and human behavior and its physiological effects on the body. This will open additional areas of consideration and also allow development and refinement of estimation procedures.

ECONOMIC BASIS FOR SOCIAL COST AND BENEFIT ANALYSIS

Efficient use of resources in producing private goods may be obtained

through the workings of the market system, provided certain conditions are met. If all conditions of the free market system are fulfilled, the private price system (i.e., without interference by government) can yield socially optimal results in production and consumption of private goods. Output will be expanded until the production of one more unit of a good would add more to cost than it would add to the benefit of the consumer. If the cost of the additional production of goods exceeds the additional benefit, then the net contribution to well-being is negative. If fewer units than optimal were produced, the contribution to benefit by the last unit would be greater than its contribution to cost. In this case, production of more units would add a net positive benefit to society, increasing the overall level of well-being. The automatic workings of the price system assure that production is carried to the optimal level, thus assuring maximum benefits to society. One of the conditions necessary for this proper automatic functioning of the market system requires that all costs and all benefits associated with a good (i.e., resulting from production and consumption) be taken into consideration by those individuals affecting output and consumption decisions.

There are, however, goods and services produced in our economy where all the relevant costs or benefits are not felt or internalized by the producers. Since all the information necessary for the socially optimal decision is not taken into account, either over- or under-production may result. The classic case where costs may fail to be considered by producers is that of industrial pollution--for example, where wastes are dumped into a nearby river. Since the producer is not charged for using the river as a waste receptacle, no cost for this use is considered in arriving at production levels. There are, of course, costs associated with the waste dumpage--e.g. loss of fish and/or other members of the food chain; loss of

property value, drinking water, recreational opportunities by those living downstream; visual pollution. These results of the production process represent costs to society, but not necessarily to the producer. Since these costs are external to the production decision, they are referred to as externalities. The existence of such negative externalities tends to cause a level of production greater than socially optimal. The socially optimal quantity may be exceeded by the private producer, if only private (internal) costs are counted while external costs are ignored. To assure that the socially optimal result is obtained, all costs and benefits, both internal and external, must be evaluated.

A similar analysis is applicable to the output and consumption decisions made regarding beverage alcohol. This case differs slightly from that of industrial pollution, for, in the case of beverage alcohol, externalities are generated in the consumption process rather than in the production of the product. However, the general framework of analysis developed above is applicable. For an appropriate outcome to be assured in the market system, all costs and benefits, whether associated with production or consumption, must be taken into account. There are several types of negative externalities which can be associated with "excess" consumption of beverage alcohol--alcoholism or alcohol abuse. For example, costs such as motor vehicle injuries and deaths, increased crime, increased susceptibility to disease, may be related to alcohol abuse. These problems represent a cost to society as well as to the individual alcohol abuser.

The meaning of "economic cost" should be clearly understood in this context. Economists define costs in terms of possible alternative uses of resources. Since total amount of resources (land, labor, and capital) available to a society are limited, and all desires or wants cannot be satisfied with these limited resources, the provision of one type of good

or service necessitates the giving up of some other good or service. The value of what is lost or given up represents the cost associated with a given use of resources. This economic cost is referred to as the alternative or opportunity cost. The cost of a decision to utilize limited resources in a specific way is the same as the value of the opportunities foregone. Thus, the use of resources to care for individuals injured as the result of alcohol abuse represents an economic cost to society associated with alcohol consumption. Were it not for alcohol abuse, these resources would be available for use elsewhere in the economy. Costs of this nature, as well as private costs and benefits, must be taken into account when evaluating the impact of sale and consumption of a commodity on society.

The sale and consumption of beverage alcohol also represents an economic enterprise that contributes to the overall production within a society. The production of beverage alcohol as well as all the related activities of the wholesale and retail sale and distribution of the commodity also results in an economic impact that is considered an economic benefit for society.

The intention of this investigation is to comprehensively consider the economic cost and the economic benefit of the sale and consumption of beverage alcohol in Alaska. In some instances, methodological and data difficulties have placed serious restrictions on the ability to precisely estimate dollar values for all relevant categories of costs and benefits. However, conservative estimates are made for the several important categories, while remaining categories are delineated and discussed.

PART II. ECONOMIC BENEFITS OF SALE AND CONSUMPTION OF BEVERAGE
ALCOHOL

STATEMENT OF PROBLEM

The purpose of this section of the report is to estimate the economic benefits to the state of Alaska made by the sale and consumption of beverage alcohol.

Two major conventional sources of economic benefits exist for analysis: (A) the value added to state production by the beverage alcohol industry in the state; and, (B) the expenditure of federal dollars that come into the state as a result of alcohol sale and consumption.

METHODOLOGY

A. VALUE ADDED TO STATE PRODUCTION

The value added to state production represents the amount of productive activity that has occurred as measured in dollar value. Value added may be computed either by summing the dollar values of the returns to all factors of the production process,* or by directly measuring the dollar value of the output.

Determination of the value added by the factors-of-production approach would require a great amount of information. It would be necessary to aggregate the gross dollar value of wages, rents, interest, depreciation, indirect business taxes (such as alcohol excise tax), etc., for all the factors of all the business activity involved with sale and consumption of beverage alcohol in the state. Because of the severe limitations imposed by the lack of availability and access to the information

*Examples of factors of production are land, labor, capital, etc.

required for this method, the alternate procedure--direct measurement of output--was utilized. Use of either of the methods should yield the same results.

The most direct procedure to determine the total dollar value added would be to subtract the value of intermediate products from the total sales. In this case the value of intermediate products would be the cost of all alcohol imports to the state, and also wholesale purchases by Alaskan retailers, from Alaskan wholesalers. Thus:

Total Value Added = (retail value added) + (wholesale value added)
where,

Retail Value Added = (total gross retail sales) - (total wholesale purchases by Alaskan retailers)

and,

Wholesale Value Added = (total gross wholesale sales by Alaskan wholesalers) - (total wholesale costs by Alaskan wholesalers)

However, all required information was not able to be obtained for the above computations.* Therefore, an alternate estimation procedure was derived (see below).

ESTIMATION PROCEDURE--TOTAL VALUE ADDED

Given the constraints of unobtainable information, the general formulae used to derive the desired estimates are given below.

The formula for total value added remains the same as stated above, but is now estimated. Thus,

Total Value Added = (estimated retail value added) + (estimated wholesale value added)

*Actual Retail sales information or tax information for beverage alcohol is not maintained in any form by Departments of Revenue, Commerce, and Labor, or any other agency.

and,

$$\begin{array}{l} \text{Estimated} \\ \text{Retail} \\ \text{Value} \\ \text{Added} \end{array} = (\text{estimated total gross wholesale sales} + \text{estimated retail mark-up}) - (\text{estimated total gross wholesale sales})$$

and,

$$\begin{array}{l} \text{Estimated} \\ \text{Wholesale} \\ \text{Value} \\ \text{Added} \end{array} = (\text{estimated gross wholesale sales}) - (\text{estimated wholesale costs})$$

Retail Value Added. An estimate of the total value added by retail sales was made using the volume (gallonage) of wholesale sales to retail outlets by type of beverage, wholesale cost per case by type of beverage, distribution by type of beverage and retail outlet (on-premise and off-premise consumption), and retail mark-up by type of beverage.

The individual items of information needed for the estimate and the required arithmetic computations are shown in Tables II-1 and II-2. The total retail sales for all types of beverage alcohol were estimated to be \$140.8 million (Table II-2). Approximately \$66.7 million was derived from sale of liquor, \$14.9 million from sale of wine and \$59.2 million from sale of beer, at the retail level. Approximately \$95.6 million of sales of all types of beverage alcohol occurred in retail establishments licensed for on-premise consumption. About half that amount, or \$45.2 million of retail sales, occurred at outlets licensed for off-premise consumption.

The aggregated total retailer's cost (wholesale sales) for all types of beverage alcohol was computed to be \$57.8 million (Table II-1). This estimation procedure appeared to be reasonably accurate in relation to the actual total wholesale gross sales dollar volume of \$58.2 (as reported by the Alcohol Beverage Control Division, Alaska Department of Revenue). That actual total figure, however, was not able to be subtotaled

TABLE II-1

ESTIMATED TOTAL WHOLESALE SALES OF LIQUOR,
WINE AND BEER FOR 1975

Beverage Alcohol	1 Total Gallonage	2 Number of Cases	3 Average Cost Per Case	4 Total Wholesale Sales (\$ Millions)
Liquor	1,236,976	458,139	60.00	27.5
Wine	801,665	296,913	20.00	5.9
Beer	8,451,841	3,756,374	6.50	24.4
Total				<u>\$57.8</u>

- Column 1 Computed from the Alaska Department of Revenue monthly "Report of Alcoholic Beverages Distributed or Sold in Alaska".
- Column 2 The number of cases of liquor and wine was determined by dividing the gallonage by a factor 2.7; for beer, the gallonage was divided by 2.25 to get the number of cases.
- Column 3 Cost per case was determined from cost estimates provided by major wholesale distributors.
- Column 4 Total wholesale sales per beverage is the product of Column 2 and Column 3.

TABLE II-2

ESTIMATED WHOLESALE AND RETAIL SALES OF BEVERAGE ALCOHOL
BY TYPE AND RETAIL OUTLET, IN DOLLARS FOR 1975

Beverage Alcohol	Wholesale Sales ¹ (\$ millions)			Retail Sales ² (\$ millions)		
	Total	On- Premise	Off- Premise	Total	On- Premise	Off- Premise
Liquor	27.5	11.3	16.2	66.7	45.1	21.6
Wine	5.9	2.6	3.3	14.9	10.5	4.4
Beer	24.4	10.0	14.4	59.2	40.0	19.2
Total	\$57.8	\$23.9	\$33.9	\$140.8	\$95.6	\$45.2

1. Estimated percentage distribution of wholesale sales to on-premise and off-premise retail outlet determined by correspondence with major distributors. For liquor and beer, approximately 41 percent sales to on-premise retail outlets, 59 percent to off-premise outlets. For wine, the corresponding figures are 44 and 56 percent.

2. Retail Sales computed by estimated mark-up provided by correspondence with major distributors. On-premise retail mark-up established at 300 percent. Off-premise retail mark-up established at 33 percent.

for liquor, wine and beer separately.

The estimated retail value added amounts to \$83.0 million (\$140.8 million minus \$57.8 million) for retail sale of all types of beverage alcohol at retail establishments licensed for on-premise and off-premise consumption.

Wholesale Value Added. The estimated amount of total gross wholesale sales was computed in Table II-1 as about \$57.8 million. The costs of beverage alcohol distribution in Alaska to wholesalers was estimated as 85% of the gross wholesale sales,* or about \$49.1 million. The wholesale value added amount is thus \$8.7 million (\$57.8 million minus \$49.1 million).

Preliminary Results. Given the findings of the above estimation procedures for retail and wholesale value added, the total value added to state production by sale of beverage alcohol in Alaska can be estimated.

The estimated total value added is equal to the sum of the retail and wholesale value added. Thus, \$83.0 million plus \$8.7 million sums to \$91.7 million.

B. FEDERAL FUNDS IN ALASKA

Certain federal dollars that come into the state as the result of the sale and consumption of beverage alcohol may also be viewed as a benefit to the state. In a sense these should be netted out against increased federal taxes as a result of federal alcohol programs, but this would be extremely difficult to do.

The federal funds that may be viewed as an economic benefit for the state are funds expended for services which are attributable to

*This percentage figure estimated by major distributors---as a conventional, "rule of thumb" proportion.

alcoholism and alcohol abuse. Certain funds are available from federal sources only if they are tied to certain "alcohol-related" activities, such as direct alcohol service programs or other programs where eligibility for financial assistance is attributable to alcoholism or alcohol abuse (e.g. transfer payments for public assistance and medical care). For convenience, these funds can be grouped and called "tied" federal funds; i.e., they are tied to particular types of expenditures. These funds would not come to the state were it not for problems associated with alcoholism and alcohol abuse. They are used to pay part of the costs of the external effects of alcohol consumption, but they constitute an economic benefit for the state because the funds are additional resources. Hence, production (services) based on these resources does not represent an opportunity cost to Alaskan citizens (although it would for the nation as a whole).

The determination and computation of the dollar amount of economic benefit from "tied" federal funds is presented and discussed in Part IX of the Volume, concerned with state government expenditures and revenues. As shown in Tables IX-2 and IX-3 of Part IX, the value of "tied" federal funds amounted to about \$2.4 million in 1975.

RESULTS

Given the findings of the estimation procedures for the different sources of economic benefits to the state as a result of the sale and consumption of beverage alcohol, the total economic benefit can be estimated.

The estimated total value added to state production is equal to the sum of the retail and wholesale value added, which amounted to \$91.7. In addition, the economic benefit of "tied" federal funds amounted to

\$2.4 million. Together, the amount of \$94.1 million is the best estimate available for the total economic benefit from the sale and consumption of beverage alcohol in the state of Alaska in 1975.

PART III. ECONOMIC COST OF LOST PRODUCTION DUE TO ALCOHOLISM
AND ALCOHOL ABUSE

STATEMENT OF PROBLEM

Abusive consumption of alcohol by workers in the labor force is generally considered to cause diminished productivity. These workers are considered to produce less because of the combined effects of alcohol abuse and absenteeism, increased injury rates, premature death and associated industrial costs. Since these workers produce less than they can (because of alcohol), society suffers as a result of fewer goods being produced (and hence, consumed). Ideally, this lost production would be measured by computing the reduced number of units produced as a result of alcohol abuse, and multiplying this by the price of these goods in order to get the dollar value of lost production. This type of information is not available, however, and therefore an alternative estimation procedure was used to compute the economic cost of lost production related to alcohol abuse.

Economic costs were computed using three main categories for estimation: (A) diminished productivity of male and female alcohol-abuser-workers (due to reduced efficiency and excessive absenteeism), (B) loss of production due to alcohol-related occupational injuries and, (C) loss of production due to alcohol-related premature death.

METHODOLOGY

A. DIMINISHED PRODUCTIVITY

1. ESTIMATION PROCEDURE--MALES

The estimation procedure is based on the assumption that workers

are paid according to their productivity, and less productivity means proportionately lower wages. Thus, the basis of measurement of productivity is workers' incomes rather than actual production units. For example, this procedure assumes that if a worker produces ten percent less than his comparable co-workers, he will be paid ten percent less.

The simplest way of computing this differential would be to compare median incomes of non-abusers and those of abusers within the labor force. However, this information obviously is not available since the abusers are not an identifiable population group. Further, an overall percentage estimate of the proportion of the population that might be abusers based only on median income census figures would ignore the possibility that abusers may have a different demographic profile than non-abusers and that other factors (age, sex, race, etc.) may also influence differences in income. Complete information regarding basic demographic characteristics of abusers and non-abusers is also not available; however, enough information does exist to stratify median income by age groups.

The median family income for heads of households for all Alaska residents by age groups is presented in Table III-1, column 1. The information was obtained from the 1970 census information. It is considered as the median income for non-abusers, although the information includes incomes for all Alaska families including the reduced incomes attributed to alcohol-abuser-workers.

The estimated percentage reduction in income by age group, due to alcohol, determined in a national study,* is presented in column 2

*The Economic Cost of Alcohol Abuse and Alcoholism, 1971, Final Report, HSM, 42-73-114 (NIA) March, 1974, p. 47. Prepared for National Institute on Alcohol Abuse and Alcoholism by Policy Analysis, Inc., Boston, Mass. Hereafter, this report will be referred to as Economic Cost.

TABLE III-1
MEDIAN INCOME DIFFERENTIAL BY AGE GROUPINGS
FOR ALCOHOL ABUSERS AND NON-ABUSERS
IN ALASKA, 1970

Age	1 Family Median Income Non-Abusers	2 % Decrease in Income Due to Alcohol Abuse	3 Decrease in Income Due to Alcohol Abuse
20-29	\$ 9,400	11.25	\$1,058
30-39	13,200	17.35	2,290
40-49	15,000	22.85	3,428
50-59	15,800	15.48	2,446

Column 1 Computed from Table 202, Alaska, U.S. Department of Commerce, Bureau of Census 1970.

Column 2 Results are from National Probability Samples of Social Research Group, School of Public Health, University of California, Berkeley, 1974 (unpublished paper), cited in Economic Cost, p. 47.

Table III-1.

Given the information in columns 1 and 2, the decrease in income due to alcohol abuse according to age group can be estimated by multiplying the two columns for each age group. Thus, column 3, Table III-1, shows the decrease in median incomes attributed to alcohol abuse for the different age groupings presented.

The information in Table III-1 reflects the differential characteristics of median incomes adjusted for age for the Alaska population and the estimated differential income characteristics of alcohol abusers by age applied to the Alaska population.

In order to compute the absolute difference in income due to alcohol abuse it was necessary to establish the number of families that have an alcohol-abusing head. Table III-2, column 1 shows the distribution and number of families by age groupings of family heads, taken from the 1970 census figures for Alaska. Estimation of the percentage of families with alcohol-abusing family heads became limited to male heads of families due to available data. Therefore, in order to calculate the number of families with an alcohol-abusing male, the percentage of all families with a male head is shown in column 2, Table III-2, by age group. Column 3 of the same table shows the estimate from a national study* of the percentage of families with an alcohol-abusing male head by age group. Finally, in column 4, Table III-2, the cross multiplication of columns 1, 2, and 3 yields estimates of the number of families with an alcohol-abusing head for each of the age groups shown.

Given the information regarding the decrease in median income due to alcohol abuse (Table III-1) and the estimated number of families

*Ibid., p. 48.

TABLE III-2
NUMBER OF FAMILIES WITH AN ALCOHOL ABUSING MALE AS HEAD,
ADJUSTED FOR 1975

Age of Head	1 Estimated Number of Families	2 Percent of Families with Male Head	3 Percent of Families with Alcohol-Abusing Male	4 Estimated Number of Families with Alcohol-Abusing Male (1 x 2 x 3)
20-29	28,815	93.9	21	5,682
30-39	36,808	93.9	13	4,493
40-49	28,814	93.9	12	3,248
50-59	17,530	93.9	11	1,811

Column 1 From Table 202 in correlation with Table 174, Alaska, U.S. Department of Commerce, Bureau of Census, 1970. A determination was made as to the number of families per age group by graphing the information provided in the tables and readjusting the data for difference in age groupings, and population projections between 1970 and 1975.

Column 2 From Table 200, Alaska, Census 1970.

Column 3 Economic Cost, p. 47.

with an alcohol-abusing male head, adjusted for age and the Alaska population (Table III-2), it is possible to calculate an estimate of the total lost income due to alcohol abuse for each age group and for the Alaska population as a total group.

Preliminary Results. The decrease in income due to alcohol abuse as computed in Table III-1, multiplied by the total number of families with an alcohol-abusing male head as determined in Table III-2, produces an estimate of total lost income, by age group, due to alcohol abuse. These results are presented in Table III-3. The unadjusted estimate of total income lost due to alcohol abuse amounts to approximately 31.86 million dollars. This figure needs to be adjusted for value in 1975 dollars since income figures were based on 1969 census information. To adjust the \$31.86 million total for inflation, the total amount was multiplied by the percentage increase in the consumer price index in Alaska between 1970 and 1975, which amounted to 50 per cent. This works out to a factor of 1.50, multiplied times the \$31.86 million, to yield an estimated adjusted total of \$47.79 million as the estimate of total lost income for males due to lowered productivity as a result of alcohol abuse.

2. ESTIMATION PROCEDURE--FEMALES

The reduced productivity of the female alcoholic was approached by utilizing two estimates regarding the prevalence of female alcoholics and the production market value of female workers. The estimates are certainly conservative, and subject to considerable debate.

The prevalence of female alcohol abusers in Alaska in 1975 was estimated by the Marden procedure* which allows estimations based on age

*Marden, Parker G., A Procedure for Estimating the Potential Clientele of Alcoholism Service Programs, Prepared for NIAAA, 1974.

TABLE III-3
LOST PRODUCTION COSTS AMONG FAMILIES WITH ALCOHOL ABUSING MALE HEADS
BY AGE GROUPS AND TOTAL POPULATION

Age Group	1	2	3
	Decrease in Median Income Due to Alcohol Abuse of Male Head of Household (1969 dollar values)	Estimated Number of Families With Alcohol-Abusing Male Head	Estimate of Total Lost Income (millions)
20-29	\$1,058	5,681	\$ 6.01
30-39	2,290	4,493	10.29
40-49	3,428	3,248	11.13
50-59	2,446	1,811	4.43
Total		15,233	\$31.86 million
Adjustment for 1975 dollar value			\$47.79 million

Column 1 From Table 1, Column 3.

Column 2 From Table 2, Column 4.

Column 3 To adjust the \$31.86 million total for inflation (since it was derived from 1969 dollar values) it was multiplied by the percentage increase in the Consumer Price Index, 50 percent, established by the Alaska Department of Labor.

groupings. This procedure however, treats females as a separate aggregated occupational category, independent of the occupational categories used to estimate prevalence of alcohol abuse among males. This procedure thus assumes that females cut across all occupational categories in unknown ways and also considers "housework" as a generalized occupational category for females eligible for the labor market by virtue of age.

The Social Security Administration recently released figures estimating the value of household services to be \$7,500 per year.* Although this estimated "value" would be questioned by many, the determination is too equivocal to argue that it is too low. However, diminished activity clearly represents a lowering of living standards for the family whether her job is away from home or in the home. Suffice it to say that the exactitude of the unit dollar value of the economic loss of women is not the present issue but rather a description of the ramifications of alcoholism as an economic problem which reflects contemporary socio-economic differentiations among females and males.

Preliminary Findings. The Marden procedure yielded an estimate of 5,625 female alcohol abusers among the drinking age population in 1975. Of this number, 5,170 were estimated in the 20-59 age group.

Accepting the \$7,500 per year average income value, regardless of age or employment, and regarding diminished productivity to be about 25 percent,** a total cost can be approximated. The average annual income per female, multiplied by the estimated number of female alcohol abusers, multiplied by the estimated proportion of diminished productivity, provides

*Bell, Carolyn Shaw, "Woman's Work and the GNP," The Boston Globe, December 25, 1975.

**Estimate provided in Report to the Special Subcommittee on Alcoholism and Narcotics, of the Committee on Labor and Public Welfare, U.S. Senate, "Substantial Cost Savings From Establishment of Alcoholism Program For Federal Civilian Employees".

a crude measure of the loss. Thus, $(\$7,500) \times (5,170) \times (.25) = \9.69 million.

B. LOST PRODUCTION--OCCUPATIONAL INJURIES

ESTIMATION PROCEDURE

It is impossible to actually determine payments made for alcohol-related occupational injuries. State laws preclude eligibility for payment if it is solely attributable to intoxication; however, such identification has occurred only once in approximately 14,000 claims. Occupational accidents are generally considered to occur more frequently for alcohol abusers than non-abusers. Some proportion of disability and death benefit payments are for alcohol abusers.

Financial payments for job-related injuries and deaths are provided each year by programs that provide disability and death benefits for workers in the Alaskan labor force. Most of the labor force, excepting military personnel, is insured by three main plans: (1) Workman's Compensation, (2) Federal Employees Compensation and, (3) Northwest Marine Welfare. Respectively these plans cover 142,057, 18,199, and 2,030, for a total of 162,286 workers (FY75).

The total cost of excess payments due to alcohol-related occupational injuries can be estimated by applying an approximate percentage of alcohol-related occupational injuries to the total payments made under all plans, including payments for death benefits. (Mortality costs will be included in the next section.) Close estimates of total costs for injury and death benefits were made for 1975, by Workman's Compensation and by the Federal Employees Compensation. Northwest Marine Welfare could not provide an estimate of loss; so, on the basis of membership numbers, a proportionate estimate of their losses was made, assuming that their cost would be comparable to Workman's Compensation and the

Federal Employees Compensation. These estimates are shown below:

Workmen's Compensation (losses)	\$33,772,000
(Administration & Support)	720,000
Federal Employees Compensation	
(Losses & Administration)	2,268,000
Northwest Marine Welfare	
(Losses & Administration)	253,000
Total Costs.....	\$37,013,000

No reliable evidence exists on the percentage of excess injuries which are attributable to alcohol abuse, although a wide range of guesses are available, which range as high as 26 percent. A conservative estimate of fifteen percent was adopted for estimating excess alcohol-related losses.

Preliminary Results. The three plans accounted for a total of \$37 million in providing disability and death benefits for slightly more than 162,000 workers. Of this total dollar value, 23 percent or \$8.5 million was deducted as an estimate of the amount paid out for death benefits. Against the balance of \$28.5 millions the estimated percentage of excess injuries for alcohol-abusers--15%--was applied to yield an amount of \$4.3 million.

Therefore, it is estimated that, of the total disabilities payments of \$28.5 million, \$4.3 million was paid out as excess due to alcohol abuse.

C. LOST PRODUCTION--EXCESS MORTALITY

The loss of production due to premature death must be considered a cost to society. In economic terms, the future production of the deceased is denied to the community. This section will provide a cost estimate of lost production for excess deaths related to alcohol abuse and alcoholism. Separate estimates will be made for males and females.

1. ESTIMATION PROCEDURE--MALES

Available information regarding mortality within the state does not accurately include alcohol involvement within causes of death and contributing factors. Thus in order to obtain an estimate of excess mortality for males, and therefore, foregone earnings, within the constructs of available data, a number of factors must be determined: excess number of deaths attributable to alcohol abuse, and age and time of death; foregone earnings for the above persons; and, an appropriate discount rate.

The number of male excess deaths estimated to be attributable to alcoholism is shown in Table III-4, along with the computational procedure. Total deaths for males, obtained from the State Bureau of Vital Statistics for 1974 (most recent available information), are shown in column 1, grouped by age categories. The percent of excess deaths attributable to alcohol (column 2) is adapted from similar material presented in the national study.*

The results of the determination of the number of person-years of lost production for premature deaths, by age categories, and up to the age of 64, are shown in Table III-5. The calculations assume that the alcohol abuser would have behaved in a statistical manner similar to persons of his age category in the general male population. The cell entries show the excess person-

*Economic Cost, p. 51.

TABLE III-4

EXCESS MALE DEATHS ATTRIBUTABLE TO ALCOHOLISM AND ALCOHOL ABUSE

Age Group	1	2	3
	Total Deaths	Percent Excess Deaths	Excess Deaths
20-24	106	19	20
25-34	103	20	21
35-44	112	40	45
45-54	118	19.5	23
55-64	163	12.3	20

Sources:

Column 1. Alaska Bureau of Vital Statistics.

Column 2. Economic Cost of Alcohol Abuse and Alcoholism, 1971,
HMS 42-73-114, NIAAA, March 31, 1974, pg. 51.

Column 3. Column 1 multiplied by column 2

TABLE III-5
PERSON-YEARS LOST DUE TO EXCESS DEATHS DUE TO ALCOHOLISM AND
ALCOHOL ABUSE FOR MALES

Age Group of Death	Age Group When Years Lost				
	20-24	25-34	35-44	45-54	55-64
20-24	49.84	196.96	191.36	179.04	153.28
25-34		102.34	200.56	187.38	160.18
35-44			222.12	421.56	360.00
45-54				112.42	189.35
55-64					93.12

years of lost production for premature deaths during the year intervals shown and for each category.

The next item needed is the income the deceaseds would have earned if they had not died. Median total income by designated age groupings for the entire Alaskan population is presented below in Table III-6.

TABLE III-6
MEDIAN TOTAL INCOME BY
AGE FOR 1970

Age Group	Median Total Income*
20-24	7,088
25-34	12,154
35-44	14,420
45-54	16,082
55-64	13,275

The results of the calculation of the undiscounted value of lost production in dollar terms is shown in Table III-7. The figures were produced by multiplying excess lost person-years (Table III-5) against median annual income at time of death (Table III-6).

At this point the present dollar value of the cost of lost production may be determined by discounting the values in Table III-7. A discount rate of seven percent was chosen as a conservative rate. The present day value of the cost of lost production related to excess mortality due to alcoholism is

*Source: Alaska Census, U.S. Department of Commerce

TABLE III-7

UNDISCOUNTED COST OF LOST PRODUCTION DUE TO EXCESS
MORTALITY ATTRIBUTABLE TO ALCOHOL ABUSE AND
ALCOHOLISM FOR MALES (millions of dollars)

Age at Death	20-24	25-34	35-44	45-54	55-64
20-24	.353	2.394	2.759	2.879	2.035
25-34		1.244	2.892	2.013	2.126
35-44			3.203	6.780	4.779
45-54				1.808	2.633
55-64					1.236

shown in Table III-8.

Preliminary Results. As indicated in the last column, the total cost for all age groups amounts to \$21.76 million. This figure includes discounted future wages that are not lost within one year. The corresponding costs attributable to 1974 only would be \$2.502 million, based on excess deaths of alcohol abusers in 1974. (Computed by multiplication of excess deaths--Table III-4--by age adjusted median income Table III-6.) Of course, this figure for only 1974 costs excludes considerations of the lost wages due to excess deaths of alcohol abusers in past years that would technically be counted in 1974. Thus, the \$21.76 million stands as the best estimate.

2. ESTIMATION PROCEDURE--FEMALES

The procedure used in estimating the cost of lost production of males as a result of excess mortality attributable to alcoholism was followed in developing comparable cost figures for lost production attributable to excess mortality due to alcoholism of females. Application of this procedure for females involved many more judgments and assumptions than was true for males. The percentage of excess deaths of females may not be the same as for males; even less data is available for females. In addition annual income for females involved many assumptions (as mentioned previously) and amounted to an almost arbitrary choice. The object of this evaluation was to produce an estimate of the economic impact upon society of the excess deaths of females due to alcoholism. It should be noted that the mortality rate is lower for women than for men, so a different mortality rate factor was used in the "years lost" calculation (Table III-10); otherwise, the procedure was identical to that used in the calculation of the present day value of the costs of lost production of excess mortality for males.

Preliminary Results. The information and procedure used in estimating costs are presented in the Tables III-9, -10, -11 and -12 on the following pages.

TABLE III-8

THE PRESENT VALUE* OF COSTS OF LOST PRODUCTION DUE TO
EXCESS MORTALITY OF ALCOHOL ABUSERS--1974
(millions of dollars)

Age at Death	20-24	25-34	35-44	45-54	55-64	Total
20-24	0.30	1.48	0.87	0.46	0.16	3.27
25-34		0.92	1.09	0.58	0.21	2.80
35-44			2.36	2.54	0.91	5.81
45-54				1.33	0.99	2.32
55-64					0.91	0.91
Total**						\$ 15.11
Adjusted Total***						\$ 21.76

*Discount Rate of 7%

**1969 dollar value

***Adjustment from 1969 to 1974 dollar value based on 44% increase in
Consumer Price Index

The sequence is the same as the previous section for males. Table III-9 shows the number of excess deaths attributable to alcoholism and annual income. Table III-10 shows the person-years lost. Undiscounted costs of lost production are presented in Table III-11, and finally, Table III-12 shows that the present day value of lost production due to excess mortality for women amounts to slightly more than \$2,829 million.

TABLE III-9
EXCESS FEMALE DEATHS AND ESTIMATED
ANNUAL INCOME--1974

Age Group	1 Total Deaths	2 Percent Excess Deaths	3 Excess Deaths	4 Annual Median Income
20-24	19	20	3.6	\$ 7,500
25-34	23	20	4.6	7,500
35-44	43	40	17.2	7,500
45-54	71	19.5	13.8	7,500
55-64	66	12.3	8.1	7,500

Sources:

Column 1. Alaska Bureau of Vital Statistics

Column 2. Economic Cost, pg. 51

Column 3. Column 1 multiplied by column 2.

Column 4. Estimate of Social Security Administration, 1974.

TABLE III-10
PERSON-YEARS LOST DUE TO EXCESS DEATHS--FEMALES

Age Group at Death	20-24	25-34	35-44	45-54	55-64
20-24	8.98	35.67	35.10	33.95	31.84
25-34		22.93	45.26	44.16	40.85
35-44			85.31	166.50	154.11
45-54				67.90	128.06
55-64					38.88

TABLE III-11

UNDISCOUNTED COST OF LOST PRODUCTION DUE TO EXCESS MORTALITY
ATTRIBUTABLE TO ALCOHOL ABUSE AND ALCOHOLISM--
FEMALES (dollars)

Age at Death	20-24	25-34	35-44	45-54	55-64
20-24	\$67,332	\$267,561	\$263,237	\$ 254,588	\$ 248,377
25-34		171,975	339,450	331,200	306,375
35-44			639,825	1,248,750	1,155,825
45-54				509,250	960,450
55-64					291,600

TABLE III-12

THE PRESENT VALUE OF COSTS OF LOST PRODUCTION DUE TO EXCESS MORTALITY
DUE TO ALCOHOLISM AND ALCOHOL ABUSE--FEMALES,
(millions of dollars)

Age at Death	20-24	25-34	35-44	45-54	55-64	Total
20-24	\$58,781	\$166,691	\$ 83,340	\$ 40,989	\$ 19,870	\$ 369,670
25-34		126,918	127,294	63,259	29,718	347,189
35-44			472,191	468,281	220,760	1,161,234
45-54				375,827	360,169	735,996
55-64					215,201	215,201
Total Present Day Value						\$2,829,290

RESULTS

A brief summary of the estimated costs of lost production attributed to alcoholism and alcohol abuse is presented in Table III-13, below.

TABLE III-13

SUMMARY
ESTIMATED COSTS OF LOST PRODUCTION ATTRIBUTABLE TO ALCOHOLISM
AND ALCOHOL ABUSE--MALES AND FEMALES--1974
(millions of dollars)

Category	Amount
Diminished Productivity	\$ 57.48
Occupational Injuries	4.30
Excess Mortality	24.59
TOTAL	\$ 86.37

The total costs estimated for males and females for production lost due to alcoholism and alcohol abuse amounts to about \$86.4 million. It should be noted that insurance payments for alcohol-related highway fatalities and for occupational deaths, a sum of more than \$16.3 million, were not included in these figures. This would be double counting since such payments intend to compensate for lost earning capacity. The total estimated cost presented here represents the aggregate social cost--the costs to society in terms of services lost. It does not refer to human cost or the aggregate economic consequence for alcoholics and/or related families.

PART IV. ECONOMIC COSTS OF ALCOHOL-RELATED MOTOR VEHICLE
ACCIDENTS

STATEMENT OF PROBLEM

Alcohol abuse is often associated with motor vehicle accidents. However, traffic accidents would still occur even without alcohol abuse. In addition, alcoholics and alcohol abusers, as drivers, would still be involved in some accidents in the absence of the effects of alcohol. If alcohol abusers as a group had no higher accident rate than non-abusers, then there would be no excess social costs of alcohol-related motor vehicle accidents.

The major economic costs involve the value of lost production of persons killed or disabled and the value of the foregone output of resources utilized because of the accident. The objective of this section is to estimate the dollar value of excess motor vehicle accidents associated with alcohol abuse.

METHODOLOGY

In somewhat oversimplified terms, the number of accidents, by type, that would have occurred in a population with no alcoholics or alcohol abusers needs to be determined. The difference between the actual number of accidents and this hypothetical number would then be the number of excess accidents attributable to alcoholism and alcohol abuse. In order to approximate this information, it is necessary to consider at least three types of accidents, since different costs are associated with different types--fatal, injury, and property damage accidents. In addition, it is necessary to determine the differential accident rate for alcohol abusers and non-abusers.

ESTIMATION PROCEDURE*

To compute the excess proportion of accidents by type, due to alcohol abuse (EAA), the following formula was used:

$$EAA = P_1 - P_3 (P_2 / P_4)$$

In other words,

$$\text{Excess proportion of accidents due to alcohol abuse} = \left(\text{Proportion of accidents with alcohol abuse} \right) - \left(\text{Proportion of alcohol abusers on the road} \right) \times \left(\text{Accident rate of non-abusers} \right)$$

Four proportions are needed for each accident type to make this comparison:

P_1 = proportion of accidents with alcohol abuse

P_2 = proportion of accidents without alcohol abuse

P_3 = proportion of drivers who are alcohol abusers

P_4 = proportion of drivers who are not alcohol abusers,

By definition, $P_1 + P_2 = 1$ and, $P_3 + P_4 = 1$. The ratio of P_2/P_4 adjusts for the effects of the excess number of alcohol-related accidents on the total accident rate.

The excess proportion of each type of accident due to alcohol abuse can then be used to calculate the dollar value cost of all traffic accidents.

In order to calculate EAA for each type of accident, of course, only P_1 and P_3 need be known. For each accident type, P_1 was obtained from the accident files of the Alaska Department of Public Safety. The values of P_3 , for each accident type, were estimated on the basis research information reviewed in a National study.**

The results of the calculations for the excess proportion of accidents by type due to alcohol abuse (EAA), and values for component elements, are

*Economic Cost, p. 64.

**Economic Cost, pp. 66-72.

presented in Table IV-1. The obtained values for EAA were then used to calculate the percentage of total costs for each type of motor vehicle accident that could be attributed to alcohol abuse.

RESULTS

The total cost of excess motor vehicle accidents attributable to alcoholism and alcohol was estimated to be over \$19.7 million. The required information and the procedure used to derive this figure is shown in Table IV-2.

When motor vehicle accidents are treated as a separate category for cost analysis, the \$19.7 million figure represents the total estimated cost. However, this figure includes costs associated with loss of future earnings for persons killed in motor vehicle accidents. Thus, for the purposes of this study, costs associated with loss of future earnings for fatalities need to be withdrawn from the total figure in order to avoid double counting, since similar costs have already been estimated as lost production costs due to excess mortality attributable to alcohol abuse.

On the basis of a recent insurance study*, 96 percent of the costs associated with motor vehicle fatality accidents account for loss of future earnings. Therefore, given the information presented in Table IV-2 for fatality accidents, approximately \$10.7 million of the excess cost for fatality accidents has already been considered. Thus, excluding this amount already considered as lost production due to excess mortality, the estimated cost for excess motor vehicle accidents due to alcoholism becomes approximately \$9 million rather than \$19.7 million.

*Compensation For Motor Vehicle Accident Losses in the Metropolitan Area of Washington, D.C., Department of Transportation, 1970.

TABLE IV-1
PROPORTION OF EXCESS ACCIDENTS ATTRIBUTABLE TO ALCOHOL ABUSE
Alaska, 1975

Accident Type	P_1	P_2 ($1-P_1$)	P_3	P_4 ($1-P_3$)	EAA [$P_1-P_3(P_2/P_4)$]
Fatality	.45	.55	.14	.86	36
Injury	.18*	.82	.032	.968	15
Property Damage	.08*	.92	.032	.968	5

*Estimate based on 1974 statistics.

TABLE IV-2

ECONOMIC COSTS OF EXCESS MOTOR VEHICLE ACCIDENTS
 ATTRIBUTABLE TO ALCOHOLISM AND ALCOHOL ABUSE
 Alaska, 1975

Accident Type	1 Number	2 Unit Cost (dollars)	3 Total Cost (dollars)	4 EAA	5 Excess Cost (dollars)
Fatalities	119	\$260,000	\$30,940,000	36%	\$11,138,400
Injuries	5,579	9,500	53,000,500	15%	7,950,075
Property Damage	17,303	(Actual Reported Damages)	12,356,565	5%	617,828
Total Excess Cost Attributable to Alcohol Abuse					19,706,303

Sources:

- Column 1. Provided by Alaska Department of Public Safety and the Department of Highways.
 Column 2. Unit Costs for Alaska provided by Mr. William Swanson, Alaska Department of Highways.
 Column 3. Product of Columns 1 and 2. Total Cost for Property damage accidents provided by actual reported damages.
 Column 4. Excess proportion due to alcohol abuse, See Table IV-1.
 Column 5. Product of Columns 3 and 4.

PART V. ECONOMIC COSTS OF ALCOHOLISM AND ALCOHOL ABUSE TO
THE CRIMINAL JUSTICE SYSTEM

STATEMENT OF PROBLEM

The objective of this section is to estimate the cost of alcohol abuse and alcoholism to the criminal justice system--police, courts and corrections. This cost estimate reflects costs to the system rather than costs of criminal acts to victims. In this economic sense, the resources used for alcohol-related crimes could have been utilized in alternate ways had these acts not taken place.

The role that alcohol plays in the commission of a criminal act is as yet mainly undefined. But several researchers have noted the consumption of alcohol immediately before or at the time of the commission of a variety of offenses. Available research has shown a significant relationship between consumption of alcohol and the commission of violent crimes--criminal homicide, assaults, forcible rape, and other sex offenses. The relationship between alcohol and violent crime does not indicate a causal relationship, however. Similarly, certain types of crimes have come to be generally referred to as "100% alcohol-related offenses," given the high degree of association between offenders and alcohol use. The crimes in this category include driving while intoxicated, vagrancy, disorderly conduct, etc. But again, the association of alcohol and these criminal acts is also not considered causal. While it is understood that the consumption of alcohol does not in itself lead to violence, increasing circumstantial evidence links alcohol to crime. Thus, the demonstrated relationship between alcohol and specific crimes will be the basis for the estimation of the corresponding proportion of the criminal justice costs which might be attributed to alcohol abuse and alcoholism.

(See Volume IV for review of research and actual available data.)

METHODOLOGY

The estimation procedure for the determination of costs to the criminal justice system attributable to alcohol-related crime utilized four basic divisions, based on the nature of the criminal activity and the available literature and actual data. The four divisions are (A) Violent Crimes, (B) Property Crimes, (C) Part II Crimes and, (D) Other Costs--all other budgeted activities not covered in the direct analysis above.

Violent crimes and property crimes are typically classified as Part I Crimes. Part II Crimes are more often misdemeanors and include offenses generally considered to be 100% alcohol-related by definition.

In all cases, for all elements of the criminal justice systems, unit costs for activities are not available. All costs were estimated from total expenditures, using slightly different procedures in each division of cost determinations.

A. VIOLENT CRIMES

Crimes against persons generally involve more intensive activity and effort from the criminal justice system in terms of investigation, apprehension and prosecution efforts. It is likely that police and court costs would be significantly greater for crimes of violence than for Part II offenses. It was necessary to use national research information for the estimation of the cost of alcohol-related violent crime. This was necessary since no unit costs for different classifications of offenses were available for arrest, court and correction efforts. Arrests for violent crimes in Alaska only accounted for four percent of the total arrests in 1975 (See Table V-1). Given the presumed greater expense of violent crimes to the system compared to lesser offenses, and the small percentage of such arrests in Alaska, estimation of costs according to a proportion of actual total expen-

TABLE V-1
TOTAL NUMBER OF ARRESTS
IN ALASKA--1975

Type of Offense	Number	Arrests* Percent	Percent Alcohol Involvement**
Part I Total	4,717	23%	
Violent Crime Subtotal	766	(4%)	
Homicide	44		64%
Rape	67		34%
Aggravated Assault	504		41%
Property Crime Subtotal	3,951	(19%)	14%
Part II Total	16,008	77%	
Other Assaults	1,384	(7%)	41%
Sex Offenses	137	(.7%)	29%
Liquor Laws	1,746	(8%)	100%
Drunkenness	278	(1%)	100%
Disorderly Conduct	1,467	(7%)	100%
Vagrancy	40	(.2%)	100%
DWI	<u>3,157</u>	<u>(15%)</u>	100%
TOTAL--All Arrests	20,725	100%	

*All FBI Uniform Crime Report classifications of offenses are not included. Part I and Part II Totals equal Total for all arrest. Number of arrests compiled from records of Alaska Department of Public Safety and fifteen municipal police departments.

**Percentage of alcohol involvement based on research results--cited in Economic Cost, pp. 120-5: Homicide--Wolfgang; Rape--D.C. Crime Commission Study; Assaults--M. Amir; Sex Offenses--P. Gebhard; Property Crime--Division of Corrections, Department of Health and Social Services, Alaska. See also Volume IV of present report for a more complete review of available literature.

ditures would most likely produce misleading underestimates.

Results from the 1967 Task Force Report, Challenge of Crime to a Free Society*, produced estimates of the proportion of cost of each violent crime to all components of the criminal justice system--police, courts, corrections. According to this report, criminal homicide constitutes two percent of the total criminal justice system costs; aggravated assault accounts for nine percent; and, one percent of the cost is for forcible rape. The total expenditure for all components of the criminal justice system in Alaska was about \$45.4 million in 1975. The expenditures of the criminal justice system are presented in Table V-2. The estimated proportion of costs for violent crime is presented in Table V-3.

Given this information, and the extent to which these offenses are considered alcohol-related, corresponding costs can be determined for the criminal justice system as a whole. The necessary information regarding the extent to which each category of offense is alcohol-related is presented in Table V-1. The computations of alcohol-related costs, in Table V-4, shows that more than \$2.4 million of the total criminal justice system expenditures for criminal homicide, aggravated assault, and forcible rape can be attributed to alcohol abuse. This cost estimate excludes violent crimes other than those indicated because generally accepted information regarding extent of alcohol involvement is not available.

B. PROPERTY CRIMES

Arrests. The actual number of arrests for the collapsed category of property crime offenses totalled 3,951 in 1975; and, 14% of arrests in this category are generally considered to be alcohol-related. This information is shown in Table V-1. Thus, 553 arrests or approximately 3% of the total

*Economic Cost, p. 127.

TABLE V-2
EXPENDITURES OF THE CRIMINAL
JUSTICE SYSTEM BY COMPONENT
ALASKA, 1975

Component	Amount
Enforcement	
State Troopers	\$ 12,556,100
Municipal Police	4,948,219
Prosecution	1,969,800
Judicial	12,690,400
Corrections	13,273,400
Other*	5,113,000
TOTAL	\$ 50,550,919

*See Table V-7. This amount is excluded in calculations in Sections A, B, and C.

Source: Budget expenditures obtained from Division of Budget and Management reports. Municipal expenditures obtained from Department of Community and Regional Affairs.

TABLE V-3
ESTIMATED COSTS OF SELECTED VIOLENT
CRIMES FOR ENTIRE CRIMINAL
JUSTICE SYSTEM, ALASKA, 1975

Offense	Percentage of Cost	Estimated Cost
Criminal Homicide	2%	\$ 908,758
Aggravated Assault	9%	\$ 4,089,413
Forcible Rape	1%	\$ 454,379

TABLE V-4

ESTIMATED COST OF VIOLENT CRIME ARRESTS TO CRIMINAL
JUSTICE SYSTEM ATTRIBUTABLE TO ALCOHOL
ALASKA--1975

Offense	Percentage Cost to CJS	Cost to Alaska CJS (dollars)*	Percent Alcohol- Related**	Alcohol- Related Cost--Alaska (dollars)
Criminal Homicide	2%	\$ 908,758	64%	\$ 581,605
Aggravated Assault	9%	4,089,413	41%	1,676,659
Forcible Rape	1%	454,579	34%	<u>154,489</u>
TOTAL Alcohol-Related Cost				\$2,412,753

*From Table V-3.

**From Table V-1.

enforcement effort was expended for arrests for property crimes due to alcoholism and alcohol abuse. In terms of dollar expenditures, this amounts to about \$.467 million for alcohol-related property crimes.

Court Costs. Estimates from the Alaska Court System indicated that the average court costs for non-violent crime cases amounted to \$245. Thus, 553 alcohol-related property crime cases at \$245/case amounts to \$.135 million.

Corrections.* The estimates of costs for corrections and rehabilitation are based on a series of calculations, listed in series below; the estimated amounts are computed, carried and totalled.

Booking Costs:

553 cases x \$22 = \$.012 million

Pre-court Incarceration Costs:

Thirty-three percent of persons arrested serve an average of fourteen days prior to court at an average institutional cost of \$41/day. Thus,
 $553 \times 33\% \times 14 \times \$41 = \$.105$ million.

Post-court Incarceration Costs:

Twenty-six percent of property crime arrests serve an average sentence of eight days at an institution cost of \$41/day. Thus,
 $553 \times 26\% \times 8 \times \$41 = \$.047$ million.

Probation Costs:

Six percent of persons arrested for non-violent crimes are placed on probation for an average of one year at an estimated cost of \$2.81 per day. Thus,
 $553 \times 6\% \times 365 \times \$2.81 = \$.034$ million.

Corrections Sub-total = \$.198 million

Property Crimes Total. The total cost estimated for the criminal justice system for alcohol-related property crimes amounts to approximately \$800,000.

*The Alaskan Division of Corrections provided statistical information and unit cost estimates regarding booking, pre-, and post-court incarcerations, and probation activities in relation to various categories of offenses.

C. PART II CRIMES

Arrests. As can be seen from Table V-1, arrests for Part II criminal offenses represent the greatest number of arrests, over 77% of the total. The necessary information to compute the cost of arrest activities that could be attributed to arrests for Part II offenses is presented in Table V-5.

As shown in Tables V-4 and V-5 (columns 1, 2, and 3), research information regarding alcohol involvement for the categories of arrest in Part II crimes only covers about 51% of all Part II arrests. This amounts to 37% of the total number of arrests, which proportionately corresponds to a cost estimate of \$6.477 million for alcohol-related Part II offenses.

Court Costs. Given the average unit cost for court cases, and the information that 96% of those arrested go to court (Alaska Court System Report, 1975), 7,295 cases x 96% x \$245 becomes \$1.716 million for alcohol-related court costs for misdemeanors.

Corrections. The series of necessary calculations is listed below:

Booking Costs:

7,295 cases x \$22 = \$.160 million

Pre-court Incarceration:

7,295 cases x 33% x 14 days x \$41 = \$1.382 million

Post-court Incarceration:

Assaults and Sex Offenses:

607 cases x 45% x 8 days x \$41 = \$.090 million

100% Alcohol-Related Cases:

6,688 x 10% x 8 days x \$41 = \$.219 million

Probation Costs:

7,295 cases x 6% x 365 x \$2.81 = \$.449 million

Corrections Sub-total = \$2.3 million

Part II Crimes Total. The total cost estimated for the criminal justice system for alcohol-related Part II crimes amounted to \$10.493 million dollars. Again, this estimate covers only those Part II-type arrests that

TABLE V-5

CHARACTERISTICS OF PART II ARRESTS ATTRIBUTABLE TO ALCOHOLISM AND
ALCOHOL ABUSE, ALASKA, 1975

Offense	1 Number of Arrests	2 Percent Alcohol- Related	3 Number Alcohol- Related Arrests	4 Percent of Arrests Sentenced	5 Number Incarcerated
Assaults	1,384	41%	567	19%	108
Sex Offenses	137	39%	40	45%	18
100% Arrests	<u>6,688</u>	100%	<u>6,688</u>	10%	<u>669</u>
TOTAL	8,209		7,295		795
Percent of Part II Arrests	51%		46%		
Percent of Total Arrests	40%		37%		

Columns 1 and 2. See Table V-4.

Column 3. Column 1 multiplied by column 2.

Columns 4 and 5. Percentage figures provided by Division of Corrections, Department of Health and Social Services.

have known alcohol involvement; about 50% in this category.

D. OTHER COSTS

A survey of all other components of the criminal justice system identified a number of agencies that have budgeted costs that included activities that were alcohol-related but not included in one of the preceding calculations. A listing of these agencies or budget areas is provided below, along with associated annual expenditures, percent of alcohol-related activity, and corresponding alcohol-related expenditures (Table V-6).

TABLE V-6

ESTIMATION OF ADDITIONAL CRIMINAL JUSTICE SYSTEM COSTS
ATTRIBUTABLE TO ALCOHOLISM AND ALCOHOL ABUSE--1975

Category	Annual Expenditure* (\$ millions)	Percent Alcohol- Involved**	Alcohol-Related Expenditures (\$ millions)
Public Defender	1.195	60%	.717
Criminal Justice Planning	3.089	2.5%	.077
Violent Crime Compensation Board	.108	37%	.040
Child Court Filings	.599	50%	.030
Pipeline Impact	.122	2.5%	.003
Prosecution	<u>1.970</u>	35%	<u>.690</u>
Total	\$ 7.083		\$ 1.557

*Budget Expenditures, Division of Budget and Management.

**Estimates derived from survey of agency.

RESULTS

A brief summary of the estimated costs of alcohol-related crime according to various components of the criminal justice system is provided

in Table V-7 below.

TABLE V-7
SUMMARY
ESTIMATED EXPENDITURES BY THE CRIMINAL JUSTICE SYSTEM ATTRIBUTABLE
TO ALCOHOLISM AND ALCOHOL ABUSE, ALASKA, 1975

System Component		Amount (millions)	Percent of Total Alcohol- Related Costs
Enforcement		\$ 7.951	52.1 %
Violent Crime*	1.007		
Property Crime	.467		
Part II Crime	6.477		
Court Costs		1.972	12.9 %
Violent Crime	.121		
Property Crime	.135		
Part II Crime	1.716		
Corrections		3.783	24.8 %
Violent Crime	1.285		
Property Crime	.198		
Part II Crime	2.300		
Other Costs (includes Prosecution)		<u>1.557</u>	<u>10.2 %</u>
Total Costs Attributable to Alcoholism and Alcohol Abuse		\$ 15.263	100.0 %

*Estimated violent crime costs disaggregated for each system component according to breakdown provided by 1967 President's Task Force Report, see Economic Cost, p. 127.

As indicated in Table V-7, the estimation of expenditures by all components of the criminal justice system that can be attributed to alcohol-related criminal acts totals over \$15 million in 1975. More than half of these costs are accounted for by enforcement activities, 52.1%; about one-quarter of the costs are for corrections, 24.8%; and, court

costs and other costs (which include state prosecution) account for 12.9% and 10.2% of the total alcohol-related costs.

In aggregate, the total amount of \$15 million represents about 30% of the total criminal justice system expenditures for 1975. Table V-8 provides a breakdown of total costs as a percentage of each and all component expenditures. Enforcement activities account for 15.7% of total costs, corrections--7.5%, courts--3.9%, and other (including prosecution)--3.1%.

The estimated alcohol-related expenditures should be considered as conservative. Not all categories of offenses were included due to lack of any information regarding their association with alcohol consumption as a basis for estimations. Also, these expenditures are estimated expenditures by the criminal justice system, not as the total cost for crime and anti-social cost to society. Theoretically, the costs estimated here are considered resources that could have been used in alternative ways.

TABLE V-8

ESTIMATED EXPENDITURES OF CRIMINAL JUSTICE SYSTEM ATTRIBUTABLE TO ALCOHOLISM AND ALCOHOL ABUSE
AS A PROPORTION OF EACH AND ALL SYSTEM COMPONENTS

Component	Total Component Expenditure	Alcohol- Related Expenditures	Percent of Expenditure for each Component	Percent of Total Expenditures
Enforcement	\$ 17.504	\$ 7.951	45.4 %	15.7 %
Courts	12.690	1.972	15.5 %	3.9 %
Corrections	13.273	3.783	28.5 %	7.5 %
Other	<u>7.083</u>	<u>1.557</u>	<u>21.9 %</u>	<u>3.1 %</u>
Total	\$ 50.550	\$ 15.263	-----	30.2 %

PART VI. ECONOMIC COST OF ALCOHOLISM AND ALCOHOL ABUSE TO
THE HEALTH CARE SYSTEMS *

STATEMENT OF THE PROBLEM

The purpose of this section is to estimate the impact of alcoholism and alcohol abuse on the health and medical care system. The primary interest is the economic cost of providing health and medical care services to alcoholics or alcohol abusers. Thus, the methods and findings presented in this section refer to excess economic costs due to alcohol abuse and alcoholism. The estimated costs refer to economic costs of providing the services rather than cost to individuals.

METHODOLOGY

A. SERVICE DELIVERY MODEL

In estimating the excess costs of health and medical care services due to alcoholism and alcohol abuse, the conception of the entire range of such services and cost measures was based on a model established by Cooper and Rice (1976). This model provides for consideration of indirect and direct costs, and was originally developed for a more general application for overall health and medical care costs. It has been adapted for the purpose of this specific investigation. This model considers two categories of costs.

1. INDIRECT COSTS

Indirect costs refer to the dollar value of foregone output, or lost production, due to disability or illness (morbidity) and/or

*The outline, methodology and basic data included in this section are based on an unpublished report prepared by Brian Saylor, M.P.H., Legislative Affairs Agency, State of Alaska. Special thanks are extended to Mr. Saylor and to Mr. Gregg Erickson, Director of Research Services, for the interest and allocation of resources for this project.

premature death (mortality).

2. DIRECT COSTS

Direct costs refer to the dollar value of services provided for direct health care and supporting services. These can be categorized as institutional and non-institutional costs.

Institutional costs cover direct services provided and refer to various measures of utilization of facilities, which differ according to type of facility or service. The institutional facilities and services investigated were: hospitals (general and psychiatric), physicians services, dental services, other professional services, drugs and nursing care.

Non-institutional costs estimate the dollar value of administration of health insurance policies, research and training.

B. ESTIMATION PROCEDURES

1. INDIRECT COSTS

Estimation of the costs of lost production due to illness, disability and premature death attributable to alcoholism and alcohol abuse is presented in the section of Lost Production.

2. DIRECT SERVICES

In order to estimate the cost of excess health and medical care services provided to alcoholics and alcohol abusers, it is necessary to determine the nature and extent of all services provided to all patients and then to estimate the extent of services that would have been provided to a hypothetical population where alcoholics and alcohol abusers did not exist. The difference between the two represents the impact of alcoholism and alcohol abuse.

In order to determine the nature and extent of all institutional health and medical care services within the state, a conventional categorization of services was employed to bring together federal, state, regional, and local service delivery systems, agencies and geographic planning and service areas. All services were divided by three major, conventional target populations. Thus, estimation of costs for institutional services provided was divided according to services provided to patient populations designated as: non-Native--general population, including both public and private institutions and practitioners; military--restricted population of military personnel, dependents and others employed by the U.S. Department of Defense; Native--the Alaska Native population, primary provider of services being Public Health Services, DHEW.

C. COMMENTS--LIMITATIONS

The nature of the available data necessitated extensive use of "opinions" within calculations of services utilization for alcoholics, and therefore within estimates of excess cost. In most cases, a low and high estimate was made in an attempt to at least define a range within which an acceptable estimate should exist.

RESULTS

The estimated excess costs due to alcoholism for institutional and non-institutional services are presented by type of facility and/or service. For each type of facility or service, the estimation procedure will be briefly outlined and the preliminary findings stated. The aggregated excess costs will then be summarized in the CONCLUSION section.

A. INSTITUTIONAL SERVICES--COSTS

Cost estimates are provided for the following facilities and services:

hospitals, physicians, dentists, nursing homes, pharmacies, foster homes, and other professional services.

1. HOSPITALS

No direct recorded information exists that describes the extent of excess inpatient hospital utilization related to alcoholism in Alaska. Thus hospital costs were estimated separately for non-Native, military and native hospitals.

Non-Native Hospitals. In the absence of recorded information regarding alcohol-related acute care admissions, relevant literature was reviewed to obtain an estimate of the proportion of acute care, alcohol-related admissions. A review of this summary is presented in Table VI-1. Review of this summary indicated that 15 to 25 percent of all acute care admissions were alcohol-related.

Two excess cost estimates were calculated--a low estimate based on the 15% alcohol-related admission rate, and a high estimate based on the 25% admission rate. A list of all non-Native hospital utilization characteristics is presented in Table VI-2. Total figures for admissions and average length of stay for non-Native patients, along with the percentage of all hospital admissions which were alcohol-related, and the fractional increased length of hospital stay required by an alcoholic as compared to a non-alcoholic, were used to calculate excess use of inpatient hospital days attributable to alcoholism.

Estimation of excess institutional services was accomplished by application of the procedures and formulae presented below.

The average use of services for all patients is a function of the extended average use of services by alcoholic patients plus the reduced average use of services by non-alcoholic patients. This can be represented by the formula:

$$L = (f \times ba) + (1 - f)bn$$

Thus the average use of service (e.g., average length of stay in

TABLE VI-I

SOME EVIDENCE FROM RELEVANT LITERATURE CONCERNING THE PROPORTION OF ALCOHOLICS IN GENERAL HOSPITALS

Author 1/	Sample Size	Alcohol Abusers as a Proportion of All Admissions or All Patients			Author's Criteria for Defining Alcohol Abuse	Sample Composition or Study Interest
		Male	Female	Total		
Pearson	100	29% (plus 9% possible)	--	29% (plus 9% possible)	By interview, 4 or more of the following criteria: 1. Alcoholic Blackouts 2. Sneaking Drinks 3. Loss of Control 4. Murring "Eye-Openers" 5. Loss of Friends, Family, Job Due to Drinking 6. Hospitalized Due to Drinking	1962 white male adults North Carolina medical and surgical patients Prevalence
Nolan	826	15%	10%	14%	Questionnaire on functional interference of alcohol with health, job, family	Adults, Connecticut 1955 Admissions
Kearney, et al.	416	--	--	8.7% (plus 17% possible)	Known to MD's as alcoholic or history of treatment for alcoholism, or treated for a diagnosed complication of alcoholism such as DT's, cirrhosis, etc. Information basically obtained from chart	Inpatients aged 14-75, upper middle class excluding obstetric patients, Connecticut, 1967 and hospitalized under the diagnosis of alcoholism or with a disease in which alcoholism can be a factor (i.e., GI or respiratory problems), Admissions
Kearney	235	--	--	13.4% (plus 27%)	Same criteria	Lower-class outpatients, otherwise same criteria, Admissions
Moore	200	18%	5.5%	10% (plus 3.5% possible)	Michigan alcoholism screening test	21 years or older, California, 1971, no OB patients, 65% female, 1971, Prevalence
Barccha et al.	392	28% (plus 7% possible)	6% (plus 2% possible)	16% (plus 2% possible)	Drinking history interview	General medical, over 20 years old, 1968, Admissions
Ewing and Rouse	130	40% 8 14	9% 0 9	28% 5 12	Barccha criteria Pearson criteria Hospital record	North Carolina, 1969, medical and surgical adult patients, data evaluated by 3 sets of criteria, Prevalence
Neustadt	67	59	18	39	Physician rating on basis of drinking enough to be a problem	Baltimore City Hospital medical wards, 1960, Prevalence
Neustadt	65	72	36	60	"	BCH, 1954, Prevalence
Neustadt	109	44	10	34	"	Johns Hopkins Hospital medical wards, 1964, Prevalence
Gaird	167			17	Questionnaire in primary or secondary diagnosis of alcoholic, directly administered	South London, 1971
West				1.09 30	Admitting diagnosis	Average daily census Total admissions, 1971
Bresand				50	Physician evaluation	France, 1974

1/ Pearson, William S., "The 'Hidden' Alcoholic in the General Hospital," North Carolina Medical Journal, 23:6-10, 1962.Nolan, J. P., "Alcohol as a Factor in the Illness of University Service Patients," American Journal of Medical Science, 249:135-42, 1965.Kearney, T. R., Bonime, H., and Cassimatis, G., "The Impact of Alcoholism on a Community General Hospital," Community Mental Health Journal, 3:373-6, 1967.Moore, Robert A., "The Prevalence of Alcoholism in a Community General Hospital," American Journal of Psychiatry, 128:638-9, 1971.Barccha, R., Steward, M. A., Guze, S. P., "The Prevalence of Alcoholism Among General Hospital Ward Patients," American Journal of Psychiatry, 125:681-4, 1968.

Ewing, John A. and Rouse, Beatrice A., "Identifying the 'Hidden Alcoholic,'" 29th International Congress on Alcohol and Drug Dependence, Sydney, N.S.W., Australia, February 3, 1970.

Neustadt, J., "The Vice of Alcohol," Maryland State Medical Journal, May 1956, pp. 29-30.Gaird, R., Personal communication cited in Drugs, Alcohol and Tobacco in Great Britain, Eds. Lacune, J. G. and Hensman, C., London, 1971.West, J. W., "Alcoholism--A General Hospital Meets the Challenge," Illinois Medical Journal, 142:2, pp. 96-97, 1974.Bresand, M., "Alcoolisme et Conscience Collective," Review of Alcoholism, 15:81-96, 1969, cited in deLint, J., "The Prevention of Alcoholism," Preventive Medicine, 3:24-35, 1974.Source: Economic Cost, pp. 83-84.

TABLE VI-2

CHARACTERISTICS OF UTILIZATION OF NON-NATIVE ACUTE CARE HOSPITALS, 1974

	Beds ¹	Avail. Patient Days	INPATIENT DAYS			ADMISSIONS			AVERAGE LENGTH OF STAY		
			Total	Non-Native	Native ¹	Total	Non-Native	Native	Total	Non-Native	Native
Anchorage Community ²	85	31,025	20,818	20,737	81	4766	4757	9	4.37	4.36	9.10
Providence (Anchorage) ²	150	54,750	47,797	47,605	192	10067	10046	21	4.75	4.74	9.10
Cordova Community ³	14	5,110	895	532	363	257	217	40	3.48	4.12	9.10
Fairbanks Memorial ²	116	43,340	27,013	24,616	2,397	5707	5444	263	4.73	4.52	9.10
Faith Hospital (Glenallen) ³	5	1,825	940	655	285	291	260	31	3.23	2.52	9.10
Homer ²	10	3,650	1,460	1,047	413	454	409	45	3.21	2.56	9.10
Bartlett Memorial (Juneau) ²	67	24,455	12,765	11,778	987	2435	2327	108	5.24	5.06	9.10
Ketchikan General ³	55	20,075	7,197	5,831	1,366	1827	1677	150	3.94	3.48	9.10
Kodiak Island ²	25	9,125	4,745	3,738	1,007	1157	1047	110	4.10	3.57	9.10
Maynard McDougall Mem. ³ (Nome)	18	6,570	2,964	859	2,105	803	398	405	3.69	2.16	5.2*
Valley General (Palmer) ²	25	9,125	2,555	2,555	-0-	647	647	-0-	3.94	3.94	-0-
Petersburg General ³	13	4,745	1,748	1,245	503	465	410	55	3.76	3.04	9.10
Seward General ²	33	12,045	2,192	1,929	263	536	507	29	4.09	3.80	9.10
Sitka General ²	24	8,760	5,107	5,107	-0-	956	956	-0-	5.34	5.34	-0-
Central Peninsula ² (Soldotna)	30	10,950	2,924	2,820	104	873	862	11	3.35	3.27	9.10
Wrangell General ³	11	4,015	1,072	770	302	306	273	33	3.50	2.82	9.10
TOTALS	676	246,740	142,192	131,824	10,368	31,256*	30,237	1,310	4.52	4.36	7.91

*Arithmetic Rounding

**The average length of stay is calculated from AANHS contract data because of the large percentage of Native admissions.

Sources:

1. Alaska Area Native Health Service Utilization of Contract Health Services, FY 1975. AANHS Contract Health Care Program.
2. Guide to the Health Care Field, American Hospital Association, 1975 edition, pp. 28-29.
3. Alaska State Plan for the Construction of Hospitals and Other Medical Facilities, Health Facilities Development, Office of Planning and Research, Department of Health and Social Services, April 1, 1976.

a hospital) for all patients (L) equals the product of the proportion of alcoholic patients (f) and their average use of services (ba), plus the product of the proportion of non-alcoholic patients (1 - f), and their average use of services (bn).

The fractional increase in average use of service (g) for an alcoholic compared to a non-alcoholic patient is the ratio of average use of service by a alcoholic patient (ba) to the average use of service by a non-alcoholic patient (bn); g is a constant adjusted for each type of health care service.

$$g = \frac{ba}{bn}$$

Therefore, the average use of service by a non-alcoholic patient (bn) would be represented as

$$bn = \frac{ba}{1 + g}$$

By substituting this representation of average use of service in the original equation and solving for the average use of service by an alcoholic patient (ba),

$$ba = \frac{L}{f + \frac{(1 - f)}{(1 + g)}}$$

Thus, with the numerical value of the average use of service by an alcoholic patient (ba), the value of the average use of service by a non-alcoholic patient (bn) may then be calculated.*

With this information, the hypothetical utilization of service by a non-alcoholic patient population can be calculated. The difference between the hypothetical and actual utilization represents excess use of service attributable to alcoholism.

The results of the computation of excess acute care hospital days attributable to alcoholism in non-Native hospitals are shown in Tables VI-3A and VI-3B. The low estimate, accepting a fifteen percent alcohol admission rate, is 8,456 excess inpatient hospital days. This compares to 13,304 excess inpatient hospital days, accepting the high estimate of

*The formulae and procedure for the estimation of excess utilization of services developed and derived by Brian Saylor, M.P.H. and Alan Latham, Ph.D. Legislative Affairs Agency, State of Alaska.

TABLE VI-3A and VI-3B
EXCESS ACUTE CARE HOSPITAL DAYS IN NON-NATIVE HOSPITALS
ATTRIBUTABLE TO ALCOHOLISM IN 1974

	All Patients	Alcohol- Related Patients	Non Alcohol- Related Patients	Constant Patient Load No Alcoholics	Excess Use
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TABLE VI-3A ASSUMING A FIFTEEN PERCENT ALCOHOL-RELATED ADMISSION RATE

Admissions	30,237	4,536	25,701	30,237	4,536
Average Length of Stay*	4.36	5.92	4.08	4.08	1.84
Inpatient Hospital Days	131,833	26,853	104,860	123,367	8,466

TABLE VI-3B ASSUMING A TWENTY-FIVE PERCENT ALCOHOL-RELATED ADMISSION RATE

Admissions	30,237	7,559	22,678	30,237	7,559
Average Length of Stay*	4.36	5.68	3.92	3.92	1.76
Inpatient Hospital Days	131,833	42,935	88,898	118,529	13,304

*The average length of stay for an alcoholic patient was found to be about 45% longer than for a non-alcoholic patient. See Economic Cost, pp. 85-91.

25 percent alcohol-related admissions.

The daily cost for inpatient care in a non-Native hospital is about \$190.* This figure reflects only the cost of providing room and board to the patient and does not include drugs, physician services, or other ancillary service. Thus the low estimate for total cost of 8,456 excess days of inpatient care would be \$1,608,540; the high estimate for 13,304 excess days would be \$2,527,760.

Public Health Service Hospitals. The same procedure for the determination of excess inpatient days due to alcoholism for non-Native hospitals was used for Public Health Service (PHS) hospitals. Characteristics of utilization are presented in Table VI-4. Additional information from Table VI-2, regarding admissions and average length of stay for Alaska Natives, was combined with PHS data to calculate excess inpatient days, shown in Table VI-5A and VI-5B.

Assuming a 15 percent rate of alcohol-related admissions, 6,811 excess days of inpatient care would be attributable to alcoholism. Given the 25% alcohol-related rate, 10,953 excess days were calculated.

The daily cost for inpatient care amounts to about \$141**; therefore, the low estimate for cost of excess inpatient care in PHS Hospitals for 6,811 days amounts to about \$960,351; the high estimate for 10,953 excess days would be \$1,544,373.

Military Hospitals. Characteristics of utilization of military hospitals are presented in Table VI-6. The information regarding the calculation of excess utilization is presented in Tables VI-7A and VI-7B. Assuming that 15 percent of all admissions are alcohol-related, 3,678 of 57,816 inpatient days in military hospitals would be considered excess days due to alcoholism; given the 25 percent estimate, the figure would

Sources:

*Selected Community Hospitals and Demographic Statistics, American Hospital Association, 1974.

**Financial Management Office, Alaska Area Native Health Service, Anchorage, Alaska

25 percent alcohol-related admissions.

The daily cost for inpatient care in a non-Native hospital is about \$190.* This figure reflects only the cost of providing room and board to the patient and does not include drugs, physician services, or other ancillary service. Thus the low estimate for total cost of 8,456 excess days of inpatient care would be \$1,608,540; the high estimate for 13,304 excess days would be \$2,527,760.

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Assuming a 15 percent rate of alcohol-related admissions, 6,811 excess days of inpatient care would be attributable to alcoholism. Given the 25% alcohol-related rate, 10,953 excess days were calculated.

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Sources:

*Selected Community Hospitals and Demographic Statistics, American Hospital Association, 1974.

**Financial Management Office, Alaska Area Native Health Service, Anchorage, Alaska

TABLE VI-4

CHARACTERISTICS OF UTILIZATION OF PUBLIC HEALTH SERVICE ACUTE CARE HOSPITALS, 1974

Hospital ¹	Beds ²	Available Patient Days	Admissions ¹	Used Patient Days ¹	Average Length of Stay	Percent Occupancy
Anchorage	183	66,795	5,276	56,742	10.7	84.94
Barrow	14	5,110	349	1,299	3.7	24.05
Bethel	42	15,330	1,590	9,941	6.2	64.84
Kanakanak	29	10,585	757	4,053	5.3	38.29
Kotzebue	40	14,600	765	3,442	4.5	23.57
Mt. Edgecumbe	82	29,930	1,288	18,311	14.2	61.17
St. Paul*	10	3,650	73	97	1.3	2.65
Tanana	26	9,490	426	4,567	10.7	48.12
TOTALS	426	155,490	10,524	98,452	9.35	63.31

*Includes St. George (St. George not reported for August 1974 thru June 1975)

¹ HSM-202-1--Monthly Report of Inpatient Services-PHS Indian and Alaska Native Hospitals

² Alaska State Plan for the Construction of Hospitals and Other Medical Facilities, Health Facilities Development, Office of Planning and Research, Department of Health and Social Services, April, 1976.

TABLES VI-5A & VI-5B
EXCESS ACUTE CARE HOSPITAL DAYS IN PUBLIC HEALTH SERVICE HOSPITALS
ATTRIBUTABLE TO ALCOHOLISM IN 1974

	All Patients*	Alcohol- Related Patients	Non Alcohol- Related Patients	Constant Patient Load No Alcoholics	Excess Use
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TABLE VI-5A ASSUMING A FIFTEEN PERCENT ALCOHOL-RELATED ADMISSION RATE

Admissions	11,834	1,775	10,059	11,834	1,775
Average Length of Stay	9.20	12.50	8.62	8.62	3.88
Inpatient Hospital Days	108,820	22,188	86,709	102,009	6,811

TABLE VI-5B ASSUMING A TWENTY-FIVE PERCENT ALCOHOL-RELATED ADMISSION RATE

Admissions	11,834	2,959	8,875	11,834	2,959
Average Length of Stay	9.20	11.99	8.27	8.27	3.72
Inpatient Hospital Days	108,820	30,682	73,396	96,867	10,953

*Information for all patients includes inpatient admissions to PHS hospitals and Alaska Native admissions to non-PHS hospitals. Sources: Total Inpatient Workload Statistics: FY 1974, Office of Systems Development, Alaska Area Native Health Services.

TABLE VI-6
CHARACTERISTICS OF UTILIZATION OF MILITARY ACUTE CARE HOSPITALS, 1974

HOSPITAL	BEDS	AVAILABLE PATIENT DAYS	ADMISSIONS (DISCHARGES)	USED PATIENT DAYS	AVERAGE LENGTH OF STAY	PERCENT OCCUPANCY
Elmendorf Air Force Base Hospital (Anchorage)	170	62,050	6,328	41,387	6.54	66.7
Bassett Army Hospital (Fairbanks)	70	25,550	2,848	16,429	5.77	64.3
TOTALS	240	87,600	9,176	57,816	6.30	66.0

Source: Guide to the Health Care Field, 1975 Edition. American Hospital Association, pp. 28-29.

TABLES VI-7A & VI-7B
EXCESS ACUTE CARE HOSPITAL DAYS IN MILITARY HOSPITALS
ATTRIBUTABLE TO ALCOHOLISM IN 1974

	All Patients*	Alcohol- Related Patients	Non Alcohol- Related Patients	Constant Patient Load No Alcoholics	Excess Use
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TABLE VI-7A ASSUMING A FIFTEEN PERCENT ALCOHOL-RELATED ADMISSION RATE

Admissions	9,176	1,376	7,800	9,176	1,376
Average Length of Stay	6.30	8.56	5.90	5.90	2.66
Inpatient Hospital Days	57,816	11,779	46,020	54,138	3,678

TABLE VI-7B ASSUMING A TWENTY-FIVE PERCENT ALCOHOL-RELATED ADMISSION RATE

Admissions	9,176	2,294	6,882	9,176	2,294
Average Length of Stay	6.30	8.21	5.66	5.66	2.55
Inpatient Hospital Days	57,816	18,834	38,952	51,936	5,880

*Source: See Table VI-6.

be 5,880 excess days.

Total cost for excess inpatient hospital days, at \$81 per day*, would be \$297,918 for the lower estimate, and \$476,280 for the higher estimate.

Alaska Psychiatric Institute.

Alaska Psychiatric Institute (API), the only state-operated and primary psychiatric inpatient facility in the state, was able to provide actual information regarding alcohol-related admissions and discharges. The nature of the facility allows accurate alcohol-associated diagnoses, due to the provision of direct alcohol treatment services. Thus, the figures to be presented represent direct, rather than estimated alcohol-related costs.

Actual data for FY 1976 provided by API show that 24.8% of all discharges (749) involved a primary or secondary alcohol-related diagnosis. The actual number of discharges with alcohol-related diagnosis totaled 186 for FY 1976, with an average length of stay of 26.9 days. The cost of API inpatient services is \$120.00 per day.** Based on these actual data findings, costs for alcohol-related patients at the Alaska Psychiatric Institute were \$600,408 for FY 1976. (See Table VI-8.)

This cost figure, then, is direct and actual as opposed to estimated. It is in this case equivalent in category to excess costs estimated thus far for other medical hospital services since these patients would not have been admitted but for the evidence of an alcohol problem.

*Hospital Administrator, Elmendorf Air Force Base Hospital, Anchorage, Alaska.

**Cost per day figure from Linda Smith, Research Analyst, Division of Mental Health, Alaska Psychiatric Institute, Anchorage, Alaska.

TABLE VI-8

ALASKA PSYCHIATRIC INSTITUTE
ALCOHOL-RELATED DISCHARGES--FY 1976*

	# of Discharges with Primary or Secondary Alcohol-Related Dx	Total # of API Discharges	% of A/R Discharges
Discharges TOTAL	186	749	24.8%
Average Length of Stay (# of days)	26.9		
Cost per day	\$120.00		
Direct alcohol- related costs (FY 1976)	\$600,408.00		

Source of data: Linda Smith, Research Analyst, Division of Mental
Health, Alaska Psychiatric Institute, Anchorage, Alaska.

SUMMARY--HOSPITALS

The following table summarizes the costs of excess use of hospital services attributable to alcoholism or alcohol abuse, using the low and high estimates of alcohol-related admissions to Alaskan acute care institutions.

TABLE VI-9

HOSPITALS
AGGREGATED EXCESS COSTS SUMMARIZED

Hospitals Acute Care	Low-Cost Estimate	High-Cost Estimate	Average Cost Estimate
Non-Native	\$1,608,540	\$2,527,760	\$ 2,068,150
Public Health Service	960,351	1,544,373	1,252,362
Military	297,918	476,280	387,099
API*	600,408	600,408	600,408
Total	\$3,467,217	\$5,148,821	\$ 4,308,019

*Alaska Psychiatric Institute was able to provide actual admission date; this cost figure is direct and actual as opposed to estimated.

2. PHYSICIANS' SERVICES

In evaluating the impact of alcoholism and alcohol abuse on the health care delivery system, it is essential to examine the physicians' services attributed to alcoholism or alcohol-related problems. To estimate excess use of physicians' services attributable to alcoholism and alcohol abuse, it is necessary to estimate the amount of services that would have been provided to a hypothetical population where alcoholics and alcohol abusers did

not exist.

Non-Native and Military Physician Services. The absence of actual statistics concerning the number or rate of alcohol or alcohol-related visits to non-Native/private general practice physicians, necessitated the use of estimates of excess use of physicians' services due to alcoholism or alcohol abuse in Alaska.

First, the estimated patient load of Alaskan physicians was developed using data from a 1975 physician relicensure survey. (See reference-- Table VI-10.) The survey response rate was over 60% for private practice physicians and 24% for military physicians. The survey results indicated that the average reported patient load for private practice physicians was 3,881 patient visits per year; for military physicians, patient visits averaged 3,444 per year. Projection of these sample results to the total number of private practice and military physicians in the state yielded an estimated total of more than 1,520,000 physician visits per year for all Alaskans.

Excess cost estimates were calculated using the projections of total physician use, the previously used formula (see pages 66 and 69), and estimates of the proportion of alcohol-related physician visits. The low estimate of the percentage of all visits which are alcohol-related was derived from figures presented in the National Disease and Therapeutic Index. NDTI estimated that 6.6% of all physicians' visits were alcohol-related. The high estimate that was used was generated in a special survey cited in The Economic Costs of Alcohol Abuse and Alcoholism (1974), which found 17% of all physician visits to be alcohol-related. If this figure is adjusted for Alaskan alcohol consumption figures, an estimated 24.3% of all physician visits are alcohol-related (see Table VI-11).

Excess usage by Alaskans of non-Native and military physicians' services, attributable to alcoholism is presented in Table VI-12. The low estimate of

TABLE VI-10
ESTIMATED PATIENT LOAD OF NON-NATIVE AND
MILITARY PHYSICIANS, 1974

	Total Physicians*	Number of Survey Responses	Percentage of Response	Reported Total Visits Per Year**	Total Visits Physician/ Year (Sample)	Projected Total Visits Per Year All Physicians
Private Physicians	320	195	60.9	755,780	3,881	1,241,920
Military	81	20	24.1	61,998	3,444	278,964
Total	401	215	53.6	817,778	7,325	1,520,884

Sources:

*Annual Health Director, Alaska State Medical Association, 1975.

**Barber, S.S.; Crouse, K.; Alaska Physician Manpower Characteristics and Trends, Alaska Medicine, 17:5 p. 80-81, 1975, and unpublished data, Office of Planning and Research, Alaska Department of Health and Social Services.

TABLE VI-11

SOME EVIDENCE FROM RELEVANT LITERATURE CONCERNING THE PROPORTION OF
ALCOHOLICS SEEN IN PRIVATE GENERAL PRACTICE

Source	Physician Visits by Alcoholic Patients as a Percentage of Total Visits
National Disease Therapeutic Index*	6.6%
Special Survey: The Economic Costs of Alcohol Abuse and Alcoholism (1974)**	17%
Adjusted for Alaska***	24.3%
Grant and Boyd (1961) Northern Ireland****	19.1%
Wilkins (1974) Great Britain*****	13.5%

*"Alcoholism," National Disease and Therapeutic Index, 4:7-8, 1973.

**The Economic Costs of Alcohol Abuse and Alcoholism, Final Report, Policy Analysis, Inc., Boston, MA, HSM, 42-73-114 (NIA) March 31, 1974. Table 4, page 89.

***Each Alaskan of drinking age consumed 4.03 gallons of absolute alcohol in 1972. This figure is 56% higher than the national average of 2.63 gallons, and assumes a linear correlation between an individual's consumption and his health status.

****Grant, A.P., Boyd, M.W.J. Ulster Medicine, 30:114, 1961.

*****Wilkins, R.H., "A Survey of General Practice Prevalence Studies in Great Britain;" paper presented at the 20th International Institute on the Prevention and Treatment of Alcoholism, Manchester, England, June, 1974.

TABLE VI-12

EXCESS USE OF NON-NATIVE AND MILITARY SERVICES ATTRIBUTABLE TO
ALCOHOLISM OR ALCOHOL-RELATED PROBLEMS, 1974

Assumptions:	6.6% of All Physician Visits are Alcohol-Related*		24.3% of All Physician Visits are Alcohol-Related*	
	Visits	Visits/Person/Year	Visits	Visits/Person/Year
Total Civilian and Military**	1,520,884	5.55***	1,520,884	5.55
Non-Alcohol-Related	1,420,506	5.17	1,151,309	4.47
Alcohol-Related****	100,378	10.21	369,575	8.83
Constant Patient Load, No Alcoholics	1,415,629	5.17	1,223,957	4.47
Excess	105,225	5.04	296,927	4.36

*See Table VI-11.

**Military and non-Native physician visits were aggregated because of incomplete information on the extent of military personnel use of private physicians.

***The estimated total number of non-Native and military physician visits is shown in Table IV-10. That number divided by the combined non-Native and military population results in the average physician visits per person, per year.

****A special survey cited in The Economic Costs of Alcohol Abuse and Alcoholism (1974) showed that physicians visits for alcohol abusers (8.5 visits per year) are 97.6% higher than for non-alcohol users (4.3 visits per year).

excess physician visits, presented in Table VI-12, shows approximately 105,000 total excess visits for all non-Native and military physicians; the high estimate shows almost 300,000 total excess visits.

The estimated costs for these excess visits to physicians, based on a per visit cost of about \$34.50,* ranges from \$3.7 million for the low estimate to \$10.5 million for the high estimate.

Alaska Native Physicians' Services. Actual data on the number of ambulatory patient care visits involving a clinical impression of alcoholism or drug abuse (provided by the Office of Systems Development, AANHS)** reveals that 1.2% of all Alaska Native physicians' visits were alcohol-related. Given its availability, this figure was used to calculate the low estimate of excess visits. It is generally accepted however that all alcohol-related visits are not recorded as such. Thus, the value derived from the literature, 24.5%, was used to calculate the high estimate (Table VI-11). Given these low and high estimates, Table VI-13 illustrates the wide range of estimated excess physician visits related to alcohol to be between 3300 and 24,000.

The estimated costs for these excess visits to Alaskan Native Health Service physicians, based on a per visit cost of about \$24.00***, ranges from over \$79,000 for the low estimate to \$582,360 for the high estimate.

SUMMARY--PHYSICIANS

A brief summary of the estimation of the results of the calculation of the excess utilization of physicians' services that is attributable to

*Average cost of a physician office visit paid by the Alaska Medicaid program, from Medicaid Annual Studies Report, Division of Medical Assistance, Department of Health and Social Services, 1975.

**Alaska Area Native Health Service

***Financial Management Office, AANHS, Anchorage, Alaska.

TABLE VI-13

EXCESS USE OF ALASKA AREA NATIVE HEALTH
SERVICE PHYSICIAN SERVICES ATTRIBUTABLE TO
ALCOHOLISM OR ALCOHOL-RELATED PROBLEMS, 1974

Assumptions:	6.6% of All Physician Visits are Alcohol-Related*		24.3% of All Physician Visits are Alcohol-Related**	
	Visits	Visits/Person/Year	Visits	Visits/Person/Year
Total Alaskan Native***	248,896	4.36	246,896	4.36
Non-Alcohol-Related	243,894	4.30	186,900	3.93
Alcohol-Related****	3,002	6.23	59,996	5.70
Constant Patient Load, No Alcoholics	243,591	4.30	222,631	3.93
Excess Use of Phy- sicians' Services	3,305	1.94	24,265	1.77

*Actual data on the number of ambulatory patient care visits involving a clinical impression of alcoholism or drug abuse, Office of Systems Development AANHS, May 12, 1976; Statistical Summary; Indian Health Service; Alaska Area Native Health Service, Office of Systems Development, June 1975, Table 5.

**See Table IV-11.

***The estimated number of physician visits by Alaskan Natives is obtained by dividing all recorded visits by the Native population. Total visits were presented in Statistical Summary, IHS, Office of Systems Development, AANHS, June 1975, Table 5.

****A special survey cited in The Economic Costs of Alcohol Abuse and Alcoholism showed that physician visits for alcohol abusers (8.5 visits per year) are 97.6% higher than for non-alcohol abusers (4.3 visits per year).

alcohol abuse or alcoholism is presented in Table VI-14.

TABLE VI-14

EXCESS COSTS OF PHYSICIANS VISITS ATTRIBUTABLE TO ALCOHOL
ABUSE AND ALCOHOLISM, ALASKA, 1974

Category	Low Estimate	High Estimate	Average
Non-Native and Military	\$3,633,419	\$10,500,000	\$7,066,710
Native	79,320	582,360	330,840
Total	\$3,712,739	\$11,082,360	\$7,397,550

The table illustrates that excess visits to physicians attributable to alcohol abuse and alcoholism have an economic value that ranges from a low estimate of about \$3.7 million, to over \$11 million. The average of the two estimates shows an excess cost of over \$7 million.

3. DENTAL SERVICES

Existing literature on the dental needs of an alcoholic population tends to be inconclusive. One study, for example, suggests that dental needs of alcoholics are generally higher than those of the rest of the population. Dunkley and Carson found that permanent tooth loss among alcohol abusers is three times higher than the national average for corresponding ages. Additionally, the cost of a dental rehabilitation program was found to be significantly higher for the alcoholic group, primarily because of a greater need for dental laboratory services.* These findings were substantiated by a study of alcoholic and psychiatric patients at a Veterans' Administration hospital.**

*Dunkley, R., and Carson, R., "Dental Requirements of the Hospitalized Alcoholic Patient," Journal of the American Dental Association, 76: 800-803, 1973.

**King, W., and Tudor, K., "Dental Problems of Alcoholic and Non-Alcoholic Psychiatric Patients." Quarterly Journal of Studies in Alcoholism, 34: 1208-1211.

However, it is not at all clear that the poorer dental health of an alcoholic is transmitted into greater usage of dental services. A special survey undertaken to assist a federal team in ascertaining the extent to which alcoholics used health services found that non-alcoholics had over twice as many dental visits per year as alcoholics.* For these reasons, no estimate of excess dental services attributable to alcoholism is offered. While there is evidence to suggest that alcoholics have poorer dental health than the average adult, there is little evidence to suggest that they use more dental care. In fact, just the opposite may be true; the lower amount of dental services may be a contributing factor to the poorer dental health of alcoholics.

The fact that no estimate for dental service costs is offered should not be interpreted as implying that alcoholism has no effect on the total dollar or human service impact of dental services. Rather, it implies that there is little basis for estimating such an impact. Therefore, while the total health care costs of alcohol abuse and alcoholism may be somewhat understated with the omission of this component, the omission is not likely to introduce a serious bias into the overall estimate of the impact of alcohol abuse and alcoholism on health and social services delivery.

4. OTHER PROFESSIONAL SERVICES

Services for the treatment and rehabilitation of alcoholics include privately practicing psychologists and social workers, trained alcoholism counselors, the clergy, and other professional counselling and rehabilitative services provided by trained health professionals. No data has been located upon which to base an estimate of the total cost of services provided by professionals to alcoholics. As in dental services, the omission of this estimate is not intended to imply that there is no cost involved. It merely

*The Economic Cost of Alcohol Abuse and Alcoholism, *op cit*, Table 4, p. 80.

means that currently there is insufficient information upon which to base an estimate. The omission of this estimate also tends to underestimate the total cost of alcoholism to the community and should be considered when evaluating the final total cost figures. Cost estimates for state-funded alcoholism counselors and social workers are considered, however, in separate chapters regarding social services and public assistance (Part VII), and direct alcohol program services (Part VIII).

5. DRUG AND DRUG SUNDRIES

Given the increased morbidity among alcoholics or alcohol abusers, it was of interest to estimate excess drug expenditures related to alcohol. Information regarding national per capita expenditures for drugs is presented in Table VI-15. Because of the decline in health conditions, the alcoholic or alcohol abuser expends about 56% more for drugs*. The average adult Alaskan spends almost \$50 per year for drugs. The national figure is slightly lower, reflecting a higher cost for drugs in Alaska, estimated to be about ten percent (see footnote Table VI-15). The same formula that was used for hospital and physician visits was used to calculate excess expenditures for drugs. The national per capita expenditure provided the basic figure for the low estimate of the calculation of excess drug expenditures attributable to alcoholism. The high estimate was the Alaska adult per capita estimate (Table VI-15). Table VI-16 shows, through estimates, that the alcohol-related excess use of drugs ranges from \$372,000 to \$418,000, with an average of \$395,00, in 1973.

6. NURSING HOME SERVICES

Nursing home services can be classified into two types of care, according to the intensity of services delivered. The more intensive of the two is termed a skilled nursing facility; the other is called an intermediate care facility. Patients often use skilled nursing facilities to convalesce following

*Economic Cost

TABLE VI-15
ESTIMATES OF PER CAPITA DRUG AND
DRUG SUNDRY EXPENDITURES

Private Consumer*	\$ 40.03
National*	43.47
Adult Expenditure**	45.00
Alaska Average Estimate***	44.03
Alaska Adult Estimate****	49.50

*U.S. Social Security Administration, Research and Statistics Note, (Note No. 1, 1975).

**Cooper, B.S. and Worthington. N.L., "Medical Care Spending for Three Age Groups; Social Security Bulletin, May 1972, pp. 3-16.

***The private consumer estimate adjusted for the increased cost of drugs and drug sundries in Alaska; 10% estimated by Stan Thompson, R.Ph., President, Alaska Pharmaceutical Association and Joy Donelson, R.Ph., Medical Arts Pharmacy, Anchorage, Alaska.

****The adult expenditure estimate adjusted for the higher costs of drugs and drug sundries in Alaska.

TABLE VI-16
EXCESS DRUG AND DRUG SUNDRY
EXPENDITURES ATTRIBUTABLE TO ALCOHOLISM
OR ALCOHOL ABUSE, 1973

	Low Estimate*	High Estimate**
Total Expenditure	\$15,461,530	\$17,382,370
Non-Alcoholic Per Capita Expenditure***	42.97	48.31
Non-Alcoholic Expenditure	14,408,474	16,210,372
Alcoholic Per Capita Expenditure	67.03	75.36
Constant Expenditure, No Alcoholics	15,089,302	16,964,491
Excess Drug Expendi- ture Attributable to Alcoholism	372,228	417,879
Average Excess Drug Expenditure		\$395,053

*Per capita estimate multiplied by total population.

**Adult per capita expenditure multiplied by total population.

***The drug expenditure for an alcoholic was found to be about 56% higher than for a non-alcoholic; The Economic Costs of Alcohol Abuse and Alcoholism, March 1974, Table 4, p. 89. Calculations assume 15,610 alcoholics in Alaska in 1973.

intensive services provided in an acute care institution. The skilled nursing facility provides services designed to help a patient receive physical or social rehabilitation services necessary to regain and maintain his former health status. Intermediate care facilities provide services to people who do not need the level of intensity of skilled services yet who require, by virtue of their physical or mental disability, a structured living situation with minimal care. Skilled and intermediate services have been combined for the purposes of estimating the use of nursing services attributable to alcohol-related medical problems.

The total number of nursing home days in 1974, shown in Table VI-17, was approximately 150,000 days. In Table VI-18, national surveys estimating the percent of alcohol-related nursing home patients are contrasted with Alaskan estimates. A weighted average reflects that approximately 30 percent of nursing home days are attributable to alcoholism or alcohol-related problems in Alaska.

Due to a lack of data, it was not possible to calculate the excess cost of alcohol-related nursing home care;* however, the calculations show that over 45,000 nursing home days are attributable to alcohol-related problems. At a cost of almost \$27** a day, the total cost of alcohol-related nursing home days is over \$1.2 million, as shown in Table VI-19.

*The use of the concept of excess care is somewhat dubious for long range nursing home care.

**Medicaid Annual Status Report, FY1974, Division of Medical Assistance, Department of Health and Social Services, 1975.

TABLE VI-17
CHARACTERISTICS OF ALASKAN NURSING
FACILITIES (SKILLED AND INTERMEDIATE)

Facility	Beds	Available Patient Days	Admissions or Discharges	Patient Days Used	Average Length of Stay (days)	Percent Occupancy
Glenmore	100*	36,500	246	32,990	135	90.3
Careage	100**	36,500	111	30,669	276	84.2
Careage North	100**	36,500	663	26,357	40	72.2
Ridgeview Memorial	74*	27,010	95	19,153	201	70.9
Cordova Community Hosp.	8*	2,920	4	2,257	564	77.0
Ketchikan General	40*	14,600	37	16,483	445	96.8
Petersburg General	12*	4,360	11	2,072	188	70.9
Maynard McDougal	6*	2,190	5	1,934	386	88.3
Wrangell	COMPLETE DATA NOT AVAILABLE					
Wesleyan Nursing Home	<u>64</u>	<u>23,360</u>	<u>59</u>	<u>18,095</u>	<u>307</u>	<u>77.0</u>
TOTAL	504	277,560	1,136	150,010	132	65.9

*Alaska State Plan for the Construction of Hospitals and Other Medical Facilities, Health Facilities Development, Office of Planning and Research, DHSS, April 1976.

**Personal correspondence with facility administrators.

TABLE VI-18
SOME EVIDENCE ON THE PERCENT
OF ALCOHOL-RELATED NURSING HOME PATIENTS

Source	Percent of Alcoholic Patients in Facility
Greenwald and Linn*	23.0
Special Survey**	8.5
<u>Alaskan Estimates</u>	
Cordova***	40.0
Wesleyan****	6.25
Careage House*****	<u>40.0</u>
Estimate Used (weighted average)	30.0

*Greenwald, S., and Linn, M., "The Younger Nursing Home Patient," Journal of Gerontology, 27, pp. 393-398, 1972.

**A special survey of alcohol-related health service use, The Economic Cost of Alcohol Abuse and Alcoholism, 1971, op. cit., p. 89.

***Correspondence with Emery Thibodeau, Administrator, Cordova Community Hospital, Cordova, Alaska, May 27, 1976.

****Correspondence with Mildred Peich, R.N., Administrator, Wesleyan Nursing Home, Seward, Alaska, May 26, 1976.

*****Correspondence with John Houser, Administrator, Careage House, Anchorage, Alaska, May 26, 1976.

TABLE VI-19
DIRECT USE OF NURSING HOME
ATTRIBUTABLE TO ALCOHOL ABUSE OR ALCOHOLISM, 1974

Total Days*	Percentage of Days Attributable to Alcoholism or Alcohol-Related Problems**	Estimated Days Attributable to Alcoholism and Alcohol-Related Problems	Cost per Day***	Cost of Alcohol- Related Care
150,010	30.0	45,003	\$26.94	1,212,380

*See Table VI-17.

**See Table VI-18.

***"Medicaid Expenditures Type," Medicaid Annual Status Report, FY1974, Division of Medical Assistance, DHSS, January 31, 1975, p. 15.

7. SUMMARY OF INSTITUTIONAL COSTS
OF HEALTH AND MEDICAL CARE
ATTRIBUTABLE TO ALCOHOLISM AND
ALCOHOL ABUSE

Estimation of the excess cost of health and medical care due to alcoholism and alcohol abuse included consideration of hospital services, physician services, drugs and nursing services. The estimate for excess costs of providing these services to alcoholics and alcohol abusers ranged from \$8.8 million to \$17.9 million. An average of the low and high estimate, or \$13.3 million, will be adopted as the working value of excess cost for health and medical care. An itemized summary of low, high, and average estimates for service category considered is summarized in Table VI-20.

B. NON-INSTITUTIONAL SERVICES--COSTS

Non-institutional services are those services which, while necessary to support the delivery of health and social services, are outside health care facilities. Within this section, a discussion of the administration of health insurance policies and research and construction costs will be presented as representative of alcohol-related non-institutional services.

1. HEALTH INSURANCE

An effort was made to obtain some estimate of administrative costs for the disposition and handling of alcohol-related claims. Very little information was released by major health insurance carriers. This lack of data results in a considerable underestimation of total costs of alcoholism and alcohol abuse on the health and social service system.

A 1976 publication from the Division of Insurance, Alaska Department of Commerce and Economic Development, reflects that \$4.6 million represents the approximate insurance administrative costs for Alaska-based insurance companies

TABLE VI-20

SUMMARY

ESTIMATED INSTITUTIONAL EXCESS COSTS OF HEALTH AND MEDICAL CARE
ATTRIBUTABLE TO ALCOHOLISM AND ALCOHOL ABUSE

	Low Estimate	High Estimate	Average (\$ millions)
Hospitals--Acute Care			
Non-Native--Private	1,608,540	2,527,760	2.069
Public Health	960,351	1,544,373	1.252
Military	297,918	476,280	.387
API	<u>600,408</u>	<u>600,408</u>	<u>.600</u>
Sub-total	3,467,217	5,148,821	4.307
Physician's Services			
Non-Native and Military	3,633,419	10,500,000	7.067
Public Health Service	<u>79,320</u>	<u>582,360</u>	<u>.321</u>
Sub-total	3,712,739	11,082,360	7.398
Drug and Drug Sundries	372,000	418,000	.395
Nursing Services	1,212,380	1,212,380	1.212
Institutional Health Care Costs Attributable to Alcoholism and Alco- hol Abuse	\$8,764,336	\$17,861,561	\$13.312

for 1972. The percentage of these administrative costs which are related was unable to be determined. However, some percentage of alcohol-related costs must be considered when estimating overall costs of alcohol. (See Table VI-21.)

The providers of health insurance for which some measure of alcohol-related administrative costs for 1975 were requested are listed below:

Blue Cross

Blue Cross Affiliated Insurance Providers:

--Medicare

--Armed Services Champus

--Federal Employees Program

Teamsters--Alaska

The estimated health care administrative costs of these providers are presented in Table VI-22, below.

The administrative costs were estimated by Accounting Office of Blue Cross and must be assumed to be considerable underestimations.

Workmen's Compensation. It is impossible to determine actual payments made for alcohol-related occupational injuries. In fact, state laws preclude eligibility for payment if the injury was due solely to intoxication. However, based on estimation procedures for determination of lost production due to illness, disability, and premature death attributable to alcoholism and alcohol abuse, an estimated cost determined in Part III (Lost Production) is again presented here.

Most of the labor force, except military personnel, is insured by three main plans: (1) Workmen's Compensation, (2) Federal Employees Compensation, and, (3) Northwest Marine Welfare. Collectively, these plans cover a total of 162,286 workers--over 95% of the Alaskan Labor Force. The three plans accounted for a total of \$37 million in providing disability and death benefits for slightly more than 162,000 workers.

TABLE VI-21

WRITERS OF GROUP ACCIDENT AND HEALTH INSURANCE, 1972

Type of Insurer	No. of Companies	Premium Income					Total Dollars	Benefits Paid	Admin- istrative Costs	Percent of Total
		Less than \$10,000	\$10,000- \$99,000	\$100,000- \$499,999	\$500,000- \$999,999	Over \$1,000,000				
Life Insurers	82	47	18	6	7	4	\$16,154,104	\$12,300,000	\$3,854,104	23.8
Hospital & Medical Service Corporations	2	0	1	0	0	1	\$ 8,454,561	\$ 7,770,000	\$ 684,561	8.1
Property & Casualty	<u>30</u>	<u>23</u>	<u>6</u>	<u>1</u>	<u>0</u>	<u>0</u>	<u>\$ 551,355</u>	<u>\$ 449,000</u>	<u>\$ 102,355</u>	<u>18.6</u>
	114	70	25	7	7	5	\$25,160,020	\$20,519,000	\$4,541,020	18.4

Source: Alaska Department of Commerce and Economic Development, Division of Insurance, May 1976.

TABLE VI-22
HEALTH CARE ADMINISTRATIVE COST
(excluding Dental) ALASKA 1975

Provider	Administrative Costs	Number of Subscribers	Administration
Blue Cross*			
Gross Premium-			
\$18,082,052			
Claims Incurred-			
\$15,638,573	\$2,443,479	28,745 (64,688 covered)	13.5%
Teamsters**	Est. 1,225,000	Est. 14,500 (Est. 31,900 covered)	Est. 13.5%
Medicare***			
(Unit administra-			
tive costs only			
available)			
\$13.94/unit x 6,343			
claims	88,421		
Hospital and			
Nursing--\$2.44/unit			
x 24,000 claims	58,560		
Physician and Drugs			
Armed Services			
Champus*			
Claims incurred--	8,600	25,000	1%
\$858,415		(Est. 55,000 covered)	
Federal Employees			
Program*			
Claims incurred--			
\$2,805,018	28,000	4,716	1%
		Est. 10,300 covered)	
Total	\$ 3,852,065		

*Information on Blue Cross, Champus, and Federal Employees Program came from Blue Cross office, 15700 Dayton Ave. N., Seattle, WN 98111; James F. Harden, Accounting Manager (1% Administration costs very questionable.)

**Very little information was released from the Teamsters (Juneau, AK office, other than size of membership.

***Cost analysis on Medicare came from Medicare Washington Physicians' Service, 220 West Harrison, Seattle, Washington 98119.

Based on estimation procedures outlined in Part III, it was estimated that \$4.3 million was the approximate excess payments due to alcohol abuse; of this amount, approximately \$.13 million would be attributable to alcohol-related administrative costs, based on the given administrative allocations.

2. RESEARCH AND TRAINING

In 1975 there was only one major research project funded within the State of Alaska. That project was organized by the Center for Alcohol and Addiction Studies at the University of Alaska. The funding for the project amounted to \$47,229. In addition, one official training project was funded (\$84,371), and conducted by the same agency (see Part VIII, and Volume III, for more information).

SUMMARY ECONOMIC COSTS OF NON-INSTITUTIONAL SERVICES

The consideration of non-institutional service costs was included for general information. For the most part, the data available are insufficient for meaningful inclusion in the overall economic costs of health care attributable to alcoholism. Economic costs that were able to be determined were included in other parts of this Volume, and thus are part of the total estimated economic cost of alcoholism and alcohol abuse.

PART VII. ECONOMIC COSTS OF SOCIAL SERVICES AND PUBLIC ASSISTANCE
DUE TO ALCOHOLISM AND ALCOHOL ABUSE

STATEMENT OF THE PROBLEM

Individual, family and community social problems can be increased as a result of alcohol abuse and alcoholism. The alcoholic may involve his or her family in a series of adverse situations such as crime, illness, accidents, lowered income, and premature death. Alcohol-related family problems may include interpersonal friction, divorce, child care, and child abuse and neglect. Thus, the extent to which the fiscal and economic costs of social services and assistance payments are occasioned by alcoholism and alcohol abuse needs examination.

METHODOLOGY

In estimating the costs of public assistance and selected social services due to alcoholism and alcohol abuse, attention will be focused on public aid cases and state social worker caseloads. Estimates of the percentage of alcohol involvement, and costs for program service and social services, will be presented for fiscal year ending July, 1976.

RESULTS

The estimated costs due to alcoholism for public assistance and social services will be presented by categories. For each category of service, the estimated costs will be briefly outlined and the preliminary findings stated. The aggregated costs will then be summarized.

A. PUBLIC ASSISTANCE--COSTS

A report prepared by the Division of Public Assistance as a result of a special request for this report, provided conservative indicators of the

percentage of alcohol-related cases passing through that department. Alcoholism is believed to significantly contribute to such eligibility factors as income below a certain level, and families with one parent absent or incapacitated.

Cost estimates are provided for the following categories of service: Aid to Families With Dependent Children, Aid to the Disabled, and Medicaid.

1. AID TO FAMILIES WITH DEPENDENT CHILDREN

Information provided by the Division of Public Assistance revealed that an estimated 15% of AFDC cases were alcohol-related. In these cases, the incapacity or absence of a parent was judged to be primarily attributable to alcoholism/alcohol abuse. AFDC assistance payments are presented in Table VII-1, illustrating an estimated cost of alcohol-related cases in this category to be \$1,805,906.00

TABLE VII-1

AID TO FAMILIES WITH DEPENDENT CHILDREN--ASSISTANCE PAYMENTS 1976

TOTAL Average # of AFDC Cases per Month	Percent Estimated Alcohol- Related	Average # of Alcohol- Related Cases per Month	Average Cost per Case per Month	Cost of all Alcohol-Related Cases	
				Per Month	Per Year
3,682	15%	544	\$276.64	\$150,492	\$1,805,906

Source: Division of Public Assistance, Dept. of Health and Social Services.

2. AID TO THE DISABLED

The estimated cost of assistance payments for alcohol-related disabilities is presented in Table VII-2. The cost is based on an estimate by the Division of Public Assistance, that 20% of the case load was due to

alcoholism and alcohol abuse. As shown in the table, the total estimated cost is \$324,791.

TABLE VII -2
AID TO THE DISABLED-ASSISTANCE
PAYMENTS, 1976

TOTAL Average # of AD Cases Per Month	Percent Estimated Alcohol- Related	Average # of Alcohol- Related Cases Per Month	Average Cost Per Case Per Month	Cost of All Alcohol-Related Cases	
				Per Month	Per Year
1,407	20%	281	\$96.32	\$27,066	\$324,791

Source: Division of Public Assistance, Dept of Health and Social Services.

3. MEDICAID

Health care services for individuals who receive public assistance are paid for by the Medicaid Program. Twenty percent of Medicaid expenditures were considered to be alcohol-related, since eligibility for Medicaid is based upon eligibility for cash assistance programs. A summation of these costs is shown in Table VII -3.

TABLE VII -3
MEDICAID PAYMENTS RELATED
TO ALCOHOL, 1976

Medicaid Cost for AD's Per Year	Estimated Percent Alcohol- Related AD Cases	Medicaid Alcohol- Related Costs for AD's Per Year	Medicaid Cost for AFDC Per Year	Estimated Percent Alcohol- Related AFDC Cases	Medicaid Alcohol- Related Costs for AFDC Cases Per Year	TOTAL
						Medicaid Costs for Alcohol- Related AFDC Cases Per Year
\$3,099,383	20%	\$619,877	\$2,249,379	15%	\$337,407	\$957,284

Source: Division of Public Assistance, Dept. of Health and Social Services.

SUMMARY

PUBLIC ASSISTANCE COSTS

The following Table summarizes estimated costs due to alcoholism for the major Alaskan public assistance categories.

TABLE VII-4

PUBLIC ASSISTANCE AGGREGATED DIRECT COSTS ATTRIBUTABLE
TO ALCOHOLISM AND ALCOHOL ABUSE, 1976

Category	Cost of All Alcohol-Related Cases per Year
AFDC	\$ 1,805,906
AD	324,791
Medicaid	<u>957,284</u>
Total Alcohol- Related Costs	\$ 3,087,981

These types of expenditures or transfer payments are often counted as economic costs. Although they do represent a fiscal expenditure they do not technically constitute an economic cost due to alcoholism and alcohol abuse. In a social and political sense, they represent a re-distribution of part of the burden of reduced income due to alcoholism (the proper economic measure of economic cost here) from the alcoholic and family to the taxpayer.

B. SOCIAL SERVICES

Unlike transfer payments, which are a redistribution of purchasing power, expenditures for social services attributable to alcoholism and alcohol abuse are indeed economic costs. Social services for alcoholism

and alcohol abuse require economic resources for their production. These resources could have produced other output which must be foregone because of alcoholism and alcohol abuse.

There is limited information available for estimating alcohol-related costs of Alaska's program services and social services. As was true for public assistance, the information used for the cost estimates was provided as a special request for this project. Such information is not routinely maintained. The major categorical program services for which some estimation of alcohol-related costs can be determined are as follows: foster care, institutional care for children, day care, protective services, homemakers and social work. The costs estimated in this section pertain to actual expenditures by the State of Alaska. Information regarding the provision of social services attributable to alcoholism, by other non-state agencies, was simply not available.

In combination, expenditures for the above categories of social services in FY 1976 ranged from 10 to 50 percent of the total budgeted amounts. The percentage of expenditures attributable to alcohol-related problems was derived from the analysis of actual cases studied and appraised (see footnote, Table VII-5). The total alcohol-related expenditures amounted to just under \$3.5 million for these services, as presented in Table VII-5, by source of funds.

SUMMARY

The total estimated economic cost for various forms of social services attributable to alcoholism and alcohol abuse amounted to about \$3.45 million for fiscal year 1976. In addition, \$3.1 million was expended in the form of assistance payments due to alcoholism and alcohol abuse. This information is summarized below in Table VII -6.

TABLE VII-5

PROGRAM SERVICES AND SOCIAL SERVICES COSTS FOR ALCOHOL-RELATED CASES,^a FY76
(thousands of dollars)

Source of Funds	44% ^b Foster Care	44% Institutional Care for Children	44% Day Care	44% Protective Services	10% Homemakers	50% Social Work	Total
GF ^c	263.0	612.0	40.2	9.5			924.7
GFM ^d	143.7	141.7	64.9	83.6	10.0	317.0	760.9
Fed.	193.3	183.7	130.4	3.3	17.8	1021.5	1550.0
Other	<u>60.0</u>	<u> </u>	<u>64.3</u>	<u> </u>	<u>12.3</u>	<u>77.5</u>	<u>214.0</u>
Total	660.0	937.4	299.8	96.4	40.1	1416.0	3449.6

^aPercentages are from the analysis of actual case load study as appraised by Connie Hansen, Social Services.

^bThe percent attributable to alcohol-related problems is based upon a weighted average, determined by a survey of actual cases reported by social workers which showed child neglect to be 47% alcohol-related and child abuse to be 32% alcohol-related. This resultant is 44%.

^cState General Fund

^dState General Fund Match

TABLE VII-6

SUMMARY
ECONOMIC COST OF SOCIAL SERVICES AND TRANSFER PAYMENTS
ATTRIBUTABLE TO ALCOHOLISM AND ALCOHOL ABUSE
ALASKA, 1976

Category	Amount (\$-millions)
Social Services	3.450
Transfer Payments Public Assistance (AFDC, AD, Medicaid)	3.088

PART VIII. ECONOMIC COSTS OF DIRECT ALCOHOLISM AND ALCOHOL ABUSE
PROGRAMS

STATEMENT OF THE PROBLEM

There are a number of organizations in Alaska whose influence on alcoholism programming and alcohol-related activities in the state is considerable. Some are devoted entirely to alcohol-related matters (e.g., the State Office of Alcoholism), others to drug as well as alcohol concerns (e.g., the Alaska Native Commission on Alcoholism and Drug Abuse), and yet others to issues and concerns which, on the surface, appear to have little or nothing to do with alcoholism or the problems it generates (e.g., the Veterans Administration). Due to the breadth and compass of their concerns, however, each of these organizations comes in one way or another face to face with the problems of alcoholism and alcohol abuse, and is compelled to formally address them.

BACKGROUND

Eleven such organizations are of particular importance to any assessment of Alaska's alcoholism programs. Through their funding activities, through their formal and informal relations with communities and regional health corporations, and through their broad attempts to mobilize human and financial resources towards the amelioration of a wide range of social problems, these organizations bear a good deal of the burden of providing direct services for alcoholism and alcohol abuse--planning, prevention, training, treatment, rehabilitation, etc. As such, any attempt to determine or estimate the direct financial costs of alcoholism and alcohol abuse to the state must necessarily include the costs of their activities.

As mentioned, eleven such organizations have been identified as particularly important to any assessment of statewide direct alcoholism services costs. Though involved in a spectrum of organizational activities, these organizations all share two common attributes which render them particularly important for such a cost assessment:

- 1) each contains an alcoholism component as part of its overall organizational purpose; and
- 2) each exerts an influence throughout Alaska by virtue of that purpose.

The eleven organizations identified as falling within this category (and hereafter referred to as "statewide organizations") are as follows:

Alaska Area Native Health Service (AANHS)
Alaska Federation of Natives (AFN)
Alaska Labor & Management Employees Association, Inc. (ALMEA)
Alaska Native Commission on Alcoholism and Drug Abuse (ANCADA)
Bureau of Indian Affairs (BIA)
Center For Alcoholism and Addiction Studies, University of Alaska (CAAS)
National Council on Alcoholism, Alaska Region (NCA-AR)
Office of Vocational Rehabilitation (OVR)
Rural Alaska Community Action Program (RurALCAP)
State Office of Alcoholism (SOA)
Veterans Administration (VA).

In the discussion following, each of these statewide organizations will be referred to by the abbreviations, above, in parentheses.

METHODOLOGY

Financial information regarding the funding sources and amounts, and expenditures, of the identified statewide organizations was obtained via per-

sonal interviews and completion of a multipurpose survey instrument. Additionally, subsequent contact was maintained with all of the organizations through telephone and letters, to validate and corroborate the survey responses submitted. Copies of the survey itself, as well as a total examination of the alcoholism services delivery system in the state, may be found in Volume III.

Due to great turnover in many of the organizations' staff, however, and to the fact that financial information for the period under review was often sketchy and irretrievable, much of the data assembled is partial or of an estimate nature.

In sum, the raw financial data which has been grouped and clustered in the following pages can only be taken as a good indication of the alcohol-related costs incurred during FY75 by these eleven organizations. The costs specified are based on expenditures solely for alcohol-related activities. While the difficulties in collecting the data preclude any specification of "administrative costs" or "costs of salaries", the figures provided can be taken as fairly reliable estimates of the cost-items they represent.

RESULTS

A. TOTAL DIRECT COSTS FOR STATEWIDE ORGANIZATIONS

Direct expenditures for alcoholism services by the eleven organizations during FY75 totalled approximately \$3,693,665. This total for the organizations does not include cost expenditures for anything else except alcoholism, nor does it include costs which may be described as "alcohol-related" (e.g., staff time and/or medical costs from other, non-alcohol-related branches of

an organization, etc.). The total also does not include any cost expenditures from two of the organizations--the Alaska Area Native Health Service and the Alaska Bureau of Indian Affairs--as such information was not obtainable at the time.

Actual reported expenditures for each of the selected statewide organizations are presented in Table VIII-1, below:

TABLE VIII-1

DIRECT COSTS FOR STATEWIDE ALCOHOLISM AND ALCOHOL ABUSE SERVICES
BY STATEWIDE ORGANIZATION (1975)

Organization	Expenditure (FY75)	Percent of State Program Total
SOA	\$ 2,107,688	53.9 %
ANCADA	740,500	19.0 %
NCA-AR	458,408	11.7 %
CAAS	188,067	4.8 %
RurALCAP	130,659	3.3 %
OVR	123,070	3.1 %
AFN	87,217	2.2 %
ALMEA	55,276	1.4 %
VA	16,500	0.4 %
Total:	\$ 3,907,385	99.8 %

The above total of \$3,907,385 includes, however, funding from SOA to ANCADA, CAAS, and NCA-AR in the amount of \$213,720. If this amount is subtracted, a non-redundant total estimated direct expenditure of \$3,693,665 is arrived at for the nine reporting organizations, during Fiscal Year 1975.

B. TOTAL DIRECT COSTS BY PROGRAM COMPONENTS

Another way of breaking down the overall alcoholism service expenditures of the eleven identified statewide organizations is in terms of the various kinds of overall program components. Again working from an approximate total cost expenditure of \$3,693,665, it has been found that eight alcoholism and alcohol-abuse components accounted for the costs shown in Table VIII-2, below:

TABLE VIII-2
TOTAL DIRECT ALCOHOLISM AND ALCOHOL ABUSE SERVICE
COST BY COMPONENT, STATEWIDE, 1975

Component	Amount (% of total dollars)
PREVENTION:	\$ 1,203,337 (32%)
Education & Information	\$ 770,851 (20%)
Alternatives To Drinking	441,667 (11%)
Driver Safety	20,819 (1%)
TREATMENT/REHABILITATION:	2,132,057 (55%)
Rehabilitation Counseling	139,570 (4%)
Outreach Counseling	130,659 (3%)
Local Programs	1,861,828 (48%)
TRAINING:	230,821 (6%)
RESEARCH:	47,229 (1%)
ADMINISTRATION:	286,039 (7%)
Technical Assistance and Coordination	40,179 (1%)
Statewide Program Funding (including administrative costs)	245,860 (6%)
	\$ 3,899,483* (101%)

*Missing from this figure are two cost expenditure items totalling \$7,902. If these are added into the total shown above, and the SOA costs for ANCADA, CAAS, and NCA-AR subtracted (total of \$213,720), the overall cost expenditure total of \$3,693,665 is reached. It bears repeating, again, that cost expenditure information for AANHA and BIA are not included in the above table.

C. TOTAL DIRECT COSTS BY FUNDING SOURCE

Yet one more way of looking at direct alcoholism and alcohol abuse costs for the selected eleven statewide organizations is to break down the total cost by the funding sources for the monies expended (i.e., in terms of the original granting agency). Since information for this portion of the cost analysis was derived from--and based on--actual amounts budgeted, a somewhat different total cost figure was used--\$3,672,247, as opposed to the earlier cost total shown of \$3,693,665. The difference, however, is not large enough for concern, as in all instances (of cost assessment) the expenditure figures are estimates.

Itemized by funding source, direct costs for the nine reporting* organizations are presented in Table VIII-3.

SUMMARY

The total estimated direct cost of alcoholism and alcohol abuse services provided by the principal statewide organizations during FY 1975 was approximately \$3.7 million, with the most reliable figure for that cost being approximately \$3,693,665. Since two of the eleven identified statewide organizations--the Alaska Area Native Health Service and the Alaska Bureau of Indian Affairs--were not able to supply financial information for direct services, the actual total was somewhat higher. This estimate, nevertheless, is based on information supplied by the organizations themselves, and therefore stands as probably the most accurate assessment possible of their direct alcohol services costs for FY 1975.

Two factors are important in interpreting this estimate (\$3.7 million) however. First, it should be emphasized that costs only for direct alcohol services have been tabulated and reported; if indirect alcohol-related costs

*Figures shown are only for nine of the eleven statewide organizations, as information for AANHS and for BIA was unobtainable.

TABLE VIII-3

TOTAL DIRECT COST FOR ALCOHOLISM AND ALCOHOL ABUSE SERVICES
BY FUNDING SOURCE, STATEWIDE, 1975

Category	Funding Source	Amount	Percentage of Total
FEDERAL:		\$3,015,646	82.1 %
	NIAAA (\$1,749,285:47.6%)		
	other federal (\$1,245,345:33.9%)		
	VA (\$21,016:0.6%)		
STATE:		439,008	11.9 %
	State General Funds (\$380,621:10.3%)		
	other state monies (\$58,387:0.6%)		
LOCAL:		18,200	0.5 %
PRIVATE:		9,710	0.3 %
OTHER:		189,683	5.2 %
	FY74 grants (\$66,613:1.8%)		
	vocational rehabilitation monies (mixed, federal and state: \$123,070:3.4%)		
Total Costs:		\$3,672,247	100.0 %

such as shared staff or administrative expenses were to be included, the total estimated cost to the organizations would be much greater. Second, it should also be stressed that a considerable amount of growth and expansion of services has occurred among the identified statewide organizations since FY 1975. Representative of this growth are the State Office of Alcoholism, which increased its expenditures from \$2,107,688 in FY75 to \$3,020,128 in FY76 (+43%), ALMEA, which has increased its direct alcoholism expenditures from \$55,276 in FY75 to \$200,000 in FY76 (+262%), and the Alaska Veterans Administration, which in the form of third-party payments has increased its alcoholism expenditures from \$16,500 in FY75 to an estimated \$1,334,700 during FY76 (+12,000%). Financial information for FY77, while still incomplete, indicates that the trend is steadily upward.

PART IX. IMPACT OF SALE AND CONSUMPTION OF BEVERAGE ALCOHOL, AND
ALCOHOLISM AND ALCOHOL ABUSE, ON STATE GOVERNMENT REVENUES
AND EXPENDITURES

STATEMENT OF PROBLEM

This part will examine revenues and expenditures of state government which are attributable to the sale and consumption of beverage alcohol. This examination represents a much more limited perspective of the economic impact of beverage alcohol sale and consumption than the overall economic analysis of social costs and benefits presented in Parts II through VIII. Each of the revenue and expenditure items to be discussed in this part have already been included as an economic cost or benefit in one of the previous Parts. More specifically, and for example, state government revenue from the excise tax on beverage alcohol will be presented in this Part. However, the dollar value of this revenue for the state government has already been considered as part of the economic benefit in the calculation of the value added to state production for the beverage alcohol industry (Part II). Similarly, the economic cost of state government funded services required due to alcoholism and alcohol abuse has, in total, already been accounted for in many of the previous Parts (e.g., criminal justice system, social services, direct alcohol services).

Neither the redistribution of resources from the private to the public sector (in the form of taxes), nor the redistribution from the public to the private sector (in the form of transfer payments), represents additional economic costs or benefits. In other words, no dollar amount of revenues or expenditures are to be added or subtracted, to or

from, the economic costs and benefits previously presented. It is important that state government revenues and expenditures attributable to the sale and consumption of beverage alcohol be distinguished from the economic analysis of social costs and benefits. The impact of beverage alcohol sale and consumption on the state treasury may be useful information for state officials and others, but it must not be confused with the overall economic impact presented as economic costs and benefits.

METHODOLOGY

Information regarding expenditures by nature of activity and source of funds was obtained by a variety of methods: (1) responses to a survey instrument distributed to all state government agencies; (2) interviews with budget officers and program managers of selected state agencies; (3) review of official budget documents for all state agencies; and, (4) estimation of expenditures based on data obtained for other parts of the study.

The information obtained will be presented in tabular form, delineating total expenditures and revenues by source of funds, which are attributable to the sale and consumption of beverage alcohol, and alcoholism and alcohol abuse.

RESULTS

DIRECT STATE GOVERNMENT REVENUE

The state regulation of sale and consumption of beverage alcohol involves licensing and taxation, which generate revenue for the state (See Volume II), in addition to associated corporation and personal income taxes.

The gross and net revenues from the sale of beverage alcohol, as able to be determined by the Department of Revenue, are provided below in

Table IX-1. Total revenues derived from corporation and personal income taxes associated with wholesale and retail sale of beverage alcohol are not able to be determined by the Department of Revenue.* Thus, net state revenue was determined to be about \$7 million

TABLE IX-1
NET REVENUE OF STATE REGULATION OF SALE AND CONSUMPTION OF
BEVERAGE ALCOHOL, ALASKA, FY 1975^a

Source	Amount (dollars)
License Fees	
Wholesale Licenses	\$ 81,850
Retail Licenses	773,041
Excise Tax	6,598,213
Wholesale Industry Income Tax ^b	81,381
Multistate Tax	3,222
GROSS STATE REVENUE	\$ 7,537,707
Administrative Costs:	
Alcohol Beverage Control Office	225,659
Audit and Collection Division	261,242
TOTAL ADMINISTRATIVE COSTS	\$ 486,901
NET STATE REVENUE	\$ 7,050,806

^aAll figures provided by Department of Revenue, Division of Audit and Collections, except as noted.

^bReview of the Wholesale Liquor Industry, State of Alaska Legislative Council, Subcommittee of Taxation and Revenue Report, prepared by Janice C. Gull, p. 1. Figure is an estimate; direct information is unavailable.

*These taxes are paid out of the wages, salaries and profits generated by the beverage alcohol industry and were thus included in the calculation of value added to state production (Part II).

STATE GOVERNMENT ALCOHOL-RELATED EXPENDITURES

Table IX-2 provides a summary overview of budgeted expenditures, for various units of state government, that are attributable to regulation of sale of beverage alcohol and/or alcoholism and alcohol abuse.

TABLE IX-2

ALCOHOL-RELATED BUDGETED EXPENDITURES OF ALASKA STATE GOVERNMENT BY TYPE OF FUNDING SOURCE, 1975/1976

State Government Agency	Funding Source and Amount (thousands)				
	State General Fund	State General Fund-Match	Federal	Other	Total
Office of Alcoholism ^a	\$ 1,302.5	\$ 400.0	\$ 1,018.9	\$ 298.9	\$ 3,020.2
Program Service and Social Services ^b	924.7	760.9	1,550.0	214.0	3,449.6
Public Assistance ^b (AFDC, AD, Medicaid)	902.9	802.6	1,381.5		3,087.0
Public Health ^c	87.0				87.0
Division of Mental Health (API/Mental Health Centers) ^d	654.7	3.2	2.2		660.1
Municipal Revenue Sharing (Law enforcement and health) ^e	1,086.8				1,086.8
Alcohol Beverage Control Office ^f	225.7				225.7
Audit and Collection-Excise Tax ^f	261.2				261.2
Public Protection ^g					
Planning and Support (CJPA)	1.4	0.1	29.2	0.6	31.3
Violent Crimes Compensation Board	30.0				30.0
Enforcement--State Troopers	5,634.0		66.0		5,700.0
Prosecution	690.0				690.0
Public Defender	717.0				717.0
Court System	1,972.0				1,972.0
Corrections	3,780.9	0.19	1.9		3,782.9
TOTAL EXPENDITURES	\$ 18,270.8	\$ 1,966.9	\$4,049.7	\$513.4	\$24,800.8

^aPart VII, this Volume.

^bPart VI, this Volume.

^cCorrespondence with Program Managers--Public Health Nursing and Family Health.

^dAlaska Psychiatric Institute--Part V, this Volume; Mental Health Centers--Annual Plan, 1975.

^eCorrespondence--Department of Community and Regional Affairs.

^fDepartment of Revenue, Division of Audit and Collection.

^gPart IV, this Volume.

The total alcohol-related state government expenditure amounted to over \$24.8 million. This figure represents the total overall fiscal expenditure that can be realistically and fairly attributed to regulation of the sale of beverage alcohol, and to alcoholism and alcohol abuse. Thus, this figure is the gross overall expenditure of the state government due to the sale and consumption of beverage alcohol. Review of the table shows the various components of this overall expenditure, by state government unit and source of funds.

Table IX-3 provides an abbreviated overview of both revenues and expenditures attributable to the sale and consumption of beverage alcohol and alcoholism and alcohol abuse. The information from Table IX-1 and IX-2 is summarized here, and shows that total revenues actually amounted to about \$10.4 million, when state government-generated revenues and "tied" federal funds (federal funds specifically available for alcohol-related expenditures) are aggregated. The amount of over about \$24.8 million for alcohol-related state government expenditures remained the same as in Table IX-2.

The amount for "tied" federal funds is included in both the revenue and expenditure column of the table. These funds are indeed additional resources for the state government. They are also expenditures. Exclusion of this amount from either column would misrepresent the situation; exclusion from both columns would distort the magnitude of the relative revenues and expenditures.

Comparison of the alcohol-related revenues and expenditures shows that, from a fiscal point of view, state government expenditures exceeded revenues by more than \$14.4 million. This comparison is useful, however, only from a fiscal perspective, and raises several questions. The most

TABLE IX-3
SUMMARY OF ALCOHOL-RELATED STATE GOVERNMENT REVENUES AND
EXPENDITURES, 1975/1976
(thousands of dollars)

Revenues		Expenditures	
State Taxes and Fees	\$ 7,537.7	State General Fund Expenditures	\$ 20,751.1
Other Sources	513.4		
"Tied" Federal Funds*	2,400.4	State Expenditure of "tied" federal funds	2,400.4
		State Expenditure of non-"tied" federal funds **	1,649.3
TOTAL REVENUES ALCOHOL-RELATED	\$ 10,451.5	TOTAL EXPENDITURES ALCOHOL-RELATED	\$ 24,800.3

Source: Table IX-1 and Table IX-2.

*"Tied" federal funds are those funds received by the state government because of beverage alcohol consumption. The \$2,400.4 figure is comprised of \$1,018.9 of federal funds for alcohol programs and \$1,381.9 of federal funds for transfer payments due to alcoholism and alcohol abuse. (See also Part I, and Table IX-2.)

**"Non-tied" federal funds are those funds received by the state independent of their expenditure for alcohol associated reasons, but expended by the state government for alcoholism and alcohol abuse problems. As resources, these funds could be used for expenditures that were not associated with alcohol problems. (See also Table IX-2.)

Note: "tied" federal funds are included in both the revenue and expenditure column (see text).

important question concerns the distribution of the revenues and expenditures. This question and other related concerns are discussed in the next Part of this Volume. However, at this point, it is interesting to take notice of the various categories of revenues and expenditures (Table IX-1 and IX-2) and their relative magnitude. For example, only about 14% of state government expenditures due to consumption of beverage alcohol are budgeted for treatment and rehabilitation of alcoholics and alcohol abusers (Office of Alcoholism and Mental Health expenditures, Table IX-2). The remainder of the expenditures are excess costs in the operation of standard government activities due to alcoholism and alcohol abuse--about 86% of all alcohol-related expenditures.

PART X. CONCLUSION

The primary objective of this Volume was to provide a measure of the magnitude of the economic cost of alcoholism and alcohol abuse, and the economic benefit from sale and consumption of beverage alcohol, in Alaska. Each of the preceding Parts of this Volume provided detailed estimates of benefits or costs associated with sale and consumption, and abusive consumption, of beverage alcohol for particular categories of costs, isolated for the purpose of analysis.

This concluding Part brings these estimates together and provides a summary overview of the economic costs and benefits. Further, a comparison is made of the relative magnitude of the cost categories. In addition, this categorical profile of economic costs due to alcoholism and alcohol abuse in Alaska is compared with a corresponding profile of economic cost estimates derived from national estimates.

PROFILE OF ECONOMIC COSTS ATTRIBUTABLE TO ALCOHOLISM AND ALCOHOL ABUSE IN ALASKA

An overview summary of the economic cost attributable to alcoholism and alcohol abuse for the state of Alaska is presented in Table X-1, by category of cost. The total economic cost for Alaska was found to be approximately \$131.2 million. The greatest portion of this amount, 65.8%, is accounted for by the economic cost associated with loss of production--diminished productivity, occupational injuries and excess mortality due to alcoholism and alcohol abuse. The next major category of economic costs, 11.7% of the total, is accounted for by the alcohol-related cost to

the criminal justice system--enforcement, prosecution, courts and corrections. The economic cost for health and medical care contributes 10.1% of the total cost, and motor vehicle accidents (minus excess mortality costs) contribute 6.9% of the total. The economic cost for social services and direct alcoholism and alcohol abuse program services account for 2.7% and 2.8% of the total.

TABLE X-1
PROFILE OF ECONOMIC COST ATTRIBUTABLE TO ALCOHOLISM AND
ALCOHOL ABUSE

Category	Item Cost (\$-millions)	Non-Redundant Total Cost (\$-millions)	Percent of Total
Lost Production:		\$ 86.4	65.8 %
Diminished Productivity	\$ 57.5		
Occupational Injuries	4.3		
Excess Mortality	24.6		
Motor Vehicle Accidents	19.7	9.0*	6.9 %
Criminal Justice System	15.3	15.3	11.7 %
Health & Medical Care	13.3	13.3	10.1 %
Social Services	3.5	3.5	2.7 %
Direct Alcohol Programs	<u>3.7</u>	<u>3.7</u>	<u>2.8 %</u>
TOTAL ECONOMIC COST ATTRIBUTABLE TO ALCOHOLISM AND ALCOHOL ABUSE:		\$ 131.2	100.0 %

*Economic cost of alcohol-related motor vehicle accidents, excluding costs of excess mortality for fatal accidents.

ECONOMIC BENEFIT

The overall economic benefit from the sale and consumption of beverage alcohol in the state of Alaska during 1975 was found to be approximately \$94.1 million. As calculated in Part II, this amount includes the

economic value added to total state production as a result of the activities of the beverage alcohol industry within the state. In addition, this total benefit figure includes certain federal funds received as resources by the state for dealing with problems of alcoholism and alcohol abuse.

ECONOMIC COSTS AND BENEFITS

Within a strict economic framework, the economic benefit of \$94.1 million can be compared to the total economic cost of \$131.2 million, and yield the result of a net economic cost of \$37.1 million. This type of economic result, however, is not a particularly useful analytic finding from a social or political perspective. Although it does indicate that the economic cost of alcoholism and alcohol abuse in the state of Alaska is greater than the overall economic benefit derived from the sale and consumption of beverage alcohol by a substantial margin, several concerns emerge.

One of the primary concerns regards the distribution of the costs and benefits. Put very simply, who receives the economic benefits and who pays for the economic costs? This question of the distribution of economic costs and benefits is not simple to answer, and demonstrates the point of limited usefulness of the net cost result mentioned above.

As previously indicated, the purpose of this investigation was to provide a measure of the magnitude of the overall economic cost and benefit associated with beverage alcohol sale and consumption. However, interpretation of this information and implications of the findings require the use of contexts other than provided by an economic framework. The question of the distribution of economic costs and benefits involves social and political concerns. Should the economic benefit be more than, less than, or equal to the economic cost? How should the costs and benefits be distributed? What level of cost or benefit is desirable or tolerable in a population group?

There are a number of other questions that could be raised for discussion of the findings of the economic cost and benefit of sale and consumption of beverage alcohol. But this discussion is beyond the scope of this study. The main point is that for practical purposes the economic cost and the economic benefit, as able to be determined in this investigation, ought to be held separate for interpretation and discussion according to the various cost categories and not combined to produce some sort of net economic impact. However the magnitude and the profile of the economic cost and benefit are useful indicators for examination and analysis of the parameters of alcoholism and alcohol abuse.

The next section will provide some additional information that may be useful for future discussion of the interpretation and implications of the findings of this economic study.

NATIONAL COMPARISON

Another perspective for analyzing the economic cost attributable to alcoholism and alcohol abuse may be useful for examination of the parameters of alcoholism and alcohol abuse in Alaska. Thus the absolute and relative magnitude of the categories of the total economic cost as determined in this study will be compared with the estimates of the corresponding economic cost for the nation.* This is the only comparison available presently. Comparable information for any other state is based on that state's proportional share of the national cost estimate.

Comparative information for the absolute magnitude of the economic cost for alcoholism and alcohol abuse for the nation and for the state of Alaska is presented in Table X-2. In order to make this comparison, the national cost estimate for each cost category, determined in 1971 (column 1),

*Economic Cost, 1971.

TABLE X-2

COMPARISON OF ECONOMIC COST ATTRIBUTABLE TO ALCOHOLISM AND ALCOHOL ABUSE FOR ALASKA AND THE NATION, 1975

Cost Categories	1 National Study 1971 (\$-Billion)	2 National Study 1975 (\$-Billions)	3 National Study Adjusted 1975 (\$-millions)	4 Alaska Study 1975 (\$-millions)	5 Alaska Study vs. National Study Dollar Difference (\$-millions)	6 Percent Difference
Lost Production	\$ 9.35	\$ 13.28	\$ 25.2	\$ 57.5	\$ +32.3	+128.2 %
Excess Mortality	4.85	6.87	13.1	21.8	+8.7	+66.4 %
Motor Vehicle Accidents	6.44	9.14	17.4	19.7	+2.3	+13.2 %
Criminal Justice System	.51	.72	1.4	15.3	+13.9	+992.9 %
Health & Medical Care	8.29	11.77	22.4	13.3	-9.1	-40.6 %
Social Welfare	.14	.21	.4	3.5	+3.1	+775.0 %
Direct Alcohol Programs	.64	.91	1.7	3.7	+2.0	+117.6 %
TOTALS	\$ 30.21*	\$ 42.9	\$ 81.6	\$ 134.8**	\$ 53.2	65.2 %

Sources:

Column 1: Economic Cost, 1971.

Column 2: Adjustment of 1971 dollar amounts to 1975 dollar value, based on a 42% increase in the Consumer Price Index, 1971-1975, U.S. Bureau of Labor Statistics, San Francisco Regional Office.

Column 3: Adjustment of 1975 dollar amounts to amounts proportional to Alaska's population. 1975 U.S. civilian and military population--212.8 million; 1975 Alaska civilian and military population--404,600. Figures provided by Alaska Department of Labor.

Column 4: Figures from this Volume, Parts III-VIII.

*The actual reported total was \$25.37 billion. This amount excluded calculated value for excess mortality, which was included for comparison here.

**The actual reported total is \$131.2 million. For purposes of comparison with national study, estimated costs for occupational injuries--\$4.3 million and excess mortality for females--\$2.8 million were excluded. However, excess mortality costs were included in Motor Vehicle Accidents--\$10.7 million. Thus, the resulting total of \$134.8 rather than \$131.2 million.

was converted to the 1975 dollar value (column 2) and then pro rated in relation to the 1975 total population for Alaska (column 3). In other words, the economic cost for each category as presented in column 3 represents Alaska's share of the estimated national economic cost for alcoholism and alcohol abuse in 1975 dollars. Column 4 shows the economic cost for each corresponding category as determined in this study, which used essentially the same methodology as the national study, but current, Alaska-specific data. The value for the total economic cost for all categories as shown for column 4 is slightly different than the actual value, because certain amounts were included or excluded in different cost categories to allow for a more appropriate comparison (see footnote, Table X-2).

The major general finding of this comparison is that the total economic cost attributable to alcoholism and alcohol abuse as calculated for Alaska in this study amounts to over 65 percent more than Alaska's proportional share of the national economic cost of alcoholism and alcohol abuse. The fact that the economic cost calculated in this study is greater than Alaska's proportional share of the national economic cost is not surprising, but the magnitude is certainly dramatic.

The fact that the economic cost is greater, as well as the magnitude of the difference, may be due to differences in available data and assumptions made in the process of estimation, or to actual differences in the parameters of alcoholism and alcohol abuse in Alaska compared to the nation as a whole. Or, of course, some combination of these two possibilities may be the explanation.

At this point, the difference will be considered to be primarily due to actual variations in the impact of alcoholism and alcohol abuse on the characteristics of the categories used to estimate the economic cost. The

design of the present study was based on the design and the procedures of the national study, since it was the only prototype available, and also for the purpose of comparison. Some differences in methodology and estimation procedures do exist, and some improvements were made. However, in most cases the calculations made in this study must be considered more accurate, even if only from the point of view of greater availability and accessibility of more complete information for the state here in Alaska, compared to the sources used for the national estimate.

In addition, and perhaps most important, the national economic cost represents a composite of the impact of alcoholism and alcohol abuse for all fifty states. It would be unreasonable to expect that alcoholism and alcohol abuse problems would be evenly distributed across all states. Obviously, all the possible variables that could influence the situation are not similarly distributed in each state. Nevertheless, the magnitude of the difference in the total economic cost is striking, and certainly must be considered as significant.

A better understanding of the nature of the differences in the two overall cost estimates is provided by the estimates of economic cost for each category, presented in columns 4 and 5 of Table X-2. Examination of these columns shows that each category of cost is greater than the corresponding national equivalent, except for the category of health and medical care.

Available information for the estimated cost produced by this study shows that the economic impact of alcoholism and alcohol abuse on the health and medical care system in Alaska is smaller than Alaska's proportional share of the national economic cost estimate. For all other categories, this study produced a cost estimate that was in excess of the national equivalent, and in some cases the differences were quite extreme. Extreme differences were found particularly for the criminal justice system and the social welfare categories, which show percentage differences in economic

cost of over 993 and 775 percent, respectively, compared to the corresponding national cost estimate.

The percentage differences in economic cost for each category are somewhat misleading, because they show the absolute difference between corresponding economic cost categories without reference to the total cost for all categories. Perhaps a better representation of the differentiation of categories of economic cost is shown in Table X-3, where each category of economic cost is presented as a percentage of the total overall cost (all categories).

TABLE X-3

COMPARISON OF ECONOMIC COSTS ATTRIBUTABLE TO ALCOHOLISM AND ALCOHOL ABUSE FOR ALASKA AND THE NATION, RELATIVE TO TOTAL COST, 1975

Economic Cost Categories	National Study Adjusted		Alaska Study*	
	1 Amount (\$-millions)	2 Percent of Total	3 Amount (\$-millions)	4 Percent of Total
Lost Production	\$ 25.2	30.9 %	57.5	42.7 %
Excess Mortality	13.1	16.1 %	21.8	16.2 %
Motor Vehicle Accidents	17.4	21.3 %	19.7	14.6 %
Criminal Justice System	1.4	1.7 %	15.3	11.3 %
Health & Medical Care	22.4	27.4 %	13.3	9.9 %
Social Welfare	.4	.5 %	3.5	2.6 %
Direct Alcohol Programs	<u>1.7</u>	<u>2.1 %</u>	<u>3.7</u>	<u>2.7 %</u>
Totals	\$ 81.6	100.1%	134.8	100.0 %

*The economic cost and percentage of total are not the same as presented in Table X-1. Certain cost categories were adjusted for purpose of comparison. See footnote for Table X-2.

From this perspective, the relative importance of each cost category in accounting for the overall difference in the Alaskan and national estimate appears quite different. Comparison of the percentage figures in column 2 and 4, Table X-3, reveals that although the category of lost production accounts for the greatest percentage of the total cost in both estimates of total economic cost due to alcoholism and alcohol abuse, the estimate produced by this study for lost production (42.7% of total cost) is disproportionately greater than the corresponding national estimate (30.9%). In addition, the impact of alcoholism and alcohol abuse on the criminal justice system is also disproportionately greater as determined by this study, 11.3% of the total compared to 1.7% of the national total estimate of economic cost.

Relatively less important as contributors to the total economic cost are the categories of health and medical care, and motor vehicle accidents, in comparison to national estimates. The economic cost of health and medical care represents 27.4% of the total cost based on the national estimate, and only 9.9% of the total cost as determined in this study. Similarly, the economic cost of alcohol-related motor vehicle accidents accounts for 21.3% of the total national estimate, and 14.6% of the Alaskan estimate.

The economic cost for the social welfare category is only slightly greater than the corresponding percentage of the national total cost estimate. Finally, the relative percentages of the total cost accounted for by the categories of excess mortality and direct alcohol programs are similar for both the Alaskan and national estimates.

SUMMARY

The overall economic cost attributable to alcoholism and alcohol abuse is significantly greater than might be expected on the basis of

pro rated national findings. The magnitude of this difference is dramatically large--65% greater than the corresponding national estimate. The total economic cost amounts to \$131.2 million.

In Alaska, as compared with national estimates, a disproportional percentage of the total economic cost of alcoholism and alcohol abuse is accounted for by the cost associated with lost production and the criminal justice system. Similarly, in Alaska, the economic cost of excess health care contributes a disproportionately smaller percentage of the total cost compared to national findings.

**WORKING PAPERS:
DESCRIPTIVE ANALYSIS OF THE IMPACT OF ALCOHOLISM AND
ALCOHOL ABUSE IN ALASKA, 1975
(FIVE VOLUMES)**

Volume II

**AN ANALYSIS OF STATE LEGISLATION PERTAINING TO REGULATION AND
CONTROL OF BEVERAGE ALCOHOL AND ALCOHOLISM AND ALCOHOL
ABUSE, ALASKA, 1975**

Final Report

January, 1977

Prepared by

**Analysis of Alcohol Problems Project
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Project Director**

Prepared for

**State Office of Alcoholism
Robert L. Cole, Coordinator
Department of Health and Social Services
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**Funded by a Special Grant for Implementation of the Uniform
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 in Alaska, 1975
- Volume II An Analysis of State Legislation Pertaining to Regu-
 lation and Control of Beverage Alcohol and Alcoholism
 and Alcohol Abuse, Alaska, 1975
- Volume III Alcoholism and Alcohol Abuse Programs, Services
 Delivery Systems, Alaska, 1975
- Volume IV Social Systems Indicators of Alcoholism and Alcohol
 Abuse in Alaska, 1975
- Volume V Executive Summary: Descriptive Analysis of the Impact
 of Alcoholism and Alcohol Abuse in Alaska, 1975

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FOREWORD

There is no topic in Alaska more familiar, more controversial, and simultaneously more opaque than alcoholism. Almost as if the problems and concerns associated with it were an intrinsic part of the Alaskan experience, everyone seems to have something to say about it. Newspaper articles and radio talk shows debate public drunkenness. Political campaigns are waged, promising greater priorities for the alcohol problem. Even the national wire services carry stories dubbing alcoholism "the bane of Alaska." From the person on the street, to merchants and city councils, to the most specialized of government and health officials--everyone seems to agree that alcoholism and alcohol abuse constitute the greatest human problem facing the state.

In short, there is no shortage of opinion in Alaska about alcoholism and alcohol abuse. In point of fact, however, there is precious little else except opinion. Theories abound as to the causes of problem drinking. Definitions of the very nature of the "problem" are as numerous as the dozens of State agencies, officials, organizations, and interest groups created (or simply compelled) to deal with it. Concerning what to do about it, feelings range all the way from simple apathy, to lip-service, to honest concern, to almost ideological fervor operating at the limits of reason. This is not to say that the public concern is in error: it is not. It is instead to say that, without foundation, not much can be done to seriously respond to that concern.

For so volatile and perduring a problem, there has been in Alaska virtually no significant statewide research to date. What research has

been conducted, has been fragmentary and poorly disseminated. Most often, as well, it has largely been based on concepts and models transplanted from other, inapplicable regions of the country. In all cases, such research has confined itself to a single problem or single aspect of a problem. Never, in other words, has an attempt been made to comprehensively conceptualize the problem in terms of all its major manifestations and attendant effects. By no means is this a denigration of any prior research efforts anywhere, for such was not their ambition. The time has simply come for a particular kind of undertaking: an integrated information and data base capable of addressing Alaska's alcoholism and alcohol abuse problems in all their important interrelationships.

The Analysis of Alcohol Problems Research Project, organized in September of 1975, began just such an undertaking. In response to the question of what (in its entirety) constitutes the problem of alcoholism and alcohol abuse in Alaska, the Project assumed as its province the full context of the intended and unintended consequences of the sale, distribution, and consumption of beverage alcohol in the state. Formally stated, the mission of the Project became the systematic collection of valid and reliable information for implementation of Alaska's Uniform Alcoholism and Intoxication Treatment Act. (The adoption of this act in 1972 essentially established policy for the State by decriminalizing public drunkenness and defining alcoholism as a public health problem.)

Throughout the Project, the nature of the research process was considerably less difficult to specify than the nature of the topic. With the health and medical services community exhibiting as much variance within its own ranks as between itself and the law enforcement or educational communities, little agreement existed as to how "alcoholism" and "alcohol abuse" should be defined. Considerable agreement existed, however, on the

fact that alcoholism and alcohol abuse impact the general public and the social system in a variety of ways. Alcoholism program client loads, child abuse, automobile accidents, alcohol-related crime, etc.--all became, from this perspective, equally valid and interconnected ways of looking at alcohol's impact on Alaskan society. In the same sense, they also thereby provided a composite basis for relating the many extant definitions of the problem (e.g., as a public health problem, mental health problem, criminal justice problem, child welfare problem, etc.).

For this reason, the Project took as its focus the measurable indicators of alcohol's impact on Alaska's social system, and on selected specific sub-systems: the economy, health and medical services delivery system, criminal justice system, et al.. The intention was not to be exhaustive, for such was impossible given the limitations of resources and time available for conduct of the study. Nor was the intention to be definitive, as the general paucity of useful information which plagues research efforts in Alaska made such a goal unrealistic. (In many cases, even basic information is not systematically reported or collected, nor kept in summary fashion.) Rather, the ambition was to develop a research methodology capable of being implemented at once, but also capable of being elaborated and refined on a continuing basis. Such an instrumentality, it was hoped, would serve the dual purpose of linking for the first time the several major areas (e.g., economic, legislative, programmatic, social, et al.) related to alcohol affairs in Alaska, and of constellating and grounding future alcohol-related research efforts in the state.

It should be said that such concentration on the collective effects of alcoholism and alcohol abuse was not intended to preclude genuine concern for the health and well being of individual alcohol abusers and their families. From the perspective taken, and because of the limitations

mentioned, it was not possible to address such highly relevant questions as whether alcoholism is a disease, addiction, defensive coping mechanism, etc.; or whether it derives from genetic transmission, learned behavior, cultural assimilation, or--in Alaska's case--a set of environmental factors so pervasive but elusive of description that it might quite unjokingly be called the "Arctic Factor". These remain, nonetheless, serious questions, and their omission had only to do with the fact that a need for the multiple-definition approach described above was considered more pressing.

The beginnings of this kind of multiple-definition approach are contained in the present report, Descriptive Analysis of the Impact of Alcoholism and Alcohol Abuse in Alaska, 1975. The title is preceded by the term "Working Papers" because this is the first time that alcohol-related information of this scope has been collected and put to use, and because a great deal more information is still missing. For these reasons, reaction to the content of the report is not only seriously invited, but regarded as indispensable. Only by such review and response, it is felt, will the efforts initiated by this project and report yield more complete and comprehensive information about the impact of alcoholism and alcohol abuse upon Alaskan society.

The five volumes of the report are described below:

VOLUME I : The Economic Impact of Alcoholism and Alcohol Abuse in Alaska, 1975

Volume I investigates and describes the economic impact on Alaska of alcoholism and alcohol abuse. Major goals of the volume include the identification and estimation of financial benefits deriving from the sale and consumption of beverage alcohol, and determination of the economic cost of alcoholism and alcohol abuse for the state as a whole. Findings and methodologies for each of the cost categories utilized are presented. Further, the absolute and relative magnitude of economic costs for each category are analyzed, then compared with corresponding estimates based on national findings. Finally, a separate part of the volume examines the fiscal revenues and expenditures for State government which are directly attributable to the sale and consumption of beverage alcohol.

VOLUME II : An Analysis of State Legislation Pertaining to Regulation and Control of Beverage Alcohol and Alcoholism and Alcohol Abuse, Alaska, 1975

Volume II identifies and analyzes all Alaskan legislative statutes and administrative codes which are in any way concerned with the sale and consumption of beverage alcohol, or with alcoholism or alcohol abuse problems. Analysis includes internal examination of all the statutes and codes, resulting in presentation of detailed summaries of each of the major provisions within a categorical structure developed in the process. (No such categorical listing or cross-reference system for alcohol-related legislation existed, previously.) Additionally, all identified statutes and codes are discussed and analyzed with respect to their consistency or inconsistency with policies and provisions set forth in the Uniform Alcoholism and Intoxication Treatment Act, the only available source of legislative policy for alcoholism and alcohol abuse. Throughout, analysis of the statutes and codes is cast within the context of existing, relevant federal legislation.

VOLUME III : Alcoholism and Alcohol Abuse Programs, Services Delivery System, Alaska, 1975

Volume III presents the findings of an analysis of the major elements of the alcohol services delivery system in Alaska. Based on a modified systems approach, the analysis employs nationally established alcohol program components promulgated by the Joint Committee on Accreditation of Hospitals for development of the concept of an appropriate statewide alcohol services delivery system. Statewide organizations providing direct and indirect alcoholism services are described with respect to their various administrative and programmatic dimensions. Local alcohol programs are similarly described and compared with respect to their various treatment or program components. Additionally, all organizations and programs are analyzed with regard to their participation in an emergent, comprehensive services delivery system at both the statewide and regional levels. Throughout, the focus of analysis is the nature of the overall delivery system itself (components, allocations, comprehensiveness, etc.), and not comparison or evaluation of individual programs.

VOLUME IV : Social Systems Indicators of Alcoholism and Alcohol Abuse in Alaska, 1975

Volume IV assembles and discusses a range of current data and information regarding the social impact on Alaska of alcoholism and alcohol abuse. The data compiled are regarded as conventional social system indicators, and discussed accordingly. Each part of the volume concentrates on a specific set of such indicators, with primary attention given to the prevalence of alcoholism in Alaska, the consumption of beverage alcohol, related mortalities, crime, and highway safety. A number of other, related indicators are also reviewed. Wherever possible, information is analyzed historically and compared with corresponding national (and, where applicable, international) information and research findings.

Volume V Executive Summary: Descriptive Analysis of the Impact of
Alcoholism and Alcohol Abuse in Alaska, 1975

As an executive summary, Volume V synoptically treats the findings contained in the four primary volumes preceding it. Additionally, it integrates various portions of these findings to provide alternative descriptions of the impact on Alaska of alcoholism and alcohol abuse. The descriptions are not viewed as competitive, but as demonstrative of the various perspectives and approaches possible for description and analysis of the associated problems. Finally, overall policy-level recommendations extrapolated from the study's findings are suggested for more effective implementation of Alaska's Uniform Alcoholism and Intoxication Treatment Act.

VOLUME II

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VOLUME II

AN ANALYSIS OF STATE LEGISLATION PERTAINING TO REGULATION AND
CONTROL OF BEVERAGE ALCOHOL AND ALCOHOLISM AND ALCOHOL
ABUSE, ALASKA, 1975

PART ONE

I. INTRODUCTION

The social policy in the United States with regard to alcohol is embodied in legislation, and as will be seen, especially in the legislation of the fifty states. Unfortunately, even a cursory glance at Federal and State legislation indicates that national and state policy is so inconsistent--especially when related to manufacture, distribution and sales regulations--that at times it seems there is no real policy at all.*

The ultimate goal of this volume of the study is to present as comprehensive a review of Alaska's alcohol-related laws and regulations as possible, and to provide an analytic description of the various policies which do exist and their relationship to each other. Hopefully, an understanding of the current state of the law will lead to a more comprehensive implementation of alcohol policies.

The lack of a cohesive Federal and State policy probably stems from the changing public attitudes toward alcohol; ideas have changed, but the laws have often not. Essentially public attitudes and legislative responses in this century have moved from temperance and prohibition, to partial attempts to control the social consequences of drinking, to emphasis on alcohol abuse as a public health problem, the latter being

*"The Enhancement of Health," Chapter X in Alcohol and Health: New Knowledge, ed. by Mark Keller (Rockville, Md.: Dept. of Health, Education and Welfare, National Institute on Alcohol Abuse and Alcoholism, June, 1974); and R.J. Driver, A Survey of Alcoholic Beverage Control in the United States, a report prepared for the National Institute on Alcohol Abuse and Alcoholism (1974) for recent studies on contemporary state alcohol-related regulatory legislation.

embodied in the Hughes Act and various state adaptations of the Model Uniform Alcoholism and Intoxication Treatment Act. Along with these changes in attitudes has come a shift in responsibility from the national to the state and local levels of government. In order to understand the difficulties involved in formulating a cohesive alcohol policy, a brief review of legislative changes at Federal and State levels is necessary. (See Part VII for overview of analysis.)

FEDERAL ALCOHOL POLICIES

The temperance movement of the late nineteenth century finally culminated in the Eighteenth Amendment and the Volstead Act, establishing a national policy regarding the sale and manufacture of alcoholic beverages. Unfortunately the hopes of the temperance movement were not realized, and Prohibition led to increased lawlessness rather than national abstention. With the repeal of Prohibition in 1933, the Federal government ended its control over the manufacture, sale and distribution of alcohol, and thrust the responsibility for these matters back on the States. As a result, it became the duty of the various state legislatures to decide whether or not alcoholic beverages were to be sold, and what control measures would best protect the public health and safety.

Beginning in the mid-sixties, the Federal government partially reentered the alcohol field in response to growing public recognition that the problems of alcohol abuse were exceeding the capacities of state and local governments to respond. The Highway Safety Act of 1966, the Economic Opportunity Act amendments of 1967 and 1969, the Alcoholism Rehabilitation Act of 1968 and the Community Mental Health Center Act amendments of 1970 all reflect awareness by the Federal government that the consumption of alcohol leads to serious social problems. The Comprehensive Alcohol Abuse

and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (known as the Hughes Act) and its 1974 and 1976 amendments, established the National Institute on Alcohol Abuse and Alcoholism (NIAAA) to initiate a policy development program for alcohol abuse, and originally provided for federal assistance to state and local treatment programs. While the Hughes Act is the main federal response to alcohol problems, the U.S. Congress has also provided for approaches to alcohol-related problems through the following Acts: The Health Maintenance Organization Act of 1973, the National Health Planning and Resources Development Act of 1975, the research provisions of the Public Health Service Act of 1944, the Comprehensive Employment and Training Act of 1973, the Omnibus Crime Control and Safe Streets Act of 1968, the Juvenile Justice and Delinquency Prevention Act of 1974, the Food Stamp Act of 1964, the medicaid, medicare and social services provisions of the Social Security Act of 1935, the Rehabilitation Act of 1973, and the Housing and Community Development Act of 1974. The Drug Abuse Act of 1970 was amended in 1974 and retitled the Alcohol and Drug Abuse Education Act in recognition of the priority which Congress has assigned to coping with the nation's alcohol-related problems by facilitating the implementation of educational programs specially designed to deal with problems associated with alcohol abuse.

The sheer bulk of Federal legislation*, along with the definition of alcohol as a dangerous drug in the Alcohol and Drug Abuse Education Act, clearly indicates that the Federal government considers alcohol a severe threat to public health and safety. Nevertheless, the fact remains that, except for a few unimportant revenue and import-export measures, the Federal government has refrained from exercising any control over the manufacture and sale of alcohol. While the Federal government has recognized the dangerous effects of alcohol, it remains the responsibility of the

*See Appendix C.

individual states to control the sale and distribution of the substance itself.

STATE ALCOHOL POLICIES

With the repeal of national prohibition, States had three options-- state-wide prohibition, which has been abandoned by all who tried it, state monopoly for off-premise sales, which is used by eighteen states, and licensing systems, which are used by thirty-two states and the District of Columbia. Alaska currently uses the licensing system, which does not allow as much control by the state as the monopoly method does.

State legislation from 1933 to the mid-sixties reflects an ambivalent attitude towards drinking which may have resulted from the public's ambivalence.* On the one hand, the fact that alcohol is a dangerous drug is tacitly recognized--although Alaska does not officially define it as such--in such control measures as required closing hours, limits on the number of licenses per capita, and the prohibition against sales to minors, on election days, and near churches. On the other hand, many alcohol-related regulations are aimed at promoting an economically healthy and stable liquor industry (especially revenue measures) and at keeping the liquor industry dissociated from criminal elements and activities. State legislation enacted during this period of history appears to be in large part a result of the experiences of National Prohibition; the laws reflect

*Selden D. Bacon, "Meeting the Problems of Alcoholism in the United States," in A World Dialog on Alcohol and Drug Dependence, ed. by Elizabeth D. Whitney (Boston: Beacon Press, 1970). Selden D. Bacon, "Alcohol and Complex Society," Chap. V. in Society, Culture and Drinking Patterns, ed. by David J. Pittman and Charles R. Snyder (New York and London: John Wiley and Sons, Inc., 1962); and Mark Keller, "Tributes to E.J. Jellinek," pp. xi-xvi in Alcohol and Alcoholism, ed. by Robert E. Popham (Toronto: Univ. of Toronto Press, 1970) for information and analysis of the social dimensions of alcohol use and misuse.

little hope of preventing alcohol abuse and instead focus on the liquor industry as a legitimate business and on limits on the availability of alcohol--issues suited more toward business stability rather than moderation of consumption. Unfortunately there is little reason to believe that this approach has been successful in promoting moderate drinking practices.*

Although there have been no major breakthroughs in the field of alcohol abuse, the states in the last decade have evidenced some hope of controlling alcohol abuse by treating it as a public health problem. The Uniform Alcoholism and Intoxication Treatment Act (hereinafter, the Uniform Act), adopted in Alaska (1972) with some modifications, attempts to treat and prevent alcohol abuse as a disease and remove it from the criminal justice system.**

The Uniform Act also provides the only clear statement of legislative policy on alcoholism and alcohol abuse for the state--that it is to be treated as a public health problem.

The net effect of this historical development in Alaska is a schizophrenic policy. On the one hand the dangerous effects of alcohol are recognized in the Uniform Act and a few control measures limiting availability

*See Don Cahalan, "Implications of National Surveys on Drinking Behavior Problems," pp. 361-2 in Alcohol Abuse and Alcoholism Vol. II of Alcoholism: A California State Senate Report (Sacramento: State of California, The Senate, August, 1974).

**See Frank Grad, Audrey Goldberg and Barbara Shapiro, Alcoholism and the Law (Dobbs Ferry, N.Y.: Ocean Publications, Inc., 1971); "The Legal Status of Intoxification and Alcoholism," Chap. VII in Alcohol and Health, Mark Keller, cons. ed. (Rockville, Md.: Dept. of Health Education and Welfare, National Institute on Alcohol Abuse and Alcoholism, Dec., 1971); Arthur D. Pratt, Jr., "A Mandatory Treatment Program for Skid Row Alcoholics; its Implication for the Uniform Alcoholism and Intoxication Act," Journal of Studies on Alcohol, Vol. 36, No. 1 (New Brunswick, N.J.: Rutgers University, The Center of Alcohol Studies, Jan., 1975); and Norman P. Kurtz and Marilyn Reiger, "The Uniform Alcoholism and Intoxication Treatment Act: The Compromising Process of Social Policy Formulation," Journal of Studies on Alcoholism, Vol. 36, No. 11, (Nov., 1975), for the legislative history of the development of, and critical comments on the implementation of the model state Uniform Alcoholism and Intoxication Treatment Act.

of alcohol. On the other hand, control of sales is minimal, despite the fact that the legislature has plenary powers over alcohol,* including but not limited to, control over closing hours, advertising, container size, excise taxes, and the criminal justice system. As a result, administrative agencies such as the Office of Alcoholism and the A.B.C. Board are not given a clear indication of the policy which they are to implement, or the changes in public opinion which they are to foster. Instead, much of the responsibility for controlling sales is passed on to the localities, while the resources needed by local governments are scarce due to revenue sharing problems and a prohibition against special local taxes on alcohol. Some of the responsibility for controlling the sale of alcohol is also passed on to individual sellers, but typically rests with local law enforcement agencies.

Ultimately, however, the responsibility for controlling the sale and distribution of alcohol rests with state legislatures, and has since the Federal government passed it back to the States in 1933. It is up to the states to formulate a sale and distribution policy which will deal adequately with the problems of alcohol abuse. Admittedly a legislature must consider the general social climate in which it operates, however shifts in public opinion in recent years** indicate that this may be an appropriate time for the legislature to exercise leadership in this area.

*See *Boehl v Sabre Jet Room Inc.*, 349 P2d 585 (Alaska, 1960).

**See L. Harris and Associates, Inc., "Public Awareness of the NIAAA Advertising Campaign and Public Attitudes Toward Drinking and Alcohol Abuse," a report prepared for the National Institute on Alcohol Abuse and Alcoholism, (1974); and D. Cahalan, I.H. Cisin and H.M. Crossley, American Drinking Practices; A National Study of Drinking Behavior and Attitudes, Monograph No. 6 (New Brunswick, N.J.: Rutgers University, Rutgers Center of Alcohol Studies, 1969) for public opinion surveys on the use of alcoholic beverages.

For this reason, the laws relating to alcohol have been summarized and organized according to the following categories: (1) Sales, covering statewide regulations, local controls, licensing, and the A.B.C. Board; (2) Revenue Measures, including license fees and the excise tax; (3) Criminal and Civil disabilities associated with alcohol; (4) The Uniform Act and Title IV; and (5) Administrative Agencies concerned with alcohol. This organizational scheme is not based on that in the statutes--none exists--but has been designed to provide the clearest presentation possible. This exhaustive legislative outline is presented in PART TWO.

Following the legislative outline, a narrative summary and analysis of all legislation considered is presented in PART THREE. This includes a brief overview of the laws and a discussion of the interrelationship of the laws with particular reference to the policies of the Uniform Act.

Additional resource materials are provided in the Appendices for further reference.

PART TWO

II. SALE: CONTROL OF ALCOHOLIC BEVERAGES PRIOR TO CONSUMPTION

A. STATEWIDE REGULATION

1. When Sales May Not Occur.

a. Between 5:00 a.m. and 8:00 a.m. on each day of the week.

1.) No person may consume, sell, offer for sale, give, furnish or deliver intoxicating liquor from an authorized licensee on any licensed premise between the hours of 5:00 a.m. and 8:00 a.m. each day of the week (1).

2.) Additional Specifications - AAC (170).

a.) No person shall sell, offer for sale, give, furnish or deliver any intoxicating liquor on any licensed premise between the hours of 5:00 a.m. and 8:00 a.m. each day.

b.) No person shall be on any licensed premise between the hours of 5:00 a.m. and 8:00 a.m. each day. This sub-section shall not apply to bona fide employees of the licensee who are on the premises for the specific purpose of preparing for the next day's business, or to persons remaining on the premises of a bona fide restaurant for the purpose of consuming food or non-alcoholic beverages.

c.) No licensee shall permit any person to be on his licensed premises between the hours of 5:00 a.m. and 8:00 a.m. each day. This sub-section shall not apply to bona fide employees of the licensee who are on the premises for the specific purpose of preparing for the next day's business or to persons remaining on the premises of a bona fide restaurant for the purpose of consuming food or non-alcoholic beverages.

d.) No persons shall consume any intoxicating liquor on any licensed premises between the hours of 5:00 a.m. and 8:00 a.m. each day.

e.) No licensee shall permit any person to consume intoxicating liquor on his licensed premises between the hours of 5:00 a.m. and 8:00 a.m. each day.

b. On an election day. It is unlawful to give, barter, sell, or in any licensed premises to dispose of intoxicating liquor on an election day until the polls have closed (2).

2. Where Sales May Not Occur.

- a. Where licensed premises is connected to another retail establishment. Retail liquor store sales may not occur on any licensed premises (retail) which is connected by a door or any other means of passage to another retail establishment (except establishments licensed under Title 4.) (3).
- b. Where entrance to the premises is near a church or school. Beverage dispensary or retail liquor store sales may not occur in any building in which the public entrance is within 200 feet of a school or church building (4).
- c. Where zoning regulations prohibit sales. Beverage dispensary or retail liquor store sales may not occur (licensees may not operate such establishments) in incorporated cities where zoning regulations prohibit liquor sales (5). (SEE LOCAL OPTIONS, PART II, B.)

3. To Whom Sales May Not Occur.

- a. To minors or intoxicated persons.
 - 1.) It is unlawful to give, barter or sell any intoxicating liquors to a person under 19 or to an intoxicated person or for a licensee to permit the giving, selling, bartering, or drinking of liquor by either of the forbidden classes within the premises (7).
 - 2.) Persons under 19 may not enter or remain on licensed premises unless accompanied by a parent, guardian or spouse who is of age (8).
 - 3.) A person or firm, company or employee thereof who sells, barter, gives or delivers liquor to a person under 19 is guilty of a misdemeanor, punishable by imprisonment of not more than one year and/or a fine of not more than \$500.00 (9).
 - 4.) It is unlawful for a person under 19 to solicit the purchase or in any other way attempt to purchase liquor (10).
 - 5.) A person who influences or attempts to influence the sale, giving or selling of liquor to a person under 19 is guilty of a misdemeanor (11).

6.) Additional Specifications - AAC (171).

- a.) No person under the age of 19 years shall knowingly enter or remain in that portion of any licensed premises wherein alcoholic beverages are being sold, served or consumed, except in the company of a parent, spouse over the age of 19 years, or a legal guardian.
- b.) A licensee, at his discretion, may refuse entry to that part of the licensed premises wherein alcoholic beverages are being sold, served or consumed to any or all persons under the age of 19, even though such person is accompanied by a parent, spouse over the age of 19 years, or legal guardian. The licensee may refuse any service to such persons under the age of 19 years and may require them to leave the portion of the licensed premises wherein alcoholic beverages are sold, served or consumed.
- c.) No licensee shall permit any person under the age of 19 years to sell or serve any alcoholic beverages.
- d.) No licensee shall permit any person under the age of 19 years to entertain or work on a paid or voluntary basis, in that portion of the licensed premises wherein alcoholic beverages are being sold, served, or consumed.

7.) Other Provisions

- a.) Proof of age.
 - (1.) A valid Alaska driver's license is acceptable as proof of age when used for identification for purchase of liquor and for presence in liquor establishments. If such identification is presented, the licensee may not be held liable for serving minors or permitting minors on the premises (12).
 - (2.) Identification cards for the same purpose as above are issued by the Department of Public Safety (13).
- b.) Employment of minors and others.
 - (1.) No person under 19 may be employed or allowed to sell or serve intoxicating liquors or to work in any room or other place where intoxicating liquors are sold for consumption on the premises, unless it is in the course of his or her employment as a musician, entertainer or busboy (14).

(2.) Additional Specifications - AAC (172).

- (a.) No person shall employ, upon any licensed beverage dispensary, any hostess or entertainer for the purpose of directly procuring or encouraging the purchase or sale of alcoholic beverages, or to pay any such hostess or entertainer a percentage or commission on the sale of alcoholic beverages for procuring or encouraging the purchase or sale of alcoholic beverages on such premises.
- (b.) No licensee, in any place of business where alcoholic beverages are sold to be consumed on the premises, shall employ or knowingly permit anyone to loiter in or about said premises for the purpose of begging or soliciting any patron or customer of, or visitor in, such premises to purchase any alcoholic beverages for the one begging or soliciting.
- (c.) Liability of employer for acts of bartenders. A licensee is responsible for his bartender's employment of girls to solicit drinks from patrons.
- (d.) Board may make further rules: The enactment of this section does not deprive the board of authority to adopt a rule against beverage dispensary licensees permitting female employees from soliciting or accepting drinks for their own consumption.
- (e.) Definitions:
 - * "solicitation" means direct solicitation of drinks and does not prohibit purchase of drinks by patrons while watching entertainment or when asked by an individual regularly employed as a waitress. An example is: evidence that a female asks a male patron, "Do you want a drinking companion?" supports a finding that she solicited or begged a drink.
 - * "loiter" means to linger idly by the way, to idle, or to loaf.

4. Controls On Number Of Licenses.

Number of licenses limited by a population base. Unless otherwise provided, no new licenses are issued where the total of licensed premises in the aggregate at one time would exceed one license of each type for each 1,500 population (16).

5. Taxation

For description of the State Excise Tax see, under REVENUE, III. Taxation is a statewide regulation because it affects the price of alcoholic beverages, which in turn affects demand (consumption).

6. Other Regulations

a. Toilet facilities required.

1.) An owner of a restaurant or tavern shall provide and maintain on the premises sanitary toilet accommodations for public use. An owner of a restaurant or tavern in operation on August 1, 1974, has two years from that date to comply with this requirement (17).

2.) A person who fails to comply with the above is guilty of a misdemeanor and upon conviction is punishable by a fine of not more than \$500.00 (18).

b. Limitations on conduct of employment agencies. The Department of Labor may not issue a permit to conduct an employment agency in connection with a pool hall, bar or intoxicating liquor dispensary, or recreation center operated for profit (19).

c. Credit sales of intoxicating beverages. No holder of a retail alcoholic beverage license may sell intoxicating beverages other than for cash, except that a hotel, boardinghouse or inn which offers lodging may sell intoxicating beverages to persons lodging there and include the charge for the beverages with the bill for the lodging, to be paid at the time the customer pays for the lodging. A person who unlawfully sells intoxicating beverages on credit is guilty of a misdemeanor, punishable by a fine of not more than \$500.00 (20).

7. Penalties

a. General penalty (for violation of Title 4). A person who violates any provision of Title 4 other than giving liquor to persons under 19, is guilty of a misdemeanor, punishable by imprisonment of not more than one year or by a fine of not more than \$500.00 (21).

b. Additional penalty for violation by licensee. Upon conviction of a licensee for violating a regulation of Title 4, the board may suspend the license for the first and second violations, and revoke it for the third (22).

B. LOCAL CONTROLS

1. The Municipality's Power to Regulate.

a. Municipality's powers include power to regulate alcoholic beverages.

Among its other powers of regulation, municipality may regulate alcoholic beverages as provided in AS 04.15.070. (23).

b. Municipality may provide rules and regulations by ordinance.

1.) A municipality may by ordinance provide rules and regulations governing the barter, sale and possession of intoxicating liquor within the municipality necessary to the orderly conduct of the business of selling liquor. The ordinance may not be inconsistent with Title 4 (24).

2.) No municipality may impose taxes other than property taxes on liquor inventories and sales taxes on liquor sales when these taxes are levied on other property and sales within the municipality (24).

2. Options For Control Available Within Incorporated Municipalities.

a. Local governing body may protest application for transfer, renewal or new license.

1.) Upon deciding to approve a license application, the board must transmit written notice of its intent to approve the transfer, renewal or new license requested, to the city governing body or borough assembly. If the local governing body wishes to protest approval, the board may not take final action on the application until it has provided for a hearing on the protest in accordance with the requirements of the Administrative Procedure Act (AS 44.62) (25).

2.) If at the hearing the application for a license is rejected, the board shall refund the application fee less the sum of \$25.00. No license fee may be refunded after the license has been issued (26).

b. Local option election. If 35% of the voters in an incorporated city petition the city council to do so, the council will place the question of whether or not intoxicating liquor is to be sold on the ballot. If, at the next municipal election, the majority of voters are against liquor sales, the board shall deny applications for licenses and shall not issue new licenses for one year. In incorporated cities where there were no licensed premises on June 19, 1976 no new license or permit may be issued until the city council conducts a local option referendum election.

c. Local authorities may further restrict hours of sale. Incorporated municipalities may provide for additional closing hours (beyond the minimum of between 5:00 a.m. and 8:00 a.m.) (1).

- d. Local authorities may permit liquor sales during local elections. The governing body of a political subdivision of the state may provide by ordinance that liquor sales are lawful in that political subdivision on election days (28).
- e. City council approval where zoning regulations prohibit sale. No licensee may operate a beverage dispensary or retail liquor store in any incorporated city where zoning regulations prohibit liquor sales, without city council approval (5).

3. Options For Control Available Outside Incorporated Municipalities.

- a. Citizen protest. An adult resident in an area outside of a municipality may protest the issuance, reissuance, renewal or transfer of a license within two miles of his residence or within his established village. If 35 percent of the residents of a village protest the issuance, reissuance, renewal or transfer of a license in writing to the A.B.C. Board, the Department of Community and Regional Affairs must conduct a local option referendum election, the results of which are binding upon the A.B.C. Board (29).
- b. Public approval in remote areas. No license for the sale of intoxicating liquor may be issued in any area which is 50 miles or more from the incorporated boundaries of a municipality, unless a petition containing the signatures of two-thirds of the residents 19 or over residing within a five-mile radius of the nearest U.S. post office station is filed with the board (30).
- c. Consent of residents outside incorporated cities. If no post office exists within a five-mile radius of the proposed business location, then a majority of the residents 19 or over residing within one mile of the location may file a petition with the board requesting that the license be issued (31).

4. Penalties.

- a. Penalty for violation of municipal ordinance. A person who violates any provision of a municipal ordinance is guilty of a misdemeanor, punishable by imprisonment for not more than one year or by a fine of not more than \$500.00 (32).
- b. Additional penalty for violation by licensee. Upon conviction of a licensee for violating a local ordinance, the A.B.C. board may suspend the license for the first and second violations, and revoke it for the third (22).
- c. Penalty for sale in violation of local option. A person who unlawfully sells or offers for sale an intoxicating liquor in an area where the local option has made it illegal is guilty of a misdemeanor, punishable by imprisonment for a period not to exceed one year, and/or by a fine not to exceed \$5,000.00 (33).

C. LICENSING

1. Control of Liquor Manufacture and Traffic Through Licensing.

- a. Appropriate license necessary for liquor manufacture and traffic. No person, firm, corporation, organization, or company may manufacture, sell, offer for sale or possess for sale or barter, traffic in, barter or exchange for goods in this state, an intoxicating liquor without first procuring an appropriate license (34).
- b. Place which is common nuisance. A place where unlicensed manufacture or sale or drinking of intoxicating liquor is allowed is declared to be a common nuisance. A person who maintains, aids or abets or is associated in maintaining such a place is guilty of a misdemeanor, punishable by a fine of not less than \$100.00 nor more than \$500.00, and/or imprisonment for not less than 30 days nor more than six months (35).
- c. Consumption may not occur upon any licensed premises, unless permitted in the terms of the license. The licensee shall not permit the drinking of hard or distilled liquors by any person upon the premises, unless it's permitted under classification of the license (7).

2. Classification of Licenses.

a. Wholesale (no sale to consumers).

1.) General Wholesale

- * Liquor sold in original packages, wine in bulk; sales in quantities not less than 5 wine gallons to license holders only. License required for each distributing point.
- * Fee: \$500.00 for first \$50,000 sales;
- * Excess Fees: \$250.00 to \$5,000 on graduated schedule, depending on total sales above \$50,000 (36).

2.) Wholesale Malt Beverage and Wine

- * Sales of malt beverages and wine in original packages and in bulk; sales in quantities not less than 5 wine gallons to license holder.
- * Fee: \$100.00 for first \$100,000 sales;
- * Excess Fees: \$150.00 to \$5,000 on graduated schedule, depending on total sales above \$10,000 (37).

b. Retail.

Additional Specifications - AAC (173).

- * A retail license gives to the holder thereof the privilege, as accorded by law, to transfer ownership of intoxicating beverages from himself to a legally qualified purchaser, for cash, paid promptly after the verbal or written solicitation for purchase has been received within his licensed premises.

* Definition:

- "sell or sale" means the transfer of ownership of alcoholic beverages from a licensee to a qualified purchaser upon the receipt of verbal or written solicitation to contract such transfer.
- "cash" means money or its equivalent paid promptly to a licensee by a qualified purchaser upon transfer of ownership of alcoholic beverages.
- "establishment" means a place of business. i.e., licensed premises as stated on a licensee's application for his current license as filed with the board.

1.) On-sale (sales by drink to consumers for on-premises consumption).

Additional Specifications - AAC (174).

No licensee, except those who qualify under AS 04.05.030, shall permit alcoholic beverages sold for consumption on the licensed premises to be removed therefrom. A licensee, his agent or employee who shall use reasonable diligence in the enforcement of this regulation shall not be deemed in violation of said regulation.

a.) Beverage Dispensary

- * Beer, wine, hard liquors sold on premises for consumption on premises.
- * \$2,500 surety bond filed when applying for license; conditions that applicant sole owner, no other person financially interested directly or indirectly, applicant conduct business under law.
- * FEE: \$500.00, pop. under 1,500; \$1,000, pop. over 1,500 (38).

Additional Specifications - AAC (175).

Any licensee who is the holder of a beverage dispensary license who maintains upon or within the premises for which his license is issued more than one room in which there is regularly maintained a fixed counter or service bar at which alcoholic beverages are served to members of the public for consumption within the licensed premises shall obtain from the board, after proper investigation and approval, a duplicate of his original license for each such additional room containing a fixed counter or service bar and shall post a duplicate of his original license in each of such rooms. He shall pay to the board at the time of application for each duplicate license an amount equal to the license payable for a like period for his original beverage dispensary license. (City Council recommendation within corporate municipalities is mandatory for the maintenance of such additional rooms.)

b.) Restaurant - Beer & Wine

- * Serve beer and wine in restaurant with meals.
- * FEE: \$300.00 (39)

Additional Specification - AAC (176)

The entire business conducted on the licensed premises of a restaurant or eating place licensed to sell beer or wine must be under the sole operation and control of the licensee. Any other arrangement is inconsistent with the Act.

c.) Roadhouse - Beer & Wine

- * Roadhouse is more than 18 miles from city limits, serves food.
- * Sell beer and wine for consumption on premises only.
- * FEE: \$150.00 (40)

d.) Club

- * Been incorporated and active for two years or more, club serves liquor on premises to members and families (state or national charter necessary).
- * FEE: \$400.00, except gross sales preceeding year under \$5,000, then \$200.00 (41).

Additional Specifications - AAC (177)

- * A member is defined as one who has paid up membership in a licensed club or organization and who, under their constitution and by-laws, has all voting rights and full membership privileges.
- * Guests (who enter the club premises on the invitation of a member) may be served alcoholic beverages if accompanied personally by said member. A guest shall be required to leave the premises immediately upon the departure of the member who extended the invitation of entry.
- * A club license may not be used to accomodate club members, officers, employees or anyone else seeking to purchase bottle or case goods for use off the licensed premises of the club.
- * The issuance of a club license is a privilege extended to certain qualified organizations which do not traffic in alcoholic beverages for profit and are operated solely for social, recreational, political, benevolent or athletic purposes, but not for pecuniary gain. The soliciting of public patronage except under circumstances approved by the board is inconsistent with the provisions of the Act.
- * The club is responsible for all activities in all parts of their licensed premises and is charged with strict adherence to all provisions of the liquor laws of Alaska and any regulations promulgated thereunder.

e.) Common Carrier Dispensary

- * Sell for consumption on boats, aircraft, railroad buffet cars, transit only, except stationary sales allowed if not prohibited by local ordinance.
- * FEE: \$250.00 per each vessel, aircraft, buffet car (42)

f.) Recreational Site - Beer

- * Sell beer at recreational event one hour before or after event, for consumption at site. Sale during school event prohibited.
- * FEE: \$300.00 (43).

g.) Pub - Beer & Wine

- * Sell beer and wine for consumption at designated location on premises of accredited college, university.
- * FEE: \$300.00 (44).

2.) Off-Sale (for off-premises consumption, package sales).

a.) Retail (sales to consumers).

- * Liquor sold original packages; wine in bulk. 20 wine gallons maximum sale at one time to one person.
- * Consumption on premises prohibited.
- * FEE: \$600.00, except sales for year not exceed \$20,000., fee is \$300.00 (45).

Additional Specifications - AAC (178).

- * Each retail licensee desiring to prove less than \$200,000 gross sales in any calendar year from the sale of intoxicating beverages must maintain a complete record of all retail package sales of intoxicating beverages. This record shall clearly show the total amount of such sales for each fiscal year period separately from sales of other commodities and for intoxicating beverages sold on any other licensed premises.
- * Any such licensee must also keep the original bills and invoices in connection with the purchase of intoxicating beverages. Also, they shall take and preserve a physical inventory of intoxicating beverages on June 30 or December 31 of each year. Such inventory shall be extended financially at cost.

b.) Retail Stock Sale (no sales to consumers).

- * Bulk quantity sale, 5 wine gal. minimum; stock of former retail liquor store when owner closing out.
- * 90 day license.
- * FEE: \$100.00 - 90 day period. (46).

c.) Community Liquor License (Beverage Dispensary or Retail).

- * Holder must be first or second class city.
- * City which has within boundaries beverage dispensary or retail license issued to private person before June 1, 1970 not eligible for community liquor license unless held liquor license through corporation or otherwise before June 1, 1970.
- * FEE: See beverage dispensary or retail license fees (47).

c. Production (No sales to consumers).

1.) Bottling Works - Beer and Wine

- * Beer and wine bottled and sold; no sales less than 5 wine gallons.
- * FEE: \$100.00 (48).

2.) Brewery - Beer

- * Beer brewed, manufactured, prepared, bottled, barreled for sale.
- * No sale less than 5 wine gallons.
- * FEE: \$100.00 (49).

3.) Distillery

- * Liquors distilled, prepared, bottled, barreled; no sale less than 5 wine gallons, sales in state only to licensees.
- * FEE: \$100.00 (50).

3. Qualifications of Licensees.

- a. Licensee is charged with knowledge that is purchasing from properly licensed source. Licensees selling to the general public are charged with the knowledge that the wholesaler, distiller, importer, brewer or bottler from whom they purchased intoxicating liquor is properly licensed (51).
- b. Residence requirement. No beverage dispensary or retail license may be issued to a person or association of persons who have not resided in the state for at least one year prior to the date of the application, or to a corporation not qualified to do business in the state (52).
- c. Financial interest. No corporation, wholesaler, owner, officer or representative of a wholesaler, brewery, winery, bottling works, or distillery may own interest in a beverage dispensary or retail liquor store, or finance directly or indirectly, a license-holder in procuring quarters, or supplying equipment, furnishings or stock (53).

d. Financial interest and personal superintendence.

- 1.) No person but the licensee shall have a direct or indirect financial interest in the licensed business (54).
- 2.) The licensee is solely responsible for the lawful conduct of the business under Title 4 (54).

e. Qualifications of non-resident licensees.

- 1.) A distiller, brewer or wholesaler, whose principal place of business is outside the state shall obtain a separate wholesale license for the sale of his or her products in the state and shall obtain a separate license for each wholesale distributing point inside the state (55).
- 2.) A non-resident selling liquors in the state, shall designate a principal place of business in the state where records shall be located, and appoint an agent upon whom process can be had (55).

4. Application For License.

a. Manner of filing and contents of application.

- 1.) An applicant shall file a written application with the director of the A.B.C. board specifying the kind of license desired, a description of the place for which the license is desired, and a statement of the citizenship or corporate qualifications of the applicant (56).
- 2.) Additional Specifications - AAC (179).
 - a.) Each license shall be issued to a specific person or persons and except in case of licenses authorizing the sale of alcoholic beverages on trains or boats, or the service of alcoholic beverages on airplanes, shall be issued for a specific location to be known as the licensed premises, the principal address of which shall be indicated on the license. The mailing address of the licensees must be kept current and on file in the main office of the Alcoholic Beverage Control Board.
 - b.) Corporations applying for licenses shall provide the names and addresses of the president, vice-president, secretary, managing officer or officers and all stockholders who own ten percent or more of the stock in said corporation, together with all other information deemed necessary by the board.
- 3.) Additional Specifications - AAC (180).

The state police shall assist in the investigation of new licensees and applications for liquor licenses outside the corporate limits of any municipality before such applications are considered or reviewed by the board.

- 4.) Any applicant making a false statement in the application is guilty of perjury, subject to the penalty provided by law for the crime of perjury (56).
- 5.) If any false statements are made in the application, it may be denied. If false statements are discovered after the license has been granted, the A.B.C. board may revoke the license. If the license is revoked, license money deposited by the applicant is forfeited to the state (56).
- b. Public notice. Before a license is issued, renewed or transferred the A.B.C. Board shall provide by regulation for adequate notice to the public and the local governing body. When necessary the notice shall be bilingual. It shall be posted at the location of the premises, at the nearest post office and at one other conspicuous location for at least 10 days. A true copy of the application must be provided to the news media 30 days before it is filed (57).
- c. Posting of the license. The licensee shall post the license conspicuously in the place of business (58).
- d. Case in which license renewal shall not be denied. No licensee shall be denied a renewal of his or her license for another location where, because the lease terminated for the old location, or because of condemnation or substantial destruction of the premises by any cause, it becomes necessary to relocate, or where public convenience is better served by the transfer. The licensee, if deprived of his or her business location, shall apply for another acceptable location within three months (59).
- e. Transfer of license. No license may be transferred without the consent of the A.B.C. Board. License transfers are subject to the population limitations on licenses under Title 4. No license may be transferred out of the election district in which it was granted except within an organized borough or a unified municipality. Licenses already issued on April 25, 1960, shall be renewed irrespective of the population limitations (60).
- f. Licensing to encourage tourist trade. The board may, in its discretion, approve the issuance or transfer of a license without regard to the quota provisions under Title 4. When it appears that the issuance or transfer will encourage the construction or improvement of a hotel, motel, resort or similar business related to the tourist trade having a minimum of 10 rooms and a dining facility (61).
- g. Other controls on application for licenses. See controls under state-wide and local regulations:
 - 1.) Regulations against monopolies. II., A., 4., a.
 - 2.) Number of licenses limited by population base. II., A., 4., b.
 - 3.) Where zoning regulations prohibit sale. II., B., 2., e.
 - 4.) Local governing body may protest application for transfer, renewal or new license. II., B., 2., a.

- 5.) Local option election. II., B., 2., b.
- 6.) Protest by individual. II., B., 3., a.
- 7.) Public approval in remote areas. II., B., 3., b.
- 8.) Consent of residents outside incorporated cities. II., B., 3., c.

5. Regulation of Existing Licenses.

- a. Provisional license. A provisional license shall be issued upon payment of the minimum fees for wholesale licenses. Not later than February 15 of each year following that for which a license has been issued to a licensee, the licensee shall file an affidavit showing the amount of business done during the preceding year, and shall pay the excess fees for the wholesale license. Unless the affidavit is filed and the fee paid, the license shall be cancelled (62).
- b. Duration of licenses. All licenses, except for lesser periods authorized, shall be issued for the calendar year ending December 31. The director may issue a license for half a year upon payment of half the license fee (63).
- c. Reissuance of licenses. A license is renewable automatically if the license fee is paid. An application for reissuance shall contain the same information as is required for a new license (proof of posting not necessary). A license which has not been active at least 30 days during the preceding year may not be reissued. The license is automatically revoked if the renewal application has not been filed and the license fees have not been paid by February 28 (64).
- d. Transfer of licenses.
 - 1.) A license may be transferred to a new location to be operated by a qualified licensee. An application for transference shall contain the information requested by the A.B.C. board and be accompanied by proof of posting of application (65).
 - 2.) No license may be transferred by the licensee to any other person except with the written consent of the A.B.C. board. The board shall not approve the transfer unless all the debts and taxes are paid, or the transferor gives security for the payment of them (66).
 - 3.) Additional Specifications - AAC (181)
No person shall receive or transfer controlling interest in a liquor license issued to a corporation without the written consent and approval of the board.

- e. Death of licensee. If the licensee dies, the executor of his or her estate shall within 90 days or before December 31 (whichever date occurs first) apply to the board for transfer of the license. If this is not done, the license is forfeited and void (67).
- f. Service of guests in public accommodations. A hotel, motel, resort or similar business holding a beverage dispensary license which has as a substantial part of its business the catering to the travelling public, may serve alcoholic beverages in its dining room, banquet room and to guests in their rooms (68).
- g. Exemption for liquor licenses. (In a bankruptcy case) the liquor license of a judgment debtor is exempt from execution (69).

6. Penalties.

Suspension or revocation of license.

- 1.) The drinking of intoxicating liquor by, or the presence of either of the forbidden classes on the premises covered by a license issued under Title 4 is cause for suspension or revocation of any license (70).
- 2.) Upon conviction of a licensee for violating a provision of Title 4 or a local ordinance, the A.B.C. board may suspend the license for the first and second violations, and revoke it for the third (22).

D. A.B.C. BOARD

1. Composition and Conditions of Membership

a. Appointment, qualifications, and terms of office of members of departmental boards, councils, or commissions. Each member of the [Alcoholic Beverage Control Board] shall be a citizen of the United States. The governor shall appoint each member on the basis of interest in public affairs, good judgment, knowledge and ability in the field of action of the [Department of Revenue], and with a view to providing diversity of interest and points of view in the membership. Appointments are subject to confirmation by a majority of the members of the legislature, joint session (71).

b. Creation of board and office of director.

1.) The A.B.C. Board is established within the Department of Revenue and consists of five members appointed for overlapping three-year terms. The governor shall appoint the board subject to legislative confirmation. No board member may hold any other state or federal office, two members shall be actively engaged in the alcoholic beverage industry (except wholesale), and no three members may be engaged in the same business. Three members constitute a quorum. The board shall meet at least once a year in each of the four judicial districts (72).

2.) The governor shall appoint a director, subject to legislative confirmation, who is the executive officer of the board, but who is not a member of the board. The director may cast a tie-breaking vote and shall issue all licenses (72).

c. Delegation of duties to the director. The board may delegate any duty to the director except its power to make rules and regulations (73).

2. As Administrator of Title 4.

a. Application of Administrative Procedures Act. The procedure of state boards, commissions, and officers, ie., of the Alcoholic Beverage Control Board, shall be conducted under the Administrative Procedures Act, not withstanding similar provisions in the statutes dealing with state boards, commissions, and officers listed. Where indicated, the procedure that shall be conducted under the A.P.A. is limited to named functions of the agency (74).

b. Powers, authority and control.

1.) The board may control the manufacture, barter, sale and possession of liquor and may adopt necessary rules and regulations to assume the proper administration of state liquor regulations in a manner that will protect the public health, safety and welfare (75).

a.) Additional Specifications - AAC (182).

Licensed premises shall be construed to mean any or all so designated portions of any building or structure, rooms or enclosures therein, or real estate leased, used, controlled and/or operated by a licensee in the conduct of the business for which he is licensed by the board at the specific address for which the license is issued. It shall be the duty of the licensee to clearly designate the limits of the licensed premises in his application for license. The board may reduce the area of the licensed premises described in the application where, in the judgement of the board, a reduction in area is in the best interests of the public or where a reduction in area is necessary to insure adequate control over the sale and consumption of alcoholic beverages on the premises.

b.) Additional Specifications - AAC (183).

(1.) It shall be illegal to sell varieties of whiskey which generally have been sold in containers of a specific size, in containers of similar appearance and size but of smaller content, which might mislead the public as to the quantity of whiskey contained in them.

(2.) Containers of whiskey of 1/10 gallon and 1/6 of a gallon capacity shall be considered prima facie to be containers which might mislead the public, as defined above, except that nothing in this regulation shall prohibit the continued sale of varieties of liquor in 1/10 gallon or 1/6 of a gallon containers, which varieties were sold in Alaska prior to August 15, 1962.

c.) Additional Specifications - AAC (184).

Any corporation holding any license under AS 04.05.030. shall report to the board any transfer of its corporate stock involving ten percent or more of said stock or any change of its corporate officers or members of its board of directors. Such report shall be made in writing in duplicate to the board at Juneau at a date not more than ten days following the transfer of the stock or the change in officers or directors. The provisions of this rule shall not apply to any corporation the stock of which is listed on a stock exchange, or to any bank, trust company, financial institution or title company to which a license is issued in a fiduciary capacity, or corporation which are required by laws to file periodic reports with the Securities Exchange Commission.

2.) The board shall review all applications for licenses and shall issue, reissue, revoke, transfer or suspend all licenses in the best interests of the public (75).

a.) Additional Specifications - AAC (185).

The following are the grounds which constitute a basis for the possible suspension or the revocation of licenses:

- (1.) When the continuance of a license would be contrary to the best interest of the public; but proceedings under this section upon this ground are not limitation on the Alcoholic Beverage Control Board to proceed under provisions of AS 04.05.030.
- (2.) A violation of any Alcoholic Beverage Control Board rule or regulation by a licensee, his agent or employee.
- (3.) The misrepresentation of a material fact by an applicant in obtaining any license.
- (4.) The plea, verdict, or judgement of guilty to any public offense involving moral turpitude or violation of any law concerning the manufacture, barter, sale and possession of intoxicating liquors.
- (5.) Where the portion of the premises of the licensee upon which the activities permitted by the license are conducted are a resort for illegal possessors or users of narcotics, prostitutes, pimps, panderers or sexual perverts. In addition to any other legally competent evidence, the character of the premises may be proved by the general reputation of the premises in the community as a resort of illegal possessors or users of narcotics, prostitutes, pimps, panderers or sexual perverts.
- (6.) Failure to correct objectionable conditions within a prescribed time or reasonable time after receipt of notice to make such correction issued by the Alcoholic Beverage Control Board or agent thereof.
- (7.) Disciplinary action by military or naval authorities against any licensed premises.
- (8.) Any failure to comply with the laws, rules and regulations pertaining to public health in Alaska.
- (9.) Conviction of a charge of gambling within the limits of any licensed premises.

b.) Additional Specifications - AAC (186).

It is the opinion of the board that any individual, group of individuals, company, corporation, agency of the state of federal government, who by writ of attachment shall force the involuntary transfer of an existing license, shall in effect become the transferrer and shall bear the responsibility for the same as provided for under AS 04.05.030.

c.) AAC (187).

(1.) The board has determined that it is against the best interests of the public for any persons to maintain any club room in which any alcoholic beverage is received or kept, or to which any alcoholic beverage is brought, for consumption on the premises by members of the public or of any club, corporation, or association, unless the person or premises are licensed under AS 04.05.030.

(2.) The board has further determined that it is against the best interests of the public for any person to keep, maintain, operate or lease any premises for the purpose of providing therein, for a consideration, a place for the drinking of alcoholic beverages by members of the public or other persons, unless the person and premises are licensed under AS 04.05.030.

(3.) As used herein, consideration includes cover charge, the sale of food, ice, mixers or other liquids used with alcoholic beverage drinks, or the furnishing of glassware or other containers for use in the consumption of alcoholic beverage drinks.

d.) AAC (188).

The board may refuse the renewal or transfer of any license when the applicant is delinquent in the payment of any taxes when such tax liability arises in full or in part out of the exercise of the privilege of an alcoholic beverage license.

e.) AAC (189).

At any time when there are no premises, the licensee shall surrender the license to the board until such time as operations are resumed.

3.) The board may hold public hearing when applications are protested and require applicants to answer pertinent questions (75).

- 4.) The board may appoint support personnel it considers necessary in giving effect to Title 4 (75).

Additional Specifications - AAC (190).

The director and the persons employed by the board for the administration and enforcement of Chapter 197, SLA 1959 have all the powers of peace officers in the enforcement of the penal provisions of this Act, the rules and regulations of the board, and any other penal provisions of the State of Alaska governing the manufacture, barter, sale and possession of intoxicating liquors in the State of Alaska.

- 5.) The board may promulgate rules and regulations necessary to effectuate the purpose of Title 4. These rules and regulations shall have the effect of law (75).

Additional Specifications - AAC (191).

- a.) Beer manufacturers or wholesalers of alcoholic beverages to non-licensees having a fixed place of business or residence upon territory within the State of Alaska which is maintained by the United States Government as a military or naval reservation or a national park, may deliver such alcoholic beverages to such instrumentalities at such premises only when the purchaser is a ship's service store, officer's club, officer's mess, post exchange or similar organization. Such deliveries may be made only to persons who present at the instrumentalities' place of business a written order for the purchase of the alcoholic beverages specified in the order, which shall be issued by the service organization for which the purchase is made. Any licensee making such sales and deliveries shall keep the original order attached to the copy of the invoice on file at the licensee's premises.
- b.) Alcoholic beverages sold to federal instrumentalities by beer manufacturers or wholesalers licensed under AS 04.05.030. may be delivered only for use within the state which comprises the military or naval reservation or national park.
- c.) Manufacturers, wholesalers, and rectifiers who deliver or cause to be delivered alcoholic beverages on federal reservations, shall pay the state alcoholic beverages tax on such alcoholic beverages so delivered and subsequently claim credit for all excise taxes paid when such deliveries are made to organizations which are instrumentalities of the federal government.

- 6.) The A.P.A. governs all proceedings under Title 4 (75).

- c. Providing for local option elections. The board shall provide a system for holding of local option elections and prescribe the rules and regulations for holding of elections and canvassing of the votes (76).
- d. Review of board action. An action relating to the administrative duties imposed by Title 4. is subject to review by the board at the instance of an aggrieved party. A board action or decision relating to the issuance, reissuance, suspension or revocation of a license under Title 4. is subject to review (77).

3. As Regulatory Agency.

- a. General power to regulate. The board shall prescribe rules and regulations consistent with Title 4. governing the manufacture, barter, sale, and possession of intoxicating liquors and shall prescribe application fees (78).

- b. Scope of regulations.

- 1.) Regulating employment, conduct and duties of board employees (79).
- 2.) Prescribing the forms of application, reports and other forms, and the terms and conditions in permits and licenses (79).

- a.) Additional Specifications - AAC (192).

- (1.) A caterer's permit shall give to the holder thereof the right to sell intoxicating beverages at conventions, picnics, social gatherings, sporting events or similar affairs where the premises are not otherwise licensed. Any holder of a beverage dispensary license currently in use may apply to the board for a caterer's permit. Before applying to the board for a caterer's permit, written notice must be given to the chief of police if the permit is sought for a location within a municipality, and to the state police officer in charge if the permit is sought for a location outside of a municipality.
- (2.) Such notice shall be given to the appropriate police authority at least one week in advance of the date for which the caterer's permit is desired, and proof of such notice having been timely given must accompany the application to the board. The board shall consider any protest made by the appropriate police authority in determining whether or not the granting of the permit would be in the best interest of the community involved.

a.) Additional Specifications - AAC (192). (Continued)

- (3.) A copy of the notice given to the proper police authority shall be submitted to the board as part of the application and shall include a description of the premises, and specific hours of intended operation. At such catered affairs, the licensee shall comply with all provisions of the law, rules or regulations pertaining to the proper conduct of business to those holders of beverage dispensary licenses. Any violation of any provisions of said law, rules or regulations may be grounds for suspension or revocation of licensee's beverage dispensary license. A caterer's permit is not transferable. The fee for a caterer's permit shall be \$25.00 and shall accompany the application for permit.

b.) Additional Specifications - AAC (193).

- (1.) A special events permit shall give the holder thereof the right to sell beer at retail for consumption on designated premises for a specific occasion and limited period of time.
- (2.) Only non-profit, fraternal, civic or patriotic organizations incorporated and active for a period of two or more years may make application for such permit and all profits derived from sale of the beer must go to the organization itself and not to any individual.
- (3.) All applications for special events permits must be received in the main office of the Alcoholic Beverage Control Board at least ten days prior to the date the permit is desired. All applications must be signed and duly notarized by both the president and secretary of the organization applying for said permit. Further, a sworn affidavit showing the length of time said organization has been in existence must accompany the application together with a certified copy of the resolution of the membership or board of directors authorizing the application.
- (4.) The written approval of the local law enforcement agency under whose jurisdiction the proposed premises are located must also accompany the application.
- (5.) The special events permit may be used only at the premises stipulated on the permit. The permit must be surrendered to the board, its agent, or the law enforcement agency approving the permit, within 48 hours of its expiration time. Failure to so surrender the permit may, in the discretion of the board, prevent the organization from acquiring future permits.

b.) Additional Specifications - AAC (193). (Continued)

(6.) Not in excess of three such special events permits may be granted to any organization, including any women's auxiliary thereof, in any one calendar year.

(7.) All regulatory measures of the Liquor Act and the rules and regulations of the board shall be strictly adhered to by the holders of a special events permit.

(8.) The fee for a special events permit shall be \$25.00 per day.

c.) Additional Specifications - AAC (194).

A conditional contractor's permit shall give to the holder thereof the right to sell beer upon specified premises located within the boundaries of a military or naval reservation, or in a remote area as designated by the board. Provided, however, that said holders thereof shall file with the board written permission for same from the commanding officer of said military or naval reservation or the prime contractor of the remotely situated project. This permission shall be renewed yearly upon re-application for permit and may be cancelled or suspended at the commanding officer's or the prime contractor's discretion. In no event shall a condition contractor's permit be transferable, nor shall it be valid after the completion of the holders' thereof contract or closing of said military or naval reservation. The conditional contractor's permit fee shall be \$300.00.

d.) AAC (195).

A conditional canteen or beer hall permit shall give to the holder thereof the right to sell beer upon specified premises located within the boundaries of a military or naval reservation or at a remotely situated project, provided however, that said holders thereof shall file with the board written permission for same from the commanding officer of said military or naval reservation or the prime contractor of the remotely situated project. This permission shall be renewed yearly upon re-application for permit and may be cancelled or suspended at the commanding officer's or the prime contractor's discretion. In no event shall a conditional canteen or beer hall permit be transferable. The conditional canteen or beer hall permit fee shall be \$300.00.

3.) Prescribing the fees to be paid for permits and licenses issued for which no fees are prescribed by statute, and prescribing the fees for anything done or permitted to be done under the regulations (79).

4.) Providing for regular and special board meetings (79).

- 5.) Providing for delegation to the director of routine administrative functions and powers, including the issuance, transfer and renewal of licenses and permits where there is no contest or protest (79).
- 6.) Prescribing the manner of giving and serving notice required by law or regulation where it is not provided for by statute (79).
- 7.) Prescribing the conditions, accommodations, qualifications, and inspections of each type or kind of license, licensee, or licensed premises (74).
- 8.) Providing for the making of returns and reports by wholesalers of wine, beer and liquor (79).
- 9.) Providing for the giving of fidelity bonds by any or all of the board employees, the state to pay the premiums for the bonds (79).
- 10.) Providing for the issuance, renewal, reissuance, revocation and suspension of licenses and permits (79).
- 11.) Prohibiting possession of alcoholic beverages by minors (79).

Additional Specifications - AAC (196).

- a.) Any person under the age of 19 years is prohibited from possessing or controlling any alcoholic beverages.
 - b.) Any person under the age of 19 years is prohibited from knowingly consuming alcoholic beverages except as provided under AS 04.15.080. However, this provision in no way exonerates parents, guardians or spouses from prosecution for contributing to the delinquency of a minor when such delinquency arises in part or full from their giving of alcoholic beverages to any said minor.
- 12.) Prescribing reports from license corporations, including reports of stock ownership transfer and changes of officers and directors (79).

d. Designation of restaurants.

- 1.) The board, with the approval of the city council or borough assembly shall designate which premises are restaurants because minors are allowed to enter and remain upon such premises where liquor is sold for the purpose of dining or dancing if accompanied by an adult (8).

2.) The board shall promulgate regulations for the designation of restaurants and the continuation or withdrawal of the designation (8).

- e. Sale on election days in unorganized areas of the state. The A.B.C. board shall adopt regulations governing the sale of liquor on election days in the unorganized areas of the state (28).

4. Penalties For Violation of Regulation.

- a. Penalty for violation of A.B.C. Board regulation. A person, firm, or corporation, who violates a board rule or regulation governing the manufacture, sale, barter, and possession of liquor, or the qualifications of those engaging in the manufacture, sale, barter, and possession of liquor, or the payment of license fees and excise taxes, is guilty of a misdemeanor, punishable by imprisonment of not more than one year or by a fine of not more than \$500.00 (80).
- b. Suspension or revocation of license. The board may, upon direction of a majority of its members, suspend or revoke a license and declare the bond forfeited upon conviction of a licensee for violation of a provision of Title 4. or of a municipal ordinance (22).

III. REVENUE FROM LICENSES AND TAXATION

A. LICENSES

1. Disposition Of Funds.

Revenue from license fees goes into general fund. Money collected or due the state for licenses under the provisions of Title 4. shall be deposited with the Dept. of Revenue and covered into the general fund (81).

2. Conditions Of Refund.

Cities and boroughs must enforce liquor laws to participate in revenue sharing. Money derived from the licenses issued, except wholesale licenses within organized boroughs and all classes of cities, shall be refunded semi-annually to the boroughs and cities. If the officers of a borough or city fail to actively enforce its ordinances, the laws of the state, and the regulations relating to the manufacture and sale of liquor in the state, the commissioner of revenue may deny the refund and no further money may be paid to the local governments until the enforcement of the laws and regulations is actively resumed (82).

3. Additional Fees.

Deposited in general fund. Any application fee prescribed by the board is in addition to any other fee charged under Title 4. and shall be deposited in the general fund (83). (SEE FEES CHARGED FOR LICENSES UNDER II., C., 2., CLASSIFICATION OF LICENSES.)

B. TAXATION

1. Excise Tax On Intoxicating Liquor.

- a. A.B.C. board's power to adopt rules & regulations. The power of the board to adopt rules and regulations includes providing for the making of returns and reports by wholesalers of wine, beer and liquor (79).
- b. Liquor tax. Every brewer, distiller, bottler, jobber, retailer, wholesaler, or manufacturer who sells intoxicating liquors in the state or who consigns shipments of intoxicating liquors into the state, whether or not the liquors are brewed, distilled, bottled or manufactured in the state, shall pay the following taxes (84):

Type of Intoxicating Liquor	Tax
Malt Beverages (Alcoholic content 1% or more).	25¢ / gallon
Wine & other liquors 21% by volume or less.	60¢ / gallon
Liquors with alcoholic content more than 21%.	\$4.00 / gallon

- c. When tax may not be levied. The excise tax may not be levied on consigned shipments of liquor into the state if the consignments are to state licensed bonded warehouses in this state until the intoxicating liquor is removed from the warehouse for sale or consignment to retailers (85).
- d. When report must be filed and tax paid.
- 1.) A statement containing an account of the liquors sold or consigned to buyers or consignees in the state during the preceding month shall be sent to the Dept. of Revenue on or before the last day of each calendar month (86).
 - 2.) The excise tax is paid to the Dept. of Revenue on or before the last day of each month for liquor sold or consigned during the preceding month (87).
- e. Delinquency. A penalty fee of 5% per 30 days for delinquent tax payments (not to exceed 25% in the aggregate) is added to the payments and interest in delinquent cases is assessed at the rate of 6% a year (88).
- f. Administration and enforcement of tax.
- 1.) Wholesalers (including brewers, distillers, bottlers, jobbers and manufacturers) are primarily liable for payment of the excise tax and they shall furnish a \$25,000. surety bond payable to the Dept. of Revenue and approved by the Dept. of Law. In the event that the wholesaler fails to pay the excise tax, the bond is forfeited and his or her license is revoked. (The Dept. of Revenue, at its discretion, may issue permits in lieu of requiring bonds of resident wholesalers, upon prepayment of the excise tax). It is unlawful for a wholesaler (including the holder of a production license) to sell intoxicating liquors in the state or consign them into the state, without first furnishing the bond and obtaining the appropriate license (89).

2.) The retailer or buyer is secondarily liable for the taxes on intoxicating liquors which are sold to him or her. The state has a lien upon the liquors, and may seize, confiscate and sell them to satisfy the payment of the taxes and the costs of the proceedings, without regard to where or in whose possession the liquors are found (90).

3.) Restrictions on flow of liquor.

a.) Stock must be confined to licensed premises. It is unlawful for a licensee to carry for sale any stock of intoxicating liquor except on the premises indicated on the license (91).

b.) Premises must be accessible for inspection. The licensed premises shall be easily accessible for inspection by peace officers, including members of the director of the A.B.C. board, during regular business hours (92).

c.) Liquor shipments to unlicensed persons are subject to confiscation. Any liquor shipped into the state for sale other than to licensees is contraband and subject to confiscation by the state (93).

d.) Restrictions on warehousing of liquor.

(1.) Liquor may not be stocked or warehoused on premises other than those indicated on the license unless the premises are inspected and approved by the board before their use; the use of the premises for storage is authorized by applicable zoning ordinances; and the premises are accessible for inspection (94).

(2.) Liquor sales may not be transacted from premises approved for storage (94).

(3.) Liquor warehoused on premises that are not licensed or that have not been approved is contraband and subject to confiscation (94).

2. Penalties Related to Excise Tax.

a. Person who wilfully fails to fulfill requirements of law. A person who wilfully fails to obtain the license certificate or permit, pay the excise tax, make a return, keep or display the required records, or supply the required information at the time required by law or regulation is, in addition to other penalties provided by law, guilty of a misdemeanor, punishable by a fine of not more than \$1,000.00 and/or imprisonment for not less than one year, together with the cost of prosecution (95).

- b. Person who wilfully lies on a return. A person who wilfully lies on a return is guilty of a felony, subject to the penalties prescribed for perjury under the laws of the state.(96).
- c. Penalty for fraud with intent to evade the tax. If a part of a deficiency in the tax is due to fraud with intent to evade the tax, then 50% of the total amount of the deficiency (in addition to the deficiency) shall be assessed and collected (97).

3. Sales And Property Tax.

No municipality may impose (alcoholic beverage) taxes other than property taxes on liquor inventories and sales taxes on liquor sales when these taxes are levied on other property and sales within the municipality (24).

IV. CONSUMPTION PROBLEMS: CRIMINAL SANCTIONS AND CIVIL DISABILITIES

A. CRIMINAL SANCTIONS

1. Voluntary Intoxication Not a Defense.

Intoxication shall not be used as a defense. An act committed by a person while in a state of voluntary intoxication is not less criminal because he or she was intoxicated. However, in considering a case the jury may take into consideration the defendant's intoxication when a particular motive, purpose or intent is a necessary element in a particular kind or degree of crime. "Intoxication" refers to intoxication from the use of a drug as well as to the intoxication from alcohol (98).

2. Operating a Motor Vehicle While Under The Influence of Intoxicating Liquor.

a. Mandatory revocation of license. Operating or driving an automobile, motorcycle or other motor vehicle while under the influence of intoxicating liquor, dangerous or narcotic drugs is grounds for immediate revocation of an operator's license (99).

b. Implied consent doctrine.

1.) Person who operates motor vehicle in this state considered to have given permission to chemical test of breath if arrested for offense related to O.M.V.I. Test administered by law enforcement officer (100).

2.) If arrested person refuses to submit to chemical test after advised by officer that refusal result in suspension, denial, or revocation of license, test not given. Upon receipt of sworn statement from officer that person refused submit to chemical test, Department of Public Safety notify person license revoked or suspended or no original license issued for 3 months (101).

3.) Department of Public Safety also inform person right to appeal decision, take to district court (without jury). Appeal limited to following issues:

a.) Whether arresting officer had reasonable grounds to believe person was O.M.V.I. (101).

b.) Whether arrested person refused to submit to breath test after being advised that refusal would result in suspension of license (101).

c.) Whether accused was fairly informed as to nature of tests, accuracy of methods, expertise of testee, and given other requested information (101).

- 4.) If issues set out in 3.) affirmative, court will sustain action of department. If one or more negative, department action rescinded (101).
- 5.) If person refusing to submit to test has been convicted in this or other state for O.M.V.I. within two years, license will be suspended for one year (101).

c. Chemical analysis of blood.

- 1.) Upon trial of civil or criminal action arising from acts committed O.M.V.I., amount of alcohol in blood at time (shown by chemical breath analysis) shall give rise to following presumptions (presumptive intoxication) (102):

(Per cent by weight alcohol defined as milligrams alcohol per 100 cubic centimeters blood.)

Amount of Alcohol	Presumption
0.05 per cent or less by weight alcohol in blood.	Person not under influence of intoxicating liquor.
More than 0.05 but less than 0.10 per cent by weight alcohol in blood.	Whether person under influence not self-evident; must be taken in conjunction with other competent evidence.
0.10 per cent or more by weight alcohol in blood.	Person under influence.

- 2.) To be valid, chemical analysis must be performed according to methods approved by Department of Health and Social Services. If established at trial that approved methods followed, is presumption that test results valid (102).

- a.) Additional Specifications - AAC (197).
The Borkenstein Breathalyzer is approved by the department for ascertaining alcohol content of blood by chemical analysis of breath.
- b.) AAC (198).
The procedures set forth in this section shall be followed to obtain and analyze breath samples by use of the Borkenstein Breathalyzer:

b.) Additional Specifications - AAC (198). (Continued)

- (1.) Complete the "Breathalyzer Operational Check List" form by recording the name of the subject, date, the ampoule control number, the name of the operator, the name of a witness if the test is witnessed by someone other than the operator, and the serial number of the instrument used. Procedures specified on the list shall be checked as they are completed;
- (2.) observe the subject to be tested for at least 15 minutes immediately prior to testing to insure that he does not regurgitate or place anything in his mouth during that period of time;
- (3.) turn on the Breathalyzer and warm the sample chamber to a temperature of 50 degrees centigrade, plus or minus three degrees;
- (4.) gauge a test ampoule and insert it in the left holder;
- (5.) gauge a second test ampoule, open it, insert the bubbler and make the connection to the outlet tube;
- (6.) turn the control knob to "TAKE", flush the sample chamber with a syringe and turn the control valve to "ANALYZE";
- (7.) wait 90 seconds after the red light appears, then turn on the photometer light source and balance the galvanometer;
- (8.) set the blood alcohol pointer on the start position;
- (9.) turn the control valve to "TAKE", procure the sample of breath and turn the control valve to "ANALYZE";
- (10.) record the time when the breath sample was acquired;
- (11.) wait 90 seconds after the red light appears, then turn on the photometer light source and balance the galvanometer;
- (12.) record the value indicated by the blood alcohol pointer;
- (13.) record the test particulars in the Breathalyzer log book.

c.) Additional Specifications - AAC (199).

A person shall be certified as a qualified Breathalyzer operator after successfully completing a course of training under a qualified Breathalyzer instructor. The training shall consist of:

- (1.) A minimum of four hours' instruction in the theory of alcohol physiology, pharmacology, toxicology and instrument function;
- (2.) a minimum of four hours of practical operation of the Breathalyzer instrument including satisfactory performance by the trainee of tests of not less than five known specimens achieving results consistent with the manufacturers recommended tolerances of accuracy and the collection and analysis of at least three samples from human subjects;
- (3.) the successful completion of a written examination demonstrating his basic knowledge of the effect of alcohol on the human body, the basic mechanical functions of the Breathalyzer and the proper collection of breath samples from human subjects.

d.) AAC (200).

- (1.) A person shall be certified as a qualified Breathalyzer instructor after completing an instructor's training course meeting the following standards:

- * The course shall be equal to or exceed the instructor course offered by the Indiana University, Department of Police Administration.
- * The curriculum shall include an advanced survey of current information on alcohol and the human body, operational principles and theories applicable to the breath testing program, instrument maintenance and calibration, legal considerations, public relations and principles of instruction.
- * The trainee must satisfactorily pass written and practical examinations demonstrating an understanding of the theory of chemical tests for intoxication, methods for determining presence of ethyl alcohol, physiological effects of alcohol on the human body, the pharmacology and toxicology of alcohol, instrument maintenance and calibration.

- (2.) A qualified breathalyzer instructor may calibrate, verify and perform routine maintenance on Breathalyzer instruments.

e.) Additional Specifications - AAC (201).

- (1.) Each Breathalyzer instrument shall be calibrated in accordance with the manufacturer's instructions at intervals not to exceed 60 days.
- (2.) At the time of calibration the instructor performing the activity shall:
 - * enter the date and calibration information in the Breathalyzer log;
 - * forward to the department a certificate containing the date of calibration, the serial number of the instrument and its location;
 - * provide a copy of the certificate calibration required by this section to the local supervisor responsible for the instrument.

f.) AAC (202).

- (1.) 10 ampoules, selected at random from each ampoule lot, shall be chemically analyzed by an approved laboratory to verify the proper chemical composition and volume stated by the ampoule manufacturer.
- (2.) The entire lot, as identified by the ampoule solution control number, may be certified if the samples analyzed meet or surpass the manufacturer's specifications.
- (3.) At the time of analysis the laboratory shall complete a written certificate setting forth the number of ampoules and the results of the analysis for each ampoule.
- (4.) Approved laboratories shall file with the department a report of the methods or tests to be employed by the laboratory to ascertain the characteristics or properties of the sample tested.

g.) AAC (203).

The Department of Public Safety shall file the following materials with the Department of Health & Social Services:

- (1.) The beginning and ending dates of each training session for operators or instructors and a copy of the training course curriculum;
- (2.) the names of instructors conducting courses in each training session;

g.) Additional Specifications - AAC (203). (Continued)

- (3.) the names and addresses of persons successfully completing the training;
- (4.) a copy of the tests employed to establish the qualifications of the persons receiving training.

h.) AAC (204).
Definitions:

- (1.) "ampoule" means the glass cuvette containing the chemical reagent used to measure the oxidation of ethyl alcohol;
- (2.) "approved laboratory" means a laboratory certified by the Division of Public Health of the Department of Health and Social Services;
- (3.) "blood alcohol pointer" means the coupled pointer whose travel across a linear scale represents the blood-alcohol concentration as measured by photometric balance between light transmitted through the test ampoules;
- (4.) "bubbler" means a glass tube that conveys the breath sample from the outlet tube into the opened test ampoule;
- (5.) "control knob" means a pointed knob controlling the three positions of sample chamber valve assembly;
- (6.) "department" means the Department of Health and Social Services;
- (7.) "galvanometer" means the electrical device that measures and indicates the balance of current produced by the photometric cells;
- (8.) "gauge" means a double ended machined tube used to verify the ampoule size and liquid volume;
- (9.) "outlet tube" means the capillary tube connecting the sample chamber to the bubbler;
- (10.) "photometer" means the electrical device used to measure the intensity of light passed through the test ampoule;
- (11.) "sample chamber" means the chamber, including a piston, used to collect a measured volume of breath and discharge the breath via the outlet tube and bubbler through the opened test ampoule solution;
- (12.) "start position" means the line designated on the percent blood alcohol scale as ".00."

- 3.) Persons being tested may have physician, or other qualified person of own choosing, administer second test. Failure to obtain second test not negate one taken by enforcement officer. Person's attempt to obtain second test is admissible as evidence. Upon request, full information on test, including results, made available to person or attorney (102).

d. Penalties.

- 1.) *First conviction - fine not more than \$1,000.00 and/or imprisonment of not more than one year.
*Second conviction - within 5 years of first, imprisonment not less than three days.
*Subsequent conviction within 5 years of second, imprisonment not less than ten days (103).
- 2.) In addition, operator's license revoked in accordance with AS 28.15.210(c). (103).
- 3.) *First conviction - license revoked for not less than 30 days.
*Second conviction - license revoked for not less than one year.
*Third or subsequent conviction - license revoked for not less than three years.
*Court may limit the license instead of revoking it for the first conviction if it determines the revocation would severely impair the person's ability to earn a livelihood (104).

3. Grounds for Arrest Without Warrant.

O.M.V.I. grounds for arrest without warrant. A peace officer may arrest a person without a warrant, whether or not the offense is committed in the presence of the officer, when the officer has probable cause to believe that the person has committed the crime of operating a motor vehicle while under the influence of intoxicating liquor or drugs (in violation of AS 28.35.030.) or a similar city or borough ordinance, if the violation is alleged to have occurred less than eight hours before the time of arrest (105).

4. Actions Which are Prohibited While Under The Influence of Intoxicating Liquor.

- a. Possession of firearm while under the influence of intoxicating liquor or drug. A person who, while under influence of intoxicating liquor or an exhilarating or stupefying drug, carries, has in possession or under control, or uses or discharges a firearm is guilty of a misdemeanor, punishable by a fine of not more than \$1,000.00 and/or by imprisonment for not more than one year (106).

b. Prohibited operation. No person shall operate a watercraft or manipulate water skis, surfboard, or similar device on inland waters while under the influence of intoxicating liquor, narcotic drug, barbituate or marijuana (107).

c. Reckless operation.

1.) No person may operate an aircraft in the air or on the ground or water while under the influence of intoxicating liquor, narcotics or other habit-forming drugs (108).

2.) No person may operate an aircraft occupied by a crew member or passenger who is obviously under the influence of intoxicating liquor or habit-forming drugs (109).

5. Physician Doing Act While Intoxicated Which Results in Death.

Intoxicated physician who does act resulting in death guilty of manslaughter. A physician, or person pretending to be a physician, who while in a state of intoxication, without a design to cause death, administers any poison, drug, or medicine, or does another act to a person which produces the person's death, is guilty of manslaughter, punishable accordingly (110).

B. CIVIL DISABILITIES

1. Marriages and Divorces

- a. Issuance of marriage license. If all requirements have been met, and there is no legal objection to the contemplated marriage, and neither party is under the influence of intoxicating liquor or otherwise incapable of understanding the seriousness of the proceeding, the licensing officer shall issue a license (111).
- b. Grounds for divorce. A divorce may be granted on the grounds of habitual gross drunkenness contracted since marriage and continuing for one year to the commencement of the action (112).

2. No Right to Worker's Compensation

- a. Cases in which no compensation is payable. No compensation may be paid if the injury was occasioned solely by the intoxication of the employee (113).
- b. Presumptions. In a proceeding for the enforcement of a claim for compensation it is presumed, in the absence of substantial evidence to the contrary, that the injury was not occasioned solely by the intoxication of the injured employee (114).
- c. Employer's failure to insure. If an employee fails to provide worker's compensation to employees he or she may not escape liability for personal injury or death sustained by an employee when the injury arises out of and in the usual course of the employment because the employee was negligent, unless it appears that the negligence was the result of wilful intoxication on the part of the injured party (115).

3. No Right to Insurance Coverage

Intoxicants and narcotics. The insurer shall not be liable for a loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of a narcotic unless administered on the advice of a physician (116).

4. Estates of Habitual Drunkards

- a. Trust company as trustee of estate. A trust company may act under court order or appointment as the trustee, guardian, receiver or committee of the estate of a habitual drunkard (117).
- b. Bank as trustee of estate. A bank may act under court order or appointment as the trustee, guardian, receiver or committee of the estate of a habitual drunkard (117).

5. Alcoholic Physician

Duty of physicians to report. A physician who professionally treats a person licensed to practice medicine and surgery or osteopathy, for alcoholism, drug addiction, mental, emotional or personality disorders shall report it to the State Medical Board if he or she feels the person may constitute a danger to patients (119).

ALCOHOLISM: PROVISIONS FOR TREATMENT, REHABILITATION AND EDUCATION

A. UNIFORM ALCOHOLISM AND INTOXICATION TREATMENT ACT

1. Policy Established.

- a. Policy of the state. Alcoholics and intoxicated persons shall not be criminally prosecuted for consumption of alcohol (120).
- b. Alcoholics and intoxicated persons shall be afforded continuum of treatment (120).

2. Administrative Structure

- a. Creation of office of alcoholism. Office of Alcoholism created in Department of Health and Social Services; headed by coordinator (121).
- b. Responsibilities of office of alcoholism.
 - 1.) Plan, establish, maintain treatment programs; make contracts incidental to performance of duties; solicit and accept gifts and grants of money from state, federal; coordinate activities and cooperate with programs; keep records, engage in research; encourage local participation; provide treatment facilities (122).
 - 2.) Develop educational programs; organize personnel training programs; advise governor in preparation of comprehensive treatment plan; cooperate with Department of Public Safety and Department of Highways in setting up programs to deal with persons O.M.V.I.; encourage hospitals admit alcoholics without discrimination, provide adequate treatment; encourage health and disability insurance programs include alcoholism as covered illness; submit annual report to legislature, covering office activities (123).
 - 3.) Establish comprehensive and coordinated treatment programs.
 - a.) Divide state into regions for administration of programs. Programs shall include: (1) emergency treatment facility affiliated with hospital; (2) inpatient treatment; (3) intermediate treatment; (4) outpatient and followup treatment (124).
 - b.) Provide adequate and appropriate treatment within limits of available state and federal funds (124).

- c.) Maintain, supervise, control all facilities operated by it; administrator of each facility shall submit annual activity report to coordinator (124).
 - d.) Publish list annually - all public and private treatment facilities (124).
- 4.) Establish standards for public and private facilities.
 - a.) Standards only include health conditions to be met, standards of treatment afforded, fixing fees to be charged for required inspections of facilities (125).
 - b.) Each facility, on request, provide office with any information about facility, statistics, schedules, data, etc. Any facility not furnishing requested information, furnishing fraudulent information, removed from list of approved facilities (125).
 - c.) Upon petition of office, district court may issue warrant to officer or employee of office, authorizing to inspect facility, examine books (125).
- 5.) Promulgate regulations for admission of persons into treatment programs. Regulations based on guidelines such as treating person, when possible, on voluntary preferable to involuntary basis and initially assigning person to outpatient or intermediate status, rather than inpatient status (126).
- c. Creation of interdepartmental coordinating committee.
 - 1.) Interdepartmental coordinating committee created, composed of coordinator and five commissioners (Commissioner of Health and Social Services, who is chairperson, and Commissioners of Education, Highways, Labor and Public Safety); committee shall meet at least twice annually (127).
 - 2.) Committee provide for coordination and exchange of information on programs relating to alcoholism; act as permanent liaison among state departments engaged in alcohol-related activities. Committee assist Commissioner of Health and Social Services and coordinator in formulating a comprehensive prevention and treatment plan (127).
- d. Establishment of advisory board on alcoholism.
 - 1.) An advisory board on alcoholism is established in the Department of Health and Social Services; it consists of nine members appointed by the governor. Members serve terms of four years (128),(129),(130).

2.) Advisory board act in advisory capacity to commissioner in following matters:

- a.) Mental health problems relating to alcoholism;
- b.) educational and research activities;
- c.) social problems affecting rehabilitation;
- d.) related legal processes;
- e.) public relations programs (131).

3. Treatment and Commitment Procedure.

a. Voluntary treatment for alcoholics. Alcoholic may voluntarily apply for treatment directly to approved public treatment facility. Administrator in charge of facility may determine who admitted for treatment. If person refused admission, administrator, if possible, refer person to other treatment facility. When patient on inpatient status leaves facility, shall be encouraged to pursue outpatient or intermediate treatment (132).

b. Treatment and services for intoxicated persons and persons incapacitated by alcohol.

1.) An intoxicated person may come voluntarily to an approved public treatment facility for emergency treatment. A person who appears to be intoxicated in public or a person who appears to be intoxicated upon a licensed premise and refuses to leave may be taken into protective custody and assisted by a peace officer or by the emergency service patrol to his home, an approved public or private treatment facility or another health facility. If none of these are available he may be taken to a state or municipal detention facility (133).

2.) A person who appears to be incapacitated by alcohol in public shall be taken into protective custody by a peace officer or the emergency service patrol and brought to an approved public or private treatment facility, or another appropriate health facility or service for emergency medical treatment. If no medical facility or service is available he may be taken to a state or municipal detention facility if that appears necessary for the protection of the person's health or safety. Protective custody does not constitute arrest (133).

3.) Person who voluntarily appears or is brought to approved public treatment facility shall be examined by physician as soon as possible, admitted or referred. If referred, facility provide transportation (133).

- 4.) No person who incapacitated by alcohol may be detained at facility after no longer incapacitated. No person who remains incapacitated by alcohol may be detained at facility for more than 48 hours. After admission, unless committed under emergency commitment, person may consent to remain in facility as long as physician in charge considers appropriate (133).
- 5.) Person who not admitted to treatment facility, not referred to other health facility, has no funds, may be taken to own home, if have one. If not, treatment facility assist in finding shelter (133).

c. Emergency commitment.

- 1.) Intoxicated person who (a) has threatened, attempted to inflict, or inflicted physical harm on another or is likely to inflict physical harm on another unless committed, or (b) is incapacitated by alcohol, may be committed to treatment facility for emergency treatment. Refusal to undergo treatment not constitute evidence of lack of judgment as to need for treatment (134).
- 2.) Certifying physician, spouse, guardian, relative of person to be committed, or other responsible person, may make written application for commitment, directed to administrator of facility. Application state facts to support need for emergency treatment, be accompanied by physician's certificate supporting need for emergency treatment and stating physician examined person sought to be committed within two days before certificate's date (134).
- 3.) Upon approval of application by administrator in charge of facility, person brought to facility by peace officer, health officer, member of emergency service patrol, applicant for commitment, patient's spouse, patient's guardian, or any other interested person. Person retained at facility, or transferred to another facility, until discharged under (5) of this section. However, no person be detained under this section for more than 48 hours unless district or superior court judge reviewed, approved commitment application (134).
- 4.) Administrator in charge of facility may refuse application if in his/her opinion, application and certificate fail to sustain grounds for commitment (134).
- 5.) When on advise of medical staff, administrator determines grounds for commitment no longer exists, shall discharge person. No person committed this section detained in treatment facility for more than five days. If petition for involuntary commitment (SEE d., INVOLUNTARY COMMITMENT) been filed within five days and administrator in charge of facility finds grounds for emergency commitment still exist, he/she may detain person until petition has been heard and determined, but no longer than 10 days after filing petition (134).

- 6.) A copy of the written application for commitment and of the physician's certificate, and a written explanation of the person's right to legal counsel, shall be given to the person within 24 hours after commitment by the administrator, who shall provide a reasonable opportunity for the person to consult with legal counsel (134).

d. Involuntary commitment.

- 1.) After hearing initiated by petition of spouse, guardian, relative, certifying physician, or administrator in charge of facility, person may be committed to custody of office by superior court. Petition shall allege that person is alcoholic who habitually lacks self-control in using alcoholic beverages and that he/she (a) has threatened, attempted to inflict, or inflicted physical harm on another and unless committed likely to inflict physical harm on another, or (b) is incapacitated by alcohol. Refusal to undergo treatment not constitute evidence of lack of judgment as to need for treatment. Petition shall be accompanied by certificate of physician who examined person within two days before submission of petition, unless person refused to submit to medical examination, in which case fact of refusal be alleged in petition (135).
- 2.) After petition filed, court fix date for hearing no later than 10 days after date petition filed. Copy of petition and notice of hearing, including date fixed by court, be served on (a) petitioner; (b) person whose commitment sought; (c) person's next of kin; (d) administrator in charge of facility, and any other person court considers appropriate. Copy of petition and certificate be delivered to each person notified (135).
- 3.) If, not less than two days before date fixed for hearing, person sought to be committed or counsel or advisor files written request with superior court, court summon and impanel jury of six, to hear, consider evidence concerning person's condition (135).
- 4.) At hearing, court or jury, shall hear all relevant testimony, including, if possible, testimony of at least one licensed physician who examined person. Person be present unless court believes presence likely be injurious to him/her, which case court appoint guardian ad litem to represent person in open court, or if advisable, examine out of court. If person refused be examined by physician, be given opportunity to request examination by court-appointed physician. If fails to request medical examination and is sufficient evidence believe allegations of petition are true, or if court believes more medical evidence necessary, court may issue temporary order committing him/her to office for period of not more than five days for purposes of diagnostic examination (136).

- 5.) If after hearing all relevant evidence, court or jury finds grounds for involuntary commitment been clearly established, court issue order of commitment to office. No court order commitment of person unless determines office able provide adequate and appropriate treatment for him/her (136).
- 6.) Person committed under involuntary commitment shall remain in custody of office for treatment for a period up to 30 days. At end of 30 days, discharged automatically unless office, before expiration, obtains court order for recommitment upon grounds set out in d., 1.) for further period up to 90 days. If person been committed because he is alcoholic likely to inflict physical harm on another, office shall apply for recommitment if after examination is determined likelihood still exists (136).
- 7.) Person may be recommitment for further period of up to 90 days for same reason as 6.) above (136).
- 8.) When petition for recommitment filed under 6.) or 7.) above, court fix date for hearing no later than 20 days after petition filed. Procedure for hearing same as for original involuntary commitment hearing (136).
- 9.) Person committed to custody of office for treatment be discharged at any time before end of period for which committed if either of following conditions met:
 - a.) When alcoholic committed on grounds of likelihood of infliction of physical harm on another no longer considered alcoholic or likelihood of infliction of physical harm no longer exists; or
 - b.) when, in case of alcoholic committed on grounds of likelihood of infliction of physical harm on another, either
 - * further treatment not likely bring about significant improvement in persons's condition, or
 - * treatment no longer adequate or appropriate (136).
- 10.) Court shall inform person whose commitment or recommitment sought of right to contest application, be represented by counsel at every stage of proceedings, have counsel provided by court, if unable to obtain counsel, and to jury trial, if requested. If court believes person needs assistance of counsel, the court require, by appointment if necessary, counsel for him/her regardless of objection. Person be informed of right to be examined by physician of his/her choice. If person unable obtain M.D., court shall provide (136).
- 11.) If private treatment facility agrees with request of competent patient or his/her parent, sibling, adult child, or guardian to accept patient for treatment, administrator of public treatment facility transfer to private treatment facility (136).
- 12.) Person committed may at any time seek discharge from commitment by writ of habeas corpus under AS 12.75 (136).

4. Miscellaneous Provisions

a. Records of alcoholics and intoxicated persons.

- 1.) Registration and other records of treatment facilities shall remain confidential; are privileged to patient (137).
- 2.) Notwithstanding 1.) this section, coordinator make available information from patient's records for purpose of research. No information disclose patient's name (137).

b. Visitation and communication of patients. Patients in facility guaranteed continuing contact with family and friends; mail, other communication to, from patient, may not be read, intercepted, censored (138).

c. Establishment of emergency service patrol.

- 1.) Office, cities, boroughs may establish emergency service patrol. Emergency service patrol consists of persons trained to give assistance in public places to intoxicated persons. Members of patrol capable providing first-aid in emergency situations, transporting intoxicated persons to homes, to and from public treatment facilities (139).
- 2.) Coordinator promulgate regulations for establishment, training, conduct of emergency service patrols (139).

d. Payment for treatment.

- 1.) Patient in approved facility or person obligated provide for patient's treatment costs, liable to office for payment, accordance with rates established by coordinator (140).
- 2.) Coordinator promulgate regulations governing financial ability of persons liable for costs (140).

e. Nonapplicability. Nothing in the Uniform Act affects statutes, ordinances and regulations relating to O.M.V.I., or the use of alcoholic beverages by particular classes of persons at specified times and places, or persons being upon the traveled portion of a highway so as to be a hazard to the motoring public. The Uniform Act does not affect the defense of voluntary intoxication (141).

f. Application of Administrative Procedure Act. Except otherwise provided this chapter, A.P.A. (AS 44.62) applies to and govern all administrative action taken by coordinator (142).

5. Definitions

Terms defined.

- a. "Alcoholic" means a person who habitually lacks self-control in using alcoholic beverages, or uses alcoholic beverages to the extent that his or her health is substantially impaired or endangered, or his or her social or economic function is substantially disrupted (143).
- b. "Approved private treatment facility" means a private agency meeting the standards prescribed in and approved under 2., b., 4.) (143).
- c. "Approved public treatment facility" means a treatment agency operating under the direction and control of the office or providing treatment under this chapter through a contract with the office and meeting the standards prescribed in and approved under 2., b., 4.) (143).
- d. "Incapacitated by alcohol" means a person who is unconscious or has his/her judgment otherwise so impaired that he or she is incapable of realizing and making a rational decision with respect to need for treatment, as evidenced objectively by extreme physical debilitation, physical harm or threats of harm to others or chronic inability to hold regular employment (143).
- e. "Incompetent person" means a person who has been adjudged incompetent by the appropriate court (143).
- f. "Intoxicated person" means a person whose mental or physical functioning is substantially impaired as a result of the use of alcohol (143).
- g. "Treatment" means a 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 (143).

B. ARTICLE 4. ALCOHOLICS

1. Powers and Duties of Department of Health & Social Services.

Powers and duties under Article 4.

- a. Keeps current list of treatment facilities (144).
- b. Encourages development of standards of treatment of alcoholics in institutions (144).
- c. Promotes and encourages alcohol education programs (144).
- d. Utilizes services/facilities at community level (144).
- e. Engages in research and education activities (144).
- f. Administers community grant-in-aid program for alcoholics (144).
- g. Submits annual report within 10 days convening of legislature (144).

2. Grant-In-Aid Program

a. Description.

1.) Grant-in-aid funds.

- a.) Non-profit corporation, city or borough government, other political subdivision of the state, or combination of these, eligible for grant-in-aid funds this section (145).
- b.) Applications sent to Department of Health and Social Services (145).

2.) Awarding of grants.

- a.) Department award grants on competitive basis in interest of providing or developing comprehensive program of alcoholic rehabilitation and prevention (145).
- b.) Department award grants with advice of Advisory Board on Alcoholism (145).

3.) Specifications of grants.

- a.) Grants awarded in ratio: (145).
 - 75% state money
 - 25% community money, except in communities designated poverty areas:
 - 90% state money
 - 10% community money

- b.) Grants are for providing staff and limited improvement, renovation of new construction of facilities for alcoholic detoxification, rehabilitation, of "half-way house" care (145).
- c.) No grant for improving, renovating, or constructing, may exceed \$50,000., except if lack of applicants for available money. If such case, needs approval of Advisory Board on Alcoholism (145).
- d.) Department not required award all money available, or full percentages specified above, if another money source available (145).

4.) Grant applications.

- a.) Money used by applicant to qualify for state money may be from any source other than state (145).
- b.) Cost of developing application not reimbursable from grant.
*Value of real property to be used in conjunction with grant may be used in calculating required amount of community money, following regulation of department (145).

b. Regulations.

- 1.) The Department of Health and Social Services shall adopt regulations implementing the grant-in-aid program. The regulations shall provide for:
 - a.) Method of application;
 - b.) time for consideration of applications;
 - c.) processing of applications;
 - d.) type of record keeping;
 - e.) requirements for reporting progress and statistics regarding program;
 - f.) notification of applicant as to action taken on application;
 - g.) issuance of licenses for facilities receiving grant-in-aid.
- 2.) The Department shall also establish the necessary forms of application and adopt other regulations considered necessary to meet health and safety requirements and the orderly administration of the grant-in-aid program (146).
 - a.) Additional Specifications - AAC (205).
Applications for matching grants for the development or continued support of alcoholism programs and facilities shall be on forms provided by the department.

b.) Additional Specifications - AAC (206).

Applications may be submitted to the department at any time during the fiscal year. However, applications which are submitted later than May 15 of any fiscal year will not be considered for funding from that current fiscal year's available money except by written request and with the approval of the commissioner based upon recommendation of the Advisory Board.

c.) AAC (207).

Applications shall be processed by the department and those correctly submitted shall be referred to the Advisory Board for review. Applications which are incorrect in form or content shall be returned to the originator by the department, citing the reasons for return. The Advisory Board shall consider each application referred by the department and recommend to the department acceptance or rejection of each application together with suggested order of priority for those applications recommended for acceptance. The department may approve an application for immediate funding, approve an application subject to later availability of funding, or reject an application for cogent and compelling reasons. Each applicant shall be notified of the decision of the department.

d.) AAC (208).

Projects funded under AS 47.30.477 shall keep records under any recognized accounting procedure approved by the department or on forms supplied by the department. In addition to financial records, the projects shall keep records regarding the persons served by the project which shall include personal histories in such detail as required of the projects by the department for the purpose of data collection and evaluation of project effectiveness. Quarterly reports shall be submitted according to the format prescribed by the department.

e.) AAC (209).

The value of property used as "in-kind" contributions for participation in the program may be:

- (1.) The value, as allowed by the department, of real property to which the grantee has title;
- (2.) the value, as allowed by the department, of real property loaned to the grantee; or
- (3.) the value of goods and services, including personnel services, given or loaned to the grantee except those given or loaned by a state agency;
- (4.) a value attributable to the services of volunteers, either skilled or unskilled, is not eligible as an "in-kind" contribution.

f.) Additional Specifications - AAC (210).

All project facilities shall be licensed by the department and shall meet all fire, life safety and building codes in 13 AAC 50.010 and all codes in 7 AAC pertaining to water, sewage and waste disposal; eating and drinking establishments; and housing.

g.) AAC (211).

A non-profit corporation operating or planning to operate a project must have a certificate of incorporation unless it is operated under public auspices.

h.) AAC (212).

- (1.) A project operated by a non-profit corporation shall comply with AS 10.20.
- (2.) The board of directors shall adopt by-laws which shall provide for the constituency of the board, the manner by which officers are elected, terms of office, responsibilities of each office, frequency of meetings, the employment of an executive director or manager and his responsibilities, and for the development of a program and personnel policies for the management of staff and for the operation of the project.
- (3.) A project under public auspices shall have a governing body charged with the same responsibilities as those described for a non-profit corporation.
- (4.) A project sponsored by a multi-service parent agency shall be governed by the parent agency's board or by a committee or other structure established by the board and charged with the same responsibilities as those for the governing bodies indicated above.
- (5.) A project associated with a community mental health center shall have a governing body recognized by the administration of the mental health center. The governing body of such a unit shall have the same responsibilities required of the governing units described above. A project is associated with a community health center if it is related to the mental health center by administration, contractual arrangement, or other working agreement.
- (6.) For each project, final authority for administrative and other non-medical matters shall be vested in the board of directors or other governing body.

h.) Additional Specifications - AAC (212). (Continued)

- (7.) The governing body of a project other than those projects under the administration of a mental health center shall appoint a professional or technical advisory committee or similar structure which shall meet at stated regular intervals or at least be on call for meetings with the governing body for the latter's guidance in relation to special problems. Members of the governing body who have specialized knowledge and skills may serve on this committee. The manager or executive director and other professional members of the staff may attend these meetings.
- (8.) The executive director or manager shall carry full responsibility for the projects being administered according to the by-laws or the written policies of the board of directors.

i.) AAC (213).

- (1.) A project shall have a prearranged medical affiliation if medical services are involved. The affiliation shall be:
- * With a general or a mental hospital or a community health center, public or voluntary, which includes in its services a specialized treatment unit which commonly treats alcoholics;
 - * a written contractual arrangement with a medical facility whereby provision is made for meeting the medical needs of alcoholic patients;
 - * a written joint working agreement with a medical facility by which mutual services are provided;
 - * a written agreement with one or more physicians or psychiatrists in private practice; or
 - * with another resource or other resources not covered above but which assure the medical needs of the persons served.
- (2.) Contracts, agreements, and arrangements with a medical facility or a medical person shall specify the separate responsibilities and the extent of the individual participation in decisions for admission, discharge, special medical care, and other matters in which a medical opinion is required.

j.) Additional Specifications - AAC (214).

Definitions:

- (1.) "department" means the Department of Health and Social Services;
- (2.) "in-kind" contributions means real or personal property counted in lieu of cash as fulfilling the grantee's required portion of the total project;
- (3.) "grantee" means a non-profit corporation or a political subdivision of the state, or combination thereof, which receives funds from the department for the purposes of this program.

3. Judicial Notice

Alcoholic suffering from illness. The superior courts of this state may take judicial notice of the fact that an alcoholic is suffering from an illness and is in need of proper medical, advisory or rehabilitative treatment (147).

4. Acceptance of Funds

Department accept funds on behalf of state. The department may accept on behalf of the state and deposit, apart from other public funds, grants from the federal government or gifts or contributions from other sources to assist in carrying out its powers and duties (148).

5. Definitions

Terms defined.

- a. "Alcoholism" means a condition related to alcohol and concerns a physical compulsion which exists, coupled with a mental obsession (149).
- b. "Poverty area" means a district in which 15% or more of the population, based on the 1970 census data, falls under 125% of the Community Services Administration poverty guidelines (149).

VI. ADMINISTRATIVE AGENCIES ENGAGED IN ALCOHOL-RELATED ACTIVITIES

A. DEPARTMENT OF REVENUE

1. Collects excise tax monthly from persons engaged in liquor industry. Upon receipt of surety bond, issues license certificate authorizing sale of liquor in state, consignment of liquor to state (150).
2. Money collected for licenses issued under Title IV is deposited with Department, covered into general fund (81).
3. Receives revenue from sales of contraband in state (53).
4. If the officers of a borough or city fail to actively enforce its ordinances, U.S. laws, the laws of the state, and the regulations relating to the manufacture and sale of liquor in the state, the Commissioner of Revenue may deny the refund and no further money may be paid to the local governments until the enforcement of the laws and regulations is actively resumed (82).

B. ABC BOARD

1. In Department of Revenue; 5 members + director (two of which engaged in liquor business except wholesaler). Three-year terms, appointed by governor. Also see AS 39.05.060 and AS 44.62.330 (72).
2. Controls manufacture, barter, sale and possession; protects public health, safety and welfare. Prescribes terms and conditions of permits and licenses; issues, renews, transfers, revokes, or suspends licenses. (Director issues licenses.) Collects license fees - deposited into general fund. Provides for local option elections (72).

C. DEPARTMENT OF HEALTH AND SOCIAL SERVICES

1. Keeps current list of alcoholism programs/facilities; encourages standards of treatment; promotes education programs/activities; engages in research; utilizes community resources; administers community grant-in-aid program; submits annual report within 10 days start of legislature (144).

2. Department promulgates regulations to enforce 19.35.100. (Requiring taverns to have sanitary toilet facilities) (17).
3. Approves methods to be used when performing chemical analysis of blood to determine if person O.M.V.I. (102).

D. OFFICE OF ALCOHOLISM

1. Located in Department of Health and Social Services, headed by coordinator, appointed by Commissioner (121).
2. Created in 1972. Plans, creates, maintains, treatment programs and centers; works for improvement of existing programs; prepares and disseminates educational material, conducts alcohol-related research (121).

E. ADVISORY BOARD ON ALCOHOLISM

1. Located in the Department of Health and Social Services, 9 members include attorney, doctors, social worker; four-year terms, appointed by governor(128).
2. Advises Commissioner on mental health problems related to alcoholism, educational and research activities, social problems affecting rehabilitation, related legal processes, public relations programs (128).
3. Advises Department in awarding grants-in-aid (145).

F. INTERDEPARTMENTAL COORDINATING COMMITTEE

1. Has 6 members: 5 commissioners + coordinator; Commissioner of Health and Social Services Chairperson (127).
2. Coordinates information on alcohol-related programs. Serves as liaison among state departments concerned with alcohol problems (127).

G. VIOLENT CRIMES COMPENSATION BOARD

1. Located in Department of Health and Social Services; three members appointed by governor for staggered three-year terms. One member licensed medical or osteopathic physician, one attorney (151).
2. Holds hearing, issues orders and decisions; has full subpoena powers; promulgates, rescinds, amends regulations, develops standards for determination of compensation (151).
3. Research has established that there is high correlation between alcohol and criminal homicides, aggravated assault and other assault, forcible rape and other sex offenses (222).

H. BANK

May act under court order as trustee of habitual drunkard (118).

I. TRUST COMPANY

May act under court order as trustee of habitual drunkard (117).

J. DIVISION OF CORRECTIONS

(In Department of Health and Social Services.) Office of Alcoholism should cooperate with them in establishing and conducting programs to provide treatment for alcoholics and intoxicated persons in or on parole from penal institutions (123).

K. STATE MEDICAL BOARD

1. Located in Department of Commerce and Economic Development; five licensed physicians, appointed by governor, confirmed by legislature, four-year terms (152) (153).
2. Physician treating person who is licensed to practice medicine in state for alcoholism shall report it to board if he/she feels person may constitute danger to health and welfare of patients or public (119).

L. DEPARTMENT OF PUBLIC SAFETY

1. Issues I.D. cards to persons not having driver's license (for purpose of purchasing liquor) (13).
2. Investigates and reports to ABC Board any liquor law violations under Title 4 (56).
3. Office of Alcoholism should cooperate with them in establishing, conducting programs dealing with problem of persons O.M.V.I. (123).
4. Peace officer may arrest person without warrant when has cause to believe person committed crime of O.M.V.I. (105).
5. Administers law concerning O.M.V.I., including chemical analysis for blood alcohol content and penalties for O.M.V.I. (154).

M. MUNICIPAL GOVERNMENTS (City or Borough Governments).

1. May regulate alcoholic beverages as provided in AS 04.15.070. (23).
2. Along with non-profit corporation, other political subdivision of state, combination of, eligible for grant-in-aid (145).
3. City council must approve operation of beverage dispensary or retail liquor store when zoning prohibits sale (5).
4. May protest board's notice of intent to approve application for transfer, renewal, or new license (125).
5. When petitioned by 35% of voters, city council place question of whether liquor to be sold on ballot (local option) (27).
6. Municipalities may provide for additional closing hours of liquor establishments (24) (1).
7. City council or Borough assembly approve ABC board's designation of premises as restaurants for purposes of Title 4. (8).

8. Governing body of political subdivision may provide by ordinance for sales on election days (28).
9. Municipalities may by ordinance provide regulations governing barter, sale, possession (24).
10. No municipality may impose taxes other than property taxes on liquor inventories and sales taxes on liquor sales when these taxes are levied on other property and sales within the municipality (24).
11. Municipality may rule by local ordinance that liquor not be sold on boats, aircraft, and railroad buffet cars that are stationary (24) (42).

N. COURTS

1. Courts in General

- a. Issue order to bank to act as trustee, receiver, of estate of habitual drunkard (118).
- b. Issue order to trust company to act as trustee, receiver, of estate of habitual drunkard (117).
- c. Voluntary intoxication not be used as defense, however, jury take into consideration defendant's intoxication when particular motive, purpose, intent is necessary element in particular kind or degree of crime (98).
- d. No person may be detained at facility over 48 hours under Emergency Commitment Section, unless district or superior court judge has reviewed and approved commitment application (22).
- e. Upon conviction of a licensee for a violation of Title 4. or of a local ordinance, the judge having jurisdiction shall send notification of conviction along with a certified copy of the record of conviction to the ABC Board (22).

2. Superior Courts

- a. Take judicial notice that alcoholic suffering from illness, in need of proper treatment (147).
- b. May commit person to custody of Office of Alcoholism under "Involuntary Commitment" section. At request of person or representative, will summon jury of six (135).

3. District Courts

- a. District Court shall revoke license of person convicted for O.M.V.I. (104).
- b. Contested cases of O.M.V.I. may be taken to; courts may modify or nullify license revocation, if would cause extreme hardship to person (154).
- c. Issue warrant to Office of Alcoholism to inspect treatment facility refusing to consent to inspection or which office has cause to believe is operating in violation this chapter (125).

O. DEPARTMENT OF LABOR

Will not issue permit to conduct employment agency in connection with bar or intoxicating liquor dispensary (19).

P. DEPARTMENT OF EDUCATION

Office should cooperate with them in establishing programs for prevention and treatment and preparing school curriculum materials (123).

Q. DEPARTMENT OF LAW

Approves \$25,000 surety bond furnished by person engaged in liquor industry to Department of Revenue (89).

R. DEPARTMENT OF HIGHWAYS

Office of Alcoholism should cooperate with them in establishing, conducting programs dealing with problem of persons O.M.V.I. (123).

S. EMERGENCY SERVICE PATROL

1. Take person incapacitated by alcohol into protective custody (or police will), escort to approved facility or emergency medical service, or home (133).
2. Established by office, cities or boroughs; coordinator of Office of Alcoholism promulgate regulations for establishment, training, conduct of Emergency Service Patrol (139).

T. BOARD OF VOCATIONAL REHABILITATION

1. Board of Education which administers program of vocational education is designated as Board of Vocational Rehabilitation (155).
2. Board may cooperate with a federal agency, as provided and required by federal law for vocational rehabilitation. Board shall comply with federal laws and conditions to secure full benefit of federal vocational rehabilitation laws, and shall do all things necessary to entitle the state to receive benefits of the federal laws (155).
3. Any "handicapped individual" may qualify for vocational rehabilitation services and a person who suffers from alcoholism is included in the definition of a handicapped individual (155).
4. Office of Vocational Rehabilitation established under the Board of Vocational Rehabilitation; director appointed by the board (155).

U. DEPARTMENT OF COMMUNITY AND REGIONAL AFFAIRS

Conducts local option referendum elections in areas outside municipalities when 35 percent of the adult population requests the A.B.C. Board to deny the issuance, reissuance, renewal or transfer of a license (29).

PART THREE

VII. SUMMARY AND ANALYSIS OF STATE LEGISLATION

Given the fact that, since 1933, it has been the states' responsibility to regulate the sale and distribution of alcohol, one would expect to find a policy statement on alcohol in Alaska's statutes enacted at statehood. In fact, however, no such legislative policy exists in Title 4; it was left to the Supreme Court of Alaska to "discover" and enunciate the state's alcohol policy in Boehl v Sabre Jet Room Inc., 349 P2d 585 (Alaska 1960). Finally, in 1972, the legislature enacted the Uniform Alcoholism and Intoxication Act, which does contain a statement of policy. The policy of the Uniform Act, which follows, but broadens, the public inebriate laws, is to treat and rehabilitate those abusing alcohol, and to decriminalize alcoholism and intoxication. Because the Uniform Act contains the only clear statement of legislative policy, and reflects the most recent attitudes towards alcohol abuse, it is assumed for the purposes of this study that the policies of the Uniform Act are the policies of the state.

In addition to the stated purpose of the Act, five other inherent policies appear in the body of the Act, all reflecting the public health approach to alcohol abuse. First, alcohol abuse is to be treated comprehensively through research, educational programs, treatment programs and facilities, and cooperation among interested groups. Second, the State must respect the autonomy and decisions of the person being treated, unless that person is incapable of rational thought, in which case the function of the State is to protect his or her safety. Third, programs should reflect

the fact that alcoholics, intoxicated persons, and persons incapacitated by alcohol may have different needs. Fourth, treatment should occur at the local level whenever possible. Finally, the Uniform Act recognizes that, while alcohol abuse is an illness, it can also have direct social consequences from which the public must be protected.

What follows will be a summary of the purposes of Alaska's alcohol-related laws, and the relationship of those purposes to the policies of the Uniform Act. The actual effect in practice of these laws on the policies of the Uniform Act is beyond the scope of this section of the study, although those effects which necessarily result from the laws as written will be noted.

Each of the sections that follow are presented in sequence, corresponding to elements of the organizational scheme devised and utilized in PART TWO, roman numerals II to VI. Following each section heading below, and then as required for reference in the text, the appropriate roman numeral, alphabetic letter, and arabic number will be given in parentheses to designate the corresponding section in PART TWO.

STATEWIDE REGULATION (II.A.)

Statewide regulation is aimed at preventing alcohol abuse, protecting the public from some of the effects of alcohol, collecting revenue, and allowing local control. (Revenue and local control will be treated separately later.) Most of the regulations designed to prevent alcohol abuse attempt to do so by limiting the availability of alcohol as to time and place, and by limiting the number of licenses per capita. (II.A. 1., 2., and 4.) Other provisions deal more directly with alcohol abuse by prohibiting sales to intoxicated persons and minors (who are apparently presumed to be incapable of exercising good judgment in this matter), sales on credit, and the procurement of sales by employees or others. (II.A.3.)

Whatever the effectiveness of these preventative measures may be, they are theoretically compatible with the Uniform Act's policy of treating and preventing alcohol abuse. Further studies of the relationship between consumption patterns and the actual abuse of alcohol may indicate which regulatory measures would be most effective in preventing and treating abuse.

Other statewide regulations are more concerned with protecting "the public welfare" than with preventing alcohol abuse. The "public welfare" may refer to the health of those who drink, whether in moderation or otherwise (e.g., the requirement that toilets be installed in restaurants and taverns; II.A.6.), or an unrelated public interest (e.g., voting; II.A.2.), or the sensibilities of those who do not consider alcohol appropriate to certain occasions (e.g., the prohibition against sales near churches; II.A.2.). None of these provisions conflicts with the Legislature's policy of treating alcohol abuse; some may further it by discouraging consumption under certain circumstances, while others simply deal with other issues related to alcohol consumption.

LOCAL CONTROLS (II.B.)

The purpose of these provisions is to allow localities to implement their own policies concerning the availability of alcohol, although provisions specifically aimed at preventing alcohol abuse are also possible (II.B.1.-3.). Furthermore, localities may apply their knowledge of local conditions by protesting the sale, renewal or transfer of liquor licenses (II.B.2.). Allowing local control could in some states result in transferring the problems associated with alcohol to a nearby locality, a result which would be inconsistent with the spirit of the Uniform Act's policy of treating alcohol abuse. Such a result is, however, currently less likely in Alaska given the distribution of the population within the

state, although it could become a problem as population increases and contiguous municipalities are formed. Local controls which take advantage of the knowledge of local conditions may encourage compliance with regulations which tend to prevent abuse; e.g., the provision allowing municipalities to protest licenses could encourage local bars to enforce regulations which prohibit sales to minors or intoxicated persons.

One of the major forms of local control is the option to go "dry." Currently, an incorporated municipality may elect to prohibit sales within its boundaries, and such an election must be held in incorporated cities which had no licensed premises on June 19, 1976, before a license may be issued in that city (II.B.2.b.). In remote areas--those which are more than 50 miles from the boundaries of an incorporated city--no license may be issued until a petition is filed with the A.B.C. Board (II.B.3.b. and c.).

While the local option is a powerful form of local control, it may have an adverse effect on the problems of alcohol abuse. Even in "dry" communities, possession and consumption of alcohol and attendant abuse problems are still possible; nevertheless, the community cannot receive a refund of liquor license fees, because such fees are not collected within the municipality. Therefore, a "dry" community may need money for law enforcement costs associated with alcohol abuse, and yet lose the revenue to pay for such needs. In short, the current method of sharing license fee revenues tends to discourage a community from exercising the option to go "dry."

Another potential form of local control--special local taxes on beverage alcohol--is apparently prohibited by statute (II.B.1.b.). As a result, municipalities are not able to equalize the income from the sale of alcohol and the costs to the city associated with it. Local treatment centers, which are encouraged by the Uniform Act, are limited by the

amount of State and Federal money available, as well as the money available for local match funds. While this may be a result of the State's desire to insure compliance with State laws, it is likely that municipalities would comply with these laws in order to receive State money in any case. Therefore it appears that the prohibition on special local liquor taxes impedes the development of local treatment centers, and is therefore in direct contradiction to the Uniform Act's policy. While it has been suggested that a special local liquor tax could be levied in the guise of a general sales tax which exempted everything but alcohol, such a law, even if it withstood legal challenge, would be very difficult to write. And, of course, the Legislature should not rely on the ingenuity of the municipalities to circumvent a law written by that same Legislature.

LICENSING (II.C.)

Aside from the collection of revenue, which will be discussed later, the regulation of liquor licenses is governed by two concerns. First, the amount of the license fee appears to depend on the amount of income received for sales of alcoholic beverages (II.C.2.). Bars, for instance, must pay a higher fee than restaurants selling beer, wine and food. The differences in licensing fees could be based on the different law enforcement problems associated with different establishments; bars, for instance, would presumably have more problems with maintaining order than restaurants serving beer and wine with meals would. However, the overall fee structure--including, for instance, the fact that common carriers, who have no impact on communities they are passing through or over, must license each alcoholic beverage dispensary--suggests that economic concerns have more impact on the fee structure than law enforcement problems do.

The second purpose of the licensing provisions is to make licensees

responsible to the community. For this reason, the licensee is required to enforce the liquor regulations and conduct his or her business within the provisions of Title 4 (II.C.3.-6.). Furthermore, public notice is required, and protests allowed in licensing procedures, so that the opinions of the community may be considered (II.C.3.). Such control over the behavior of licensees can aid the prevention and treatment of alcohol abuse by encouraging compliance with other provisions designed for that purpose--e.g., the provision prohibiting sales to intoxicated persons--if the state actually enforces those provisions.

THE ABC BOARD (II.D.)

Essentially, the ABC Board regulates the business of liquor sales. For this reason, two of the five members of the Board are members of the liquor industry--membership by a person with a public health background is not required (II.D.1.b.(1.))--and provision is made for reports by wholesalers, reports of stock ownership transfer or licensed corporations, and the like (II.D.3.b.(8.)). However, the ABC Board also has the duty of minimizing the impact which the sale and consumption of alcohol has on the public, and for this reason enforces laws designed to prevent deceptive sales (II.D.2.b.), to keep licensees from criminal connections and practices (II.D.2.b.), and to preserve public order in places where liquor is sold (II.D.3.b.). The ABC Board does not deal directly with problems caused by alcohol abuse, except insofar as those provisions designed to keep order tend to prevent abuse. A clear indication by the Legislature that alcohol is to be treated as a dangerous drug might allow the ABC Board to promulgate regulations dealing with the sale and consumption of alcoholic beverages which were specifically aimed at treating and preventing alcohol abuse. Also, a substantial

organizational link with alcoholism and alcohol abuse service agencies would provide the necessary knowledge for such regulations.

REVENUE-LICENSES (III.A.)

As noted in the summary of licensing laws (II.C.), the amount collected from license fees is apparently determined by business needs and considerations rather than the social costs resulting from the sale of alcohol. Nevertheless, the fees collected within cities and organized boroughs are refunded to those cities and boroughs after being deposited in the general fund (II.A.1. and 2.). In order to receive these fees, the cities and boroughs must enforce their own ordinances as well as the State's liquor regulations (III.A.2.)--a condition that strongly suggests that the refund is intended to offset local law enforcement costs resulting from alcohol consumption. This procedure is not a "dedication" of funds, which is prohibited by Article IX, Section 7 of Alaska's Constitution, but rather a revenue-sharing plan with conditions attached.

This sharing of license fee revenue relates to the Uniform Act in two ways. First, law enforcement agencies often help intoxicated or incapacitated persons to treatment centers. Second, local police can enforce local and state laws which reduce or prevent abuse; e.g., laws against sales to minors or inebriated persons. License fee revenues will probably not, however, have much impact on local treatment centers, since the refunds are so small that they would probably not exceed alcohol-related law enforcement costs.

REVENUE-TAXATION (III.B.)

Most of the provisions in this section are designed to ensure that the excise tax is actually collected. The tax itself appears to be a general revenue measure, similar to taxes on other luxury goods. The

relationship of the excise tax to the Uniform Act's policy of preventing and treating alcohol abuse depends on the extent to which the taxes collected are actually used to defer the costs engendered by alcohol abuse (see Volume I). Since the Legislature, in passing the Uniform Act, recognized that alcohol, unlike many other luxury goods, has a strong impact on public health and safety, the excise tax should reflect this assumption if the State's alcohol policy is to be cohesive. Little attention, however, has been given the excise tax, or its relationship to alcohol abuse, since the tax was last increased in 1961. Despite dramatic increases in the cost of living in the last fifteen years, the excise tax has remained stable. One can only conclude that alcohol is still viewed as a luxury in the tax structure, despite the fact that other parts of the law treat alcohol as a public health hazard.

The excise tax could be used to defer the social costs of alcohol abuse, or as a way of controlling consumption and possibly abuse of alcohol. The details of these two approaches are discussed elsewhere in this study (see Volumes IV and V), but both approaches would be consistent with the Uniform Act's emphasis on prevention and treatment of alcohol abuse. It should be noted that Article IX, Section 7, of Alaska's Constitution prohibits dedication of the excise tax on beverage alcohol, but this provision would not prevent the Legislature from considering the social costs of alcohol consumption in setting the excise tax rate.

CRIMINAL SANCTIONS (IV.A.)

Most criminal statutes dealing with alcohol are designed to deter intoxicated persons from doing certain acts which would not otherwise be criminal, but which require enough judgment and skill to be dangerous to the public if done by an intoxicated person (IV.A.2. and 4.). The

primary purpose of these statutes is to deter a person who is already intoxicated from engaging in the prohibited activities. These statutes do not conflict with the Uniform Act's decriminalization of intoxication because it is the activities which are prohibited, not the mere state of intoxication.

Other criminal statutes deal with the effects of intoxication on acts which would be crimes even if the person were sober (IV.A.1. and 5.). The purpose of these statutes is to ensure that the defendant is not able to escape or reduce the consequences of his acts by raising his intoxication as a defense. These statutes do not conflict with the Uniform Act's decriminalization policy; the Legislature is simply ensuring that criminal acts remain criminal, even when committed by an intoxicated person.

Both types of criminal statutes, however, may conflict with the Uniform Act's treatment policy. A person who commits a crime while intoxicated may simply be punished by incarceration. While jails are required to have treatment facilities in order to qualify for certain federal funds, it is possible that in many cases the underlying alcohol problem would be treated more effectively in a local treatment center. In contrast, AS 47.37.190 provides for involuntary commitment to the custody of the Office of Alcoholism when an alcoholic has committed an assault and is likely to do so in the future, and AS 47.37.180 provides for emergency commitment of an intoxicated person under the same circumstances. Therefore, an intoxicated person or alcoholic who commits an assault could find himself in the custody of the Office of Alcoholism or in a jail. In short, whether or not the Legislature's policy of treating alcohol abuse is carried out depends on whether the offender is "processed" through the Uniform Act's provisions or the criminal justice system, and if the latter occurs, the type of sentence which is given. Despite the inter-

relationship of crime and alcohol (Volume IV), the Legislature has not indicated the course which the courts and treatment agencies are to follow in dealing with alcohol-related crime, nor provided a mechanism through which courts and the treatment agencies could coordinate their efforts.

CIVIL DISABILITIES (IV.B.)

Most of the statutes covering civil disabilities arising from alcohol abuse are designed to protect either the person abusing alcohol or other persons. These statutes do not conflict with the decriminalization of intoxication, nor do they interfere with treatment programs except insofar as it is necessary to protect the mental and physical health of others; e.g., in divorces. However, two statutes--that denying Workman's Compensation where the injury was caused solely by the intoxication of the employee, and that allowing a similar restriction in disability insurance policies--may make treatment more difficult by leaving a disabled alcohol abuser without financial resources. Unless these restrictions are necessary for the solvency of the insurance program, or in fact do deter alcohol-related accidents, their only purpose seems to be to punish people who abuse alcohol since simple negligence of other illnesses which cause accidents does not preclude recovery.

THE UNIFORM ALCOHOLISM AND INTOXICATION TREATMENT ACT (V.A.)

The Uniform Act itself first sets up an administrative structure to formulate and implement educational, prevention and treatment programs. Much of the Act, however, outlines the procedures to be followed in admitting or committing a person to these programs, and reflects an attempt to reconcile the need for public order with the rights and needs of the person abusing alcohol. Because these procedures are complex, they will be summarized here.

First, the Act expresses a clear preference for voluntary treatment programs for alcoholics (V.A.3.a.). Due to the nature of alcohol abuse, however, provisions have also been made for emergency treatment (V.A.3.b.). A person who is intoxicated in public may be taken home, to a treatment facility, or to a detention facility if no treatment facilities are available and kept there for no more than twelve hours. (The Model Uniform Act does not consider detention facilities appropriate; the change was apparently due to current conditions in Alaska.) If the person is incapacitated by alcohol in public, he or she must be taken to a treatment or medical facility (or detention center if necessary for the person's safety), and kept there until no longer incapacitated, but in any case no longer than 48 hours. These provisions essentially replace the former practice of putting intoxicated persons in jail to "dry out."

There are also provisions for emergency commitment where an intoxicated person has committed an assault, or is likely to, or is incapacitated by alcohol, though not necessarily in public (V.A.3.c.). The purpose of these provisions is to prevent an intoxicated person from harming himself or others without putting him in jail. Nevertheless, since the person is not voluntarily seeking treatment, a statement of facts by the person seeking the commitment and a physician's statement are required. The maximum length of an emergency commitment is 48 hours, unless the application is approved by a judge, in which case there is a five-day maximum; or unless a petition for involuntary commitment has been filed within five days, in which case the maximum is ten days after the petition is filed (V.A.3.c.).

Finally, the Uniform Act provides for involuntary commitment of alcoholics (V.A.3.d.). The requirements for this procedure are rather

stringent. First the person must be proven to be an alcoholic--one who habitually lacks self-control in using alcohol, or uses alcoholic beverages to the extent that his or her health, social, or economic function is substantially impaired. Secondly, the person must be incapacitated by alcohol (incapable of making a rational decision about treatment) or have committed an assault, and be likely to do so in the future. Furthermore, a court must hear the petition for involuntary commitment, while a petition for emergency commitment is decided by the treatment facility administrator. A person may not be committed unless treatment is available, and is committed for a maximum of 30 days, with two 90 day recommitments possible. Alaska did, however, make some rather strange changes in the Model Uniform Act in this area. In both the Model Act and Alaska's statutes, a person committed because he or she was likely to commit an assault must be discharged when he or she is no longer an alcoholic, or no longer likely to commit an assault. Under Alaska's statute, such a person must also be discharged if further treatment is no longer adequate or appropriate (V.A.3.d.(9.)). These latter two are the circumstances under which the Model Uniform Act requires a person committed because of incapacity to be discharged, and Alaska makes no provision for the early release of a person who was merely incapacitated by alcohol. The result is that a person who was merely an incapacitated alcoholic may have no right to a release before 30 days, but an alcoholic who committed an assault would. It is possible that alcoholics who have committed assaults are given more grounds for early release because they are still liable to criminal prosecution. Nevertheless, it would seem that some provision for early release of an alcoholic committed for incapacity should be made, if the Act's preference for voluntary treatment

is to be carried out.

There is another apparent internal inconsistency in the Uniform Act. Although the Act in general emphasizes local treatment, custody in an involuntary commitment is given to the Office of Alcoholism rather than the local treatment centers. This may present problems in a State as large as Alaska, where the Office of Alcoholism is a great distance from many localities.

ALCOHOLICS--TITLE 4 (V.B.)

The main purpose of the provisions in this section is to implement the grant-in-aid program. The grant-in-aid program itself is intended to encourage and facilitate the operation of local treatment programs. Such programs not only allow localities to experiment with different types of treatments, but also keep the person being treated in the community near his family and work. This emphasis on local treatment is clearly consistent with the policy of the Uniform Act, although it is undermined by the prohibition against special local liquor taxes and problems with the local option to go dry which were discussed earlier.

ADMINISTRATIVE AGENCIES AND OTHER PUBLIC AGENCIES (VI.)

The agencies of primary concern are the ones mentioned as having some sort of administrative responsibility, in any of the statutes reviewed. An overview listing of these agencies and primary alcohol-related responsibilities, as identified in the statutes, produces twenty major organizational entities. All are in some way concerned with alcohol and its social consequences and each would fall into one of three general categories. In the first group would be those whose connection with alcohol is incidental to their main functions, while the second group is significantly involved with the prevention and treatment of alcohol abuse. The third group

would be public bodies whose concern is with the public safety in general, but is in fact extensively involved with the social consequences of alcohol consumption and abuse.

It is obvious that--when various aspects of the general social and material welfare of the state as a collectivity and the welfare of each of the residents, are considered (on the basis of each of the statutes reviewed)--the Legislature has seen the need to account for the potential and predictable consequences of alcohol abuse. The recognition of the pervasiveness of the consequences of alcohol abuse and alcoholism is easily demonstrated by the listing of the twenty major categories of organizational entities. However, even a cursory examination of the twenty entities reveals the shortcomings of this organizational presentation. Each of the entities has in fact many more administrative and bureaucratic subdivisions, many of which act independently of one another (e.g., municipal governments are listed as one entity; similarly, the courts are listed as one entity). Obviously, the number of separately administered agencies that have legislative directives concerning sale and consumption of beverage alcohol is more than twenty.

As has been noted in previous sections of this overall review, there has been no truly clear definition of policy by the Legislature that would serve to link the responsibilities of each of the agencies in a cohesive and meaningful fashion. A weak attempt at something of this sort was mentioned in the Uniform Act, whereby one of the provisions specifies the formation of an Interdepartmental Coordinating Committee that includes a small subset of the above agencies. The responsibility for the operation of this committee rests with the Department of Health and Social Services, whose Commissioner is Chairman of the Committee. It

would seem, then, that to the extent that legislative policy regarding alcohol abuse and alcoholism is specified or inferred by the various statutes, administrative responsibility for coordination is in the hands of the Commissioner of Health and Social Services and the Coordinator of the Office of Alcoholism.

In addition, the limited perspective given to this Committee is evidenced not only by its composition but by its duties. In referring to interdepartmental coordination, only the Departments of Education, Highways, Labor and Public Safety, are mentioned in addition to Health and Social Services. Further, the Committee is charged to operate within the policy set out within the Uniform Act.

It is clear now that the policy set out in the act is only concerned with dealing with the consequences of alcoholism and alcohol abuse. The membership of the Committee also reflects this same view. No representation is required of agencies dealing with the control and regulation of the availability and consumption of alcohol, nor the financial revenues and expenditures regarding sale, consumption and abuse of alcohol.

VII. CONCLUSION

Despite the resurgence of Federal interest in alcohol abuse in the 1960's, the primary responsibility for formulating an alcohol policy rests on the states. In Alaska, the Legislature did not meet this responsibility until 1972, fourteen years after Statehood, and even then the Legislature's statement of policy was merely added to the statutes, with little regard for its relationship to other laws.

In passing the Uniform Alcoholism and Intoxication Treatment Act in 1972, the Legislature chose to attack the problems of alcohol abuse from a public health perspective. The Uniform Act attempts to solve the

problem of alcohol abuse by preventing it, and treating those who already abuse alcohol, rather than by relying on the criminal justice system to deter abuse per se. However, other laws which originated in the social climate prevailing immediately after the repeal of National Prohibition have not been changed to reflect the public health orientation of the Uniform Act.

Statewide regulations, licensing procedures, and the ABC Board emphasize an economically stable liquor industry, divorced from criminal activities, but do not treat alcohol as a dangerous drug. The effects of alcohol are treated as a public health hazard, yet little is done to control the sale of the substance itself.

Local governments, which could develop programs to deal with alcohol abuse, are in many cases left without the resources to do so. The excise tax, a potentially powerful force in controlling the consumption of alcohol, reflects a view of alcohol as a mere luxury rather than a public health hazard. Furthermore, some of the State's insurance provisions still suggest a punitive approach to the deterrence of alcohol abuse. One can, of course, live with inconsistencies; but the inconsistency in this case makes it difficult for different state agencies which deal with alcohol-related problems to coordinate their efforts. If the State is to deal with alcohol-related problems as efficiently as possible, some attempt must be made to form a cohesive alcohol policy.

One of the major policy conflicts involves the control of sales on one hand and the control of abuse on the other. The ABC Board and statewide controls do not treat alcohol as a dangerous drug, while the Uniform Act assumes that it is. If alcohol were officially designated as a dangerous drug, the ABC Board would have stronger grounds for implementing sales regulations which discourage abuse when such control measures are

identified by scientific research. Because of the vital role of the ABC Board in controlling sales of alcohol, the Legislature should also consider requiring at least one member to have experience with the prevention and treatment of alcohol abuse.

Because the Legislature has delegated some of its power to control the sale of alcohol to the municipalities, some changes in the laws need to be made in order to help them exercise that power. If municipalities are to carry some of the State's burden in this area, they must be given the means to do it effectively. The first problem is the local option to go "dry." The current system of license fee rebates tends to discourage municipalities from exercising that option. Several alternatives are available. If the Legislature wants to spend more money on treatment and abuse, the license fee revenue could be used for the grant-in-aid program. If the Legislature wants to continue to direct the money to alcohol-related law enforcement costs, the money could be divided among the municipalities on the basis of population or some other formula which gave "dry" communities at least some of this revenue. In order to discourage the importation of alcohol into "dry" communities, the Legislature should also consider prohibiting common carriers from transporting alcohol from one part of the state to a "dry" community in the state. The second problem is the prohibition against special local liquor taxes. If the localities are to be innovative in developing methods of controlling alcohol abuse, or even be able to meet their needs in this area, they should not be denied special local liquor taxes. Allowing such taxes would enable localities to experiment with tax as a way of controlling consumption, as well as of providing money for local treatment and prevention programs, and would provide a realistic alternative for local responsibility for alcohol problems other than exercise of the local option.

The State's taxing power is also relevant to a cohesive alcohol policy. While a fuller discussion of the role the excise tax can play in controlling alcohol abuse or paying for its social cost is found in Volumes IV and V of this study, it can be said at this point that the stability of the excise tax during the last fifteen years, when compared with dramatic increases in the consumer price index, has resulted in a relative decline in alcohol prices (in excess of 40% since 1970, Volume IV). In effect, the Legislature has subsidized the liquor industry. This treatment of alcohol as a mere luxury and source of general revenue is inconsistent with the Uniform Act's treatment of alcohol as a danger to public health.

In addition to a reluctance to control sales, some of the current statutes also reflect a punitive response to alcohol abuse which is inconsistent with the Uniform Act's emphasis on prevention and treatment. Both Workman's Compensation and private disability insurance can be denied one, if his or her injuries resulted from his or her intoxication. If these provisions are not necessary for the solvency of the fund or do not in fact deter abuse, consideration should be given to allowing compensation, at least if the compensation were used for treatment and vocational rehabilitation purposes. In the area of insurance, the State should also consider requiring alcoholism to be covered as a primary diagnosis in the health insurance and health care payment plan for carriers in the state. This would allow treatment of alcoholism as such before the effects of the disease required more extensive (and probably expensive) medical intervention.

The punitive approach to alcohol abuse also seems to have found its way into Alaska's changes in the Uniform Act itself. While the Act as a whole favors voluntary treatment, and provision is made for the early

release of one involuntarily committed on grounds of assault, no such provision is made for involuntary commitment on grounds of incapacity in Alaska's version of the Uniform Act. If there was a good reason for this change, it is not readily apparent. If it is a result of an oversight, the law should be changed. In addition, involuntary commitment proceedings allow an easy change to voluntary status during the proceedings, which typically results in voluntary entry to treatment and then voluntary exit almost immediately. Obviously, the intent and use of the involuntary commitment alternative has been effectively eliminated. Consideration should also be given to another modification of the Uniform Act. Currently a person is committed to the custody of the Office of Alcoholism, while the emphasis on local treatment would be better served if the local treatment center had custody.

Finally, it should be obvious that a cohesive alcohol policy will not be effective unless administrative efforts are coordinated. While cooperation among all state agencies is desirable, the three most important are the ABC Board in regulating sales, the Department of Health and Social Services and Office of Alcoholism in preventing and treating abuse, and the criminal justice system (including the Courts, Division of Corrections, and Parole Boards) in protecting the public and rehabilitating offenders who abuse alcohol. Requiring at least one member of the ABC Board to have a public health background in alcoholism would help coordinate sales, prevention and treatment policies. In addition, representation of the ABC Board on the Interdepartmental Coordinating Committee is essential. The possibilities for interaction between the Office of Alcoholism and the criminal justice system include cooperation in sentencing and parole procedures, although specific recommendations should come from the people who would be involved. Perhaps the greatest aid to interdepartmental

cooperation, however, will be the formulation at the legislative level of a clear and coherent alcohol policy.

In brief, the inconsistencies in current laws fall into three categories. First, the conflict between a punitive and a health-oriented alcohol policy still exists in insurance provisions, the Uniform Act's provisions for early release, and the lack of communication between the courts and treatment agencies. Second, the State has delegated some of its responsibility to municipalities, while at the same time making it more difficult for them to meet that responsibility; e.g., the license fee rebate system which discourages the local option, the prohibition on special local liquor taxes, and the failure to allow commitment to local treatment centers. Finally, and perhaps most importantly, controls on the sale of alcohol through the ABC Board and the excise tax are totally divorced from the prevention and the treatment of alcohol abuse. The Legislature must make some adjustments in these three areas if it is to fulfill its responsibility for developing a cohesive alcohol policy.

PART FOUR

IX. ALASKA STATUTE REFERENCES

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|-----------------------------|-------------------------|-------------------------|
| (1) A.S. 04.15.010. | (26) A.S. 04.10.280. | (51) A.S. 04.15.040. |
| (2) A.S. 04.15.020(c). | (27) A.S. 04.10.430. | (52) A.S. 04.10.110. |
| (3) A.S. 04.10.390. | (28) A.S. 04.15.020(g). | (53) A.S. 04.10.160. |
| (4) A.S. 04.15.020(e). | (29) A.S. 04.10.300. | (54) A.S. 04.10.110. |
| (5) A.S. 04.10.230. | (30) A.S. 04.10.310. | (55) A.S. 04.10.110. |
| (6) A.S. 04.10.410. | (31) A.S. 04.10.440. | (56) A.S. 04.10.130. |
| (7) A.S. 04.15.020(a). | (32) A.S. 04.15.070(b). | (57) A.S. 04.10.210. |
| (8) A.S. 04.15.020(d). | (33) A.S. 04.15.110. | (58) A.S. 04.10.250. |
| (9) A.S. 04.15.080(a). | (34) A.S. 04.10.010. | (59) A.S. 04.10.220. |
| (10) A.S. 04.15.060(a). | (35) A.S. 11.60.170. | (60) A.S. 04.10.240. |
| (11) A.S. 04.15.060(b). | (36) A.S. 04.10.110(a). | (61) A.S. 04.10.260. |
| (12) A.S. 04.15.065. | (37) A.S. 04.10.110(b). | (62) A.S. 04.10.310. |
| (13) A.S. 18.65.310. | (38) A.S. 04.10.040. | (63) A.S. 04.10.310. |
| (14) A.S.*23.10.355. | (39) A.S. 04.10.050. | (64) A.S.*04.10.350. |
| (15) A.S. 04.10.255. | (40) A.S. 04.10.060. | (65) A.S. 04.10.350. |
| (16) A.S. 04.10.210. | (41) A.S. 04.10.070. | (66) A.S. 04.10.310. |
| (17) A.S. 18.35.100. | (42) A.S. 04.10.130. | (67) A.S. 04.10.370. |
| (18) A.S. 18.35.110. | (43) A.S. 04.10.145. | (68) A.S. 04.10.410. |
| (19) A.S. 23.15.420. | (44) A.S. 04.10.146. | (69) A.S. 09.25.010. |
| (20) A.S. 04.15.035. | (45) A.S. 04.10.100. | (70) A.S. 04.15.010(b). |
| (21) A.S. 04.15.100(a). | (46) A.S. 04.10.140. | (71) A.S. 39.05.110. |
| (22) A.S. 04.15.100(b). | (47) A.S. 04.10.139. | (72) A.S. 04.05.010. |
| (23) A.S. 29.48.035(a)(10). | (48) A.S. 04.10.080. | (73) A.S. 04.05.010. |
| (24) A.S. 04.15.070(a). | (49) A.S. 04.10.090. | (74) A.S. 44.62.310. |
| (25) A.S. 04.10.270. | (50) A.S. 04.10.120. | (75) A.S. 04.05.010. |
| | | (76) A.S. 04.05.010. |

ALASKA STATUTE REFERENCES (continued)

- | | | |
|-----------------------------|--------------------------|------------------------------------|
| (77) A.S. 04.10.380. | (103) A.S. 28.35.030. | (128) A.S. 47.37.060. |
| (78) A.S. 04.05.020. | (104) A.S. 28.15.210(c). | (129) A.S. 47.37.070. |
| (79) A.S. 01.05.040. | (105) A.S. 12.25.033. | (130) A.S. 47.37.090. |
| (80) A.S. 04.05.070. | (106) A.S. 11.55.070. | (131) A.S. 47.37.110. |
| (81) A.S. 04.10.450. | (107) A.S. 05.25.060. | (132) A.S. 47.37.160. |
| (82) A.S. 04.10.460. | (108) A.S. 02.03.030(a). | (133) A.S. 47.37.170. |
| (83) A.S. 04.10.420. | (109) A.S. 02.30.030(b). | (134) A.S. 47.37.180. |
| (84) A.S. 43.60.010(a). | (110) A.S. 11.15.070. | (135) A.S. 47.37.190. |
| (85) A.S. 43.60.010(b). | (111) A.S. 25.05.111. | (136) A.S. 47.37.200. |
| (86) A.S. 43.60.020(a). | (112) A.S. 09.55.110(6). | (137) A.S. 47.37.210. |
| (87) A.S. 43.60.020(b). | (113) A.S. 23.30.235. | (138) A.S. 47.37.220. |
| (88) A.S. 43.60.030. | (114) A.S. 23.30.120(3). | (139) A.S. 47.37.230. |
| (89) A.S. 43.60.040. | (115) A.S. 23.30.080(3). | (140) A.S. 47.37.240. |
| (90) A.S. 43.60.040(c). | (116) A.S. 21.51.260. | (141) A.S. 47.37.250. |
| (91) A.S. 04.15.030. | (117) A.S. 06.25.140. | (142) A.S. 47.37.260. |
| (92) A.S. 04.15.020(f). | (118) A.S. 06.05.180(4). | (143) A.S. 47.37.270. |
| (93) A.S. 04.15.050. | (119) A.S. 08.64.336. | (144) A.S. 47.30.470. |
| (94) A.S. 04.15.035. | (120) A.S. 47.37.010. | (145) A.S. 47.30.475. |
| (95) A.S. 43.60.040(d). | (121) A.S. 47.37.020. | (146) A.S. 47.30.477. |
| (96) A.S. 43.60.040(e). | (122) A.S. 47.37.030. | (147) A.S. 47.30.480. |
| (97) A.S. 43.60.010(f). | (123) A.S. 47.37.040. | (148) A.S. 47.30.490. |
| (98) A.S. 11.70.030. | (124) A.S. 47.37.130. | (149) A.S. 47.30.500. |
| (99) A.S. 28.15.210.(a)(5). | (125) A.S. 47.37.140. | (150) A.S. 43.60.010. - 43.60.040. |
| (100) A.S. 28.35.031. | (126) A.S. 47.37.150. | (151) A.S. 18.67.010. - 18.67.175. |
| (101) A.S. 28.35.032. | (127) A.S. 47.37.050. | (152) A.S. 08.64.010. |
| (102) A.S. 28.35.033. | | |

ALASKA STATUTE REFERENCES

(Continued)

- (153) A.S. 08.64.020.
- (154) A.S. 28.35.030. - 28.35.034.
- (155) A.S. 23.15.010. - 23.15.210.
- (156) A.S. 47.30.340.
- (157) A.S. 17.12.150(3).
- (158) N/A
- (159) N/A
- (160) A.S. 11.45.032.
- (161) A.S. 47.37.010. - 47.37.270.
- (162) A.S. 44.29.030. - 44.29.090.
- (163) A.S. 11.45.030.
- (164) A.S. 11.60.210.
- (165) A.S. 04.20.010.

ALASKA ADMINISTRATIVE CODE REFERENCES

- | | |
|--------------------------------|----------------------|
| (168) 13 AAC 02.175(c). | (193) 15 AAC 20.230. |
| (169) 15 AAC 20.010. - 20.270. | (194) 15 AAC 20.240. |
| (170) 15 AAC 20.070. | (195) 15 AAC 20.250. |
| (171) 15 AAC 20.110. | (196) 15 AAC 20.100. |
| (172) 15 AAC 20.030. | (197) 7 AAC 30.010. |
| (173) 15 AAC 20.160. | (198) 7 AAC 30.020. |
| (174) 15 AAC 20.200. | (199) 7 AAC 30.030. |
| (175) 15 AAC 20.260. | (200) 7 AAC 30.040. |
| (176) 15 AAC 20.150. | (201) 7 AAC 30.050. |
| (177) 15 AAC 20.170. | (202) 7 AAC 30.060. |
| (178) 15 AAC 20.270. | (203) 7 AAC 30.070. |
| (179) 15 AAC 20.180. | (204) 7 AAC 30.080. |
| (180) 15 AAC 20.020. | (205) 7 AAC 28.010. |
| (181) 15 AAC 20.140. | (206) 7 AAC 28.020. |
| (182) 15 AAC 20.190. | (207) 7 AAC 28.030. |
| (183) 15 AAC 20.050. | (208) 7 AAC 28.040. |
| (184) 15 AAC 20.130. | (209) 7 AAC 28.050. |
| (185) 15 AAC 20.010. | (210) 7 AAC 28.060. |
| (186) 15 AAC 20.120. | (211) 7 AAC 28.070. |
| (187) 15 AAC 20.040. | (212) 15 AAC 20.080. |
| (188) 15 AAC 20.030. | (213) 15 AAC 20.090. |
| (189) 15 AAC 20.210. | (214) 15 AAC 20.100. |
| (190) 15 AAC 20.060. | |
| (191) 15 AAC 20.090. | |
| (192) 15 AAC 20.220. | |

FEDERAL LAW REFERENCES

- (215) P.L. 89-564, 80 STAT. 731, 736 (1966).
- (216) P.L. 90-222, 81 STAT. 672, 697 (1967).
- (217) P.L. 91-177, 83 STAT. 827, 829 (1969).
- (218) P.L. 90-574, 82 STAT. 1005, 1006 (1968).
- (219) P.L. 91-211, 84 STAT. 54, 57, (1970).
- (220) P.L. 91-616, 84 STAT. 1848 (1970).
- (221) P.O. 93-282, 88 STAT. 125 (1974).

OTHER REFERENCES

- (222) "The Economic Cost of Alcohol Abuse and Alcoholism", 1971.

X. APPENDICES

- A. CHRONOLOGY OF STATE AND FEDERAL TREATMENT LEGISLATION.
- B. LISTING OF ALASKA STATUTES RELATING TO ALCOHOL AND ALCOHOL ABUSE
- C. DIGEST AND SUMMARY OF FEDERAL LEGISLATION RELATING TO ALCOHOL ABUSE AND ALCOHOLISM
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APPENDIX A CHRONOLOGY OF STATE AND FEDERAL TREATMENT LEGISLATION

CHRONOLOGY OF STATE AND FEDERAL TREATMENT LEGISLATION

FEDERAL	DATE	STATE
Supreme Court Decisions Easter V. District of Columbia and Driver V. Minnert: Held that because alcoholism is an illness, a homeless alcoholic could not avoid being drunk in public and therefore could not be punished for his or her public intoxication.	1966	Advisory Board on Alcoholism created in Department of Health & Social Services (A.S. 44.29.030.-080.) Powers and duties of Department of Health & Social Services concerning alcoholics & alcoholism set forth in "Article 4. Alcoholics." (A.S. 47.30.470.) Superior Courts instructed to take judicial notice: "The Superior Courts of this State may take Judicial Notice of the fact that an alcoholic is suffering from an illness and is in need of proper medical, advisory or rehabilitative treatment." (A.S. 47.30.480, under "Article 4. Alcoholics".) Department of Health & Social Services authorized to accept grants and contributions on behalf of the State: "The Department may accept on behalf of the State and deposit, apart from other public funds, grants from the Federal Government or gifts or contributions from other sources to assist in carrying out the powers and duties of the Dept." (A.S. 47.30.490., under "Article 4. Alcoholics.") Alcoholism defined as "a condition related to alcohol and concerns a physical compulsion which exists, coupled with a mental obsession." Alcoholic defined as "a person who chronically and habitually uses alcoholic beverages to the extent that he or she loses the power of self-control with respect to the use of alcoholic beverages; or a person who chronically and habitually uses alcoholic beverages to the extent that he or she becomes a menace to the public morals, health, safety or welfare." (A.S. 47.30.500, under "Article 4. Alcoholics.")

CHRONOLOGY OF TREATMENT LEGISLATION

FEDERAL	DATE	STATE
	1967	Advisory Board membership increased from five to nine members. (A.S. 44.29.040.)
		Position of Alcoholism Program Coordinator added under Advisory Board Statute (A.S. 44.29.090.)
District of Columbia Alcoholism Rehabilitation Act (P.L. 90-452). First legislative consideration in which alcoholism viewed as an illness and public intoxication no longer handled as a criminal offense.	1968	
Alcoholic Rehabilitation Act of 1968 (P.L. 90-574). First Federal Law dealing specifically with the treatment of alcoholism on a national basis. Congress declared in that Act that "The handling of chronic alcoholics within the system of Criminal Justice perpetuates and aggravates the broad problem of alcoholism whereas treating it as a health problem permits early detection and prevention of alcoholism and effective treatment and rehabilitation, relieves police and other law enforcement agencies of an inappropriate burden that impedes their important work, and better serves the interests of the public."		

CHRONOLOGY OF TREATMENT LEGISLATION

FEDERAL	DATE	STATE
	1969	
Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (P.L. 91-616). Another name for this is The Hughes Act. * Established NIAAA in National Institute of Mental Health. * Authorizing increasing formula grants to States to assist them in planning and establishing programs for FY '71, '72 & '73. - Grants allotted to States on basis of population, financial need, and need for prevention, treatment and rehabilitation services. - In order to qualify for grant, State must submit State Plan within which is designated single State Agency. * Hospitals receiving Federal Funds for alcohol treatment programs must treat alcohol abusers and alcoholics. * Provide for establishment of treatment and rehabilitation programs for federal civilian employees.	1970	Grant-In-Aid Program added under "Article 4. Alcoholics." (A.S. 47.30.475.) Stipulation that Department of Health & Social Services submit an annual report concerning Alcoholism in Alaska and the Grant-In-Aid Program within 10 days after the convening of the Legislature added under "Article 4. Alcoholics." (A.S. 47.30.470.(7).)

CHRONOLOGY OF TREATMENT LEGISLATION

FEDERAL	DATE	STATE
	1971	
	1972	State adopted Uniform Alcoholism and Intoxication Treatment Act (A.S. 47.37.010.-270.) * Contains legal framework within which to approach alcoholism and public intoxication from a health standpoint. * Establishes policy that alcoholics and intoxicated persons not be criminally prosecuted for consumption of alcoholic beverages and that they be afforded a continuum of treatment so they may lead normal lives as productive members of society. (A.S.47.37.010.) * Creates Office of Alcoholism within the Department of Health & Social Services. (AS 47.37.020.) * Creates Interdepartmental Coordinating Committee. (A.S. 47.37.050) * Establishes Advisory Board on Alcoholism in Department of Health & Social Services (A.S. 47.37.060.) and repeals former Advisory Board Statute (A.S.64.29.040.) * Sets forth definitions, including definition for alcoholic and repeals former definition of alcoholic under "Article 4. "Alcoholics." Article 4. "Alcoholics." (A.S. 47.37.070.) New definition of alcoholic - "A person who habitually or uses alcoholic beverages to the extent that his or her health is substantially impaired or endangered, or his/her social or economic function is substantially disrupted. (A.S. 47.37.270.(a).) * Repeals Public Drunkenness Statute (A.S. 11.45.032.)
Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Amendments of 1972 (S. 1165) passed by Senate on June 21, 1973.	1973	

CHRONOLOGY OF TREATMENT LEGISLATION

FEDERAL	DATE	STATE
Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act Amendments of 1974 (P.L. 93-282) passed by Congress in May of 1974. * Extends through FY 1976 the State formula grant program originally authorized by the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (P.L. 91-616). FY 1973 Formula Grant Authorization of \$80 million had been extended for one additional year, through Fiscal 1974 by P.L. 92-564, approved October 25, 1972. P.L. 93-282 extends it for two more years, maintaining the annual authorization level at \$80 million. * Extends Contract and Project Grant Authority of P.L. 91-616 for additional three years, through Fiscal 1976. * Adds new special grant authority providing additional allotment of \$100,000 plus 10% of its formula allotment for each State which has adopted the Uniform Act, or legislation similar to it. * Prohibits public or private general hospitals receiving Federal funds from discriminating in their admissions or treatment policies against any person solely because of the persons alcohol abuse or alcoholism. * Takes NIA out of NIMH and puts it into Department of Health, Education and Welfare.	1974	

APPENDIX B LISTING OF ALASKA STATUTES RELATING TO ALCOHOL AND ALCOHOL ABUSE

- 02.30.030 Reckless operation (AERONAUTICS)
- 04.05.010 - 04.20.010 (ALCOHOLIC BEVERAGES)
- 05.25.060 Prohibited operation (AMUSMENT AND SPORTS)
- 06.05.180 Powers as trustee authorized (BANKS AND FINANCIAL INSTITUTIONS)
- 06.25.140 Estates of incompetents (BANKS AND FINANCIAL INSTITUTIONS)
- 08.64.336 Duty of physicians to report (BUSINESS AND PROFESSIONS)
- 08.64.380 Definitions (BUSINESS AND PROFESSIONS)
- 09.35.087 Exemption for liquor licenses (CODE OF CIVIL PROCEDURE)
- 09.55.110 Grounds for divorce (CODE OF CIVIL PROCEDURE)
- 11.15.070 Physician administering poison or doing act resulting in death while intoxicated (CRIMINAL LAW)
- 11.45.032 Public drunkenness (CRIMINAL LAW) [REPEALED]
- 11.55.070 Possession of firearm while under influence of intoxicating liquor or drug (CRIMINAL LAW)
- 11.60.170 Places where gambling or unlicensed liquor traffic conducted as nuisances (CRIMINAL LAW)
- 11.70.030 Intoxication as defense (CRIMINAL LAW)
- 12.25.033 Grounds for arrest by peace officer without warrant (CODE OF CRIMINAL PROCEDURE)
- 18.35.100 - 18.35.120 Toilet facilities required (HEALTH AND SAFETY)
- 18.65.310 Identification cards (HEALTH AND SAFETY)
- 18.67.010 (Chapter 67) Violent crimes compensation board (HEALTH AND SAFETY)
- 21.51.260 Intoxicants and narcotics (INSURANCE)

- 23.10.355 Persons under 19 (LABOR AND WORKMEN'S COMP.)
- 23.15.420 Limitations on conduct of employment agencies (LABOR AND WORKMEN'S COMP.)
- 23.30.080 Employer's failure to insure (LABOR AND WORKMEN'S COMP.)
- 23.30.235 Cases in which no compensation is payable (LABOR AND WORKMEN'S COMP.)
- 23.30.120 Presumptions (LABOR AND WORKMEN'S COMP.)
- 25.05.111 Issuance of license (MARITAL AND DOMESTIC RELATIONS)
- 28.15.210 & 28.15.260 Mandatory revocation of license (MOTOR VEHICLES)
- 28.35.030 - 28.35.034 Driving while under the influence of intoxicating liquor or drugs (MOTOR VEHICLES)
- 29.48.035 Regulatory powers (MUNICIPAL GOVERNMENT)
- 39.05.060 Appointment, qualifications, and terms of office of members of departmental boards, councils, or commissions. (PUBLIC OFFICERS AND EMPLOYEES)
- 43.60.010 - 43.60.040 (Chapter 60) Excise tax on intoxicating liquor (REVENUE AND TAXATION)
- 44.29.030 - 44.29.090 Advisory board on alcoholism (STATE GOVERNMENT) [REPEALED]
- 44.62.330 (Administrative Procedures Act) Application of chapter (STATE GOVERNMENT)
- 47.30.470 - 47.30.500 Article 4. Alcoholics (WELFARE, SOCIAL SERVICES AND INSTITUTIONS)
- 47.37.010 - 47.37.270 (Chapter 37) Uniform alcoholism and intoxication treatment act (WELFARE, SOCIAL SERVICES AND INSTITUTIONS)

APPENDIX C

DIGEST AND SUMMARY OF FEDERAL LEGISLATION RELATED TO ALCOHOL ABUSE AND ALCOHOLISM

In the formulation of overall national policy on alcohol abuse and alcoholism the U.S. Congress has intervened with many specific policies, some new and others representing renewals and adjustments of longstanding policies in related fields. The effective formulation of state and local aspects of alcoholism policy depends considerably upon its being tailored and designed to mesh with and balance out to the maximum feasible extent possible with the myriad aspects of related federal policy. This digest and summary of federal alcoholism related legislation is appended to the Outline and Analysis of Legislation to provide a perspective on that corpus of legislation. It is a modified and condensed abstraction from the publication, Federal Legislation Relating to Alcohol Abuse and Alcoholism prepared by Ellen L. Akst for the United States Conference of Mayors in December, 1975.

Providing the core framework for all federal-state-local alcoholism policy development, federal legislation which is directly addressed toward coping with alcohol abuse and alcoholism is of prime importance. Federal public health legislation which provides direct support and establishes parameters for many aspects of alcoholism policy development is a second category of federal legislation to be

reviewed. Federal community planning and development legislation, many provisions of which have been specifically structured to foster state and local initiatives in policy formulation, provides a third species of federal legislation to be reviewed. Federal criminal justice legislation and highway safety legislation which has been formulated and redesigned to comprehend the relationship between alcoholism problems and public safety is a fourth policy area to be reviewed. Federal legislation in the general areas of human development and supportive services is a fifth species to be reviewed because of the actual and potential support which federal programs in these areas contribute toward alcoholism program development.

I. ALCOHOLISM LEGISLATION

- A. Comprehensive Alcohol Abuse and Alcoholism Prevention treatment and Rehabilitation Act of 1970, as amended (P.L. 91-616; P.L. 93-282)

This act established the National Institute on Alcohol Abuse and Alcoholism, provides for formula grants, project grants and contracts for states, localities and private agencies to establish alcoholism programs, provides for the confidentiality of records and state compliance with the essential provisions of the model state Uniform Alcoholism and Intoxication Treatment Act, and established the National Council on Alcohol Abuse and Alcoholism.

- B. Alcohol and Drug Abuse Education Act of 1970, as amended (P.L. 91-527; P.L. 93-422)

This act provides grants to and contracts with post-secondary educational institutions and state and local public and private educational institutions and organizations to support, encourage and evaluate alcohol and drug abuse projects, to train educational and community personnel, and to provide technical assistance in program development.

II. PUBLIC HEALTH LEGISLATION

- A. Public Health Service Act of 1944, as amended (58 Stat. 691; P.L. 94-63)

1. Research Provision

Under this provision the Secretary of Health, Education and Welfare has broad authority to support research, education and training and the dissemination of information in all areas of public health. Research on the use and effect of alcohol is included under this provision.

2. Title V., Sec. 330, Community Health Centers

Newly enacted, Section 330 of the Public Health Service Act authorizes grants for the planning, development and cost of operation of community health centers which serve medically underserved populations. Support for facilities and program development for alcoholism programs is available under the provisions of this act.

B. Community Mental Health Centers Act of 1963, as amended

This act provides federal funding for commencing new and for continuing existing community mental health centers and initiating new services within existing centers. Alcoholism programs must be included among the services provided by institutions funded under this act unless there is no need for such services in a community mental health center's service area or unless the need is currently being met in some other manner.

C. Special Health Revenue Sharing Act of 1975
(P.L. 94-63)

This act requires that comprehensive public health services be provided in accordance with a state plan prepared under the provisions of the National Health Planning and Resources Development Act or a state plan for comprehensive state health planning under Sec. 314 of the Public Health Service Act. Both acts allow for alcoholism services to be included in state comprehensive health planning. Consequently alcoholism facilities and programs may be supported through the framework of the Special Health Revenue Sharing Act of 1975.

D. National Health Planning and Resources Development Act of 1974 (P.L. 93-641)

This act created comprehensive state and areawide health planning procedures to replace several existing public health planning and development programs. Its principal significance for alcoholism programs lies in its timely appearance as alcoholism programs are going through their early planning stages.

E. Health Maintenance Organization Act of 1973
(P.L. 93-222)

This act provides for special funding for health maintenance organizations. Oriented toward medically underserved health services consumer groups, the act establishes a pre-payment membership framework for these groups to approach their problems of obtaining needed services. The act provides that medical treatment for alcohol abuse and alcoholism must be provided among the health services offered before a health maintenance organization becomes eligible for federal certification.

III. COMMUNITY PLANNING AND DEVELOPMENT LEGISLATION

A. Housing and Community Development Act of 1974
(P.L. 93-383)

This act provides for block grants and other assistance to states and localities. The objective of the act is to enhance the livability of urban communities. Interim projects as well as long-range projects are supported. For alcoholism facilities and program development purposes the significance of this act lies in its availability to provide for community needs when or because other support and services are not available.

B. State and Local Fiscal Assistance Act of 1972
(P.L. 92-512)

This act provides for the return to states and communities of a portion of federal income tax receipts. Its significance for alcoholism program development and support lies in the flexible uses which states and localities may make of returned revenues and the continuing nature of the revenue sharing program.

IV. CRIMINAL JUSTICE AND HIGHWAY SAFETY LEGISLATION

A. Highway Safety Act of 1966, as amended
(P.L. 89-564; P.L. 90-150; P.L. 90-495; P.L. 91-605;
P.L. 93-87)

This act mandates that states and localities must develop and sustain highway safety programs in order to remain eligible for federal highway funds. It makes extensive funding available for highway safety research and education. These funds are supporting numerous highway safety programs which are concerned with alcohol-related traffic problems.

B. Juvenile Justice and Delinquency Prevention Act of 1974
(P.L. 93-415)

Under the provisions of this act responsibility for the coordination of federal juvenile delinquency programs was transferred to the Law Enforcement Assistance Administration. This agency was charged with the responsibility of inaugurating new programs for juvenile delinquency prevention. Among these are program formula grants to states and localities to support programs and activities related to juvenile delinquency, prevention, control, diversion, treatment, rehabilitation, planning, education, training and research including drug and alcohol abuse programs.

C. Omnibus Crime Control and Safe Streets Act of 1968, as amended (P.L. 90-351; P.L. 91-644; P.L. 93-83; P.L. 93-415)

This act established the Law Enforcement Assistance Administration to strengthen and improve criminal justice systems at every level of government. Comprehensive state and local criminal justice planning commenced with funding provided by this act. Its provisions have been tailored to facilitate the development of research and rehabilitation programs to combat alcohol related crime.

V. HUMAN DEVELOPMENT AND SUPPORTIVE SERVICES LEGISLATION

A. Comprehensive Employment and Training Act of 1973, as amended
(P.L. 93-203; P.L. 93-516)

This act decentralized the administration of federal manpower programs and decategorized their funding framework. Its purpose is to provide job training and transitional public service employment opportunities for economically disadvantaged, unemployed and underemployed persons by establishing a flexible, federal-state-local system for public manpower development programs. CETA funds may be used to provide identification and referral services to cope with that range of problems where alcohol abuse and alcoholism are identified as causing or aggravating unemployment. CETA funds may also be used to support employment rehabilitation programs among its program clientele whose unemployment can be attributed to alcohol abuse.

B. Rehabilitation Act of 1973, as amended
(P.L. 93-112; P.L. 93-516)

This act authorizes grants to assist states in meeting the needs of handicapped individuals so that they may prepare for and engage in gainful employment to the extent of their capabilities. It provides for formula grants to states to support a broad range of education and rehabilitation programs. Since the handicapped are also affected by problems of alcohol

abuse and alcoholism this act furnishes an alternative funding source to support alcoholism treatment and rehabilitation programs.

C. Food Stamp Act of 1964, as amended
(P.L. 88-525)

This act provides for the issuance of coupons which increase the purchasing power of consumer dollars available for the purchase of food. Generally supporting many categories of eligible persons, the food stamp program has proved to be beneficial to the many halfway houses and other private alcoholism treatment and rehabilitation centers where the clientele, or a significant portion of them, are eligible for this assistance.

D. Social Security Act of 1937, as amended
(Titles XVI, XVIII, XIX)

1. Title XVI., Supplementary Security Income for the
Aged, Blind and Disabled

Benefits under this title are available for supplemental security income to certain individuals who are eligible for retirement benefits under the Social Security Act or the Railroad Retirement Act. Designed as an incentive to encourage the aged, blind and disabled to seek health care when the cost of such care might otherwise be prohibitive, eligibility standards are rigorous to avoid duplicating benefits. These standards have been designed with a view toward providing support for alcoholism treatment for the aged, blind and disabled who need this care and are willing to comply with terms, conditions and regulations of such treatment.

2. Title XVIII., Health Insurance for the Aged, Blind
and Disabled (Medicare)

This title provides hospital insurance benefits and supplementary medical insurance benefits to persons who are eligible for retirement benefits under the Social Security Act or the Railroad Retirement Act. This title provides another method for supporting individuals undergoing alcoholism treatment and rehabilitation.

3. Title XIX., Grants to States for Medical Assistance
Programs (Medicaid)

Under this title the federal government funds state programs which furnish medical assistance on behalf of families with dependent children and aged, blind or disabled individuals, and rehabilitative and other services to help such families attain or retain capability for independence or self-care. Designed as an incentive to maintain the integrity of families, federal standards allow for the development of state health plans which will comprehend alcoholism treatment under this title.

APPENDIX D ALASKA UNIFORM ALCOHOLISM TREATMENT AND INTOXICATION ACT

Chapter 37. Uniform Alcoholism and Intoxication Treatment Act.

Section	Section
10. Declaration of policy	170. Treatment and services for intoxicated persons and persons incapacitated by alcohol
20. Office of alcoholism	180. Emergency commitment
30. Powers of office	190. Involuntary commitment of alcoholics
40. Duties of office	200. Hearing on petition for involuntary commitment of alcoholics
50. Interdepartmental coordinating committee	210. Records of alcoholics and intoxicated persons
60. Advisory board on alcoholism	220. Visitation and communication of patients
70. Composition	230. Establishment of emergency service patrol
80. Qualifications of board members	240. Payment for treatment
90. Term of office	250. Nonapplicability
100. Compensation, per diem, or expenses	260. Application of Administrative Procedure Act
110. Duties	270. Definitions
120. Alcoholism program coordinator	
130. Comprehensive program for treatment; regional facilities	
140. Public and private treatment facilities	
150. Acceptance for treatment	
160. Voluntary treatment of alcoholics	

Revisor's note (1972).—In ch. 207, SLA 1972, AS 47.37.070—47.37.270 were designated AS 47.37.062—47.37.210.

Sec. 47.37.010. Declaration of policy. It is the policy of the state that alcoholics, and intoxicated persons should not be criminally prosecuted for their consumption of alcoholic beverages and that they should be afforded a continuum of treatment so they may lead normal lives as productive members of society. (§ 1 ch 207 SLA 1972)

Sec. 47.37.020. Office of alcoholism. An office of alcoholism is established in the department. The office shall be headed by a coordinator appointed by the commissioner. The coordinator shall be a qualified professional who has training and experience in the organization and administration of treatment services for persons with medical-social problems. The coordinator is in the classified service. (§ 1 ch 207 SLA 1972)

Sec. 47.37.030. Powers of office. The office may

(1) plan, establish, and maintain treatment programs as appropriate;

(2) make contracts necessary or incidental to the performance of its duties and the execution of its powers, including contracts with public and private agencies, organizations, and individuals, to pay them for services rendered or furnished to alcoholics or intoxicated persons;

(3) solicit and accept for use a gift of money or property or a grant of money, services, or property from the federal government, the state, or a political subdivision of it or a private source, and do all things necessary to cooperate with the federal government or any of its agencies in making an application for a grant;

(4) administer or supervise the administration of the provisions relating to alcoholics and intoxicated persons of any state plan submitted for federal funding under federal health, welfare, or treatment legislation;

(5) coordinate its activities and cooperate with alcoholism programs in this and other states, and make contracts and other joint or cooperative arrangements with state, local, or private agencies for the treatment of alcoholics and intoxicated persons and for the common advancement of alcoholism programs in this and other states;

(6) keep records and engage in research and the gathering of relevant statistics;

(7) do other acts necessary to implement the authority expressly granted to it;

(8) acquire, hold, or dispose of real property or any interest in it, and construct, lease, or otherwise provide treatment facilities for alcoholics and intoxicated persons; however, the office shall encourage local initiative, involvement and financial participation under grants-in-aid whenever possible in preference to the construction or operation of facilities directly by the office. (§ 1 ch 207 SLA 1972)

Sec. 47.37.040. Duties of office. The office shall

(1) develop, encourage, and foster statewide, regional, and local plans and programs for the prevention of alcoholism and treatment of alcoholics and intoxicated persons in cooperation with public and private agencies, organizations, and individuals, and provide technical assistance and consultation services for these purposes;

(2) coordinate the efforts and enlist the assistance of all public and private agencies, organizations, and individuals interested in prevention of alcoholism and treatment of alcoholics and intoxicated persons;

(3) cooperate with the division of corrections in establishing and conducting programs to provide treatment for alcoholics and intoxicated persons in or on parole from penal institutions;

(4) cooperate with the Department of Education, school boards, schools, police departments, courts, and other public and private agencies, organizations and individuals in establishing programs for the prevention of alcoholism and treatment of alcoholics and intoxicated persons, and preparing curriculum materials for use at all levels of school education;

(5) prepare, publish, evaluate, and disseminate educational material dealing with the nature and effects of alcohol;

(6) develop and implement, as an integral part of treatment programs, an educational program for use in the treatment of alcoholics and intoxicated persons which includes the dissemination of information concerning the nature and effects of alcohol;

(7) organize and foster training programs for all persons engaged in treatment of alcoholics and intoxicated persons;

(8) sponsor and encourage research into the causes and nature of alcoholism and treatment of alcoholics and intoxicated persons, and serve as a clearinghouse for information relating to alcoholism;

(9) specify uniform methods for keeping statistical information by public and private agencies, organizations, and individuals, and collect and make available relevant statistical information, including number of persons treated, frequency of admission and readmission, and frequency and duration of treatment;

(10) advise the governor in the preparation of a comprehensive plan for treatment of alcoholics and intoxicated persons;

(11) review all state health, welfare, and treatment plans to be submitted for federal funding, and advise the commissioner on provisions to be included relating to alcoholism and intoxicated persons;

(12) assist in the development of, and cooperate with, alcohol education and treatment programs for employees of state and local governments and businesses and industries in the state;

(13) utilize the support and assistance of interested persons in the community, particularly recovered alcoholics, to encourage alcoholics to voluntarily undergo treatment;

(14) cooperate with the Department of Public Safety and the Department of Highway Safety in establishing and conducting programs designed to deal with the problem of persons operating motor vehicles while intoxicated;

(15) encourage, coordinate, and utilize appropriate state facilities to admit alcoholics, alcoholics and intoxicated persons and to provide them with adequate and appropriate treatment.

(16) encourage all health and disability insurance programs to include alcoholism as a covered illness;

(17) submit to the legislature an annual report covering the activities of the office. (§ 1 ch 207 SLA 1972)

Sec. 47.37.050. Interdepartmental coordinating committee. (a) An interdepartmental coordinating committee is created, composed of the coordinator and the commissioners of health and social services, education, highways, labor and public safety. The committee shall meet at least twice annually at the call of the commissioner of health and social services who is its chairman. The committee shall provide for the coordination and exchange of information on all programs relating to alcoholism, and act as a permanent liaison among state departments engaged in activities affecting alcoholics and intoxicated persons. The committee shall assist the commissioner of health and social services and the coordinator in formulating a comprehensive plan for prevention of alcoholism and for treatment of alcoholics and intoxicated persons.

(b) In exercising its coordinating functions, the committee shall assure that the appropriate state agencies

(1) provide all necessary medical, social, treatment, and educational services for alcoholics and intoxicated persons and for the prevention of alcoholism, without unnecessary duplication of services;

(2) cooperate in the use of facilities and in the treatment of alcoholics and intoxicated persons;

(3) adopt approaches for the prevention of alcoholism and the treatment of alcoholics and intoxicated persons consistent with the policy of this chapter. (§ 1 ch 207 SLA 1972)

Sec. 47.37.060. Advisory board on alcoholism. There is established in the Department of Health and Social Services an advisory board on alcoholism. (§ 1 ch 207 SLA 1972)

Editor's note.—Section 3, ch 207, SLA 1972, provides: "Because the provisions in this Act relating to the advisory board on alcoholism and the provisions in AS 41.20.010-41.20.020, which are repealed by sec 2 of this Act, appearing in this Act requires the appointment of a new board." §§ 41.20.010-41.20.020 are identical to the provisions in AS 41.20.010-41.20.020.

Sec. 47.37.070. Composition. The advisory board on alcoholism consists of nine members appointed by the governor. (§ 1 ch 207 SLA 1972)

Editor's note.—(1972). In ch 207, sec 1, ch 207, SLA 1972, AS 41.20.010-41.20.020.

Sec. 47.37.080. Qualifications of board members. (a) Two members of the board shall be persons who are members of the state board of psychiatry and psychology or shall be persons who are

tion, except that if a psychiatrist is not available, a clinical psychologist may be appointed.

(b) One member shall be a practicing attorney who has been admitted to the practice of law by the supreme court of the State of Alaska.

(c) One member shall be a person who has evidenced an interest in the problems of alcoholism and who has knowledge of the social problems encountered in the rehabilitation of alcoholics.

(d) One member shall be a public health nurse.

(e) One member shall be a representative of the liquor industry.

(f) One member shall be a member of Alcoholics Anonymous.

(g) One member shall be from the public at large.

(h) One member shall be a social worker. (§ 1 ch 207 SLA 1972)

Sec. 47.37.090. Term of office. (a) The members of the board initially appointed under § 80(a) of this chapter serve terms of four years.

(b) The member initially appointed under § 80(b) of this chapter serves a term of three years.

(c) The member initially appointed under § 80(c) of this chapter serves a term of two years.

(d) The members initially appointed under § 80(d)—(h) of this chapter serve terms of four years. Subsequent terms for all board members are four years.

(e) A vacancy occurring in the membership of the board shall be filled by appointment of the governor for the unexpired portion of the vacated term.

(f) Board members serve at the pleasure of the governor. (§ 1 ch 207 SLA 1972)

Sec. 47.37.100. Compensation, per diem, or expenses. Members of the advisory board on alcoholism are not entitled to a salary, but are entitled to per diem, reimbursement for travel and other expenses authorized by law for other boards. (§ 1 ch 207 SLA 1972)

Sec. 47.37.110. Duties. The board shall act in an advisory capacity to the commissioner in the following matters:

(1) special problems affecting mental health which alcoholism may present;

(2) educational and research activities conducted by the office in respect to the problems presented by alcoholism;

(3) social problems which affect rehabilitation of alcoholics;

(4) legal procedures which affect the treatment and rehabilitation of alcoholics;

(5) a program of public relations concerning the problem of alcoholism conducted by a duly authorized person, agent or

by an organized group whose purpose is the rehabilitation of alcoholics. (§ 1 ch 207 SLA 1972)

Sec. 47.37.120. Alcoholism program coordinator. The alcoholism program coordinator shall carry out the development and implementation of a comprehensive program dealing with the treatment of, research on and education concerning alcoholic problems as they affect the state. (§ 1 ch 207 SLA 1972)

Sec. 47.37.130. Comprehensive program for treatment; regional facilities. (a) The office shall establish a comprehensive and coordinated program for the treatment of alcoholics and intoxicated persons. Subject to the approval of the commissioner, the coordinator may divide the state into appropriate regions to conduct the program and establish standards for the development of the program on the regional level. In establishing the regions, consideration shall be given to the city and borough lines and population concentrations and when feasible, programs shall be established with maximum local community involvement.

(b) The program of the office shall include

(1) emergency treatment provided by a facility affiliated with or part of the medical service of a general hospital;

(2) inpatient treatment;

(3) intermediate treatment; and

(4) outpatient and follow-up treatment.

(c) The office shall provide adequate and appropriate treatment for alcoholics and intoxicated persons admitted under §§ 160—190 of this chapter within the limits of available state and federal funds.

(d) The office shall maintain, supervise and control all facilities operated by it subject to the regulations of the department. The administrator of each facility shall make an annual report of its activities to the coordinator in the form and manner the coordinator specifies.

(e) If possible, the office shall coordinate the activities of the program with all appropriate public and private resources.

(f) The coordinator shall prepare, publish, and distribute annually a list of all approved public and private treatment facilities.

(g) The office may contract for the use of any facility as an approved public treatment facility if the coordinator, subject to the regulation of the department, considers that an effective and economical course to follow. (§ 1 ch 207 SLA 1972)

Sec. 47.37.140. Public and private treatment facilities. (a) The office shall establish a list of public and private treatment facilities as public and private treatment facilities. The list shall be changed for the removal or addition of facilities. The state

dards shall concern only the health conditions to be met and standards of treatment to be afforded patients.

(b) The office shall inspect, on a regular basis, approved public and private treatment facilities at reasonable times and in a reasonable manner.

(c) The office shall maintain a list of approved public and private treatment facilities.

(d) Each approved public and private treatment facility shall file with the office on request, data, statistics, schedules, and information which the office reasonably requires. An approved public or private treatment facility that without good cause fails to furnish any data, statistics, schedules, or information as requested, or files fraudulent returns of them, shall be removed from the list of approved treatment facilities.

(e) The coordinator, after holding a hearing under the provisions of the Administrative Procedure Act (AS 44.62), may suspend, revoke, limit, restrict, or refuse to grant an approval for a treatment facility, for failure to meet its standards.

(f) Upon petition of the office and after a hearing held upon reasonable notice to the facility, the district court may issue a warrant to an officer or employee of the office authorizing him to enter and inspect at reasonable times, and examine the books and accounts of an approved public or private treatment facility refusing to consent to inspection or examination by the office or which the office has reasonable cause to believe is operating in violation of this chapter. (§ 1 ch 207 SLA 1972)

Sec. 47.37.150. Acceptance for treatment. The coordinator shall promulgate regulations for the admission of persons into the treatment program, considering available treatment resources and facilities, for the purpose of early and effective treatment of alcoholics and intoxicated persons. In establishing the regulations the coordinator shall be guided by the following standards:

(1) if possible a patient shall be treated on a voluntary rather than an involuntary basis;

(2) a patient shall be initially assigned or transferred to outpatient or intermediate treatment, unless he is found to require inpatient treatment;

(3) a person shall not be denied treatment solely because he has withdrawn from treatment, sought medical advice on a prior occasion or because he has received treatment elsewhere;

(4) an individualized treatment plan shall be prepared and maintained for each patient;

(5) provision shall be made for a continuum of coordinated treatment services, so that a person may leave a facility or a form

of treatment will utilize other appropriate treatment and facilities. (§ 1 ch 207 SLA 1972)

Sec. 47.37.160. Voluntary treatment of alcoholics. (a) An alcoholic may voluntarily apply for treatment directly to an approved public treatment facility.

(b) Subject to regulations promulgated by the coordinator, the administrator in charge of an approved public treatment facility may determine who shall be admitted for treatment. If a person is refused admission to an approved public treatment facility the administrator shall, if possible, refer the person to another approved public treatment facility.

(c) When a patient receiving inpatient care leaves an approved public treatment facility, he shall be encouraged to consent to appropriate outpatient or intermediate treatment. If it appears to the administrator in charge of the treatment facility that the patient is an alcoholic who requires help, the office shall arrange for assistance in obtaining supportive services and residential facilities. (§ 1 ch 207 SLA 1972)

Sec. 47.37.170. Treatment and services for intoxicated persons and persons incapacitated by alcohol. (a) An intoxicated person may come voluntarily to an approved public treatment facility for emergency treatment. A person who appears to be intoxicated in a public place and to be in need of help, if he consents, may be assisted by a peace officer or the emergency service patrol to his home, an approved public treatment facility, an approved private treatment facility, or another appropriate health facility.

(b) A person who appears to be incapacitated by alcohol shall be taken into protective custody by a peace officer or a member of the emergency service patrol and immediately brought to an approved public treatment facility for emergency treatment. If no approved public treatment facility is readily available he shall be taken to an emergency medical service customarily used for incapacitated persons. The peace officer or a member of the emergency service patrol, in detaining the person and in taking him to an approved public treatment facility, is taking him into protective custody and he shall make every reasonable effort to protect his health and safety. In taking the person into protective custody, the detaining officer may take reasonable steps to protect himself. Protective custody does not constitute an arrest under this section and a entry or other record shall be made to indicate that the person has been arrested or charged with a crime.

(c) A person who voluntarily appears to be brought to an approved public treatment facility shall be examined by a licensed physician as soon as possible. After the examination, he may be

admitted as a patient or referred to another health facility. The approved public treatment facility which refers him shall arrange for his transportation.

(d) No person who, after medical examination, is found to be incapacitated by alcohol at the time of his admission or to have become incapacitated at any time after his admission, may be detained at a facility after he is no longer incapacitated by alcohol. No person may be detained at a facility if he remains incapacitated by alcohol for more than 48 hours after admission as a patient, unless he is committed under § 180 of this chapter. A person may consent to remain in the facility as long as the physician in charge considers it appropriate.

(e) A person who is not admitted to an approved public treatment facility, is not referred to another health facility, and has no funds, may be taken to his home, if any. If he has no home, the approved public treatment facility shall assist him in obtaining shelter.

(f) If a patient is admitted to an approved public treatment facility, his family or next of kin shall be promptly notified. If an adult patient who is not incapacitated requests that there be no notification of next of kin, his request shall be granted.

(g) Peace officers or members of the emergency service patrol who comply with this section are acting in the course of their official duty and are not criminally or civilly liable for it.

(h) If the physician in charge of the approved public treatment facility determines it is for the patient's benefit, an attempt shall be made to encourage the patient to submit to further diagnosis and appropriate voluntary treatment. (§ 1 ch. 207 SLA 1972)

Sec. 47.37.199. Emergency commitment. (a) An intoxicated person who (1) has threatened, attempted to inflict, or inflicted physical harm on another or is likely to inflict physical harm on another unless committed, or (2) is incapacitated by alcohol, may be committed to an approved public treatment facility for emergency treatment. A refusal to undergo treatment does not constitute evidence of intent justifying commitment to the facility for treatment.

(b) The certifying physician, spouse, guardian, or relative of the person to be committed, or any other responsible person, may make a written application for commitment under this section, directed to the administrator of the approved public treatment facility. The application shall state the facts of the case and the reasons for the commitment. It shall also state that the person is an alcoholic who habitually lacks self-control in using alcoholic beverages and that he (1) has threatened, attempted to inflict, or inflicted physical harm on another or is likely to inflict physical harm on another or (2) is incapacitated by alcohol. The application shall also state that the person is an alcoholic who habitually lacks self-control in using alcoholic beverages and that he (1) has threatened, attempted to inflict, or inflicted physical harm on another or is likely to inflict physical harm on another or (2) is incapacitated by alcohol. The application shall also state that the person is an alcoholic who habitually lacks self-control in using alcoholic beverages and that he (1) has threatened, attempted to inflict, or inflicted physical harm on another or is likely to inflict physical harm on another or (2) is incapacitated by alcohol.

(c) Upon approval of the application by the administrator in charge of the facility, the person may be brought to the facility by a peace officer, a health officer, a member of the emergency service patrol, the applicant for commitment, the patient's spouse, the patient's guardian, or any other interested person. The person shall be retained at the facility to which he was admitted, or transferred to another appropriate public or private treatment facility, until discharged under (e) of this section. However, no person may be detained under this section for more than 48 hours unless a district or superior court judge has reviewed and approved the commitment application.

(d) The administrator in charge of an approved public treatment facility may refuse an application if in his opinion the application and certificate fail to sustain the grounds for commitment.

(e) When on the advice of his medical staff the administrator determines that the grounds for commitment no longer exist, he shall discharge a person committed under this section. No person committed under this section may be detained in a treatment facility for more than five days. If a petition for involuntary commitment under § 190 of this chapter has been filed within the five days and the administrator in charge of an approved public treatment facility finds that grounds for emergency commitment still exist, he may detain the person until the petition has been heard and determined, but no longer than 10 days after filing the petition.

(f) A copy of the written application for commitment and of the physician's certificate, and a written explanation of the person's right to legal counsel, shall be given to the person within 24 hours after commitment by the administrator, who shall provide a reasonable opportunity for the person to consult with legal counsel. (§ 1 ch. 207 SLA 1972)

Sec. 47.37.199. Involuntary commitment of alcoholics. (a) After a hearing initiated by petition of his spouse or guardian, a relative, the certifying physician, or the administrator in charge of an approved public treatment facility, a person may be committed to the custody of the officer by the superior court. The petition shall allege that the person is an alcoholic who habitually lacks self-control in using alcoholic beverages and that he (1) has threatened, attempted to inflict, or inflicted physical harm on another or is likely to inflict physical harm on another or (2) is incapacitated by alcohol. The petition shall also state that the person is an alcoholic who habitually lacks self-control in using alcoholic beverages and that he (1) has threatened, attempted to inflict, or inflicted physical harm on another or is likely to inflict physical harm on another or (2) is incapacitated by alcohol. The petition shall also state that the person is an alcoholic who habitually lacks self-control in using alcoholic beverages and that he (1) has threatened, attempted to inflict, or inflicted physical harm on another or is likely to inflict physical harm on another or (2) is incapacitated by alcohol.

mitment is sought has refused to submit to a medical examination, in which case the fact of refusal shall be alleged in the petition. The certificate shall set out the physician's findings in support of the allegations of the petition.

(b) After the petition is filed, the court shall fix a date for a hearing no later than 10 days after the date the petition was filed. A copy of the petition and of the notice of the hearing, including the date fixed by the court, shall be served on (1) the petitioner; (2) the person whose commitment is sought; (3) the next of kin of the person whose commitment is sought; (4) the administrator in charge of the approved public treatment facility in which the committed person has been committed for emergency care, and any other person the court considers appropriate. A copy of the petition and certificate shall be delivered to each person notified.

(c) If, not less than two days before the date fixed for the hearing, the person sought to be committed or his counsel or advisor files a written request with the superior court, the court shall summon and impanel a jury of six adult residents of the judicial district in which the court officiates, preferably from the court's jury list or the last voters list, if available, to hear and consider evidence concerning the condition of the person sought to be committed. (§ 1 ch 267 SLA 1972)

Sec. 47.37.200. Hearing on petition for involuntary commitment of alcoholics. (a) At the hearing required under § 190(b) of this chapter, the court or the jury, if requested under § 190(c) of this chapter, shall hear all relevant testimony, including, if possible, the testimony of at least one licensed physician who has examined the person whose commitment is sought. The person whose commitment is sought shall be present unless the court believes that his presence is likely to be injurious to him, in which case the court shall appoint a guardian of his person to appear and act throughout the proceeding. The court may examine the person in open court, or if advisable, examine him out of court. If the person has refused to be examined by a licensed physician, he shall be given an opportunity to request examination by a court-appointed licensed physician. If he fails to request a medical examination and there is sufficient evidence to believe that the allegations of the petition are true, or if the court believes that more medical evidence is necessary, the court may order the person to be committed to the custody of the court for a period of not more than five days for purposes of a diagnostic examination.

(b) It shall be the duty of the court or the jury, including the results of any diagnostic examination by the office, the court or the jury find that grounds for involuntary commitment have been clearly

established, the court shall issue an order of commitment to the office. No court may order the commitment of a person unless it determines that the office is able to provide adequate and appropriate treatment for him.

(c) A person committed under §§ 190—200 of this chapter shall remain in the custody of the office for treatment for a period of up to 30 days. At the end of the 30-day period, he shall be discharged automatically unless the office, before the expiration of the period, obtains a court order for his recommitment upon the grounds set out in § 190(a) of this chapter for a further period of up to 90 days. If a person has been committed because he is an alcoholic likely to inflict physical harm on another, the office shall apply for recommitment if after examination it is determined that the likelihood still exists.

(d) A person recommitted under (c) of this section who has not been discharged by the office before the end of the 90-day period shall be discharged at the expiration of that period unless the office, before expiration of the period, obtains a court order on the grounds set out in § 190(a) of this chapter for recommitment for a further period not to exceed 90 days. If a person has been committed because he is an alcoholic likely to inflict physical harm on another, the office shall apply for recommitment if after examination it is determined that the likelihood still exists. No more than two recommitment orders may be permitted under (c) and (d) of this section.

(e) Upon the filing of a petition for recommitment under (c) or (d) of this section, the court shall fix a date for hearing no later than 10 days after the date the petition was filed. A copy of the petition and of the notice of hearing, including the date fixed by the court, shall be served on (1) the petitioner; (2) the person whose commitment is sought; (3) the next of kin of the person whose commitment is sought; (4) the original petitioner under § 190(a) of this chapter, if different from the petitioner for recommitment; (5) any other person the court considers appropriate. Section 190(c) of this chapter applies to hearings for recommitment under this section. At the hearing the court or the jury shall proceed as provided in (a) of this section.

(f) The office shall provide adequate and appropriate treatment for a person in its custody. The office may transfer a person from custody from one approved public treatment facility to another if the transfer is medically indicated.

(g) A person committed to the custody of the office for treatment shall be discharged at any time before the end of the period for which he has been committed if either of the following conditions is met:

(1) when an alcoholic committed on the grounds of likelihood of infliction of physical harm on another is no longer considered an alcoholic or the likelihood of his infliction of physical harm no longer exists; or

(2) when, in the case of an alcoholic committed on the grounds of the likelihood of infliction of physical harm on another, either

(A) further treatment will not be likely to bring about significant improvement in the person's condition, or

(B) treatment is no longer adequate or appropriate.

(h) The court shall inform the person whose commitment or recommitment is sought of his right to contest the application, be represented by counsel at every stage of the proceedings relating to his commitment and recommitment, to have counsel appointed by the court or provided by the court, if he is unable to obtain counsel, and to a jury trial, if requested, as specified in § 190(c) of this chapter. If the court believes that the person needs the assistance of counsel, the court shall require, by appointment if necessary, counsel for him regardless of his objection. The person whose commitment or recommitment is sought shall be informed of his right to be examined by a licensed physician of his choice. If the person is unable to obtain a licensed physician and requests examination by a physician, the court shall employ a licensed physician for the examination.

(i) If a private treatment facility agrees with the request of a competent patient or his parent, sibling, adult child, or guardian to accept the patient for treatment, the administrator of the public treatment facility shall transfer him to the private treatment facility.

(j) A person committed under this chapter may at any time seek discharge from commitment by writ of habeas corpus under AS 12.75. (§ 1 ch 207 SLA 1972)

Sec. 47.37.210. Records of alcoholics and intoxicated persons

(a) The registration and other records of treatment facilities shall remain confidential and are available to the patient.

(b) Notwithstanding (a) of this section, the coordinator may make available information from patient records for purposes of research into the causes and treatment of alcoholism. No information regarding names of patients may be disclosed. (§ 1 ch 207 SLA 1972)

Sec. 47.37.220. Visitation and communication of patient's (a) The coordinator shall establish rules governing visitation and communication of patients with family and friends. The rules shall be consistent with the treatment program and shall not be more restrictive than those of a hospital.

including the use of telephone facilities, consistent with an effective treatment program.

(b) No mail or other communication to or from a patient in any approved treatment facility may be intercepted, read, or censored. (§ 1 ch 207 SLA 1972)

Sec. 47.37.230. Establishment of emergency service patrol. (a) The office and cities and boroughs may establish emergency service patrols. An emergency service patrol consists of persons trained to give assistance in public places to persons who are intoxicated. Members of an emergency service patrol shall be capable of providing first aid in emergency situations and shall be capable of transporting intoxicated persons to their homes and to and from public treatment facilities.

(b) The coordinator shall promulgate regulations for the establishment, training, and conduct of emergency service patrols. (§ 1 ch 207 SLA 1972)

Sec. 47.37.240. Payment for treatment. (a) A patient in an approved treatment facility, or the person obligated to provide for the cost of treatment of a person committed under this chapter, is liable to the office for the cost of maintenance and treatment of the patient in accordance with rates established by the coordinator.

(b) The coordinator shall promulgate regulations governing financial ability that take into consideration the income, savings and other personal and real property of the person liable for the cost and maintenance of the patient. (§ 1 ch 207 SLA 1972)

Sec. 47.37.250. Nonapplicability. (a) Nothing in this chapter affects a statute, ordinance, or regulation relating to (1) drunken driving, driving under the influence of alcohol, or other similar offenses involving alcohol and the operation of a vehicle, aircraft, boat, machinery, or other equipment, or (2) the sale, purchase, dispensation, possession, or use of alcoholic beverages at specified times and places or by a particular class of persons.

(b) Nothing in this chapter affects AS 11.70.030, relating to the defense of voluntary intoxication. (§ 1 ch 207 SLA 1972)

Sec. 47.37.260. Application of Administrative Procedure Act. Except as otherwise provided in this chapter, the Administrative Procedure Act (AS 17.05) applies to and governs all administrative action taken by the coordinator under this chapter. (§ 1 ch 207 SLA 1972)

Sec. 47.37.270. Definitions. In this chapter:

(a) "Person" means a person who has not yet been convicted of

§ 47.40.030 WELFARE, SOCIAL SERVICES & INSTITUTIONS § 47.40.030

in using alcoholic beverages, or uses alcoholic beverages to the extent that his health is substantially impaired or endangered, or his social or economic function is substantially disrupted;

(2) "approved private treatment facility" means a private agency meeting the standards prescribed in § 140(a) of this chapter and approved under § 140(c) of this chapter;

(3) "approved public treatment facility" means a treatment agency operating under the direction and control of the office or providing treatment under this chapter through a contract with the office under § 139(g) of this chapter and meeting the standards prescribed in § 140(a) of this chapter and approved under § 140(c) of this chapter;

(4) "commissioner" means the commissioner of health and social services;

(5) "coordinator" means the coordinator of the office of alcoholism;

(6) "department" means the Department of Health and Social Services;

(7) "emergency service patrol" means a patrol established under § 230 of this chapter;

(8) "incapacitated by alcohol" means a person who is unconscious or has his judgment otherwise so impaired that he is incapable of realizing and making a rational decision with respect to his need for treatment, as evidenced objectively by extreme physical debilitation, physical harm or threats of harm to others or chronic inability to hold regular employment;

(9) "incompetent person" means a person who has been adjudged incompetent by the appropriate court;

(10) "intoxicated person" means a person whose mental or physical functioning is substantially impaired as a result of the use of alcohol;

(11) "office" means the office of alcoholism within the Department of Health and Social Services;

(12) "treatment" means the broad range of emergency, outpatient, intermediate, and inpatient services and care which may be extended to alcohol and drug dependent persons, including diagnosis, evaluation, medical, psychological, psychiatric, and social service care, vocational rehabilitation and other services. (S 1-230.1 (3) & (4))

WORKING PAPERS:
DESCRIPTIVE ANALYSIS OF THE IMPACT OF ALCOHOLISM AND
ALCOHOL ABUSE IN ALASKA, 1975

VOLUME IV

SOCIAL SYSTEMS INDICATORS OF ALCOHOLISM AND ALCOHOL
ABUSE IN ALASKA, 1975

Final Report

November, 1977

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- Volume I The Economic Impact of Alcoholism and Alcohol Abuse
 in Alaska, 1975
- Volume II An Analysis of State Legislation Pertaining to Regu-
 lation and Control of Beverage Alcohol and Alcoholism
 and Alcohol Abuse, Alaska, 1975
- Volume III Alcoholism and Alcohol Abuse Programs, Services
 Delivery Systems, Alaska, 1975
- Volume IV Social Systems Indicators of Alcoholism and Alcohol
 Abuse in Alaska, 1975
- Volume V Executive Summary: Descriptive Analysis of the Impact
 of Alcoholism and Alcohol Abuse in Alaska, 1975

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FOREWORD

There is no topic in Alaska more familiar, more controversial, and simultaneously more opaque than alcoholism. Almost as if the problems and concerns associated with it were an intrinsic part of the Alaskan experience, everyone seems to have something to say about it. Newspaper articles and radio talk shows debate public drunkenness. Political campaigns are waged, promising greater priorities for the alcohol problem. Even the national wire services carry stories dubbing alcoholism "the bane of Alaska." From the person on the street, to merchants and city councils, to the most specialized of government and health officials--everyone seems to agree that alcoholism and alcohol abuse constitute the greatest human problem facing the state.

In short, there is no shortage of opinion in Alaska about alcoholism and alcohol abuse. In point of fact, however, there is precious little else except opinion. Theories abound as to the causes of problem drinking. Definitions of the very nature of the "problem" are as numerous as the dozens of State agencies, officials, organizations, and interest groups created (or simply compelled) to deal with it. Concerning what to do about it, feelings range all the way from simple apathy, to lip-service, to honest concern, to almost ideological fervor operating at the limits of reason. This is not to say that the public concern is in error: it is not. It is instead to say that, without foundation, not much can be done to seriously respond to that concern.

For so volatile and perduring a problem, there has been in Alaska virtually no significant statewide research to date. What research has

been conducted, has been fragmentary and poorly disseminated. Most often, as well, it has largely been based on concepts and models transplanted from other, inapplicable regions of the country. In all cases, such research has confined itself to a single problem or single aspect of a problem. Never, in other words, has an attempt been made to comprehensively conceptualize the problem in terms of all its major manifestations and attendant effects. By no means is this a denigration of any prior research efforts anywhere, for such was not their ambition. The time has simply come for a particular kind of undertaking: an integrated information and data base capable of addressing Alaska's alcoholism and alcohol abuse problems in all their important interrelationships.

The Analysis of Alcohol Problems Research Project, organized in September of 1975, began just such an undertaking. In response to the question of what (in its entirety) constitutes the problem of alcoholism and alcohol abuse in Alaska, the Project assumed as its province the full context of the intended and unintended consequences of the sale, distribution, and consumption of beverage alcohol in the state. Formally stated, the mission of the Project became the systematic collection of valid and reliable information for implementation of Alaska's Uniform Alcoholism and Intoxication Treatment Act. (The adoption of this act in 1972 essentially established policy for the State by decriminalizing public drunkenness and defining alcoholism as a public health problem.)

Throughout the Project, the nature of the research process was considerably less difficult to specify than the nature of the topic. With the health and medical services community exhibiting as much variance within its own ranks as between itself and the law enforcement or educational communities, little agreement existed as to how "alcoholism" and "alcohol abuse" should be defined. Considerable agreement existed, however, on the

fact that alcoholism and alcohol abuse impact the general public and the social system in a variety of ways. Alcoholism program client loads, child abuse, automobile accidents, alcohol-related crime, etc.--all became, from this perspective, equally valid and interconnected ways of looking at alcohol's impact on Alaskan society. In the same sense, they also thereby provided a composite basis for relating the many extant definitions of the problem (e.g., as a public health problem, mental health problem, criminal justice problem, child welfare problem, etc.).

For this reason, the Project took as its focus the measurable indicators of alcohol's impact on Alaska's social system, and on selected specific sub-systems: the economy, health and medical services delivery system, criminal justice system, et al.. The intention was not to be exhaustive, for such was impossible given the limitations of resources and time available for conduct of the study. Nor was the intention to be definitive, as the general paucity of useful information which plagues research efforts in Alaska made such a goal unrealistic. (In many cases, even basic information is not systematically reported or collected, nor kept in summary fashion.) Rather, the ambition was to develop a research methodology capable of being implemented at once, but also capable of being elaborated and refined on a continuing basis. Such an instrumentality, it was hoped, would serve the dual purpose of linking for the first time the several major areas (e.g., economic, legislative, programmatic, social, et al.) related to alcohol affairs in Alaska, and of constellating and grounding future alcohol-related research efforts in the state.

It should be said that such concentration on the collective effects of alcoholism and alcohol abuse was not intended to preclude genuine concern for the health and well being of individual alcohol abusers and their families. From the perspective taken, and because of the limitations

mentioned, it was not possible to address such highly relevant questions as whether alcoholism is a disease, addiction, defensive coping mechanism, etc.; or whether it derives from genetic transmission, learned behavior, cultural assimilation, or--in Alaska's case--a set of environmental factors so pervasive but elusive of description that it might quite unjokingly be called the "Arctic Factor". These remain, nonetheless, serious questions, and their omission had only to do with the fact that a need for the multiple-definition approach described above was considered more pressing.

The beginnings of this kind of multiple-definition approach are contained in the present report, Descriptive Analysis of the Impact of Alcoholism and Alcohol Abuse in Alaska, 1975. The title is preceded by the term "Working Papers" because this is the first time that alcohol-related information of this scope has been collected and put to use, and because a great deal more information is still missing. For these reasons, reaction to the content of the report is not only seriously invited, but regarded as indispensable. Only by such review and response, it is felt, will the efforts initiated by this project and report yield more complete and comprehensive information about the impact of alcoholism and alcohol abuse upon Alaskan society.

The five volumes of the report are described below:

VOLUME I : The Economic Impact of Alcoholism and Alcohol Abuse in Alaska, 1975

Volume I investigates and describes the economic impact on Alaska of alcoholism and alcohol abuse. Major goals of the volume include the identification and estimation of financial benefits deriving from the sale and consumption of beverage alcohol, and determination of the economic cost of alcoholism and alcohol abuse for the state as a whole. Findings and methodologies for each of the cost categories utilized are presented. Further, the absolute and relative magnitude of economic costs for each category are analyzed, then compared with corresponding estimates based on national findings. Finally, a separate part of the volume examines the fiscal revenues and expenditures for State government which are directly attributable to the sale and consumption of beverage alcohol.

VOLUME II : An Analysis of State Legislation Pertaining to Regulation and Control of Beverage Alcohol and Alcoholism and Alcohol Abuse, Alaska, 1975

Volume II identifies and analyzes all Alaskan legislative statutes and administrative codes which are in any way concerned with the sale and consumption of beverage alcohol, or with alcoholism or alcohol abuse problems. Analysis includes internal examination of all the statutes and codes, resulting in presentation of detailed summaries of each of the major provisions within a categorical structure developed in the process. (No such categorical listing or cross-reference system for alcohol-related legislation existed, previously.) Additionally, all identified statutes and codes are discussed and analyzed with respect to their consistency or inconsistency with policies and provisions set forth in the Uniform Alcoholism and Intoxication Treatment Act, the only available source of legislative policy for alcoholism and alcohol abuse. Throughout, analysis of the statutes and codes is cast within the context of existing, relevant federal legislation.

VOLUME III : Alcoholism and Alcohol Abuse Programs, Services Delivery System, Alaska, 1975

Volume III presents the findings of an analysis of the major elements of the alcohol services delivery system in Alaska. Based on a modified systems approach, the analysis employs nationally established alcohol program components promulgated by the Joint Committee on Accreditation of Hospitals for development of the concept of an appropriate statewide alcohol services delivery system. Statewide organizations providing direct and indirect alcoholism services are described with respect to their various administrative and programmatic dimensions. Local alcohol programs are similarly described and compared with respect to their various treatment or program components. Additionally, all organizations and programs are analyzed with regard to their participation in an emergent, comprehensive services delivery system at both the statewide and regional levels. Throughout, the focus of analysis is the nature of the overall delivery system itself (components, allocations, comprehensiveness, etc.), and not comparison or evaluation of individual programs.

VOLUME IV : Social Systems Indicators of Alcoholism and Alcohol Abuse in Alaska, 1975

Volume IV assembles and discusses a range of current data and information regarding the social impact on Alaska of alcoholism and alcohol abuse. The data compiled are regarded as conventional social system indicators, and discussed accordingly. Each part of the volume concentrates on a specific set of such indicators, with primary attention given to the prevalence of alcoholism in Alaska, the consumption of beverage alcohol, related mortalities, crime, and highway safety. A number of other, related indicators are also reviewed. Wherever possible, information is analyzed historically and compared with corresponding national (and, where applicable, international) information and research findings.

Volume V : Executive Summary: Descriptive Analysis of the Impact of Alcoholism and Alcohol Abuse in Alaska, 1975

As an executive summary, Volume V synoptically treats the findings contained in the four primary volumes preceding it. Additionally, it integrates various portions of these findings to provide alternative descriptions of the impact on Alaska of alcoholism and alcohol abuse. The descriptions are not viewed as competitive, but as demonstrative of the various perspectives and approaches possible for description and analysis of the associated problems. Finally, overall policy-level recommendations extrapolated from the study's findings are suggested for more effective implementation of Alaska's Uniform Alcoholism and Intoxication Treatment Act.

VOLUME IV

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PART I. INTRODUCTION AND OVERVIEW: SOCIAL SYSTEMS INDICATORS OF
ALCOHOLISM AND ALCOHOL ABUSE IN ALASKA, 1975

A. INTRODUCTION

Alcoholism and alcohol abuse are terms that appear elusive to define and terms that produce a good deal of confusion in both social and business discourse. These terms have come to function as general catch-all categories for the adverse personal and social events that are typically linked with excessive alcohol consumption.

In view of the many alternative ways for describing alcoholism and alcohol abuse, the differing opinions about the topic, and the available research and information regarding descriptions and analysis of alcohol problems, there is a need to specify the problems that are alcohol-related rather than continue to use such broad, ambiguous terms as "alcoholism" and "alcohol abuse". For certain levels of discourse, such terms are wholly appropriate, but for the purposes of social problem solving, a more refined specification of problems is required.

B. STATEMENT OF PROBLEM

For these reasons, the intent of this Volume is to focus attention on the known, measurable indicators of the adverse impact of alcohol on Alaska's social system in general, and on selected subsystems--health and social services, criminal justice system, traffic safety system, the economy,* and the alcohol consumers. The identification of the

*Economic analysis provided in Volume I, The Economic Impact of Alcoholism and Alcohol Abuse in Alaska, 1975.

character and the magnitude of the different configurations of alcohol problems for the Alaskan population also serves to provide a context for the conventionally known alcohol-related events--deaths, accidents, arrests, etc. Within the identified contexts, these events can comprise a system of social indicators that describe and measure the events generated by people with problematic behavior.

Such social system indicators can thus provide a profile of alcohol-related problems for the population as a whole or for various subpopulation groups. This would allow for any changes in the nature or extent of problems to be monitored over time; or, it could also be used to compare similar changes in subpopulation groups. In addition, specific programs designed and implemented to reduce or prevent a designated problem--a set of social indicators, may also be evaluated over a period of time, for a whole population or for various subpopulation groups. Thus the appropriateness or effectiveness of institutional responses to social problems could also become a matter of serious consideration within this framework.

It is important that knowledge of these indicators not be ignored in the consideration of various government policies for the general welfare of the population. These indicators may be viewed separately, for the purposes stated above, but in combination, they represent an interrelated set of factors which simultaneously provide not only a better understanding of alcoholism and alcohol abuse, but also provide multiple comprehensive directions for the creation or development of meaningful responses.

The beginnings of such a system of indicators that profile the state's alcohol-related problems are outlined in this volume, given the availability of data. The general categories for the investigation of measurable indicators considered in this Volume include: the prevalence of problem drinkers; alcohol consumption rates and drinking patterns; alcohol-related motor vehicle accidents; alcohol-related mortality; alcohol-related crime; and, other various physical and mental health factors.

C. SUMMARIES OF EACH OF THE MAJOR PARTS
OF THIS VOLUME AND MAJOR FINDINGS

PART II. The Prevalence of Alcoholism and Alcohol Abuse in Alaska:
A Description and Comparison of Procedures and Estimates

There are several accepted formulae for the estimation of the number of alcoholics and/or problem drinkers in any given population group. Each is based on different population characteristics and therefore each may have certain limitations when applied to various population groups.

For the first time in Alaska, each of these procedures is described and applied to the Alaskan population to yield an estimate of prevalence. In addition, the advantages and disadvantages of each procedure, for application to Alaska, are discussed and the various estimates are compared. In the past, only the Jellinek method has been calculated for Alaska. In addition to this more popular method, the Marden, Ledermann, Keller, and various mortality procedures are discussed and developed.

Also, estimation procedures based on the size of the population and identifiable alcohol problems are also explored.

No individual procedure was found to be totally acceptable for singular application to Alaska. However, three procedures--the Jellinek, Marden, and Ledermann methods each produced similar estimates. In view of the fact that each of these methods is based on independent variables, and other evidence presented in this Part, an estimate of 30,000 problem drinkers was accepted as reliable in Alaska for 1975.

Part III. Major Theories Regarding the Etiology of Alcoholism

There is little understanding about the causes underlying the development of alcohol addiction. Because the addiction syndrome of alcoholism takes so long to become established in a person, its developmental antecedents are particularly obscure and difficult to isolate. From a biological point of view, causality is difficult to establish simply because of the sheer number of symptoms. No one theory suffices for all the known manifestations and/or syndromes of alcoholism, alcohol abuse, alcohol dependence, alcohol addiction, etc. Similarly, it has proven difficult to identify behavioral factors which may contribute to the etiology of alcoholism in a person. Researchers have been unable to develop a suitable animal behavioral model for studying alcohol dependence. This combination of difficulties prevents any real certainty about the etiology of alcoholism. The crucial determinants in the developmental process are still unknown, and the very

nature of the addictive process remains largely a matter of conjecture.

A number of theories that have been advanced to attempt to explain alcohol dependency in the individual are summarized in this part. These theories can be generally categorized into three classes--physiological, psychological, and sociological. The rather brief overview of these major theoretical formulations is presented only for general reference. Hopefully, the discussion at least establishes the full range of positions regarding the etiology of alcoholism and provides a general background for the consideration of the material in the rest of this Volume.

Part IV. Consumption of Beverage Alcohol: Trends, Comparisons and Implications for Alaska

The relationship between the consumption of beverage alcohol and alcoholism and alcohol abuse has long been the focus of scientific researchers, particularly epidemiologists whose major concern is the mass aspects of diseases and behavioral disorders. The mass aspects of alcoholism have recently become the subject of increasing research activity.

This Part covers three main areas: a comparison of Alaska's alcohol consumption characteristics with other states, the nation, and international patterns of consumption; an analysis of Alaskan consumption patterns in relation to the prevalence of alcoholism; and, a discussion of various factors which are associated with increased rates of

consumption in certain population groups, with a particular emphasis on government control measures.

The per capita consumption of absolute alcohol in Alaska was found to be very high. It is high by international standards, and even higher by national standards. Alaska is also distinguished by its definitive preference for distilled spirits over beer and wine. Most alarming, however, and independent of the level of annual consumption, or beverage of preference, is the dramatic rate of increase in annual consumption. Although annual consumption of beverage alcohol is increasing throughout the world, Alaska's annual consumption increased 80% in the period from 1958 to 1975, compared to a national increase of 46%.

Epidemiological research indicates that an increasing rate of annual consumption corresponds to an increasing prevalence of alcoholism--a fact which makes Alaska's extremely rapid rate of increasing annual consumption most disturbing. Increases in annual consumption in Alaska correspond to similar increases in the rates of deaths due to alcoholism and cirrhosis of the liver.

In populations with a relatively high rate of annual consumption, alcoholism is more likely the result of social practices, whereas in low consumption populations, it is more likely the result of individual psychopathology or sociopathology. Given the relationship between patterns of excessive consumption and moderate consumption, attention must be given to factors that affect rates of consumption in a population in order to reduce the prevalence of alcoholism.

consumption of alcohol in Alaska is higher than in any other state to the nation as a whole. Alaska has more than twice as many retail outlets per 1000 persons as the competitive average of the other states. Also, Alaska has fewer hours of prohibited sales than other license states. In addition, the relative price of alcohol has actually decreased by 40% in the period from 1970 to 1975. In Alaska, the consumer relative price for beverage alcohol rose by .3% during that period, while the consumer relative price for all other commodities increased by 41.2%. One reason for this disparity may be the stability of taxes on alcohol. Since state and federal taxes account for 50% to 75% of the price of alcohol, taxes which do not increase with inflation prevent the price of alcohol from behaving like other commodities in the free market. The state excise tax on alcohol has not changed since 1961.

Part V. Mortality and Consumption of Alcohol

The effects of alcohol consumption on the health of Alaskans is considered in this section which concentrates on the relationship between excess mortality and excessive consumption of beverage alcohol. For general reference the connections between alcohol abuse and specific causes of death are presented. The section on Alaska's excess mortality covers overall mortality rates within regions of the state. In each category, high risk populations are identified by age, race and sex, whenever the data allow.

General research findings show that heavy drinkers have a mortality rate that is two to four times higher than those who are not. Abuse of alcohol has been linked to cirrhosis of liver, cardiovascular disease and cancer of the upper respiratory and digestive tracts. There is also a very strong link between alcohol abuse and violent deaths--accidents, suicide, homicide and alcoholism. Alaska was found to have higher mortality rates for specific causes that have been linked to alcohol abuse. The main high risk populations for these categories are the young and middle age ranges, and the state's Native population.

Part VI. Alcohol-Related Crime and the Criminal Justice System

Part VI investigates a variety of indicators concerning the relationship between alcohol consumption and crime, and the effects of alcohol-related crime on the criminal justice system. The analysis reflects the nature and extent of the impact of alcohol-related crime on the criminal justice system, rather than the impact of the adverse consequences of alcohol-related criminal acts on victims or society in general.

The evidence presented shows that, in spite of the attention given by the media and the general public to the relationship between alcohol consumption and violent crimes, the greatest impact on the criminal justice system of alcohol-related crimes derives primarily from the commission of misdemeanor type offenses. The high degree of general public

concern about violent crimes and alcohol is in part justified; a large percentage of violent crimes (homicide, rape, and aggravated assault) are alcohol-related. But arrests for all violent crimes, and robbery, account for only four percent of total arrests for all offenses in the state. In terms of number of arrests, alcohol-related misdemeanors have a much greater effect on the criminal justice system.

During the period from 1973 to 1975, arrests for alcohol-related misdemeanor offenses accounted for 39% of the total number of adult and juvenile arrests for all offenses. If juveniles and adults are separated for analysis, then 47% of all adult arrests are for alcohol-related offenses. This group of adults, primarily males (85%) account for 87% of all alcohol-related arrests.

The relative impact of the arrests of alcohol-related offenses on the criminal justice system appears to be greater in rural-city areas. In these areas, arrests for alcohol-related offenses account for a greater percentage of all arrests (47%), compared to urban areas (39%), and rural areas (34%).

The impact of arrests for alcohol-related offenses on the prosecution, judicial, and correction components of the criminal justice system is also considered, but only in brief overview due to the nature of the available data.

Part VII. Alcohol and Traffic Safety

The purpose of this part is to describe the relationship between alcohol and motor vehicle crashes. As background, the relation between

alcohol consumption, blood alcohol concentration, and degree of physical and mental impairment is reviewed. In addition, an overview of different types of crashes in Alaska is presented and compared with national findings. Then, the actual extent of alcohol-involvement in different types of crashes in Alaska is presented. Other sections describe the characteristics of drunk drivers, enforcement activities throughout the state, and the outcomes of judicial processing.

One of the most important indicators for traffic safety concerns is the motor vehicle fatality rate. In Alaska, the fatality rate has been increasing annually, while that for the whole nation has been steadily decreasing. Statewide records show that about 46% of motor vehicle fatalities involved alcohol impaired drivers in 1975. In Anchorage, 18 of 20 (90%) of the traffic fatalities were alcohol-related.

Available research shows that drivers are impaired physically and mentally, and the probability of a crash increases, when a person's blood alcohol concentration (BAC) reaches .05%. The statutory limit for presumption of operating a motor vehicle while intoxicated is .10% BAC in Alaska. The average BAC level for a person arrested for OMVI in Alaska in 1975 was .18%. Of those arrested, 92% had a BAC over .10%.

Of those convicted for OMVI during that same year, two out of ten had at least one prior OMVI conviction, 18 of 20 had at least one prior major traffic violation (reckless driving, negligent driving, leaving the scene of an accident), and 13 of 20 had one or more traffic accidents. This type of driving record is, of course, not typical of the average

licensed driver. These distinguishing characteristics, along with the person's drinking history, make drunk drivers an important target group not only for highway safety concerns but for early intervention for treatment for problem drinker drivers. Arrests for drunk driving accounted for 22% of all adult arrests in the state in 1975.

Given the large proportion of young drivers in Alaska, the increasing number of drivers, the increasing recreational nighttime driving, and increasing alcohol consumption, alcohol involvement in motor vehicle accidents will also probably increase.

Part VIII. Other Social Systems Indicators of Alcoholism and Alcohol Abuse

There are a number of other indicators of the impact of excessive drinking of beverage alcohol that need to be mentioned--that provide yet other perspectives on the social impact of alcoholism and alcohol abuse. They comprise the general category of reported morbidity, including both disease and trauma, which can be directly or indirectly linked to alcohol abuse. This Part brings together the available data on the incidence of various adverse events as reported in the utilization of inpatient and outpatient health services, and other social services.

Such information, even if complete and exhaustive of all relevant units of service, would not be truly indicative of the nature and magnitude of the impact of alcoholism and alcohol abuse on the health and well-being of the general population. Neither is such information truly representative of the impact on the health and social services delivery system, since only a small portion of the presenting problems necessary for admissions (diagnosis) for alcoholism or alcohol abuse ever become

documented in a health care setting. Although there are great limitations on the adequacy of these data, the presentation does provide some idea of the known, minimum impact of alcohol misuse on the health and social service delivery systems.

The findings provided are numerous, and only loosely related. In spite of the data limitations, the information does demonstrate that a large, and increasing, portion of both inpatient and outpatient admissions, and social service encounters may be attributed to abusive alcohol consumption.

Part IX Summary Discussion and Conclusion

This last Part provides an overview of the major findings contained in each of the Parts. Also, in this Part, the Marden procedure, for the estimation of the prevalence of problem drinkers in a population, was used to provide a more refined specification of target groups within the total group of drinkers with problems. These findings indicate that:

The distribution of drinkers with problems in Alaska shows that males who are employed, particularly craftsmen and kindred workers, primarily in the age group 20-29 years old, constitute the largest categorical target group.

It is clear that public inebriates do not constitute the greatest proportion of the population of problem drinkers; but unemployed male drinkers with problems are much younger than might have been expected.

Males in the military, aged 20-29, constitute a disproportionate share of the population of drinkers with problems, relative to their total numbers.

Females, unemployed and employed, aged 30-49, constitute a clearly identifiable target group.

The thrust of this Volume is on the specification of alcohol problems in order to develop a clear identification of the character of the problems to be attacked.

Out of the many findings in this Volume, two particular notions emerge that deserve special attention. First, the population of the state of Alaska qualifies, without question, as a high consuming population, with regard to beverage alcohol. Further, and most important, there appears to be a very high degree of correspondence between the increasing average annual consumption of beverage alcohol in the state, and the nature and extent of individual public health and social problems associated with the current use of beverage alcohol. This notion directs attention to factors that control levels of population consumption.

The second notion of particular import, though not so certain as the first, is the appearance of discrepancies in the characteristics of the sub-populations receiving treatment services for alcoholism and alcohol abuse. This last notion raises the question of the effective and efficient distribution of treatment resources.

There exist many different views about the various factors involved in each and all of the various configurations of specific alcohol problems. There also exist a variety of organizations--official, voluntary and professional, that all play important roles in efforts to reduce and prevent alcohol problems. Because of this diversity, it is extremely important that there be general agreement on the part of those involved as to the

goals and objectives to be achieved and a mutual understanding of the approaches and methods to be used. If such agreement and understanding are not achieved, then the actions taken by the various groups may be discordant and ineffectual, or even counterproductive.

PART II. THE PREVALENCE OF ALCOHOLISM AND ALCOHOL ABUSE IN
ALASKA: A DESCRIPTION AND COMPARISON OF PROCEDURES
AND ESTIMATES

A. INTRODUCTION

In any society, the most elemental indicator of the impact of alcohol is the size of the alcoholic sub-population. Epidemiologically,¹ this is referred to as the prevalence² of alcoholism in that society, by which is meant the number of alcoholics or problem drinkers within the general population. The size of this group governs the interpretation of all other alcohol-related indicators. Related mortalities, attendant social costs, alcoholism program client loads, etc.--all depend for their value and meaning on the known size and characteristics of this sub-population.

The prevalence of alcoholism or problem drinking in a society is not only important as an indicator, however. It is also taken as a focus and point of departure in virtually every undertaking which has as its goal either the treatment or prevention of alcoholism or the amelioration of its effects on society. Whether the purpose is to establish the client needs of regional and local alcoholism programs, formulate relevant legislation, or identify the human sub-stratum of social and economic costs, the size and characteristics of the alcoholic sub-population become extremely important.

From almost any perspective, in fact--whether as indicator, planning focus, or other--the estimation of alcoholism prevalence is important because it affords the single, most tangible clue to the pervasiveness

¹The epidemiology of alcoholism is that science which deals with the incidence, distribution, and control of alcoholism as a disease.

²As opposed to the incidence of alcoholism, which refers to its rate of occurrence in a society.

of alcohol-related problems in a society: the number (and kind) of people having them.

For this reason, the present report has as its purpose the estimation of alcoholism prevalence in Alaska. Because a variety of approaches to prevalence estimation exist, the most important and commonly employed methods are presented and discussed. The key indicators on which they depend are identified, their particular limitations are noted, and each of the methods is applied to Alaska. The multiple estimates of prevalence so generated are then compared and evaluated in terms of their suitability to Alaska's population base. Following examination of the factors most known to affect alcoholism prevalence (anywhere), an attempt is made to resolve the various estimates and arrive at a best possible estimate of alcoholism prevalence in the state.

Problems In Estimating Prevalence

There are significant problems involved in estimating the prevalence of alcoholism or problem drinking in a society. While most of them are taken up on an individual basis during discussion of the estimation procedures themselves, some are worth mentioning at the outset because of their categorical nature.

The most important problem, affecting all methods of prevalence estimation, is one of definition: specifically, the nature of the sub-population to be measured. Some methods address "alcoholics" as the relevant sub-population. Others address "problem drinkers". Yet others address drinkers who consume at the same rate as known alcoholics. This disparity in the methods' definition of a target group for measurement is important for two reasons: first, different data need to be collected, depending on which conceptualizations of the target group are used; and

second, use of different estimation procedures (and thus different conceptualizations of the target group) makes comparison of prevalence estimates difficult, if not impossible.

In the present report, two conceptualizations of the target population have been employed: "alcoholics" and "problem drinkers". Generally, the number of problem drinkers has been taken as approximately twice the number of alcoholics in a population, and note has been made where departures from this approach have been necessary. Other forms of nomenclature found in the methods described ("excessive drinkers", "alcohol abusers", "alcoholic-level consumers") have been regarded as synonymous with "problem drinkers".

Several other categorical difficulties surrounding the estimation of prevalence are also worth mentioning at the outset, since they have important ramifications for alcoholism program planning as well as for simple understanding of the respective prevalence estimates obtained.

Chief among these is the fact that many alcohol-related patterns may not, in themselves, be indicative of pathological behavior; they might, in fact, describe perfectly harmless behavior. For example, the consumption of beverage alcohol at a given level no matter how high, is not in itself sufficient proof of alcoholic or pathological behavior. Particularly with regard to prevalence estimation procedures focusing on societal consumption rates, it is important that this be kept in mind.

Another problem relevant to prevalence estimation is the difficulty in estimating the size of a population's "hidden drinker" sector.

Unless an alcoholic or problem drinker dies, develops an illness which is treated, has an automobile accident, registers in an alcohol treatment program, or otherwise "impacts" the social system, it is impossible to identify him or her as an alcoholic or problem drinker. There is no easy way to get around this problem, but it is worth keeping in mind that the "hidden drinker" portion of any alcoholic sub-population is, for the most part, statistically inaccessible. The corollary of this, of course, is that any prevalence estimate will constitute an under-enumeration by virtue of its insensitivity to "hidden" drinkers.

A final problem has as much to do with Alaska itself as with the difficulties in prevalence estimation. This is simply that most prevalence estimation procedures apply only (or best) to large populations, and rapidly lose sensitivity when applied to small (under a few hundred thousand) or local population bases.³ Given Alaska's relatively small population (approximately 404,600 in 1975),⁴ this becomes an important consideration.

Methods Of Estimating Prevalence

Granted the foregoing problems and caveats, it remains to be said that the prevalence estimation procedures discussed and employed in this report are of the kind termed "indirect" methods. Unlike "direct" methods (e.g., a direct head count of alcoholics, either on a sample or comprehensive basis), indirect methods are a means of determining prevalence through the use of documentary statistics known to vary with the rate of

³ Parker G. Marden, A Procedure For Estimating The Potential Clientele Of Alcoholism Service Programs. Prepared for the Division of Special Treatment and Rehabilitation Programs, National Institute on Alcohol Abuse and Alcoholism, 1974. Note 2, page 4.

⁴ From Alaska Department of Labor.

alcoholism or problem drinking in a population.⁵

The purpose and advantage of such methods lie in the fact that they are easier and cheaper to employ than direct methods of prevalence estimation. Also, given the relative abundance of epidemiological data for alcoholism, the use of indirect methods permits an enviable latitude approaching the problem of estimating alcoholism prevalence.⁶

In the ensuing portions of the report, several such indirect methods of prevalence estimation are discussed and employed to estimate Alaska's alcoholic or problem drinker population. Table II-1, below, synthesizes these estimation procedures, showing the primary indicator(s) monitored by each and the particular target population measured:

TABLE II-1

PREVALENCE ESTIMATION PROCEDURES (INCLUDING PRIMARY INDICATORS AND PARTICULAR TARGET POPULATION)

Method	Primary Indicator	Prevalence Conceptualization
Jellinek	Deaths due to liver cirrhosis	"alcoholics"
Marden	Demographic data and established risk factors	"drinkers with problems"
Ledermann	Mean annual per capita consumption level	"alcoholic"-level consumers
Other Mortality Methods	Various deaths attributable to alcoholism, cirrhosis, and suicide	"alcoholics"
"Other" Methods	Various	various

⁵Robert E. Popham, "Indirect Methods Of Alcoholism Prevalence Estimation", p. 294. In Alcohol and Alcoholism (Popham, ed.).

⁶ Ibid.

B. PREVALENCE METHODS AND ESTIMATES

A variety of prevalence estimation procedures have been employed to obtain estimates of alcoholism prevalence in Alaska. In this section of the report, the various methods used are presented and discussed. Background essential for understanding the methods and primary data necessary for their application are synopsized, and the mechanics of each method outlined. Additionally, the major limitations of each method are noted, and each is employed to obtain an estimate of the number of alcoholics or problem drinkers in the state.

1. JELLINEK METHOD

Background⁷

The prevalence estimation procedure formulated by E.M. Jellinek is probably the best known and most widely applied method for enumerating the number of alcoholics in a given population. Based on projections from official liver cirrhosis mortality statistics, the method dates back to 1942 when the research which ultimately spawned the method was first reported. The estimation formula itself was first described in 1951, with the first full account appearing in 1956.

Description Of The Method

The Jellinek Alcoholism Estimation Formula determines the number of "alcoholics" in a given population. Based on the official mortality rate from cirrhosis of the liver, it is expressed as:

$$A = \frac{PD}{K} \times R$$

⁷From Popham, Ibid., pp. 294-306.

where:

A = total estimated number of alcoholics living in a given area during a given year

B = total number of deaths (for males, for females) during a given year in a given area due to cirrhosis of the liver (reported officially for the area of jurisdiction)

P = percentage of liver cirrhosis deaths attributable to alcoholism (a constant: 62.8% for males, 21.6% for females)

K = percentage of all alcoholics with complications who die of liver cirrhosis (a presumed constant: 0.694%)

R = ratio of all alcoholics to the number of alcoholics with complications (a constant: 5.3)

Thus, to determine the number of living alcoholics in a given area during a given time, only the official number of cirrhosis deaths for males and females must be determined.

Application To Alaska

During 1975, there were a total of 49 deaths in Alaska due to cirrhosis of the liver.⁸ Since 25 of these deaths are known to have occurred among males, and 24 among females, the respective prevalence within each group may be estimated via the Jellinek formula.

For males, the number of alcoholics in 1975 may be expressed as:

$$A = \frac{PD}{K} \times R$$

where:

A = estimated number of male alcoholics in Alaska during 1975

D = 25 deaths among males due to liver cirrhosis

⁸Bureau of Vital Statistics, Alaska State Department of Health and Social Services.

$$P = 0.628 \text{ (constant)}$$

$$K = 0.00694 \text{ (constant)}$$

$$R = 5.3 \text{ (constant).}$$

Thus, the number of male alcoholics can be determined as:

$$A = \frac{(0.628) (25)}{0.00694} \times 5.3$$
$$= 11,990 \text{ male alcoholics.}$$

Similarly, the number of female alcoholics in Alaska during 1975 may be expressed by the Jellinek formula (substituting the relevant values of 24 and 0.216 for D and P, respectively) as follows:

$$A = \frac{(0.216) (24)}{0.00694} \times 5.3$$
$$= 3,959 \text{ female alcoholics.}$$

Thus, the total number of alcoholics in Alaska during 1975 may be estimated at approximately 15,949--of whom approximately 11,990 were males and some 3,959 were females.⁹

It is interesting to note that an earlier Alaska prevalence study¹⁰ utilizing the Jellinek method estimated the total number of alcoholics in the state during 1971-72 to be approximately 15,610 persons. Comparison of this estimate with our 1975 estimate of 15,949 alcoholics would seem to indicate that the state has gained only some 339 alcoholics since 1971-72. This is probably not true, however, as cirrhosis deaths very rarely occur in younger persons (alcoholism being a progressive disease), and it is younger persons who presumably are most responsible for the gains since

⁹ Estimates of prevalence obtained via the different methods are compared are displayed in Table II-4, in Section C.

¹⁰ Allocation of Adult Alcoholics in Alaska by Geographic, Sex and Racial Indices. Prepared by Alaska Center for Research, Planning and Evaluation for the Alaska State Office of Alcoholism, July, 1973.

1971-72 in population. Much more likely is the probability that current liver cirrhosis mortality statistics do not yet register or reflect the growth in overall population in Alaska since 1971-72, nor therefore any accompanying increase in the number of alcoholics and problem drinkers. (Population size and annual fluctuations in cirrhosis mortality rates have long been recognized as important factors affecting the validity of prevalence estimates based on the Jellinek equation. See section immediately following for discussion of these and other limitations of the method.)

If cirrhosis statistics have not been able to reflect a significant change since 1971-72 in the overall size of the alcoholic sub-population, however, they do strongly indicate a dramatic increase in the number of female alcoholics in Alaska. Specifically, application of the Jellinek formula to cirrhosis data for 1971-72 produced an estimate of approximately 2,642 female alcoholics in the state at that time,¹¹ while our present estimate indicates that there were approximately 3,959 female alcoholics in Alaska during 1975--an increase of some 50%. (Male alcoholics would seem to have decreased during the same period by approximately 7.5%, but change of such small scale is not considered significant.)

Limitations Of The Method

An entire body of literature exists describing the various limitations and controversies of the Jellinek method--e.g., that official mortality statistics underreport the true incidence of liver cirrhosis, that transient causes such as epidemic hepatitis can distort the validity of liver cirrhosis as an index, that the method is not valid for various societies which show a high incidence of parasitic liver disease mortality, etc.

¹¹Ibid.

No attempt is made here to comprehensively treat the matter of these limitations. The intent, rather, is to point out those specific limitations and considerations which either address the overall validity of the method or point towards problems in applying the method to Alaska.

One such limitation of the Jellinek method is that liver cirrhosis mortality rates have been known to fluctuate randomly and considerably from one year to the next.¹² If so, estimates based on liver cirrhosis mortality rates from preceding years could seriously underestimate the number of alcoholics actually alive in a population at a given time. Jellinek himself has noted that such variation is "especially marked" in populations of 300,000 or less.¹³ This factor is of considerable importance in attempting to estimate prevalence in Alaska, where the annual number of liver cirrhosis deaths has fluctuated extensively in recent years. For example, a high cirrhosis mortality rate several years ago (e.g., in the 1973 Alaska study), when compared with current rates, would indicate little growth in the estimated number of alcoholics in the state. Had a lower mortality rate from a more recent year been taken for the same comparison, however, a dramatic increase in prevalence would have been indicated. By the same process, had an earlier annual mortality rate been taken which was higher than current rates, comparison would indicate not an increase in prevalence, but a decrease. The method's susceptibility to such annual fluctuations, therefore, stands as a critical limitation of its validity for Alaska.

Other relevant limitations of the Jellinek method have to do with the values of constants P, K, and R. With regard to P (percentage of liver cirrhosis deaths attributable to alcoholism), it has been shown¹⁴ that the percentage not only varies from one country to

¹²Popham, loc. cit., p. 296.

¹³Ibid.

¹⁴Ibid., p. 297.

another, but specifically that it varies according to temporal changes and (particularly) regional differences in the prevalence of alcoholism within the same country. As a consequence, the formula may underestimate prevalence when the cirrhosis death rate exceeds that for the year to which P applies, and overestimate it when the rate is lower.¹⁵

Given Alaska's rapid growth in recent years, as well as its degree of regional difference from the rest of the nation, the degree of error in estimation due to this could be significant.

Concerning the constant K (percentage of all alcoholics with complications who die of liver cirrhosis), theorists have warned that it is probably not representative of the death rate from liver cirrhosis among living alcoholics. They also caution, that because Jellinek's estimated value for K tends to run high, it causes an underenumeration of the number of estimated alcoholics in a population.¹⁶

In a like manner, the value assigned by Jellinek to constant R (ratio of all alcoholics to the number of alcoholics with complications) is said¹⁷ to further underestimate prevalence because it is derived from clinical samples, and the proportion of alcoholics with complications tends to run higher in clinical samples.

Overall, however, perhaps the most important limitation of the Jellinek method is that it, in effect, "homogenizes" a population.¹⁸ This occurs because the method (and the estimate it arrives at) does not reflect the fact that persons from different backgrounds may have different probabilities of becoming alcoholics or alcohol abusers. For

¹⁵ Ibid.

¹⁶ Ibid.

¹⁷ Ibid.

¹⁸ Marden, loc. cit. p. 5.

a state as variegated in its racial and cultural composition as Alaska, such an "homogenization" would give an overall estimation of the number of alcoholics in the state, but little indication of any significant cluster within a particular subpopulation. (The Jellinek-based prevalence study done in Alaska in 1973, mentioned earlier, did attempt to stratify the alcoholic subpopulation by age, race, sex, and geographic location, but must be regarded as highly unreliable due to the known statistical limitations of the method for small subpopulations.)

In sum, it should be said that the Jellinek method of prevalence estimation shows a high correlation with estimates generated by other prevalence methods, and is generally agreed to be sufficiently accurate for purposes of education and program development.¹⁹ The fact remains, however, that its strength is in producing an estimate of the total number of alcoholics in an area. If, on the other hand, concern is more with the differences in prevalence--both through time or across regions--the Jellinek method evidences a number of significant shortcomings with respect to its application to Alaska.

2. MARDEN METHOD

Background²⁰

The prevalence estimation procedure developed by Parker G. Marden in 1974 was an outgrowth of two related purposes. The first was to develop a method which would estimate not only the size, but the composition as well, of the potential clientele for alcoholism service programs. The second was to develop a prevalence estimation procedure which would recognize and reflect the fact that problems of alcohol abuse vary in degree and kind among various sub-populations.

¹⁹Popham, p. 299.

²⁰From Marden, op. cit.

In both these respects, the Marden procedure can be seen as a reaction to earlier prevalence estimation procedures (e.g., the Jellinek method) which produced estimates only of the overall size of the alcoholic sub-population, and which thus had proven unreflective of local and sub-population conditions. The Marden method remains, to date, the only prevalence estimation procedure which provides a stratification of the estimated abuser sub-population.

Description Of The Method

The Marden method estimates the number of "drinkers with problems" (age 20+) in an overall population. To achieve this, it relies on U.S. Census statistics pertaining to age, sex, and occupation, as well as on established alcoholism risk factors for each of a specified set of sub-populations. Knowing the number of persons in a particular sub-population, and the established percentage of individuals in that sub-population who are likely to be problem drinkers, allows easy calculation of the number of problem drinkers in each sub-population, and, therefore, in the overall population.

The method involves the use of three matrices. The first, Matrix A (Figure II-1), is simply a categorization of the population being inspected according to age, sex, and occupational status. Based on the most recent U.S. Census statistics (or on any other more recent survey of the relevant population), the cells of the matrix are used to record the number of individuals within the overall population who fall into each of the cell-categories so represented.

The second matrix, Matrix B (Figure II-2), contains the sub-populations risk factors for each of the cells in Matrix A, as established

through a national sample survey conducted in 1972 by Cahalan and Room.²¹

The third matrix for the method, Matrix C (Figure II-3) is simply a combination of the first two matrices. That is, if the number of persons in each of the subpopulation cells in Matrix A is multiplied by the corresponding cell risk factor from Matrix B, and the product entered into the appropriate cell of Matrix C, the result will be a stratification (by age, sex, and occupation) of the total problem drinker subpopulation. In this way, both a total number of problem drinkers may be obtained, as well as the number of such persons within the various specified subpopulations.

Application To Alaska

Application of the Marden method to Alaska's 1975 population proved easy, once a series of adjustments were performed to reflect population increases (and redistribution) in the state since the 1970 U.S. Census. It has been hoped that the method could be used to stratify the state's population along four dimensions--age, sex, occupational status, and race--but the unavailability of relevant risk factors for Alaska's ethnic subpopulations and the unsuitability of occupational employment data classified by race precluded isolation and identification of problem drinkers among ethnic subpopulations. Such problem drinkers are included in the various subpopulation estimates arrived at (by age, sex, and occupation), although probably underenumerated. Should risk factors appropriate to Alaska's ethnic and racial composition be determined and pertinent employment data become available, the Marden method could be

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Sub-population risk factors were established by determining, on a sample basis, the relative percentages of individuals in each cell category who manifested at least seven (out of a total of 11) specific problems commonly associated with drinking. Such persons were designated as "drinkers with problems." The problems were: frequent intoxication, binge drinking, symptomatic drinking, psychological dependence, problems with spouse or relatives, problems with friends or neighbors, job problems, problems with the law (or police, or accidents), health problems, financial problems, and belligerence. (From Marden, op. cit., p. 8.)

employed to further stratify the overall population and permit identification of problem drinkers among racial categories as well.

For ease of computation, the civilian and military sectors of the statewide population were held separate, and the number of problem drinkers in each calculated independently. Figure II-4 shows the state's 1975 (adjusted) civilian population, allocated among the various subpopulation cells of the Marden "A" matrix. Figure II-5 shows the relevant subpopulational risk factors of Matrix "B". Figure II-6 shows the number of estimated problem drinkers within the civilian sector of Alaska's populace, as apportioned among the subpopulational cells of the Marden "C" matrix.

In similar fashion, Figures II-7, II-8, and II-9 show the allocation of the 1975 Alaska military population (adjusted), the relevant risk factors (averaged) from Matrix B and the apportioning of the estimated military problem drinkers among the various subpopulational categories.

The results of these determinations are shown in Table II-2, below.

TABLE II-2

ESTIMATES OF PROBLEM DRINKERS AGE 20+ AMONG ALASKA'S 1975
POPULATION (ADJUSTED), AS DETERMINED BY THE MARDEN
PREVALENCE ESTIMATION PROCEDURE

	Male	Female	Total
Civilian Population			
Employed	15,631	*	
Unemployed	4,532	*	
Subtotal	20,163	5,799	25,962
Military Population	5,721	26	5,747
TOTAL	25,884	5,825	31,709

*females not separated in the instrument

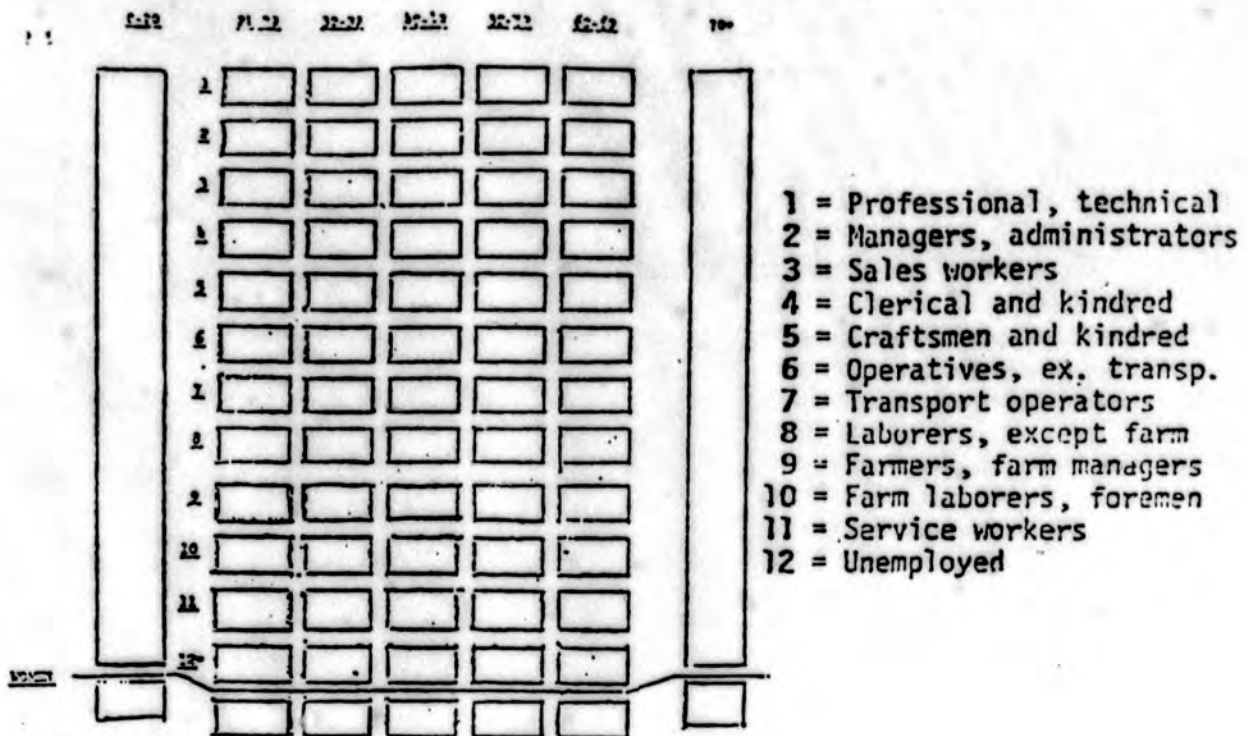


FIGURE II-1 Marden Matrix A

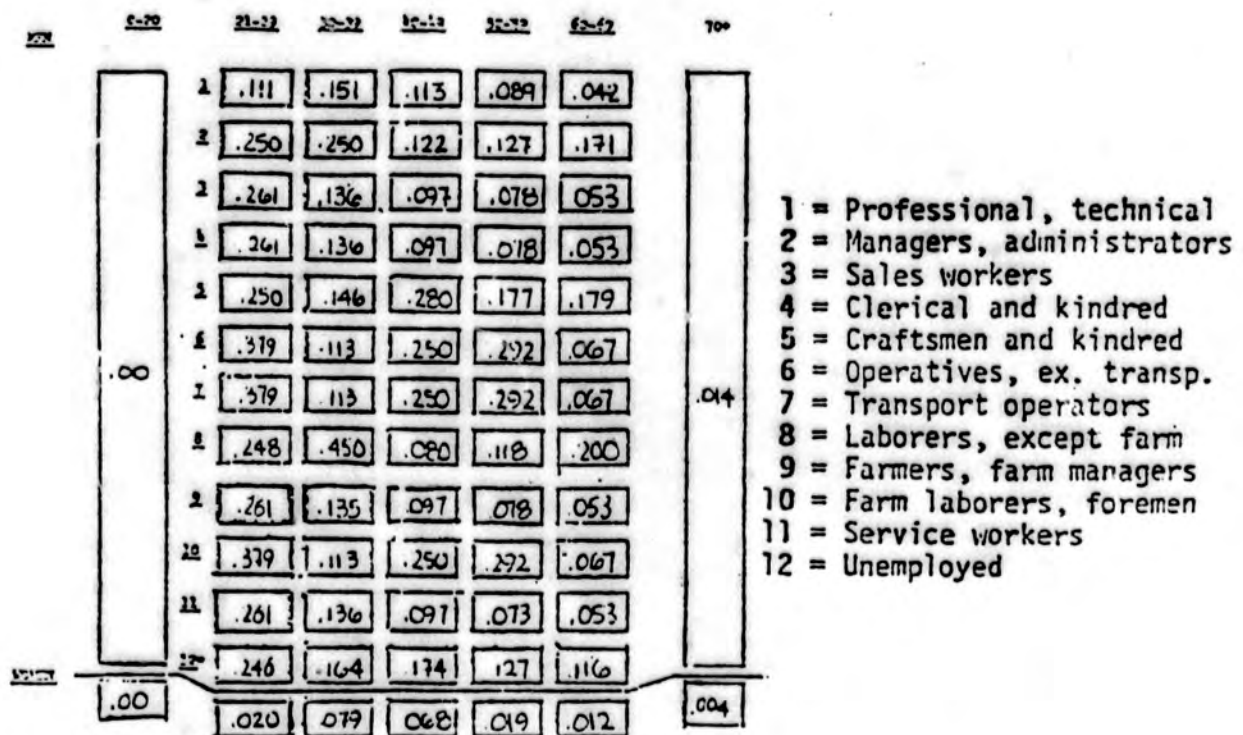


FIGURE II-2 Marden Matrix B

	0-20	21-31	32-41	42-51	52-61	70+
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						

- 1 = Professional, technical
- 2 = Managers, administrators
- 3 = Sales workers
- 4 = Clerical and kindred
- 5 = Craftsmen and kindred
- 6 = Operatives, ex. transp.
- 7 = Transport operators
- 8 = Laborers, except farm
- 9 = Farmers, farm managers
- 10 = Farm laborers, foremen
- 11 = Service workers
- 12 = Unemployed

FIGURE II-3 Marden Matrix C

	0-20	21-31	32-41	42-51	52-61	70+
1	5030	5074	4006	2008	401	
2	1956	4072	4086	2840	618	
3	1018	966	878	629	162	
4	1764	1182	1014	707	195	
5	4520	6226	5397	4031	964	
6	1931	1831	1305	807	290	
7	1197	1243	837	516	138	
8	2174	1619	1495	1056	228	
9	40	7	8	28	52	
10	49	54	41	36	20	
11	2409	1898	1622	1416	549	
12	8090	4816	4743	3942	3288	
	44975	34291	26026	17555	6529	2120

- 1 = Professional, technical
- 2 = Managers, administrators
- 3 = Sales workers
- 4 = Clerical and kindred
- 5 = Craftsmen and kindred
- 6 = Operatives, ex. transp.
- 7 = Transport operators
- 8 = Laborers, except farm
- 9 = Farmers, farm managers
- 10 = Farm laborers, foremen
- 11 = Service workers
- 12 = Unemployed

total males 20+ = 113,049
total females 20+ = 131,305
Total Civilian Population
in 1975 Age 20+ = 244,354

FIGURE II-4 1975 civilian population of Alaska* by sex, age, and occupational category--Matrix A

*(Adjusted population figures based on 1970 U.S. Census)

		0-20	21-30	31-40	41-50	51-60	61-70	70+
	1	.111	.151	.116	.084	.042		
	2	.250	.250	.122	.127	.171		
	3	.261	.136	.097	.078	.053		
	4	.261	.136	.097	.078	.053		
	5	.250	.146	.280	.277	.179		
	6	.379	.113	.250	.292	.067		
	7	.379	.113	.250	.292	.067		
	8	.248	.450	.080	.118	.200		
	9	.261	.135	.097	.078	.053		
	10	.379	.113	.250	.292	.067		
	11	.261	.135	.097	.076	.053		
	12	.248	.164	.174	.127	.116		
		.020	.079	.068	.029	.012		.004

- 1 = Professional, technical
- 2 = Managers, administrators
- 3 = Sales workers
- 4 = Clerical and kindred
- 5 = Craftsmen and kindred
- 6 = Operatives, ex. transp.
- 7 = Transport operators
- 8 = Laborers, except farm
- 9 = Farmers, farm managers
- 10 = Farm laborers, foremen
- 11 = Service workers
- 12 = Unemployed

FIGURE II-5 Probabilities of problems related to drinking by sex, age, and occupational category--Matrix B

		0-20	21-30	31-40	41-50	51-60	61-70	70+
	1	558	887	453	179	21		
	2	489	1018	499	361	106		
	3	266	131	85	49	9		
	4	460	1101	90	55	10		
	5	1130	900	1511	713	173		
	6	732	207	326	236	19		
	7	454	140	209	151	9		
	8	539	729	120	125	46		
	9	10	1	1	2	3		
	10	19	6	10	11	1		
	11	629	258	157	110	29		
	12	2001	798	825	501	381		
		899	2709	1770	334	78		9

- 1 = Professional, technical
- 2 = Managers, administrators
- 3 = Sales workers
- 4 = Clerical and kindred
- 5 = Craftsmen and kindred
- 6 = Operatives, ex. transp.
- 7 = Transport operators
- 8 = Laborers, except farm
- 9 = Farmers, farm managers
- 10 = Farm laborers, foremen
- 11 = Service workers
- 12 = Unemployed

Total Civilian Problem Drinkers Age 12+ in Alaska During 1975 = 25,582

FIGURE II-6 Estimated number of problem drinkers in Alaska's 1975 civilian population--Marden procedure

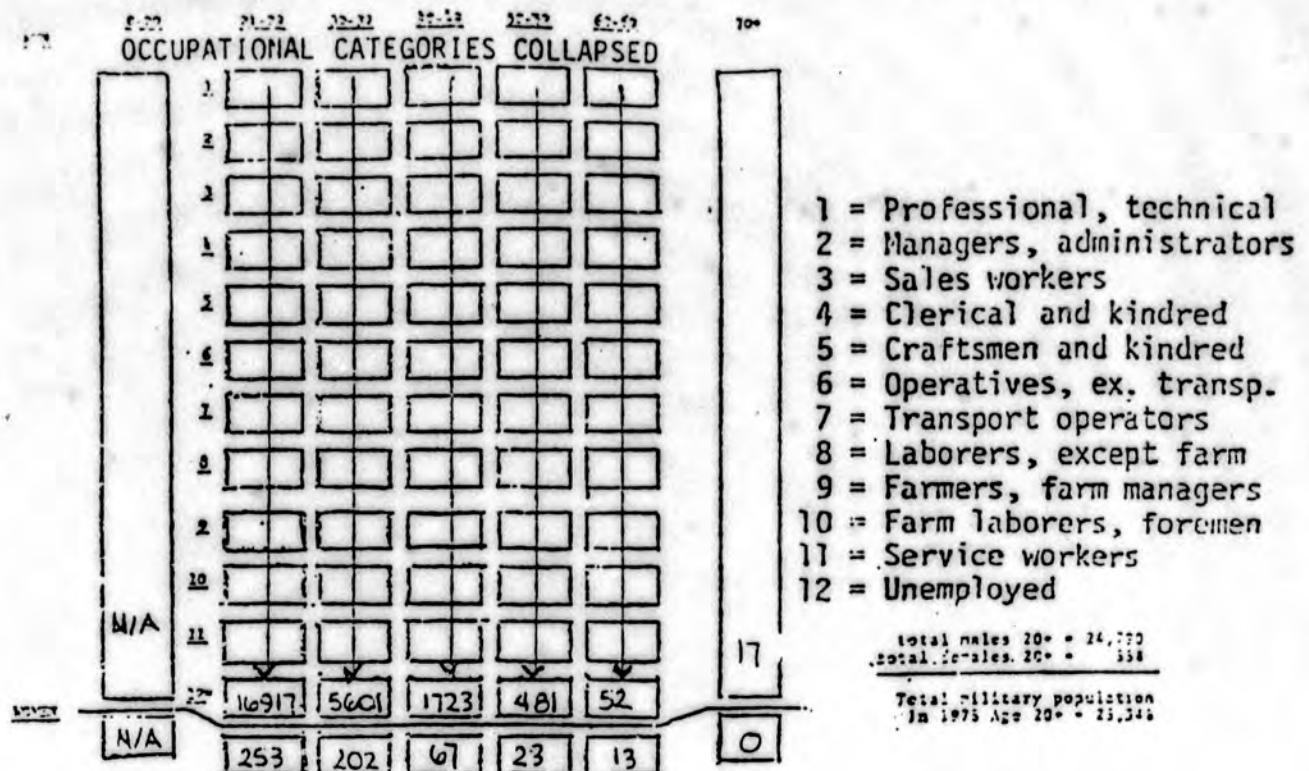


FIGURE II-7 1975 military population of Alaska (adjusted)*--Matrix A

*(Military population figures from Department of Military Affairs, Anchorage, and 1970 U.S. Census.)

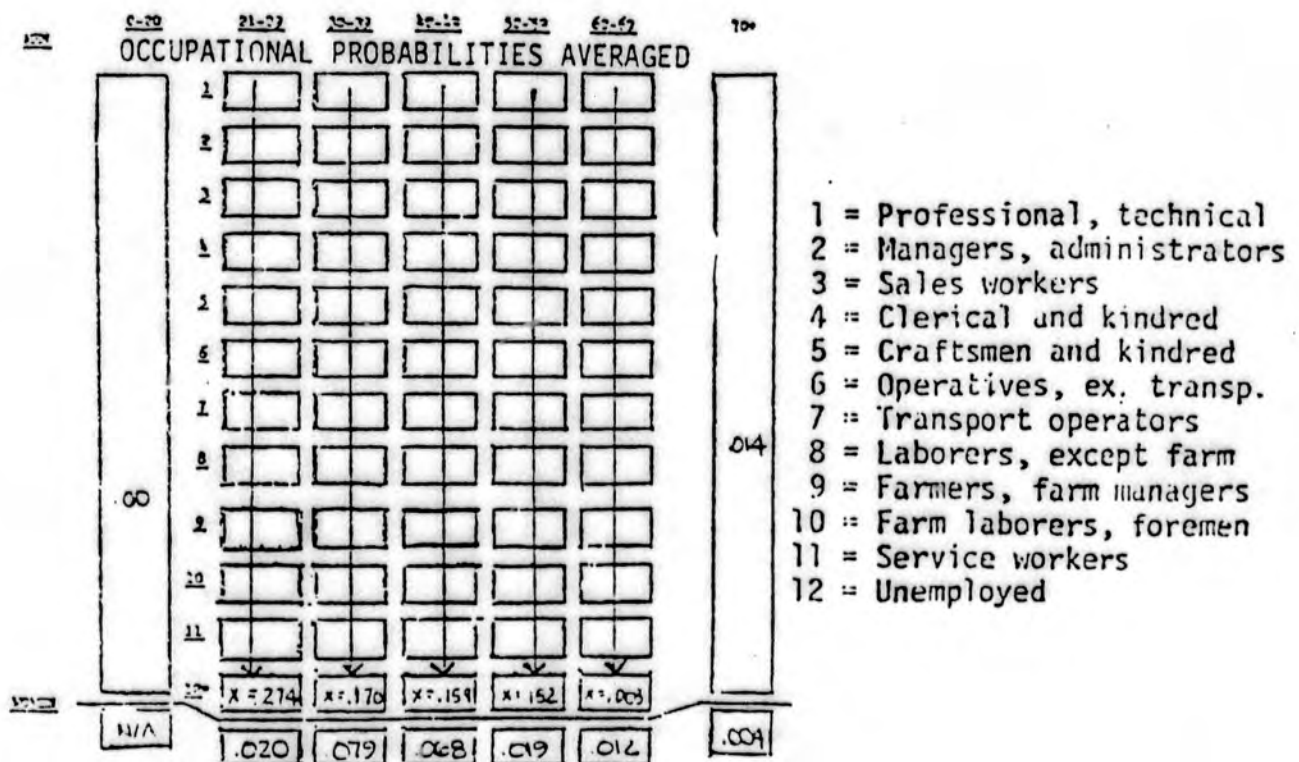


FIGURE II-8 Military problem drinker probabilities*

*Occupational probabilities averaged for each age group.

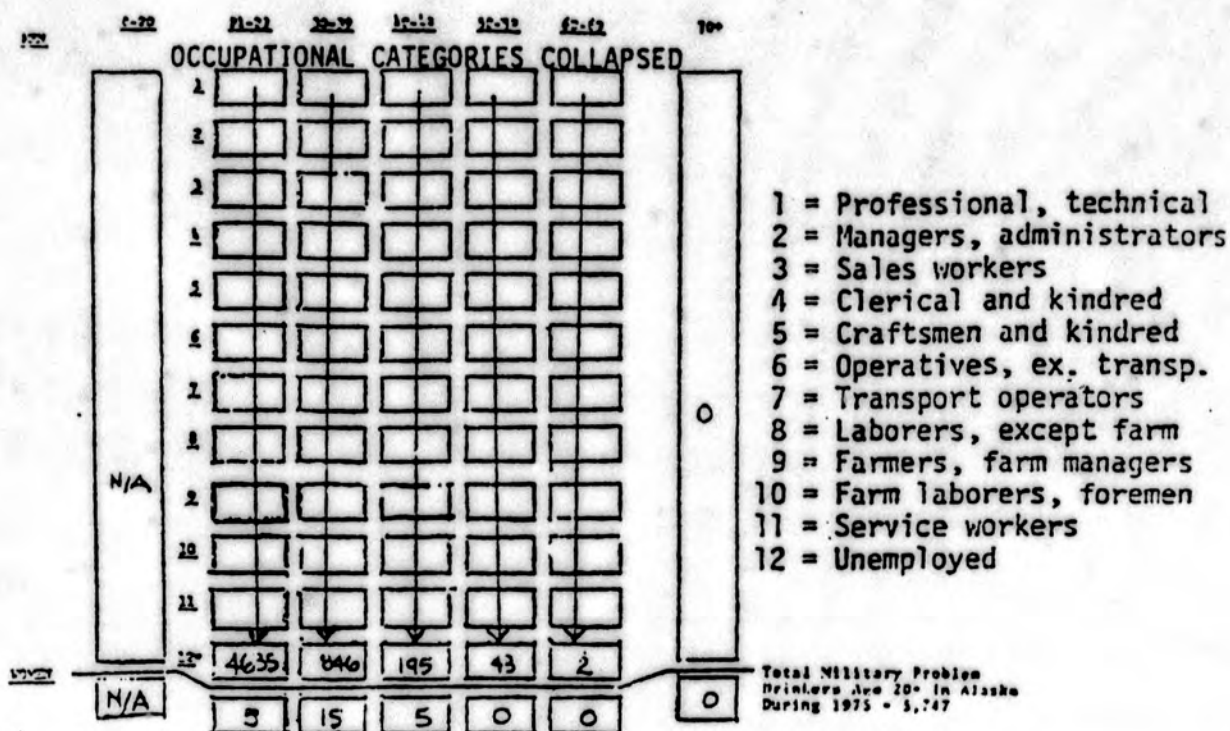


FIGURE II-9 Estimated number of problem drinkers in Alaska's 1975 military population--modified Marden procedure

Thus, it can be seen that application of the Marden estimation procedure to Alaska's population results in an estimate of 31,709 problem drinkers age 20+ in the state during 1975, with approximately 25,884 of these being males and an additional 5,825 being females.

Limitations Of The Method

While the obvious advantage of the Marden method lies in its ability to estimate prevalence within various sub-populations, it does suffer from several disadvantages and insensitivities. Some of these, discussed below, directly affect interpretation of the results as the method is applied to Alaska.

One such limitation of the Marden method is clearly the datedness of the sub-population risk factors determined by Cahalan and Room in 1972, as the drinking patterns of the national populace have shifted since that time. Even if these patterns had not shifted, however, there is still reason to doubt whether risk factors based on the national demographic composition are characteristic of Alaska's culturally pluralistic population.

Another limitation of the Marden method, and one with particular importance for Alaska, is that it tends to systematically underenumerate racial and ethnic minorities within a population. This occurs because of the difficulty in obtaining reliable estimates of minority populations in general.²² For a state such as Alaska, with its several sizeable minority populations (and relatively small overall total population) such an underenumeration could likely produce a substantial distortion of the estimated number of drinkers with problems in minority categories.

A third limitation of the method is that it produces no estimate of

²²Analyses of the 1960 U.S. Census showed significant undercounting of black and other minority populations, averaging about 10%. In high-risk categories, however, such as males aged 20-39, the underenumeration is even more pronounced, approaching 15-20%. (Marden, p. 23)

the number of problem drinkers under age twenty. For a state such as Alaska, where the young comprise a substantial portion of the overall state population, and where alcohol abuse is decidedly a problem among youth, such an omission should be regarded as serious.

Yet another relevant limitation of the Marden method with respect to its utility in Alaska is that it systematically underestimates the number of problem drinkers within the unemployed population.²³ Given Alaska's generally high rate of unemployment and seasonal employment, such an underestimation warrants attention.

Finally, the Marden method may likely underestimate the prevalence of "drinkers with problems" in Alaska due to the fact that it is systematically insensitive to the kinds of population shifts characteristic of rapid-growth areas. The method's dependence on census data prevents correction for the fact that rapid growth in an area or region is usually caused by significant in-migration, and that such in-migrants are predominantly younger people in those age groups for which risk factors are highest.²⁴ Given the kind of growth which has characterized Alaska during recent years, such an omission could easily be sizeable.

In sum, the Marden estimation procedure suffers from several categorical deficiencies which render its application to Alaska problematic--deficiencies which directly coincide, as it happens, with known eccentricities of Alaska. These deficiencies, however, do not alter the fact that the Marden method is still the only prevalence estimation procedure with any sensitivity whatsoever to rates of problem drinking within sub-population categories. Whatever the problems involved in applying the method to Alaska, this distinct advantage over other estimation procedures argues strongly for its use. If its various biases and underenumerations

²³Marden, p. 26.

²⁴*ibid* " 27

(relative to Alaska) are understood and allowed for, the method may prove to be more valuable--and more useful for planners--than any other method.

3. LEDERMANN (CONSUMPTION) METHOD

Background

The prevalence estimation procedure developed in 1954 by the French theorist Sully Ledermann is based on the fact that the number of excessive drinkers in a population increases disproportionately as the overall level of alcohol consumption in that population rises. The link between the two, Ledermann found, was that changes in the overall level of annual per capita intake of alcohol in a society caused a redistribution of the number of individuals consuming at specific levels. As the overall per capita intake went up, Ledermann found, so did the number of persons whose consumption level could be described as "excessive".

In his studies of consumption frequencies²⁵ Ledermann discovered that the distribution of such frequencies tended to be log normal in character, and further that the log normal character of the distribution held for populations which differed greatly in such things as drinking habits and attitudes, beverage preference, legislative controls, etc.²⁶ Although unable to establish precisely why such a distribution should recur across different populations, Ledermann discovered that the relation was definitely fixed. From this, he generated a prevalence estimation procedure which would determine the number of persons in a given society or population who would consume alcohol at any specified level of intake.

²⁵I.e., the number of persons in a society consuming alcohol at various levels of annual intake.

²⁶Wolfgang Schmidt and Jan de Lint, "Estimating The Prevalence Of Alcoholism From Alcohol Consumption And Mortality Data," Quarterly Journal of Studies on Alcohol, 31 (1970), 957-964.

The Ledermann method does not estimate the number of "alcoholics" or "problem drinkers" in a population. Instead, it estimates the number of persons who are likely to consume at or above a prescribed level. For example, hospital and clinical studies have shown that alcoholic clients generally consume an average of 15 cl. of absolute alcohol per day.²⁷ (See bottom of Table II-3 in the following section for English system equivalents.) If this is taken as an indication of the consumption level above which alcohol-attendant problems are likely to emerge in an individual's life, the Ledermann method of prevalence estimation becomes valuable for its ability to estimate how many persons in a population consume in excess of that amount (and who are, therefore, potential clients for treatment programs).

Description Of The Method

The Ledermann method requires as its primary datum the average annual per capita consumption of absolute alcohol for a given population. In effect, if the assumption is made that consumption frequencies adhere to a logarithmic normal distribution (explained below), the mean annual per capita consumption level will be sufficient for determining the number of persons in that population who consume at or beyond a specified level of individual intake.²⁸

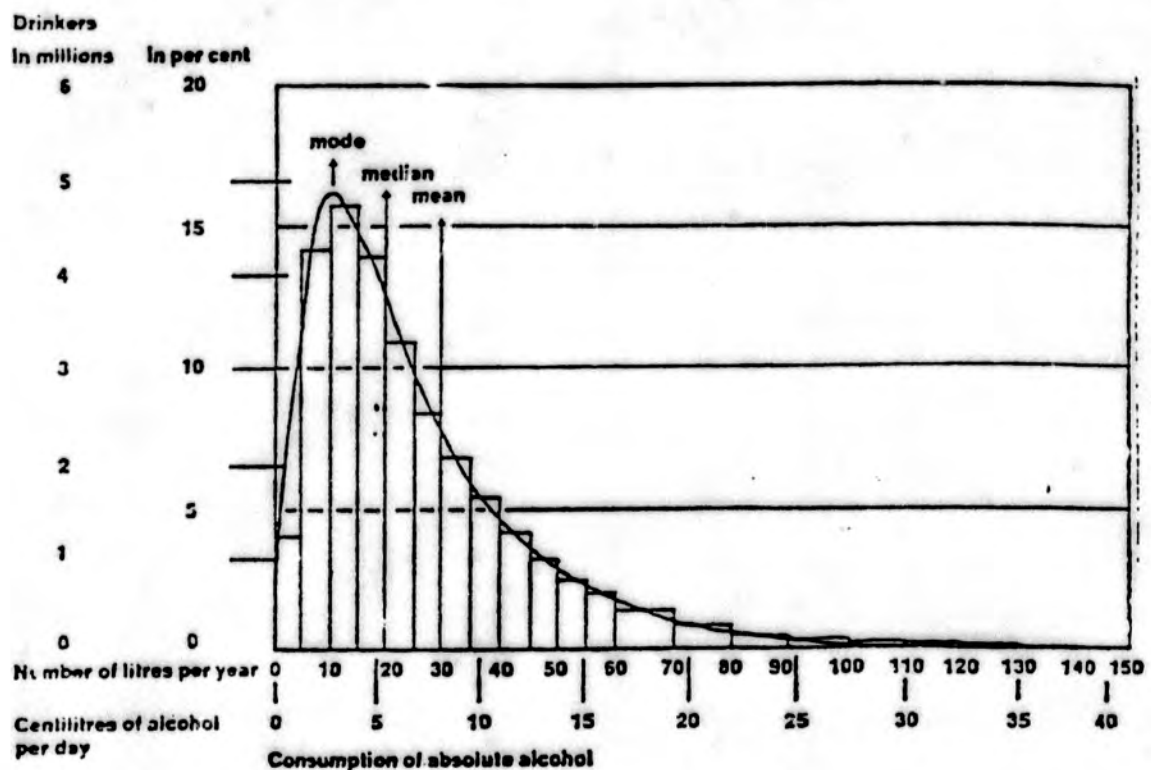
If the number of liters of absolute alcohol that each person in a given population consumed annually were to be plotted on a graph, the resultant curve would not be a normal Gaussian or "bell" shaped distribution curve. This is because, as with the distribution of personal in-

²⁷ Gary Miller and Neil Agnew, "The Ledermann Model Of Alcohol Consumption", Quarterly Journal of Studies on Alcohol, 35 (1974), 877-898.

²⁸ More recent consumption-based estimates of prevalence have been based on direct observation of liquor purchases (Popham, p. 303). Such a method is normally too costly and burdensome for widescale application, but possibly could be very useful in a state such as Alaska, if conducted on a sample basis.

comes in a society, the distribution of liquor consumed is not uniform; rather, the greatest majority of persons drink (or earn) a relatively small amount, while a small minority of persons drink (or earn) a great deal. Thus, the greatest majority of the population would be included under the left-hand portion of a frequency distribution curve, and a very small percentage included under the right-hand portion, or "tail" (see Figure II-10).

FIGURE II-10
DISTRIBUTION OF CONSUMPTION FREQUENCIES



Source: R.E. Popham, "Indirect Methods of Alcoholism Prevalence Estimation", in Alcohol and Alcoholism, R. E. Popham, ed..

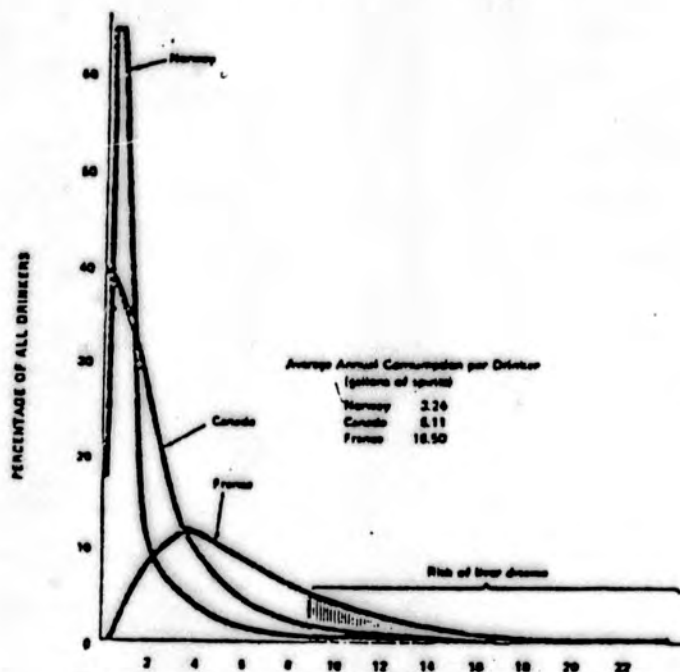
In his studies, Ledermann noted that the frequency distribution of consumption averages in a society greatly approximated the shape of the logarithmic normal curve.²⁹ Given certain standard properties of log

²⁹In a logarithmic normal curve, the natural logarithms (exponents) of the data--rather than the data themselves--are normally distributed.

normal curves, he was then able to make certain generalizations; in particular, concerning the relative percentages of consumers described by certain portions of the curve, as the overall level of consumption for the society increased or decreased. For example, Figure II-11 shows 1968 consumption curves for Norway, Canada, and France. As can be seen, the percentage of the population consuming at high-intake levels (and therefore risking liver disease) tends to increase dramatically as the overall mean annual per capita consumption level ($\bar{c}$) increases.

FIGURE II-11

RELATIONSHIP BETWEEN LEVEL OF OVERALL CONSUMPTION AND SIZE OF "RISK" POPULATION



Distribution Curves of Alcohol Use in Norway, Canada and France in 1968 by Average Daily Consumption (Ounces of Spirits). The average annual consumption is in Imperial gallons. The higher the average per capita intake, the more the distribution curve shifts toward the high-intake end of the scale. The hatched area indicates the levels of intake associated with a proven risk of liver disease.

Source: G.H. Miller and N. Agnew, "The Ledermann Model of Alcohol Consumption", Quarterly Journal of Studies on Alcohol, 35, 1974.

Thus, argued Ledermann, if some level of consumption were to be arbitrarily defined as "excessive" (et al.), the log normal characteristics of the alcohol consumption curve would allow easy estimation of how many

people in a society drink less than that amount of alcohol (e.g., 15 cl./day), and how many drink more than that.³⁰

The implication of Ledermann's method, of course, is that a reduction in the overall level of alcohol consumption in a given society will have the salutary effect of disproportionately lowering the number of drinkers consuming at all (and, therefore, also "excessive") levels. Researchers, however, have cautioned against taking too simplistic an approach to this possibility.³¹

Application To Alaska

The Ledermann procedure may be applied to Alaska, as explained, to determine the number of persons consuming at or above any level of consumption. Since, as mentioned earlier, it has been established that known alcoholics consume on the average of 15 cl. of absolute alcohol a day, that level has been taken here as indicative of "excessive drinking".³² Thus, the number of "excessive drinkers" estimated in this portion of the report refers to the number of persons in Alaska during 1975 who consumed at or above the level of 15 cl. of absolute alcohol per day.

³⁰ Normally, there is a family of log normal distributions for each level of mean consumption. By assuming first, however, that very few individuals in a society would drink more than a liter of absolute alcohol per day (likely to be fatal), and second, that the number of such drinkers would be independent of a population's mean consumption, Ledermann "fixed" the right-hand tail of the distribution, as a utilitarian device. Thus, his distribution curve is a special instance of the log normal curve in which the mean consumption level completely defines the distribution. (Miller and Agnew, p. 879.)

³¹ Miller and Agnew cite Robin Room: "The existence of the log normal distribution as an approximation of cross-sectional empirical realities does not demand that prevention measures, to be effective, must apply to all consumers, as for instance a rise in price does." The authors use the analogy of income distribution, where attempts are made to redistribute incomes among individuals rather than lowering all incomes with a general tax hike. (Miller and Agnew, op. cit., p. 885.)

³² NIAAA Alcoholism Treatment Center Monitoring System output reports for 1975 show that clients at 44 treatment centers about the country averaged

Since the primary datum needed to employ the Ledermann method is Alaska's annual per capita level of consumption ($\bar{c}$), this must first be computed. Overall consumption of absolute alcohol in Alaska during 1975 totaled approximately 1,106,403 gallons--comprised of 584,562 gallons of absolute alcohol from liquor sales, 122,227 gallons from wine sales, and 399,614 gallons from the sale of beer.³³ Given a 1975 drinking-age (18+) population in Alaska of approximately 243,416--of whom approximately 158,220 persons, or 65%, may be considered as actual drinkers--the overall 1975 per capita level of consumption ($\bar{c}$) for Alaska may be determined as:

$$\bar{c} = \frac{1,106,403}{158,220} = 6.99 \text{ gallons/drinker/year}$$

Converting to liters (1 gallon = 3.785 liters), a ($\bar{c}$) of 26.47 liters per person is arrived at. Thus, the 1975 level of per capita consumption among actual drinkers in Alaska can be said to have been approximately 26.47 liters of absolute alcohol per drinker.

Table II-3, adapted from Jan de Lint's 1973 study of consumption averages and other epidemiological factors,³⁴ shows the respective percentages of consumers³⁵ drinking in excess of 15 cl. of absolute

16.56 cl. (5.6 oz.) of absolute alcohol daily when drinking. The rate shows considerable fluctuation annually, however, and is here mentioned simply as general corroboration of the 15 cl. level. It might be noted that clients at Juneau and Ketchikan treatment centers during 1975 averaged 24.25 cl. (8.2 oz.) and 19.22 cl. (6.5 oz.) of absolute alcohol daily, respectively--indicative of the generally higher levels of consumption found in Alaska.

33Computed from Department of Revenue Monthly reports, "Report of Alcoholic Beverage Distributed or Sold in Alaska", 1975.

34Jan de Lint, The Epidemiology of Alcoholism: The Elusive Nature of the Problem, Estimating the Prevalence of Excessive Alcohol Use and Alcohol-Related Mortality, Current Trends and the Issue of Prevention. Addiction Research Foundation manuscript, 1973.

35Defined by de Lint (and Ledermann) as the drinking-age population, as opposed to the population of actual drinkers used to determine ($\bar{c}$).

alcohol daily, given certain overall annual levels of intake ($\bar{c}$). Thus, it can be seen by inspection that Alaska's 1975 level of per capita intake ($\bar{c}$ = 26.5 liters) indicates that between 9.97% ($\bar{c}$ = 26.0) and 10.62% ($\bar{c}$ = 27.0) of its drinking-age consumers (243,416), or between 24,269 and 25,851 individuals, were "excessive drinkers". Taking a mean between the two,³⁶ an estimate of approximately 25,060 excessive drinkers is obtained. (See Figure II-12.)

TABLE II-3
PERCENTAGE OF CONSUMERS WHO DRINK IN EXCESS OF 15 CL. OF ABSOLUTE ALCOHOL DAILY, FOR PER DRINKER CONSUMPTION ($\bar{c}$) RANGING FROM 4.0 TO 30.0 LITERS OF ABSOLUTE ALCOHOL YEARLY

Annual Per Drinker Consumption in Liters ($\bar{c}$)	15+ cl. Daily* (%)
4.0	0.91
5.0	1.14
6.0	1.38
7.0	1.64
8.0	1.91
9.0	2.19
10.0	2.49
11.0	2.81
12.0	3.14
13.0	3.50
14.0	3.88
15.0	4.27
16.0	4.68
17.0	5.11
18.0	5.56
19.0	6.04
20.0	6.53
21.0	7.05
22.0	7.59
23.0	8.15
24.0	8.73
25.0	9.34
26.0	9.97
Alaska: 26.5	10.30 (mean)
27.0	10.62
28.0	11.30
29.0	12.00
30.0	12.72

Adapted from: Jan de Lint, The Epidemiology of Alcoholism, Addiction Research Foundation manuscript, 1973.

*15 cl. of absolute alcohol equals approximately:

- (A) 12 oz. liquor @ 86 proof (12 standard mixed drinks); OR,
- (B) 36 oz. table wine @ 14% alcohol (9 standard glasses); OR,
- (C) 113 oz. beer @ 4.5% alcohol (9-1/2 12 oz. bottles).

³⁶ Due to the curvilinear relationship between mean levels of consumption ($\bar{c}$), direct interpolation is impossible. Thus, a mean has been taken, here, between a $\bar{c}$ of 26.0 and one of 27.0, to arrive at a reasonable estimate of the number of drinkers consuming in excess of 15 cl. of absolute alcohol daily, given Alaska's mean intake level ($\bar{c}$) of 26.47.

In sum, then, it can be said that application of the Ledermann estimation procedure to Alaska indicates that there were approximately 25,060 excessive drinkers in the state during 1975.

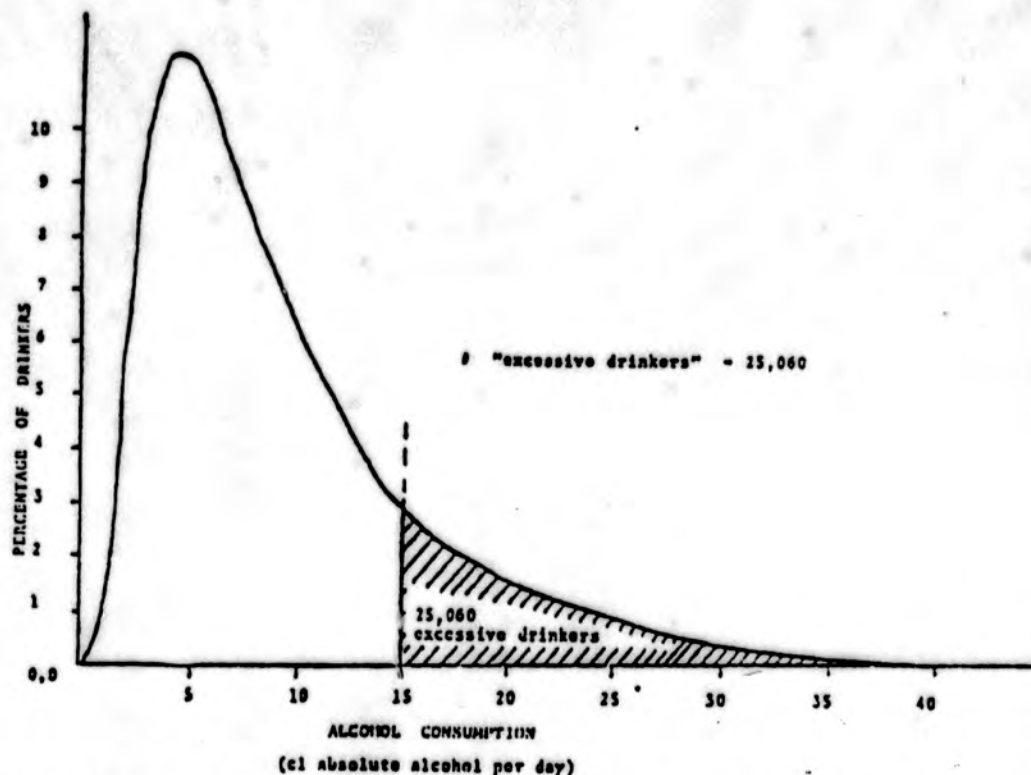


Figure 11-12 Prevalence of excessiver drinkers (15+ cl. daily) in Alaska during 1975 ($\bar{c}$ = 26.5 liters)

Limitations Of The Method

Perhaps the major limitation of the Ledermann (consumption) method is that it does not directly address the question of "alcoholics", "problem drinkers", etc. The method merely specifies the number of persons in a population likely to be consuming at, or beyond, certain levels of alcohol intake--persons, it has been noted, who may or may not in fact actually be alcoholics or problem drinkers. In short, the log normal distribution does not suggest a point at which alcohol use can be labeled

"abnormal" or "pathological".³⁷

A second major limitation of the method--and one very relevant to Alaska--is that it applies best to those societies whose consumer population is homogeneous. Cultural and religious differences within a population introduce heterogeneity, and empirical data analyses support the fact that the distribution of consumption in heterogeneous groups does not approximate the Ledermann (log normal) distribution.³⁸

Yet another limitation of the Ledermann method is rooted in the fact that correlation is not causality. By this is meant specifically that, while a high overall consumption level in a population might be responsible for an inordinate number of high-level consumers, both of those rates (overall consumption level, number of high-intake consumers) might themselves be due to yet a third, unknown factor.

4. OTHER MORTALITY METHODS

Background

Numerous studies have shown that the alcoholic lifestyle leads to a distinct mortality pattern, and that while deaths among alcoholics are attributable to a variety of causes, a few--viz., alcoholism, liver cirrhosis, and suicide--are either unique to the alcoholic lifestyle or at least occur disproportionately often. Given this fact, it is possible to use such death rates, to determine the estimated number of alcoholics in a given population.

To do this, it is necessary to first determine the death rates among alcoholics due to these specific causes. This is accomplished through investigation of death certificates, and judicious assignation of causes

³⁷ Jan de Lint and Wolfgang Schmidt, "The Distribution of Alcohol Consumption in Ontario", Quarterly Journal of Studies on Alcohol, (1974), p. 973.

³⁸ Miller and Agnew, op. cit., p. 886.

of death (necessary because "alcoholism" as a cause of death is ambiguously and variously used). The relevant primary data thus become the number of deaths in a population certified as due to these causes (alcoholism, liver cirrhosis, suicide), and the number reported in the population at large.³⁹

Description Of The Method

Taking first the problem of estimating prevalence from the mortality rate among alcoholics due to "alcoholism", it can be seen that:

$$A = \frac{D}{R}$$

where:

A = the number of alcoholics in a given population,

D = the total number of deaths in a population due to "alcoholism", and,

R = the alcoholism death rate among alcoholics (per 100,000 population).

Thus, knowing the total number of deaths in a population due specifically to "alcoholism", and the death rate due to alcoholism among alcoholics, will generate an estimate of the total number of alcoholics in a population at a given time.⁴⁰

In similar fashion, a modification of the Jellinek formula can be used to estimated prevalence from the known number of liver cirrhosis deaths in a given population. Given the Jellinek formula of

$$A = \frac{PD}{K} \times R$$

a single factor may be substituted for K and R, namely the rate of death

³⁹ Schmidt and de Lint, op. cit., p. 959.

⁴⁰ Ibid.

from liver cirrhosis among all alcoholics (R_c).⁴¹ If this is done, the modified formula may be stated as:

where:

A = the estimated number of alcoholics in a given population;

P_c = the per cent of liver cirrhosis deaths due to alcoholism;

D_c = the total number of cirrhosis deaths in a given population; and,

R_c = the rate of death from liver cirrhosis among alcoholics.

Using the (re-) formulation, the number of alcoholics within a population may be computed from the number of recorded liver cirrhosis deaths.

Yet a third method of estimating prevalence from known mortality statistics is to derive an estimate from the excess mortality rate due to suicides among the alcoholic population.⁴² The formula for doing so can be stated as:

$$A = \frac{D_s P_s}{R_s}$$

where:

A = the total number of alcoholics in a society;

D_s = the number of suicides in the general population;

P_s = the proportion of alcoholics among suicides; and

R_s = the rate of death from suicide among alcoholics.

Each of these three approaches--deaths due to alcoholism, to liver cirrhosis, and to suicide--can thus be used to estimate the number of alcoholics within a given population at a given time.

Application To Alaska

Using the method of prevalence estimation based on deaths due to

⁴¹ Ibid., p. 960.

⁴² Ibid., p. 962.

"alcoholism", it can be seen that:

$$A = \frac{D}{R}$$

where:

A = the number of alcoholics

D = the total number of deaths in a population due to "alcoholism"

R = alcoholism death rate per 100,000 population among alcoholics

Since there were 46 deaths due to alcoholism reported during 1975, and using an alcoholism death rate of 8.02 per 10,000 population,⁴³ the estimated number of alcoholics in Alaska during 1975 may be expressed as:

$$\begin{aligned} A &= \frac{46}{8.02} \times 10,000 \\ &= 57,357 \end{aligned}$$

Thus, using the number of known deaths in Alaska due to "alcoholism" during 1975, it can be estimated that there were approximately 57,357 alcoholics at that time in the state.

Using the known number of deaths in 1975 due to liver cirrhosis, prevalence in Alaska may be estimated according to the following formula:

$$A = \frac{P_c D_c}{R_c}$$

where:

P_c = 0.37 (in Ontario)

D_c = 49

R_c = 16.5 (in Ontario) (per 10,000 alcoholics)

⁴³Based on Ontario studies, this alcoholism death rate is not generally accepted as valid for other areas. Nonetheless, it is employed here to allow computation.

$$\begin{aligned} \text{Thus, } A &= \frac{(0.37) (49)}{(16.5/10,000)} \\ &= 10,988 \text{ alcoholics.} \end{aligned}$$

Therefore, the estimated number of alcoholics in Alaska, based on the number of known liver cirrhosis deaths, was 10,988 during 1975.

Using the suicide deaths method, yet a third such formulation of prevalence can be made:

$$A = \frac{D_S P_S}{R_S}$$

where:

$$D_S = 74$$

$$P_S = 0.25 \text{ (estimate for North America)}^{44}$$

$$R_S = 12.39 \text{ (in Ontario) (per 10,000 alcoholics)}$$

$$\begin{aligned} \text{Thus, } A &= \frac{(74) (0.25)}{(12.39/10,000)} \\ &= 14,931 \text{ alcoholics in 1975.} \end{aligned}$$

Therefore, using the suicide deaths method, the estimated number of alcoholics in Alaska during 1975 was approximately 14,931.

Limitations Of The Method(s)⁴⁵

The greatest limitation with respect to estimating prevalence from deaths due to "alcoholism" has to do with the known rate of death from alcoholism among alcoholics, which in the original study was computed solely for the Canadian province of Ontario. As the rate may show considerable variation over time and from one location to another, proper application of the method to Alaska should include a re-figuring of the

⁴⁴ Schmidt and de Lint, op. cit., p. 962.

⁴⁵ Ibid.

death rate (due to alcoholism) among a sample of Alaskan alcoholics.

With respect to using the re-formulation for liver cirrhosis deaths, major limitations derive from two similar considerations: first, the value for R_a (rate of death from liver cirrhosis among alcoholics) in the original study was determined only for Ontario, and may be different for Alaska; and second, the value for P_c (percent of liver cirrhosis deaths due to alcoholism) needs to be determined for Alaska through investigation of the drinking histories of a representative sample of persons who have died from liver cirrhosis.

Similarly, in estimating prevalence from suicides, a certain inaccuracy results from using the Ontario-based value for R_s (rate of death from suicide among alcoholics), as the rate is undoubtedly different for Alaska.

5. OTHER METHODS

The prevalence of alcoholism in Alaska may also be estimated by comparing Alaska's population with that of the nation as a whole, and taking a proportion of the known number of "alcoholics and alcohol abusers" nationwide, which has been estimated as approximately 9.5 million.⁴⁶ Given a 1975 national population of approximately 212.8 million,⁴⁷ then, and a 1975 Alaska population of approximately 404,600,⁴⁸ the following proportion may be established:

$$\frac{X}{404,600} = \frac{9.5 \text{ million alcoholics and alcohol abusers (in 1975)}}{212.8 \text{ million U.S. population in 1975}}$$

(Alaska Population 1975)

$$X = 18,062 \text{ alcoholics}$$

⁴⁶ Report On Alcohol, Summer 1976, p. 41.

⁴⁷ Alaska Department of Labor.

⁴⁸ Ibid.

thus, on the basis of population, Alaska would be expected to have approximately 18,062 alcoholics and alcohol abusers among its 1975 population.

Another method for crudely estimating prevalence is based on Keller (1975), who estimated that approximately 5.2% of the drinkers in a population have problems related to their drinking.⁴⁹ In 1975, the Alaska drinking-age population (18+) included approximately 243,416 persons, of whom some 158,220 (65%, based on national figures)⁵⁰ may be considered as actual drinkers. If 5.2% of these can be considered to have had "problems related to their drinking", this would indicate a total of approximately 8,227 people.

Yet a third relatively crude method for estimating prevalence is referred to as the Alcohol Problems Index (API), and is based on the ratio of a state's total consumption of alcohol (in absolute alcohol) to that of the nation as a whole.⁵¹ The method further assumes an estimated 9.5 million alcoholics and alcohol abusers, nationwide. Thus, the following proportion may be established:

$$\frac{X}{9.5 \text{ million alcoholics and alcohol abusers in 1975}} = \frac{\text{Alaska total consumption during 1975}}{\text{U.S. total consumption during 1975}}$$

Therefore:

$$X = \frac{852,610 \text{ (gallons)}}{414,324,400 \text{ (gallons)}} \times 9.5 \text{ million}$$

$$= 19,551 \text{ alcoholics and alcohol abusers in Alaska during 1975.}$$

⁴⁹ Nebraska Alcoholism Services System Plan, p. 12.

⁵⁰ Ibid.

⁵¹ Report On Alcohol, p. 40.

C. COMPARISON OF ESTIMATES

In the preceding sections of this report, a variety of methods have been employed to estimate the number of alcoholics and problem drinkers in Alaska. As these procedures employed different data bases for their determinations, and often different definitions of the population being measured, some discussion was introduced along the way concerning their respective strengths and limitations. The fact is clear, however, that even apart from their intrinsic merits or demerits, the methods display varying degrees of suitability for a state such as Alaska. In the present section, therefore, an attempt is made to discuss and evaluate the methods (and their respective estimates of prevalence in Alaska) from two related points of view: (1) the factors known to influence alcoholism prevalence anywhere, and (2) the particular eccentricities of Alaska itself.

Factors Affecting Alcoholism Prevalence

The number of alcoholics, problem drinkers, alcohol abusers, etc., in any society or population depends on a number of important factors. Generally, these factors fall into one of two large classes: cultural or societal factors which exert a categorical influence on the overall population, and those factors which pertain more to particular groups or sub-populations within the overall populace.

Among the societal or cultural class of factors affecting alcohol prevalence, perhaps the most important is the overall level of alcohol

consumption in a population. It has been argued that regardless of the arbitrary definition of alcoholism chosen, the level of prevalence in a society is invariably fixed by that society's overall level of consumption;⁵² viz., that as the mean annual consumption of alcohol increases in a population, the number of alcoholics increases disproportionately.

Two other important societal factors affecting prevalence, both related to consumption, are the general accessibility of alcoholic beverages in a society and their relative cost.⁵³ Accessibility refers to the number and type of drinking establishments in a society, as well as the hours of operation. It also refers to the number and type of liquor outlets, and a society's home drinking preferences.

In a similar fashion, the overall level of consumption of alcohol in a society has a great deal to do with its relative cost. Figure II-13, which depicts the relationship of price (expressed as a fraction of average disposable income) to consumption for the Canadian province of Ontario, shows this relationship graphically.⁵⁴

As can be seen, consumption tends to rise steadily in a society when the relative cost of beverage alcohol declines; however, it may not be the case that general consumption (and therefore prevalence) would decline were prices relative to disposable income to increase.⁵⁵ Nevertheless, the fact remains that the relative cost of beverage alcohol in

⁵² Jan de Lint and Wolfgang Schmidt, "Consumption Averages and Alcoholism Prevalence", British Journal of Addictions, 66 (1971).

⁵³ Jan de Lint and Wolfgang Schmidt, "Alcohol Use and Alcoholism", Addictions, 18(2), 1971, pp. 4-8.

⁵⁴ Ibid., p. 7.

⁵⁵ Ibid., p. 6.

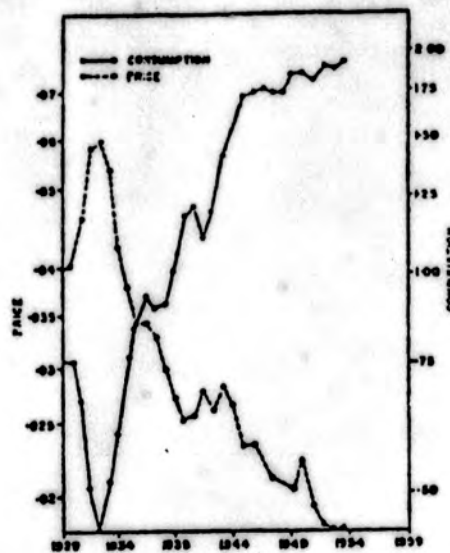


FIGURE IX-13 Alcohol Price (P) and Consumption (C), Ontario, 1929-1953.*

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

Source: Jan de Lint and Wolfgang Schmidt, "Consumption Averages and Alcoholism Prevalence: A Brief Review of Epidemiological Investigations," British Journal of Addiction, 66 (1971), p. 101.

a society, like the general accessibility of alcoholic beverages, is significantly related to the overall consumption level and thus to a society's probable rate of alcoholism prevalence. In a situation such as exists in Alaska, where the liquor excise tax has not been increased since 1961 (and only once since statehood), the relative cost of alcohol is undoubtedly related to the high rate of consumption.

Yet another categorical factor affecting alcohol prevalence has to do with a society's general level of tolerance for drinking in conjunction with the relative degree of inner stress precipitated in people by

the environment.⁵⁶ This theory argues that in environments (such as Alaska) which produce a great deal of stress and tension among the populace and simultaneously tolerate "utilitarian drinking" (e.g., drinking to unwind) as a way of coping with such stress, high rates of alcoholism will occur. Though difficult to measure, such a factor, if true, could clearly have relevance to a state such as Alaska, where environmental conditions are generally regarded as stressful.

Beyond such societal factors affecting alcohol prevalence, there are also several noteworthy factors which have more to do with sub-populational or group drinking habits of a society. One of these, largely discredited, is the notion that prevalence will probably be greater in societies where drinkers' preferences are for distilled spirits rather than beer or wine. Cross-cultural studies do not generally support this conception, however, and indicate that while the general level of intoxication may decrease if drinkers' preferences are shifted to beer or wine, the level of actual alcoholism prevalence does not necessarily follow.⁵⁷

Another important factor affecting alcoholism prevalence has to do with group drinking practices, as in the case of various ethnic sub-populations.⁵⁸ For example, the low prevalence of alcoholism among North American Jews has been attributed to their strong disapproval of drunkenness and their use of alcoholic beverages in religious observances. Similarly, the "utilitarian" drinking practices of the Irish have been associated with the avoidance of stressful situations, and their high rate of prevalence explained along these lines. While such correlations do not hold across all situations, the influence of group drinking prac-

⁵⁶ de Lint and Schmidt, "Consumption Averages" *op. cit.*, p. 104.

⁵⁷ de Lint and Schmidt, "Alcohol Use and Alcoholism", p. 9.

⁵⁸ *Ibid.*, p. 8.

tices on overall alcoholism prevalence remains important. With respect to Alaska, unfortunately, no research has been conducted to date on the effects of ethnic or other subpopulational drinking patterns on alcoholism prevalence.

Other factors affecting prevalence among groups of subpopulations of a society include areas of residence, occupation, sex and age.⁵⁹ For example, rates of prevalence (in the United States) tend to be higher in urban areas than in rural ones (though not always), and among certain occupations such as waiters, bartenders, and cooks. Also, prevalence rates tend to be much higher among men than women, and--if "alcoholism" is being measured--among the middle-aged. (Being a progressive illness, however, alcoholism would obviously not show up in a person or particular group of persons until many years of abusive drinking had passed.) If, on the other hand, it were the prevalence of "abusive drinking" that were being measured, instead of "alcoholism", clearly a younger age group would become judged as "at risk".

Comparing The Estimates

Given the role played by such factors (as mentioned) in the prevalence of alcoholism or problem drinking in a society, it becomes possible to talk of "resolving" the various prevalence estimates which have been arrived at. Table II-4, shows the estimates of prevalence in Alaska produced by each of the methods used.

Taking each of the estimates in turn, the following remarks can be made:

The Jellinek method, while consistently one of the most reliable prevalence estimation procedures used, evidences several major limitations which tend to underestimate alcoholism prevalence in a populace such as Alaska's. These have been shown to be an untoward sensitivity with

⁵⁹ de Lint and Schmidt, "The Epidemiology of Alcoholism", pp. 10-14.

TABLE II-4
ESTIMATES OF ALCOHOLISM PREVALENCE IN ALASKA DURING 1975,
AS CALCULATED BY VARIOUS PROCEDURES

Estimation Procedures	Alcoholics	Excessive or Problem Drinkers
Jellinek Method	15,949	*
Marden Method	*	31,709
Ledermann Method	*	25,060
Other Mortality Methods		
Alcoholism Deaths	57,357	*
Cirrhosis Deaths	10,988	*
Suicide Deaths	14,931	*
Other Methods		
Population	18,062	*
Keller Method	8,227	*
Alcohol Problems Index	19,551	*

* = N/A for the method

respect to yearly fluctuations in liver cirrhosis rates--a variance particularly pronounced in populations of under 300,000, as in Alaska--a pronounced insensitivity to rapid growth and regional variations in an area, and a quite possibly misleading reliance on (unrepresentative) clinic samples for its estimate of liver complication rates. In addition, and perhaps most relevant from the point of view of Alaska, the Jellinek method tends to "homogenize" a population, failing to reflect the fact that persons from different ethnic, cultural, and geographic-social backgrounds may have different probabilities of becoming alcoholics or problem drinkers. Thus, the prevalence estimate for Alaska produced by the Jellinek method (15,949 alcoholics) is, if anything, probably low.

The Marden method, on the other hand, seems to possess advantages which may outweigh its several disadvantages (with respect to Alaska). Regarding its disadvantages, the method relies on outdated risk probabilities for its sub-population categories, systematically underenumerates racial and ethnic minorities within a population (though this is due primarily to reporting difficulties, and is not really a limitation of the instrument itself), produces no estimate of the number of problem drinkers under age twenty, underestimates alcoholism prevalence among the unemployed, and is insensitive to the kind of population shifts in areas (such as Alaska) characterized by rapid growth. In spite of these disadvantages, however, the Marden method possesses the unique advantages of being able to isolate and identify the number of problem drinkers within a variety of sub-population categories, and to identify high-risk groups. Given the need for more specific information than simply an alcoholic "body count", such sub-population determinations become extremely valuable from an alcoholism treatment and prevention perspective. As such, the Marden estimate of 31,709 problem drinkers--while probably itself still an underestimation (due to the systematic underenumerations mentioned)--probably stands as the most detailed and accurate prevalence estimate currently available for Alaska.

The Ledermann method, based on consumption frequencies within the overall population, suffers primarily from a definitional problem: i.e., it does not specify the number of "alcoholics" or "problem drinkers" (et al.) within a populace, but simply the number of people known to consume at or beyond particular levels of alcohol intake. While estimates of prevalence based on the method therefore remain only approximations, however, recent research (see Part IV) provides evidence that level of apparent consumption may be a reliable indicator of excess

drinking and associated health problems. Other shortcomings of the method include the fact that it applies best to culturally homogeneous populations (unlike Alaska's), and that it skirts the question of causality: viz., whether high levels of consumption in a society may cause high rates of problem drinking, or vice versa, or whether both phenomena may be due to yet other, external causes. On the whole, however, the method is quick and relatively easy to apply, and depends on data which are readily available. In addition to its obvious utility, the method also shows good correspondence between its estimate of prevalence in Alaska (25,060 "excessive drinkers") and that of the Marden method (31,709 "problem drinkers").

The three estimation procedures collected under the heading of "Other Mortality Methods"--based on deaths in a population due, respectively, to alcoholism, liver cirrhosis, and suicide--are each reasonably reliable methods of prevalence estimation. Because death rates valid only for Ontario had to be used for each of the methods, however, considerable distortion and variance in estimates has resulted. Thus, the respective estimates of 57,357 alcoholics, 10,988 alcoholics, and 14,931 alcoholics in Alaska during 1975 should probably be disregarded.

Finally, the three prevalence estimation procedures collected under the heading of "Other Methods" also share a common bias: their dependence on the assumption (incorrect) that Alaska has its fair share--and only its fair share--of the nation's alcoholics and problem drinkers (i.e., a number in proportion to its overall population). Such estimates, based as they are on such gross criteria as overall population, standardized percentages, and overall consumption gallonage, are so crude as to be useful only in the absence of all other prevalence estimation procedures.

What is left after all this, can best be described as an unavoidable reliance on the three major prevalence estimation procedures: the Jellinek method, the Marden method, and the Ledermann (consumption) method. Given their respective limitations noted above, particularly their insensitivities to conditions peculiarly Alaskan, none of them can independently be regarded as reliable for Alaska. If they are viewed in combination, however, a more favorable picture begins to emerge.

Most importantly, there is very good correspondence among the prevalence estimates produced by these three methods. The Jellinek estimate of 15,949 alcoholics (or, therefore, 31,898 problem drinkers) in the state matches well with the Marden estimate of 31,709 problem drinkers, as well as with the Ledermann estimate of 25,060 problem drinkers. Given the fact that each method depends on a different data base from the other two, and thus purports to be tapping different indicators of alcoholism or alcohol abuse, the correspondence of their final estimates indicates that the figure of about 30,000 problem drinkers in Alaska in 1975 is justifiable if very likely low. (Such factors as Alaska's extremely rapid rate of growth, high unemployment rate, racial and cultural heterogeneity, large youth population, etc.--factors to which all three methods are variously insensitive--virtually insure that this is the case.) Until more can be learned about actual rates and patterns of alcohol use and abuse in Alaska, thus ending reliance on transplanted methods and practices such as these, this estimate is the best available.

In closing, it can be said that the Jellinek, Marden, and Ledermann methods can each have important roles as program planning and development tools. While it is beyond the purview of this study to investigate such possibilities, it is clear that such things as the identification of risk populations within the various occupational and social strata of Alaska's

populace as afforded by the Marden method, and the monitoring and projective capabilities of the Ledermann (consumption) method, can have important applications in planning for the prevention and treatment of alcohol abuse and alcoholism. To make these applications relevant, however, much more must be learned about the particular indicators on which these estimation procedures (as well as other conceptual vehicles) depend--particularly about the way those indicators behave in the Alaskan setting. In the following parts of this volume, therefore, attention is focused on precisely these and other indicators. A further discussion of the estimated distribution of problem drinkers according to occupation, age, and sex, is, however, provided in Part IX.

BIBLIOGRAPHY

- Alaska Center For Research, Planning and Evaluation. "Allocation of Adult Alcoholics in Alaska by Geographic, Sex, and Racial Indices." (July 1973). Prepared for the Alaska State Office of Alcoholism.
- Argeriou, Milton. "The Jellinek Estimation Formula Revisted." Quarterly Journal of Studies on Alcohol, 35 (1974), pp. 1053-1057.
- de Lint, Jan. "Current Trends in the Prevalence of Excessive Alcohol Use and Alcohol-Related Health Damage." British Journal of Addictions, 70 (1975), pp. 3-13.
- de Lint, Jan. "The Epidemiology of Alcoholism: The Elusive Nature of the Problem, Estimating the Prevalence of Excessive Alcohol Use and Alcohol-Related Mortality, Current Trends and the Issue of Prevention." Addiction Research Foundation manuscript, (1973).
- de Lint, Jan, and Schmidt, Wolfgang. "Alcohol Use and Alcoholism." Addictions, 18(2) (1971), pp. 97-107.
- de Lint, Jan, and Schmidt, Wolfgang. "Consumption Averages and Alcoholism Prevalence: A Brief Review of Epidemiological Investigations." British Journal of Addictions, 66 (1971), pp. 97-107.
- de Lint, Jan and Schmidt, Wolfgang. "The Distribution of Alcohol Consumption in Ontario." Quarterly Journal of Studies on Alcohol, (1974), pp. 968-973.
- de Lint, Jan, and Schmidt, Wolfgang. "The Epidemiology of Alcoholism." Addiction Research Foundation manuscript, (Project 92), (1970).
- Hammond, Robert L. Report On Alcohol. American Business Men's Research Foundation, (Summer 1976), pp. 35-48.
- Keller, Mark, consulting ed. Alcohol and Health. Report to the U.S. Congress, December, 1971. Washington, D.C.: Government Printing Office, 1971.
- Keller, Mark. "Problems of Epidemiology in Alcohol Problems." Quarterly Journal of Studies on Alcohol, 36 (1975), pp. 1442-1451.
- Marden, Parker G. "A Procedure for Estimating the Potential Clientele of Alcoholism Service Programs." Prepared for the Division of Special Treatment and Rehabilitation Programs, National Institute on Alcohol Abuse and Alcoholism, (19).
- Miller, Gary H., and Agnew, Neil. "The Ledermann Model of Alcohol Consumption: Description, Implications, and Assessment." Quarterly Journal of Studies on Alcohol, 35 (1974), pp. 877-898.

Nebraska, State Division on Alcoholism. Nebraska Alcoholism Services System Plan. (19).

Popham, Robert E. "Indirect Methods of Alcoholism Prevalence Estimation: A Critical Evaluation." Alcohol and Alcoholism. Edited by R.E. Popham. Addiction Research Foundation.

Schmidt, Wolfgang and de Lint, Jan. "Estimating the Prevalence of Alcoholism from Alcohol Consumption and Mortality Data." Quarterly Journal of Studies on Alcohol, 31 (1970), pp. 957-964.

PART III. MAJOR THEORIES REGARDING THE ETIOLOGY OF ALCOHOLISM*

No discussion of alcoholism, its prevalence, or its various indicators, would be complete which did not raise the question of its etiology, or causality. While it is not intended here to present a full-scale analysis of the issues and considerations surrounding the question of what causes alcoholism, a brief overview of the major extant theories is considered indispensable. Certainly with respect to considerations about alcohol-related legislation, and with respect to the ultimate concern of alcohol treatment and prevention programs, an overview of the theories about the factors producing or resulting in alcoholism is essential.

Because the addiction syndrome of alcoholism takes so long to become established in a person, its developmental antecedents are particularly obscure and difficult to isolate. From a biological point of view, causality is difficult to establish simply because of the sheer multiplicity of symptoms; specifically, no one theory suffices for all the known manifestations and/or syndromes of alcoholism, alcohol dependence, alcohol addiction, etc. Similarly, it has proven difficult to identify behavioral factors which may contribute to the etiology of alcoholism in a person. Attempts by researchers to date to develop a suitable animal behavioral model for studying alcohol dependence and its development have done little to either corroborate or contradict extant theory, and in general may be described as inconclusive. This com-

*Adapted from Alcohol and Health, December 1971, Chapter V, "Theories About the Causes of Alcoholism," pp. 61-70.

bination of difficulties, then, prevents any real certainty with respect to the question of the etiology of alcohol-related dependencies. The crucial determinants in the developmental process are still unknown, and the very nature of the addictive process remains largely a matter of conjecture.

A number of theories do exist, however, which attempt to explain the origin and genesis of alcohol dependency in the individual. Generally falling into three classes--physiological, psychological, and sociological theories--they are synopsized below.

A. PHYSIOLOGICAL THEORIES

Physiological theories concerning the causes of alcoholism attempt to explain chronic alcohol intake in terms of physiological and biological mechanisms. Being disease theories which are founded to a lesser or greater extent on experimental research and life studies, they focus on the physiological functions and processes surrounding phenomena such as addiction, habituation, tolerance, dependence, loss of control, craving, and "appetite" for alcohol. Chief among such theories are the genetotrophic theory, the genetic theory, and the endocrine theory, explained below.

Genetotrophic Theory

The genetotrophic theory of alcoholism postulates that some persons, due to an inherited defect or "error" of metabolism, require unusual amounts of certain essential vitamins. Since their normal diet does not supply these vitamins in the quantities needed, such persons have a genetically-caused and chronic nutritional deficiency. If exposed to alcohol, they develop an abnormal craving for the substance--the consequence of which is alcoholism. Dietary experimentation with animals has proven inconclusive, however, and longitudinal studies attempting to breed high- and low- consuming strains of

rat suggest that alcohol preference is not inherited in a simple genetic fashion. Other animal studies, nonetheless, suggest that drinkers and non-drinkers may inherit different enzymatic systems--which, if true, would provide a biological basis for the disease concept of alcoholism.

Genetic Theory

Because alcoholism appears to run in families, it has been suggested that alcoholics may have inherited a physical or genetic susceptibility to be influenced adversely by ingested alcohol. The idea of a genetically-transmitted alcoholic "constitution" has not been very well supported by experimental data, however, and attempts to link alcohol preference to other inherited characteristics (color-blindness, blood type, etc.) have proven uninformative. In such studies, environmental and cultural influences, in particular, seem to have had at least as much influence on behavior such as beverage preference and level of consumption as any inherited characteristics. Thus, while the possibility of an inherited predisposition for--or immunity to--alcoholism has not been ruled out, it does seem likely that, at the least, the onset and development of alcoholism and other alcohol-related dependencies is not solely under biological control.

Endocrine Theory

Another major physiological theory of alcoholism causality is the endocrine theory, based on the observed similarities between alcoholics and persons with known endocrine disorders. This theory postulates that some failure or dysfunction of the endocrine system might be responsible for the onset of alcoholism in a person. While research studies do indicate a relationship (inverse) between thyroid activity and alcohol consumption level, however, most other endocrine activity (or the lack of it)--e.g., in the pituitary gland, adrenal cortex, etc.--appears to have little relationship to any development of alcoholism. In fact, if there is a case to be made for

the association of alcoholism and endocrine dysfunction, most of the available clinical and experimental information suggests that the endocrine characteristics associated with alcoholism may actually be the result of heavy drinking, rather than its cause.

B. PSYCHOLOGICAL THEORIES

Psychological theories regarding the etiology or causation of alcoholism categorically assume that it is a symptom of underlying personality or emotional disorder in a person. Not attempting to delineate whether such disorder is inherited or learned, these theories focus on the psychodynamic role which drives and self-conceptions play in the alcoholic person's relationship with drinking. Generally, these theories stand without benefit of experimental support, as the data themselves--drives, needs, character traits, etc.--permit only a degree of measurement. They have proven suggestive, however, as well as very useful for diagnostic and therapeutic purposes. The three principal psychological theories, outlined below, are based on psychoanalytic theory, learning and reinforcement theory, and personality trait theory.

Psychoanalytic Theory

Attempts to explain the etiology of alcoholism from the point of view of psychoanalytic theory have generally focused on the alcoholic's alleged powerlessness and tendencies towards self-destruction. The three major theoretical positions adopted in such attempts have been: (a) the Freudian view that alcoholism derives from defects in the parent-child relationship, leading to unconscious tendencies towards self-destruction, oral fixation, and/or latent homosexuality; (b) the Adlerian view that alcoholism represents a struggle for power, a compensating for feelings of inferiority first established in childhood due to overindulgent parents; and

(c) the more recent view that alcoholism develops originally as a means of coping with frustrated ambitions or desires, but (because it only further precludes attainment of such goals) becomes all the more necessary to the alcoholic for its compensatory, if false, sense of power and achievement. Application of these kinds of psychoanalytic approaches has proven quite helpful in clinical settings; scientific evidence to support such views, however, has been necessarily inconclusive, due to the difficulties involved in testing and measuring psychodynamic events.

Learning Theory

According to the precepts of learning and reinforcement theory, the etiology of alcoholism lies in the fact that ingestion of alcohol becomes a successful reflex response in coping with unpleasant or anxiety-producing situations. In particular, alcohol is said to reduce fear in approach-avoidance life situations, thereby lowering the alcoholic's level of anxiety concerning (originally) unpleasant situations and (at a later stage) the unpleasant consequences of chronic alcoholism. In fact, guilt feelings induced by the consequences of prolonged, excessive drinking may themselves become the stimulus and motivation for further drinking as a means of escape. Experiments using punishment and aversive conditioning have generally supported the stimulus/response relationship of anxiety and alcohol ingestion, and have also strongly supported the view that such reflexive behavior can be learned.

Personality Trait Theory

Attempts to identify the so-called "alcoholic personality" are generally conceded to have failed. While it would obviously be very valuable to know the constellation of personality characteristics peculiar to persons in a pre-alcoholic stage, attempts to isolate such characteristics (and their

configuration) have not resulted in identification of a common set. Major personality traits and tendencies so far identified in clinical experiments include low tolerance, sociability, feelings of inferiority (often in combination with attitudes of superiority, fearfulness, and dependency), intense dependence-independence conflicts, unresolved love-hate ambivalences, et al. Presumably, a personality configuration involving traits and tendencies such as these would be predisposed towards resorting to alcohol as a means of coping with the world's stresses. What experiments have not been able to determine, however, is whether these admittedly recurring personality characteristics are, instead of causes of excessive drinking, actually consequences of it.

C. SOCIOLOGICAL THEORIES

The sociological theories regarding the causes of alcoholism generally represent a shift in attention from the pathologies of the individual to the cultural and national values of a society or populace. Essentially, such theories hold that alcohol consumption (and therefore alcoholism) is directly related to the values and attitudes which a society holds regarding drinking. Thus, on the one hand, it is possible to view the near-universal use of alcohol as a symptom of its adjudged value in nearly all societies as an anxiety-reducer; and, on the other, it is possible to view alcoholism as a form of cultural deviance. Both--the cultural theory of alcoholism and the deviant behavior theory--have great relevance for the development of a generalized sociocultural explanation of alcoholism; as such, they are synopsized below.

Cultural Theory

The almost universal appearance of drinking in various societies suggests strongly that its acceptance is due in large part to the utilitarian function

it performs in the reduction of socially-caused anxieties. That function, however, is said to be mediated by several important factors--notably, the degree to which a culture or society operates to cause inner tensions or needs for adjustment in its members (certain societies producing more anxiety than others among their members), the overall attitudes toward drinking which a culture fosters and maintains (e.g., abstinence, ritual drinking, convivial drinking, utilitarian drinking, etc.), and the degree to which a culture or society provides other means of satisfaction than recourse to alcohol (e.g., other drugs, culturally acceptable ceremonies and rituals, etc.). Thus, according to cultural theories regarding the causes of alcoholism, the tension-relieving capacity of alcohol is utilized differently by various societies depending on the different drinking attitudes in effect, the respective pressures generated by the culture, and the presence or absence of any substitute methods for relieving societally-induced tensions.

Deviant Behavior Theory

In contrast to how--or whether--a society condones the consumption of alcohol by its members, the manner in which it may define consumption as undesirable behavior is also of relevance to questions of causality. The way a society chooses to define for itself what alcohol consumption, intoxication, and drunken behavior shall mean, establishes a code of conduct over and against which the inebriate or alcohol abuser comes to view himself. Theories of causality which adopt this frame of reference, therefore, portray the alcoholic as some one who, by his actions, becomes deviant, and who, by society's response (public labeling of him as a deviant), is further reinforced (and imprisoned) in that deviance. Factors contributing to such deviance, it is stressed, include strains between socially established goals

and objectives and publicly available means of attaining them, and the competition by subcultures in a populace whereby an action judged acceptable by one is considered deviant within the context of another. Through-
out, the process whereby the society or culture at large validates the alcoholic's behavior (i.e., labels it as deviant) is seen by theorists as being equal in importance to the initial activity of alcoholism.

PART IV. CONSUMPTION OF BEVERAGE ALCOHOL: TRENDS,
COMPARISONS AND IMPLICATIONS FOR ALASKA

A. INTRODUCTION

The relationship between consumption of beverage alcohol and alcoholism and alcohol abuse has long been the serious focus of scientific research. The main body of research attention comes from epidemiologists whose major concern is the mass aspect of diseases and behavioral disorders. Applied to alcoholism and alcohol abuse, one epidemiological approach involves the establishment and comparison of rates of occurrence of alcoholism in different population groups, over specified time periods. Another approach is the study of afflicted populations, which involves the collection of information about habits and conditions of life preceding the affliction. Still another approach is to investigate groups of peoples exposed to conditions suspected of producing the disorder.

The major variables associated with beverage alcohol consumption from each of the above approaches will be discussed in this section. Section B compares the characteristics of apparent alcohol consumption in the state of Alaska with other state, national, and international consumption trends and characteristics.

Section C is an analysis and discussion of Alaskan consumption patterns in relation to the major consumption theory and its implications. According to this theory, the level of average annual consumption of any population group is directly related to the prevalence of alcoholism

within that population.

Section D discusses various factors which are associated with increases in the rates of consumption in a population group, with emphasis on government control measures.

Section E is a summary of the findings in this Part.

Definitions

For purposes of clarity, it is necessary to define various terms as they are used in the context of this section:

1. "Consumption": The intake of beverage alcohol in the form of beer, wine, or distilled spirits. Excessive consumption, problem drinking, heavy consumption, etc., have various definitions.
2. "Absolute Alcohol": Ethyl Alcohol (C_2H_5OH), the intoxicating agent in alcoholic beverages, varies in percentage content by type of beverage. Conversion of different types of alcoholic beverages into absolute alcohol allows comparisons involving combinations of beverage types by considering only the total volume of absolute alcohol. The conventional conversion factors are given below:

Distilled Spirits: 43% absolute alcohol (based on an average of 86 proof liquor)

Beer: 4.5% absolute alcohol

Wine: 14% absolute alcohol

3. "Apparent Consumption": An estimate of consumption of beverage alcohol reported in terms of annual per capita consumption for a specifically designated population. Apparent consumption may be reported in units of volume by beverage type (beer, wine, liquor) or by volume of absolute alcohol, and for a total population (e.g., all persons in a state) or for just the drinking age population (typically 15 years and older).

Measures of volume of beverage alcohol may vary according to basic data source. International estimates tend to be made from reported annual sales volume.* National consumption averages are estimated from

*To arrive at an estimate of per drinker consumption, the annual sales volume of beverage alcohol is converted into units of absolute alcohol, to which estimates of illicitly produced beverage alcohol are added. This sum is then divided by the estimated number of users of beverage alcohol in a population. The overall consumption level is usually expressed as the annual alcohol consumption per drinker.

tax paid quantities entering consumer outlets.* For purposes of this report, Alaska estimates are based on taxable wholesale gallonage shipped into the state (through calendar year 1975, no appreciable quantity of beverage alcohol was manufactured in Alaska), based on excise tax payments maintained by the Alaska Department of Revenue.

The drinking age population from which estimates are made may also differ somewhat. The drinking age population is typically defined as 15 years and older. For this study, Alaska estimates of apparent consumption are based on a drinking age population of 18 years and older, due to the nature of available data.

B. COMPARISON OF THE CHARACTERISTICS OF APPARENT CONSUMPTION

Total Consumption of Beverage Alcohol

Available data on the consumption of beverage alcohol indicate a persistent trend of increasingly greater per capita consumption throughout the world.

Table IV-1, below, illustrates this trend by showing the apparent consumption of absolute alcohol for 26 industrialized countries for the years of 1960 and 1973, and the percentage change over time. The appropriate consumption rates for Alaska were computed and included in the international comparisons.

Of these countries, only one (France)** reported a decline in alcohol consumption. All others indicated increased consumption over the 13-year period. Although by international standards, the level of

*Temporary stocking up or inventory overloads may thus distort the apparent national consumption in any one year.

**France leads the world in per capita consumption of alcohol.

consumption for the U.S. does not appear very high during the indicated years,* a 36% increase in consumption was reported. The significant factor to be considered is that the U.S. showed an increase in the use of beverage alcohol similar to the international trend.

TABLE IV-1
ANNUAL ALCOHOL CONSUMPTION IN LITERS OF ABSOLUTE ALCOHOL PER
CAPITA 15 YEARS AND OLDER IN A NUMBER OF COUNTRIES
1960, 1973

Country	1960	1973	Change (%)
France	27.3	24.1	- 12
Italy	19.1	21.1	+ 10
Spain	11.9	18.5	+ 55
Luxembourg	13.8	18.5	+ 34
W. Germany	10.2	16.8	+ 65
Portugal	15.3	17.9	+ 17
Alaska	11.0	15.6	+ 42
C.S.S.R.	10.4	14.7	+ 41
Switzerland	12.5	19.3	+ 54
Austria	10.9	16.0	+ 47
Belgium	11.7	14.5	+ 24
Hungary	9.2	13.2	+ 43
Australia	9.5	12.2	+ 28
New Zealand	9.3	11.7	+ 26
E. Germany	7.8	12.3	+ 58
Yugoslavia	8.0	10.5	+ 31
U.S.A.	7.8	10.6	+ 36
Denmark	6.1	11.0	+ 80
Canada	7.8	11.1	+ 42
Great Britain	6.8	10.0	+ 47
Sweden	5.9	8.0	+ 36
Netherlands	3.8	10.1	+166
Poland	6.2	9.2	+ 48
Rep. of Ireland	4.9	9.0	+ 84
Finland	3.9	7.8	+100
Norway	3.6	5.4	+ 50

Source: Jan de Lint, Alcohol Consumption and Alcohol Problems from an Epidemiological Perspective, (unpublished manuscript, Addiction Research Foundation, Toronto, Canada, 1976), Table III.

The steady upward progression in beverage alcohol consumption seems to be a relatively recent phenomenon in the United States. Table IV-2 shows the apparent consumption of absolute alcohol in the U.S. from 1850 through 1975, and in Alaska from 1958-1975.

Between 1850 and 1945, American drinkers consumed a yearly average of slightly under two gallons of absolute alcohol per drinker. By 1945, average consumption increased to more than two gallons per drinker, remaining stable for about the next fifteen years, until 1960. Beginning

*U.S. ranked 15th (1960) and 16th (1973).

in 1960, however, apparent consumption in the U.S. increased very rapidly,* and by 1975 American drinkers were consuming approximately 40% more alcohol than they had been fifteen years earlier.

TABLE IV-2

APPARENT CONSUMPTION OF BEVERAGE ALCOHOL IN U.S. GALLONS
OF ABSOLUTE ALCOHOL PER CAPITA IN THE DRINKING AGE
POPULATION, U.S. (1850-1975)^a AND ALASKA
(1958-1975).

Year	U.S.	Alaska
1850	2.10	
1871-1880	1.72	
1891-1900	2.15	
1901-1910	2.50	
1916-1919	1.96	
1935	1.20	
1940	1.56	
1946	2.28	
1950	2.04	
1955	2.00	
1958	1.98	2.52 ^b
1959	2.06	2.70 ^c
1960	2.07	2.91
1961	2.06	2.88
1962	2.11	2.87
1963	2.15	2.91
1964	2.23	3.08
1965	2.27	3.25
1966	2.32	3.28
1967	2.37	3.58
1968	2.45	3.64
1969	2.51	4.04
1970	2.61	3.95
1971	2.61	4.34
1972	2.63	4.03
1973	2.80	4.13
1974		4.40
1975	2.90	4.54

^aExclusive of prohibition era for which accurate data are not available.

^b6/57-7/58

^c6/58-7/59

Sources: Alaska apparent consumption--computed from Department of Revenue monthly "Report of Alcohol Beverages Distributed and Sold in Alaska".
U.S. apparent consumption--multiple sources.

Dramatic as such a national increase was, the increase in apparent consumption within the state of Alaska was even more dramatic. In comparison to both international and national standards, Alaska

*Keller, Mark, ed., Alcohol and Health (Washington, D.C.: Gov't Printing Office, 1974), p. 19. An alternate explanation is that the rise in apparent consumption may not be due solely to a real increase in the average amount consumed per drinker but that a part of the total may reflect a higher proportion of actual drinkers within the drinking age population, especially women and youth.

ranks quite high in overall apparent consumption of absolute alcohol, as well as in its rate of increased use of beverage alcohol. During the years 1960 to 1973, for example, Alaska ranked within the upper third of 25 reporting countries, with respect to overall annual per capita consumption of alcohol (see Table IV-1).

When compared to national consumption figures, the recent increases in Alaska's level of apparent consumption appears even more drastic, as shown in Table IV-2. As can be seen, Alaska's level of annual consumption of absolute alcohol in 1958* was 27% greater than the national level--2.52 compared to 1.98 gallons of absolute alcohol, per person, in the drinking age population. By 1975, Alaska's rate of per capita annual consumption was 57% greater than the nation's--4.54 compared to 2.90 gallons of absolute alcohol, per person. In other words, while average annual consumption for the nation had increased by 46% from 1958 to 1975 for Alaska, it had increased by 80%. This relationship is depicted in Figure IV-1, below, which graphically shows the trend of greater annual consumption for Alaska compared to the U.S. as a whole, as well as the trend of the increasing rate of greater consumption for Alaska. There are no indications that these trends will not persist.

In short, the apparent consumption of absolute alcohol in Alaska since statehood is characterized by three facts. First, the quantity of absolute alcohol consumed annually by Alaskans has been, and still is, relatively high by both international and national standards.

*Consumption data for Alaska are not available prior to 1958, working date for statehood (actually January 3, 1959).

Second, the apparent consumption of absolute alcohol in Alaska has increased steadily since statehood--a trend consistent with international and national patterns. Finally, and most importantly, the rate of increasing annual consumption is alarmingly greater for Alaskans than the rate of increase for the national average--almost twice the rate of increase.

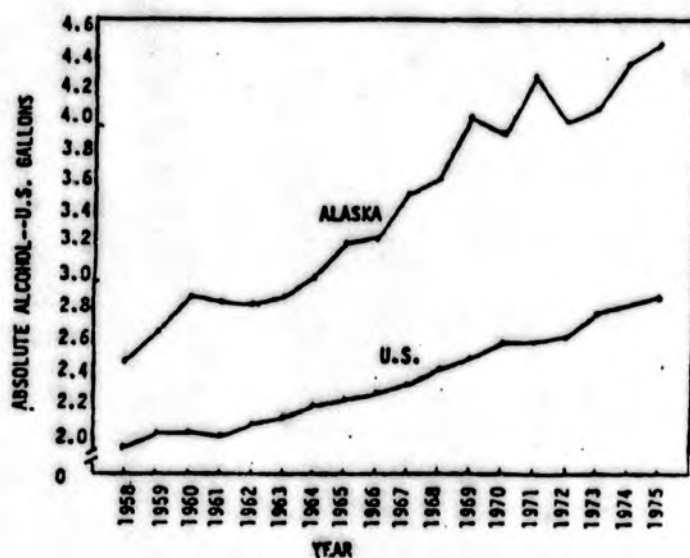


FIGURE IV-1 Apparent consumption of beverage alcohol in U.S. gallons of absolute alcohol per person in drinking-age population, Alaska and U.S., 1958-1975.

Source: Consumption figures from Table IV-2, this Volume.

Consumption of Specific Types of Beverage Alcohol

The conventional categories or types of beverage alcohol for purposes of analysis are beer, wine, and liquor. Each type has its own distinguishing characteristics and, of course, many types are included within each category. The primary characteristic of concern for division of types of beverage alcohol, however, is the alcoholic content, or percentage of absolute alcohol per unit of volume. Generally, wines contain a higher percentage of absolute alcohol (average of 14%) per unit volume than beer (average of 4.5%), while liquors contain the highest percentage of all (average of 43%).

Two major international trends have become apparent within the

last quarter-century. First, the consumption of all three major beverage types has increased.* Second, a gradual shift away from the consumption of distilled spirits** and toward greater consumption of lighter alcoholic beverages (beer and wine) has become more evident throughout the world.***

To illustrate, Table IV-3 shows the changes in consumption of each beverage type for 25 industrialized countries, and Alaska, for the period from 1960 to 1975. The countries are grouped according to preferred alcoholic beverage, based on the relative proportions (in absolute alcohol) of their specific-beverage consumption rates. The bulk of the countries (including the U.S. as a whole) fall into a group reporting beer as the most frequently consumed alcoholic beverage (14 countries). The second largest group, including seven countries, show wine as the preferred alcoholic drink. The smallest group, four of 25 countries, prefer distilled spirits. Alaska is included in this last group.

As indicated in the table, any decreases in specific beverage consumption were relatively few--only three of the 25 countries reported decreases, in wine consumption, and those were minimal. All other countries reported increases in wine consumption, while the consumption of beer and distilled spirits increased, without exception, in all reporting countries. Percentage increases were generally greater for beer and wine, compared to distilled spirits, independent of preferred beverage, but particularly so in cases where the preferred national

*Jan de Lint, "The Background and Efficacy of Alcoholism Prevention Programs: A Brief Overview," (paper presented at the meeting of the Education Commission of the States Task Force on Responsible Decisions about Alcohol, Miami, Florida, June 23-25, 1974), p. 3.

**Primarily in countries with a traditional heavy distilled spirits consumption.

***Although increases in distilled spirits consumption have been noted for all countries, the proportion of total alcohol consumed in this form is decreasing. Lighter alcoholic beverages are those with a lower percentage content of absolute alcohol.

beverage is distilled spirits.

TABLE IV-3

PERCENTAGE INCREASES IN THE CONSUMPTION OF WINE, BEER AND DISTILLED SPIRITS IN PREDOMINANTLY WINE, BEER AND DISTILLED SPIRITS CONSUMING COUNTRIES, 1973 (1960-100)

Beverage of Preference	Country	Wine	Beer	Distilled Spirits
A Wine	France	-19	22	10
	Hungary	20	57	93
	Italy	-1	157	131
	Portugal	3	733	96
	Spain	35	287	56
	Switzerland	19	22	34
	Yugoslavia	11	359	8
B Beer	Australia	84	24	23
	Austria	75	57	4
	Belgium	97	27	127
	Canada	181	23	65
	C.S.S.A.	-15	37	161
	Denmark	241	53	140
	E. Germany	73	36	119
	Luxembourg	30	13	162
	Netherlands	339	191	111
	New Zealand	257	18	28
	Rep. of Ireland	225	59	143
	Great Britain	228	33	86
	U.S.A.	75	26	42
	W. Germany	112	57	60
C Distilled Spirits	Finland	359	98	75
	Norway	135	68	28
	Poland	28	48	55
	Sweden	118	49	14
	Alaska	180	41	34

Source: Jan de Lint, "Alcohol Consumption and Alcohol Problems from an Epidemiological Perspective," (unpublished manuscript, Addiction Research Foundation, Toronto, Canada, 1976), Table 5.

The shift away from the consumption of distilled spirits to greater consumption of beer and wine has been a gradual but nevertheless definite trend in the United States for the last 100 years. In 1850, distilled spirits accounted for 90% of the total absolute alcohol consumed in this country. By 1974, spirits accounted for less than half of the total absolute alcohol consumed yearly. Beer now leads as the most popular alcoholic beverage among American drinkers. For the United States, 46% of the total absolute alcohol consumed was in the form of beer; 42% from distilled spirits.

Although Alaska differs from the nation as a whole in still preferring distilled spirits, the national and international trend toward increased wine and beer consumption can nonetheless be seen in Alaska, too.

As indicated by Table IV-4, distilled spirits accounted for 53% of the total absolute alcohol consumed in Alaska in 1975, (down from 58% in 1958), while beer increased from 35% in 1958 to 36% in 1975, and wine increased from 7% in 1958 to about 11% in 1975.

TABLE IV-4
ALASKA SPECIFIC BEVERAGE CONSUMPTION IN GALLONS OF ABSOLUTE ALCOHOL
PERCENTAGE OF TOTAL ABSOLUTE ALCOHOL CONSUMED
(Per Capita 18 years +)

Year	Spirits		Wine		Beer		Total	
	A/A	%	A/A	%	A/A	%	A/A	%
1958*	1.46	58%	.18	7%	.88	35%	2.52	100%
1959*	1.54	57%	.18	7%	.98	36%	2.70	100%
1960	1.70	58%	.20	7%	1.01	35%	2.91	100%
1961	1.71	59%	.20	7%	.97	34%	2.88	100%
1962	1.64	57%	.21	7%	1.02	36%	2.87	100%
1963	1.72	59%	.20	7%	.99	34%	2.91	100%
1964	1.84	60%	.22	7%	1.02	33%	3.08	100%
1965	1.99	62%	.24	7%	1.02	31%	3.25	100%
1966	1.97	60%	.24	7%	1.07	33%	3.28	100%
1967	2.06	58%	.29	8%	1.23	34%	3.58	100%
1968	2.12	58%	.29	8%	1.23	34%	3.64	100%
1969	2.33	58%	.37	9%	1.34	33%	4.04	100%
1970	2.25	57%	.36	9%	1.34	34%	3.95	100%
1971	2.37	55%	.44	10%	1.53	35%	4.34	100%
1972	2.16	54%	.46	11%	1.41	35%	4.03	100%
1973	2.18	53%	.48	12%	1.46	35%	4.13	100%
1974	2.27	52%	.52	12%	1.61	36%	4.40	100%
1975	2.40	53%	.50	11%	1.64	36%	4.54	100%

*Fiscal Year

Compiled from gallonage totals contained in Alaska Department of Revenue monthly reports, "Report of Alcoholic Beverages Distributed or Sold in Alaska."

Although it is useful to compare Alaska's drinking patterns with the nation as a whole, a more informative picture can be obtained by comparison with other states and regions in the country. Table IV-5 shows the ranking of states according to apparent consumption for all types of beverage alcohol, and for each type separately, for 1972 (the most recent year of readily available information). Table IV-6 is a graphic representation of the total absolute alcohol consumed, and

TABLE IV-5

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 POPU-
LATION, U.S.A. AND BY STATES, 1972

State	Distilled Spirits	Absolute Alcohol	Wine	Absolute Alcohol	Beer	Absolute Alcohol	TOTAL Absolute Alcohol	Rank Order
Alabama	1.88	0.80	0.83	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	0.38	34.70	1.56	3.04	9-10
Arkansas	1.38	0.59	0.55	0.14	17.68	0.79	1.52	50
California	3.17	1.36	4.66	0.88	26.00	1.20	3.24	8
Colorado	2.95	1.27	2.64	0.38	29.61	1.33	2.99	12
Connecticut	3.26	1.40	2.43	0.35	21.81	0.98	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	0.88	0.13	22.78	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	0.08	21.32	0.96	1.72	47
Kentucky	1.93	0.83	0.70	0.10	22.30	1.01	1.94	39
Louisiana	2.04	0.88	2.20	0.32	28.11	1.26	2.46	33
Maine	2.35	1.01	1.68	0.24	29.92	1.35	2.60	28
Maryland	3.37	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	0.28	31.25	1.41	2.77	20
Minnesota	2.65	1.14	1.41	0.20	29.88	1.16	2.50	27-28
Mississippi	1.82	0.78	0.87	0.11	21.93	0.99	1.88	42
Missouri	2.18	0.94	1.34	0.19	25.66	1.15	2.28	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	0.76	41.86	1.88	6.19	1
New Hampshire	7.41	3.19	2.67	0.39	40.93	1.84	6.42	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	3.08	0.44	25.78	1.16	2.86	16
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	29.25	1.32	2.69	24
Ohio	1.84	0.79	1.40	0.20	38.33	1.72	2.71	22-23
Oklahoma	1.79	0.77	1.05	0.15	19.67	0.88	1.80	45
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	2.77	1.19	2.97	0.43	30.62	1.38	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	38
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	2.11	33
Utah	1.37	0.59	1.08	0.15	18.15	0.82	1.56	49
Vermont	4.41	1.90	3.15	0.48	34.78	1.56	3.92	3
Virginia	2.35	1.01	1.81	0.22	22.29	1.00	2.23	37
Washington	2.36	1.01	3.03	0.44	28.05	1.26	2.71	27-28
West Virginia	1.74	0.75	0.69	0.10	20.00	0.90	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	9.91	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: Mark Keller, ed., Alcohol and Health, 1974. (Washington, D.C.: Government Printing Office, 1974), p. 2, Table 1.

*Figures for Alaska in this Table vary somewhat from Table IV-4, due to use of drinker population as 18 and over and inclusion of consumption by military (non-taxable) in Table IV-4.

percentage by beverage type, in each of the nine U.S. Census Regions.

As can be seen in Table IV-5, Alaska ranked as the fourth highest state in consumption of absolute alcohol in 1972. Although border-crossing by tourists, vacationers, travelers, and others seeking lower prices or drinking ages may cause some distortion in these figures, Alaska's relative isolation, despite the presence of tourists, suggests that the figure for Alaska is not underestimated. In fact, because the top three states--Nevada, New Hampshire and Vermont--are more likely to experience border-crossing than is Alaska, it is quite possible that this state had the dubious distinction of having the highest consumption (real consumption, by residents) of absolute alcohol in 1972.

TABLE IV-6
REGIONAL SPECIFIC BEVERAGE CONSUMPTION AS A PERCENTAGE OF TOTAL
CONSUMPTION AND TOTAL CONSUMPTION OF ABSOLUTE ALCOHOL IN
U.S. GALLONS, 1972^a

	Spirits	Wine	Beer	
Alaska ^b	67%	11	32%	3.4 ^c
Pacific ^c	41%	20%	39%	3.10
New England	49%	12	39%	3.00
Mountain	41%	11	48%	2.92
Middle Atlantic	42%	14	44%	2.70
South Atlantic	49%	10	41%	2.63
East North Central	41%	10	49%	2.58
West North Central	42%	7	51%	2.23
West South Central	35%	10	55%	2.18
East South Central	42%	5	52%	1.81
U.S.A.	42%	12	46%	2.63

^aSource: Modified from Alcohol and Health, Mark Keller, ed. (Washington, D.C.: Gov't Printing Office, 1974), p. 4.

^bComputed from information in Table IV-5.

^cPacific Region includes Washington, Oregon, California, Hawaii and Alaska.

As can be seen from Table IV-6 Alaska is also within the region (Pacific) with the highest annual consumption of absolute alcohol

(3.10 gallons). The East South Central region had the lowest average consumption (1.81 gallons). This table also indicates that three regions--the Pacific, New England, and South Atlantic--share Alaska's preference for distilled spirits. Nevertheless, the extent of this preference and the high amount of total absolute alcohol consumed per capita set Alaska apart from other regions and most other states, as well as from the nation as a whole.

Brief Summary--Apparent Consumption

The per capita apparent consumption of alcoholic beverages in Alaska is high, viewed from various perspectives. As is true nationally and internationally, overall per capita consumption of beverage alcohol in Alaska, has also steadily increased. The average level of per capita consumption for Alaska, however, is relatively high by international comparison, and significantly higher than averages for the nation, national regions, and other states. Further, Alaska's increasing overall per capita consumption has been marked by a gradual shift away from consumption of distilled spirits toward lighter alcoholic beverages, but the shift is very slight. Alaska is distinguished from most other countries, the nation, most national regions, and states, by its continued and definitive preference for distilled spirits over beer and wine. Perhaps most important, however--and independent of its overall level of consumption or its specific beverage preference--is Alaska's dramatic and alarming rate of increase in annual per capita consumption.

Recent epidemiological research indicates that an increasing rate of average annual consumption indicates an increasing prevalence of alcoholism--a fact that makes Alaska's rapid rate of increasing consumption all the more disturbing. This area of investigation is

the topic of the next two sections of this Part of this Volume.*

C. APPARENT CONSUMPTION AND ALCOHOLISM

The relationship between rates of consumption of beverage alcohol and rates of alcoholism in a population has been the topic of considerable epidemiological investigation,** particularly in recent years as the rates of annual consumption of absolute alcohol have risen rapidly around the world. One major position states that the overall level of consumption of beverage alcohol in a population determines both the prevalence of alcoholism as well as the extent and nature of alcohol-related organic pathologies.***

It has been demonstrated for a wide variety of populations that there is a predictable pattern of individual consumption levels. This is to say that, within the range of different levels of individual alcohol consumption in a population, each individual consumption level occurs with a certain frequency. Thus, a certain percentage of drinkers may typically consume up to 1 cl. of absolute alcohol as a daily average. Another given percentage may consume between 1 and 2 cl. of absolute alcohol daily. Yet a third given percentage of the drinkers may consume between 3 and 4 cl. daily; and so on. Further, the portions of the drinking age population that consume these particular quantities of absolute alcohol are distributed in recurring and predictable patterns, depending on the mean annual consumption level for that population group.

*Also see Part II of this Volume, PREVALENCE, for discussion of the relationship between alcohol consumption in Alaska and the statewide alcoholic and alcohol abuser populations.

**See also Part II, this Volume.

***Concepts in this section are based on published research by Research Addictions Foundation, Ontario, Canada. See Reference List at end of this Part.

A graphic representation of these different specific-level consumption frequencies shows that their distribution tends to be log normal in character. This is to say that the distribution pattern formed by plotting the different individual frequencies creates a rather smooth, skewed curve that is referred to as a log normal curve, because it characterizes a known logarithmic normal distribution.*

Research information regarding the actual distribution of frequencies of individual consumption levels in different population groups supports the theory that this distribution is indeed log normal in character. Thus, because of known properties and characteristics of log normal distributions, this particular distribution of individual consumption frequencies can be used to estimate the percentage of drinkers at any level of consumption in a given population, given the average annual consumption of beverage alcohol for that population group.

As an example, for a population with an average annual consumption of 25 liters (6.61 US gallons) of absolute alcohol, the distribution curve would be as is presented in Figure IV-2.

In such a population, the greatest percentage of the drinkers is distributed under the left-hand portion of the curve, in the lower consumption ranges. A smaller percentage of drinkers is located under the right-hand side, or tail of the curve, in the higher consumption levels.

More specifically, 55 percent of the drinkers in this population consume rather small quantities of alcohol--i.e., less than an average daily amount of 5 cl (1.69 oz.) of absolute alcohol. On the other side,

*In a logarithmic normal distribution, as opposed to a Gaussian or bell-shaped distribution, the natural logarithms (exponents) of the data--rather than the data themselves--are normally distributed.

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about 20 percent of the drinkers consume 10 cl. (3.38 oz.) or more as a daily average.

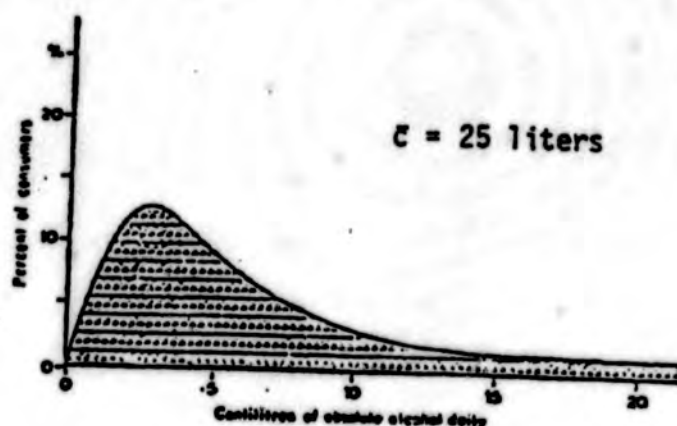


FIGURE IV-2 Frequency distribution of alcohol consumption

Source: Jan de Lint, "The Prevention of Alcoholism," Preventive Medicine, 3 (1974), p. 25.

By contrast, in a population where the average yearly consumption level of absolute alcohol is only 15 liters (3.96 gallons), as illustrated below in Figure IV-3, compared to 25 liters (as in Figure IV-2), only about 9 percent of the drinkers (instead of 20%) would be in the tail-end of the distribution and consume in excess of a daily average of 10 cl. of absolute alcohol.

These examples of alcohol consumption distribution curves serve to illustrate that, at higher levels of average daily consumption, gradually decreasing numbers of drinkers consume gradually increasing amounts of alcohol. However, the more important consideration illustrated by these distribution curves is the fixed relationship of excessive levels of consumption to lower alcohol use levels that apply in different populations. This is to say that, if changes occur in the prevalence of low or medium levels of consumption, then changes in the prevalence of excessive consumption must also occur. This can be seen

in the two different alcohol consumption distributions presented in Figure IV-2 and IV-3. In the population where the annual consumption per drinker is higher (i.e., 25 liters, Figure IV-2), the proportion of heavy drinkers who consume daily averages in excess of 10, 15, or 20 cl. per day of absolute alcohol is much larger than in the population where the annual per drinker consumption is lower (15 liters, Figure IV-3). Thus, according to this theory, the relationship between the overall level of alcohol consumption and the prevalence of excessive drinking in any populations is relatively, and predictably fixed.

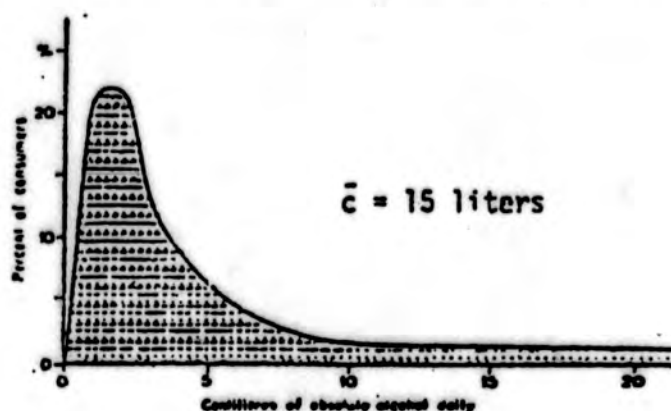


FIGURE IV-3 Frequency distribution of alcohol consumption

Source: Jan de Lint, "The Prevention of Alcoholism," Preventive Medicine, 3 (1974), p. 25.

Alcoholics are assumed to be located in the tail-end of these consumption distributions, for the purposes of this type of population-level analysis. Alcoholics are defined as drinkers who consume an average daily quantity of 15 cl. of absolute alcohol. This definition has been adopted by the Addictions Research Foundation, the center of the most active research on this topic in recent years. This arbitrary

definition is based on the reported daily averages of consumption of absolute alcohol for patients admitted to alcoholism clinics, and on estimates based on mortality rates of alcoholics.

A definition of alcoholism on the basis of consumption quantities is an arbitrary one, but justifiable and useful for population-level research. On an individual level (e.g., in a clinical setting), defining a person as alcoholic solely on the basis of consumption would not be satisfactory, as the sheer amount of alcohol consumed may or may not by itself indicate abnormal or alcoholic behavior.

There are several implications of this formulation. Independent of the exact definition of alcoholic drinking, the fact that the distribution of individual levels of consumption approximates a logarithmic normal curve means that the relationship between alcoholic levels of consumption and lower levels is fixed in any population group. Thus, as the annual average consumption of beverage absolute alcohol increases, so does the prevalence of excessive drinking. If this is the case, alcoholism may then theoretically be viewed as a behavioral disorder--since it would differ only in degree from "normal" drinking--rather than be defined as a discrete illness with a specific etiology. A further refinement of this theory would revise and adjust definitions of alcoholism, at the population-level of analysis, on the basis of the annual average consumption of absolute alcohol, particularly for the purposes of responding to alcoholism and alcohol abuse problems.

This application becomes more evident if two population groups with extreme differences in annual average consumption levels are compared. In a population with a very low average annual level of consumption (e.g., five liters), the very small percentage of drinkers who

consume excessive levels of beverage alcohol would have to be judged as deviating drastically from the drinking norm. In such a population, alcoholism would probably not be considered as primarily a consequence of the prevailing drinking norm. However, in a population where the annual average level of consumption is very high (e.g., 25 liters of absolute alcohol), the percentage of excessive drinkers would be relatively greater. Such a drinking pattern would be much more common throughout the population and thus not be judged to deviate as much from the drinking norm. Under this latter consideration, alcoholism in a high-consuming population would less likely be regarded as a result of an underlying socio- or psycho-pathology, but rather as a consequence of prevailing drinking customs.

In general, then, it can be said that the overall level of alcohol consumption, regardless of beverage source, determines the prevalence of excessive or hazardous consumers. Further, this relationship is fixed and applicable to different population groups. Thus, estimates of prevalence of hazardous drinkers are predictable. That these higher levels of consumption are hazardous is supported by the relationship between rates of consumption and rates of alcohol-related pathologies.

The important implication of this formulation is that it is not possible to reduce the rate of alcoholism in a population group without affecting the rate of other, non-alcoholic levels of consumption.

Consumption Averages and Alcohol-Related Mortality

According to the formulation presented in this section, as the rate of annual average consumption increases, so does the rate of

excessive drinkers, and so, too, does the rate of alcohol-related mortality. Table IV-7 provides an overview of this phenomenon and focuses on deaths due to cirrhosis of the liver, a conventionally accepted indicator of alcoholism in a population group (see Part II, Prevalence). Presented in this table, for a number of industrialized countries, are the annual average consumption of absolute alcohol, the estimated number of drinkers in excess of an average of 15 cl. of absolute alcohol daily, and the rates of death due to cirrhosis of the liver.

TABLE IV-7

ANNUAL PER DRINKER CONSUMPTION IN LITRES OF ABSOLUTE ALCOHOL, ESTIMATED RATES OF DRINKERS IN EXCESS OF A DAILY AVERAGE OF 15 CL OF ABSOLUTE ALCOHOL AND RATES OF DEATH FROM LIVER CIRRHOSIS

Country	Consumption (1966 or 1967)*	Estimated Rates of Drinkers in Excess of a Daily Average of 15 cl of Absolute Alcohol per 100,000 Population Aged 15 and Older**	Rate of Death from Liver Cirrhosis per 100,000 Population Aged 15 and Older (1963, 1964, or 1965)***
France	25.9	9405	45.3
Italy	20.0	5877	27.3
Portugal	19.5	5652	42.7
Spain	17.1	4625	24.3
Austria	16.0	4212	35.0
W. Germany and W. Berlin	16.0	3978	26.7
Switzerland	15.8	3901	19.7
Luxembourg	12.5	2988	34.2
Hungary	12.4	2952	12.9
U.S.A.	12.0	2198	18.4
C.S.S.R.	11.4	2655	13.1
Canada	11.1	2272	10.0
England and Wales	10.9	1946	3.7
Rep. Of Ireland	10.9	1946	4.5
Denmark	9.4	1848	10.2
Belgium	9.3	2052	12.9
Poland	9.0	1752	8.6
Sweden	8.4	1515	7.9
Netherlands	7.7	1456	4.9
Finland	5.9	945	4.6
Norway	5.8	945	4.7

*Alcohol consumption data were taken from the 1968 Annual Report of the Dutch Distillers' Association.

**The numbers of drinkers in excess of a daily average of 15 cl of absolute alcohol were tabulated on the basis of data provided in J. Hyland and S. Scott, "Alcohol consumption tables: an application of the Ledermann equation to a wide range of consumption averages".

***Demographic Yearbook of the United Nations, 1966.

Source: Jan de Lint and Wolfgang Schmidt, "Consumption Averages and Alcoholism Prevalence: A Brief Review of Epidemiological Investigations," British Journal of Addiction, 66 (1971), p. 109.

These data indicate that countries reporting relatively higher rates of consumption also report higher abuser rates, as well as higher rates of death from cirrhosis of the liver.

Given the fact, then, that consumption levels in Alaska have increased substantially since statehood, it follows that death in the state due to cirrhosis of the liver should show a similarly proportional increase, if this theoretical formulation holds true. That this is indeed the case, is clearly evident in the graphic presentation of information in Figure IV-4.

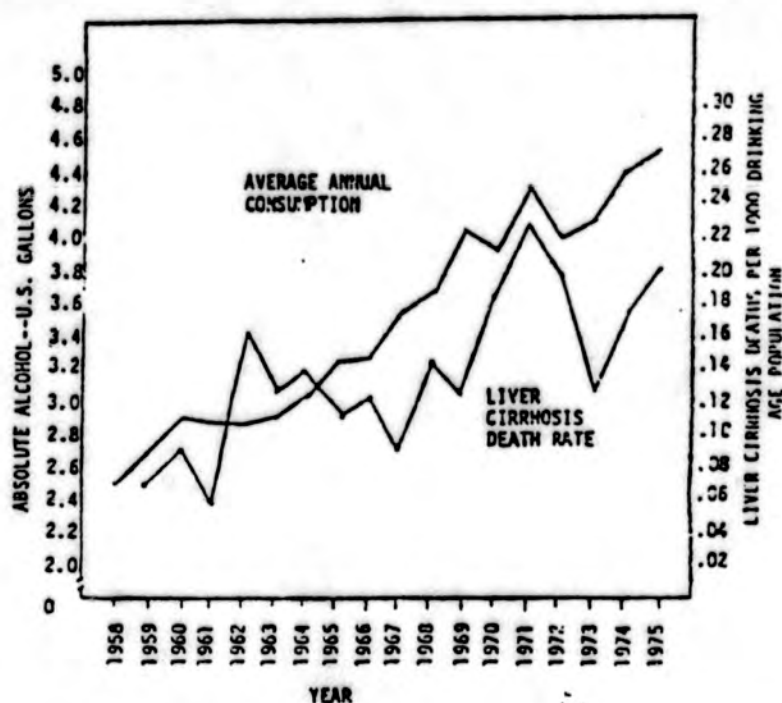


FIGURE IV-4 Annual per capita consumption and cirrhosis deaths per 1000 in the drinking age population, Alaska, 1958-1975.

Source: Consumption figures from Table IV-2, this Volume. Death information compiled from statistics provided by the Health Information Systems Section, Department of Health and Social Services.

This figure shows the average annual consumption of absolute alcohol in Alaska, from 1958 to 1975, and the rate of death due to cirrhosis

of the liver per 1000 persons in the drinking age population for the same period. As can be seen, the dramatic increases in Alaska's annual average consumption of absolute alcohol since 1958 have been matched very closely by equally significant increases in the death rate due to cirrhosis of the liver.

Figure IV-5 presents similar information for the state, but in this case shows the relationship between rate of consumption and rate of death due to alcoholism (as a reported cause of death).

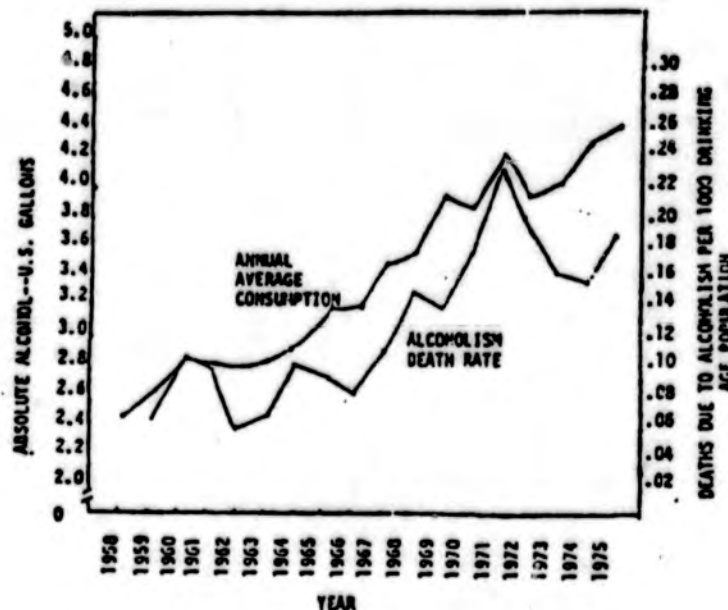


FIGURE IV-5 Annual per capita consumption and deaths due to alcoholism per 1000 in the drinking age population, Alaska, 1958-1975.

Source: Consumption figures from Table IV-2, this Volume. Death information compiled from statistics provided by the Health Information Systems Section, Department of Health and Social Services.

The findings are the same for this comparison. The rate of death due to alcoholism in Alaska has increased significantly from 1958 to 1975, and corresponds directly with the known increases in the annual average

consumption of absolute alcohol.

If the correlation between level of consumption and liver cirrhosis or alcoholism death rates is extremely high, however, such is not always the case with certain other types of mortality which, at first glance, might also be expected to positively co-vary. If consumption is compared with annual death rates for homicide, suicide, and accidental deaths, for example (as shown in Figure IV-6), there appears to be little positive correspondence. Certainly alcohol consumption plays an important role in the genesis of these death rates; nonetheless, intervening environmental and behavioral variables come into play in affecting them, and prevent unilinear covariance. What is lacking, in short, is the direct (in this case, organic) connection which exists between alcohol consumption and liver cirrhosis or death by alcoholism. Nevertheless, if it is impossible to graphically portray any direct correlation between alcohol consumption and these other mortality rates,

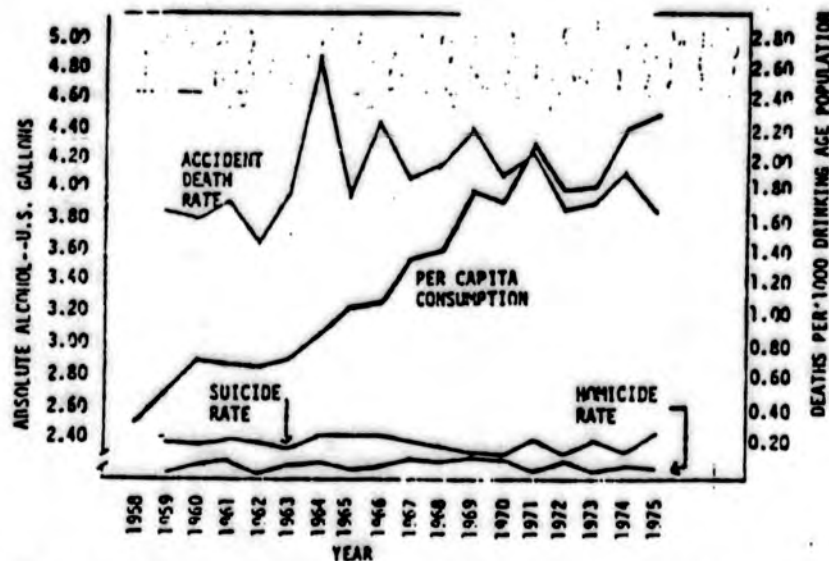


FIGURE IV-6 Annual per capita consumption and death rate for homicide, suicide and accidental deaths (per 1000 drinking age population), Alaska, 1958-75.

Source: Consumption figures from Table IV-2, this Volume.
Death information compiled from statistics provided by the Health Information Systems Section, Department of Health and Social Services.

it should be understood that an indirect relationship does exist.

It is evident that in Alaska the relationship between increasing annual consumption and chronic excessive use, along with increasing annual rates of alcohol-related mortality, is particularly well demonstrated. That the relationship is so well demonstrated is perhaps indicative of an exaggeration of the phenomena due to the unusual conditions found in the state--i.e., a population group where the number of excessive users has reached extreme proportions.

D. FACTORS AFFECTING CONSUMPTION

Significant increases in the annual rates of consumption of absolute alcohol have occurred in many countries in recent years. The increases in consumption rates have also been accompanied by corresponding increases in alcohol-related mortality. This same trend holds true for the state of Alaska. According to the reported fixed relationship between excessive consumption and other more moderate use patterns, the overall level of consumption must be reduced if the rate of excessive consumption, and consequently, alcohol-related health problems, is to be reduced.

A number of factors are frequently discussed as facilitating the recent increases in levels of consumption--increasing diffusion of alcohol use patterns (more frequent use of alcohol for an increasing number of occasions), relaxation of government control measures, and increased consumer affluence. More specifically, there are a number of factors that are regarded as importantly related to the rate of consumption and require attention for consideration of methods to reduce excessive use of alcohol and alcohol-related damage to health.

In the past, alcoholism prevention and control measures have

included such considerations as prohibition of the sale of alcoholic beverages, control of the number and type of outlets, control of advertising, the taxation of beverage alcohol, and alcohol education. It has been noted that, in countries ranking highest in overall consumption and rates of death from liver cirrhosis (France, Italy, Portugal), alcoholic beverages are easily obtained and relatively inexpensive. Available information for Alaska regarding number and type of outlets for beverage alcohol, closing hours, and taxation of beverage alcohol, will be briefly presented within the context of their relationship to rates of consumption.

Number and Type of Outlets
for Beverage Alcohol

The effectiveness of government control of licensing and regulation of the number and the type of retail sales outlets is very difficult to determine. The complex relationship between these measures and hours of sale, legal age of consumption, urban or rural influence, etc. makes it difficult to determine, let alone monitor, any systematic effects of any one of the measures or combinations of the measure. Such other factors as available transportation, size of outlet, and differences in regional and socio-cultural drinking patterns also contribute to the problem.

However, it is quite evident that in countries where the consumption of alcohol is quite high, there are numerous package stores and/or public drinking places. In the information that is provided below for Alaska, this same trend is evident.

Information about the number and type of retail sales outlets for distilled spirits for Alaska and the nation, for the period from 1973

to 1975, is presented in Table IV-8.* A retail outlet licensed for on-premises sales allows the consumption of alcoholic beverages on the premises. Conversely, an off-premise license allows only for bulk or package purchase of beverage alcohol for consumption at some other location.

TABLE IV-8
RETAIL LICENSES--SALE OF LIQUOR, ALASKA AND U.S., 1973-1975

Type of License	Number of Licenses per 1,000		Number of Persons per License	
	Alaska	U.S.	Alaska	U.S.
<u>1973</u>				
On Premises	1.73 (571)	.065	587	1,536
Off Premises	<u>1.07 (352)</u>	<u>.025</u>	<u>938</u>	<u>3,985</u>
Total Licenses	2.80 (923)	1.14*	358	876
<u>1974</u>				
On Premises	1.23 (413)	.067	816	1,499
Off Premises	<u>1.01 (340)</u>	<u>.026</u>	991	3,883
Total Licenses	2.23 (753)	1.16*	448	859
<u>1975</u>				
On Premises	1.82 (639)	.069	551	1,459
Off Premises	<u>1.07 (377)</u>	<u>.025</u>	934	3,972
Total Licenses	2.89 (1,016)	1.19*	346	842

*Includes "On and Off" Premises as another category not applicable in Alaska.

Source: 1975 Annual Statistical Review, Distilled Spirits Council of the United States, 1976.

Inspection of Table IV-8 reveals that in terms of total number of licenses per 1000 population, there were proportionately more licensed retail outlets for liquor in Alaska than for the composite average of all the states. In fact, there were more than twice as many licensed outlets per 1000 persons for each of the three years shown. Similarly, there were about half as many people for each license in Alaska compared to the national average for each of the three years.

*Information for retail outlets licensed only for sale of wine and/or beer was unavailable. Thus, the actual number of licensed outlets is greater than shown.

The proportion of total liquor licenses for on-premises sales, compared to the total number of licensed outlets, is about the same for Alaska as for the national composite. On the average, about 60% of retail liquor licenses allow on-premises consumption.

Compared to national averages, consumer accessibility to retail liquor sales appears to be greater in Alaska.

Closing Hours

Additional information regarding regulation of retail sales of beverage alcohol is presented in Table IV-9, which provides a comparison of prohibited hours of sale as fixed by state law for license states. This information shows that there are fewer hours of prohibited sales for either on-premises or off-premises sales in Alaska than in other license states. (The states not listed regulate off-premises retail sales through a direct government monopoly.)

Even though the available information regarding the effectiveness of various government control measures is ambiguous, the comparative information for Alaska indicates considerably less government control than in other states. Consumer accessibility, in terms of numbers and types of outlets and closing hours, appears to be greater in Alaska.

Taxation

Taxation is another, and perhaps more extensively used, method of controlling alcohol abuse. Taxes affect the consumer price of alcoholic beverages, and there are strong indications that the price of alcohol relative to personal disposable income is closely related to overall consumption and the prevalence of alcoholism.

TABLE IV-4
PROHIBITED HOURS OF SALE FIXED BY STATE LAWS*

Licenses 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	Nrs. Set By Counties	Nrs. Set By Counties	-	-
Illinois	Fixed Locally	Fixed Locally	-	-
Massachusetts	Fixed Locally	Fixed Locally	-	-
New Jersey	Fixed Locally	Fixed Locally	-	-
Phone 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

Source: Distilled Spirits Council of the United States, Inc., Summary of State Laws and Regulations
Relating to Distilled Spirits, 22nd Edition, 1975.

The recent increases in annual consumption of absolute alcohol in Canada and several other countries have been associated with a decreasing relative cost of beverage alcohol.* This relationship is illustrated in Figure IV-7, which shows the price of absolute alcohol (expressed as a fraction of average disposable income) compared to annual average consumption of absolute alcohol in Ontario, Canada from 1929 to 1958.

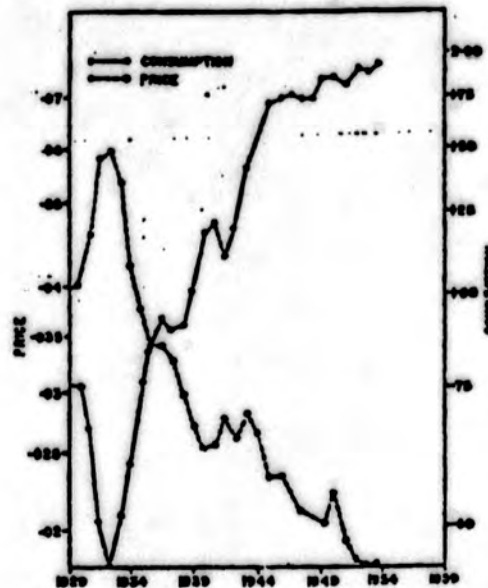


FIGURE IV-7 Alcohol Price (P) and Consumption (C), Ontario, 1929-1953.*

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

Source: Jan de Lint and Wolfgang Schmidt, "Consumption Averages and Alcoholism Prevalence: A Brief Review of Epidemiological Investigations," *British Journal of Addiction*, 66 (1971), p. 101.

In this illustration, a relationship between the decreasing relative price of alcohol and increasing consumption levels in Ontario is quite clear. As the relative price of alcohol declines, average

*See reference Figure IV-7.

annual consumption increases.

A similar comparison of annual consumption averages and price of alcohol was made for the United States, for the period from 1958 to 1975 (Figure IV-8). As can be seen the same relationship of decreasing relative price of alcohol and increasing rate of consumption is demonstrated.

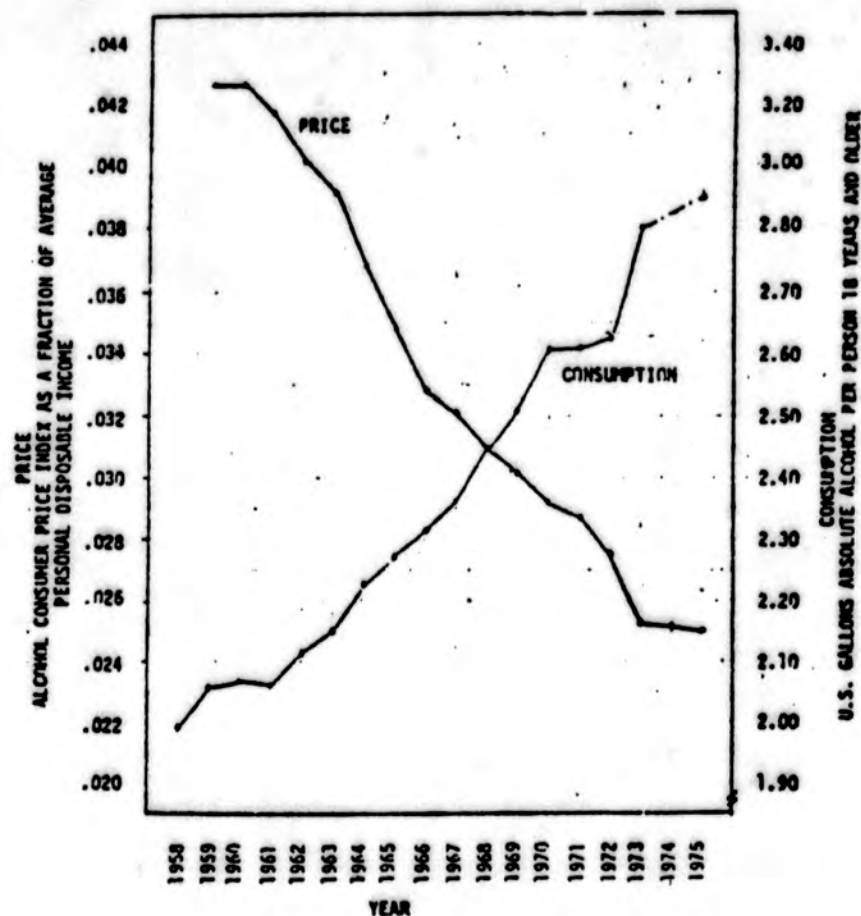


FIGURE IV-8 Price of beverage alcohol and consumption, U.S.A., 1958-1975.

Source: Consumer Price Index--Bureau of Labor Statistics, U.S. Dept. of Labor.
Disposable Income--Survey of Current Business, U.S. Dept. of Commerce.

The same relationship between the relative price of alcohol and consumption levels is clearly evident for Alaska, (see Figure IV-9), although the lack of data limits the time period for comparison.

Annual consumption averages were able to be computed from 1958 to 1975, but the Consumer Price Index of alcohol as a function of disposable income was able to be computed only for the years 1970-1975.

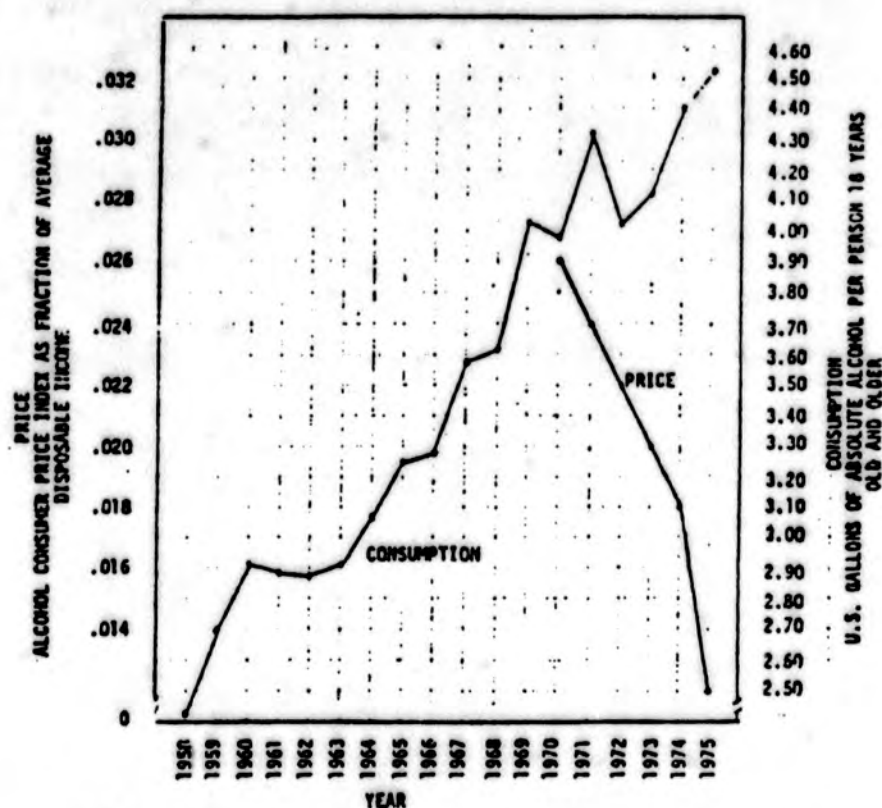


FIGURE IV-9 Price of beverage alcohol and consumption, Alaska, 1970 to 1975.

Sources: Consumer Price Index--Bureau of Labor Statistics, U.S. Dept. of Labor.
Disposable Income--Survey of Current Business, U.S. Dept. of Commerce.

Note: Information necessary for computation of price prior to 1970 is not available.

The data for Alaska show a corresponding inverse relationship between consumption levels and the price of alcohol within the economic structure and consumption averages of the state.

In different terms, the Consumer Price Index (CPI) for alcoholic beverages in Alaska increased by .3% (three-tenths of one percent) in the period from 1970 to 1975. The CPI for all items increased 41.2% during the same time period. Average disposable income increased by

92%, while real disposable income (average disposable income adjusted for CPI changes) increased 35.7%. In effect, then, the consumer price of all commodities from 1970-1975 increased by more than 40%, while the price of beverage alcohol increased by only .3%--which means that, in relation to all other commodities, the price of alcohol decreased by more than 40%.

According to the distilled spirits industry, more than half the price of alcohol is comprised of taxes--federal and state; thus, if taxes do not change, the price of alcohol obviously does not behave like other noncontrol commodities in the free market. In Alaska the excise tax on beverage alcohol has not changed since 1961 (see Volume II).

It would seem that, particularly as applied to Alaska, the relationship between increasing annual average consumption and decreasing relative price of beverage alcohol is quite clear. Along with relatively greater accessibility, the decreasing price helps explain the dramatic increases in consumption that were noted for Alaska.

E. SUMMARY

By international comparison, the annual rate of consumption of beverage alcohol in Alaska is relatively high. By national comparison, the consumption level for Alaska is significantly higher. It is likely that, of all states, Alaska had the highest level of consumption of absolute alcohol in 1972 and probably still does. Alaska is further distinguished from most of the rest of the world in that the preferred beverage is still distilled spirits. The world-wide trend to lighter alcoholic beverages has also begun to show in Alaska, although it is very gradual. Independent of the relative consumption of specific

types of beverage alcohol, the average annual amount of absolute alcohol is the most important factor of concern. And, in Alaska, the rate of increase in average annual consumption is significant and dramatic. The average annual consumption of absolute alcohol per drinker in Alaska increased by 80% since 1958, a rate twice as fast as (or 100% greater than) the rate of increase for the nation as a whole.

The rate of increase is more than significant and dramatic. It is, in fact, quite alarming; particularly if viewed from the perspective of the information presented in this part, showing that the overall level of alcohol consumption, regardless of beverage source, determines the prevalence of hazardous consumers and alcohol-related organic pathologies. As overall levels of alcohol consumption increase, so does the prevalence of chronic excessive use, reflected by such indicators of health problems as deaths due to liver cirrhosis and deaths due to alcoholism. The application of this analytic framework to Alaska shows this correspondence among increasing consumption, alcoholism prevalence, and related health problem indicators, to be strikingly clear.

That Alaska can be characterized as a high consuming population goes without question, in view of the information presented in this part. Excessive drinking appears to approach the normative drinking pattern, rather than represent deviant behavior. The prevalence of alcoholism and high rates of alcoholism indicators appear to be more appropriately viewed within the context of social customs, rather than from the perspective of socio- or psycho-pathological illness or other disease concepts.

In addition, review of a few selected measures of government control of alcohol abuse showed that formal controls appear more

relaxed in Alaska than in many other states of the nation. Significant within this framework, is the evidence showing the high degree of correspondence between the increasing rate of annual consumption and the decreasing relative price of alcohol in the state. The relative price of alcohol is more closely associated with level of taxation than other market factors, as so much of the price of alcohol is comprised of federal and state taxes.

BIBLIOGRAPHY

- Archibald, David H. "Toward Saturation-In Search of Control." Addictions, Fall, 1975
- Bruun, Kettil. "Legislation and Alcoholism." In Alcohol and Alcoholism. Edited by R.E. Popham. Addiction Research Foundation/University of Toronto Press, 1970, pp. 356-359.
- de Lint, Jan. "Epidemiological Aspects of Alcoholism." Int.J.Ment. Health, 5, No. 1 (1976), pp. 29-51
- de Lint, Jan. "Current Trends in the Prevalence of Excessive Alcohol Use and Alcohol-related Health Damage." British Journal of Addictions, 70 (1975), pp.3-13.
- de Lint, Jan. "Control Laws and Taxation as Prevention Strategies." Paper presented at the 1975 Triennial Refresher Course for Alumni of the Summer School for Alcohol Studies, Rutgers University, New Brunswick, New Jersey, USA.
- de Lint, Jan. "The Epidemiology of Alcoholism: the elusive nature of the problem, estimating the prevalence of excessive alcohol use and alcohol related mortality, current trends and the issue of prevention." In: Alcoholism: A Medical Profile, N. Kessel, A. Hawker and H. Chalke (Eds.), Proceedings of the First International Medical Conference on Alcoholism, Edsall & Co., London, 1975.
- de Lint, Jan. "The Background and Efficacy of Alcoholism Prevention Programs: A Brief Overview." Paper presented at the meeting of the Education Commission of the States Task Force on Responsible Decisions about Alcohol, Miami, Florida, June, 1974.
- de Lint, Jan. "The Prevention of Alcoholism." Preventive Medicine, 3 (1974), pp. 24-35.
- de Lint, Jan., et al: "Alcoholism and Mortality." In B. Kissen & H. Begleiter (Eds.), The Biology of Alcoholism, Vol. IV, (1975), Plenum: New York
- de Lint, Jan and Schmidt, Wolfgang. "Alcohol Use and Alcoholism." Addictions, 18:2, (1975), pp. 1-15.
- de Lint, Jan and Schmidt, Wolfgang, "The Distribution of Alcohol Consumption in Ontario." Quarterly Journal of Studies on Alcohol, (1974), pp. 968-973.
- de Lint, Jan and Schmidt, Wolfgang. "Consumption Averages and Alcoholism Prevalence: A Brief Overview of Epidemiological Investigations." British Journal of Addictions, 66 (1971), pp. 97-107.

Popham, Robert, Schmidt, Wolfgang and de Lint, Jan. "The Prevention of Alcoholism: Epidemiological Effects of Government Control Measures." British Journal of Addictions, 70, (1975), pp. 125-144.

Schmidt, Wolfgang and de Lint, Jan. "Estimating the Prevalence of Alcoholism from Alcohol Consumption and Mortality Data." Quarterly Journal of Studies on Alcohol, 31 (1970), pp. 957-964.

BIBLIOGRAPHY

- Archibald, David H. "Toward Saturation-In Search of Control." Addictions, Fall, 1975
- Bruun, Kettil. "Legislation and Alcoholism." In Alcohol and Alcoholism. Edited by R.E. Popham. Addiction Research Foundation/University of Toronto Press, 1970, pp. 356-359.
- de Lint, Jan. "Epidemiological Aspects of Alcoholism." Int.J.Ment. Health, 5, No. 1 (1976), pp. 29-51
- de Lint, Jan. "Current Trends in the Prevalence of Excessive Alcohol Use and Alcohol-related Health Damage." British Journal of Addictions, 70 (1975), pp.3-13.
- de Lint, Jan. "Control Laws and Taxation as Prevention Strategies." Paper presented at the 1975 Triennial Refresher Course for Alumni of the Summer School for Alcohol Studies, Rutgers University, New Brunswick, New Jersey, USA.
- de Lint, Jan. "The Epidemiology of Alcoholism: the elusive nature of the problem, estimating the prevalence of excessive alcohol use and alcohol related mortality, current trends and the issue of prevention." In: Alcoholism: A Medical Profile, N. Kissel, A. Hawker and H. Chalke (Eds.), Proceedings of the First International Medical Conference on Alcoholism, Edsall & Co., London, 1975.
- de Lint, Jan. "The Background and Efficacy of Alcoholism Prevention Programs: A Brief Overview." Paper presented at the meeting of the Education Commission of the States Task Force on Responsible Decisions about Alcohol, Miami, Florida, June, 1974.
- de Lint, Jan. "The Prevention of Alcoholism." Preventive Medicine, 3 (1974), pp. 24-35.
- de Lint, Jan., et al: "Alcoholism and Mortality." In B. Kissen & H. Begleiter (Eds.), The Biology of Alcoholism, Vol. IV, (1975), Plenum: New York
- de Lint, Jan and Schmidt, Wolfgang. "Alcohol Use and Alcoholism." Addictions, 18:2, (1975), pp. 1-15.
- de Lint, Jan and Schmidt, Wolfgang, "The Distribution of Alcohol Consumption in Ontario." Quarterly Journal of Studies on Alcohol, (1974), pp. 968-973.
- de Lint, Jan and Schmidt, Wolfgang. "Consumption Averages and Alcoholism Prevalence: A Brief Overview of Epidemiological Investigations." British Journal of Addictions, 66 (1971), pp. 97-107.

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PART V. MORTALITY AND CONSUMPTION OF ALCOHOL

A. INTRODUCTION

No account of alcohol and the problems it generates would be complete which failed to investigate the effects of alcohol consumption on society's death rates. Certainly, mortality rates and the events underlying them would still occur, even if alcohol did not exist. Nonetheless, it is a fact that the consumption of beverage alcohol does contribute to these rates an additional increment which otherwise would not be there. Accidental deaths, motor vehicle fatalities, homicides, suicides, etc.--all are increased, to one degree or another, by virtue of the presence or availability of alcohol in a society.

This increment--these additional deaths--for which alcohol consumption is directly responsible, is referred to as "excess mortality" due to alcohol. It is the purpose of this section of the Volume to identify that excess mortality as it occurs in Alaska; to delineate its characteristics across a variety of mortality categories; and, in general, to describe the nature of the relationship which obtains among alcohol consumption, alcohol abuse, and alcohol-related (-caused) excess mortality.

Since significantly elevated death rates have been consistently revealed in mortality studies of alcoholics and heavy drinkers,¹ discussion of the alcohol-related excess mortality in Alaska is presented within the context of the rates, patterns, and implications of consumption of beverage alcohol provided in Part IV.

B. EXCESS MORTALITY AND EXCESS CONSUMPTION

Closely related to the fact of increasing alcohol consumption in the nation is the matter of alcohol-related excess mortality. The precise point at which alcohol consumption begins to affect a person's health or others' well-being is not ascertainable; nor is the relationship which unquestionably obtains between excess mortality and moderate drinking. Whatever these ambiguities, however, there is little dispute over the relation between excess mortality and heavy or excessive drinking.

While clinical studies of patients known to be "excessive drinkers" constitutes most of the available literature--requiring us to be mindful of the fact that their physical health was already sufficiently grave for them to seek some kind of treatment--the occurrence of high mortality rates among such persons remains, at the least, telling.

Such higher mortality rates were indicated by a series of studies, of alcoholic patients conducted by Schmidt and de Lint in Ontario between 1951 and 1963, showing a mortality rate among alcoholics over twice as high as that for the overall population.²

Similarly, a 1973 London study of hospital patients admitted with primary or secondary diagnoses indicating excessive drinking found a mortality rate 2.7 times greater than that for the general population.³

A large corporate study in the U.S., in 1973, of 899 known, suspected, and recovered alcoholics also showed an abnormally high death rate, 3.2 times greater than the normal.⁴

Further corroboration of the relation can be found in studies conducted by U.S. insurance companies to assess their "risk" population.⁵ Comparing "standard" to "substandard" policyholders--the latter being

those whose records included adverse information regarding drinking-- it was found that overall mortality among the "substandard" group outstripped that for the other, by a ratio ranging from 2.14 to 4.54 times.

Virtually all reported studies, in fact, supply evidence for significantly higher mortality rates among alcoholics and heavy drinkers. The greatest portion of the findings and compiled evidence by Schmidt and de Lint suggests strongly that the rate of excess mortality in such cases is about two to four times greater than the normal.⁶

Alcohol and Specific Causes of Death

Given the fact of generally increased mortality among heavy drinkers, it remains to be said that the specific causes of alcohol-related deaths can themselves throw light on the relationship between alcohol consumption and mortality.

In general, research findings show that alcoholics manifest especially high death rates due to (1) cirrhosis of the liver, (2) heart disease and hypertension, (3) cancer of the upper digestive and respiratory tracts, and, also (4) pneumonia, and (5) vascular lesions of the central nervous system. While excess mortality in these instances cannot be entirely attributed to chronic heavy alcohol use-- nutritional and hygienic factors, emotional state, and heavy smoking being particularly important intervening variables⁷--a definitive association is indisputable.

Additionally, and of particular importance to Alaska, is the category of "violent" deaths, or deaths due to "violent causes"-- including accidents, suicides, homicides, and deaths attributable directly to alcoholism. Because of the extremely high mortality rates in Alaska from these causes, attention has been focused on them. The following discussion is an overview of substantive studies charting

the direct association between excessive alcohol consumption and deaths due to these specific causes. A discussion of overall and cause-specific mortality rates in Alaska follows in the context of these known associations.

Violent Causes

The depressive effects of alcohol on the central nervous system result in altered sensation, perception, motor performance, and emotional set. It is not surprising, therefore, that a strong relationship exists between the abuse of alcohol and accidental, and other violent deaths (homicide, suicide), and death by alcoholism.

The disinhibitory effects of alcohol may be expected to release suppressed feelings of aggression and hostility, and recent studies do indicate an association between alcohol intoxication and violent behavior. A comprehensive investigation of 588 criminal homicides, for example, showed that 55% of the offenders had been drinking at the time of their offense⁸ (see also Part VI Alcohol and Crime).

A national study in 1970 by Michigan's Highway Safety Research Institute found that excessive alcohol intake was reported to have been associated with approximately one-half of all auto fatalities in one year. A number of similar studies have shown that drivers who have been drinking are much more likely to be involved in automobile accidents than non-drinking drivers⁹ (see also Part VII).

A California coroner's study of over 300 fatalities resulting from non-highway accidents found that alcohol plays a major role in deaths from unintentional injuries such as accidental falls, poisonings, and accidents caused by fire. Of all cases, 58% of the fatalities had at least one indication of being an alcohol abuser or alcoholic individual, while a full 30% were known to be heavy drinkers or alcoholic persons. It has been documented that deaths from alcohol-related injuries occur

more often at home or during recreational events, than at work.

Studies have also been reported which link high rates of suicide among alcoholics to the depressing and isolating condition of an alcoholic's life. According to Schmidt and Popham, suicide has been found to be one of the more frequent causes of death among chronic heavy drinkers; similarly, a high proportion of alcoholics can be found among suicide cases.¹⁰ Schmidt and de Lint have also noted the high rates of suicide among publicans, restaurateurs, and hoteliers who have in common a very high exposure to alcoholic beverages.¹¹

Cirrhosis of the Liver

Because the liver is the organ most significantly involved with processing alcohol in the body, it is most often seriously affected by heavy drinking and alcohol abuse. It has been estimated that 10% of all alcoholic persons develop liver cirrhosis, a disease characterized by diffuse scarring of the liver, and that continued heavy drinking often leads to premature death by liver failure or hemorrhaging.¹²

Major studies of both clinical and non-clinical alcoholics and heavy drinkers have consistently found a very substantial degree of excess mortality from liver cirrhosis. In the Schmidt and de Lint sample, for example, it ranked second only to cardiovascular diseases in its contribution to total excess mortality for all causes of death.¹³

Numerous national and international studies have shown also that a decline in the general availability of beverage alcohol (such as during Prohibition, or following World War I) usually results in a sharp decline in the liver cirrhosis death rate. This, along with other clinical evidence, has caused Schmidt (et al.) to conclude that the

rate of death from cirrhosis usually rises and falls with the apparent level of alcohol consumption in the general population.¹⁴ (See Parts on Prevalence and Consumption for more explanation.) In New York City, for example, which has one of the highest consumption rates in the country, cirrhosis of the liver ranks as the third leading cause of death between the ages of 25 and 65.¹⁵

Heart Disease

Several studies of samples of alcoholics have shown that 10 to 40 percent of all excess deaths are attributable to cardiovascular diseases.¹⁶ Given the high incidence of cigarette smoking among alcoholics, as well as their significantly high rate of hypertension, it is virtually certain that alcoholism and alcohol abuse contribute significantly, if indeterminately, to excess deaths in this category.

Cancers of the Upper Digestive and Respiratory Tracts

As in most cause-specific deaths, it is not always clear to what extent the apparently high rate of death from the various cancers can be attributed to excessive alcohol use, to heavy smoking, or to some other cause. The relative risk of incurring cell carcinomas of the oral cavity, pharynx, larynx, and esophagus is increased independently by the duration and intensity of exposure to tobacco or alcohol, with sustained joint exposure enhancing the risk in a synergistic fashion.¹⁷

Overview: Mortality in the Nation

It is clear that excessive alcohol consumption is an important factor in contributing to many premature and excess deaths among

alcoholics and heavy drinkers. Specifically, it has been associated with excess mortality due to: accidents and other violent deaths, liver cirrhosis deaths, heart disease and associated hypertension, cancers of the upper digestive and respiratory tracts, and many other causes of death.

Major points of the preceding discussion are synopsized below:

- excessive alcohol consumption contributes a significant increment to national mortality rates, reflected across almost all causes of death;
- virtually all studies conducted report significantly higher mortality rates among alcoholics and heavy drinkers, with the bulk of the evidence suggesting strongly that the rate of excess mortality in such cases is two to four times greater than the normal;
- documentary evidence indicates a very strong influence of alcoholism and heavy drinking on accidents and other violent deaths (including homicides, suicides, liver cirrhosis deaths, and deaths due to alcoholism);
- studies of alcoholics have shown that 10 to 40 percent of all excess deaths in the nation are attributable to cardiovascular diseases (heart diseases and associated hypertension), with alcohol ingestion and smoking as significant contributing syndromes;
- the relative risk of incurring cell carcinomas (cancers) of the upper digestive and respiratory tracts is significantly increased by the duration and intensity of exposure to alcohol.

It can be seen from the findings noted above that the role of alcoholism and heavy drinking is spread across a range of mortality categories and related behaviors, manifesting itself as a significant contributing agent to mortality in the nation from a variety of causes. In the following section of the report, these and other national findings regarding the relationship of excessive consumption

and mortality will be applied to mortality and consumption rates as they occur in Alaska.

C. ALCOHOL AND MORTALITY IN ALASKA

Two factors are important in discussing alcoholism and mortality in Alaska: the high average annual consumption of alcohol, and the relatively young age of the state's population.

The rates and patterns of beverage alcohol consumption have been discussed in detail in Part IV.

Alaska's population has been growing rapidly for the past thirty years, after remaining relatively unchanged during the first four decades of this century. During the 1960's, the birth rate in the state was 40% higher than in the United States as a whole, resulting in a distinctly young statewide population base. By 1970, for example, the median age was 22.9 years, compared with a national figure of more than 28. Also, more than 55% of the population was by then under 25 years old, with only 16% past the age of 44. During the same period, more than 31% of the national populace was past age 45. Given the high mobility of the younger age groups, and the considerably higher rates of alcohol consumption associated with them, this large number of young persons (especially age 15-44) now plays an important role in determining Alaska's generally low crude mortality rate.¹⁸

Crude Death Rate. The average annual rate of death for Alaska was 3.8 per 1000 population in 1975, compared to the national average of 9.2. The crude death rate has been about half the national average, as can be seen in Table V-1, which shows the crude death rates for

Alaska and the nation from 1970-to 1975.

TABLE V-1
CRUDE DEATH RATES FOR ALASKA AND THE U.S., 1970-1975
(PER 100,000 POPULATION)

Year	Alaska ^a	U.S. ^b
1970	4.7	9.5
1971	4.7	9.3
1972	4.6	9.4
1973	4.4	9.4
1974	4.2	9.2
1975	3.8	9.2

Sources:

^aAlaska Vital Statistics, 1975, Health Information Section, Division of Public Health, Dept. of Health and Social Services.

^bVital Statistics of the United States, annuals--1970-1975, U.S. National Center for Health Statistics.

Although the crude death rate for Alaska is lower than the national average, this same relationship does not obtain when age, race and specific cause of death are considered.

Age. More specifically, mortality data for all causes of death show unequivocally that Alaska's mortality rate runs higher than the national average in the younger and middle age ranges, and lower in the more advanced age ranges. A comparison of expected and observed deaths by age in Alaska during 1974, Table V-2, shows that observed deaths were lower than expected (based on national averages) among persons under five years of age and also for persons over 75

(1,656 deaths expected, compared to 558 observed). The actual number of deaths for persons between age 5 and 44 was significantly greater than expected (490 observed compared to 310 expected). This effect is even more pronounced in males than in females.

TABLE V-2
EXPECTED AND OBSERVED DEATHS IN ALASKA, 1974

	Alaska Population ^a			U.S. Mortality Rate per 1000 ^b			Alaska Expected Number of Deaths			Alaska Observed Number of Deaths ^c		
	Males	Females	All Persons	Males	Females	All	Males	Females	All	Males	Females	All
Under 5	16,400	15,600	32,000	25.06	19.22	22.19	411	300	710	95	64	159
5-14	35,300	34,700	71,000	.52	.33	.43	19	11	30	34	22	56
15-24	36,600	25,700	62,300	1.92	.60	1.29	70	17	87	123	20	153
25-34	26,600	23,000	49,600	2.17	1.03	1.59	56	24	80	103	23	126
35-44	21,000	17,000	38,000	4.10	2.37	3.21	86	40	122	112	43	155
45-54	15,000	12,000	27,000	9.68	5.13	7.33	145	62	208	118	71	189
55-64	8,000	6,000	14,000	22.89	10.93	16.59	183	66	232	163	66	229
65-74												
75 & over	4,000	3,000	7,000	165.56	113.74	135.19	662	341	946	252	147	399
Unknown										2		2
Total	163,300	137,000	300,300				1,632	861	2,396	1,002	466	1,468

Sources:

^a Statistical Bulletin, April, 1973. Based on 1970 Census.

^b Alaska Vital Statistics, 1974, Health Information Section, Division of Public Health, Department of Health and Social Services.

Table V-2 indicates that mortality was exceptionally high for the age group 15-44, where the observed deaths exceeded the expected number by 59% (338 to 212). The number of female deaths in the same age bracket was also higher than expected, (by 19%) but the difference was far less compared to males, and the lower expectation for death among

females.

Race. With respect to race, Alaskan mortality data show clearly that the death rate for Natives is substantially greater than that for non-Natives. Table V-3 shows the number of deaths among Natives and non-Natives in Alaska during 1974, as well as the respective death rates. As can be seen, the crude mortality rate for Natives for that year was 7.36 per 1,000 population--more than twice as great as the mortality rate for non-Natives, which was 3.51 per 1,000 population. Another way of expressing the greater death rate for Natives is to note that, while comprising about 17% of the states population in 1974, about 30% of all deaths were Native. This is consistent with findings based on national trends, which also indicate a significantly greater death rate among non-whites than whites.¹⁹

TABLE V-3
ALASKA DEATH RATES, BY RACE, 1974

Race	Population	Number of Deaths 1974	Death Rate (Per 1,000)
Native	59,536 (16.9%)	438 (29.8%)	7.36
Non-Native	293,761 (83.1%)	1,030 (70.2%)	3.51
TOTAL	353,297	1,468	4.16

Source: Alaska Vital Statistics, 1974, Health Information Services,
Division of Public Health, Department of Health and Social Services.

It can also be easily said that while the number of Native deaths in the very young and very old age categories are generally less than might be expected, the death rate in the 15-44 age group is astonishingly high. Table V-4 shows a comparison of expected and observed deaths for both Natives and non-Natives in Alaska during 1974. Looking at the

difference between expected and observed deaths for Natives in the 15-44 age category, it can be seen that Native males had 81 more deaths (or 389+ %) than might have been expected on the basis of overall U.S. rates, while Native females evidenced an even greater number of excess deaths, 37 (408+ %). A less high, but still excessive number of deaths in the 15-44 age bracket may also be noticed for non-Native males, but on a scale very much lower than that applicable to excess Native male deaths. Non-Native females, on the other hand, showed a rate of observed deaths which was lower than what might have otherwise been expected. (See Table V-4.)

Recent mortality data for 1975, as well, confirm the fact that the death rate for Natives in Alaska is much greater than that for non-Natives, and particularly high among the younger age categories. Table V-5 shows that in 1975 almost 40% of all Native deaths (168 of 441) occurred between the ages of 15 and 44, while those for non-Natives occurred predominantly after age 45 (over 60%).

Further evidence of the higher rate of mortality faced by Alaskan Natives are the disparate infant death rates and neonatal death rates faced by Natives and non-Natives. For example, in 1975 (see Table V-5) the infant death rate for whites was 12.2 per 1,000 live births, while that for Natives was 20.9. Similarly, the neonatal death rate for the same year among whites was 7.3 per 1,000 live births, while for Natives it was 14.6. Altogether, these data combine forcefully to establish the fact that Natives in Alaska suffer a much greater overall rate of death than non-Natives.

TABLE V-4
EXPECTED AND OBSERVED DEATHS FOR NATIVES AND NON-NATIVES, ALASKA, 1974

Age	Alaska Native Population ^a			Alaska Non-Native Population ^b			U.S. Mortality Rate per 1,000 ^a			Alaska Observed Number of Deaths ^b						Alaska Native Expected Number of Deaths			Alaska Non-Native Expected Number of Deaths		
	Males	Females	All	Males	Females	All	Males	Females	All	Males	Females	All	Males	Females	All	Males	Females	All	Males	Females	All
Under 5	3,570	3,326	6,896	13,049	12,377	25,426	25.06	19.22	22.19	32	25	57	63	39	102	89	64	153	327	233	560
5-14	8,143	7,703	15,846	28,459	27,180	55,649	.52	.33	.43	15	9	24	14	13	32	4	3	7	15	9	24
15-24	4,955	4,779	9,734	31,943	21,125	53,068	1.92	.68	1.29	41	17	58	82	13	95	10	3	13	61	14	75
25-34	3,216	3,157	6,373	23,323	19,960	43,282	2.17	1.03	1.59	37	9	46	66	14	80	7	3	10	51	21	69
35-44	2,696	2,555	5,251	18,565	14,389	32,954	4.10	2.37	3.21	31	23	54	81	20	101	11	6	17	76	34	106
45-54	1,890	1,660	3,549	12,988	10,615	23,603	9.68	5.13	7.33	30	18	48	88	53	141	18	9	26	126	54	173
55-64	1,319	1,094	2,413	6,619	4,938	11,557	22.89	10.93	16.59	32	23	55	131	43	174	30	12	40	152	54	192
65-74	715	552	1,267	1,960	1,514	3,474	165.56	113.74	135.19	22	18	40	107	40	147	118	63	171	324	172	470
75 and over	450	306	756	761	677	1,438				33	22	55	90	67	157	76	35	104	126	77	194
Missing										1		1	1		1						
TOTAL	25,955	25,231	52,186	137,677	112,784	250,461				274	164	438	728	302	1,030	363	198	541	1,253	673	1,926

Sources:

^aStatistical Bulletin, 1973. Based on 1970 Census.

^bVital Statistics, 1974, Health Information Systems, Division of Public Health, Dept. of Health and Social Services.

TABLE V-5

RESIDENT DEATHS BY AGE BY RACE
ALASKA, 1975

Age	Absolute Frequency			Relative Frequency		
	White	Native	All Races	White	Native	All Races
Under 1 month	40	23	70	3.9%	5.2%	4.6%
1-11 months	27	10	37	2.6	2.3	2.4
1-4 years	16	13	29	1.6	2.9	1.9
5-14 years	25	12	38	2.4	2.9	2.5
15-24 years	102	73	100	9.9	16.6	11.0
25-34 years	95	50	151	9.3	12.2	9.9
35-44 years	88	45	138	8.6	10.2	9.1
45-54 years	165	59	233	16.1	13.4	15.3
55-64 years	181	56	245	17.6	12.7	16.1
65-74 years	142	43	195	13.8	9.8	12.8
75 years and over	146	57	205	14.2	12.9	13.5
TOTAL	1,027	441	1,522	100.0%	100.0%	100.0%

Infant Death Rate*		Neonatal Death Rate*	
White	12.2	White	7.3
Native	20.9	Native	14.6
All Races	14.3	All Races	9.4

*Rate per 1,000 live births.

Source: Alaska Vital Statistics, 1975, Health Information Sections, Division of Public Health, Department of Health and Social Services.

Specific Causes of Death. The profile of the leading causes of death in Alaska is somewhat different compared to the national average. The profile of the ten leading causes of death, in terms of percentage of total number, for Alaska and the U.S. is presented in Table V-6. Accidents account for the greatest percentage of deaths in Alaska, 27% in 1975 compared to 5% for the national average. Deaths due to suicide, alcoholism and homicide similarly account for a disproportionate share of the total compared with the national profile. Alcoholism and homicide, ranked as eight and ten in Alaska, are not even with the top leading ten causes for the U.S.

In addition, Alaska's pattern of leading causes of death differs in the relatively low percentage of deaths due to heart diseases and malignant neoplasms.

TABLE V-6
TEN LEADING CAUSES OF DEATH, ALASKA AND THE U.S., 1975
(Percent of Deaths)

Alaska	Percent of Total	United States	Percent of Total
1 Accidents	27%	Heart Diseases	38%
2 Heart Diseases	17%	Malignant Neoplasms	20%
3 Malignant Neoplasms	9%	Cerebrovascular Diseases	10%
4 Suicide	5%	Accidents	5%
5 Cerebrovascular Disease	5%	Influenza and Pneumonia	3%
6 Diseases of Early Infancy	3%	Diabetes	2%
7 Cirrhosis of Liver	3%	Cirrhosis of Liver	2%
8 Alcoholism	3%	Arteriosclerosis	2%
9 Influenza and Pneumonia	3%	Diseases of Early Infancy	2%
10 Homicide	2%	Suicide	1%
Remainder	23%	Remainder	16%
	100%		100%

Source: Alaska Vital Statistics, 1975. Health Information Section, Division of Public Health, Department of Health and Social Services.

Alcohol-Related Mortality in Alaska: Specific Causes

The very brief summary of available research findings presented in a previous section indicated the relationship between alcoholism or alcohol abuse or heavy drinking and excess deaths due to such specific causes as cirrhosis of the liver, heart disease and hypertension; in addition, excess deaths due to accidents, homicide, suicide, and alcoholism are known to be related to consumption of beverage alcohol. Each of these specific causes of death are examined in relation to consumption of alcohol for Alaska in the following sections. It is interesting to note, though, the relatively high correspondence

between the increased mortality due to specific causes of death considered most closely associated with abusive consumption and the ten leading causes of death for Alaska.

Violent Deaths: Accidents

Historically, the most common cause of the selected causes of death shown in Table V-7, has been death by accident, from 1963 to 1975. Comparison of Alaska's accident mortality rate with that of the United States shows also that the Alaska rate has been--and remains--more than twice as high as the nation's, from 1959 to 1975. With the exception of one year, 1962, Alaska's accidental death rate has averaged over 118 deaths per 100,000 population since 1959, ranging from approximately 99 to 168 per 100,000 population. During the same period the overall average for the United States ranged from about 42 to 58 deaths per 100,000 population, but evidenced a definite declining trend. The trend for Alaska is mostly consistently high, but with wide fluctuation, as can be seen in Figure V-1.

Given the fact, then, that accidents are the number one cause of deaths in Alaska, and occur at a rate more than twice that of the rest of the nation, the extent of alcohol's involvement in accidents becomes an important question. To date, the most comprehensive reply has been a 17-month study of accidental deaths by the Anchorage Coroner-Public Administrator, completed in 1972. In that case, study of alcohol's possible involvement in 267 coroner's cases--all violent deaths and deaths unattended by a physician, including accidents, homicides, suicides, drownings, natural causes, and fire--found 115 cases, or 43% of the total, to be directly due to alcohol or its effects.²⁰

TABLE V-7

NUMBER AND RATES OF SELECTED CAUSES OF DEATH, ALASKA AND THE NATION, 1959-1975

	1959	1960	1961	1962	1963	1964	1965	1966	1967	1968	1969	1970	1971	1972	1973	1974	1975
Accidents	257	243	255	240	266	425 ^a	303	376	323	353	392	353	400	338	354	410	419
Alaska Rate	116.8	107.5	113.8	98.8	114.4	167.9	114.3	138.2	116.2	123.9	132.9	116.9	128.6	104.9	107.3	116.8	100.5
U.S. Rate	52.0	52.3	50.4	52.3	53.4	54.3	55.7	58.5	57.2	57.5	57.6	56.4	55.0	55.4	55.2	49.5	41.7
Homicides	11	20	24	11	22	26	24	26	26	26	24	36	26	31	26	33	26
Alaska Rate	4.9	8.8	10.1	4.5	8.8	10.2	9.1	9.6	9.4	9.1	8.1	11.9	8.4	9.6	7.9	9.4	6.4
U.S. Rate	4.6	4.7	4.7	4.8	4.9	5.1	5.5	5.9	6.8	7.3	7.7	8.3	9.1	9.4	9.8	10.2	10.2
Suicides	35	31	38	37	35	45	47	46	43	37	22	40	48	36	56	43	74
Alaska Rate	15.9	13.7	16.1	15.2	14.0	17.6	17.8	16.9	15.5	13.0	7.5	13.2	15.4	11.2	16.9	12.2	18.3
U.S. Rate	10.6	10.6	10.4	10.9	11.0	10.8	11.1	10.9	10.8	10.7	11.1	11.6	11.7	12.0	12.0	12.1	12.6
Alcoholism	10	16	16	10	12	18	17	15	20	27	25	33	45	38	34	35	46
Alaska Rate	4.5	7.4	6.8	4.1	4.8	7.0	6.4	5.5	7.2	9.7	8.8	10.9	14.5	11.0	10.3	10.0	11.4
U.S. Rate	1.2	1.3	1.3	1.2	1.3	1.3	1.4	1.6	1.6	2.0	2.0	2.1	2.1	2.1	2.2 ^b	2.2 ^b	2.2 ^b
Liver Cirrhosis	11	14	9	24	20	22	19	21	15	26	23	34	42	38	26	37	49
Alaska Rate	5.0	6.2	3.8	9.9	8.0	8.7	7.2	7.7	5.4	9.1	7.8	11.2	13.5	11.8	7.9	10.6	12.1
U.S. Rate	10.9	11.3	11.3	11.7	16.9	12.1	12.8	13.6	14.1	14.6	14.8	15.5	15.4	15.6	15.9	15.8	14.7
Heart Disease and Hypertension	213	267	243	268	245	277	262	273	214	231	204	264	269	319	285	294	262
Alaska Rate	96.8	118.1	102.5	110.3	98.0	109.5	90.9	100.4	94.9	81.1	69.2	87.3	86.5	99.0	86.3	83.7	64.7
U.S. Rate	363.2	369.0	362.4	370.1	375.2	365.7	367.4	372.0	364.5	372.6	366.1	362.0	360.5	363.0	360.8	349.2	358.4

^aIncludes 113 victims of March 27, 1964 earthquake
^bEstimated--no information available

Sources: Vital Statistics of the United States, annuals (1959-1973); Vital Statistics Monthly Reports, 1973-1976; Alaska Vital Statistics, 1974 and 1975.

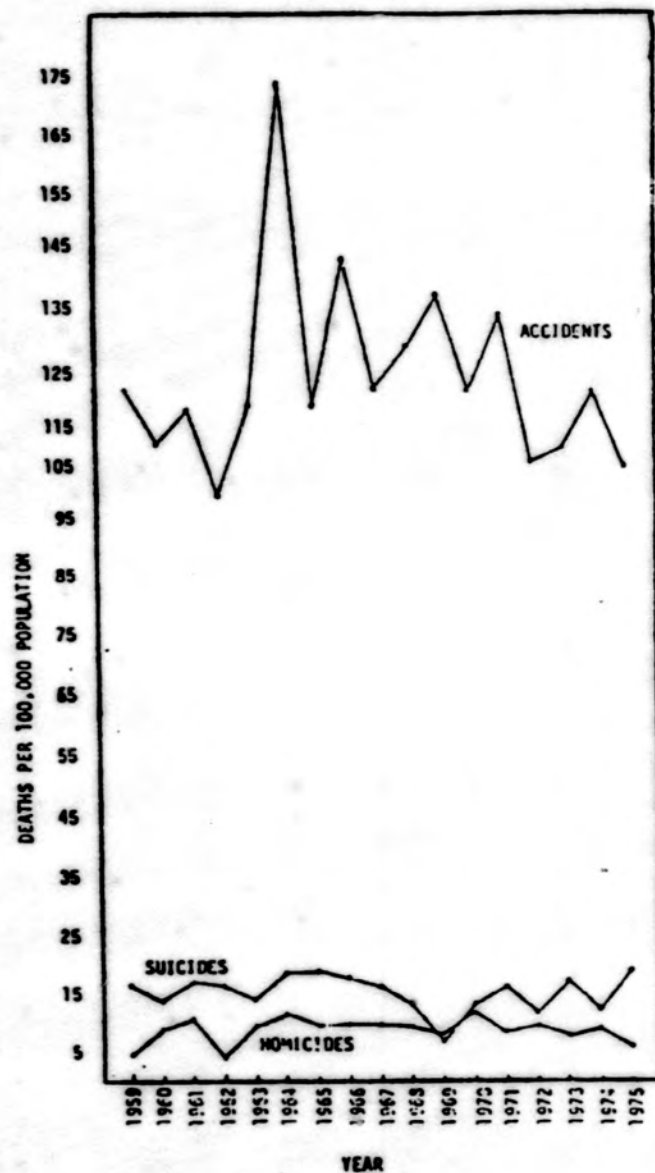


FIGURE V-1 Rate of death for accidents, suicides, and homicides, Alaska, 1959-1975 (per 100,000 population)

Source: See Table V-7 for rates.

Keeping the above in mind, it becomes possible to look at Alaska's accidental deaths from yet another perspective: transportation. As Table V-8 shows, the most common forms of accidents in Alaska during 1959-1966* were water transportation (16.8% of all accidents), motor vehicle (16.0%), and aircraft (15.7%). Also worth noting, however, were drownings: if water transport drownings over the period are combined with non-transport drownings, the sum represents some 24.6% of all accidents. Thus, it can be seen that during 1959-1966 these four categories--all very characteristic of Alaska and its peculiar lifestyle--accounted for nearly 60%** of all these accidents. Table V-8 also shows that these overall patterns had not changed significantly by 1974 and 1975. However, the percentage of accidental deaths due to motor vehicle crashes increased considerably during 1974 and 1975, compared to the 1959 to 1966 average of about 16% of the total number of accidental deaths. During 1974 and 1975, the percentage of motor vehicle deaths increased to about 18% and 28%. Investigation of motor vehicle fatalities found that 46% of all fatalities in 1975 involved alcohol. (See Part VII, Alcohol and Traffic Safety for more complete discussion).

The only information available regarding the extent of alcohol involvement in accidental deaths in Alaska is the Anchorage Coroner's study, 1972, showing that 43% of the accidental deaths investigated were alcohol-related, and the motor vehicle fatality files, 1975, showing that 46% of the fatalities involved alcohol. Obviously, generalizations about the extent of alcohol involvement in all accidental deaths cannot be

*Breakdown of accidental deaths by type for 1967 to 1974 was not available.

**Non-redundant tally equals 58.4%.

TABLE V-8
ALASKAN ACCIDENTAL DEATHS AND DEATH RATES FROM SELECTED CAUSES BY YEAR
1959-1966 and 1974 and 1975*

	1959	1960	1961	1962	1963	1964	1965	1966	Total Deaths 1959-66	% of all Deaths 1959-66	1974	%	1975	%
All Accidents--Total	257	243	268	240	286	312**	303	376	2,285	100%	410		419	
Transport Accidents--														
Total	126	108	102	126	145	161	168	192	1,128	49.4%	155		238	
Railway and Other														
Road Accidents	3	2	2	-	3	1	3	4	18	0.9%	-			
Motor Vehicle	34	43	26	39	45	47	57	74	365	16.0%	72	17.5%	119	28.4%
Water Transport--														
Drowning	29	27	44	33	51	46	55	52	337	14.7%	29	7.1%	49	11.7%
Other	4	2	4	6	8	9	12	4	49	2.1%	2	0.5%	2	0.5%
Aircraft	56	34	26	48	38	58	41	53	359	15.7%	52	12.7%	68	16.2%
Non-Transport Accidents														
Total	131	135	166	114	141	151*	135	184	1,157	50.6%	255		181	
Poisoning	12	11	12	8	13	10	17	8	91	4.0%	14	3.4%	21	5.0%
Falls	10	10	11	3	15	6	7	11	73	3.2%	22	5.4%	12	2.9%
Fire	18	19	46	27	30	34	21	68	265	11.6%	37	9.0%	22	5.3%
Firearms	16	14	15	12	12	15	11	15	110	4.8%	29	7.1%	16	3.8%
Drowning (non-transport)	25	32	22	22	26	32	38	30	227	9.9%	48	11.7%	37	8.8%
Excessive Cold	3	4	5	2	7	9	6	6	42	1.8%	4	1.0%	22	5.2%
Other	47	45	53	40	38	45*	35	46	349	15.3%	101	24.6%	51	12.2%
Total											100.0%			100.0%
Estimated Population	224,000	228,200	235,500	242,800	250,000	255,800	264,600	272,000			353,000		434,000	

Source: 1959-1966: Statistical Services Report, Dept. of Health and Welfare. 1974-1975: Alaska Vital Statistics, 1974 and 1975, Health Information Services, Division of Public Health, Department of Health and Social Services.

*Breakdown of accidental deaths by type for years 1967-1974 is not available.

**Includes victims of March 27, 1964 earthquake (113)

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ALASKAN ACCIDENTAL DEATHS AND DEATH RATES FROM SELECTED CAUSES BY YEAR
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Transport Accidents--														
Total	126	108	102	126	145	161	168	192	1,128	49.4%	155		238	
Railway and Other														
Road Accidents	3	2	2	-	3	1	3	4	18	0.9%	-			
Motor Vehicle	34	43	26	39	45	47	57	74	365	16.0%	72	17.5%	119	28.4%
Water Transport--														
Drowning	29	27	44	33	51	46	55	52	337	14.7%	29	7.1%	49	11.7%
Other	4	2	4	6	8	9	12	4	49	2.1%	2	0.5%	2	0.5%
Aircraft	56	34	26	48	38	58	41	53	359	15.7%	52	12.7%	68	16.2%
Non-Transport Accidents														
Total	131	135	166	114	141	151*	135	184	1,157	50.6%	255		181	
Poisoning	12	11	12	8	13	10	17	8	91	4.0%	14	3.4%	21	5.0%
Falls	10	10	11	3	15	6	7	11	73	3.2%	22	5.4%	12	2.9%
Fire	18	19	46	27	30	34	21	68	265	11.6%	37	9.0%	22	5.3%
Firearms	16	14	15	12	12	15	11	15	110	4.8%	29	7.1%	16	3.8%
Drowning (non-transport)	25	32	22	22	26	32	38	30	227	9.9%	48	11.7%	37	8.8%
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Other	47	45	53	40	38	45*	35	46	349	15.3%	101	24.6%	51	12.2%
Total											100.0%		100.0%	
Estimated Population	224,000	228,200	235,500	242,800	250,000	255,800	264,600	272,000			353,000		404,000	

Source: 1959-1966: Statistical Services Report, Dept. of Health and Welfare. 1974-1975: Alaska Vital Statistics, 1974 and 1975, Health Information Services, Division of Public Health, Department of Health and Social Services.

*Breakdown of accidental deaths by type for years 1967-1974 is not available.

**Includes victims of March 27, 1964 earthquake (113)

made on the basis of this information alone, but the interrelation of alcohol abuse, transportation patterns and accidental deaths in the state is substantial, and clearly warrants intense further study.

Examination of the distribution of accidental deaths according to age shows a "high risk" population to be in the 15 to 34 age group. (See Table V-9.) During 1975, 217 of the 419 accidental deaths, or 50% of all accidental deaths were accounted for by the 15 to 34 age group; about 30% of the total deaths were in the 15 to 24 group. This general bracket also corresponds with the highest risk population of drinkers with problems as determined for Alaska in Part II of the Volume.

Finally, it can be noted that Alaska Natives, who in 1974 constituted approximately 17% of the state's total population were victims in over 30% (125 of 410) of all accidental deaths in 1974 and almost 32% (134 of 419) in 1975. (See Table V-10.)

Violent Deaths: Homicide and Suicide

It is characteristic of Alaska that violent deaths, including homicide and suicide, tend to occur more frequently than in the nation as a whole. This is especially true for suicides, and--until recent years, anyway--generally true for homicides, as well.

For example, the suicide rate in Alaska has been relatively constant during the period from 1959 to 1975. (See Figure V-1.) It has averaged almost 15 deaths per 100,000 population over the 17 year period, and reached a high point at 18.3 in 1975. (See Table V-7.) This compares to an increasing U.S. rate that has changed from 10.6 per 100,000 in 1959 to 12.6 in 1975.

With respect to homicides, however, Alaskan and national death rates show a different relationship. While the homicide mortality rate in Alaska in 1960 was originally much higher than in the nation

as a whole (8.8 compared to 4.7 per 100,000 population), it has risen relatively little since then. (See Table V-7 and Figure V-1.) The national rate has jumped from 4.7 per 100,000 population in 1960 to 10.2 during 1975 (See Table V-7). Thus, the difference between the Alaskan and national rate has decreased, relative to the increasing national average.

Concerning the role of alcoholism or alcohol abuse in these categories of Alaskan violent deaths, national and international studies conducted by Schmidt and de Lint, found suicide to be one of the more frequent causes of death among chronic heavy drinkers; also, among suicide cases, there tends to be a high proportion of alcoholics.²¹ Other studies, pertaining to suicides among Alaskan Eskimos, further echo the involvement of alcohol.²² Considering the relatively high number and rate of suicides in Alaska, the role of alcohol--though unspecifiable--is presumed significant. Similarly, no reliable information about the extent of alcohol involvement for homicides exists for Alaska. A generally accepted national estimate indicates alcohol involvement in approximately 64% of homicide cases.²³

Concerning "risk populations" for Alaska's violent deaths rates, Table V-9 shows that in 1975 the 15-34 age group was most vulnerable, with respect to both suicide mortality (52 of 74 deaths, or 70% of all suicides) as well as homicide mortality (17 of 26 deaths, or 65% of all homicides).

Finally, it can be noted that Alaska Natives, who represented approximately 17% of the state's 1974 population appear to be victims of both suicide and homicide to a very disproportionate high degree. For example, Natives were involved in 47% of the state's suicides in 1974 (see Table V-16), and 43% in 1975. Similarly, they were the victims of homicides in 48% of all cases in 1974, and in 38% during 1975.

TABLE V-9
RESIDENT DEATHS BY CAUSE BY AGE GROUP, ALASKA, 1975

Cause of Death	Under 5	5-14	15-24	25-34	35-44	45-54	55-64	65+	TOTAL
Heart Disease and Hypertension	4	1	1	5	17	47	75	112	262
Cirrhosis of Liver	0	0	1	5	7	16	15	5	49
Accidents	17	27	126	91	55	53	26	24	419
Suicides	0	0	32	20	12	0	9	1	74
Homicides	0	0	6	11	6	1	2	0	26
Alcoholism	0	0	2	3	12	16	11	3	46
All Other Causes	<u>115</u>	<u>10</u>	<u>12</u>	<u>16</u>	<u>29</u>	<u>92</u>	<u>116</u>	<u>256</u>	<u>646</u>
TOTAL	136	38	180	151	138	233	245	401	1,522

Source: Alaska Vital Statistics, 1975. Health Information Services, Division of Public Health, Department of Health and Social Services.

Alcoholism

A major indicator of alcohol's involvement in Alaska's mortality rates, valuable for its specificity (alcoholism deaths being 100% alcohol-related), is the extremely high rate of deaths due directly to alcoholism (see Table V-7). Traditionally four to five times as high as the nationwide rate, Alaska's alcoholism mortality rate has dramatically increased by 153% from 1959 to 1975, 4.5 deaths per 100,000 population compared to 11.4 in 1975. (See Table V-7 and Figure V-2.) The national rate has also increased during the same period, but not to the same extent, from 1.2 deaths per 100,000 to 2.2, an increase of 83%. In 1959 the alcoholism mortality rate for Alaska, compared to the U.S., was 275% greater, in 1975, it had jumped to 418% greater than the national average.

With regard to "high risk" populations, Table V-9 shows that fully 85% (39 of 46 deaths) of all deaths due to alcoholism in Alaska during 1975 occurred in the 35-64 age group, with almost 35% of them (16 of 46) occurring in the 45-54 bracket.

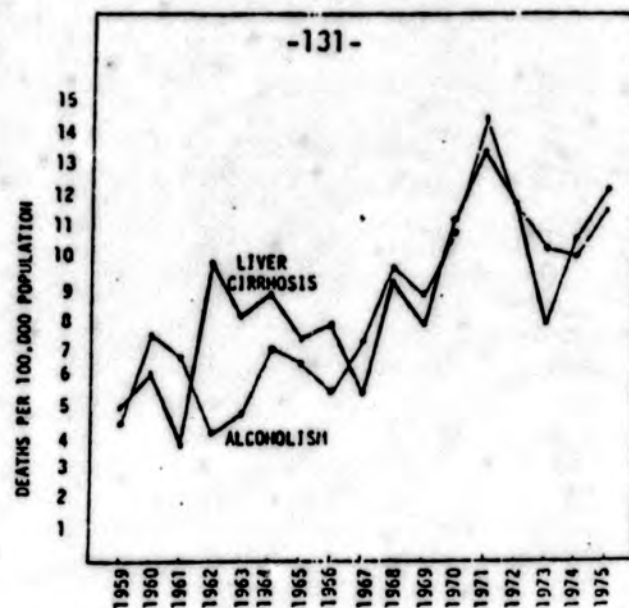


FIGURE V-2 Rate of death for liver cirrhosis and alcoholism deaths, 1959-1975 (per 100,000 population)

Source: See Table V-7 for rates.

Finally, it should be noted that the alcoholism mortality rate in Alaska--like virtually all other mortality rates in the state--is tremendously higher for Natives than for non-Natives. In Table V-10, for example, it can be seen that Natives (17% of the 1974 population--Table V-10) accounted for some 60% of all deaths (21 of 35) due to alcoholism in 1974, and almost 50% (22 of 46) in 1975.

TABLE V-10

RESIDENT DEATHS IN ALASKA, BY CAUSE AND RACE, 1974-75

Cause	1974			1975		
	White	Native	All Races	White	Native	All Races
Heart Disease	220	63	294	203	50	262
Liver Cirrhosis	28	9	37	28	19	49
Accidents	279	125	410	276	134	419
Suicides	22	20	43	39	32	74
Homicides	14	16	33	11	10	26
Alcoholism	14	21	35	24	22	46
Other Causes	410	104	616	446	174	646
TOTAL	987	438	1,468	1,027	441	1,522

Source: Alaska Vital Statistics, 1975. Health Information Services, Division of Public Health, Department of Health and Social Services.

Cirrhosis of the Liver

Another major indicator of alcohol's impact on Alaskan mortality is the number of deaths due each year to cirrhosis of the liver--a condition often resulting directly from alcoholism and/or alcohol abuse. Deaths due to liver cirrhosis are conventionally used in estimates of prevalence of alcoholics in a population.*

The absolute number of deaths, as well as the rate of death per 100,000 population, for liver cirrhosis has increased dramatically during the period from 1959 to 1975. Table V-7 shows that the number of liver cirrhosis deaths changed from eleven in 1959, to 49 in 1975, and despite fluctuations represents a real increase as indicated by the changes in rates. The rate of liver cirrhosis deaths increased by over 142% during that time period, 5.0 per 100,000 to 12.1 (Figure V-2).

This increase in the liver cirrhosis mortality rate also corresponds to increases in annual average rate of consumption of beverage alcohol during the same period. The rate of alcohol-related mortality is theoretically linked to the prevalence of alcoholism in a population. According to one major theory, the rate of alcoholism is directly related to level of consumption in a population.** Figure V-3 shows the correspondence between the increases in the mortality rate for liver cirrhosis and increases in average annual consumption of absolute alcohol. The pathological relationship between excessive drinking and liver cirrhosis is well established and direct. The relationship between increasing average

*See Part II, PREVALENCE, for a more complete discussion.

**See Part IV, CONSUMPTION.

consumption in Alaska and increasing mortality due to liver cirrhosis is clearly demonstrated in Figure V-3.

In terms of a "high risk" population, it can be seen from Table V-9 that in 1975 approximately 63% (31 of 49) of all liver cirrhosis deaths occurred in the 45-64 age group. Table V-10 adds to this the fact that Natives, only 17% of the 1974 population accounted for almost 25% (9 of 37) of all cirrhosis deaths in Alaska during 1974, and almost 40% of them (19 of 49) in 1975. Another way of looking at the same data reveals that, while white cirrhosis deaths in 1975 remained the same as in 1974 (28 deaths, each year), Native deaths due to liver cirrhosis almost doubled in the same period, from 9 in 1974 to 19 in 1975 (See Table V-10)--indicative, perhaps, of a shift begun years earlier, due to the progressive nature of the disease.



FIGURE V-3 Annual per capita consumption and cirrhosis deaths per 1000 in the drinking age population, Alaska, 1953-1975.

Source: Consumption figures from Table IV-2, this Volume. Death information compiled from statistics provided by the Health Information Systems Section, Department of Health and Social Services.

Heart Disease

Next to accidents, heart disease and associated hypertension were the greatest cause of death in Alaska in 1975 (Table V-6); deaths from heart disease accounted for 17% of all deaths in 1975. Alaska's overall 1975 heart disease mortality rate (64.7 per 100,000 population)--albeit the second highest death rate in the state--is still considerably lower than the overall national heart disease rate (358.4 per 100,000). In addition this rate of death has steadily decreased since 1959, similar to the United States trend.

While the direct relationship of alcoholism or alcohol abuse to heart-related mortality is not specifiable, national samplings of alcoholic populations indicate that from 10 to 40 percent of all excess deaths are attributable to cardiovascular disease.²⁴

Regarding a "high risk" population and heart disease, Table V-9 illustrates that the greatest risk of death from cardiovascular causes is to persons over age 45; who in 1975 accounted for 89% (234 of 262) of all such deaths. Also predictably, the table shows clearly that the risk of heart-related death increases steadily in proportion to advancing age.

Finally, it can be said that neither Alaskan Natives nor their non-Native counterparts appear to suffer disproportionally high heart disease mortality rates. As Table V-10 shows, Natives accounted for 21% (63 of 294) of all heart-related deaths in 1974, and 19% (50 of 262) in 1975--only slightly higher than their populational proportion. Non-Native Alaskans--approximately 83% of the 1974 population were, correspondingly, slightly low in their heart-related death rate, showing 75% (220 of 294) of all such deaths in 1974, and 77% (203 of 262) in 1975. (See Table V-10.)

D. REGIONAL DISTRIBUTION OF MORTALITY IN ALASKA (1974)

In the foregoing sections, Alaska's various mortality rates have been reviewed with regard to their relationship with alcoholism and alcohol abuse. Further, the role played by the state's exceptionally high overall level of alcohol consumption has been viewed as central to any understanding of that relationship. Given this, it will be helpful before concluding to briefly look at the geographic distribution of mortality in the state, as a means of identifying those areas and subpopulations most at risk with respect to alcohol-related excess mortality.

The geographical and racial (Native/non-Native) distribution of deaths in 1974* will be presented by Native Regional Corporation and, alternatively, by Health Systems Agencies (health planning areas). Geographically the state is divided into twelve Native Regional Corporations; groups of these regions cluster to form the boundaries of three Health Systems Agencies (HSA). Accordingly the three HSA's and the component Native Corporation regions are: Northern Region HSA--Arctic Slope, Doyon, and Nana; Southcentral Region HSA--Ahtna, Chugach, Cook Inlet, Bristol Bay, Koniag, Aleut, Calista, and Bering Straits; and, the Southeast HSA--Sealaska. (See Figures V-4 and V-5.)

General Mortality: Findings

Table V-11 shows the distribution of deaths for Native and non-Natives, for each Native Corporation Region, along with rates and percentages for selected categories.

One evident pattern is the much greater rate of death in isolated and less populous areas. There were 1,468 deaths (all causes)

*1975 Mortality data were not available in time for compilation of regional analysis.

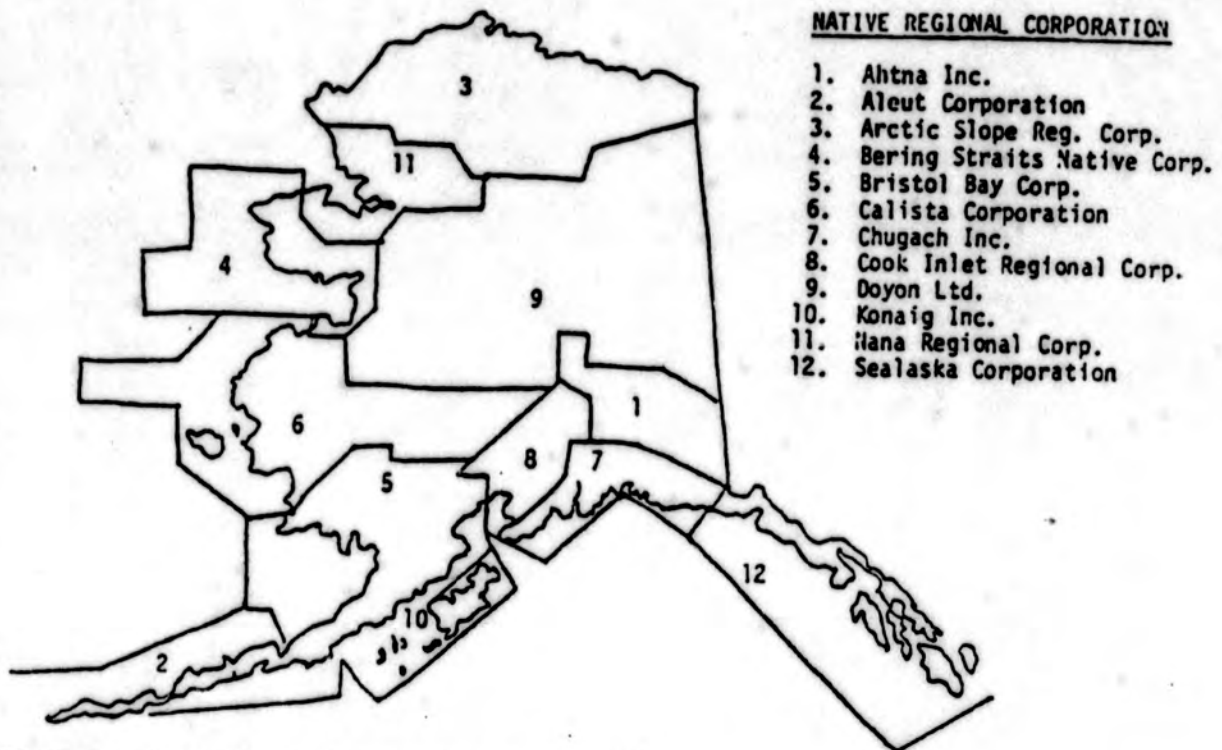


FIGURE V-4 Native Regional Corporation boundaries

Source: Alaska Vital Statistics, 1975, Health Information Services Section, Department of Health and Social Services.

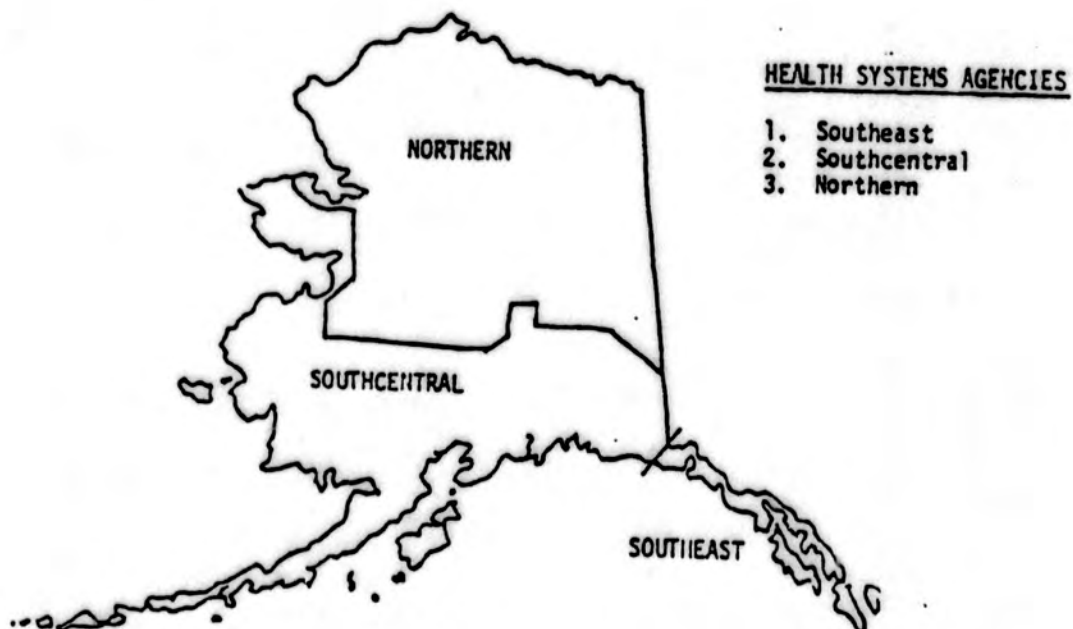


FIGURE V-5 Health Systems Agency boundaries

Source: Ibid.

in Alaska in 1974, resulting in a statewide overall death rate of 4.16 deaths per 1,000 population.* For nine of the twelve regional corporations, regional death rates exceeded the statewide rate; regional rates for three regions were below the state average. Regional Corporations with deaths per 1,000 population above the state average of 4.16 were: Koniag--6.81, Chugach--6.64, Calista--5.60, Sealaska--5.26, Bristol Bay--5.14, Bering Strait--4.86, Arctic Slope--4.70, Nana--4.50, Ahtna--4.34. The three Native Regional Corporations with death rates below the state average were Doyon--3.8, Cook Inlet--3.53, and Aleut--3.39. If the populations of the regions are considered, however, it results that the nine regions with death rates higher than the statewide average (4.16) had a 1974 total population of only 109,312 people (31% of total 1974 population). The three regions with lower death rates represented a combined 1974 total of 243,985 people (68% of total). Thus, it is strongly evident that death rates in 1974 were highest in the less densely populated areas of Alaska, and lowest in the more populous areas.

Another pattern of overall Alaskan mortality is shown in the extremely high rate of death, statewide, among Natives (7.36 deaths per 1,000)--more than twice the 1974 rate for non-Natives (3.51). As Table V-11 shows, Native death rates in 1974 ranged as high as 11.59 per 1,000 in Aleut Native Corporation, almost three times the overall state death rate (4.16). Even Ahtna Native Corporation, it can be seen, with the lowest Native death rate of all the corporations (3.68), was still higher than the statewide average for non-Native (3.51 per 1,000).

Combining the twelve regional corporations into the recently established three health systems agencies--Northern, Southcentral, and Southeastern Regions--produces yet another set of mortality patterns.

* Total population of Alaska in 1974 was estimated to be 353,297 of whom 59,536 were Natives and 293,761 non-Natives.

TABLE Y-1

RESIDENTS BY CAUSE BY NATIVE REGIONAL CORPORATION (GROUPED BY HEALTH SYSTEMS AGENCIES) BY RACE 1974

Health Systems Agency Native Corporation Region	Arctic Slope	Southcentral										South- Eastern	Total Native Subtotals	Total Non-Native Subtotals	State Totals
		Yukon Dayton	Yukon Nana	Yukon Ahtna	Yukon Aleut	Yukon Bering Strait	Yukon Bristol Bay	Yukon Calista	Yukon Chupach	Yukon Cook Inlet	Yukon Koniag	Yukon Sealaska			
Total Population ^a	5,939	68,416	4,414	2,534	7,384	9,468	6,739	14,195	8,776	169,185	9,246	50,770			353,297
Native Population ^a	2,939	7,651	3,121	544	1,725	4,725	3,854	11,773	1,264	8,432	2,310	9,405	59,536	293,761	59,536
Non-Native Population ^a	3,000	60,515	723	1,990	5,659	4,743	2,172	2,332	5,507	159,243	6,936	40,862			293,761
Deaths by Corporation ^b (Native/Non-Native)	28 28	260 90 170	20 16 4	11 2 9	25 20 5	46 41 5	31 24 7	79 71 8	45 4 39	593 54 539	63 14 49	267 72 195	438 325	1,039 (76%)	1,468 (100%)
Death Rate (per 1000)															
Total Population	4.71	3.80	4.50	4.34	3.39	4.86	5.14	5.69	6.64	3.53	6.81	5.26			4.16
Native	4.56	11.41	4.30	3.68	11.59	8.68	11.05	6.06	4.73	6.04	6.36	7.27		3.51	
Non-Native	0.00	2.81	5.53	4.52	0.88	1.05	3.22	3.36	7.00	3.38	7.06	4.74	7.36		
Cause of Death (Native/Non-Native)															
Tuberculosis		2	1			1		2		2			8		8
Other Infectious		1	1					1		1			3		3
Inflammatory Dis. of CHS		1	1				1	1		1			1		4
Gastritis and Enteritis															1
Influenza and Pneumonia	1	5	5					5		3	1	3	15	28	43
Other Respiratory		2	5	1		2	2	2	3	13		5	9	26	35
Maternal															
Congenital Malform.		2	1	1		1	1			1	11	2	8	12	22
Dis. of Early Infancy		6	12		1	5	2	6		3	22	1	25	42	67
Ill Defined	1	3	2	1	1	2	1	3	2	4	13	3	22	27	49
Heart Disease	2	13	37	1	2	5	2	5	2	8	115	3	63	231	294
Malignant Neoplasms	4	8	10	1	1	6	2	7	1	5	76	4	49	139	179
Diabetes			1							3		1	1	14	15
Vascular Lesions of CHS	1	3	16		3		1	5	1	38	1	4	19	76	95
General Arteriosclerosis		1	4							1			2	9	10
Chronic Nephritis														2	2
Other Degenerative	3	1	1					1		2	18	1	6	24	30
Alcoholism	1	3	4		1			3		2	7	1	21	14	35
Cirrhosis of Liver		1	4		1			1	2	3	19	1	9	28	37
Homicides	1	4	2	1	1	1		3		2	11	2	16	17	33
Suicides		4	6	6	1	5	1	2		2	8	2	23	23	43
All Accidents (sub-total)	15	25	43	1	2	12	2	7	1	14	14	5	23	125	149
Motor Vehicles	1	1	8			4	1	1		5	37	1	16	54	72
Water Trans.--Drown.		2				3		1		10		8	11	20	31
Other Drowning	3	4	2	1	1		1	5		17	2	4	18	39	48
Firearms		1	2					4		2	11	3	12	17	29
Poison			2		1			2		8		1	3	12	15
Fire	4	5	2				1	7		7		5	23	13	34
Falls	1	1	2			1			1	9		2	7	15	27
Aircraft		1	13	1				1		20	1	5	2	59	52
Excess Cold	1	1	1										1	2	4
Other Accidents	5	9	11	1	1	4	1	3	3	5	22	8	29	72	101
All Other	1	6	7	2		2	2	2		2	16	2	25	27	52
Violent Deaths	17	37	54	8	2	19	2	31	5	33	124	6	27	357	554
Percentage of Total Rate (per 1000)	61%	41%	35%	59%	59%	67%	40%	42%	14%	43%	15%	43%	55%	30%	38%
Total Population	2.86	1.40	7.75	2.37	1.63	2.22	1.82	2.55	1.22	1.74	1.57	1.85			1.58
Native	5.09	4.69	2.15	0.60	5.80	1.67	2.59	2.64	2.16	2.57	2.60	2.91	3.21		
Non-Native	0.09	0.94	2.77	1.02	0.35	0.84	0.44	2.19	1.02	1.17	1.89	1.57		1.25	

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^a Estimates based on information from Alaska Dept. of Labor, U.S. Census Report, and BIA Native Enrollment Print-out.

Based on the data displayed in Table V-11, a series of findings regarding overall mortality in Alaska in 1974 can be synopsized as follows:

The highest overall mortality rate in 1974 was in the Southeastern Region* (5.26, compared to statewide average of 4.16 per 1,000), where the highest 1974 non-Native death rate (4.77) was also recorded. Additionally, the estimated population of 9,908 Natives in this health systems agency--representing 2.8% of the total statewide population--accounted for almost 5% of all 1974 deaths (72 of 1,468).

The highest Native death rate in 1974 of the three health systems agencies occurred in the Northern Region** of Alaska, at 9.22 deaths per 1,000 population (compared to overall statewide Native death rate of 7.36). In that health systems agency, Natives--representing 18% of the systems agency population (14,352 of a total 78,799)--accounted for almost 44% of the total service area deaths (134 of 308).

In the Southcentral Region,*** the only 1974 mortality pattern of note was that Natives, while only 15% of the total systems agency population (35,096 of 223,728), accounted for 26% of the deaths in that agency (232 of 893)--thus repeating the pattern of high Native mortality, relative to death among non-Natives.

In sum, then, analysis of the distribution of mortalities (all causes) in Alaska during 1974 reveals the following patterns:

- overall death rates were highest in the less densely populated regions;

- the rate of death among Natives in the state (7.36 per 1,000 population) was more than twice as high as the rate of death among non-Native (3.51);

*Includes only Sealaska Native Corporation.

**Includes Arctic Slope, Doyon, and Nana regional corporations.

***Includes Ahtna, Aleut, Bering Strait, Bristol Bay, Calista, Chugach, Cook Inlet, and Koniag regional corporations.

- the highest overall rate of death for a regional corporation occurred in Koniag (6.81), and for a health systems agency in the Southeastern Region (5.36), compared to a statewide rate of 4.61;
- the highest Native death rate occurred in Aleut Regional Corporation (11.59), and in the Northern Region (9.22), compared to a statewide Native death rate of 7.36;
- the highest death rate among non-Natives occurred in Chugach regional corporation (7.08), and in the Southeastern Region (4.77), compared to a statewide non-Native mortality rate of 3.51.

Given the previously mentioned known associations among alcohol consumption, alcoholism and alcohol abuse, and excess mortality, the identification of these distribution patterns and subpopulational rates will hopefully prove useful in future planning and prevention efforts aimed at reducing alcohol-related excess mortality. Major efforts were required to enable the re-compilation of mortality data for the preceding regional distribution of mortality information. Further analysis on the basis of the data for only one year is not justified, particularly in view of the small numbers in each cell.

However, one item is noteworthy, at least in passing. Although the information only covers one year, the number of Native deaths due to alcoholism and liver cirrhosis was disproportionately greater for Natives in the Sealaska Regional Corporation (Southeastern Health Systems Agency) than any other corporation regions or Health Systems Agencies. This region had approximately 16% of the Native population in 1974, yet accounted for 40% of all Native deaths due to these two causes. Further, 17% of all Native deaths in the Southeast HSA were accounted for by alcoholism and liver cirrhosis, compared to 4% and 6% for the Northern and Southcentral HSA's.

E. SUMMARY

The present discussion of mortality in Alaska has been undertaken to focus attention on the relationship between alcohol consumption and excess mortality due to alcoholism and alcohol abuse. As stated at the beginning, the specific purposes in mind were to identify that excess mortality as it occurs in Alaska, to delineate its characteristics across a variety of mortality categories, and to understand its relationship to the statewide (and behind that, both the national and international) background of alcohol consumption.

What has been obtained by this effort, is best described as a sense of context. Without being able to pin-point or specify, it has been possible to generally ascertain and describe the involvement of alcohol consumption in the state's various forms of mortality.

This has been possible, most directly of all, through recognition of the definitive contribution that alcohol consumption--or, at least, excessive alcohol consumption--makes to social problems in general, and specifically to mortality. In this respect, the fact that the United States (eighth among nations in alcohol consumption) and especially Alaska (probably first among all states) have extremely high and rapidly increasing annual levels of consumption, indicates that the involvement of alcohol in excess mortality--always significant--is, in Alaska's case, probably tremendous.

This is supported, of course, by the fact that Alaska annual level of per capita alcohol consumption is nearly double that of the nation (4.54 gallons of absolute alcohol per person in 1975, compared to the nation's 2.90). It is also supported by the fact that Alaska's rate of deaths due to violent causes--a mortality category always greatly influenced by alcoholism and alcohol abuse--ranges anywhere from

two to five times the national rate, depending on the specific cause of death. The strength of correspondence between the dramatic and rapidly increasing rates of alcohol consumption and mortality rates for liver cirrhosis and alcoholism, direct indicators of prevalence of alcoholism, confirms the pervasive influence of excess consumption.

Given the linkages, then, that national and international studies have established between alcohol abuse and the various specific-cause categories of mortality, it is evident that Alaska's mortality rates (overall, cause-specific, subpopulational) and patterns (trends, increases, distribution) provide valuable and significant clues to the nature and character of excess mortality in the state due to alcohol.

With respect to the most important specific causes of death, it turns out that violent causes (including cirrhosis)--which presume the greatest extent of indirect alcohol involvement--account for almost 40% of all deaths in the state. A very important consideration in regard to these deaths and one very relevant to Alaska and its peculiar lifestyle is that over 68% of all accidental deaths in the state (1975) were linked to transportation--in one form or another (water transportation, motor vehicles, aircraft, drownings). It is known that at least 46% of all motor vehicle fatalities involved alcohol.

With respect to the human consequences of (alcohol-related) excess mortality, it results that the younger and middle age-ranges of the population suffer the highest rates of death--a fact doubly significant if it is remembered that by 1970 almost 85% of the state-wide population was under age 44, and that the 15-44 age-bracket stands as the very most "at risk" of all age groups in the state with respect to alcoholism and alcohol abuse, and death, particularly violent death.

With respect to such "risk populations" in general, specific-cause mortality data show that two subpopulations in Alaska are characterized by especially high mortality: (1) the young, as mentioned above, and (2) the state's Native population, whose overall rate of death in Alaska is more than twice that of non-Natives (1974).

Finally, the regional distribution of fatalities in Alaska (in 1974) indicated that overall death rates were highest in the less populous regions of the state, but that overall mortality was concentrated in the Southeastern Region. The pattern of mortality distribution also shows that Native death rates were greatest in the Northern Region (least densely populated region in the state), while the highest non-Native rate of mortality occurred in the Southeastern Region.

In the aggregate, these trends and apportionments of mortality in Alaska suggest a confluence with other, known characteristics of the effects and consequences of excessive alcohol consumption in the state. With respect to known patterns and levels of consumption in Alaska, as with respect to the known patterns and characteristics of alcoholics and alcohol abusers, alcohol-related excess mortality in Alaska provides yet one more way of estimating and understanding the overall and specific effects of alcohol on the state, and its various sub-systems. In the parts of this Volume to follow, other such indicators will be adduced and examined in an effort to capture still other possible perspectives on alcohol's impact on Alaska.

FOOTNOTES

1. Wolfgang Schmidt and Robert Popham. "Alcohol Consumption and Physical Health." Addiction Research Foundation, Mimeo, #659, 1975.
2. Jan de Lint and Wolfgang Schmidt. "Alcoholism and Mortality." In B. Kissen & H. Begleiter (Eds.), The Biology of Alcoholism, Vol. IV, Plenum, New York, 1975.
3. P. Nichols, G. Edwards, and E. Kyle. "A Study of Alcoholics Admitted to Four Hospitals. II. General and Cause Specific Mortality During Follow-up." Quarterly Journal of Studies on Alcohol, 35, 841-855, 1974.
4. de Lint and Schmidt, op. cit.
5. U. S. Department of Health, Education and Welfare: National Institute on Alcohol Abuse and Alcoholism. Second Special Report to the U. S. Congress on Alcohol and Health, from the Secretary of Health, Education and Welfare. (DHEW Publication No. (ADM) 75-212) Washington, D. C.: U.S. Government Printing Office, 1975, pp.80.
6. Wolfgang Schmidt and Robert Popham. "Alcohol Consumption and Public Health Problems." Addiction Research Foundation, Mimeo, #604, 1974.
7. U. S. Department of Commerce, Bureau of Census. Statistical Abstracts of the U.S., 1975.
8. U.S. Department of Health, Education and Welfare: National Institute on Alcohol Abuse and Alcoholism. First Special Report to the U.S. Congress on Alcohol and Health, from the Secretary of Health, Education and Welfare. (DHEW Publication No. HSM-72-9099) Washington, D.C.: U.S. Government Printing Office, 1971. Reprinted, 1974.
9. The Economic Cost of Alcohol Abuse and Alcoholism, 1971. Prepared for the National Institute on Alcohol Abuse and Alcoholism by Policy Analysis, Inc. Boston, Mass. 1974.
10. Alcohol and Health, 1974, pp. 97-110.
11. Schmidt and Popham, "Alcohol Consumption and Physical Health", p. 11
12. de Lint and Schmidt, op. cit.
13. *ibid.*
14. *ibid.*
15. *ibid.*

16. Schmidt and Popham, op. cit., p.20.
17. de Lint and Schmidt, op. cit.
18. Alcohol and Health, 1974, pp. 53-75.
19. U. S. Department of Commerce, Bureau of Census. Statistical Bulletin, April, 1973.
20. Statistical Abstracts of the U. S., 1975, op. cit.
21. National Council on Alcoholism-Alaska Region. Facts on Alcoholism in Alaska, Anchorage, 1974.
22. Schmidt and Popham, op. cit.
23. Robert Kraus. "Suicidal Behavior in Alaska Natives". Alaska Medical Journal, 1974.
24. The Economic Cost of Alcohol Abuse and Alcoholism, op. cit.

PART VI: ALCOHOL-RELATED CRIMES AND THE CRIMINAL JUSTICE SYSTEM

A. INTRODUCTION

In Alaska it is a widespread belief, almost considered a truism, that the greatest majority of crime committed in the state is alcohol-related. This is to say that either the offender or the victim, or both, had been drinking heavily before or during the commission of the crime, and that their general behavior would be considered by most to be "drunken behavior".

In public testimony collected during the spring of 1976, for example, the Criminal Justice Planning Agency found that the general public ranked alcohol abuse as the primary cause of crime in the state, in both urban and rural settings.* Consistently, witnesses linked alcohol abuse to such social and criminal problems as juvenile crimes, public inebriation, child abuse, homicides, rape, assault, other violent crimes, etc., and called for additional rehabilitation programs to help deal with these alcohol-related problems. In particular there seemed to be considerable agreement at the hearings--especially among representatives of urban centers and rural cities**, that court sentencing, particularly for offenders convicted for multiple OMVI offenses and violent crimes, should be more severe and more swift than is currently imposed.

*Except in Anchorage, where alcohol was ranked behind poverty and personal character deterioration as major causes of crime.

**Urban centers include Anchorage/Spenard, Fairbanks, Juneau, Ketchikan, and Alaska State Trooper Detachment C (surrounding Anchorage). Rural cities include Cordova, Haines, Homer, Palmer, Petersburg, Sitka, Valdez, Wrangell, and Kenai. See following pages for discussion of this typology.

Similar feelings were reported in responses to a statewide sample survey conducted that same spring by the Rowan Group, Inc., an Anchorage-based research corporation. Also sponsored by the Criminal Justice Planning Agency, the survey queried some 245 urban and rural respondents, and 72 "bush" residents, aged 16 to 65, about their feelings regarding criminal activity and the involvement of alcohol in crime. Results showed that almost 75% of the urban population sampled--and over 95% of the rural respondents--felt that most crimes committed in Alaska are related to alcohol abuse and drug abuse.² Further, these respondents believed that crimes against persons (robbery, homicide, rape, assault) constitute the major category of alcohol-related crime.³ Echoing the earlier public testimony, results of the survey also showed that the overall public surveyed rated the job being done by Alaskan courts as poor, and that they considered leniency in sentencing as the criminal justice system's major problem.⁴

It is not surprising that the public feels this way. Given the attention devoted to crime and violence by the media, and repeated statements by government and public officials that alcohol is the state's number one health and social problem, it is understandable in the extreme that alcohol abuse and crime should be linked in the public consciousness. Add the known association between alcohol and crime as borne out by numerous criminal justice studies, and the fact that in 1975 there were an estimated 30,000 or more alcohol abusers and alcoholics in the state*, the perceived accompaniment of crime and alcohol abuse in Alaska becomes a belief almost unassailable in its prima facie veracity.

* See Part II of this Volume

Clearly, reliable and valid information is needed. While no one can seriously doubt the fact of alcohol's involvement in crime, the nature and extent of that involvement, though most important, is what is least understood. The nature and extent of public opinion regarding the relationship of alcohol abuse and crime is clear. However, little is known about the relationship between alcohol abuse and particular types and frequency of criminal offenses.

Purpose

It is the purpose of this Part, therefore, to examine the nature and the extent of alcohol-related crime in Alaska.

The focus of the analysis is on the impact of alcohol-related crime on the criminal justice system--law enforcement, prosecution, judicial, and corrections. The analysis thus reflects the nature and the extent of alcohol-related crime on the system, rather than the impact of the adverse consequences of alcohol-related criminal acts on victims or society in general.

A further consideration that must be noted at the onset is the forced emphasis on the impact of alcohol-related crime on the law enforcement component of the criminal justice system throughout the following analysis. The nature of the available data requires this emphasis. Unless a reported actual crime is cleared by arrest, the impact of that criminal behavior on the criminal justice system is extremely difficult to measure.

In addition, the data regarding nature and extent of the impact of alcohol-related crime on other components of the criminal justice system--activities after arrest, become even more obscure as a case moves from arrest to final disposition. For all these reasons the analysis must focus

on law enforcement arrest activity. Nevertheless, an attempt is made to at least indicate the scope of the impact of alcohol-related arrests on the remainder of the criminal justice system. In addition, a detailed description of the estimated economic impact of alcohol-related crime on each and all components of the criminal justice system is presented in Volume I, Part V, of this report.

B. ALCOHOL-RELATED CRIME AND LAW
ENFORCEMENT IN ALASKA

Because law enforcement functions represent the initial point of contact between all forms of crime and the criminal justice system, they provide the most direct and specific information regarding the relative impact of alcohol-related crime. It thus becomes useful to compare national and statewide reported criminal offenses and crime rates, and to attempt to establish with some specificity the portion of them which is due to alcoholism or alcohol abuse.

The primary source for data on reported crimes in the nation is the FBI Unified Crime Reporting Program, under the terms of which law enforcement agencies throughout the nation tally all crimes as they become known. Since a very large number of offenses go unreported each year, however, it is difficult to estimate the total volume of crime for almost any given period or specific offense. Unified Crime Reporting Program information is therefore accepted by criminal justice authorities only as a valid indicator of crime trends and patterns. Even on such a basis, however, such information becomes indispensable for understanding crime in Alaska; and, more specifically, alcohol-related crime.

The Uniform Crime reporting Program is divided by offenses known as the Crime Index Offenses. Part I crimes are divided into "violent" crimes and "property" crimes. The former include such offenses as criminal homicide, forcible rape, robbery, and aggravated assault. The latter include such offenses as burglary, larceny-theft, and auto-theft. Part II crimes, which are "non-violent" in nature, include all other offenses.

In the present report, attention will be focused on the "violent" crimes of Part I (homicide, rape, robbery, assault), and selected (i.e., alcohol-related) offenses classified as Part II crimes. The "property" crimes (included in Part I offenses), and Part II crimes not related to alcohol will not be discussed, except by way of reference.

Violent Crime in Alaska

From the perspective of the impact of alcohol use and abuse on the criminal justice system, this analysis is focused on the distribution of actual arrests for the various crime index categories of offenses--on cases which allow at least some sort of determination of alcohol involvement. While it may be largely correct to associate the use or abuse of alcohol with the commission of a major portion of violent crimes, as is reflected in public opinion studies, it is important to distinguish between the number of violent crimes reported to have occurred and the actual number of arrests made for those offenses, for the purpose of analysis. There is no known reliable way to investigate the extent of alcohol involvement in the commission of reported offenses.

The most important point to be made at first is that total arrests for violent crimes account for only a small portion of the total number of arrests

for all categories of offenses. Various indicators of crime are used to reflect crime trends. Part I crimes are typically reported in terms of the crime rate index, or the victim rate index, which is the number of reported offenses (Part I type offenses) per 100,000 population. In terms of this crime index, reported Part I crime has increased steadily in Alaska in the period from 1973 to 1975 and the index is greater than the national average. As can be seen in Table VI-1, the crime rate for violent crimes (personal crimes) in Alaska was greater than the national average in 1973 and 1974, but dropped below the national average in 1975. However, the overwhelming proportion of Part I crimes is composed of property crimes, as opposed to violent (personal) crimes. Reported violent crimes accounted for about six percent of the total reported Part I crimes, for each year from 1973 to 1975.

TABLE VI - 1
CRIME RATES FOR REPORTED PART I OFFENSES, ALASKA AND U.S., 1973-1975

	Crime Index ^a Total Part I	Violent Crime Rate (without robbery) ^b	Robbery Rate	Property Rate (without robbery)
1973				
Alaska	4,943.3	317.5	67.0	4,558.8
U. S.	4,129.7	232.7	182.6	3,714.4
1974				
Alaska	5,239.8	364.8	88.4	4,786.6
U. S.	4,850.4	252.3	208.8	4,389.3
1975				
Alaska	5,413.7	347.9	116.7	4,949.1
U. S.	5,281.7	263.3	218.2	4,800.2

a. Number of reported Part I crimes per 100,000 population
b. Robbery is considered to include aspects of both personal and property crimes.

Source: Calculations based on information provided in Alaska Criminal Justice Plan, 1977, Volume I, p.8., prepared by the Criminal Justice Planning Agency.

Another index of criminal activity, which also reflects impact on the criminal justice system, is the number of actual arrests for the various types of criminal offenses. Review of actual arrest information for all arrests and for Part I and Part II offenses, as presented in Table VI-2, shows that arrests for violent crimes accounted for only about three-to-four percent of the total number of arrests made during each of the years from 1973 to 1975. Arrests for all types of Part I offenses accounted for about 22-23 percent of all actual arrests during the same period.

TABLE VI - 2
ARRESTS FOR VIOLENT CRIMES, BY SPECIFIC OFFENSE, IN
RELATION TO ALL PART I AND PART II TYPE
ARRESTS, ALASKA, 1973-1975

Arrest Category	1973		1974		1975	
	Number	Percent of Total	Number	Percent of Total	Number	Percent of Total
Part I Offenses						
Violent Crimes						
Homicides	29	*	49	*	44	*
Rape	49	*	56	*	67	*
Aggravated Assault	338	2%	469	3%	504	2%
Robbery	98	*	99	*	151	*
Property Crimes	2,836	19%	3,376	19%	3,951	19%
Total Part I	3,342	22%	4,049	23%	4,717	23%
Total Part II	11,801	78%	13,917	77%	16,008	77%
All Arrests	15,143	100%	17,966	100%	20,725	100%

* Less than one percent

Source: See reference tables at end of this Part.

The distribution of actual arrests for Part I and Part II type offenses, which can be seen to be rather stable, shows that only a small proportion of law enforcement activity is reflected in actual arrests for violent crimes. This is important to keep in mind when discussing the role or involvement of alcohol use and abuse on the criminal justice system. As indicated earlier, a good deal of public attention and government response seems to be focused on violent or personal crimes. Although the crime rate for violent crimes is well above the national average, it is important not to lose sight of the fact that persons arrested for violent crimes represent only a very small portion of the total number of arrests made for all categories of offenses. Arrests for criminal offenses in Alaska are predominantly and consistently for Part II type offenses.

Violent Crime and Alcohol Involvement

The role that alcohol consumption plays in the commission of a criminal act is as yet mainly undefined. Several researchers have, however, noted the consumption of alcohol immediately before or at the time of the commission of a variety of criminal offenses. Available research has shown significant relationship between the consumption of alcohol and the commission of violent crimes--criminal homicide, assaults, forcible rape, and other sex offenses. The relationship between alcohol consumption and violent crime does not, however, indicate a causal relationship. It is clearly understood that the consumption of alcohol does not in itself lead to violence, but increasing circumstantial evidence seems to link alcohol consumption to crime. Only the major studies that demonstrate the relationship between alcohol consumption and violent crime are presented in this section.

The most reliable and generally accepted estimate of the relationship between alcohol consumption and criminal homicide comes from a four-year study by M. E. Wolfgang. During the study period from 1948 to 1952, alcohol was found to be present in either victim or offender, or both, in 64% of the 588 cases investigated.⁵ Close support for this estimate comes from a 1951 Baltimore study by Fisher, in which 69% of homicide victims showed evidence of alcohol consumption.⁶ While no definitive national study yet exists, other national findings have confirmed this general level of alcohol involvement.⁷ In Alaska, case information presented to the Alaska Parole Board during 1974-75 indicated that alcohol was involved in approximately 69% of the homicides considered.⁸ In the absence of any other more specific information, it is likely that alcohol is involved in approximately 64% of all criminal homicides in Alaska.

With respect to forcible rape, the most reliable estimates of alcohol-related involvement came from an extensive study in 1967 by M. Amir, in which alcohol was found to be directly involved in 34% of 646 investigated rape cases.⁹ Other, less comprehensive evidence of alcohol involvement in forcible rape offenses comes from a study reported in 1971 by L. Shupe, in which 45% of rape cases studies involved persons with a B.A.C. level of more than .10%.¹⁰ Finally, an informal study during 1974-75 by the Alaska Parole Board indicated that 67% of the rape offenders seeking parole during that time had been drinking at the time of their offense.¹¹ Thus, a reasonable estimate of alcohol involvement in Alaskan rape cases would be approximately 34%.

Regarding aggravated assault, the extent of alcohol-related involvement is also significant, though not quite as great as in homicide or rape cases.

Findings by the District of Columbia Crime Commission in 1966, for example, found alcohol to be involved in 35% of the offenders and 41% of the victims of felonious and other assaults;¹² a 1964 study in St. Louis by Pittman and Handy found that alcohol was present in approximately 25% of all assaults studied.¹³ Similarly, the National Commission on the Causes and Prevention of Crime has estimated that 24% of all violent crimes, including aggravated assault, involve the use of alcohol.¹⁴ Thus, a reasonable estimate would be that approximately 35% to 41% of all aggravated assaults in Alaska are alcohol-related.

Research evidence regarding the extent of alcohol involvement in robbery cases is very conflicting, although an informal study conducted by the Alaska Parole Board indicated that 57% of the convicts seeking parole during 1974-1975 had been drinking at the time of the commission of their offense.¹⁵ No good, reasonable estimate of alcohol involvement, however, is considered justifiable at this time.

In brief summary, a review of the national and Alaska findings indicates that reasonable estimates of alcohol involvement in the various kinds of violent crimes in Alaska are: criminal homicides--64%; forcible rape--34%; and, aggravated assault--41%. No estimate is judged reliable for robbery offenses. Although the number of annual arrests for violent crime offenses in Alaska represent only a very small proportion of the total number of actual arrests, the extent of alcohol involvement for these offenses would appear to be very high.

Part II Crimes and Alcohol Involvement

As previously indicated, arrests for Part II offenses in Alaska during 1973 to 1975 represented approximately 77% of the annual total arrests for all offenses. Given such a preponderance, it becomes necessary to determine the nature and extent of alcohol involvement among the multiple classifications of offenses designated within the Part II category of offenses.

Among all Part II offenses, there are six specific offense classifications which are conventionally regarded as virtually "100% alcohol-related".* These offenses are: driving while intoxicated, drunkenness,** violation of liquor laws,*** disorderly conduct, other (non-aggravated) assaults and vagrancy. The first three of these offenses are legally defined by virtue of involvement with alcohol. The latter three--disorderly conduct, assaults and vagrancy, are commonly regarded as more often-than-not associated with the use and misuse of alcohol, and often tend to be employed as alternative charges for drunken behavior.

* The Economic Cost of Alcohol Abuse and Alcoholism, 1971, Final Report, HSM, 42-73-114(NIA), March, 1974. pp. 120-136. Prepared for the National Institute on Alcohol Abuse and Alcoholism by Policy Analysts, Inc.

** In spite of the adoption of the Uniform Act in 1972, which decriminalized drunkenness (among other provisions), arrests for drunkenness are still made and recorded.

***Typically, violation of sales, distribution, and other regulatory laws-- sales to minors, violation of closing hours, unauthorized sales.

Table IV-3 shows the number and percentage of annual arrests in Alaska during 1973 to 1975 for each of the "100% alcohol-related" offenses, in relation to all arrests for all Part II offenses, as well as Part I arrests and total arrests.

TABLE VI-3
"100% ALCOHOL-RELATED" ARRESTS IN RELATION TO ARRESTS FOR
PART I AND PART II TYPE OFFENSES AND ALL OFFENSES,
ALASKA, 1973-1975.

	1973		1974		1975	
	Number	Percent of Total	Number	Percent of Total	Number	Percent of Total
Total Part I Arrests	3,342	22%	4,049	23%	4,717	23%
Total Part II Arrests	11,801	78%	13,917	77%	16,008	77%
"100% alcohol-related" arrests:						
DUI	2,267	15%	2,107	12%	3,157	15%
Disorderly conduct	1,257	8%	1,328	7%	1,476	7%
Liquor laws	862	6%	1,033	6%	1,746	8%
Other assaults	788	5%	1,010	6%	1,384	7%
Drunkenness	609	5%	1,545	9%	278	1%
Vagrancy	61	*	17	*	40	*
Sub-total	6,054	40%	7,040	39%	8,072	39%
All Other Part II Arrests	5,747	38%	6,877	38%	7,936	38%

* Less than one percent

Source: See reference tables at end of this Part.

As can be seen, arrests for these "100% alcohol-related" offenses accounted for at least 39% of the total annual arrests during each of the years shown. Arrests for the three offense classifications defined in terms of involvement with alcohol, accounted for about 25% of the annual total arrests. In different terms, arrests for these six characteristic "100%

alcohol-related" offenses accounted for more than 50% of the annual total arrests for Part II offenses. Thus, on a statewide basis, arrests for criminal offenses defined by alcohol-involvement and, those conventionally considered as "100% alcohol-related," comprised at least 39% of all arrests for all offenses in the state. Three of the six conventional alcohol-related arrest categories are defined in terms of the abusive consumption of alcohol--DWI, violations of liquor laws and, drunkenness; arrests for these three offenses alone comprise about 25% of all arrests on a statewide basis. These figures exclude all those arrests for other categories that were indeed alcohol-related, but the arrest classification does not so define it, for example--violent and property crimes, and misdemeanor assaults, shoplifting, joyriding, etc. Thus, the percentage figure of at least 39% as the percentage of all arrests which are alcohol-related must be considered to be a very low estimate.

These figures are descriptive of arrest patterns for all enforcement jurisdictions within the state. The following section examines these arrest patterns in terms of characteristically different socio-geographic settings within the state.

Geographical Distribution of Alcohol-Related Arrests

The enforcement information for Part II type criminal offenses has been categorized according to similar socio-geographic settings within the state. Three types of settings were developed to distinguish among: "urban settings"--densely populated areas and environs; "rural-cities"--relatively populated areas, transportation and government sub-centers, and environs that consist of areas of low population density; and,

"rural areas"--outlying rural and bush areas of low population density. Table VI-4 presents this typology and the law enforcement jurisdictions assigned to each region for comparative analysis of the data.

TABLE VI - 4
CATEGORIZATION OF LAW ENFORCEMENT JURISDICTIONS ACCORDING TO
SIMILAR SOCIO-GEOGRAPHIC SETTINGS, ALASKA, 1973-1975

Settings	Law Enforcement Jurisdictions	Characteristics
Urban Centers	Anchorage/Spennard, Fairbanks, Juneau, Ketchikan, and AST Detachment "C" (surroundings of Anchorage)	Densely populated metropolitan areas, with densely, or relatively densely populated environs.
Rural Cities	Cordova, Ft. Yukon, Homer, Hoonah, Valdez, Kenai, Petersburg, Palmer, Sitka, Wrangell	Densely, or relatively densely populated city areas, but sharply demarcated by surrounding areas of extremely low population density.
Rural Areas	Alaska State Trooper Detachments B, D, E, F, G, H, I, J.	Outlying rural areas of extremely low population density.

Note: Cities and towns not included in above groupings failed to provide comparative information or allow information to be collected. Information was collected from multiple sources including direct request from local law enforcement agencies.

As presented in Table VI-3, the overall statewide distribution of arrests for Part I and Part II type offenses has been rather stable over the three year period from 1973 to 1975. Part I type offenses account for about 23% of all arrests, and Part II type offenses constitute about 77% of all arrests. Similarly, the overall statewide distribution of "100% alcohol-related" arrests has also been relatively stable--about 39% of all arrests.

Examination of the same enforcement data according to the different socio-geographic settings shows some variation in the proportional distribution of arrests for Part I and Part II type offenses, according to setting. The information, in Table VI-5, shows primarily that rural-city settings differ somewhat from the urban and rural settings in that a slightly greater percentage of all arrests are for Part II type offenses.

TABLE VI -5
PERCENTAGE OF TOTAL ARRESTS FOR PART I
AND PART II TYPE OFFENSES ACCORDING TO
SOCIO-GEOGRAPHIC SETTING, ALASKA, 1973-1975

	Percentage of Total Arrests			
	Urban	Rural/City	Rural	Statewide
Part I Offenses				
1973	22%	22%	20%	22%
1974	23%	17%	23%	23%
1975	24%	18%	22%	23%
Average (three years)	23%	18%	22%	23%
Part II Offenses				
1973	78%	78%	80%	78%
1974	77%	83%	77%	77%
1975	76%	82%	78%	77%
Average (three years)	77%	82%	78%	77%

Source: Percentages computed from actual arrest figures.
See reference tables at end of this part.

For the purpose of comparison, arrests for each criminal offense classification were averaged for each of the three years, according to designated socio-geographic settings. Thus, the average number of annual arrests for all offense classifications and for each of the selected "100% alcohol-related" offenses for each setting is

presented in Table VI-6. The relative impact of the alcohol-related arrests seems to be greatest in the rural-city setting. Collectively, the total average number of all alcohol-related arrests in rural-city settings constitutes about 48% of arrests for all offenses. In the urban and rural settings, alcohol-related arrests account for 39% and 34% of all arrests. Comparatively, the impact of alcohol-related arrests on law enforcement seems to be least in the rural areas.

TABLE VI-6
PERCENTAGE OF AVERAGE ANNUAL ARRESTS FOR *100% ALCOHOL-RELATED OFFENSES
ACCORDING TO SOCIO-GEOGRAPHIC SETTINGS DURING
1973 TO 1975, ALASKA

	Urban		Rural-City		Rural		Statewide	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Total Arrests ^a								
All Offenses	12,617	100%	1,910	100%	3,418	100%	17,945	100%
Section *100% Alcohol-related Arrests:								
DWI	1,619	13%	286	15%	606	18%	2,510	14%
Disorderly conduct	1,113	9%	145	8%	97	3%	1,354	8%
Liquor laws	757	6%	251	13%	206	6%	1,214	7%
Other assaults	774	6%	81	4%	206	6%	1,061	6%
Drunkenness	678	5%	137	7%	62	2%	877	5%
Vagrancy	75	*	14	*	1	*	39	*
All 100% alcohol- related arrests	4,967	39%	914	48%	1,177	34%	7,055	39%

a. Arrest figures represent the average number of annual arrests during the three-year period from 1973-1975. See reference tables at end of this Part.

* less than one percent

The above notion of relative impact of alcohol-related arrests on law enforcement is, of course, based on the ratio of alcohol-related arrests to the number of total arrests for all offenses. It does not describe impact of alcohol-related arrests in terms of the volume of total number of arrests. It is obvious, from the figures in Table VI-6, that the greatest volume of arrests is in the urban settings and that the smallest volume of arrests is in the rural-city settings. In terms of total number of average arrests, for the reporting jurisdictions during the period from 1973 to 1975, about 70% of arrests for all offenses took place in urban settings; the rural settings accounted for 19% of all arrests and the rural-city settings accounted for the remaining 11%. However, as can be seen in Table VI-7, the rural-city settings still accounted for a disproportionately greater number of alcohol-related arrests, compared to the relative volume of total arrests for all offense classifications in each of the three socio-geographic settings.

TABLE VI-7
PERCENTAGE DISTRIBUTION OF AVERAGE ANNUAL ARRESTS
AND ALCOHOL-RELATED ARRESTS BY SOCIO-GEOGRAPHIC
SETTINGS, ALASKA, 1973-1975

Socio- geographic Settings	Total Arrests	Percent of Total	Total alcohol-related Arrests	Percent of total alcohol- related Arrests
Urban	12,617	70%	4,967	70%
Rural-city	1,910	11%	914	13%
Rural	3,418	19%	1,177	17%
Statewide	17,945	100%	7,055	100%

Source: Average number of arrests computed from actual number of arrests during 1973, 1974 and 1975. See reference tables at end of this Part.

In summary, if viewed from the statewide perspective of average annual arrests, rural-city areas account for about 11% of all arrests but 13% of all alcohol-related arrests. If viewed from the perspective of volume of arrests within each setting, arrests for alcohol-related offenses constitute a disproportionately greater number of total arrests, 48%, compared to urban and rural settings, 39% and 34%.

Examination of the selected alcohol-related arrest categories according to each offense classification in Table VI-6, in relation to the total number of arrests for all offenses for each socio-geographic setting shows that arrests for DWI constitute the largest single category of alcohol-related arrests for each and all settings. Arrests for driving-while-intoxicated range from 13% to 18% of all arrests, among the three socio-geographical settings, and comprise 14% of arrests for all offenses statewide. It should be further noted that of all the FBI classifications of arrest, the category of DWI represents the largest single category of arrests, not just the largest single category of alcohol-related arrests.

The greatest variation in the percentage distribution of arrests for each of the alcohol-related offenses, according to socio-geographic setting, is for violations of liquor laws in rural-city settings. There is a disproportionately greater number of arrests for liquor law violations in the rural-city settings, 13% of total arrests compared to 6% of the total arrests in the urban and rural settings. The proportion of arrests for drunkenness is also somewhat higher in the rural-city settings than in the urban and rural settings.

In summary, the greatest impact of alcohol-related crime on law enforcement would seem to be in the rural-city settings of the state. In these areas, 48% of all arrests are for offenses considered to be "100% alcohol-related". Three of these six offenses are defined in terms of the abusive consumption of alcohol--DUI, liquor law violations and drunkenness; these three offenses alone account for 35% of all arrests in the rural-city settings. Comparatively, these types of arrests account for about 25% of all arrests within the urban and rural settings. Further, in terms of the total number of all arrests statewide, rural-city settings account for a larger proportion of alcohol-related arrests in relation to the volume of arrests for all offenses.

Law Enforcement, Alcohol-Related Arrests and Sex

Review of all arrests for all offenses in the state in 1975, as presented in Table VI-8, indicates that about 82% of all persons arrested were males and 18% were females. This same proportion applies to the distribution of persons arrested for Part I and Part II type offenses--82% of those arrested were males, 18% were females.

TABLE VI - 8
PERCENTAGE DISTRIBUTION OF TOTAL
ARRESTS FOR ALL OFFENSES AND
PART I AND PART II TYPE OFFENSES
BY SEX, ALASKA, 1975.

Arrest Category	Males	Females	Total
Part I Offenses	82%	18%	100%
Part II Offenses	82%	18%	100%
Total All Offenses	82%	18%	100%

Source: Calculations based on data provided
in Alaska Criminal Justice Plan, 1977, Volume I,
p. 46. Prepared by Criminal Justice Planning Agency.

Analysis of all males arrested shows that about 23% of the male arrests was for Part I type offenses and 77% was for Part II type offenses. This compares to a similar distribution of 25% and 75% for Part I and Part II type offenses, for females, as shown in Table VI-9.

TABLE VI-9
PERCENTAGE DISTRIBUTION OF MALE
AND FEMALE ARRESTS FOR ALL
OFFENSES AND PART I AND PART II
TYPE OFFENSES, ALASKA, 1975

Sex	Part I Offenses	Part II Offenses	All Offenses
Males	23%	77%	100%
Females	25%	75%	100%
Both	23%	77%	100%

Source: Based on data provided in
Alaska Criminal Justice Plan, 1977, Volume 1,
p. 46, Prepared by Criminal Justice Planning Agency.

The percentage of alcohol-related arrests that were males is 85%, which is only slightly higher than the percentage of male arrests for all categories of offenses. This same percentage distribution of alcohol-related arrests by sex applies to each of the individual alcohol-related offenses except for liquor law violations and vagrancy offenses, for which the percentage of arrests which are female is higher. See Table VI-10 below.

TABLE VI-10
PERCENTAGE DISTRIBUTION OF ALCOHOL-RELATED
ARRESTS BY SEX AND CRIMINAL OFFENSES,
ALASKA, 1975

	Males	Females	Both
DWI	89%	11%	100%
Disorderly conduct	62%	18%	100%
Liquor laws	77%	23%	100%
Other assaults	87%	13%	100%
Drunkenness	88%	12%	100%
Vagrancy	75%	25%	100%
All Alcohol-Related Arrests	85%	15%	100%

Source: Based on data provided in
Alaska Criminal Justice Plan, 1977, Volume 1,
p. 46. Prepared by Criminal Justice Planning Agency.

The percentage distribution of arrests for each alcohol-related offense within each sex category is presented in Table VI-11. It can be seen that arrests for DWI constitute the largest category of male arrests--43% of all male alcohol-related arrests were for DWI. The remainder of arrests are approximately divided among the offenses of disorderly conduct, liquor law violations and assaults, ranging from 15-19%. The pattern of female alcohol-related arrests shows a somewhat more even distribution of arrests for the categories of DWI, disorderly conduct and liquor law violations--31%, 24% and 26%. Although arrests for DWI still constitute the greatest concentration of arrests, as for males, it is not so pronounced. This analytic perspective also

shows the differential impact of female alcohol-related arrests for the offense category of liquor law violations--20% of all female alcohol-related arrests.

TABLE VI-11
PERCENTAGE DISTRIBUTION OF MALE AND
FEMALE ALCOHOL-RELATED ARRESTS BY
CATEGORY OF OFFENSE, ALASKA, 1975

Alcohol-related Offenses	Males	Females	Both
DWI	43%	31%	41%
Disorderly conduct	19%	24%	20%
Liquor laws	15%	26%	17%
Other assaults	19%	16%	18%
Drunkenness	4%	3%	4%
Vagrancy	*	*	*
All Alcohol-related Arrests	100%	100%	100%

* Less than one percent

Source: Based on data provided in
Alaska Criminal Justice Plan, 1977, Volume 1,
p. 46. Prepared by Criminal Justice Planning Agency

In summary, the basic distribution of alcohol-related arrests by sex shows a slightly greater percentage of males arrested than is characteristic of arrests for all offenses. The distribution of arrests for each alcohol-related offense shows a major concentration of male arrests for the offense of driving-while-intoxicated, whereas female alcohol-related arrests are more evenly distributed across the offenses of DWI, liquor violations and disorderly conduct. One of the other distinguishing characteristics of female alcohol-related arrests is

the relatively greater percentage of arrests for liquor law violations, compared to male alcohol-related arrest patterns.

Law Enforcement, Alcohol-Related Arrests and Age

The distribution of all arrests for Part I and Part II type offenses by age shows marked differences for juveniles (under 18) and adults (over 18). During 1975, about 70% of all persons arrested for all offenses were adults and 30% were juveniles. However as can be seen in Table VI-12, 53% of all arrests for Part I type offenses were juveniles. Thus, although 70% of all persons arrested are adults, more than half of all arrests for Part I offenses are juveniles and more than three-fourths of arrests for Part II offenses are adults.

TABLE VI-12
PERCENTAGE OF ARRESTS FOR ALL OFFENSES AND
PART I AND PART II OFFENSES FOR
JUVENILES AND ADULTS
ALASKA, 1975

	Part I Offenses	Part II Offenses	All Offenses
Juveniles (under 18)	53%	22%	30%
Adults (over 18)	47%	78%	70%
Both	100%	100%	100%

Source: Based on data provided in
Criminal Justice Plan, 1977, Volume 1,
p. 45. Prepared by Criminal Justice Planning Agency.

From the perspective of adult and juvenile arrests, as provided in Table VI-13, the preponderance of adult arrests for Part II type offenses can be seen again. Of all adults arrested only 15% are arrested for Part I type offenses and 85% of all adults are arrested for Part II type offenses. The pattern for juvenile arrests is very different. The distribution of juvenile arrests between Part I and Part II type offenses is much more even, about 43% and 57%.

TABLE VI-13
PERCENTAGE OF JUVENILE AND ADULT
ARRESTS FOR ALL OFFENSES AND
PART I AND PART II
OFFENSES, ALASKA
1975

	Juvenile Arrests	Adult Arrests	All Arrests
Part I Offenses	43%	15%	23%
Part II Offenses	<u>57%</u>	<u>85%</u>	<u>77%</u>
All Offenses	100%	100%	100%

Source: Based on data provided in Criminal Justice Plan, 1977, Volume 1, p. 45 Prepared by the Criminal Justice Planning Agency.

The distribution of juvenile and adult arrests for the designated alcohol-related offenses is presented in Table VI-14. This distribution is similar to the pattern for arrests for Part II type offenses. Of all arrests for all of the alcohol-related offenses, 87% were adults compared to 13% which were juvenile. Review of each of the alcohol-related offenses indicate that the percentage of adult arrests equalled or exceeded 95% for four of the designated offenses.

However, for the offenses of liquor law violations and other assaults, the percentage of juvenile arrests exceed adult arrests--52% for liquor law violations and 64% for other assaults.

TABLE VI - 14
PERCENTAGE OF ALCOHOL-RELATED ARRESTS BY
OFFENSE FOR JUVENILES AND ADULTS, ALASKA
1975

	Juveniles	Adults	Both
DWI	2%	98%	100%
Disorderly conduct	5%	95%	100%
Liquor laws	52%	48%	100%
Other assaults	64%	36%	100%
Drunkenness	2%	98%	100%
Vagrancy	4%	96%	100%
All alcohol-related arrests	13%	87%	100%

Source: Based on data provided in
Criminal Justice Plan, 1977, Volume I, p. 45.
Prepared by the Criminal Justice Planning Agency.

The distribution of the percentage of all juvenile and all adult arrests that are alcohol-related is presented in Table VI-15. Arrests for all alcohol-related offenses comprised about 39% of the total number of arrests in 1975. But review of juvenile and adult arrests separately shows that about 16% of all juvenile arrests were alcohol-related compared to about 47% of all the adult arrests.

TABLE VI - 15
PERCENTAGE OF TOTAL JUVENILE AND ADULT
ARRESTS BY EACH AND ALL ALCOHOL-RELATED
OFFENSES, ALASKA, 1975

	Juveniles	Adults	Both
DWI	1%	22%	14%
Disorderly conduct	1%	10%	8%
Liquor laws	11%	4%	7%
Other assaults	3%	9%	6%
Drunkenness	*	2%	5%
Vagrancy	*	*	*
All alcohol-related arrests	16%	47%	39%

* less than one percent

Source: Based on data provided in
Criminal Justice Plan, 1977, Volume I, p. 45.
Prepared by the Criminal Justice Planning Agency.

For adults, the offense category of DWI accounted for 22% of all the arrests (or 46% of all adult arrests for alcohol-related offenses). For juveniles, arrests for liquor law violations accounted for 11% of all juvenile arrests, and 3% of all juvenile arrests were for other assaults (These two categories account for 85% of all juvenile arrests for alcohol-related offenses).

Sample Survey: Alcohol-Related Arrests

The records maintained for persons arrested for any offense do not systematically include information regarding whether or not the person's behavior or self-report indicated the consumption of alcohol during, or prior to, the commission of the offense, or drunken or intoxicated behavior.

In an attempt to obtain more accurate and clear information regarding the relationship between alcohol-involvement and arrest, the Criminal Justice Planning Agency and the State Office on Alcoholism jointly conducted an enforcement study. Law enforcement officers were asked to make a notation at the time of each arrest indicating that: the arrested person had been drinking; the arrested person had not been drinking; or, no determination could be made.

During this one month sample study, conducted in May of 1976, three law enforcement jurisdictions provided information complete enough to be able to make some determination about the number of alcohol-related arrests for any and all offenses. The information has several limitations. The information pertains only to the jurisdictions reporting and applies only to the one month during which the information was collected. It does not allow for consideration of seasonal variations in arrest patterns or rates.

Nevertheless, in spite of these limitations, the information is provided below in Table VI-16, for each of the reporting jurisdictions. In the municipality of Anchorage, during the month of May, 1976, 49% of all arrests were determined to be alcohol-related, whereas for adults, 58% of arrests for all offenses were alcohol-related.

In the other urban reporting area, the results were very similar. Forty-eight percent of all arrests were alcohol-related. For adults and juveniles, the alcohol-related percentage of arrests was 59% and 16%.

TABLE VI-16
SAMPLE SURVEY: ALCOHOL-RELATED ARRESTS
IN THREE LAW ENFORCEMENT JURISDICTIONS,
ALASKA, MAY, 1976

	All Arrests	Alcohol- Related Arrests	Percent Alcohol- Related
Anchorage:			
Adults	419	244	58%
Juveniles	90	9	10%
Both	509	253	49%
Fairbanks			
Adults	155	92	59%
Juveniles	57	9	16%
Both	212	101	48%
Alaska State Trooper Detachment I: *			
Adults	123	99	80%
Juveniles	27	10	37%
Both	150	109	73%
All Adults	697	435	62%
All Juveniles	174	28	16%
Adults & Juveniles	871	463	53%

* AST Detachment I is an area of jurisdiction that surrounds the city of Fairbanks.

The Alaska State Trooper Detachment I represents a jurisdiction that would be classified a rural setting. It is the area that surrounds the city of Fairbanks. In this rural jurisdiction the percentage of alcohol-related arrests was considerably higher than in the urban areas. About 73% of all arrests were alcohol-related. For adults, 80% of all arrests for all offenses were alcohol-related and for juveniles, the figure was 37%.

These figures, of course, cannot be generalized to the entire state. But even though they represent a somewhat scattered sampling, the results do demonstrate the conservative nature of the estimate of alcohol-related arrests presented in the preceding sections. The information also serves to reinforce the urban-rural, and adult-juvenile differences described earlier, for the designated alcohol-related offenses.

C. ALCOHOL-RELATED CASES AND PROSECUTION,
ADJUDICATION AND CORRECTIONS

The nature of the records system for the disposition of court cases precludes definitive analysis of the nature and extent of the alcohol-related caseload for the judicial system. However, the impact of the nature and extent of alcohol-related arrests on the judicial and corrections components of the criminal justice system is clear. Although an in-depth analysis cannot be attempted at this time, a few remarks are provided to at least set some rough estimates of the scope of the impact of alcohol-related criminal cases.

Alcohol-Related Cases and
the Judicial System

The indicators provided to consider the scope of alcohol-related impact on the judicial system are the relative proportion of alcohol-related misdemeanor case filings and convictions. With respect to misdemeanor cases filed with the district courts within the state, in 1975, if the same categories of offenses that were used to define alcohol-related cases for the law enforcement analysis were applied to the judicial system, then somewhere between 48% and 75% of the misdemeanor cases filed

were alcohol-related.¹⁶ More specifically, at least 48% of the cases may be classified as alcohol-related on the basis of their conventional association with alcohol. These cases include charges for driving-while-intoxicated (or OMVI), liquor law violations, reckless driving, negligent driving, and leaving the scene of an accident. The other 27% of the misdemeanor filings that may be alcohol-related are those cases very often associated with alcohol-abuse-assault, malicious destruction, carrying a concealed weapon, and nuisance violations such as loitering, indecent exposure and disorderly conduct. If only the nuisance type violations were added to the minimum estimate of 48%, excluding filings for the more violent type of misdemeanors, then the revised estimate would be 62% of all misdemeanor filings (15,450)¹⁷ as alcohol-related in 1975. For the purpose of this section, the estimate of 62%, with a range from 48% to 75%, is sufficient.

Judicial convictions for alcohol-related cases ranged from 42% to 78% of all convictions during 1975.¹⁸ The estimate of 42% of all convictions (about 9,042)¹⁹ as alcohol-related refers only to those cases defined by alcohol involvement or excess--driving-while-intoxicated, liquor law violations, etc. The addition of the cases typically regarded as alcohol-related would bring the estimate to about 68% of all convictions as alcohol-related, with a range from 42% to 78%.

Alcohol-Related Cases and Corrections

Following law enforcement arrest and judicial conviction, the corrections system represents the next level of contact between alcohol-related crimes and the criminal justice system. Clearly, the impact is

not nearly as great for the corrections component, as dismissed charges and suspended sentences substantially reduce the number of persons who enter the corrections system. Nonetheless, the numbers and types of cases that eventually do become part of the corrections system represent another indicator of the impact of alcohol-related crime on the criminal justice system.

Perhaps the most important overall effect on the Alaska corrections system, with respect to alcohol-related crime, has been one of the consequences of passage of the state's Uniform Alcoholism and Intoxification Treatment Act, in 1972. By decriminalizing drunk-in-public offenses, this single piece of legislation has had a dramatic effect in eliminating the incarceration of many cases and thus lowering the number of alcohol-related cases serving sentences of more than ten days. From 1971 to 1975, the number of releases for jail sentences of ten days or longer for alcohol-related offenses decreased by 72%. During 1975, the only year for which statistics are available, more than 59% of all served sentences of fewer than ten days were for alcohol-related offenses.

Another indicator of systematic impact is the recidivism rate for offenders whose original incarceration was for alcohol-related offenses.²⁰ As shown by the results of a recidivism study conducted by the Criminal Justice Planning Agency, the second highest rate of recidivism, 43% among persons released in 1971 and 1972, occurred for alcohol-related offenders.²¹

D. SUMMARY

In spite of the attention given by the media and the public to the relationship between alcohol consumption and violent crimes, inspection of the current arrest data indicates clearly that the greatest impact on Alaska's criminal justice system derives primarily from Part II type, misdemeanor offenses. The public's concern about alcohol and violent crime is in part justified. Alaska's rate for serious crimes against persons (homicide, rape and aggravated assault) is higher than the national average and reasonable estimates indicate that 64% of homicides, 34% of rapes, and 41% of aggravated assaults are related to alcohol. Nevertheless, these three crimes, and robbery, account for only 4% of all arrests in Alaska. Although these crimes are of concern to the public precisely because they are serious and violent, it is that 77% of lesser, non-violent, misdemeanor crimes which has the greatest impact on the criminal justice system in Alaska. (The remaining 19% are Part I, serious, property crimes.) In terms of numbers of arrests, alcohol-related misdemeanor offenses have a much greater effect on the criminal justice system.

During the three years from 1973 to 1975, the Part II type, misdemeanor offenses considered to be "100% alcohol-related"--driving while intoxicated, disorderly conduct, liquor law violations, non-aggravated assaults, drunkenness, and vagrancy--accounted for 39% of all adult and juvenile arrests in the state. This figure should be considered as a conservative estimate since many individual arrests for other offenses

which involve alcohol could not be considered due to the present reporting systems. Thus, while alcohol plays a significant role in the serious crimes against persons, its main impact occurs at the misdemeanor level.

A consideration of the different socio-geographic settings showed that although the greatest volume of arrests for alcohol-related offenses is in the urban settings, where most of the people live, the greatest impact is in the rural-city settings. In these settings, a somewhat greater percentage of all arrests are for Part II type offenses. More significantly, however, nearly half, 48%, of all arrests were for alcohol-related offenses, compared to 39% in urban settings, and 34% in rural settings.

If attention is focused on adult arrests in the state, which comprise about 70% of all arrests for all offenses, then at least 47% of adult arrests should be considered to be alcohol-related. This group of adults accounts for 87% of all arrests for alcohol-related offenses, and is primarily composed of males--85%. Most of the adult arrests for alcohol-related offenses were for driving while intoxicated for both men and women. Females, however, showed a pattern of alcohol-related arrests more evenly divided among DWI, disorderly conduct and liquor law violations, whereas male alcohol-related arrests were very definitely concentrated on the DWI offense.

For juvenile arrests for alcohol-related offenses, about two-thirds were for liquor law violations. Liquor law violations and assaults together accounted for 85% of all juvenile arrests for alcohol-related offenses.

Although there is not enough data to adequately address the impact of alcohol-related arrests on the court and corrections components of the criminal justice system, it appears that misdemeanors would again be emphasized. Forty-eight to 75% of all misdemeanor cases filed with the district court were for alcohol-related offenses in 1975. Also, 42% to 78% of all misdemeanor convictions were for alcohol-related offenses.

During the period from 1971 to 1975, the number of releases for jail sentences of ten days or longer for alcohol-related offense decreased by 72%. Also, during 1975, more than 50% of all served sentences fewer than ten days were for alcohol-related offenses. In addition, the recidivism rate for alcohol-involved offenders was demonstrated to be about 43%.

A great deal of additional study is clearly in order for better understanding the impact of alcohol-related crime on the criminal justice system, particularly in the areas of Part I, felony offense, and civil court actions. On the basis of the information that is at hand, however, the nature and extent of the impact of alcohol-related crime on the criminal justice system in Alaska would have to be considered as quite significant and dramatic.

REFERENCE TABLE
TABLE VI-17

TOTAL ARRESTS FOR SELECTED OFFENSES FOR EACH
SOCIO-GEOGRAPHIC SETTING IN ALASKA, 1973.

	Urban ^a	Rural-City ^b	Rural ^c	Totals
Total Arrests	10,831	1,188	3,124	15,143
Part I Total	2,435	267	640	3,342
Violent Crime Subtotal	357	43	106	506
Homicide	19	0	10	29
Rape	26	5	10	41
Aggravated Assault	222	36	80	338
Property Crime Subtotal	2,078	224	534	2,836
Part II Total	8,396	921	2,484	11,801
Other Assaults	608	42	138	788
Sex Offenses	51	6	32	89
Liquor Laws	518	113	231	862
Drunkenness	563	149	97	809
Disorderly Conduct	1,084	99	87	1,267
Vagrancy	46	15	0	61
DWI	1,468	169	633	2,267

^a Includes Anchorage, Spenard, Fairbanks, Juneau, Ketchikan, and AST Detachment "C".

^b Includes Cordova, Haines, Homer, Hoonah, Palmer, Sitka, Valdez, Petersburg, and Wrangell. 1973 data for Ft. Yukon and Kenai were not available.

^c Includes AST Detachments B, D, E, F, G, H, I, and J.

Source: Based on compilation of data provided on FBI Unified Crime Reports obtained from each jurisdiction by special request for this study.

REFERENCE TABLE
TABLE VI-18

TOTAL ARRESTS FOR SELECTED OFFENSES FOR EACH
SOCIO-GEOGRAPHIC SETTING IN ALASKA, 1974.

	Urban ^a	Rural-City ^b	Rural ^c	Totals
Total Arrests	12,523	2,054	3,389	17,966
Part I Total	2,934	339	776	404
Violent Crime Subtotal	433	93	137	673
Homicide	29	2	18	49
Rape	37	8	11	56
Aggravated Assault	292	79	98	469
Property Crime Subtotal	2,491	246	639	3,376
Part II Total	9,589	1,715	2,613	13,917
Other Assaults	765	44	201	1,010
Sex Offenses	92	12	17	121
Liquor Laws	606	229	198	1,033
Drunkenness	1,228	239	78	1,545
Disorderly Conduct	1,079	146	103	1,328
Vagrancy	14	2	1	17
DWI	1,243	308	556	2,017

^aIncludes Anchorage, Spenard, Fairbanks, Juneau, Ketchikan, and AST Detachment "C".

^bIncludes Cordova, Haines, Homer, Hoonah, Palmer, Sitka, Valdez, Petersburg, and Wrangell.

^cIncludes AST Detachments B, D, E, F, G, H, I, and J.

Source: Based on compilation of data provided on FBI Unified Crime Reports obtained from each jurisdiction by special request for this study.

REFERENCE TABLE
TABLE VI-19

TOTAL ARRESTS FOR SELECTED OFFENSES FOR EACH
SOCIO-GEOGRAPHIC SETTING IN ALASKA, 1975.

	Urban ^a	Rural-City ^b	Rural ^c	Totals
Total Arrests	14,496	2,489	3,740	20,725
Part I Total	3,446	446	825	4,717
Violent Crime Subtotal	490	104	172	766
Homicide	22	2	20	44
Rape	39	11	17	67
Aggravated Assault	298	81	125	504
Property Crime Subtotal	2,956	342	653	3,951
Part II Total	11,050	2,043	2,915	16,008
Other Assaults	950	156	278	1,384
Sex Offenses	109	7	21	137
Liquor Laws	1,147	411	188	1,746
Drunkenness	244	24	10	278
Disorderly Conduct	1,175	190	102	1,467
Vagrancy	15	25	0	40
DWI	2,147	381	629	3,157

^aIncludes Anchorage, Spenard, Fairbanks, Juneau, Ketchikan, and AST Detachment "C".

^bIncludes Cordova, Haines, Homer, Hoonah, Palmer, Sitka, Valdez, Petersburg, and Wrangell.

^cIncludes AST Detachments B, D, E, F, G, H, I, and J.

Source: Based on compilation of data provided on FBI Unified Crime Reports obtained from each jurisdiction by special request for this study.

FOOTNOTES

1. Summaries of the Transcripts of Public Hearings conducted by the Criminal Justice Planning Agency. Prepared by the State Criminal Justice Planning Agency.
2. Criminal Justice Plan, 1977. Volume I. pp.69. Prepared by the State Criminal Justice Planning Agency.
3. ibid.
4. ibid.
5. The Economic Cost of Alcohol Abuse and Alcoholism, 1971. Prepared for the National Institute on Alcohol Abuse and Alcoholism by Policy Analysis, Inc. Boston, Mass. pp. 122.
6. ibid.
7. ibid.
8. Alaska Criminal Justice Plan, 1976. Volume II. Prepared by the State Criminal Justice Planning Agency. pp.36.
9. The Economic Cost of Alcoholism and Alcohol Abuse, op.cit.
10. ibid.
11. Alaska Criminal Justice Plan, 1976, op.cit., pp.40.
12. The Economic Cost of Alcohol Abuse and Alcoholism, 1971, op.cit, pp.125
13. ibid.
14. Alaska Criminal Justice Plan, 1976, op.cit, pp.47.
15. ibid. pp.43.
16. Alaska Court System, 1975 Annual Report, pp.77-122.
17. ibid.
18. ibid.
19. ibid.
20. Recidivism in Alaska, 1971-1975. Report prepared by the Division of Corrections, Department of Health and Social Services. 1976
21. ibid.

PART VII. ALCOHOL AND TRAFFIC SAFETY

A. INTRODUCTION

Highway or traffic accidents do not seem to be totally random events. At least for large population groups, the total number of accidents is statistically predictable. Examination of traffic crashes, particularly fatal crashes, over the recent years has resulted in the identification of certain recurring patterns and common factors. Within this area of interest, causes of accidents tend to be classified in one of three broad categories--the highway, the vehicle and the driver. Each of these general categories has multiple components. However, about 80% of all traffic accidents are caused by the driver, rather than malfunction of the vehicle or poorly designed or maintained roads. Within this major category, driver impairment as a result of the consumption of beverage alcohol has been identified as a factor very frequently associated with fatal and injury crashes as well as property damage crashes.

It is known that alcohol impairs a driver's capability and thus actual driving performance; consequently, the probability of being involved in an accident is greatly increased. In addition, the probability of being responsible for the accident also increases dramatically.

Thus, the subpopulation of motorists who drive while impaired by alcohol, or drive while legally drunk, have become a primary target group--a group of immediate concern and direct action in attempts to reduce the number of accidents and resulting human and economic losses.

Attempts to reduce motor vehicle crashes in general, and alcohol-related fatalities in particular, have involved the investigation of a number of general factors. The relationship between motor vehicle crashes and alcohol consumption in Alaska is described and discussed in terms of several of these factors in the following sections: first, the relationship between alcohol consumption and physical and mental impairment; second, the nature and trends of different types of motor vehicle crashes; third, the nature and trends of alcohol-involvement in motor vehicle crashes; and fourth, characteristics of drunk drivers in Alaska, and legal consequences.

Each of the categories is described and discussed in terms of current available information for Alaska and compared where possible with corresponding nationally reported findings.

B. ALCOHOL AND IMPAIRMENT

Investigation of alcohol involvement in highway accidents is based on a determination of the actual amount of alcohol in the body. The amount of alcohol in the body is referred to as blood alcohol concentration (BAC). Blood alcohol concentration is measured by means of a variety of chemical tests typically using samples of either blood, breath or urine. The most common method for expressing the concentration of alcohol in the blood is based on the number of grams of alcohol per 100 milliliters of blood. A BAC of .10% really means 100 milligrams of alcohol per 100 milliliters of blood.

There are several different ranges of BAC concentration that have become distinguished as indicative of different levels of impairment, based on medical and scientific investigation. A BAC up to about .04% indicates a level of impairment that is generally not considered serious.

From .05% to .09% BAC, ability and judgment are impaired, and the impairment can be observed in most people. In the range from .10% to .14%, ability and judgment are notably impaired in everyone. BAC's above .15% indicate very serious impairment. In most instances, a BAC of .50% or .60% is fatal. These ranges along with brief statements of explanation are presented in Table VII-1.

TABLE VII-1
BLOOD ALCOHOL CONCENTRATION AND PREDICTABLE KINDS OF IMPAIRMENT

BAC	Impairment
.00-.04%	Impairment--Not Serious Absence of overt effects; mild alteration of feelings, slight intensification of existing moods.
.05-.09%	Ability and Judgment Impaired Feelings of warmth, relaxation, mild sedation; exaggeration of emotion and behavior; impairment of fine motor skills; increase in reaction time. Visual and hearing acuity reduced; slight speech impairment; minor disturbance of balance; increased difficulty in performing motor skills, feelings of elation or depression.
.10-.14%	Ability and Judgment Notably Impaired in Everyone Difficulty in performing many gross motor skills; uncoordinated behavior; definite impairment of mental faculties, memory and judgment.
.15%+	Ability and Judgment Seriously Impaired in Everyone Exhibition of major impairment of all physical and mental functions; irresponsible behavior; general feeling of euphoria; difficulty in standing, walking, talking, distorted perception and judgment. If the BAC reaches .50% a coma develops and by .60% death can result.

Source: Adapted from Manual for Judicial Seminar in Alcohol and Highway Safety, C-9, Indiana University Institute for Research in Public Safety.

Alcohol is absorbed very quickly into the blood stream. As an illustration of how these different BAC's might be achieved, the following example is given. A 160 lb. drinker (assuming normal good health) drinking one ounce of 86 proof alcohol per drink, would need to

consume about four drinks in two hours to reach .05% BAC, about six and one-half drinks in two hours to reach .10%, and about nine drinks in two hours to attain a BAC of .15%.

BAC and Probability of Crash Involvement

In addition to describing the nature and levels of impairment associated with different blood alcohol concentrations, research has estimated the probability of involvement in an accident associated with different BAC levels. The following range of estimated probabilities has gained general acceptance over the last few years.* In the BAC range from .05% to .10%, the relative probability of being involved in a crash begins to increase considerably, such that the chances of a crash are seven times greater by the time the level of .10% BAC is reached. Beyond this point, the relative hazard of a crash increases appreciably. At the BAC level of .15%, the chances of a crash are 25 times more likely. At .18% BAC (the average BAC level for DWI arrests in Alaska, see following section) the chances of a crash are sixty times more likely. By .20% the probability of crash involvement is 100 times more likely.

In general, the chances of a more serious accident, compared to the run of the mill fender-bender, increases at a faster rate above the .08% BAC level. This level-- .08% blood alcohol concentration or higher-- is really considered to be incompatible with safe driving. The probabilities presented here refer to the probability of responsibility for the crash, not just involvement in one.

Although the predictable levels of impairment and probabilities of

*For more complete review of information, see Chapter VI, Alcohol and Health, NIAAA, June, 1974.

crash involvement associated with specific BAC ranges are generally accepted within the scientific and medical community, there is less acceptance and agreement among different legislative and judicial jurisdictions regarding legal interpretations of this information. However, in many American jurisdictions, including Alaska, a BAC of .10% is the legal standard for defining or presuming impairment or intoxication.

C. MOTOR VEHICLE CRASHES--ALASKA

An overall view of the number and rates of motor vehicle crashes for the state of Alaska, from 1971 to 1975 is presented in Table VII-2. The total number of all motor vehicle crashes increased from 13,655 in 1971 to 22,522 in 1975, a 65% increase. During the same period the number of vehicle miles driven in the state increased by 74%, from 1,469 million miles to 2,560 million miles, and the number of licensed drivers increased by 39%, from 160 thousand to 222.5 thousand. During this same period the overall population of the state increased by about 102,000, which represents an overall increase of about 33%.

Each of the types of motor vehicle crashes and fatalities are also expressed in terms of rates--number per 100 million vehicle miles and per 1000 licensed drivers in order to provide a more realistic perspective. As can be seen on the basis of vehicle miles, the rate of total accidents actually declined somewhat, from 929 to 881 crashes per 100 million miles, a decrease of about 5%. However, in terms of licensed drivers, there was a 19% increase in the rate for all types of crashes. It would seem that, on the average, licensed drivers covered disproportionately more miles in 1975 compared to 1971, but were involved in more accidents.

TABLE VII-2
MOTOR-VEHICLE CRASHES, ALASKA, 1971-1975

	1971			1972			1973			1974			1975		
	H	Per 10 ⁸ V-M	Per 10 ³ Lic'd Dr. ^b	H	Per 10 ⁸ V-M	Per 10 ³ Lic'd Dr.	H	Per 10 ⁸ V-M	Per 10 ³ Lic'd Dr.	H	Per 10 ⁸ V-M	Per 10 ³ Lic'd Dr.	H	Per 10 ⁸ V-M	Per 10 ³ Lic'd Dr.
Motor Vehicle Crashes	13,655	929	85.3	15,085	988	91.4	15,671	959	84.1	18,619	888	96.5	22,544	851	101.3
Fatal Crashes	57	3.88	.356	54	3.53	.327	70	4.29	.376	74	3.53	.353	105	4.10	.47
Persons Killed	65	4.42	.406	61	3.99	.369	79	4.85	.425	89	4.24	.461	119	4.64	.53
Personal Injury Crashes	1,975	134	12.3	2,009	131	15.4	2,117	130	11.4	2,332	111	12.1	2,819	110	12.7
Persons Injured	2,826	192	17.6	2,957	193	17.9	2,916	179	15.7	3,280	156	17.0	3,997	156	17.2
Property Damage	11,623	791	72.6	13,022	853	78.9	13,434	825	72.3	16,213	773	84.0	19,525	763	87.5
Annual Vehicle Miles (millions)	1,469			1,526			1,628			2,095			2,560		
Annual Licensed Drivers (thousands)	160.0			165.0			185.7			192.9			222.5		

^aVehicle Road miles expressed per 100 million miles

^bLicensed drivers expressed per 1000 licensed drivers

Inspection of all the information for each type of accident in Table VII-2 shows that the overall increase in total accidents was accounted for mainly by the increase in property damage accidents and fatal crashes. Particularly important are the numbers and rates for fatal crashes and fatalities. Except for the year of 1972, both the number of fatal crashes and fatalities have increased steadily. However, the rates of occurrence have vacillated over the years. Nonetheless, given the data available for the last five years, the net effect has been a gradual increase of about 32% in both fatal crashes and persons killed in terms of rate per licensed drivers (40 compared to 50 fatalities per 100,000 licensed drivers).

This trend is notably different from the national trend. The motor vehicle fatality rate for the nation has decreased steadily

since 1925.* A graphic comparison of the fatality rate for the U.S. and for Alaska is presented in Figure VII-1. The generally increasing fatality rate, in terms of both vehicle miles driven and number of licensed drivers, can be seen more clearly in contrast to the generally decreasing fatality rate for the nation.

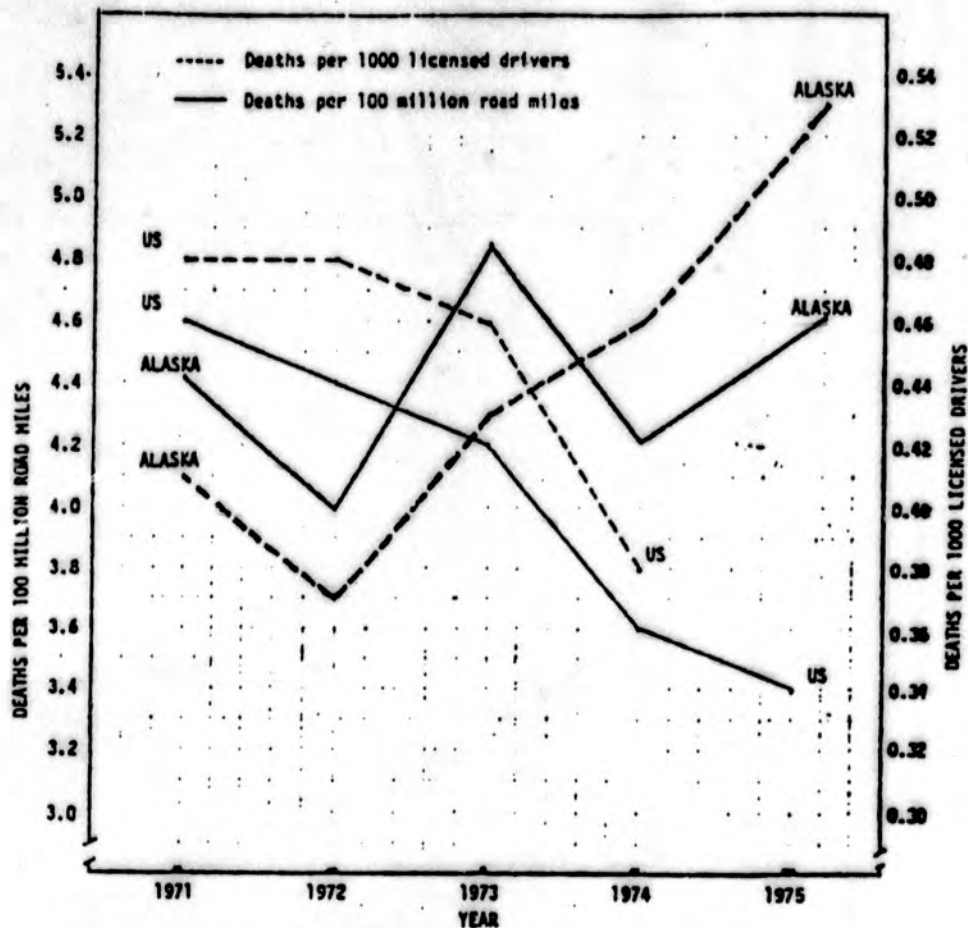


FIGURE VII-1 Fatality rates, U.S. and Alaska, 1971-1975

Sources: U.S. information--Accident Facts, 1975 edition, National Safety Council.
Alaska information--Computed from raw data obtained from the Department of Highways and the Department of Public Safety.

D. MOTOR VEHICLE CRASHES AND ALCOHOL INVOLVEMENT--ALASKA

An overview of the available data for the number of different types of motor vehicle crashes and the known extent of alcohol involvement,

*Accident Facts, 1975 Edition, National Safety Council.

for the years 1971 to 1975, is presented in Table VII-3. For the last five years the extent of alcohol involvement in fatal crashes shows considerable fluctuation. Independent of the number of fatal crashes, the percentage of fatalities that were known to involve alcohol ranged from 24% to 46%; an average for the last five years would be about 38%.

TABLE VII-3
MOTOR VEHICLE CRASHES AND ALCOHOL INVOLVEMENT^a
ALASKA, 1971-1975

Crash Data	1971		1972		1973 ^c		1974		1975	
	Total	% A-R ^b	Total	% A-R	Total	% A-R	Total	% A-R	Total	% A-R
Motor Vehicle Crashes	13,655		15,085		15,621		18,619		22,544	
Fatal Crashes	57	46%	54	20%	68	37%	74	23%	105	45%
Persons Killed	65	46%	61	28%	76	33%	89	25%	119	46%
Single-Vehicle Fatalities					47	31%	54	24%	56	33%
Multi-Vehicle Fatalities					29	38%	35	26%	63	61%
Pedestrian Fatalities ^d					7	29%	17	26%	19	37%
Personal Injury Crashes	1,975		2,009		2,117		2,332		2,819	
Property Damage Crashes	11,623		13,022		13,434		16,213		19,525	

^aInformation missing from Table is not available from existing records.

^bPercent of Total that is alcohol-related.

^cNumber of total crashes and persons killed not the same as in Table VII-2. Files for two crashes, (three crashes) were missing.

^dNumber of pedestrian fatalities also included within single- and multiple-vehicle totals.

Source: Data compiled from multiple files of Division of Research and Planning, Department of Public Safety.

The upper range of the extent of alcohol involvement for Alaska overlaps with the range of alcohol involvement in nationally reported findings. These findings show that from 40% to 55% of all fatalities are alcohol-related.* Alaska's lower average of alcohol involvement, and the extreme fluctuation shown in Table VII-3 for the last five years, may result from the difficulties of collecting data in Alaska.

*Alcohol and Health, Chapter VI, NIAAA.

Because the nature, time, and place of the accident all affect the ability to measure blood alcohol concentration at the time of the accident, the figures for accidents in remote areas may underrepresent the actual extent of alcohol involvement. In contrast, reported findings for the Municipality of Anchorage in 1976 showed that 16 of 20 fatalities--80%--were alcohol-related. Even if one accepts available statewide information, almost one-half of the motor vehicle fatalities in 1975, and one-fourth to one-half from 1971 to 1975, involved alcohol. Any improvement in collection and reporting procedures could only increase that figure.

Single and Multiple Vehicle Fatalities

Examination of the extent of alcohol involvement in single and multiple vehicle fatalities again shows fluctuation for the three year period for which data are available. For each of the years however, a greater percentage of multiple vehicle fatalities, compared to single vehicle fatalities, involved alcohol. This trend is distinguished from nationally reported findings which show a greater extent of alcohol involvement for single vehicle fatalities compared to multiple vehicle fatalities and, also, a much higher extent of alcohol involvement than is the case for Alaska. Over the three years shown for Alaska, from 24% to 33% of all single vehicle fatalities were alcohol-related compared to a range of 26% to 61% of all the fatalities for multiple vehicle fatalities. Nationally reported findings show that from 55% to 65% of all single vehicle fatalities are alcohol-related compared to 25% to 50% for multiple vehicle fatalities.*

*Alcohol and Health, Chapter VI.

Daytime and Nighttime Fatalities

The time of day of an accident is another factor for consideration. For the purpose of this analysis, fatalities will be reviewed by time of occurrence during the nighttime or daytime. Nighttime is defined as the period from 8 PM to 8 AM. The number of fatalities, expressed in terms of number per 1000 licensed drivers, for 1973 to 1975, is provided in Table VII-4.

TABLE VII-4
DAYTIME AND NIGHTTIME FATALITIES AND ALCOHOL INVOLVEMENT, ALASKA, 1973-1975*

	1973		1974		1975	
	Total	A/R	Total	A/R	Total	A/R
All	.422	.140	.459	.114	.535	.247
Night	.224	.108	.258	.098	.297	.171
Day	.198	.032	.201	.016	.238	.076
Night/ Day	1.131	3.28	1.284	6.13	1.248	2.25

*Fatalities expressed as number per 1000 licensed drivers (see Table VII-2).

The ratio of nighttime to daytime fatalities for all fatalities shows less variation over the three year period than the ratio for alcohol-related fatalities. However, the ratio of nighttime to daytime alcohol-related fatalities is consistently much larger than the night/day ratio for all fatalities. This is to say that alcohol-related fatalities occur to a much greater extent in the evening hours than the daytime hours, and that the difference is much greater than the difference in the time of occurrence for all fatalities. For all fatalities, the ratio was a little more than one fatality at night for each daytime fatality. But for alcohol-related fatalities, the ratio ranged from more than two, to more than six nighttime alcohol-related fatalities for each daytime alcohol-related fatality. The hours of nighttime and daytime used here cover the same hours of driving that are generally considered to be the time for recreational driving compared to the daytime hours that cover commercial driving and the to- and from-work

traffic.

Pedestrian Fatalities

When viewed as a separate category, pedestrian fatalities as a result of either single or multiple vehicle crashes ranged in extent of alcohol involvement from 26% to 37% for the three year period. Nationally reported findings show that about 25% of all motor vehicle pedestrian fatalities were alcohol-related in 1974.*

E. MOTOR VEHICLE DRIVERS

The great bulk of the driving population is comprised of persons who have had few if any reportable crashes or traffic convictions for serious traffic offenses. In addition, random samples of drivers have shown that 80% to 90% register no measurable blood alcohol concentration. About 5% to 10% of the drivers have low BAC's, under .05%. Another 3% to 10% measure in the range of .05% to .09%. About 3% to 5% have a BAC greater than .10%, with about 1% higher than .15% BAC.**

This general picture contrasts very sharply with the BAC characteristics of persons involved in accidents, particularly fatal accidents. Nationally reported information states that from 40% to 55% of all fatally injured drivers had a blood alcohol concentration that exceeded .10%. Similarly about 10% to 25% of drivers in serious injury crashes had BAC's that exceeded .10%, and about 5% to 10% of the drivers in general run-of-the-mill fender-benders had BAC's in the range above .10%. In addition, about 25% of pedestrian fatalities involved pedestrians with BAC's above .10%.

*Alcohol and Health, Chapter VI, 1974.

**Ibid.

The information regarding BAC levels and accident involvement seems to be alarmingly consistent across many different cities and state, including Alaska. Although there are many differences in measurement and reporting procedures, the evidence is quite clear that drivers with high BAC levels constitute an extremely high proportion of the group of persons involved in fatal and serious injury crashes.

Drunk Drivers

The only information about the BAC levels of Alaskan drivers comes from the recorded findings of the measurement of blood alcohol concentration at the time of an accident or arrest for driving while intoxicated (DWI; or OMVI--operating a motor vehicle while intoxicated) from a variety of jurisdictions around the state. This information, of course, characterizes only a subpopulation of drivers in the state. The information regarding alcohol involvement and fatalities concerned only those drivers in fatal accidents. No other random or systematic sampling of drivers has been done in the state to determine the distribution of BAC levels among the population of drivers not involved in an accident or not arrested for DWI. Nonetheless, the relationship between high BAC levels and the increased probability of being involved in an accident is quite clear, and focusing on the subpopulation of drivers arrested and convicted for DWI is very useful since this group is defined by its BAC level. In the state of Alaska, presumption of intoxication is legally based on a blood alcohol concentration of .10% or above. (Under the law, other evidence is required to substantiate the BAC finding and the arresting officer must have had probable cause to stop the driver in the first place--usually driving behavior indicative of impairment.)

DWI Arrests and BAC Statistics

The vast majority of drivers arrested for DWI have BAC levels in the extremely high range. Nationally reported findings show that about two-thirds of the DWI drivers have BAC's above .185%. This contrasts sharply with nationally reported findings of BAC levels of randomly selected drivers that show less than 1% of the drivers not involved in an accident or a DWI arrest have that high a BAC level.*

The number of persons arrested for DWI in Alaska and the distribution of BAC's from 1973 to 1975 is presented in Table VII-5. The number of arrests for DWI for each of the years is significantly above nationally reported averages. In 1974, the national average was 9.1 arrests per 1000 licensed drivers, an increase of 75% compared to 1969.** This figure contrasts with rates of arrest in Alaska in 1973, 1974, and 1975 of--12.6, 11.6 and 14.9 per 1000 licensed drivers.

TABLE VII-5
BAC STATISTICS AT TIME OF ARREST FOR ALL ENFORCEMENT JURISDICTIONS, ALASKA, 1973-1975

LOCAL ARREST/BAC STATISTICS	1973	1974	1975
Arrests For Drinking Driving	2337	2244	3330
BACs Obtained (Total)	1849	1880	2410
Refusals	168	178	291
Negative	20	35	50
.01 to .04	31	26	43
.05 to .09	66	64	117
.10 to .14	280	376	497
.15 to .19	622	682	805
.20 to .24	556	502	601
.25 +	274	195	297
Average BAC Obtained	.187 %	.176 %	.177 %

Based on data from AS: Detachments B, C, D, G, H, I; and Anchorage, Spenard, Fairbanks, Ketchikan, Kodiak, and Sitka Police Departments.

*Alcohol and Health, Chapter IV, 1974.

**The National Highway Safety Needs Study, U.S. Department of Transportation, April, 1976.

The range and distribution of BAC levels obtained at the time of arrest is similar to national findings, but the average BAC level for Alaska during the years shown is somewhat lower than the national average. The average BAC's in Alaska for each of the three years shown was .187%, .176%, and .177%; this compares to a national average BAC of about .20%.

Review of the distribution of BAC's in Table VII-5 shows the greatest number of DWI's to be in the upper range of the distribution. In fact, during 1975, over 92% of the DWI's registered a BAC level above .10%, the legal lower limit for presumption of intoxication in Alaska, a limit indicative of notable impairment in everyone (see Table VII-1). Further calculation shows that more than 71% of the persons arrested for DWI registered a BAC at or above .15%--indicative of very seriously impaired judgment and ability. (A 160 lb. person would need to consume nine drinks of one ounce 86 proof liquor each, within two hours to reach .15%BAC). This distribution of BAC's is considerably different from the BAC distribution for all drivers which shows that 80%-90% register no measurable BAC.

Generally in most jurisdictions, arrests for DWI made by the Alaska State Troopers (AST) are outside of the municipal boundary. The number of arrests and overall distribution of BAC's for Alaska State Troopers and for municipal police departments (PD) are presented in Table VII-6. Comparison of the distribution of BAC's for all AST detachments and all municipal police departments shows very little difference. The average BAC level for the AST arrests is very slightly higher for each of the years but the differences would be insignificant.

It should be noted however, in Table VII-6, that the total number of DWI arrests by the Alaska State Troopers increased quite dramatically in the three year period shown. Total AST arrests for DWI increased by 56%, total municipal police department arrests increased by about 35%.

No accurate information is available, but general consensus indicates that most of the population gain, and gain in licensed drivers, occurred in the city areas, compared to the outlying areas.

TABLE VII-6

BAC STATISTICS AT TIME OF ARREST BY ALL REPORTING ALASKA STATE TROOPER (AST) DETACHMENTS AND CITY POLICE DEPARTMENTS (PD), ALASKA, 1973-1975

LOCAL ARREST BAC/STATISTICS	1973		1974		1975	
	AST	PD	AST	PD	AST	PD
Arrests For Drinking Driving	875	1462	732	1512	1361	1969
BACs Obtained (Total)	995	1554	1015	865	1360	1050
Refusals	98	70	114	64	167	124
..... Negative	5	15	14	21	11	39
..... .01 to .04	11	20	13	13	18	25
..... .05 to .09	32	34	40	24	61	56
..... .10 to .14	159	121	222	154	298	199
..... .15 to .19	342	280	347	335	466	339
..... .20 to .24	296	260	275	227	358	243
..... .25 +	150	124	104	91	148	149
Average BAC Obtained	.188%	.184%	.176%	.175%	.177%	.176%

Based on data from AST Detachments B, C, D, G, H, I; and Anchorage, Spenard, Fairbanks, Ketchikan, Kodiak, and Sitka Police Departments.

A further breakdown on DWI arrests and average BAC level is provided by location--by each AST detachment and each municipal location, in Table VII-7. (See state map showing detachment boundaries--at end of this Part, Figure VII-2.) Review of the magnitude and changes in BAC's for each year for each location shows only the slight downward trend that was evident in the presentation of overall statewide findings. However, review of the magnitude and changes in the number of DWI arrests for each jurisdiction shows the location of the changes. Most notable is AST Detachment C, a metropolitan jurisdiction, around the city of Anchorage, which showed a change in number of DWI arrests from 242 in 1973 to 710 in 1975, an increase of about 193%. During that same period, the municipal area of Anchorage/Spenard, located within Detachment C showed only a modest change, an increase

of about 1%. Similarly, Detachment E showed a substantial increase of 98% in number of DWI arrests from 1973 to 1975, as did the major municipal areas within that detachment, Juneau and Sitka; Ketchikan, also located within that detachment showed a slight decrease. Detachment I, in the Fairbanks area, showed a decrease in total number of DWI arrests that was about equal to the increase for the Fairbanks Police Department, during the three years shown.

TABLE VII-7
AVERAGE BAC LEVELS AND NUMBER OF DWI ARRESTS
BY AST DETACHMENTS AND CITY POLICE DEPARTMENTS AND STATEWIDE
ALASKA, 1973-1975

AST Detachments City Police Department	1973		1974		1975	
	DWI Arrests	Ave BAC	DWI Arrests	Ave BAC	DWI Arrests	Ave BAC
B	98	.184	138	.171	194	.171
Ketchikan	120	.167	76	.170	107	.184
Juneau	53	.181	101	.171	189	.173
Sitka	37	.175	73	.178	61	.182
C	242	.196	176	.180	710	.175
Anchorage/Spennard	863	.187	710	.175	873	.174
D	16	.183	7	.209	43	.178
E	18	-	19	-	13	-
Kodiak	67	.188	136	.164	151	.166
F	8	-	6	-	5	-
G	13	.180	16	.184	35	.188
H	10	.213	24	.210	82	.196
I	470	.182	346	.170	282	.180
Fairbanks	190	.188	180	.180	268	.182
J	0	.000	0	.000	2	-
Ave. BAC AST Detachments	875	.188	732	.176	1361	.177
City Police Departments	1462	.184	1312	.175	1969	.176
Ave. BAC State.	2337	.187	2244	.176	3330	.177

Based on FBI UCR reports, and breathalyzer logs provided by the Alaska State Troopers and indicated City Police Departments.

*See map at end of this Part for detachment boundaries, Figure VII-2.

The increase in the total number of arrests for the entire state was about 42% in absolute numbers; in terms of arrests per 1000 licensed drivers,

the increase was about 18% from 1973 to 1975. Arrests by the Alaska State Troopers increased by about 56%, while arrests by municipal police departments increased 35%. In total, the respective increases in arrests by each enforcement category contributed approximately equal proportions to the overall increase, but the DWI enforcement activity of the Alaska State Troopers showed a proportionally greater increase than the level of activity of the municipal departments.

Personal Characteristics--DWI Drivers

The demonstrated relationship between the high BAC levels and involvement in crashes, particularly fatal crashes, has resulted in the investigation of the personal characteristics of drivers arrested and convicted for DWI. Such investigation has the purpose of identifying factors or characteristics that can be used to develop and implement effective countermeasure programs to reduce not only the incidence of drunk driving, but the incidence of motor vehicle crashes as well.

A number of factors are considered in investigating the personal characteristics of DWI drivers. They generally concern the typical demographic variables of age, sex, race, etc., as well as driving history and drinking-and-driving patterns, and patterns of alcohol use. Limited data concerning some of these factors are available for Alaska and will be reviewed in this section. No data exists regarding drinking-and-driving patterns, and patterns of alcohol use for DWI drivers in this state. Such information is obtained mainly by means of specially designed research investigations. The information that will be reviewed in this section is data recombined in the categories of interest, based on data regularly collected for a variety of other purposes.

Demographic Characteristics. Limited information regarding the age, sex, and race of DWI's is available from the arrest records and driver license files. However, none of the information is systematically assembled. The information used is compiled from information recorded for a variety of purposes and summarized for varying time intervals (as opposed to review of individual case files). No information is available regarding such characteristics as marital status, occupation, or income.

Information obtained from summarized arrest data shows that most--98%--of the persons arrested for DWI during the three year interval from 1973 to 1975 were over 18 years of age. This figure did not vary more than 1% during the three year time period. Most of the arrested drivers were also males, a range of 88% to 91% for the three years. Further, most of the DWI's were non-Native, a range of 84% to 86%. This information is provided in Table VII-8, which also provides a division of information for arrests by the Alaska State Troopers and the various municipal police departments.

TABLE VII-8
AGE, SEX, AND RACE OF DRIVERS ARRESTED FOR DWI, ALASKA, 1973-1975

	AST ^a	1973 MPD ^b	State	AST	1974 MPD	State	AST	1975 MPD	State
Age									
<18	2%	1%	1%	1%	2%	2%	3%	2%	2%
>18	98%	99%	99%	99%	98%	98%	97%	98%	98%
Sex									
Male	93%	90%	91%	90%	92%	91%	90%	88%	88%
Female	7%	10%	9%	10%	8%	9%	10%	12%	12%
Race									
Native	7%	19%	14%	10%	19%	16%	9%	19%	14%
Non-Native	93%	81%	86%	90%	81%	84%	91%	81%	86%

^aAST--Alaska State Troopers

^bMPD--Municipal Police Departments (grouped together)

Additional information regarding demographic characteristics of DWI's was obtained from summarization of portions of driver license files. This information is presented along with available information concerning the driving history of drivers convicted for DWI during 1975, in Table VII-9. An attempt was made to summarize the information according to drivers who had one, two, or three or more convictions during the year, and by location of the court of conviction grouped in geographical areas corresponding to Alaska State Trooper Detachments.* The information presented represents the best that could be done at this time given the nature of the data, its accessibility, and available resources.

DWI convictions grouped by age groups show that about 99% were for persons 18 years or older. Almost two-thirds (64%) of the convictions involved drivers between the ages of 18 and 39. Another one-third were above the age of 40. Most of these convicted DWI's--88%--were males.

Given this limited demographic information from arrest and court records, DWI's in Alaska can be characterized as non-Native males between 18 and 39 years of age. This very brief profile corresponds with similar aspects of nationally reported characteristics of DWI drivers which show the typical drunken driver to be a male, between 25 and 35 years of age, who is single, separated or divorced, has a high school education and drives an older car (He also displays overly aggressive drinking habits and is a heavy drinker who often prefers beer to other alcoholic beverages).**

Driving History. Available information from the licensed driver files shows that 2,510 licensed drivers accounted for 2,618 DWI convictions during 1975. (Court records show a total of 2,668 convictions for DWI, see next

*See Table VII-11 at end of this Part for listing of court locations by AST Detachments.

**"The Drunken Driver: A Profile", Transportation Research News, May-June, 1976.

TABLE VII-9

OMVI DRIVER PROFILE--1975 OMVI CONVICTIONS, NUMBER OF DRIVERS, TOTAL PRIOR OMVI AND OTHER MAJOR TRAFFIC VIOLATIONS, TOTAL PRIOR ACCIDENT INVOLVEMENT AND SEX AND AGE DISTRIBUTION OF DRIVERS--DISTRICT AND MAGISTRATE COURTS--GROUPED BY ALASKA STATE TROOPER DETACHMENT REGIONS AND STATEWIDE ALASKA*

Detachment	1st, 2nd, 3rd Conviction in 1975	Number of Drivers 1975	Total Prior 1975 OMVI Convictions	Total Other Major Violations	Total Number Accident Involvements	Sex				Age							
						Female		Male		17		18-39		40-59		60	
						N	%	N	%	N	%	N	%	N	%	N	%
B	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	2	15	5	30	7	0	0	14	0	0	0	10	4	1	1	1	1
	1	436	67	414	231	47	11	377	89	0	0	305	69	109	25	15	6
	Total	451	72	444	238	47	11	391	89	0	0	315	69	117	25	15	6
C	3	2	1	0	4	0	0	2	0	0	0	1	1	0	0	0	0
	2	50	17	58	63	8	0	43	0	0	0	32	19	1	1	1	1
	1	1,134	229	1,147	825	148	13	984	87	3	<1	727	62	377	33	26	4
	Total	1,186	247	1,205	892	156	13	1,027	87	3	<1	760	62	397	33	27	4
D	3	1	0	2	2	0	0	1	0	0	0	0	1	0	0	0	0
	2	7	3	11	13	0	0	7	0	0	0	5	7	1	1	1	1
	1	173	39	110	87	20	12	144	88	0	0	89	54	69	41	5	5
	Total	181	42	123	102	20	12	152	88	0	0	94	54	71	41	5	5
E	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	2	3	1	4	4	0	0	3	0	0	0	1	2	0	0	0	0
	1	132	28	99	62	14	11	115	89	1	<1	89	67	39	31	1	1
	Total	135	29	103	66	14	11	118	89	1	<1	90	67	41	31	1	1
F	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	2	1	0	0	1	0	0	1	0	0	0	1	0	0	0	0	0
	1	16	1	4	1	0	0	16	100	0	0	13	3	3	18	0	0
	Total	17	1	4	2	0	0	17	100	0	0	14	82	3	18	0	0
G	3	1	0	0	1	0	0	1	0	0	0	1	0	0	0	0	0
	2	3	0	5	6	0	0	4	0	0	0	2	0	0	0	0	0
	1	66	13	71	45	3	4	59	96	0	0	42	18	18	27	4	6
	Total	70	13	76	52	3	4	64	96	0	0	45	67	18	27	4	6
H	3	1	0	0	0	0	0	1	0	0	0	0	1	0	0	0	0
	2	3	4	5	5	0	0	4	0	0	0	3	1	1	1	1	1
	1	116	26	104	72	9	8	100	92	0	0	57	52	47	43	6	5
	Total	120	30	109	77	9	8	105	92	0	0	60	52	49	43	6	5
I	3	1	0	2	0	0	0	1	0	0	0	0	1	0	0	0	0
	2	20	2	28	12	0	0	14	0	0	0	8	5	1	1	1	1
	1	434	58	416	217	45	10	380	90	2	<1	277	64	132	31	15	4
	Total	455	60	446	229	45	10	395	90	2	<1	285	64	133	31	17	4
J	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	1	3	1	1	0	0	0	3	100	0	0	2	1	1	33	0	0
	Total	3	1	1	0	0	0	3	100	0	0	2	67	1	33	0	0
State Total	3	6	1	4	7	0	0	6	0	0	0	2	4	0	0	0	0
	2	102	32	141	111	8	0	90	0	0	0	62	32	4	4	4	4
	1	2,510	462	2,366	1,540	287	11%	2,175	88%	6	<1%	1,601	75%	95	32%	95	4%
	Total	2,618	495	2,511	1,658	295	11%	2,271	88%	6	<1%	1,665	64%	99	32%	100	4%

*All information derived from drivers license files maintained by Division of Research and Planning, Department of Public Safety.

section, Table VII-10. The small difference is probably accounted for by the lag time for reporting and recording information.) This means also that 108 drivers received two or more convictions during the same year--actually 102 had two convictions, and six had three convictions during the one year of 1975 (about 4% of the total).

Review of prior driving records shows that about 19% of the drivers had one or more convictions for DWI's prior to 1975. Further, these drivers collectively accounted for 2,511 major traffic violations (reckless driving, speeding, etc.), and were involved in 1,658 accidents, within and prior to 1975.

In brief summary overview to this point: During 1975, 15 of 1000 licensed drivers were arrested for DWI; 12 out of 1000 were convicted.* Out of this subpopulation of convicted drunk drivers and in terms of computed averages, it can be said that 2 of 10 had one or more prior DWI convictions; 18 of 20 had one or more prior major traffic violations, and, 13 of 20 had one or more accidents.

A quick review of drivers with one or more DWI convictions in the same year shows that this group of 108 accounted for 144 major traffic violations (an average of 1.4 each) and 111 accidents (an average of 1.1 each).

A similar review of each of the AST detachment regions (groups of court locations) in Table VII-9 shows no major departures from the statewide averages just presented.

The limited array of characteristics of driving history for convicted DWI drivers in Alaska corresponds with nationally reported information. In general, convicted DWI drivers as a subpopulation of all licensed drivers account for a disproportionate share of other DWI convictions,

*These arrests and convictions are not comparable within the same time period due to the time period from arrest to final court action.

major traffic violations and accident involvement, compared to a random sample of licensed drivers. National information also shows that about sixty percent of convicted DWI's had already experienced two or more license suspensions or revocations.* Similar information is not yet available for Alaska. The contrast in the driving history of DWI's as a group with the population of all drivers is quite remarkable.

Drinking Patterns. Very little information has been reported regarding the drinking patterns of DWI drivers from any location in the nation. Such information is also unavailable in Alaska.

Court Actions and Criminal Sentencing Patterns

A DWI driver is identified as such by the criminal justice system. Detection, apprehension, prosecution and court action are all required for legal identification. The action of the court becomes a matter of interest from the highway safety perspective given the demonstrated relationship between motor vehicle drivers with high BAC's and accident involvement. For general information, statistics regarding DWI court actions and criminal sentencing patterns are presented by groupings of court locations corresponding to AST detachment regions, and also summarized for overall statewide averages.

Table VII-10 shows that all courts in the state accounted for a total of 2,975 DWI dispositions. There were 2,668 convictions within the total number of dispositions for a conviction rate of 89% (convictions divided by dispositions times 100). Of this number, 2,086, or 78% received some sort of sentence by the court. The average jail sentence was fourteen days with ten days suspended. Similarly, 2,480, or 93% of those convicted,

*Alcohol and Health, Chapter VI, 1974.

were fined an average of \$316, with an average of \$92 suspended. A total number of 1,929, or 72% of those convicted received both a sentence and a fine while about eight percent received either a suspended imposition of sentence or no sentence or fine at all. Additional information about driver's license action (limitation, suspension, revocation) by the court was not available. Similarly no information was available regarding imposition of any other court sanctions or referrals or periods of probation, etc.

TABLE VII-10
DWI COURT ACTIONS AND SENTENCING PATTERNS BY COURT LOCATIONS GROUPED BY AST DETACHMENTS AND STATEWIDE, ALASKA, 1975

	ALASKA STATE TROOPER DETACHMENTS										STATE TOTAL
	D	C	D	E	F	G	H	I	J	AVERAGE	
Total DWI Dispositions	505	1464	204	145	37	31	64	517	8	2975	
Total Convictions	471	1287	192	133	31	29	62	459	4	2668	
Conviction Rate	93	87	94	91	83	93	97	89	50	89	
Sentencing Patterns											
Number Sentenced	254	1136	164	120	14	17	43	335	3	2086	
Average Sentence	10	16	16	6	23	9	12	14	5	14	
Average Sentence Suspended	7	12	14	6	14	8	7	11	4	10	
Number Fined	457	1163	101	120	26	28	61	432	4	2480	
Average Fine	240	349	292	187	225	401	358	352	312	316	
Average Fine Suspended	62	82	45	16	41	202	130	156	237	92	
Number Sentenced and Fined	241	1027	155	116	11	17	43	316	3	1929	
Number - Suspended Imposition of Sentences	6	21	1	26	2	0	14	15	0	85	
Number - No Sentence or Fine	6	52	4	3	3	1	4	25	0	98	

Court actions include all courts--magistrate, municipal, district and federal--for 65 court reporting locations.

Source: Basic information provided by Alaska Court System, Technical Operations Office.

The variations in court actions and sentencing patterns can be seen by comparison of each of the regions. Utilization of the various traditional legal sanctions, and combinations of them, as well as other sentencing alternatives, and their effectiveness in dealing with convicted DWI's, is a matter of focused research and experimentation in various jurisdictions throughout the nation at this time. Such information for Alaska

is presently incomplete and insufficient for any further analysis of the differential effects of various court actions on the DWI population. It is interesting to note, however, that court locations within three AST detachment regions accounted for approximately 83% of all DWI dispositions and convictions for the state.

F. SUMMARY

In Alaska, as elsewhere, most people killed after drinking and driving have a very high blood alcohol concentration. During 1975, 46% of the motor vehicle fatalities involved alcohol. Most drivers convicted for DWI have very high BAC's. The average BAC for DWI drivers in the state is almost twice the statutory legal limit of impairment. Even this level of .10% blood alcohol concentration is too high for safe driving when one considers the scientific and medical evidence of the extent of impaired judgment and ability indicated by the various ranges of blood alcohol concentration. Additional research information clearly demonstrates the increasing probability of involvement in any kind of crash with increasing BAC levels, as well as the increasing likelihood of responsibility for the crash with increasing BAC's. The probability for crash involvement begins to increase appreciably above .08% BAC. The presumptive limit for intoxication for conviction for OMVI is .10% BAC. The average BAC of arrested DWI drivers in 1975 was .18%. Ninety-two percent of all DWI arrests recorded BAC's above .10%.

The great majority of drivers have generally clear driving records, a very low rate of previous crash involvements, and account for very few of the crashes and traffic convictions. The great majority--80%-90%--also registers no measurable BAC; about 3%-5% show BAC levels above .10%. This contrasts very sharply with both the

subpopulations of drivers involved in crashes and drivers convicted of DWI. The average BAC level of these drivers is almost twice that of the limit of legal impairment. They account for an extremely disproportionate number of prior DWI convictions, as well as other serious and minor traffic violations and involvement in accidents. Given the array of information available about these drivers, it is logical and valid to conclude that the great majority were indeed drunk, independent of one's precise definition of the term. While the conclusion seems obvious, the information available also allows the inference that a very high proportion of these drivers also qualify for the label of "problem-drinker" or "alcoholic drinker". In fact, a number of detailed studies have shown this to be the case. One study shows that approximately 80% of the population of convicted drivers were problem-drinker-drivers.* As such, these problem-drinker-drivers are valid clients for alcoholism treatment and rehabilitation as well as for the judicial-correctional system. This group of people is generally well known to the courts, accounting as they do for so many traffic violations and accidents. They tend to be younger, between 18 and 39 years old, non-Native and male. The general trends of increasing consumption in Alaska, along with increasing numbers of licensed drivers, roadways, and vehicle miles driven, can be expected to continue. Given the nature of the increases--a younger population, more drivers, less driving experience, increasing consumption, and increased recreational, nighttime driving, the extent of alcohol involvement in crashes will probably increase.

*Sandler, I., et al., "Drinking Characteristics of DWI's Screened as Problem Drinkers," Alcohol Health and Research World, Fall, 1975, pp. 19-23.

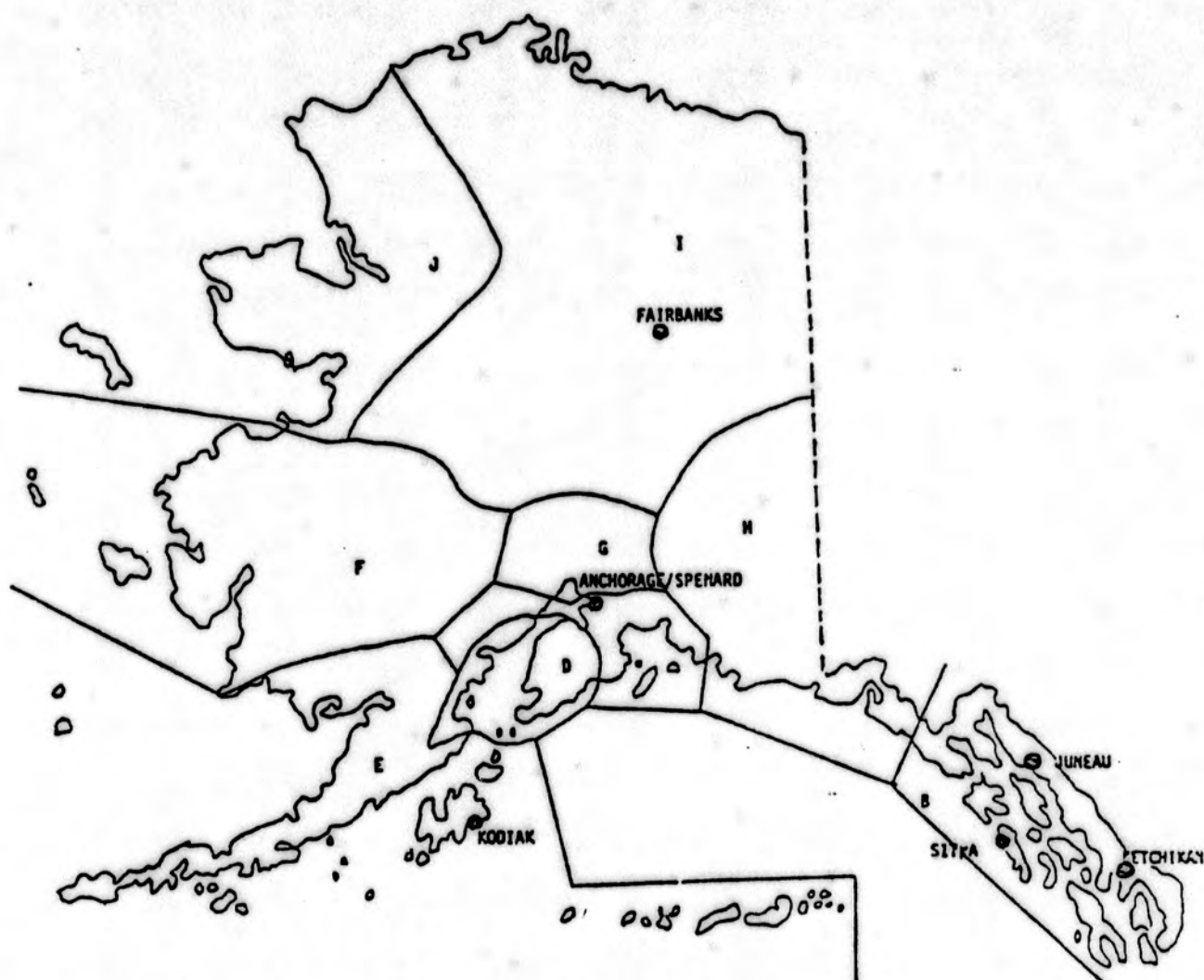


FIGURE VII-2 Alaska State Trooper Detachment Boundaries, 1975

TABLE VII-11

LOCATIONS OF ALL COURT TYPES GROUPED
BY STATE TROOPER DETACHMENT REGIONS

1975

KEY

ADDITIONAL INFORMATION

- * Police Department
- ** AST Detachment Post
- *** AST Detachment Headquarters
- [] Not a Court Location

<u>B Detachment</u>	<u>E Detachment</u>	<u>H Detachment</u>
*Ketchikan**	*Kodiak***	Glennallen***
*Juneau***	Sand Point**	*Cordova**
*Haines**	*Dillingham**	Tok**
Craig**	Naknek (King Salmon)**	*Valdez**
*Petersburg**	Unalaska	[Ernestine**]
Yakutat**	St. Paul Island	[Nelchina**]
*Hoonah	Cold Bay	[Paxon**]
Kake		[Northway**]
Angoon		[Eagle**]
*Sitka		
*Skagway		
*Wrangell		
	<u>F Detachment</u>	<u>I Detachment</u>
<u>C Detachment</u>	*Bethel***	*Fairbanks***
*Anchorage**	St. Mary's**	*Barrow**
	McGrath	Cantwell (Healy)**
	Hooper Bay	Delta Junction**
	Mekoryuk	*Ft. Yukon**
	Tununak	Galena**
	Aniak	Nenana**
	Mountain Village	*North Pole
	Emmonak	Tanana
	Nunapitchuk (Kasigluk)	Rampart
		Manley Hot Springs
<u>D Detachment</u>		Mulato
*Seward**		Weinwright
*Kenai***		[Deadhorse (Fairbanks)**]
*Homer**		[Livengood**]
*Seldovia	<u>G Detachment</u>	<u>J Detachment</u>
[Cooper Landing**]	*Palmer***	*Nome***
[Moose Pass**]	[Big Lake**]	*Kotzebue**
[Ninilchik**]	[Nancy Lake**]	Savoonga**
[*Soldotna]	[Talkeetna**]	Unalakleet**
	[Wasilla**]	Wales
		Pt. Hope
		Selawik
		Kiana
		Noorvik
		Gambell
		Buckland
		Teller

PART VIII OTHER SOCIAL INDICATORS OF ALCOHOLISM AND ALCOHOL ABUSE

A. INTRODUCTION

Each of the preceding Parts of this Volume has provided a description and analysis of a cluster of indicators of the impact of alcoholism and alcohol abuse on social systems of Alaska. Each of the areas also provides an alternative configuration of a set of social problems associated with alcoholism and alcohol abuse in the state.

There are a number of other indicators of the impact of excessive drinking that need to be mentioned, that provide yet other perspectives of the social impact, and further develop the reported range of the pervasiveness of alcoholism and alcohol abuse. Such cases are reported in inpatient service utilization, outpatient service utilization and in utilization of social services. Because of the variety of types of services considered, such alcohol-related encounters will be presented in this Part according to commonality of service category.

Such alcohol-related encounters, even if complete and exhaustive of all relevant units of service, would not be indicative of the magnitude of alcoholism and alcohol abuse in the overall population. Only a small portion of the presenting problems necessary for service delivery for alcoholism or alcohol abuse become documented in the health care setting. Additionally, indicators which are based on utilization of services assume equal access of the entire population to the entire range of services. This

is particularly not the case in Alaska. However, the reporting of such alcohol-related events do approximate at least the minimum impact on the existing service delivery systems and thus function as useful indicators, in combination with others, with which to amplify the description of the nature and extent of alcoholism and alcohol abuse in the population.

B. ADDITIONAL SOCIAL INDICATORS

General Hospital and Specialty Hospital Admissions

In the area of health care and medical services, one indicator of the impact of alcoholism and alcohol abuse is the number of inpatient admissions or discharge diagnoses involving alcoholism or alcohol abuse. Information was collected by a special survey for this project regarding the number of patients admitted to hospitals throughout the state with a primary or secondary diagnosis of alcohol disorder. It is recognized that this procedure has several drawbacks. The recording of cause for hospital admission or discharge is a subjective process. Typically alcohol-related admissions are compounded by other morbidities, any one of which may contribute to the patient's entry into the acute care treatment setting. Financial barriers (not all third-party payors reimburse for alcoholism inpatient care) and social stigmas associated with hospitalization for alcoholism, often preclude listing the disease as the first or second cause of hospitalization. Thus, providers are under considerable pressure to either intentionally or unintentionally mask the occasions for recording alcoholism as a cause of hospitalization, affecting the

overall frequency with which it is reported as a discharge cause in inpatient statistics. For this study, however, the primary purpose was to collect routinely recorded information that was readily accessible and could be regularly monitored over time.

Information was requested from private community hospitals, public health service hospitals (Alaska Area Native Health Service: AANHS), the state operated Alaska Psychiatric Institute (API), and military hospitals. Table VIII-1 shows the combined number of recorded alcoholic admissions for each type of hospital for each of the years from 1973-1975. It should be noted that this survey of private hospitals was conducted by mail and telephone; eleven of 18 hospitals responded, accounting for 70% of the total hospital beds. During 1975, the combined total for all alcoholic admissions for all types of hospitals numbered 2,460, an increase of about 11% over 1974. This discharge category represented about 9% of the total reporting private hospital discharges for that year. The decrease in admissions for API reflects the termination of the activities of the alcoholism ward (Alcohol Re-Education Unit) during that reporting period.

It should be emphasized again that the presented information can only be said to reflect the minimum utilization of inpatient services for alcohol-related causes. It should also be noted that significant differences from institution to institution in rank order of hospitalization cause (as a part of overall hospitalization statistics) may be as much a function of institution funding source or hospital policy as it is a function of actual patient condition. For instance, in federally funded hospitals (AANHS and Elmendorf) where cause and reimbursement are unrelated,

alcohol misuse is ranked #3 and #1 respectively as cause of hospitalization (by frequency of discharge diagnosis).

TABLE VIII 1
TOTAL HOSPITAL ADMISSIONS REPORTED
FOR ALCOHOLIC DISORDERS FOR MILITARY, PRIVATE,
PUBLIC HEALTH SERVICE AND PSYCHIATRIC HOSPITALS
ALASKA, 1973-75

	1973		1974		1975	
	Total	Alcohol Related	Total	Alcohol Related	Total	Alcohol Related
Military	7,143	142	6,138	128	5,874	117
Private Hospitals	17,192	971	18,457	1,436	19,333	1,766
PHS/AAHNS Hospitals	10,614	476	10,035	471	8,927	414
API	875	340	682	185	852	163
TOTAL	35,824	1,929	35,312	2,221	34,986	2,460

Sources: Private Hospitals. Information compiled by special survey of all state hospitals for this report. Survey was conducted in cooperation with the Alaska Hospital Association, which approved the concept, and assisted in the design of the survey instrument. The survey was conducted by mail; replies were received from 11 of 18 hospitals, accounting for 70% of the beds.

PHS/AAHNS Hospitals. Information was obtained from regular reporting systems managed and maintained by the Office of Systems Development, Area Office, Anchorage.

Alaska Psychiatric Institute. Information obtained by special request for this report from Division of Mental Health, Department of Health and Social Services.

Military Hospitals. Information obtained from Elmendorf AFB for 1974 and 1975. Total admissions for 1973 obtained from AMA Guide.

Note: Information presented for each designated year includes overlapping calendar year and fiscal year reporting periods.

In spite of all the constraints, the data regarding alcoholic admissions for the hospitals surveyed (70% of state beds) showed a 28% increase from 1973 to 1975, even though there had been a small decline in all admissions (about 2%). Furthermore, private hospitals, which account for 55% of all admissions, accounted for 72% of all admissions for alcoholic disorders.

Outpatient Care--Hospital Encounters

Outpatient care is one of the "least measurable" units of service delivery in the health field due to the variety of types and settings of providers, non-standardized or non-existent reporting systems, and lack of a systematic pattern of delivery. Most hospitals have some outpatient services. A common outpatient service that hospitals have is the emergency room and is of relevance to this study for the measurement of alcohol-related encounters, particularly for incidence of accidental trauma. In Alaska, where the death rate due to accidents is extremely high, it would seem that outpatient visits and particularly visits for treatment due to accidents, would be an important indicator to monitor. Unfortunately, most private hospitals in Alaska do not keep appropriate emergency room, or other outpatient service, records necessary to develop indicators on the extent of alcohol-related encounters in these settings. The major exception to this are the hospitals supported by the Alaska Area Native Health Service which record both outpatient visits and emergency room visits to alcohol misuse. This information is presented in Table VIII-2. During FY 76, total ambulatory patient visits that were attributable to alcohol misuse for all AANHS hospitals in the state numbered 3,365, a slight 3% and 4% increase over FY 75 and FY 74. The total number of outpatient visits for all accidents that were reported to be alcohol-related was 2,122 which was a 2% increase over FY 75 but a 12% decrease compared to FY 74.

Altogether, outpatient visits for alcohol misuse totaled 5,487 during FY 1976, for all AANHS hospitals.

TABLE VIII-2
ALCOHOL-RELATED OUTPATIENT VISITS
ALASKA AREA NATIVE HEALTH SERVICE HOSPITALS
1973-1975

	FY 1974	FY 1975	FY 1976
APC Total visits attributed to alcohol misuse	3,230	3,329	3,365
Alcohol-related accident visits	<u>2,415</u>	<u>2,067</u>	<u>2,122</u>
TOTAL VISITS	5,645	5,396	5,487

Source: Office of Systems Development, AANHS, Area Office, Anchorage, Alaska.

Admissions to Alcoholism and Drug Abuse Programs

Part of the range of services for treatment and rehabilitation of persons who abuse, or are addicted to, alcohol and other drugs includes a number of local community programs that exist mainly apart from the more traditional health and medical care facilities. The number of people admitted to these local community programs would also provide a measure of the impact of alcoholism and alcohol abuse. The adequacy of this measure is again limited by lack of reporting as well as non-presentation of clients for delivery of services due to unwillingness, unawareness or physical inaccessibility. Thus, such a measure provides an indication of the impact on such resources, not the magnitude of the disease or problem.

In 1975 local alcoholism programs in the state numbered about 25; there were about eleven drug abuse programs in the state. Admissions to drug abuse programs are included in this category because alcohol is generally considered to be frequently used in conjunction with the primary use of other drugs. In addition, 29% of the admissions of drug abuse programs in 1975 reported alcohol as the primary drug of use. (See reference Table VIII-3) The number of admissions for alcoholism and other drug abuse programs in Alaska, for fiscal years 75 and 76 are presented in Table VIII-3. It can be seen that 3,573 admissions were made into alcoholism programs during FY 1976, an increase of 44% over the previous year. There were a total of 365 admissions to drug abuse programs in FY 76, a 30% decrease compared to the previous year. In combination, there were 3,938 admissions into alcoholism and drug abuse programs during fiscal 1976 which is about a 32% increase over the previous year.

TABLE VIII-3
ADMISSIONS TO LOCAL ALCOHOLISM AND DRUG ABUSE PROGRAMS
ALASKA, FY 1975 & 1976

	FY 1975	FY 1976
Local Community Alcoholism Programs Admissions	2,474	3,573
Local Community Drug Abuse Programs Admissions	524	365
TOTAL ADMISSIONS	2,998	3,938

Sources: Alcoholism Program Admissions from Monthly Program Activity Reports. State Office of Alcoholism.

Drug Abuse Program Admissions from Annual Publication, Statistics of Alaska's Drug Abuse Treatment Program, FY 75, FY 76, State Office of Drug Abuse

Mental Health and Social Services
and Child Abuse and Neglect

Another general category of source of alcohol-related client admission or intake information is the area of mental health and social service programs and agencies. Cases of child abuse and neglect are included in this category for convenience of presentation. It is recognized that there is a distinction between client encounter information, presented so far, and cases of child abuse. Nevertheless, both provide quantifiable measures of alcohol-related impact and serve as indicators of such.

Available recorded information is presented below in Table VIII-4. It covers the activities of the AANHS Mental Health and Social Services, State Community Mental Health Centers, State Public Health Nurse Activities, and cases of child abuse reported to the state. (General feeling and limited research show a high correlation between alcohol intoxication and child abuse and neglect). Unfortunately, the present nature of the recording, collection and reporting activities for most of the appropriate programs and agencies preclude ready compilation of desired information. The information that is available is presented in the table. It can be seen that during FY 1976, the total patients discharged with diagnosis of alcohol and or drug abuse misuse numbered 454 for the AANHS Social and Mental Health services and 98 for the Community Mental Health Centers. There were an estimated number of 1,751 patient encounters with Public Health Nurses for alcoholism and

alcohol abuse. In addition, there were 2,422 cases of child abuse reported during approximately the same period.

TABLE 1981-4
ALCOHOL-RELATED MENTAL HEALTH SOCIAL SERVICES
AND CHILD ABUSE CASES
ALASKA, 1973-1975

	FY 74	FY 75	FY 76
AAHMS-Social & Mental Health Service: Total patients with discharge diagnosis of alcohol and drug misuse. ^a	538	477	454
Community Mental Health Centers: Total patients with discharge diagnosis of alcohol disorder or drug abuse ^b		109	98
State Public Health Nurse--Patient Encounters ^c		1,751	1,751 [*]
Child Abuse and Neglect Cases of child abuse and neglect reported to the state--total cases ^d	684	863	2,422 ^{**}

Sources:

^aAAHMS-Social and Mental Health Services from AAHS Division of Social and Mental Health Services, Area Office, Anchorage.

^bCommunity Mental Health Centers client discharges from Division of Mental Health, Department of Health & Social Services.

^cAlaska Division of Public Health, Nursing Section. As reported in Alaska Mental Health Needs Assessment, Vol. 5, Division of Mental Health and Developmental Disabilities, Department of Health and Social Services.

^dChild abuse cases from Division of Family and Childrens Services, Department of Health and Social Services.

* Estimate based on FY 1975 information.

**The dramatic increase in number of cases is due to changes in the reporting system.

Note: Fiscal year designations include overlapping reporting periods for fiscal and calendar years.

Client Characteristics

Despite limited client admissions data, it is still informative to review and describe the personal characteristics of the alcoholic client population. Only very basic, minimal information is available and not even from all programs, thus only a partial profile of client characteristics can be presented. The following statements can be made:

- almost two-thirds of the client admissions to local alcoholism treatment programs during 1975 were Natives,
- 61% of the client population of State Office of Alcoholism funded local programs were designated as Native. For State funded drug abuse programs, 50% of the patient population was non-white, 19% were Natives.
- three-fourths of all admissions were males -- 76% of the SOA local programs and 64% of the local drug abuse programs.
- three-fourths of all admissions were unemployed -- 75% (based on two programs reporting to NIAAA).
- most clients were not married -- 80% were either single, separated or divorced (based again on two programs).
- the median age was in the low thirties.

These characteristics of clients admitted to local alcoholism treatment programs contrast somewhat with the client characteristics of CMHC admissions, which had similar sex and age characteristics but most, 64%, were non-Native. This same distinction holds true for the inpatient population of client admissions for API--similar age and sex characteristics, but 63% non-Native.

No personal characteristics of the alcoholic admissions in private hospitals were collected, but the greatest proportion can be expected

to be non-Native. The information available from the AANHS hospitals for both inpatient and outpatient admissions apply to Natives.

A discussion of the similarities and differences of the personal background characteristics of the groups of persons involved in the clusters of alcohol-related events presented in the preceding parts of this Volume and client admissions for alcoholism treatment services, as well as for other alcohol-related health and social services is really impossible at this time, without additional data that would allow appropriate analysis. However, the limited but perhaps misleading information on hand indicates interesting disparities between the characteristics of the theoretical subpopulations at risk, and the subpopulations involved in various alcohol-related encounters with service delivery systems.

C. SUMMARY

The main purpose of this Part was to bring together a number of social indicators of the impact of alcoholism and alcohol abuse not already considered in preceding Parts. The general category of indicators concerned selected measures of health and social service delivery system units that may be attributed to alcoholism or alcohol abuse. These indicators were confined to the general area of physical and mental health, and social services. Each of the indicators presents a bit of additional information about other components of the various configurations of the impact of alcoholism and alcohol abuse in Alaskan society.

All the indicators presented in this brief Part are summarized in Table VIII-5 below. A simple arithmetic summation of the various alcohol-related admissions/encounters shows a total number of 16,610 during 1975.

TABLE VIII-5
SUMMARY OF ALCOHOL-RELATED ENCOUNTERS
FOR SELECTED MEDICAL, HEALTH, AND
SOCIAL SERVICES, ALASKA, 1973-1975

	1973	1974	1975
Hospital Admissions	1,929	2,221	2,460
APC Hospital Visits	5,645	5,396	5,487
Community Alcohol and Drug Program Admissions	--	2,998	3,938
Mental Health and Social Service Encounters	--	3,200	4,725
Total Alcohol-Related Encounters for Medical, Health, and Social Services	--	13,815	16,610

The magnitude of the social impact evidenced by the presentation of these indicators must be considered as severely understated. Not only are many areas of concern missing (eg. private and military hospital ambulatory patient care visits, accident visits, etc.), but the nature of the available recorded data represents minimum accounts of the real number of admissions rather than any sort of exaggeration (eg. alcoholic admissions to hospitals do not include missed diagnoses). The information is not representative of the nature and extent of need for services but rather, reflects present utilization.

PART IX. SUMMARY DISCUSSION AND CONCLUSION

A. INTRODUCTION

The intent of this Volume was to focus attention on the known, measurable indicators of the adverse impact of alcoholism and alcohol abuse on Alaska's social system in general, and on selected subsystems-- health and social services, criminal justice, traffic safety, and alcohol consumers. For certain levels of discourse, the terms alcoholism and alcohol abuse are sufficient, but for social problem solving, a more refined specification of problems is required. The specification of such indicators thus provides a profile of alcohol-related problems that can be used to monitor changes over periods of time, or to compare population or sub-population groups, or to evaluate specific programs designed to reduce or prevent a designated problem.

In the preceding Parts of this Volume, detailed investigations were made of various indicators of the impact of alcoholism and alcohol abuse. This last Part provides a summary overview of the major findings contained in each of the Parts, and additional discussion and elaboration where appropriate.

B. SUMMARY DISCUSSION

Etiology of Alcoholism

There is little understanding about the underlying causes of alcoholism or alcohol abuse. Because the addiction syndrome takes so

long to become established in a person, its developmental antecedents are particularly obscure and difficult to isolate. But a number of theories have been advanced to attempt to explain alcohol dependency in an individual (presented in Part III). But no one theory suffices for all known manifestations and/or syndromes of alcoholism, alcohol abuse, alcohol dependence, alcohol addiction, etc. The crucial determinants in the developmental process are still unknown, and the very nature of the addictive process remains largely a matter of conjecture. The presentation of various theories regarding the etiology of alcoholism provides a general background for the consideration of the information in the rest of the Volume.

Estimated Prevalence of Problem Drinkers

Although it is impossible to explain the causes of alcoholism and alcohol abuse, the social impact is not so elusive. Various procedures have been developed to estimate the prevalence of alcoholics or alcohol abusers in a population group, that are based on a variety of measures that reflect some of the consequences of alcoholism and alcohol abuse.

The prevalence of alcoholism in a population group is a general, large scale, indirect indicator of the number of alcoholics or problem drinkers in that population. Independent of the specifics of the estimation procedure involved, the final count is generally considered to enumerate a subpopulation group loosely characterized by behaviors defined as problematic because of their relation to the consumption of alcohol.

Review and application of several estimation procedures for prevalence of alcoholism found each and all of the procedures deficient in some respects for a theoretically close estimation of prevalence in Alaska. Most of the deficiencies had to do with the interaction between the unique population characteristics of Alaska and the estimation procedures. Most of the procedures are useful primarily for population groups larger than the population of Alaska. This is to say that because of the relatively small size of Alaska's population, for the use of such procedures, the elements used in the computation procedures fluctuate in erratic ways that result in the distortion of their intended outcomes. Furthermore, such general characteristics of the population as the recent rapid rate of growth, the cultural diversity, the high proportion of relatively younger persons, and the extreme fluctuations in the economic and employment situation, obtain to produce a less than stable population group amenable to these estimation procedures. Nevertheless, it was concluded that there were approximately 30,000 problem drinkers in Alaska in 1975. This was based on the strength of the correspondence of the findings of the three major methods--Jellinek, Marden and Ledermann, and the fact that each method uses independent sources of data. This number must be considered an underestimate because of the interplay of the factors mentioned above.

One of these three methods, the Marden method, provides for a more refined specification of target groups within the total population of drinkers with problems. This procedure estimated about 31,700 drinkers

with problems in the State of Alaska in 1975. About 15,630 were employed civilian males, and 4,530 were unemployed civilian males. There were about 5,800 civilian females (employed and unemployed) and about 5,740 military men and women (about 26 women). Of course, as with most estimation procedures more credibility must be given to the total number, than to any of the subdivisions.

Generally, the distribution of drinkers with problems was fairly evenly distributed over the occupational and analytic categories employed for estimation. A summary of the distribution of the estimated drinkers with problems in Alaska is provided in Table IX-1.

TABLE IX-1
PREVALENCE OF DRINKERS WITH PROBLEMS BY OCCUPATIONAL GROUP
ALASKA, 1975

Occupational/Analytic Group	N	Z
Women	5,970	19
Unemployed males	4,506	14
Craftsmen & kindred	4,436	14
Managers, Administrators	2,473	8
Professional, technical	2,089	7
Laborers	1,559	5
Operatives	1,520	5
Service workers	1,183	4
All others (clerical, sales, transport operators)	2,315	7
Military personnel	5,747	18
	31,709	100%

Source: Compiled from information in Figures II-1 to II-9,
Part II, this Volume.

It can be seen from this table that there was a noticeable disproportionate number of drinkers with problems in the groups analytically defined as "women", "military", "unemployed males", and "craftsmen and kindred workers". Collectively, these groups account for 65% of the estimated number of drinkers with problems, as defined by this procedure.

Some further explanation of this distribution is necessary however. The Marden procedure does not distinguish occupational categories for women. This group contains all employed women for all occupational categories, as well as unemployed women. Similarly, military personnel were treated collectively in this estimation, independent of the various occupational classifications they might occupy. These considerations leave the groups of unemployed males and males in the occupational category of craftsmen and kindred workers as showing a clear, relatively greater prevalence of problem drinkers, compared to the other occupational categories. In overall terms, however, civilian employed males (all categories) constitutes a full 50% of all estimated drinkers with problems and 78% of all civilian male drinkers with problems.

Re-examination of the distribution of drinkers with problems for selected age groups and employment status shows some interesting though not unexpected findings. This distribution is shown in Table XI-2.

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Re-examination of the distribution of drinkers with problems for selected age groups and employment status shows some interesting though not unexpected findings. This distribution is shown in Table XI-2.

TABLE IX-2

DISTRIBUTION OF DRINKERS WITH PROBLEMS BY SELECTED AGE AND EMPLOYMENT CATEGORIES, ALASKA, 1975

Categories	Percent of Total	Age - Percent of Row Total					Total
		20-29	30-39	40-49	50-59	60-69	
Males-civilian employed	49	36	26	21	16	2	101
Males - civilian unemployed	14	44	18	18	11	8	99
Military(males)	18	81	15	3	1	1	101
Males-all	(82)	46	24	17	10	3	100
Females -employed and unemployed	18	16	47	31	6	1	101
Total	100	32	31	23	11	3	100

Source: Computations based on information in Figures II-1 to II-9, Part II, this Volume.

The estimated number of drinkers with problems among employed males is greatest for the 20 to 29 age group, accounting for 36% of the estimated total for that group. However, 83% of that number is spread over the age group from 20-49 years of age. The prevalence of drinkers with problems among unemployed males is definitely greatest within the 20-29 age group, 44% of the total in that group. Similarly, but to a much greater degree, the greatest, and almost entire proportion

of estimated problem drinkers in the military group is concentrated in the 20-29 age group, (81%).

An overall comparison of the distribution of drinkers with problems for all males with that for all females shows definite differences. The greatest concentration of female problem drinkers is in the 30-39 age group, which is older than their male counterparts. The greatest concentration for females is in two age categories--30-39 (47%) and 40-49 (31%) for a total of 78%. For all males the greatest percentage is concentrated in the age groups of 20-29 (46%) and 30-39(24%) for a total of 70%.

Estimated Problem Drinkers: Group Characteristics

Drinkers with problems in Alaska are primarily males, 82%, compared to 18% females; drinkers with problems comprise about 15% of the drinking age population; they number approximately 31,000 (Marden Procedure).

Civilian, employed males make up half of the estimated number of drinkers with problems in Alaska (during 1975);and 78% of all civilian male problem drinkers are employed. They are distributed fairly evenly over all age groups and occupational categories. There are however, minor concentrations within the occupational category of craftsmen, and the age group of 20-29.

Males in the military comprise 18% of the total population of estimated drinkers with problems. Over 80% are in the 20-29 age category.

Unemployed males comprise about 14% of the estimated population of drinkers with problems. About 44% of their numbers are concentrated in the 20-29 age group.

Females comprise about 18% of the total number of estimated drinkers with problems in the state. Of these numbers, 78% are in the age groups of 30-39(47%) and 40-49(31%).

Estimated Problem Drinkers: Summary Remarks

The distribution of drinkers with problems in Alaska shows that males who are employed, particularly craftsmen and kindred workers, primarily in the age group of 20-29 years old, constitute the largest categorical target group.

It is clear that public inebriates do not constitute the greatest proportion of the population of problem drinkers; but unemployed male drinkers with problems are much younger than might have been expected.

Males in the military, aged 20-29, constitute a disproportionate share of the population of drinkers with problems, relative to their total numbers.

Females, unemployed and employed, aged 30-49, constitute a clearly identifiable target group.

It is clear that the application of these various methods for estimating the prevalence of problem drinkers in the Alaskan population can have important roles as program planning and development tools--for the identification of target populations at risk, the monitoring of changes, and the projection of future estimates.

Consumption of Beverage Alcohol

Additional indicators that reflect the impact of alcoholism and alcohol abuse, and provide valuable program planning and development information are also necessary. One of the most important indicators, and also easy to obtain (on a statewide basis) is the average annual consumption of beverage alcohol.

The per capita apparent consumption of alcoholic beverages in Alaska is high, viewed from various perspectives. As is true nationally and internationally, overall per capita consumption of beverage alcohol in Alaska has also steadily increased. The average level of per capita consumption for Alaska however, is relatively high by international comparison, and significantly higher than averages for the nation, national regions, and other states. Further, Alaska's increasing overall per capita consumption has been marked by a gradual shift away from consumption of distilled spirits towards lighter alcoholic beverages, but the shift is very slight. Alaska is distinguished from most other countries, the nation, most national regions, and states, by its continued and definitive preference for distilled spirits over beer and wine. Perhaps most important, however--and independent of its overall level of consumption or its specific beverage preference--is Alaska's dramatic and alarming rate of increase in annual per capita consumption.

Recent epidemiological research indicates that an increasing rate of average annual consumption indicates an increasing prevalence of alcoholism--a fact that makes Alaska's rapid rate of increasing consumption all the more disturbing.

When compared to national consumption figures, the recent increases in Alaska's level of apparent consumption appear even more drastic. Alaska's level of annual consumption of absolute alcohol in 1958 was 27% greater than the national level--2.52 compared to 1.98 gallons of absolute alcohol per person in the drinking age population. By 1975, Alaska's rate of per capita annual consumption was 57% greater than the nation's--4.54 compared to 2.90 gallons of absolute alcohol per person. In other words, while average annual consumption for the nation had increased by 46% from 1958 to 1975, for Alaska it had increased by 80%. (See Figure IV-2).

In short, the apparent consumption of absolute alcohol in Alaska since statehood is characterized by three facts. First, the quantity of absolute alcohol consumed annually by Alaskans has been, and still is, relatively high by both international and national standards. Second, the apparent consumption of absolute alcohol in Alaska has increased steadily since statehood--a trend consistent with international and national patterns. Finally, and most importantly, the rate of increasing annual consumption is alarmingly greater for Alaskans than the rate of increase for the national average--almost twice the rate of increase.

Consumption of Beverage Alcohol and Prevalence of Alcoholism

The relationship between the rate of consumption of beverage alcohol and the rate of alcoholism in a population has been a topic of increasing research investigation. One major position states that the overall level of consumption of beverage alcohol in a population determines both

the prevalence of alcoholism and the extent and nature of alcohol-related organic pathologies.

According to this formulation, as the rate of average annual consumption increases, so does the rate of excessive drinkers; and so, too, does the rate of alcohol-related mortality.

Given the fact, then, that consumption levels in Alaska have increased substantially since statehood, it follows that death in the state due to cirrhosis of the liver and alcoholism should show a similarly proportional increase, if this theoretical formulation holds true. The dramatic increases in Alaska's annual average consumption of absolute alcohol since 1958 have indeed been matched very closely by equally significant increases in the death rate due to cirrhosis of the liver, and alcoholism (See Figures IV-4 and 5).

It is evident that the relationship between increasing annual consumption and chronic excessive use, along with increasing annual rates of alcohol-related mortality, is particularly well demonstrated in Alaska.

That Alaska can be classified as a high consuming population goes without question. Excessive drinking of beverage alcohol appears to approach normative drinking patterns, rather than representing deviant behavior. In populations with a relatively high rate of average annual consumption, alcoholism is more likely the result of social practices, whereas in low consuming populations, it is more likely the result of individual psychopathology or sociopathology. Given the relationship between excessive consumption and moderate consumption, attention must be focused on factors that affect rates of consumption in a population, in

order to reduce the prevalence of alcoholism.

Factors Affecting Consumption of Beverage Alcohol

A number of factors that affect consumption--the number and type of retail outlets for beverage alcohol, closing hours, and taxation of beverage alcohol, are also government measures for the regulation and control of the sale and consumption of beverage alcohol in Alaska. Available information regarding these factors indicates that consumer accessibility is greater in Alaska, and that government control measures are considerably more relaxed than in other states.

Compared to national averages, there are twice as many retail liquor outlets per 1000 persons in Alaska. In addition, there are fewer prohibited hours of sale in Alaska than in most other states. Further, the relative price of beverage alcohol in Alaska has actually decreased by 40% in the period from 1970 to 1975.

Taxation

Taxes affect the consumer price of alcoholic beverages, and there are strong indications that the price of alcohol relative to personal disposable income is closely related to overall consumption and the prevalence of alcoholism.

In Alaska, the Consumer Price Index (CPI) for alcoholic beverages in Alaska increased by .3% (three-tenths of one percent) in the period from 1970-1975. The CPI for all items increased 41.2% during the same time period. Average disposable income increased by 92%, while real disposable income (average disposal income adjusted for CPI changes)

increased 35.7%. In effect, the consumer price of all commodities from 1970-1975 increased by more than 40%, while the price of beverage alcohol increased by only .3%--which means that, in relation to all other commodities, the price of alcohol decreased by more than 40%.

According to the Distilled Spirits Council, 50% to 75% of the price of alcohol is comprised of taxes--federal and state; thus, if taxes do not change, the price of alcohol obviously does not behave like other noncontrolled commodities in the free market. In Alaska the excise tax on beverage alcohol has not changed since 1961.

It would seem that, particularly applied to Alaska, the relationship between increasing annual average consumption and decreasing relative price of beverage alcohol is quite clear. Along with the relatively greater accessibility, the decreasing price helps explain the dramatic increases in consumption that were noted for Alaska.

As the overall level of average annual consumption is allowed to increase, so does the prevalence of chronic excessive use and thus, the prevalence of hazardous consumers and alcohol-related pathologies.

Alcohol-Related Mortality

It has already been demonstrated that increasing average annual consumption is associated with increasing rates of death due to cirrhosis of the liver and alcoholism. Although it is impossible to conclusively link alcohol to a precise portion of mortality for other causes of death, national and international studies have established that heavy drinkers

have a mortality rate that is two to four times higher than those who are not. Given the rates of mortality in Alaska for causes of death known to be frequently related to excessive drinking, and the relatively high level of consumption, alcohol involvement in the deaths of Alaskans is probably quite high.

With respect to such "risk populations" in general, specific-cause mortality data show that two subpopulations in Alaska are characterized by especially high mortality: (1) the young, as mentioned above, and (2) the state's Native population, whose overall rate of death in Alaska is more than twice that of non-Natives (1974).

The regional distribution of fatalities in Alaska (in 1974) indicated that overall death rates were highest in the less populous regions of the state, but that overall mortality was concentrated in the Southeastern Region. The pattern of mortality distribution also shows that Native death rates were greatest in the Northern Region (least densely populated region in the state), while the highest non-Native rate of mortality occurred in the Southeastern Region.

In the aggregate, these trends and apportionments of mortality in Alaska suggest a confluence with other, known characteristics of the effects and consequences of excessive alcohol consumption in the state.

Alcohol-Related Arrests

Hazardous consumption of beverage alcohol by individual consumers also contributes to excessive or increased impact on society in general,

and on its subsystems. The impact of alcohol-related crime on the criminal justice system is particularly evident in Alaska.

The greatest impact on the criminal justice system of alcohol-related crimes derives primarily from the commission of misdemeanor type offenses. A large percentage of violent crime is considered to be alcohol-related: homicide-64%; rape-34%; and, aggravated assault-41%. But arrests for all violent crimes, and robbery, only account for about four percent of the total number of arrests for all offenses in the state. On the other hand, arrests for alcohol-related misdemeanors account for about 39% of the total number of arrests for all offenses, for both adult and juvenile arrests for all offenses. If juvenile and adult arrests are separated, then 47% of all adult arrests are for alcohol-related misdemeanor offenses. This group of adults is primarily male (85%) and accounts for 87% of all arrests for alcohol-related offenses.

A consideration of the different socio-geographic settings showed that although the greatest volume of arrests for alcohol-related offenses is in the urban settings, where most of the people live, the greatest relative impact is in the rural-city settings. In these settings, a somewhat greater percentage of all arrests are for Part II type offenses. More significantly, however, nearly half, 48%, of all arrests were for alcohol-related offenses, compared to 39% in urban settings, and 34% in rural settings.

Most of the adult arrests for alcohol-related offenses were for driving while intoxicated, for both men and women. Females, however,

showed a pattern of alcohol-related arrests more evenly divided among DWI, disorderly conduct and liquor law violations, whereas male alcohol-related arrests were very definitely concentrated on the DWI offense.

For juvenile arrests for alcohol-related offenses, about two-thirds were for liquor law violations. Liquor law violations and assaults together accounted for 85% of all juvenile arrests for alcohol-related offenses.

Although there is not enough data to adequately address the impact of alcohol-related arrests on the court and corrections components of the criminal justice system, it appears that misdemeanors would again be emphasized. Forty-eight to 75% of all misdemeanor cases filed with the district court were for alcohol-related offenses in 1975. Also, 42% to 78% of all misdemeanor convictions were for alcohol-related offenses.

During the period from 1971 to 1975, the number of releases for jail sentences of ten days or longer for alcohol-related offenses decreased by 72%, most likely in relation to the decriminalization of public drunkenness provided in the Uniform Act (1972). Also, during 1975, more than 50% of all served sentences fewer than ten days were for alcohol-related offenses. In addition, the recidivism rate for alcohol-involved offenses was established to be about 43%.

Limitations on available data most certainly restricted this section of the analysis of the impact of excessive drinking on the

court and corrections components of the criminal justice system. Certainly additional investigation is necessary.

Alcohol and Traffic Safety

The misdemeanor offense of driving-while-intoxicated is the offense category that accounts for the largest number of arrests annually. Drunk drivers are one of the primary concerns for the problem of traffic safety.

In Alaska, as elsewhere, most people killed after drinking and driving have a very high blood alcohol concentration. During 1975, 46% of the motor vehicle fatalities involved alcohol. Most drivers convicted for DWI have very high BAC's. The average BAC for DWI drivers in the state is almost twice the statutory legal limit of impairment. Even this level of .10% blood alcohol concentration is too high for safe driving when one considers the scientific and medical evidence of the extent of impaired judgment and ability indicated by the various ranges of blood alcohol concentration. Additional research information clearly demonstrates the increasing probability of involvement in any kind of crash with increasing BAC levels, as well as the increasing likelihood of responsibility for the crash with increasing BAC's. The probability for crash involvement begins to increase appreciably above .05% BAC. The presumptive limit for intoxication for conviction for OMVI is .10% BAC. The average BAC of arrested DWI drivers in 1975 was .18%. Ninety-two percent of all DWI arrests recorded BAC's above .10%.

The greatest majority of drivers have generally clear driving records, a very low rate of previous crash involvements, and account for very few of the crashes and traffic convictions. The great majority of drivers--80%-90%--also register no measurable BAC; about 3%-5% show BAC levels above .10%. This contrasts very sharply with both the subpopulations of drivers involved in crashes and drivers convicted of DWI. The average BAC level of these drivers is almost twice that of the limit of legal impairment. They account for an extremely disproportionate number of prior DWI convictions, as well as other serious and minor traffic violations and involvement in accidents. Given the array of information available about these drivers, it is logical and valid to conclude that the great majority were indeed drunk, independent of one's precise definition of the term. While the conclusion seems obvious, the information available also allows the inference that a very high proportion of these drivers also qualify for the label of "problem-drinker" or "alcoholic drinker". As such, these problem-drinker-drivers are valid clients for alcoholism treatment and rehabilitation as well as for the judicial-correctional system.

This group of people is generally well known to the courts, accounting as they do for so many traffic violations and accidents. In Alaska, about 22% of all adult arrests are for OMVI. Of those convicted, two out of ten had at least one prior OMVI conviction, 18 of 20 had at least one prior major traffic violation (reckless or negligent driving, etc.), and 13 out of 20 had one or more traffic accidents. Drivers

convicted of OMVI tend to be younger, between 18 and 39 years old, non-Native, and male.

The general trends of increasing consumption in Alaska, along with increasing numbers of licensed drivers, roadways, and vehicle miles driven, can be expected to continue. Given the nature of the increases--a younger population, more drivers, less driving experience, increasing consumption, and increased recreational, nighttime driving, the extent of alcohol involvement in crashes will probably increase.

Alcohol Abuse and Health and Social Services

There are also a number of other indicators of the impact of excessive drinking that comprise the general category of reported morbidity, including both diseases and trauma. This category represents the incidence of various adverse events as reported in the utilization of inpatient and outpatient health services and other social services. This information needs to be approached with a great deal of caution, since the inadequacies of the reporting systems, combined with the differing philosophical, financial and administrative practices of the various health and social service agencies, aggregate to mainly underrepresent the impact on this category of service. Further, this information does not reflect the nature or extent of the need for services in the population, but rather the nature and extent of the reported utilization by the agencies.

The findings mainly point to the lack of inclusion of the effects of alcoholism and alcohol abuse in the reporting systems of the agencies that concern themselves with alcohol-related health and social service consequences. In spite of the inadequacy of the reporting systems, the limited information did show a system wide impact that can be felt in inpatient and outpatient hospital services, emergency room services, mental health services, alcoholism and drug programs, and in field services provided by public health nurses, as well as in reported cases of child abuse and neglect. In addition, some of the very limited client data available hints that there seems to be some interesting disparities in the characteristics of the theoretical subpopulations at risk, and the subpopulations of clients that obtain health and social services. Much more investigation is needed.

Generally, it can be expected that the existing minimal indications of the already pervasive impact of alcoholism and alcohol abuse on health and social services will increase dramatically in the near future. This will probably be the combined result of not only better reporting systems (and changes in third party reimbursement regulations) but also the result of real increases related to the patterns of increasing average annual consumption of beverage alcohol in the state.

C. CONCLUSION

The information presented in this Volume, along with supplemental information in the other Volumes, has provided a description of the

nature and the extent of alcohol problems in the state. In general, the presentation and analysis only serves to reinforce what Alaskans have perceived now for several years--alcoholism and alcohol abuse constitute the greatest social problem facing the state. But more specifically, the ambiguous term "alcoholism and alcohol abuse" have been replaced with specific problems. The specification of the alternative configuration of alcohol problems is by no means complete. But this initial effort has produced outcomes that now allow not only the definition of the needs for more precise research, but it provides critical baseline information for the development of coordinated social policy, and the definition of specific programs for the reduction and prevention of designated alcohol problems.

The thrust of this Volume was on the measurable indicators of the impact of alcohol-related problems. This approach, of course, is necessary in order to develop a clear identification of the character or nature of the problems to be attacked. However, it is clearly understood that compiling only measurable indicators omits from immediate consideration some types of problematic behaviors that have not been, or cannot be measured. Nonetheless, the number and diversity of events that can be measured serve to more clearly reflect the actual state of affairs, and also serve to focus problem solving efforts on events and social and institutional response rather than vague notions about alcoholism or alcohol abuse.

Out of the many findings in this Volume, two particular notions emerge that deserve special attention. First, the population of the state of Alaska qualifies, without question, as a high consuming population, with regard to beverage alcohol. Further, and most important, there appears to be a very high degree of correspondence between the increasing average annual consumption of beverage alcohol in the state, and the nature and extent of individual public health and social problems associated with the current use of beverage alcohol. This notion directs attention to factors that control levels of population consumption.

The second notion of particular import, though not so certain as the first, is the appearance of discrepancies in the characteristics of the target populations at risk, and the characteristics of the sub-populations receiving treatment services for alcoholism and alcohol abuse. This last notion raises the question of the effective and efficient distribution of treatment resources.

There are many different views about the interplay of the various factors involved in each and all of the alternative configurations of specific alcohol problems. It seems that these views are also influenced by differing sociocultural and personal value systems as well as by evidence from actual research evidence. There also exists a diversity of organizations--official, voluntary, and professional, that all play important and interrelated roles in efforts to reduce and prevent alcohol problems. Because of this diversity of views and organizations, it is extremely important that there be general agreement on the part of those

involved as to the goals and objectives to be achieved and a mutual understanding of the approaches and methods to be used. If such agreement and understanding are not achieved, then the actions taken by the various groups may be discordant and ineffectual, or even counterproductive.

**THE
ALASKA
STATE
ALCOHOLISM
& DRUG ABUSE
PLAN
1984 - 1986**

STATE OF ALASKA

ALCOHOLISM AND DRUG ABUSE STATE PLAN

1984 - 1986

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The National Conference of Commissioners on Uniform State Laws, in 1971, approved the Uniform Alcoholism and Intoxication Treatment Act and agreed to recommend its adoption by every State. Since that time several States have adopted this model law or legislation very similar to it, removing public-intoxication from criminal justice systems and providing for the treatment of alcoholism by the public health and community service agencies. Legislators in many other States agree that such statutes should be enacted but hesitate because of the cost entailed in this sweeping change of policy.

The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Amendments of 1973 (S. 1125), which was passed by the Senate on June 21, 1973, includes a section providing for special grants of \$100,000 plus 10% of its formula allotment for alcoholism program to each state which adopts the Uniform Action or legislation substantially similar to it. A nearly identical provision is included in a similar bill (H.R. 10019) now under consideration in the House of Representatives.

I consider the adoption by the State of the Uniform Alcoholism and Intoxication Treatment Act an important step toward providing enlightened treatment for the millions who suffer from alcoholism. I am therefore pleased to make copies of the Act available for distribution.

Harrison A. Williams, Jr.
Chairman, Committee on Labor and Public Welfare.

U.S. SENATE,
COMMITTEE ON LABOR AND PUBLIC WELFARE,
Washington, D.C., September 28, 1973.

Hon. Harrison A. Williams, Jr.
Chairman, Committee on Labor and Public Welfare,
U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: In 1971 the National Conference of Commissioners on Uniform State Laws approved the Uniform Alcoholism and Intoxication Treatment Act and encouraged its introduction in the State legislatures. The then Secretary of Health, Education, and Welfare, Elliot Richardson, wrote me on November 3, 1971 concerning this draft and stated: "For too long, public intoxication has been the responsibility of the criminal justice system. Experience has demonstrated that existing laws and existing ways of handling alcoholic persons only helped to perpetuate human misery and suffering and to create burdens for their families, local communities, police departments, courts and other agencies. The failure to provide for the medical and social needs of alcoholic persons on the other hand has contributed to high rates of recidivism and the evolution of a revolving door system of ineffectiveness."

Several States have already adopted this or similar legislation but most have not done so because of the cost. In order to encourage the remaining States to take this action a provision was included in the Comprehensive Alcoholism Prevention, Treatment and Rehabilitation Amendments of 1973 (S. 1125) which was passed by the Senate on June 21, for a special grant to States which adopt this act. I am convinced that every effort should be made to encourage this action by the States. Consequently, I am transmitting a copy of the Uniform Act to you, together with notes and comments thereon, with the recommendation that the document be made available for distribution by the Committee.

Sincerely yours,

Harold E. Hughes,
Chairman, Subcommittee on Alcoholism and Narcotics.

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ACRONYMS

AA	- Alcoholics Anonymous
A-95	- Governor's Statewide Clearinghouse for Program Coordination
AANHSA	- Alaska Area Native Health Service
ABC	- Alcohol Beverage Control Board
ACC/ALL	- Anchorage Community College/Adult Literacy Lab
ABE	- Adult Basic Education
ACOPADA	- Alaska Council on Prevention of Alcoholism & Other Drug Abuse
ADACA	- Alcoholism/Drug Abuse, Mental Health Administration
AS	- Alaska Statute
ASAP	- Alcohol Safety Action Program
ATA	- Alcohol Treatment Center (NAPIS)
APU	- Alaska Pacific University
BBAHC	- Bristol Bay Area Health Corp. (Dillingham)
BIA	- Bureau of Indian Affairs
CAAS	- Center for Alcohol & Addiction Studies
CHAMPUS	- Civilian Health & Medical Program of the Uniformed Services
CMHC	- Community Mental Health Center
COA	- Council on Alcoholism
C&RA	- Department of Community & Regional Affairs
CRNA	- Copper River Native Association
D/A	- Drug Abuse
DAIS	- Drivers Alcohol Information School
DAWN	- Drug Abuse Warning Network (DEA-NIDA)
DEA	- Drug Enforcement Administration (Department of Justice)
DHSS	- Department of Health & Social Services
DOT	- Department of Transportation
DPC	- Data Processing Center
DPS	- Department of Public Safety
EAP	- Employee Assistance Program
EMS	- Emergency Medical Services
FAS	- Fetal Alcohol Syndrome
FDA	- Food & Drug Administration (concerned with use of methadone in treatment of narcotic addiction)
FDTC	- Fairbanks Drug Treatment Center
FFA	- Federal Funding Agency
FFC	- Federal Funding Criteria
FMIS	- Financial Management Information System
FNA-CAP	- Fairbanks Native Association-Comprehensive Alcoholism Program
FY	- Fiscal Year (State of Alaska's is July 1 - June 30, FY 85 is July 1, 1984 - June 30, 1985)
HLAY	- "Here's Looking At You" (school-based education program)
HSA	- Health Systems Agency
HSP	- Health Systems Plan
H&SS	- Department of Health & Social Services
ICC	- Interdepartmental Coordinating Committee
IHS	- Indian Health Service
J	- Joint Commission on Accreditation of Hospitals
JCAH	- Joint Commission on Accreditation of Hospitals

K-12	- Kindergarten through Twelfth Grade
KANA	- Kodiak Area Native Association
KILA, Inc.	- Composed of a treatment/counseling program (FDIC) and a prevention/education component.
LEAA	- Law Enforcement Assistance Administration
M/H	- Mental Health
MIS	- Management Information System
MOA	- Municipality of Anchorage
NAHRA	- Northern Alaska Health Resources Association
NA	- Native Association
NAPIS	- National Alcoholism Program Information System
NASADAD	- National Association of State Alcohol & Drug Abuse Directors
NCA	- National Council on Alcoholism
NCA-AR	- National Council on Alcoholism - Alaska Region
NDATC	- National Drug Abuse Training Center
NDATUS	- National Drug Abuse Treatment Utilization Survey (NIDA)
NGA	- Notice of Grant Award
NIAAA	- National Institute on Alcohol abuse & Alcoholism
NIDA	- National Institute on Drug Abuse
NIMH	- National Institute of Mental Health
NSHC	- Norton Sound Health Corp. (Nome)
OPPM	- Operating Policies & Procedures Manual
PHS	- Public Health Service
PL	- Public Law (federal)
QPR	- Quarterly Progress Report (SOADA)
RHC	- Regional Health Corporation
RFP	- Request for Proposals
RSA	- Reimbursable Services Agreement (between State agencies)
Rural CAP	- Rural Alaska Community Action Program
SAA	- State Alcoholism Authority (NIAAA)
SACAS	- Salvation Army Comprehensive Alcoholism Services (Anchorage)
SAPIS	- State Alcohol Profile Information System (NIAAA)
SCRO	- South Central Regional Office (SOADA)
SCHPD	- South Central Health Planning & Development Inc. (HSA)
SEAGSA	- Southeast Alaska Health Systems Agency
SEARCH	- Southeast Alaska Regional Health Corp.
SHCC	- State Health Coordinating Council
SHPDA	- State Health Planning & Development Agencies
SOADA	- State Office on Alcoholism & Drug Abuse
SPD	- State plan Development
SPSS	- Statistical Package for the Social Services
T/A	- Technical Assistance
TASC	- Treatment Alternatives to Street Crime
T/C	- Therapeutic Community
TCC	- Tanana Chiefs Conference
U of A	- University of Alaska
UTRCA	- Upper Tanana Regional council on Alcoholism (Tok, AK)
UCR	- Uniform Crime Reports
VA	- Veterans Administration
YKHC	- Yukon-Kuskokwim Health Corporation

CHAPTER I
INTRODUCTION AND BACKGROUND

CHAPTER I INTRODUCTION AND BACKGROUND

HISTORY AND STATUTORY AUTHORITY OF THE STATE OFFICE OF ALCOHOLISM AND DRUG ABUSE

The Alaska State Office of Alcoholism and Drug Abuse (SOADA) is a separate office within the State's Department of Health and Social Services. On July 1, 1977, the former State Office of Drug Abuse was merged with the Office of Alcoholism. Since that time, the SOADA has functioned as the Single State Agency for implementation of both Public Law 91-616 and Public Law 92-255. Alaska Statutes 47.37, 47.30.470-500, and 44.29.100-150 defines the powers and duties of the Office of Alcoholism and Drug Abuse.

Alaska Statute 47.37 incorporates in its Declaration of Policy the Uniform Alcoholism and Intoxication Treatment Act of 1972: 1) "It is the policy of the state that alcoholics and intoxicated persons should not be criminally prosecuted for their consumption of alcoholic beverages and that they should be afforded a continuum of treatment so they may lead normal lives as productive members of society." (sec. 1 ch. 207 SLA 1972). The legislation details the duties of the office with regard to developing and maintaining a comprehensive program of services for the prevention of alcoholism and treatment of alcoholics and intoxicated persons. Alaska Statute 44.29 establishes that "the drug abuse program coordinator shall carry out the development and implementation of a comprehensive program to prevent and treat the use and abuse of drugs as they affect the people of Alaska." (sec. 1 ch. 198 SLA 1972). Alaska Statute 47.30.470-500 sets for the grant-in-aid program through which this comprehensive program is funded. This statute details what information shall be considered when reviewing grants as well as the review process itself.

The Governor's Review Board on Alcoholism

The statewide citizens' advisory council for alcoholism programming in Alaska is the Review Board on Alcoholism. The Board was established under the provisions of AS 47.37.060-110. Nine members are appointed by the Governor to serve four year terms. Alaska Statute 47.37, included as Attachment A, details the composition of the Board and its duties. Bylaws adopted by the Board establish that a Chairperson and Vice-Chairperson will be elected for one-year terms, and the Coordinator of the State Office will serve as Executive Secretary. See Attachment B. Additionally, the Board now serves as a standing committee to the Statewide Health Coordinating Council (SHCC) under HB 830 passed in 1980.

The Governor's Advisory Board on Drug Abuse

The statewide citizens' advisory council for drug abuse in Alaska is the Governor's Advisory Board on Drug Abuse. The Board was established under the provisions of AS 44.29. Nine members are appointed by the Governor to serve four-year terms. Alaska Statute 44.29, included as Attachment D, details the composition of the Board and its duties, and Attachment E lists the current membership.

Legislative Policy (Alcohol abuse and alcoholism)

Alaska Statute 47.37.130(a) sets forth the policy of the State of Alaska as it relates to treatment services.

"Comprehensive program for treatment; regional facilities.

- (a) The office shall establish a comprehensive and coordinated program for the treatment of alcoholics and intoxicated persons. Subject to the approval of the commissioner, the coordinator may divide the state into appropriate regions to conduct the program and establish standards for the development of the program on a regional level. In establishing the regions, consideration shall be given to the city and borough lines and population concentrations and, when feasible, programs shall be established with maximum local community involvement.
- (b) The program of the office shall include:
 - (1) emergency treatment provided by a facility affiliated with or part of the medical service of a general hospital;
 - (2) inpatient treatment;
 - (3) intermediate treatment; and
 - (4) outpatient and follow-up treatment.

There are equally detailed statute citations that deal with prevention services.

AS.47.37.040 The office shall:

- (1) develop, encourage and foster statewide, regional and local plans and programs for the prevention of alcoholism....;
- (2) coordinate the efforts and enlist the assistance of all public and private agencies, organizations, and individuals interested in prevention of alcoholism and treatment of alcoholics and intoxicated persons;

Statements related to prevention of alcoholism can be found throughout Alaska Statute 47.37., as well as in AS 44.29.100-150, and AS 17.30.140.

The Legislative session of 1980 produced a major increase in funds available for alcoholism services. Along with this monetary increase came a major statement of intent. The House Finance Committee produced a report entitled "Special Efforts in Response to Alcoholism and Alcohol Abuse Problems." This document states in part:

"The provisions of the Uniform Act* are reaffirmed.....Special attention is hereby directed to the rapid and intensive development of the full range of comprehensive alcoholism and alcohol services on a statewide basis which are equally available and accessible within the three primary health service regions of the state.

Single State Agency

The single state agency is directed to undertake special efforts during the next five years to develop and coordinate prevention, treatment, research and administrative programs that are commensurate with the high prevalence and incidence of alcohol problems in the state."

For the past four fiscal years (FY'81 through FY'84) AS 47.37 and the House Finance Committee document and the subsequent state plans have guided the development of alcoholism services in Alaska.

Legislative Policy (Drug Abuse)

The legislative directives around drug abuse have not been as extensive nor as firm. Alaska Statute 44.29 sets forth the composition and duties of an Advisory Board on Drug Abuse. The duties of the Board are to act as an advisor to the commissioner of the Department of Health and Social Services (AS 44.29.140) in regard to:

- (3) social problems which affect rehabilitation of drug users and addicts;
- (5) development of programs of prevention, treatment and rehabilitation for drug abusers and addicts;
- (7) evaluation of effectiveness of drug abuse programs in the state.

AS 44.29.150 states:

"The drug abuse program coordinator shall carry out the development and implementation of a comprehensive program to prevent and treat the use and abuse of drugs as they affect the people in Alaska.

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

The Legislative session of 1982 produced a major revision of Alaska's laws regarding controlled substances. The changes brought Alaska law closer to federal law and the criminal penalties were revised to reflect the most recent criminal code. However, this major revision did not produce a clarification of state policy. In almost every instance where treatment is an issue the law states that a court may consider treatment as part of a criminal penalty or that treatment may be considered in probation or parole decisions.

The legislation did, however, add to the clarity regarding prevention. AS 17.30.140 states:

- (a) The commissioner of health and social services shall provide for educational programs designed to prevent and deter the abuse of controlled substances.

Philosophy of the Office of Alcoholism and Drug Abuse

From the above legislative directives it is clear that SOADA's mission is to create and maintain a comprehensive program of prevention, intervention and treatment for all Alaskans that may be affected by alcohol and drug abuse.

The mission of this agency has its roots in both federal and state law that recognizes the need for and legitimate place of prevention and treatment as the appropriate response to recognized alcohol and drug problems. Alaska Statute 47.37.010 states that alcoholics and intoxicated persons should be afforded a continuum of treatment and not be criminally prosecuted for their consumption of alcohol alone. AS. 11.71.305 states that a person convicted of violating the law in regard to controlled substances, when such violation relates to personal use may be ordered to receive treatment. These citations are rooted in research and law that substance abuse is preventable and treatable.

Alcoholism, drug addiction, substance abuse, substance abuser, drug abuse, alcohol abuse, chemical addiction, and/or problem drinker are all terms that are often used and widely misused by many. It is often unclear whether whether the terms are describing a physical condition, defining a behavior, labeling a person or a combination of these items. To complicate the issue further, the term poly-drug abuse or abuser when there is confusion regarding who or what is the problem. These terms are not the issues that must be addressed as this office strives to meet the mission set forth in statute. The categorizing of addicted individuals or the etiology of disease is secondary to reducing the human devastation of chemical dependency.

At issue is how this office defines alcoholism and drug abuse. The Office of Alcoholism and Drug Abuse supports the reality that alcoholism and drug abuse are diseases for which there are effective treatment and rehabilitation modes. Alcoholism and drug abuse have an effect on and interfere with the physical, social, psychological and spiritual aspects of a person's life. Alcoholism and drug abuse can be diagnosed, can be subjected to an intervention process, and can be treated.

Alcoholism and drug abuse require divergent treatment modalities due to the multi-faceted ways in which the disease affects the individual. Not everyone who suffers this disease consumes the same drug(s) in the same manner or in the same setting. Not everyone is the same age, sex, race, or has the same marital or economic status when the disease becomes apparent to significant others or to themselves.

At the core of any or all treatment modalities there must be the basic belief that:

Use of alcohol and/or other drugs in a manner that repeatedly interferes with the major life functions of the individual (e.g. health, work, family, etc.) is defined as alcoholism/ alcohol abuse or drug abuse.

If this definition is used, the primary goal of any treatment program is to encourage and support the individual to become and remain abstinent from alcohol and other drugs. The Office of Alcoholism and Drug Abuse supports the idea that lasting changes in an individual's physical, social, psychological or spiritual health must take place in order for lasting abstinence to be achieved. However, no changes in an individual's life/ health style can take place as long as alcohol and/or drug taking is still present. Therefore, abstinence remains the base response to recovery.

There still remains the question of those persons who use alcohol and/or other drugs and do not now and may never fit the above definition. How does this person fall within the mission of this agency? Drunk or drugged behavior can often be obnoxious, embarrassing and sometimes damaging. An inexperienced drinker, driving while drunk, is a danger to him or herself as well as everyone nearby. Overconsumption of alcohol or drugs in any situation that calls for accurate thinking or physical coordination can cause problems for all concerned. Alcohol abuse or drug misuse remains as an important health risk concern as alcoholism.

Drinking during pregnancy has been shown to have effects on the unborn fetus. Fetal Alcohol Syndrome (FAS) research has yet to define if any alcohol consumption is safe. Therefore, the general medical advice recommended is that if a person is planning to become pregnant or is pregnant that drinking alcohol should stop. It is common medical practice that, during pregnancy, all drug taking should be done only under a physician's orders. Fetal alcohol syndrome becomes a special office health priority in light of the state per capita consumption statistics.

During adolescence, research has shown that the body is still growing and developing. Even more important is that potential or actual intellectual growth is enormous. Research has demonstrated that alcohol and/or other drug abuse can affect that ability to learn. Nutrition, good health, and exercise are all established prerequisites for proper adolescent growth. The point that alcohol or drug taking behavior interferes with this process mandates that education and information about these dangers be offered at a young age.

There are also many drugs that serve a beneficial medical purpose. These controlled substances can also be abused and the potential for abuse is a prime concern as to the amount of control exercised. The medically approved, therapeutic use of these drugs is not abuse and would not fit the above definition. Even so, warnings about driving, operating machinery or doing detailed manual work while using these drugs are given by doctors and pharmacists. It is crucial that consumers be aware of these consequences or, at least, educated enough to ask their doctor or pharmacist about possible restrictions or potential for abuse and addiction.

School education (K-12), public education, advertising, public information campaigns and other educational efforts are vitally important in developing an educated populace. Education about effects of alcohol and drugs, about the legal issue of the use of alcohol and drugs, and education about alternative behaviors are a major part of this effort.

The provision of addictions counseling inside correctional facilities is being provided by community programs in those cities where state correctional facilities exist. It has been found that offenders have extremely high rates of addiction and substance abuse. The in-facility programs are specifically designed to lower recidivism rates for offenders while providing an opportunity to initiate changes in physical, social, psychological and spiritual health.

Early identification of persons who may be having problems due to alcohol and/or drug use is a proven capability. Education and information programs have the effect of making persons look at their drug use. Employee Assistance Programs and Alcohol Safety Action Programs are based on the premises that poor work performance or drunk driving or misdemeanor violation may be related to alcoholism and/or drug abuse. If not, then other issues may arise, but if alcoholism and/or drug abuse are at the root of the problem then treatment can be started.

It is the belief of the Office of Alcoholism and Drug Abuse that alcoholism and drug abuse is a disease that is primary, progressive, chronic and fatal. If it is not prevented, it must be treated. If the disease is not treated, the person suffering the disease will die from it or a related cause. Even after long periods of abstinence, if the drinking or drug taking resume so will the symptoms of the disease.

Alcoholism and drug abuse is a disease that can present multiple symptoms at varying stages of the disease. These symptoms may mask other problems or may be masked by other problems (e.g. mental illness, mental retardation, physical problems, or other diseases, etc.).

For these reasons, the systematic responses to alcoholism and drug abuse must be varied and must be comprehensive. A full range of services must be included.

SOADA Structure and Organization

Since the last plan there have been some significant changes in SOADA's operational abilities. Due to budget reductions beginning in FY'83 (July 1, 1982), the SOADA staff was reduced from 25 positions to 19. This resulted in the loss of the trainer position and two grants administrators.

As a result, several staff persons have taken on additional duties.

The SOADA over the past two years has developed and has operationalized the automated Management Information System. This has greatly aided us in providing much needed current data. The M.I.S. has also added to the workload; thus, two additional staff positions have been reclassified to provide the necessary support to this major endeavor. (see next page for current organizational chart)

The loss of staff persons and the reclassification of others has had an impact. This impact has been both negative and positive. There has been a loss in ability to provide all requested technical assistance. Training has not been as visible, although still at existing levels. Our planning and policy capabilities have been reduced. On the positive side has been a better communication among staff; the M.I.S. is operational and very useful, and grantee programs are operating better each year.

The election of a new governor and the appointment of a new commissioner has changed the structure of the Department of Health and Social Services. SOADA has been placed under a Deputy Commissioner for Health along with the Division of Mental Health and Developmental Disabilities and the Division of Public Health. A separate arena in the Department is Social Services which has a separate Deputy Commissioner.

Funding for Alcohol and Drug Abuse Services

Funding for alcohol and drug abuse grants are appropriated by the State Legislature. Ideally, this funding is reflective of identified need and the tools (financial) to implement legislative policy. Funding has been anything but stable over the past six fiscal years.

FUNDING BY FISCAL YEAR (In Thousands)

	<u>Administration</u>	<u>Alcohol Grants</u>	<u>Drug Grants</u>	<u>Total</u>
FY'79	708.1	2471.0	872.1	4051.2
FY'80	1379.3	2739.3	1085.3	5203.9
FY'81	2009.3	9346.9	1183.0	17444.0
FY'82	2368.6	15697.9	1550.0	19616.5
FY'83	1593.9	14865.7	1550.0	18009.6
FY'84	1534.4	12513.2	1550.0	15597.6
FY'85	1374.0	11680.4	2082.0	15136.4

Contributing to this funding pattern have been federal budget actions. The major jump in FY'81 was in response to the afore-mentioned House Finance Committee report that heralded a very detailed legislative policy change. Changes in funding since that time have been relective of lower state revenues and a change of legislative policy.

While the SOADA cannot predict future legislative appropriations there is evidence that state revenues will stabilize at current levels or lower. We must anticipate less state revenues.

Summary

The task of this plan is simple. We must document the need for alcohol and drug abuse services. Using statutory and policy directives, we must describe a comprehensive prevention, intervention, and treatment strategy. Finally, we must define the parameters as to how the Department of Health and Social Services intends to invest its funding.

CHAPTER II

SUBSTANCE ABUSE

GOALS, PRINCIPLES, OBJECTIVES AND SERVICES

The plan by which the State Office of Alcoholism and Drug Abuse translates the mandate to provide substance abuse prevention, rehabilitation and treatment services into action is comprised of a series of policies, principles and objectives encompassing the various service components. The policies, principles and objectives have been developed as part of the office's annual budget preparation and ongoing planning process and are derived from: (1) a review of the performance in meeting goals in the 1981 to 1983 plan; (2) an analysis of major need indicators relevant to alcohol and drug abuse problems in the State; (3) input from field operations staff regarding feedback from survey reports and field observations; (4) data available via the Management Information System (MIS) concerning service population and treatment system characteristics; (5) specifics outlined in State statutes establishing the office; and (6) an analysis of data received from a needs assessment questionnaire distributed statewide.

The organization of this section consists of a listing of three policy statements that serve to drive the following component principles and objective statements. These statements reflect the overall policy and philosophy of the office regarding its efforts to positively affect substance abuse problems. A discussion of target groups follows that identifies specific recipients of increased prevention and treatment services outlined in the general plan for services. The component principles represent the office's philosophy and policy regarding specific components of service and illustrates what is deemed to be appropriate for service delivery in Alaska. The objectives and strategies are statements that delineate specific programmatic responses the office has selected as being integral for the operation of a comprehensive service delivery system. A set of program measures has been included that provides quantitative projections of service levels consistent with the goals and objectives of the plan. This constitutes the overall plan for service delivery that the State office has determined should be emphasized for its planning and future decision making. Therefore, to express SOADA's mission the following three overall policy statements have been developed.

POLICY STATEMENTS

Maintain and continue to improve the delivery of alcohol and drug abuse services by developing a long range strategic service delivery system that will allow the accomplishment of statutory mandates and the governor's policies in the most efficient and cost effective manner.

To develop, encourage, and foster statewide, regional, and local responses and programs for the prevention of alcohol and drug abuse and the treatment of alcoholics and substance abusers in cooperation with public and private organizations, and individuals.

To increase the provision of therapeutic and cost effective alternatives to the more costly criminal justice system responses to both alcohol- and drug-related offenders.

TARGET GROUPS

Based on a review of the needs assessment data, and the experience of the SOADA staff, the following target groups have been identified. The groups are women, rural and Native Alaskans, youth and alcohol and drug related offenders. The estimated number of alcoholics and problem drinkers in Alaska in 1983 was 13,484 and 35,282 respectively. Adult problem drinkers are estimated at about 83% male. Arrests for offenses directly related to alcohol consumption constituted about 34% of reported arrests during 1979-1981, and the rate is increasing. These arrests were 85% to 89% male except for liquor law violations which were only about 72% males. The mortality rates related to alcoholism and alcohol abuse are much higher than rates in the rest of the nation, and Native Alaskans are overrepresented in these mortality data. Given the rates cited above and information from the following, four groups are being specifically targeted for service due to their problems and underserved status.

Women

It has been estimated that women constitute one-fourth of the alcoholics and one-fifth of the problem drinkers in Alaska's population. The data concerning substance abuse outcomes shows that the number of women dying from cirrhosis is equal to that of men in Alaska. Both the alcoholism and Community Mental Health Center treatment service data indicate an over representation of women among their clients. They represent 26% of alcoholism program admissions and 35% of community mental health admissions for alcohol disorder. It is, also, the sense of the community and local service providers that many female problem drinkers are in need of services but are not receiving them through criminal justice referrals and are not seeking them themselves. Furthermore, the effect of maternally ingested alcohol on a fetus can be described as a "pickling" effect. This toll on a future generation of health and social care costs and lost human productivity is a tremendous burden. The SOADA needs to increase the attractiveness of treatment services to this group and raise public awareness of this problem and of the availability of services for women. Additionally, training and prevention efforts are needed.

Rural and Native Alaskans

Native Alaskans are overrepresented on a variety of alcohol abuse indicators. It is unclear at this time as to whether Natives do, in fact, have greater difficulty with alcohol or if the perception of alcoholism as a Native problem has caused them to be identified at a greater level than their representation in the general population. In the general population Native Alaskans account for 18% of the total. In the category of alcohol related arrests,

Natives were cited for 30% of the total and 55% of the liquor law violations. It is interesting that they only represent 15% of driving while intoxicated arrests. The low percentage of DWI arrests could be the result of either a low rate of ownership of vehicles by Natives, or the necessity of having to gain a positive breathalyzer for DWI arrest. Native Alaskans also account for 49% of the alcoholism deaths and 28% of the cirrhosis deaths during the average year. Current alcoholism treatment services are heavily overrepresented by Native Alaskan clients who make up 51% of the caseload. The same is true for diagnosis of alcohol disorder in community mental health centers where Natives represent 38% of the clients. It is clear that SOADA needs to continue its efforts of increased outreach and community development/advocacy in rural areas where most Native Alaskans reside.

Youth

There are three areas of substance abuse indicators in which Alaskan youth are overrepresented. The most dramatic is juvenile involvement in fatal accidents. It was shown that over a four year period youth were responsible for 22% of fatal alcohol accidents and 24% of alcohol accident fatalities while comprising 9.2% of all drivers. Youth also represented over one half of those arrested for liquor law violations. The drug arrest data indicates that juveniles were arrested in 62% of all drug cases, most commonly for possession of marijuana. The treatment data for SOADA programs show that youth are treated in less numbers than their representation in the general population. Data from a school drug usage survey showed that while one time usage or experimentation with drugs is much higher than the national average, prevalence is about equal.

Alcohol and Drug Related Offenders

In 1981, offenses directly related to alcohol (DUI, Drunkenness, Liquor Law Violations) constituted 37.5 percent of all male arrests and 36.4 percent of female arrests. Males were arrested more often for driving under the influence and females were arrested for liquor law violations most often. During the same period 41.4 percent of all adult arrests were for these alcohol related crimes compared with 28.7 percent of juvenile crime. While drug arrests represent only 4.3 percent of all arrests, they include a heavy overrepresentation of juveniles. More than half of the annual drug arrests are for juvenile possession of marijuana. As the number of arrests in Alaska is growing annually, the impact of the substance abusing offender is becoming a greater burden on the criminal justice system. The referral of clients to substance abuse treatment is currently recognized as an effective method of easing this burden...

* Support data for all target group statements can be located in Appendix A.

PREVENTION

Prevention is those activities that are designed to prevent individuals and groups from becoming dependent on the regular use of alcohol and/or other drugs. Prevention Services may vary widely but are generally associated with information, education, alternatives, literature distribution, media campaigns, clearinghouse activities, speakers' bureau, and school or peer group situations. These services may be directed at any segment of the population.

The fundamental objective of prevention is to assist Alaskan citizens to develop into and continue being healthy and productive members of society. Prevention involves professionals, lay-persons, family members and friends in a process that enables Alaskan citizens to create and maintain positive attitudes, values, behaviors, skills and lifestyles in which alcohol abuse and/or drug abuse is considered unacceptable. The desired outcome of this prevention process is the reduction of behavior that distracts Alaskan citizens from achieving the goal of being healthy and productive individuals.

There are varied methods by which the prevention process can operate. Among them are organizational change strategies, school education, alcohol and drug free alternatives, public information, community action strategies and cultural/heritage strategies.

COMMUNITY DEVELOPMENT

Under the prevention definition, services targeted to the community as a whole are termed "Community Development" There are several methods of service delivery that could be considered. Specifically, the Office of Alcoholism and Drug Abuse considers the following methods appropriate, productive and supportable.

1. "Institutional Change Strategies"

This method is the systematic development and implementation of activities designed to change the institutional structure of the community. Such activities could include: school alcohol and drug use suspension policies; insurance coverage for alcoholism and drug abuse treatment; alcohol or drug free social and/or recreational events for the community; community awareness of and support for current limitations of alcohol use or drug use (e.g. smoking in public places, hours of alcohol sales, underage consumption); and community activities that will change current limitations on alcohol use or drug use as permitted by Alaska statutes.

<u>Objective</u>	<u>Strategies</u>	<u>Measure</u>
Support and encourage an annual meeting focusing on the needs of rural substance abuse problems to promote the planning and development of services.	Sponsor an annual meeting of rural providers.	Number of annual meetings. Number of rural programs attending
Increased coordination with the Department of Education and with local school districts to ensure the development and implementation of school substance abuse policies consistent with the public health model.	Establish a joint policy development group with the Department of Education. Require local programs to provide assistance to their school districts in developing substance abuse policies.	Number of meetings. Completed draft of model school policies. Number of meetings. Number of local districts adopting policies.

Quantitative Measures

To increase the community participation in the area of program responses to youth drug usage and abuse through a 5% increase in activity by the several youth alternative programs above the FY'84 level.

	FY'84	FY'85	FY'86
*Number of hours spent by staff	16852	19000	21000
*Number of activities	3587	4000	4200
*Number of youth participants	41413	42000	42000
*Number of referrals from youth alternative programs into drug treatment programs	N/M	100	114
*Number of parent groups	N/M	3	4

2. "Community Response Strategies"

This method encompasses activities which impact and involve the community as a whole. Impact on the individual may also occur as the result of community action.

Activities such as speakers' bureaus, community action committees-volunteer development and other activities designed to encourage community members to actively participate in confronting and changing unacceptable attitudes and behaviors around alcohol abuse, drug abuse and alcoholism.

<u>Objective</u>	<u>Strategies</u>	<u>Measures</u>
To increase community substance abuse awareness and alternatives, by increasing the number of SOADA sponsored local activities in rural communities.	To fund, monitor and evaluate annually rural programs and their informational, outreach and early intervention efforts.	Number of local activities.
Provide technical assistance to any group that desires to accept responsibility for the control of substance abuse in their community.	Maintain financial support for a mix of programs designed to enable communities to develop freedom from abuse and promote self-sufficiency.	Number of grant awarded to providers for community action projects.

Quantitative Measures

To increase the number of local staff hours spent in rural communities to develop and increase community substance abuse awareness and alternatives.

FY'84

FY'85

FY'86

*Number of staff hours

3687

3800

4000

To increase the number of hours spent working with other community agencies on drug prevention strategies to better involve the whole community.

*Number of staff hours working with other agencies

14614

15000

15000

3. "Cultural/Heritage Strategies"

Alaska is unique in that there is a cultural diversity that many individuals feel should be maintained. Such diversity is a part of both institutional and individual identities. Activities that explore cultural values, attitudes, behaviors and lifestyles as they relate to unacceptable alcohol abuse or drug abuse are beneficial.

Such activities that involve cultural leaders, helpers and/or healers, that involve the examination of cultural identity (past and future) and activities which provide a base for community attitudes regarding alcohol abuse and drug abuse are also supported.

Activities are encouraged that define traditional cultural beliefs so as to aid in the development of and effective integration of current lifestyle expectations in such a manner that alcohol abuse and drug abuse are not the barriers to a healthy and productive life.

<u>Objective</u>	<u>Strategies</u>	<u>Measures</u>
To increase by 10% from the FY'84 level the number of Alaska Native counselors currently employed in state-funded programs who have received Alcohol/Drug Abuse Counselor Certification.	To provide a system of training programs reaching rural Alaska and to provide assistance to the establishment and maintenance of an objective state-wide Counselor Certification process.	Number passing exam. % passing exam. Number of Alaska Natives passing exam. % of Alaska Natives passing exam Number with Certification. Number of alaska Natives with Certification.
Improve the interface between regional trainers and cultural/traditional leaders.	Incorporate participation by cultural/traditional leaders into training activities.	Number of training activities incorporating traditional or cultural leaders

SCHOOL EDUCATION

School education is defined as approaches that focus on skill building through the use of a well defined and structured affective learning process and the production and distribution of accurate and objective information in a school based setting. School education can be delivered to all students in grades K-12 through utilization of curriculums that are already available. Examples of skills that are to be developed or enhanced include values clarification, problem solving, decision making, coping, and cultural values and identities of the local (regional) community.

Examples of information giving activities including pamphlet distribution, health fairs, as well as using school children in the actual development of and distribution of the information.

<u>Objectives</u>	<u>Strategies</u>	<u>Measures</u>
Provide the K-12 program to all school districts state-wide.	To increase by 10% the level of knowledge of youth grades kindergarten through 12th grade in substance use and abuse as measured by inference from the performance study entitled: "An Evaluation of the Statewide Alcohol Education Project Years 1, 2, and 3".	Number of teachers trained. Number of students receiving curriculum. Calculation of the change in knowledge as formulated in the study.
To increase by 10% the number of educational presentations to teachers in the schools.	Provide mechanisms making K-12 training available to all teachers in the state.	Number of presentations for whom teachers are the target group. Number of community outreach for whom teachers were the target group.
Continue to support school education programs which include curriculum for defensive driving and material addressing drunk driving.	Provide material and training for those districts wanting to provide this curriculum.	Number of districts given support.

Quantitative Measures

To increase the level of knowledge
of youth, grades K thru 12, in
substance use and abuse.

	FY'84	FY'85	FY'86
*Number of teachers trained	345	370	400
*Number of students receiving curriculum	45454	45500	47000

ALCOHOL AND DRUG ABUSE ALTERNATIVE ACTIONS

Alternative strategies include approaches that provide growth-inducing experiences through which individuals develop increased levels of confidence and self-reliance. The primary focus of these programs is the prevention of substance abuse, this focus represents the sole purpose of the programs. Enhancement in these areas is provided through social, occupational, esthetic, affective, and cognitive experiences. Alternatives-based activities are designed to provide exposure to a variety of rewarding activities that offer positive alternative to alcohol and drug taking behavior. Activities should be specific to age and culture but are not limited by same. Youth or elderly populations have a need for alternative activities but these activities are not identical. Families may also need alternatives that involve the entire family or community at the same time, place and event. Alternative actions can be delivered on a non-scheduled, continual, or special events basis appropriate to the activity or target group.

<u>Objectives</u>	<u>Strategies</u>	<u>Measures</u>
To increase the community participation in the area of program responses to youth drug usage and abuse through a 5% increase in activity by the several youth alternative programs above the FY'84 level.	Provide on-site technical assistance as requested. Continue to support youth alternative programs.	Number of hours spent by staff. Number of activities. Number of youth participants. Number of referrals from youth alternative programs into drug treatment programs. Number of parent groups.
Emphasize skill and knowledge building activities geared towards substance abuse to motivate youth toward responsible behaviors.	Continue to encourage the development/or identification and adoption of new activities.	Number of activities selected for use in programs. Number of programs adoption new activities.

PUBLIC INFORMATION

Public information is the dissemination of accurate and objective information specifically aimed at increasing the awareness, receptivity, and sensitivity of the community and individuals regarding problems associated with alcohol abuse or drug abuse.

Activities can be in the form of a materials clearinghouse, newsletters, alcohol/drug awareness weeks, press releases, participation in health/state fairs or information given through media outlets such as radio, newspapers, and television.

Information giving can also take the form of documentaries, poster development or other methods of information dispersal used in the particular area.

<u>Objectives</u>	<u>Strategies</u>	<u>Measures</u>
To increase by 10% the number of referrals to substance abuse treatment programs.	To provide intensive substance use and abuse informational campaigns and to intensify the local out-reach efforts.	Number of referrals. Number self-referrals. Number of family referrals. Number of API referrals. Number of educational facility referrals. Number of non-criminal justice related referrals. Number of staff hours spent in information referral services.
To increase by 10% the number of educational presentations to parents in the community.	Provide support for prevention components of local programs. Provide programs with technical assistance and information.	Number of presentations for whom parents are the target group. Number of community outreach.
Continue to support special events such as alcohol action week and drug prevention month.	Provide funding and support for special events. Provide coordination and leadership to programs in sponsoring events.	Number of special events. Number of communities holding special events.

Quantitative Measures

To increase the number of educational presentations to parents in the community.

FY'84

FY'85

FY'86

*Number of presentations for whom parents are the target group

411

475

575

INTERVENTION

Intervention is actively and systematically working within a community for the purposes of identifying persons in need of services, alerting persons and their families to the availability of services, locating needed services, and enabling persons to enter and accept the service delivery system. Outreach needs to facilitate procurement and availability of alcoholism and drug abuse services, and to alert all public and private human service agencies who serve the same target population, to the importance of early identification and easy access to the service delivery system.

The outreach function is the most visible service of the program to the local community. It is very important that the advisory board, other agencies and the general public be given a voice in the review of this service to ensure acceptability. It is essential that the outreach process involve as many organizations and individuals as may be in contact with various parts of the treatment delivery system.

COURT/JUSTICE SYSTEM SERVICES

The Alcohol Safety Action Program (ASAP) is a systematic means of evaluating and referring persons convicted of alcohol and drug abuse related offenses by the District Court of the State of Alaska. ASAP is viewed as a means of differentiating the effect of the drinking problems and referring them to appropriate agencies for treatment depending on the client's needs. It is seen as a very structured system that is governed by a set of predetermined standards designed to assist in diagnosing problem levels of clients involved with the system.

The goal of each community ASAP is to provide reliable and continuous early identification and appropriate intervention services for DWI and other alcohol or drug related misdemeanor cases. The services that an ASAP program would typically make are referrals to an outpatient counseling and/or alcohol/ drug information school.

These services are based on the premise that early identification and intervention of persons with alcohol/drug related problematic behavior increases the likelihood of success of education and treatment, and that less intensive and extensive resources are, therefore, required and can more easily be provided in each community.

Objectives

To increase by 10% the number of persons entering treatment programs as a result of the criminal justice system responses to alcohol related offenders and to maintain the cost effectiveness of this type of response.

Strategies

Maintain the Alcohol Safety Action Program in a state-wide system. Fund substance abuse counselors at the major state-operated corrections institutions.

Measures

Number of ASAP programs.
Number of persons whose legal status at time of admission is probation/parole and DUI/OMVI conviction.
Average cost for clients with single OMVI convictions.
Average cost for clients with multiple OMVI convictions.
Average cost for clients on probation.
Cost per client served in ASAP.

Provide substance abuse programming and counseling at state-operated corrections institutions.

Fund substance abuse counselors at the major state-operated corrections institutions.

Number of counselors at correctional institutions.
Number of hours of counseling at correctional institutions.

To decrease by 10% the number of clients readmitted to treatment programs as referrals from the criminal justice system from FY'84 levels.

To continue funding for court diversion programs.
To provide support for treatment programs in urban areas.

Number of clients referred and readmitted to treatment from criminal justice system.

Conduct a review and make appropriate revisions of all policies, procedures and criteria related to referral mechanisms for receiving clients from the Criminal Justice system into the Alcohol and Drug treatment system.

Conduct and review of the referral process to treatment from the following programs:
A: Pre-Trial Diversion
B: A.S.A.P.
C: Misdemeanant Probation
D: Felony Probation
E: Suspended Imposition of Sentence
F: Corrections Furlough

Number of Clients Referred from:
A: Pre-Trial Diversion
B: A.S.A.P.
C: Misdemeanant Probation
D: Felony Probation
E: Suspended Imposition of Sentence
F: Corrections Furlough

Objectives

To increase by 10% the number of persons entering drug treatment programs as a result of the criminal justice system responses to drug related offenders and to maintain the cost effectiveness of the type of response from 1984 levels.

Services

Continue to support court diversion programs.
Continue to support drug treatment programs.
Provide coordination of effort with other involved department at state level.
Complete on-site evaluation for each program.

Actions

Number of persons admitted to a drug treatment program as a result of involvement with the criminal justice system.
Cost per client in the drug treatment.
Number of counselors at correctional institutions.
Number of hours of counseling at correctional institutions.
Average cost for clients with single drug-related convictions.
Average cost for clients with multiple drug-related convictions.

Quantitative Measures

To increase the number of persons persons entering treatment programs as a result of criminal justice system responses to alcohol related offenders and to maintain the cost effectiveness of this type of response.

	FY'84	FY'85	FY'86
*Number of ASAP programs	10	10	12
*Number of persons whose legal status at time of admission is probation/parole and DUI/OMVI conviction	N/M	2500	2830
*Cost per client served in ASAP	N/M	Estimate not yet available	
*Number of counselors at correctional institutions		3 FTE's	
*Number of hours counseling at correctional institutions	N/M	4900	5561

To decrease the number of clients readmitted to treatment programs from the criminal justice system.

*Number of clients referred and readmitted to treatment from criminal justice system

N/M

500

570

*(Measure illustrates a measure in readmission that is less than overall client increase.)

CORRECTIONS BASED

Persons confined in youth and adult correctional facilities are often identified as an at risk population in need of alcoholism and drug abuse services. Systematic approaches to identification, screening, assessment, and referral of incarcerated persons for services is a high priority strategy. Services aimed at a reduction of recidivism such as on and off site treatment, referrals, and release planning are acceptable activities. Training for correctional officers, probation and parole officers, and other corrections personnel, likewise is a desirable activity.

Objectives

To increase by 40% the number of clients completing their treatment plans in youth adult correctional settings.

Strategies

To provide treatment services in correctional setting to those seeking them or required to receive them as part of sentence.

Measures

Number of persons treated in youth or adult correctional settings
Number completing treatment plan
% completing treatment plan

EMPLOYEE ASSISTANCE PROGRAMS

The purpose of Employee Assistance Programs is to improve the productivity of public and private sector employees and their dependents. The work place is an excellent environment for the early identification and referral of alcoholics and drug abusers. Strategies such as marketing programs, training supervisors, screening, assessment, referral, and follow-up are acceptable Employee Assistance Program activities. To the maximum extent possible, employee assistance programs should maintain separate identities to ensure maximum utilization within the community.

<u>Objective</u>	<u>Services</u>	<u>Actions</u>
To continue to support at current levels the development of employee assistance programs and coordinating with existing employee assistance programs.	Provide support to employee assistance program referral project. Provide support to programs to conduct employee assistance coordination.	Number of EAP programs in operation Number of clients served by EAP programs Number of referrals between programs

STUDENT ORIENTED PROGRAMS Youth are often identified as a high at risk group that can benefit from alcoholism and drug abuse services. Close cooperation with school administrators is essential for success with this target group. Strategies such as teacher training, assist programs similar to employee assistance programs, use of natural helpers, family involvement, parent groups, tutoring, and alternatives to suspension efforts are example of acceptable approaches.

Ohjectives

Increase the number of student assistance programs in the State by 50% over the FY'84 level.

Strategies

Continue to support the development of student assistance programs.
Provide school groups and districts with technical assistance and information.

Measures

Number of student assistance programs

SYSTEMS COORDINATION

The alcoholic or drug abuser often comes in contact with related agencies that can assist in the process of ensuring that persons in need of alcohol or drug abuse treatment are afforded care. Therefore, specific and systematic identification, screening, assessment, and referral services offered to related health, social service and allied agencies sharing target group clients are beneficial.

<u>Objectives</u>	<u>Strategies</u>	<u>Measures</u>
To continue coordination with private sector providers by sponsoring joint needs review and committee meetings.	Provide support to employee assistance program referral project. Continue to provide on-site evaluations for private treatment facilities.	Trip Reports/meetings. Memorandum of Agreement written among provider.
To continue the number of hours spent working with other community agencies on drug prevention strategies to better involve the whole community.	Provide support to local programs to conduct coordinative activities.	Number of staff hours working with other agencies. Number of cooperative efforts mentioned in quarterly narrative reports.
To increase by 10% the number of referrals from community agencies and other non-treatment programs to drug treatment programs.	Provide technical assistance on improving referral capabilities.	Number of referrals. Number of self-referrals. Number of family referrals. Number of church referrals. Number of friends referrals. Number of hours spent in I&R services.
Continue coordination with Indian Health Service and with state agencies for the purpose of ensuring quality and comprehensiveness of care.	Provide leadership for the Interagency Coordinating Committee Continue to hold joint policy and review meetings with IHS.	Number of meetings with federal agencies. Number of meetings with state agencies.

Quantitative Measures

	FY'84	FY'85	FY'86
To increase the number of agency, community and self referrals to alcohol and other substance abuse programs			
*Number of referrals	9000	9500	10100
To increase the number of referrals from community agencies and other non-treatment programs to drug treatment programs.			
*Number of referrals	N/M	1300	1430
*Number of hours spent in I&R services	N/M	600	640

TREATMENT PRINCIPLES

Treatment is the formal and organized provision of services for persons who have abused alcohol and/or drugs, and is designed to alter specific physical, mental, social and spiritual problems caused by such abuse.

The primary functions of any alcoholism or drug abuse treatment program are to identify, evaluate, and treat persons who experience problems related to alcohol or drug abuse. Through the process of needs identification and evaluation of a client, the appropriate treatment milieu is identified. The alcoholism or drug abuse program staff evaluation of each client's needs is used to establish a written treatment plan for each client. The modality of treatment shall be based upon known, demonstrable and/or generally accepted methods of treatment and directed towards the specific needs of the clients.

To deal with the complex problems related to the use of alcohol or drugs, multiple theories and modes of clinical evaluation and treatment should be considered. Planning for treatment shall take into account the physical, social, cultural, educational, vocational, spiritual and psychological needs of each client. The patient's progress and outcome shall be reviewed in the light of the objectives of the individualized treatment plan.

The comprehensive and state approved treatment components are: emergency care, inpatient care, intermediate residential care, outpatient care and aftercare.

EMERGENCY CARE

Emergency care systems provide for twenty-four hour availability of the following services to all persons and their families with problems related to alcohol or drug 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.

Emergency care comprises a network of services that provides all persons having acute problems related to alcohol or drug use and abuse immediate diagnosis and care, as well as appropriate referral for continuing care after emergency treatment. Primary emergency services in Alaska are community service patrols, and medical or social detoxification.

In cases of severe acute intoxication, detoxification is to be provided utilizing one of three modes: medical detoxification or short term treatment usually less than 10 days, during which medication (i.e., prescription drugs) may be used; social detoxification or non-medical treatment in a caring and supervised environment; and outpatient methadone detoxification may combine counseling and medication in an outpatient setting.

<u>Objectives</u>	<u>Strategies</u>	<u>Measures</u>
To increase from 9,000 (FY'84 level) to at least 10,000 vehicle transports for severely intoxicated persons who are in a life endangering situation as a result of alcohol or other substance abuse.	To provide funding for community service patrols.	Number of transportees (level of activity). Number of patrol trips.
To increase the rate of referral to treatment by 10% above FY'84 level from Emergency Care Services	To provide emergency care and services to 400 persons having acute problems with substance use and abuse.	Number of beds available for emergency use and services. Number of persons admitted to detox. Number of persons discharged & referred vs terminated + %.

Quantative Measure

	FY'84	FY'85	FY'86
To increase vehicle transports for severely intoxicated persons who are in a life endangering situation as a result of alcohol abuse or other substance abuse.			
*Number of Transportees (level of activity)	12500	13000	13000
To increase the rate of referral to treatment from detoxification.			
*Number of beds available for emergency use and services	33	33	33
*Number of persons admitted to detox	2916	3000	3100
*Number and percentage of persons discharged to treatment vs. terminated.	$\frac{725}{25\%}$	$\frac{750}{25\%}$	$\frac{775}{25\%}$

HOSPITAL CARE (INPATIENT)

The process of providing care to persons who require 24-hour medical supervision in a hospital or other suitably equipped medical setting as a result of acute or chronic medical, social, cultural, spiritual and psychological problems associated with alcohol abuse, drug abuse and/or alcoholism. The average planned length of stay in these units is twenty-eight days and incorporates intoxicant-free therapy and shall promote involvement with available aftercare planning and community support resources.

Objectives

To continue the number of persons who have completed the treatment plan in a 24 hour hospital or other suitably equipped medical setting who are in such a program as a result of acute or chronic substance abuse.

To continue the number of persons completing individualized treatment plans in a residential setting who are in such a program as a result of substance abuse.

Strategies

To provide funding for inpatient substance abuse treatment.

Provide technical on-site assistance as requested.
Continue to support residential setting programs for drug abusers in urban areas.
Complete on-site evaluations of each program.
Provide assistance to improve outreach and referral capabilities of programs.

Measures

Number of beds available.
Number of persons treated inpatient
Number of persons completing treatment plan.
% completing treatment plan.
Number referred to other components of care at discharge.
% referred to other components of care at discharge.

Number of beds available.
Number of clients treated in the residential drug free setting.
Number of clients completing intermediate care treatment plan.
% completing intermediate care treatment plan.
Number of intermediate care clients referred to outpatient care.
% referred to outpatient care.
Average length of stay.

INTERMEDIATE RESIDENTIAL CARE

Intermediate care shall be designed to facilitate the rehabilitation of the alcohol or drug abusing persons by placing them in an organized therapeutic environment in which they may receive diagnostic services, counseling, vocational rehabilitation and/or work therapy while benefiting from the support which a full 24-hour or partial, less than 24-hour, residential setting can provide.

1. Short term intermediate residential care is the provision of counseling and social adjustment services to persons who require 24-hour supervision as a result of alcohol or drug abuse. This process is more intensive than other forms of intermediate care with an average length of stay of twenty-eight days. This process is similar to inpatient care without the medical staff and the hospital setting.
2. Transitional care is delivered in Halfway Houses and involves a one to six months length of stay. At the start of transitional care, the client spends most of their time at the house in a therapeutic and support environment. As they advance through treatment, more time may be spent on habilitation or rehabilitation until re-entry into the community is made. Most individuals will enter this care from some other component of service.

3. Long term care is a long term therapeutic environment for a period of six months to two years. Each of the clients is required to assist in the upkeep and operation of the facility as well as attending the therapeutic activities conducted. Such care may be rather intense (e.g. in a Therapeutic Community or TC) or be closer to transitional care in treatment intensity.

Objective

To increase by 10% from the FY'84 level, the number of persons completing the individualized treatment plan in a 24 hour or less-than-24 hour residential setting who are in such a program as a result of alcohol/drug abuse.

Strategies

To provide funding for community-based intermediate care substance abuse treatment facilities and one long-term care facility.

Measures

Number of beds available short-term.
Number treated short-term.
Number completing short-term intermediate treatment plan.
% completing short-term intermediate care treatment plan.
Number of beds available long-term.
Number treated long-term.
Number completing long-term intermediate care treatment plan.
% completing long-term intermediate care treatment plan.
Number of short-term intermediate care clients referred to outpatient care.
% of short-term intermediate care clients referred to outpatient care.
Average length of stay - long-term care.

INTERMEDIATE CARE (cont)

Quantitative Measures

To increase the number of persons completing the individualized treatment plan in a 24 hour or less than 24 hour residential setting who were in such a program as a result of alcohol/drug abuse.

*Number of beds available short-term	145	133	135
*Number treated short-term	1250	1300	1350
*Number completing short-term intermediate treatment plan	852	975	1000
*% completing short-term intermediate care treatment plan	68%	75%	75%
*Number of beds available long-term	169	169	169
*Number treated long-term	639	650	670
*Number completing long-term intermediate treatment plan	146	325	390
*% completing long-term intermediate care treatment plan	23%	50%	60%

OUTPATIENT CARE SERVICES

Outpatient care services provide non-residential, diagnostic and primary alcoholism and drug abuse treatment services on both a scheduled and a nonscheduled basis.

Outpatient counseling can be provided through various modalities deemed appropriate for alcohol or drug abuse treatment, such as but not limited to, individual counseling, group counseling, family counseling, intensive, antabuse, or methadone maintenance.

Intensive outpatient care may be a combination of the outlined activities but is offered to the client in a more compressed time frame. Antabuse therapy shall only be administered by a licensed physician. Education and didactic activities may be a part of any outpatient care services. Methadone maintenance shall only be provided in state and federally approved programs.

Objectives

To increase the number of persons completing their treatment plans in a non-residential, substance-free setting.

To increase by 10% the number of clients discharged from methadone maintenance by increasing by 10% the clients referred to drug free outpatient treatment from FY'84 levels.

Strategies

To provide out-patient care to those seeking such assistance.
Complete on-site evaluations of each program.
Provide technical on-site assistance as requested.
Continue to support non-residential treatment programs.

Inform users of changes in state and federal regulations.
Provide technical on-site assistance as requested.
Facilitate coordination between methadone maintenance and drug free outpatient programs.
Complete on-site evaluation of program.

Measures

Number treated.
Number completing treatment plan.
% completing treatment plan.
Number of clients admitted to drug free outpatient care.
Methadone detox.
Methadone maintenance.

Number of clients discharged from methadone maintenance.
Number of referrals from methadone maintenance to drug free outpatient.

Quantitative Measures

To increase the number of persons completing their treatment plans in a non-residential, substance-free setting.

	FY'84	FY'85	FY'86
*Number treated	9164	9200	9300
*Number completing treatment plan	1632	3200	3250
*% completing treatment plan	18%	25%	35%

To continue the number of persons completing their treatment plans in methadone maintenance and methadone detox

	FY'84	FY'85	FY'86
*Number treated	136	136	136
*Number completing treatment plan	21	28	28
*% completing treatment plan	15%	20%	20%

To decrease the number of clients readmitted to treatment programs as referrals from the criminal justice system from FY'84 levels.

	FY'84	FY'85	FY'86
*Number of clients referred and readmitted to treatment from criminal justice system	N/M	60	68
*Number of hours of counseling at correctional institutions	N/M	1170	1328
*Average cost for clients with single drug-related convictions	*Baseline to be established		
*Average cost for clients with multiple drug-related convictions	*Baseline to be established		

To increase by the number of persons entering treatment programs as a result of criminal justice systems responses to alcohol or drug related offenders and to maintain the cost effectiveness of these programs.

*Number of persons admitted to a drug treatment program as a result of involvement with the criminal justice system

N/M

700

795

*Cost per client in the drug treatment

*Baseline to be established

AFTERCARE

Aftercare provides care to patients who have progressed sufficiently through emergency, inpatient, intermediate and/or outpatient services to a point in their recovery where they will benefit from a level of continued contact which will support and increase the gains made to date in the treatment process. Aftercare must be delivered through the development of an individualized aftercare plan developed between the aftercare counselor and the client. In a sense, aftercare could be termed self care under the general guidance of the aftercare counselor.

<u>Objective</u>	<u>Strategies</u>	<u>Measures</u>
To increase by 20% the persons receiving continued aftercare services for the purpose of providing support and increasing the gains made during the treatment process.	To provide funds for after-care services at the community level.	Number of formal after-care programs. Number of persons treated in aftercare. Number of staff hours provided to former treatment clients.
Increase substance abuse clients exposure and referral to Alcoholic Anonymous and Narcotic Anonymous prior to discharge from the program.	Maintain as a grant condition the utilization of AA and NA concepts as an integral part of the program delivery.	Number of programs utilizing AA and NA principles.
Provide at least 50% of all client with an AA or NA sponsor prior to discharge.	Require treatment programs to maintain referral networks with AA and NA groups.	Number of programs with referral network with AA or NA group.

Quantitative Measures

	FY'84	FY'85	FY'86
To increase the number of persons receiving aftercare services.			
*Number of formal after-care programs	N/M	25	25
*Number of persons treated in after-care	1000	1000	1000
*Number of staff hours provided to former treatment clients	40546	41000	43000

ADMINISTRATIVE SUPPORT SERVICES

Among central office functions, highest priority is accorded to those which enhance the State's ability to identify and meet client needs, especially the functions of data acquisition, analysis and planning, and those administrative functions by which the Office assures accountability and costeffectiveness in existing uses of public money for substance abuse services, especially grant/contract administration, monitoring and evaluation, technical assistance, training and research. Additionally, in fulfilling its mandate to develop comprehensive prevention programs, the SOADA cannot ignore the important role of the legal and institutional systems responsible for identifying and controlling substance abuse. The office therefore, assumes a strong advocacy posture toward those key elements outside its authority and assumes a leadership role in coordination. The SOADA's advocacy efforts focus on 1) legislative change, 2) performance quality in regulatory and enforcement systems, and 3) special needs of substance abusers in other service delivery systems.

PROGRAM MONITORING

This procedure includes all activities that relate to the review of and assistance to Grantees with respect to their conformance to the conditions of their grant. The procedures focus on the planning for and the conduct of onsite reviews of programs and facilities by Field Operations staff.

<u>Objectives</u>	<u>Strategies</u>	<u>Measures</u>
To increase the aggregate evaluation scores of each program by 5% from the FY'84 aggregate level in FY'85. Evaluations will be based upon the State standards.	Base Health Facilities Surveyors in Anchorage to evaluate all State funded substance abuse programs. To provide intensive, strategic programmatic assistance to improve local community-based programs. To annually conduct one on-site evaluation and follow-up of each program receiving State A/DA funds. To provide one technical assistance contact for each program meeting the State standards and two such contacts for programs not meeting the State standards.	Average evaluation scores. Number of programs meeting state standards level. Number of programs failing to meet state standards level. Number of on-sites. Number of follow-ups. Number of T.A. on-sites to each type of program.
To develop improved State standards for alcoholism programs to more appropriately address the uniqueness of urban and rural programs by the end of FY'86.	Provide program managers and advisory board with mechanism to give input in State standard revision process. Form a standards review committee to meet four times, holding public hearings in 10 communities.	Number of sets of minutes of Review Committee Meetings. Number of sets of minutes of public hearings. Revised Standards developed in draft by June 1985.

Quantitative Measures

To increase the aggregate evaluation score of each program. Evaluations will be based on state standards.

*Average evaluation score	N/M	82%	85%
*Number of programs meeting state standards	35	38	39
*Number of on-sites	53	53	53
*Number of follow-ups	43	43	43
*Number of T.A. visits	30	30	30

To continue the development of state standards for drug and alcohol abuse programs.

*Number of meetings	N/M	3	3
*Number of hearings	N/M	3	3

FISCAL MONITORING

This procedure includes all activities that relate to the handling of Grantee requests for funds and the monitoring of these requests for conformance to the Grant or Contract conditions. The procedures focus on the activities of the Administrative Officer.

Objectives

To decrease the in-house request for payment turn-around time to three working days.

To decrease the request for line item budget revision turn-around time to fourteen days.

To increase the utilization of alternative funding mechanisms by 10% over FY'84 levels by identification and promotion of strategies.

Strategies

Maintain the Central Office administrative staff and to fund training for the same.

To provide budgetary technical assistance to grantees.

Research, analyze and experimentally implement alternative State funding mechanisms.

Measures

Payment turn-around time in days (mean).

Turn-around time in days (mean).

Produce report of strategies and analysis of their utility to the Commissioner.
Revise statute to match requirements.

Quantitative Measures

To audit 23 FY'85 grants in FY'86.

*Number of audits

FY'84

FY'85

FY'86

23

23

23

PLANNING AND RESEARCH

This procedure includes all activities that relate to the development, review and approval of both the Drug Abuse and the Alcoholism State Plans. The procedure focuses on the activities of the planners and the review of the Draft State Plans with various review and approval groups.

<u>Objectives</u>	<u>Strategies</u>	<u>Measures</u>
To continue to support a variety of special evaluation projects specific to the subject of substance abuse or system components.	Provide support for special evaluation projects as directed by advisory board.	Contract file -- Number of contracts in aggregation.
To continue the distribution of publications by State office to the legislature, Department and field over 20% FY'84 level.	Publish: Four newsletters, One Annual Report, One Alaska Services Directory, Four Quarterly Performance Reports.	Number of newsletters. Annual Report to Legislature. Alaska Services Directory. Quarterly Performance Reports.
To increase the number of meetings of the Review Board on Alcoholism and the Advisory Board on Drug Abuse from two to three per year to accept plans and to make funding recommendations.	Provide staff, technical and financial assistance to the Alcoholism and Drug Abuse Boards.	Minutes of Board Meetings. Number of meetings.
Establish a free-standing board to be responsible for the review of applications and certification of substance abuse counselors.	Provide coordination and start up funding for a non-profit organization to provide this service.	Establishment of board.
Continue to assess the scope of youth substance abuse needs for outpatient and residential treatment.	Review appropriateness of present treatment responses and investigate the cost effectiveness of alternative approaches	Prepare a document assessing the scope of youth needs and describing cost effective alternatives.

Quantitative Measures

To continue the distribution
of publications.

FY'84

FY'85

FY'86

*Number of newsletters

4

4

4

*Annual Report

1

1

1

*Alaska State Directory

1

1

1

*Quarterly Performance reports

4

4

4

To continue the number of
meetings of the Review Board
on Alcoholism and the Advisory
Board on Drug Abuse.

*Number of meetings

3

3

3

To increase coordination
with private sector
treatment agencies.

*Number of on-sites

5

9

10

*Number of joint meetings

0

3

5

GRANT APPLICATIONS

This procedure includes all activities that relate to the solicitation, review, and final negotiation and approval of grant proposals from prospective program operators. The procedures focus on the review activities of all SOADA staff and the review and approvals with the Alcoholism and Drug Abuse Boards and the Commissioner of Department of Health and Social Services respectively.

Objective

To decrease volume of material required and duplication of previous year information from the office's grant application package future grant cycles.

Strategies

Review and analyze the office's grant application procedures.

Measures

Development and distribution of a new grant application.

TRAINING

Training activities are comprised of all procedures directed towards increasing the knowledge, skills or competency of those providing substance abuse treatment services. The primary delivery of training services is accomplished through the regional training network and directed towards counselor trainee attainment of level I or level II certification. The delivery of training is also provided through the support of special purpose conferences, symposiums and schools.

<u>Objective</u>	<u>Strategies</u>	<u>Measures</u>
To increase the number of Alaska Native counselors employed in state funded programs who have received Alcohol/Drug Abuse Counselor Certification.	Provide funds to regional programs with intent of targeting Natives. Actively recruit Native counselors.	Number of Native trainees Number of Natives taking test Number of Native counselors
Continue to conduct addictions school and prevention symposium annually.	Provide funds for addictions school and prevention symposium.	Number of attendees at Addictions School Prevention Symposium
Maintain regional training system the three health service areas	Provide funding for regional training network.	Number of regional training programs Number of students in training programs

APPENDIX - A

NEEDS ASSESSMENT

Appendix A Index

Pages 1-6	A. Description of State and Demographic Data
7-9	B. Alcohol/Drug Abuse indicators intro
9-16	Per Capita Sales
16-20	Prevalence of alcohol abuse
21-24	Alcohol and Highway Safety
25-30	Alcohol and Criminal Activity
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APPENDIX A

NEEDS ASSESSMENT

This section of the State Plan consists of an analysis of statistical data to illustrate the extent of alcohol/drug abuse problems in Alaska. The three parts of this Needs Assessment are: A.) a description of the State and demographic data, B.) an analysis of alcohol abuse indicators, C.) an analysis of drug abuse indicators.

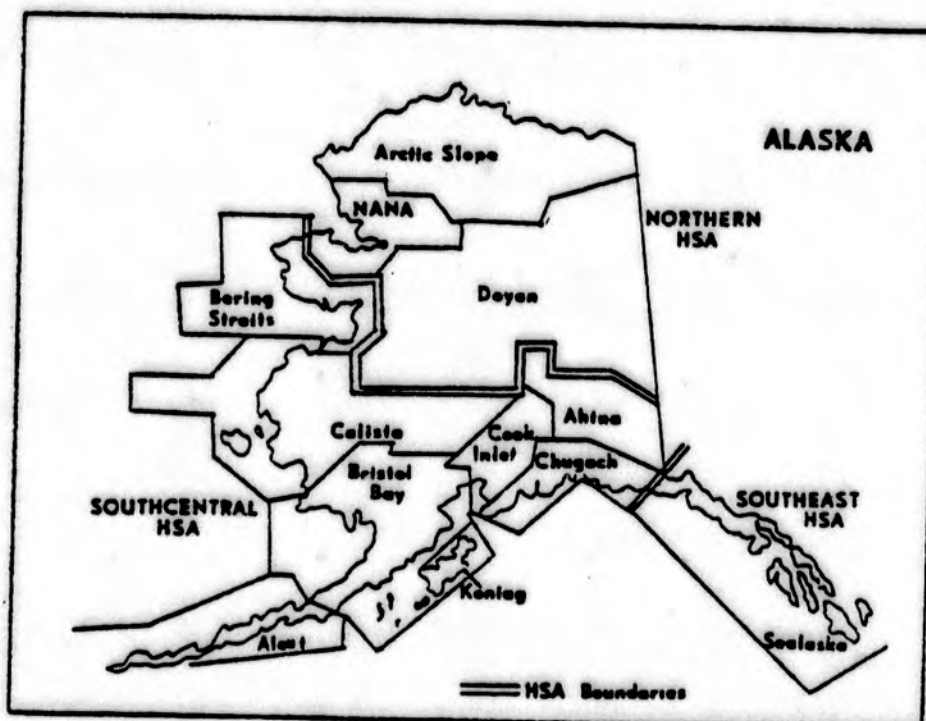
A. DESCRIPTION OF THE STATE AND DEMOGRAPHIC DATA

Regions of Alaska

The 586,400 square mile territory of Alaska is one-fifth the size of the entire Lower 48 states, because of its sub-continental size, Alaska is not a single, homogeneous region, but consists of several distinct regions, each with differing climate, physical features and population.

For purposes of demographic statement and analysis, the State can meaningfully be divided into three large regions. These are Southeast Alaska, Southcentral Alaska, and Northern Alaska.

Map 1. Alaska by Major Regions.



The Southeast, Alaska's "Panhandle", is a thin strip of coastline which is separated from the rest of the State by Canadian territory, the Malaspina Glacier, and the St. Elias Range. Juneau, the capitol, is located in the Southeast, and, with an estimated population of 24,000, is this region's largest city.

Central and Interior Alaska is the area south of the Brooks Range and east of longitude 151°W. This region includes Kodiak Island, Cook Inlet, and the Copper, Susitna, Tanana and Upper Yukon River Basins. The major towns in this region are Anchorage, in Central Alaska, and Fairbanks, in Interior Alaska. Anchorage, with an estimated population of 197,000 is Alaska's largest city; Fairbanks, population estimated at 54,000, is the State's second largest city. This region is divided into distinct coastal and interior units by the Alaska Range, but it is tied together by the Alaska Railroad, a highway system, and installations of the defense establishment, which give both sub-areas a similar economic and social character.

The third region of the State is Northern and Western Alaska, which includes the remaining portions of the State to the west and north. The area of this region is approximately 330,000 acres, and it is characterized by sparse population, isolated and remote centers of settlement, and an undeveloped economy. The region has no cities; its largest towns are Kotzebue, Barrow, Nome and Bethel. Populations of these towns range from 2300 to 3000.

Land and Climate

Alaska is a land of superlatives and extremes, having the country's highest point (Mt. McKinley, 20,320 feet); the nation's northernmost point (Point Barrow, 71°23' north); 33,000 miles of coastline; some of the world's largest and most easily accessible glaciers (the largest, the Malaspina Glacier, measures 2937 square miles, almost as large as the states of Delaware and Rhode Island combined); the nation's largest national forest, and largest national park and monument (Tongass National Forest, 16 million acres; Glacier Bay National Monument, 2.8 million acres); 1800 named islands and thousands more which have never been given official names; and the famous Midnight Sun, that period during the summer months when there is daylight round the clock -- for up to three months in Barrow and for shorter periods of time in other parts of northern Alaska.

In terms of weather and climate, Alaska, contrary to popular opinion, has it all -- hot and cold, wet and dry. Temperatures can range from 100° to -80°F. Average annual rainfall in the rain forests of the Southeast is 200 inches while the Arctic North has desert-like dry conditions. The most snowfall in one season was 974.5 inches at Thompson Pass, just east of Valdez, in 1952-1953.

Transportation is important in Alaska, and often takes unusual, or unique forms. Dog sleds, snow machines, automobiles, state-run ferry boats, commercial and private airplanes (float-and ski-equipped) and helicopters, trains, trucks, and boats are all vital modes of transportation. Air travel is more unpredictable, time consuming, and expensive than in the Lower 48. Nevertheless, air travel is perhaps the most important, because so many areas of the State--especially isolated coastal towns and remote "bush" communities in the Interior--are inaccessible by other means.

Population

Alaska's population in 1982 was estimated at 460,837; this represents a jump of 160,000 people since the 1970 census. Alaska has a relatively large military population, amounting to 23,000 in 1982; the military establishment is concentrated in Anchorage, Fairbanks, and the Aleutian Islands. The population is 54.4% male and 45.6% female. Alaska has a young population--the median age is 26.1 years compared to a national average of 30 years. On the other hand, the proportion of older people in Alaska's population is much smaller than in the U.S. population, perhaps because of the vicissitudes of life and high cost of living in Alaska, which cause many to leave the State at retirement age. See Table I.

Table 1. POPULATION BY AGE GROUP, HSA, ALASKA, US
1982

AGE	SEHSA	NHSA	SHSA	ALASKA	US
0-14	29.2	32.4	26.9	26.9	22.7
15-24	21.9	23.5	20.5	20.5	18.7
25-34	12.6	16.3	22.6	22.6	16.4
35-54	23.1	18.7	21.9	21.9	21.8
54+	13.3	9.0	8.0	8.0	20.9

The categories for the analysis of Alaska's racial composition are: 1) white, 2) non-white, which includes Natives, Blacks, Chinese, Japanese, Filipino, Hispanic, etc. Whites constitute the major part of Alaska's population. About seventy-seven percent of the population is Caucasian, and about sixteen percent is Native (Alaska Native and Alaska Indian). About five percent of the population is Black. The remaining one percent is composed of Other Minorities, including Filipino, Chinese, Japanese and other minorities.

The population distribution, by race, for 1982, is shown in Table 2.

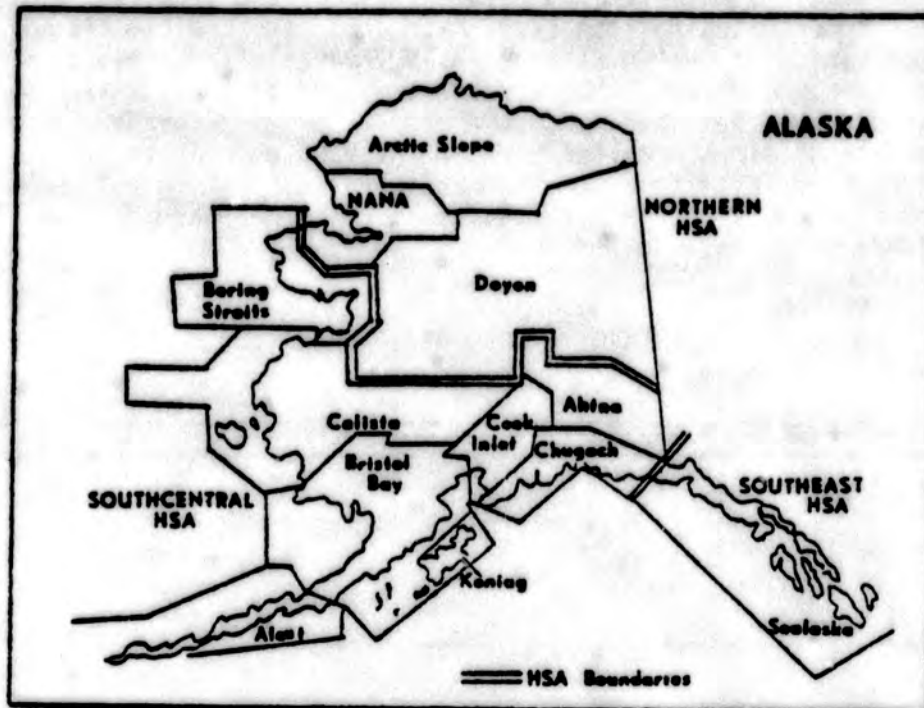
Table 2. POPULATION DISTRIBUTION BY RACE
ALASKA '82

RACE	NUMBER	PERCENT
WHITE	354,475	76.92
NON-WHITE	106,352	23.08
TOTAL	460,837	100.00

Health Systems Agencies and Native Regional Corporations

Three Health Systems Agencies (HSAs) have been established in Alaska, the Southeast Alaska Health Systems Agency, Southcentral Health Planning and Development, Inc., and the Northern Alaska Health Resources Association, Inc. Map 2.

Map 2. Health Systems Agencies and Native Regional Corporations, Alaska



Total population, and cumulative population change between 1970-1977-82 for each HSA is shown in Table 3.

Table 3. TOTAL RESIDENT POPULATION, BY HSA AND STATEWIDE AND POPULATION CHANGE ALASKA 1970-77-82

AREA	1970 Pop.	1977 Pop.	1970-1977 Cumulative Pop. Change	1982 Pop.	Cumulative Pop. in 1980 Change From	
					1970	1977
NORTHERN	64,630	74,014	+14.52	83,159	+28.66	+12.35
SOUTHEAST	42,565	53,162	+24.90	59,201	+39.08	+11.35
SOUTHCENTRAL	195,166	284,035	+45.54	318,477	+63.18	-12.12
TOTAL	302,361	411,211	+36.00	460,837	+36.12	-12.06

The State's Native Regional Corporations number twelve. Their locations and boundaries, and their relationship to the three HSAs, are shown in Map 2.

Density of Population

Despite Alaska's recent rapid rate of population growth, the State is still very sparsely settled. For purposes of comparison, Alaska's sparsity of population in 1980 resembled that of the Mountain States (Montana, Idaho, Wyoming, Utah, and Colorado) in the 1870s and 1880s. The 1960 census showed a population density of only 0.40 persons per square mile for Alaska, compared with the United States average of 60.0 persons per square mile. The 1970 census enumeration showed a population density of about 0.53 persons per square mile, while in 1980 (based on the most current population estimate), population density was only 0.70 persons per square mile for the state as a whole. See Table 4, which illustrates the quite marked differences in population density among various regions.

Table 4. POPULATION DENSITY PER SQUARE MILE, BY HSA AND TOTAL ALASKA
1980

AREA	AREA SQ. MILES	POPULATION	DENSITY PER SQ. MILE
NORTHERN HSA	320,000	76,656	.24
SOUTHEAST HSA	32,000	53,794	1.60
SOUTHCENTRAL HSA	218,000	270,126	1.24
	570,300	400,481	.70

Urbanization and Population Growth

Urbanization has been an important trend in Alaska, as it has been elsewhere in the United States; however, the pattern and timing of urbanization in Alaska have been somewhat different than in the rest of the nation.

In 1890, there was no urban population in Alaska, by 1900, there was a substantial urban population (for example, in Nome) as a result of the gold rush. As the gold rush subsided, the urban population declined, but by 1920 it had begun to increase again. Urban population has increased steadily since the 1920s and more rapidly, since the 1950s. In the 1950 census enumeration, 26.6% of Alaska's population lived in urban areas; by the 1960 census, the urban segment of the population amounted to 37.9% of the total; and, by the 1970 census, 48.4% of the population was classed as urban. (NOTE: "Urban" is defined as places of 2,500 or more).

The distribution of Alaska's total population by size of place in 1950, 1960, and 1970 is shown in Table 5. In 1950, nearly 62% of the total population resided in places of less than 1000 persons. By 1960, this percentage had dropped to 52%. By 1980, the percentage of the total population residing in places of less than 1000 persons had declined even further, to 27%.

Table 5. DISTRIBUTION OF TOTAL ALASKA POPULATION BY SIZE OF PLACE
1950 - 1980

SIZE OF PLACE	1950		1960		1970		1980	
	POP.	% of Pop.	POP.	% of Pop.	POP.	% of Pop.	POP.	% of Pop.
<1,000	79,394	61.7	116,446	51.5	117,017	38.4	108,625	27.1
1,000 - 1,500	3,575	2.8	12,444	5.5	15,170	5.1	3,487	.8
1,500 - 2,000	7,190	5.6	7,032	3.1	6,918	2.3	10,201	2.5
2,000 - 2,250	4,222	3.3	4,478	2.0	15,765	5.2	15,416	3.8
2,500 - 5,000	5,976	4.6	5,865	2.6	21,355	7.1	25,914	6.5
5,000 - 10,000	17,032	13.2	22,354	9.9	43,268	14.4	20,233	5.1
10,000 - 25,000	11,254	8.7	13,311	5.9	32,860	10.9	42,173	10.5
25,000 - MORE	0	0	44,237	19.6	48,029	16.0	174,431	43.7

The major peaks in Alaska's population growth were caused by the gold rush at the turn of the century, resource development, expansion of the military presence, and, most recently, the construction of the trans-Alaska Oil Pipeline. The latter event, occurring in the mid-1970s caused population fluctuations, which were primarily in-migrational in nature, all along the 800 mile route of the pipeline, from Prudhoe Bay on the North Slope, south to Valdez on the Prince William Sound, and caused economic and social reverberations throughout the State.

Despite trends of urbanization and population growth, which have intensified since the beginning of the construction of the Trans-Alaska Pipeline, it is clear that Alaska is, even in 1979, significantly rural in character, compared to the Lower 48.

B. ALCOHOL ABUSE INDICATORS

The best available method we have for estimating the extent of alcohol abuse is through the analysis of indirect "indicators," or quantifiable measures, of alcohol abuse.

These indicators are believed to be related to alcohol abuse in such a way that changes in the indicators correspond to changes in actual alcohol abuse patterns. If a number of indicators are analyzed together, and if consistent patterns are observed, over time, then these indirect indicators may be assumed to provide a reasonably reliable indication of the nature and extent of alcohol abuse, and alcohol related problems, within a state. It must be emphasized that no one indicator alone can be used to quantify the extent of alcohol abuse within an area or state.

The indicators selected for this Needs Assessment, their sources, the rationale for the use of each, and the limitations of each as an indicator, are described below.

Per Capita Sales of Alcoholic Beverages

Source:	Department of Revenue
Rationale:	Relative measure, over time, of per capita amount of alcoholic beverages sold in the State. Useful for comparison with other states', and national, per capita sales data.
Limitations:	If used as a measure of "apparent consumption," many assumptions are necessary to relate per capita sale to per capita "apparent consumption."

Prevalence Estimates:

Source:	Demographic data/mortality data used in conjunction with standard prevalence estimate formulas (Marden procedure; modified Jellinek procedure).
Rationale:	To provide estimates of population "at risk," and in need of alcoholism treatment services.
Limitations:	Procedures are standard methodologies which are not Alaska-specific, and they do not take account of unique population-specific factors.

Alcohol and Highway Safety

Source: Department of Public Safety

Rationale: To provide an estimate of alcohol involvement in a major cause of preventable death. Assists in identification of populations particularly at risk.

Limitations: Data may understate actual alcohol-involvement.

Arrests for Alcohol-Related Offenses

Source: Department of Public Safety

Rationale: May assist in identifying high risk populations.

Limitations: Local law enforcement activities/policies may vary without relationship to actual extent of alcohol-related offenses. Arrest data indicate alleged offenses only. Only directly alcohol-related offenses can be quantified with these data.

Alcohol-Related Mortality

Source: Department of Health and Social Services, Office of Information Systems

Rationale: Health indicator which is directly related to actual prevalence of alcohol abuse.

Limitations: There is a potential for underreporting due to reluctance to attribute death to alcohol-related causes.

Other Alcohol-Related Mortality

Source: Department of Health and Social Services, Office of Information Systems, and death certificate data submitted to Bureau of Vital Statistics.

Rationale: Data concerning accidental deaths which are directly related to prevalence of alcohol abuse.

Limitations: There is a potential for underreporting due to differences in reporting practices by medical examiners and/or fire officials.

Alcoholism Treatment Programs

Source: Department of Health and Social Services,
Office of Alcoholism and Drug Abuse, Information System.

Rationale: Reporting on individual clients allows study of specific populations. Demographic characteristics may be used as a tool in identifying high risk populations.

Limitations: Necessary assumption: that characteristics of those persons seeking treatment at public treatment programs are representative of the entire alcohol abusing population.
Voluntary/involuntary entry bias.
Unavoidable internal problems with information system during 1978.

Mental Health

Source: Department of Health and Social Services,
Division of Mental Health and Developmental Disabilities.

Rationale: Demographic characteristics of patients may be used to identify high risk populations.

Limitations: There is a potential for underreporting due to misdiagnosis of alcohol problems.

Child Abuse and Child Neglect

Source: Department of Health and Social Services,
Division of Family and Youth Services.

Rationale: Indicates the consequences for the family unit of alcohol abuse.

Limitations: Exact nature of the correlation between child abuse/child neglect and alcohol abuse by a family member has not been determined. Potential for underreporting of child abuse/child neglect cases because some cases never come to the attention of Division of Social Services.

Analysis of Alcohol Abuse Patterns

Per Capita Sales of Alcoholic Beverages

Note on Terminology

The amount of legal alcoholic beverages sold, per capita, is sometimes referred to as "apparent consumption" of alcoholic beverages. Some of the more important assumptions necessary to relate sales to actual consumption, as "apparent consumption," are: 1) All the alcoholic beverages sold in a state are consumed by the resident population; 2) All alcoholic beverages consumed are legally purchased (and, thus, all are included in government reports of alcoholic beverages sold/distributed; and 3) Persons who abstain from alcohol consumption do not constitute a significant proportion of the drinking age population (and, therefore, the drinking age population figure is not adjusted downward to reflect the existence of an abstaining sub-population group).

In fact, these assumptions should be questioned, or at least, taken into account, when "apparent consumption" data are presented. For example, an unknown number of non-residents -- tourists and other visitors -- purchase and consume alcoholic beverages while visiting this State; failing to account for their presence in the population tends to inflate "apparent consumption" figures. Also, illegally manufactured alcoholic beverages may contribute significantly to the amount of alcohol consumed in the state. And, as no current survey information concerning the proportion of abstainers in the population exists for Alaska, it is impossible to make valid adjustments in the size of the "drinking age" population which would take these abstainers into account. Failure to make allowances for the latter two factors results in understatement of "apparent consumption" of alcoholic beverages in the State. Furthermore, the definition of "drinking age" population, if unrealistic in terms of a state's drinking habits and practices, can result in distortion of the actual relationship of sales to consumption.

Hence, we have avoided "apparent consumption" terminology here because so many assumptions have to be made to relate alcoholic beverage sales data to actual consumption of alcoholic beverages; we will use instead the terminology "per capita sales" in this section. What is meant by "per capita sales" is this: if all legally sold alcoholic beverages were divided equally among all persons who could legally purchase such beverages, then the average amount sold to each person would be expressed as per capita sales of alcoholic beverages.

At best, sales of alcoholic beverages, when expressed as an amount per

capita, can be used as a comparative or relative measure: 1) to show trends or changes, over time, in the per capita amount of alcoholic beverages sold in the State; 2) to compare state trends with national trends, or to compare trends among several states; and 3) because sales data are presented with regional breakdowns, those data can be used to compare per capita sales of alcoholic beverages among sub-state regions.

TRENDS IN PER CAPITA SALES OF ALCOHOLIC BEVERAGES, ALASKA, 1958 - 82

When per capita sales, by beverage type, are analyzed, for the period 1958-1982, it appears that there has been a significant decrease in sales of distilled spirits, with corresponding increases in sales of beer and wine. The proportionate share of distilled spirits in total per capita sales fell from 58 percent in 1958, to 43 percent in 1982, on the other hand, the share of beer increased from 35 percent in 1958 to 43 percent in 1982, while the proportion of total per capita sales accounted for by wine rose more noticeably from 7 percent in 1958 to 14 percent in 1982. See Table 6.

Table 6. Sale/Distribution of Legal Alcoholic Beverages, Percent in each Beverage Class, and Per Capita Sale/Distribution Expressed as Gallons of Absolute Alcohol, for Persons 19 Years of Age and Older¹, Alaska, FY 76-82.

Year	PERCENTAGE OF ALC. BEV. SOLD			Absolute Alcohol in Gallons
	Distilled Spirits	Wine	Beer	
1982	43%	14%	43%	4.58
1981	44%	13%	43%	4.48
1980	45%	13%	42%	3.93
1979	46%	13%	41%	3.72
1978	47%	12%	41%	3.79
1977	49%	11%	40%	3.87
1976	51%	11%	38%	3.94
1958	58%	7%	35%	2.52

¹Drinking Age Population.

Comparison of Trends in Per Capita Sales of Alcoholic Beverages, United States and Alaska, 1958-1977

For the nation as a whole, per capita sales of alcoholic beverages rose during the 1960's, increasing by approximately 26 percent during the decade. There has been virtually no change in U.S. per capita sale during the 1970's; per capita sales have remained at the peak level reached during the early 1970's. Increased per capita sales during the past two decades

generally are believed to be due to liberalization of alcohol control laws, in combination with a larger proportion of young people in the total population, and a larger number of women who drink alcohol. Alaska's per capita sale of alcoholic beverages for the period 1958-1977 is very high relative to the national average.

This same trend, with Alaska per capita sales greatly exceeding those of the United States, has continued in 1980. See Table 7 for comparative data.

Table 7. Per Capita Sale of Legal Alcoholic Beverages, U.S. Gallons of Absolute Alcohol Per Person, 18 Years of Age and Older, Alaska and United States, 1980.

AREA	U.S. GALLONS OF ABSOLUTE ALCOHOL			
	Distilled Spirits	Wine	Beer	Total
ALASKA	1.75	0.51	1.67	3.93
UNITED STATES (NAT'L VALUE)	1.13	0.38	1.69	3.20

On the national level, beer is the leading class among alcoholic beverages in per capita sales, whereas, in Alaska, the leading beverage class is distilled spirits.

When compared to other states, on a state-by-state basis, Alaska's per capita sales figure is ranked fourth in the nation, behind Nevada, the District of Columbia, and New Hampshire. With respect to interstate comparisons, various reasons for extremely high rates of per capita sales (or, "apparent consumption") have been offered in the national literatures for each of the top three states. High amounts attributed to the District of Columbia are explained by the facts that (1) there is no balance between urban and rural areas there - the District is a metropolis where a high rate of sales "is expected"; (2) it is also a tourist and convention center, which "implies a high drinking rate"; and (3) its low prices attract a vast suburban and transient population to purchase their supplies there. The high rates in Nevada are explained generally entirely in terms of vacationers, tourists, and convention-goers, while the high per capita sales in New Hampshire are attributed to that state's status as a vacation state, and to the lower prices of alcoholic beverages there compared to neighboring states. Alaska's high level of per capita sales has not been explained in the explanatory literature, but presumably, at least the tourism cause for high level per capita sales applies to Alaska.

Table 8 presents a summary of per capita sales, in terms of beverage alcohol and absolute alcohol, of all alcoholic beverages, and by beverage class, for persons 19 years of age and older, in the State of Alaska, for the years 1976 through 1982.

Table 8. Per Capita Sales, Total Sales and Sales by Beverage Class, Beverage Alcohol and Absolute Alcohol, for Persons 19 Years of Age and Older, Alaska, 1976-1982.

YEAR	BEVERAGE CLASS	GALLONS PER CAPITA		19 YRS. & OLDER POPULATION Estimated 81/82
		VOLUME OF Beverage Alcohol	VOLUME OF Absolute Alcohol	
1982	Distilled Spirits	4.81	1.98	272,796
	Wine	4.92	.63	
	Beer	43.69	1.97	
	TOTAL	---	4.58	
1981	Distilled Spirits	4.83	1.99	259,806
	Wine	4.65	.60	
	Beer	42.05	1.89	
	TOTAL	---	4.48	
1980	Distilled Spirits	4.26	1.75	264,991
	Wine	3.92	.51	
	Beer	37.13	1.67	
	TOTAL	---	3.93	
1979	Distilled Spirits	4.17	1.71	271,439
	Wine	3.62	.47	
	Beer	34.15	1.54	
	TOTAL	---	3.72	
1978	Distilled Spirits	4.39	1.80	269,570
	Wine	3.51	.45	
	Beer	34.21	1.54	
	TOTAL	---	3.79	
1977	Distilled Spirits	4.63	1.90	271,546
	Wine	3.44	.44	
	Beer	34.03	1.53	
	TOTAL	---	3.87	
1976	Distilled Spirits	4.83	1.99	263,876
	Wine	3.28	.42	
	Beer	33.89	1.53	
	TOTAL	---	3.44	

Source: Alcohol sales - Department of Revenue.
Population - Department of Labor.

Calculated with the following percentages of absolute alcohol:
Distilled spirits: 0.43; wine: 0.14; beer: 0.045.

Relationship of State Law to Per Capita Sales

The legal framework provided for the sale of alcoholic beverages in the State of Alaska does nothing to inhibit high volume per capita sales of alcoholic beverages.

Retail Distribution: Liquor Store Licenses

In terms of retail distribution, by-the-bottle, through liquor stores, Alaska is a "license" state, i.e., there are privately owned liquor stores licensed by the State for distribution of alcoholic beverages, rather than a "control" state in which there are government-owned liquor stores. In 1970, there were 319 retail licenses for liquor store sales by the bottle for off-premises consumption. In 1979, there were 424 retail licenses. In 1982, there were 458 retail licenses.

Total Licenses for Sale of Alcoholic Beverages

In 1970 there were 915 beverage dispensary licenses in the State of Alaska; this included 596 licenses for on-premises sale of liquor by-the-drink, and 319 liquor store licenses for sales by-the-bottle for off-premises consumption. That was 3.03 licenses per 1000 population, which, relative to the other states, was by far the highest ratio of licenses to population in the United States. In 1970, the national average for the ratio of liquor licenses to each 1000 population was 1.2. In 1982 the Alaska ratio of liquor licenses to each 1000 population rose to 3.68.

In 1982, there were 1474 liquor licenses in the State of Alaska. By category, these licenses were distributed among the available liquor license types as follows:

Table 9. Total Number of Licenses by Type,¹ by Year, Alaska
1978 - 1982.*

	1978	1979	1980	1981	1982
Beverage Dispensary Club	483	583	592	624	629
Commercial Carrier	51	61	62	66	66
Restaurant	64	78	79	83	84
Retail	181	218	222	234	236
Pub	351	424	431	454	458
Total	1	1	1	1	1
	1,131	1,365	1,387	1,462	1,474
On-Premise	780	941	956	1,008	1,016
Off-Premise	351	424	431	454	458

1. Department of Revenue: Alcohol Beverage Control Board

* The total number of Liquor License's was made available by the ABC Board. The distribution of license's by type was based on the percentage breakout for 1981 a year for which data on number of each type of license was available. Data on the exact type breakout for previous years was unavailable.

DEFINITIONS OF LICENSE TYPES:

Pub License - may sell beer and wine for consumption at a designated location on the premises of a campus of an accredited university or college.

Beverage Dispensary License - may sell for cash, or serve on the premises, beer, wine, and hard liquors for consumption on the premises only.

Club License - clubs, fraternal organizations and patriotic organizations that have state/national charter have the right to sell intoxicating liquor to members and families, but only in club rooms.

Common Carrier - may sell intoxicating liquors for consumption aboard a boat, aircraft or a railroad buffet car while in transit, and may sell intoxicating liquors while stationary if not prohibited by local ordinance.

Restaurant License - may sell beer and wine only, with meals.

Excluding wholesale licenses, there were 1474 liquor licenses in the State of Alaska in 1982. This amounts to 1 license for every 185 persons 19 years of age or older or 1 license for every 283 persons in Alaska.

Table 9a. Number of persons per license, Alaska , 1978-1982

	1978	1979	1980	1981	1982
ON PREMISE LICENSE'S	780	941	956	1008	1016
19+ Population	345	288	277	271	291
State Population	525	431	418	426	452
OFF PREMISE LICENSE'S	351	424	431	454	458
19+ Population	766	639	614	603	646
State Population	1168	957	928	947	1004
TOTAL LICENSE'S	1131	1365	1387	1462	1474
19+ Population	237	198	191	187	200
State Population	363	297	288	294	312
STATE POP. (000's) ¹					
19+ years 2	269	271	265	274	296
State Pop. 3	410	406	400	430	460

1. Department of Labor: Annual Population Statistics.
2. The number of state population aged 19 and over.
3. The entire state population.

Long Hours of Sale

Alaska statutes provide that "no person may consume, sell or give.... any liquor on any licensed premises between the hours of 5 A.M. and 8 A.M." Thus, liquor sale is permitted, at the maximum level, for twenty-one hours per day. These are some of the longest hours of sale in the entire United States. NOTE: Hours may be shortened by local option. Also, the sale of liquor is on a local-option basis, and may be prohibited in a given area altogether. Bar hours have been shortened by local vote in Juneau, Anchorage, Sitka, Kenai-Soldotna, Fairbanks and other communities.

No Prohibited Days of Sale

Except during the hours noted, liquor may be sold on any day of the week, including Sunday, except on election day, and then, liquor may be sold after the polls have closed.

Age Requirement

Alaska has reduced the age requirement for buying and consuming alcoholic beverages (beer, wine and distilled spirits) to nineteen years. The age requirement was raised to 21 effective January 1, 1984. A part of the legislation raising the drinking age allowed those who were 19 on or before January 1, 1984 to retain their drinking privilege.

Other

- Liquor advertising and advertising of liquor stores is permitted.
- Meals do not have to be served with alcoholic beverages, or on premises where alcoholic beverages are sold.
- Sale of alcoholic beverages in containers of any available size is allowed.
- Revised Title 04 permits local communities to reduce or limit availability of beverage alcohol.

Prevalence of Alcohol Abuse: Estimates of Persons with Alcohol-Related Problems, Problem Drinkers, and Alcoholics

Prevalence estimates attempt to quantify (1) the size of alcoholic population, or (2) the size of the population at risk of abusing alcohol, and who constitute, therefore, at risk of experiencing alcohol-related problems and alcohol-related disabilities (physical, mental or psychological, or social problems). Prevalence estimate procedures are based on such medical or social indicators as incidence of cirrhosis of the liver, alcoholism and cirrhosis of the liver mortality data, suicides, beverage alcohol consumption, alcohol-related arrests or alcohol-related accidents, and alcoholism treatment program client loads.

Two prevalence estimate procedures have been selected for use here, in order to make estimates based on current data of the "at-risk-population", and of need for alcoholism treatment services in Alaska. The first estimation procedure selected is the Marden method, which seeks to identify the number of persons with alcohol-related problems. The second estimation procedure elected is a modified version of the Jellinek formula, which seeks to identify the number of alcoholics in a discrete population. An estimate of problem drinkers, both adult and juvenile, based upon national problem drinker estimates, is included in this section, too.

A summary of the several prevalence estimates derived by these methods for the State of Alaska is set forth in Table 10.

Table 10. Prevalence Estimates, Alaska

ESTIMATED NO. OF ALCOHOLICS	ADULTS		TOTAL ADULTS
	Male	Female	
MURDEN FORMULA Persons with Alcohol - Related Problems, 1982	29262	6002	35282
JELLINEK FORMULA Alcoholics, 1980	11516	1968	13484

Before proceeding to the actual prevalence estimates, it is necessary to define the different groups to which these estimations relate.

PERSONS WITH ALCOHOL-RELATED PROBLEMS: Persons with alcohol-related problems are persons who are prospective clients of alcoholism treatment programs, because of the various problems they may be having with alcohol or which are caused by drinking alcohol.

ALCOHOLISM. Alcoholism is an addiction to alcohol. It is also defined as alcohol dependence syndrome by the World Health Organization and in the ninth revision of the International Classification of Diseases. Alcoholism is characterized by a compulsion to take alcohol on a continuous or periodic basis to experience is psychological and physical effects, and sometimes to avoid the discomfort of its absence. Tolerance may or may not be present.

PROBLEM DRINKER. A problem drinker is a person who drinks alcohol to an extent, or in any manner, that an alcohol-related disability is manifested. Therefore, the term problem drinker generally is applied to those who demonstrate problems in relation to drinking alcohol.

ALCOHOL-RELATED DISABILITY. Alcohol-related disability is a broad term that includes alcoholism but doesn't require that alcoholism be present. An alcohol-related disability exists when there is an impairment in the physical, mental or social functioning of an individual, so that it may be reasonably inferred that alcohol is part of the cause of that disability. Impairment includes actual health problems related to a specific drinking bout; offensive behavior caused by heavy drinking; injuries, death and property loss caused by accidents related to drinking; failure of the chronic excessive drinker to fulfill his or her roles in family or on the job; and mental problems such as depression and anxiety, related to drinking.

Marden Procedure for Estimation of Prevalence of Persons with Alcohol-Related Problems

The Marden procedure provides estimates of the probability of persons in various population sub-groups (sub-groupings by age, race, sex, or occupation, for example) of having a problem with alcoholism or alcohol abuse, i.e., the probability of occurrence of problem drinking for a given population segment. Actual population data for a discrete locale or area are classified according to the sub-groups for whom probability estimates are available, and the probabilities provided by the Marden method are applied to this population data. The method yields an estimate of the number of drinkers with alcohol-related problems in a given area, and for the various sub-populations included in the estimate. A modified version of the Marden method, which is based upon only the age and sex distribution of the population (race/ethnicity, and occupation, not being taken into account) is used here. Use of this version of the Marden procedure will necessarily reduce the precision of the estimate derived because socio-economic status (which is derived from occupational status in this method), and race/ethnicity, will not be considered; the results, however, will be more exacting than those obtained when the total population of an area is multiplied by a single figure.

MATRIX A
POPULATION 1982

AGE GROUP	MALE	FEMALE
0-19	84,574	81,089
20-29	55,577	50,406
30-39	45,911	39,449
40-49	26,580	21,916
50-59	16,914	15,314
60-69	7,249	6,575
70+	4,835	4,382
TOTAL	241,640	219,160

MATRIX B
PROBABILITIES FOR PROBLEM DRINKING (AGE-SEX ONLY)

AGE GROUP	MALE	FEMALE
0-19	.000	.000
20-29	.248	.020
30-39	.164	.079
40-49	.174	.068
50-59	.127	.019
60-69	.116	.012
70+	.014	.004

MATRIX C
NUMBER OF PERSONS WITH ALCOHOL-RELATED PROBLEMS IN POPULATION - 1982

AGE GROUP	MALE	FEMALE	TOTAL
0-19	0	0	0
20-29	13,783	1,008	14,791
30-39	7,529	3,116	10,645
40-49	4,625	1,490	6,115
50-59	2,418	291	2,709
60-69	840	79	919
70+	67	18	85
TOTAL	29,262	6,002	35,282

Thus, the total prevalence estimate of persons with alcohol-related problems derived by the Marden procedure is 35,282.

Among other things, the Marden method assumes that there are no "drinkers with problems" in the under 20 year old population. This directly contradicts recent evidence on the rising amount of alcohol abuse among young people. According to Marden, the reason for his assumption in his prevalence estimation procedure is that no solid figures were available upon which to base probability estimates for young people, hence they were omitted from the procedure.

Finally, Marden has cautioned that the number produced in Matrix C should be interpreted in the light of several factors, which are unique to particular populations, or areas, and which can influence the quantitative estimates derived from the method, as follows: 1) youthful drinkers and drinking practices in a community or geographic region; 2) ethnicity -- there may be varying ethnic drinking practices in a community or region; 3) unemployment; 4) areas of rapid growth in a region, and in-migration of young persons in those age groups for which there is a high incidence of alcohol-related problems; and 5) urban/rural distribution of the population.

Modified Jellinek Procedure for Estimation of Alcoholics

The second procedure selected is a modified Jellinek estimation formula, which estimates, separately, the number of male alcoholics and the number of female alcoholics.

The Jellinek formula, as it originally appeared in the 1940's was

$$A = \left(\frac{PD}{K} \right) R, \text{ where}$$

A = total number of alcoholics alive in a given year

D = number of reported deaths from liver cirrhosis in given year

P = percentage of liver cirrhosis deaths attributable to alcoholism
(a presumed constant: .515 for males and .177 for females)

K = percentage of all alcoholics with medical complications who die of
cirrhosis of the liver (a presumed constant: .00694)

R = ratio of all alcoholics to those alcoholics with medical complications
(in the original Jellinek formula, R = 4)

In the version of the Jellinek formula adopted here, several of the constants
have been revised, as follows:

P = .628 for males This represents an increased percentage of
 = .216 for females the contribution of alcoholism to total
 deaths from cirrhosis of the liver.

R = 5.3 This represents a decreased proportion of
 alcoholics with medical complications.

The other constant factors remain as they were in the original formula.

Applied to Alaska data for six years -- 1975 to 1981 -- for which years
cirrhosis of the liver mortality data, by sex, is available, this version
of the modified Jellinek formula produces the following series of preva-
lence estimates:

Table 11. Cirrhosis Mortality, by Sex, and Estimated Number of
Alcoholics, Alaska, 1975-1981.

YEAR	CIRRHOSIS MORTALITY		NUMBER OF ALCOHOLICS		
	MALE	FEMALE	MALE	FEMALE	TOTAL
1975	25	24	11,990	3,956	15,946
1976	31	18	14,892	2,978	17,879
1977	16	18	7,637	2,978	10,615
1978	26	14	12,410	2,296	14,706
1979	22	20	10,500	3,280	13,780
1980	24	12	11,516	1,968	13,484
1981	20	18	9,597	2,978	12,575

Alcohol and Highway Safety

Motor vehicle traffic accidents are the largest cause of violent death in the United States today, and, at the national level, approximately one-half of the fatalities resulting from traffic accidents are alcohol-related. In addition, about one-third of the injuries resulting from motor vehicle traffic accidents show alcohol involvement.

Alcohol consumption causes degeneration of driving skills and impairment of good driving judgment, generally. Alcohol also impairs the visual function of glare recovery, and reduces the ability to detect objects in the peripheral visual field. These detrimental effects of alcohol are particularly hazardous for the driver under the influence of alcohol.

Alcohol-Involvement in Motor Vehicle Traffic Fatality Accidents, Alaska, 1975-1981.

Alcohol-involvement in motor vehicle fatality accidents has ranged from 45 percent to 73 percent during the past seven reported years (1975-1981). (MOTOR VEHICLE TRAFFIC ACCIDENT means all reported accidents involving a motor vehicle, or motor vehicles, and which occur on a trafficway, or which occur after the motor vehicle or vehicles ran off the trafficway, but before events are stabilized). See Table 12.

Table 12. Total Motor Vehicle Traffic Fatality Accidents, and Total Fatalities, and Motor Vehicle Traffic Fatality Accidents with Indication of Alcohol for One or More Drivers, Alaska, 1975 - 1982.

Year	1975	1976	1977	1978	1979	1980	1981	1982
Total Fatal Accidents	100	111	130	112	81	86	90	98
Accidents with Indication of Alcohol for one or more drivers: ⁽¹⁾								
Number.....	45	67	64	54	57	58	66	51
Percentage of Total	45.0	60.4	49.2	48.2	70.3	67.4	73.3	52.0
Total Motor Vehicle Traffic Fatalities	114	127	138	127	91	95	100	107
Alcohol Involvement in Fatalities	34	86	104	93	66	64	76	53

Table: 13 JUVENILE INVOLVEMENT IN FATAL ACCIDENTS/FATALITIES
AND ALCOHOL INVOLVMENT 1979-82

Driver Age	Fatal Accidents	Alcohol Accidents	Fatalities	Alcohol Fatalities
1979				
all ages	81 (23%)	57 = 70%	91 (25%)	69 = 75%
0 - 18	<u>17</u>	<u>11</u> = 64%	<u>20</u>	<u>13</u> = 65%
19	2	2 = 100%	2	2 = 100%
20	9	6 = 66%	11	8 = 72%
0 - 20	<u>28</u>	<u>19</u> = 67%	<u>32</u>	<u>23</u> = 71%
0 - 20 as % of all ages	34%	33%	35%	33%
1980				
all ages	86 (8%)	58 = 67%	95 (8%)	64 = 67%
0 - 18	<u>10</u>	<u>5</u> = 50%	<u>11</u>	<u>6</u> = 54%
19	2	1 = 50%	4	1 = 25%
20	3	1 = 33%	3	1 = 33%
0 - 20	<u>15</u>	<u>7</u> = 46%	<u>18</u>	<u>8</u> = 44%
0 - 20 as % of all ages	17%	12%	18%	12%
1981				
all ages	90 (26%)	66 = 73%	100 (23%)	76 = 76%
0 - 18	<u>13</u>	<u>11</u> = 84%	<u>18</u>	<u>16</u> = 88%
19	4	4 = 100%	4	4 = 100%
20	2	2 = 100%	3	3 = 100%
0 - 20	<u>19</u>	<u>17</u> = 89%	<u>25</u>	<u>23</u> = 92%
0 - 20 as % of all ages	21%	25%	25%	30%
1982				
all ages	98 (9%)	51 = 52%	107 (8%)	53 = 49%
0-18	<u>2</u>	<u>2</u> = 100%	<u>2</u>	<u>2</u> = 100%
19	5	5 = 100%	5	5 = 100%
20	2	2 = 100%	2	2 = 100%
0 - 20	<u>9</u>	<u>9</u> = 100%	<u>9</u>	<u>9</u> = 100%
0 - 20 as % of all ages	9%	17%	8%	16%
4 YEAR TOTAL				
all ages	355 (15%)	232 = 65%	393 (16%)	262 = 66%
0-18	<u>42</u>	<u>29</u> = 69%	<u>51</u>	<u>37</u> = 73%
19	13	12 = 92%	15	12 = 80%
20	16	11 = 69%	19	14 = 74%
0-20	<u>61</u>	<u>52</u> = 85%	<u>85</u>	<u>63</u> = 74%
0-20 as % of all ages	17%	22%	21%	24%

(%) = Of the total for all ages the % involving alcohol affected youth.

Total 1/7/83
Licensed Drivers 281,841

0 - 20
Licensed Drivers 8081 = 2.9%

Source: Highway Safety Planning Agency

Table 14. Total Arrests for Alcohol-Related Offenses, Alaska, 1979-1982

ARRESTS FOR ALCOHOL-RELATED OFFENSES	1979		1980		1981		1982	
	¹ NO.	%	¹ NO.	%	¹ NO.	%	¹ No.	%
Driving under the Influence	3,006	16.0	2,575	16.0	3,481	18%	4,988	26
Drunkenness	585	3.1	181	2.0	139	.1%	0	0
Liquor Law Violations	2,429	12.9	2,346	15.0	2,536	13%	2,781	14
Total Arrests for Alcohol-Related Offenses	6,020	32.1	5,102	32.9	6,156	34%	7,769	40
TOTAL ARRESTS, ALL OFFENSES	18,698	100.0	16,102	100.0	18,825	100%	19,485	100.0

¹ Percentage of Total Arrests, All Offenses.

Arrests for these directly alcohol-related offenses have increased approximately 30 percent during the four-year period 1979-1982 (from 6020 to 7769). The category which has shown the greatest increase is the liquor law violation arrests category. See Table 15.

Table 15. Alcohol-Related Offenses, Percentage Increase or Decrease, by Category, 1978-81.

OFFENSE CATEGORY	PERCENTAGE INCREASE OR DECREASE IN ARRESTS 1978-1981
Driving under the Influence	+ 6%
Drunkenness	-78%
Liquor Law Violations	+20%
TOTAL	+ 3%

Data is available for 1981 that allows the determination of fatal accident and fatality rates per 100 million miles driven. The fatal accident rate for Alaska is 3.40 compared to the national rate of 2.84. The fatality rate for Alaska is 3.74 compared to 3.74 compared to 3.18 for the national rate. Alaska's fatality accident and fatality rates per 100 million vehicle miles are 20% and 18% higher than the national averages. There are probably several factors affecting these higher rates alcohol certainly being one of them.

The Department of Public Safety, which is the source of all traffic safety information, also collects data on the circumstances, or factors, which have contributed to motor vehicle traffic fatalities (not accidents). Up to four factors may be reported by investigating officers as being contributory circumstances for any fatality. For the period 1979-1982 alcohol-involvement was the most frequently reported contributing circumstance in fatality accidents. See Table 13.

During the years 1979 - 1982, there were 355 fatal highway accidents resulting in 393 fatalities. Data from the Highway Safety Planning Agency shows that 65% or 232 of the fatal highway accidents were alcohol related, and 66% or 262 of the highway fatalities were alcohol related.

The proportion of alcohol relatedness for the 0-20 age group was significantly higher than the overall rate. The 0-20 age group was involved in 61 fatal accidents, 52 or 85% of which were alcohol related.

The 19 year old age group showed a markedly higher rate for the four periods than the other groups, 92% (12 of 13) of the fatal accidents and 80% (12 of 15) of the fatalities were alcohol related. The legal age for drinking during this period was also 19.

While accounting for only 2.9% of licensed drivers the 0-20 drivers were involved in 17% of fatal accidents, 22% of fatal alcohol related accidents, and in 21% of fatalities, 24% of alcohol related fatalities.

ALCOHOL AND CRIMINAL ACTIVITY

On the national level, criminal offenses which are, by definition, directly related to alcohol consumption -- driving under the influence, drunkenness, and liquor law violations -- accounted for 27 percent of all FBI-reported crime in 1977, 29 percent in 1978, 32 percent in 1979, 33 percent in 1980, and 34 percent in 1981. The largest number of these arrests were in the driving under the influence category (17%-18%), with liquor law violations as the next largest category of arrests (9%-13%). See Table 16

Table 16. Selected FBI Arrest Data, Alcohol-Related Offenses
Computed as a Percentage of All Reported Arrests,
United States, 1977-1982.

YEAR	DRIVING UNDER THE INFLUENCE	DRUNKEN- NESS	LIQUOR LAW VIOLATIONS	TOTAL
1982	24%	0%	7%	31%
1981	18%	.1%	15%	34%
1980	16%	2%	15%	33%
1979	16%	3%	13%	32%
1978	16%	3%	10%	29%
1977	17%	.9%	9%	27%

NOTE: Under the Uniform Crime Reporting Program of the FBI, the definition of alcohol-related offense in the three categories, above, are as follows:

DRIVING UNDER THE INFLUENCE: operating any motor vehicle or common carrier while drunk or under the influence of alcohol or narcotics.

DRUNKENNESS: all offenses of drunkenness or intoxication, with the exception of "driving under the influence."

LIQUOR LAW VIOLATIONS: state or local liquor law violations with the exception of "drunkenness" and "driving under the influence."

In Alaska, too, arrests for alcohol-related offenses constituted almost one-third of all reported arrests. At the state level, arrests in these three categories accounted for about 29 percent of all FBI-reported criminal arrests in 1978, about 32 percent in 1979, about 33 percent in 1980, 34 percent in 1981, and 31% in 1982. See Table 15.

In 1980, these liquor law violation arrests were distributed across the state as follows, see Table 17 A.

Table 17 A. Liquor Law Violations, by selected towns, Alaska, 1980

LIQUOR LAW VIOLATIONS BY TOWN	ARRESTS			PERCENTAGE
	ADULT	JUVENILE	TOTAL	
Anchorage	79	81	160	16%
Kodiak	56	11	67	7%
Sitka	29	84	113	11%
Juneau	94	166	260	26%
Soldotna	6	10	16	2%
Fairbanks	265	120	375	38%
TOTAL	529	472	991	100%

In 1981, offenses directly related to alcohol use constituted 37.5 percent of all male arrests; the comparable percentages for 1980 and 1979 were 32 percent and 32.3 percent, respectively. A similar proportion of female arrests were for directly alcohol-related offenses, amounting to 36.4 percent of all female arrests in 1981; 34 percent in 1980; and 31.3 percent in 1979. See Table 19.

For the period 1979-1981, about 18 percent of all male arrests were for the offense of driving under the influence; by comparison, only about 13 percent of all female arrests were for this offense. Equal proportions of male arrests and female arrests were for drunkenness, although the absolute number of male arrests in this category was much larger than the absolute number of female arrests, as was the case in the other alcohol-related offense categories. Of the three classes of directly alcohol-related offenses, the proportionately largest, for females, was the liquor law violation category, with arrests ranging from 14 percent to 21 percent of all female arrests for the period 1979-1981. See Table 19.

Table 19. Total Arrests, and Alcohol-Related Offenses, by Category and by Sex, Number and Percent of Total, Alaska, 1979-1981.

MALES/ARREST CATEGORY	1979		1980		1981	
	No.	%	No.	%	No.	%
Total Arrests	15,504	100.0	13,214	100.0	15,443	100.0
Total Alcohol-Related Arrests	5,019	32.3	4,129	32.0	5,795	37.5
Alcohol Related Arrests:						
DUI	2,599	16.7	2,240	17.0	3,012	19.5
Drunkenness	453	2.9	144	1.0	99	.6
Liquor Law Viol.	1,967	12.6	1,745	14.0	1,811	11.7
FEMALES/ARREST CATEGORY	1979		1980		1981	
	No.	%	No.	%	No.	%
Total Arrests	3,197	100.0	2,888	100.0	3,382	100.0
Total Alcohol-Related Arrests	1,001	31.3	973	34.0	1,234	36.4
Alcohol Related Arrests:						
DUI	407	12.7	335	12.0	469	13.8
Drunkenness	132	4.1	37	2.0	40	1.1
Liquor Law Viol.	462	14.4	601	21.0	725	21.4

DUI = Driving under the Influence

When alcohol-related arrests are analyzed in terms of the adult or juvenile status of the arrestee, noticeable age-related differences can be noted. For each year during the period 1979-1982, approximately 97 percent of all driving under the influence arrests occurred among adults. Most drunkenness arrests involved adults, too; the proportion of drunkenness arrests varied from 92 percent in 1979 to 99 percent in 1981. Arrests for liquor law violations were more equally distributed between adults and juveniles; juveniles accounted for roughly one-half of all the liquor law violation arrests over this period. See Table 20.

Table 21. Total Arrests, and Alcohol-Related Offenses, by Adult/Juvenile Status, Number and Percent of Total, Alaska, 1980-1982.

ADULTS/ARRESTS BY OFFENSE	1980		1981		1982	
	No.	%	No.	%	No.	%
Total Arrests	10,533	100.0	12,697	100.0	14,320	100.0
Total Alcohol- Related Arrests	3,830	37.0	4,636	36.5	5,970	41.4
Alcohol Related Arrests:						
DUI	2,484	24.0	3,384	26.6	4,465	31.2
Drunkenness	175	.2	125	.1	0	0.0
Liquor Law Viol.	1,171	12.0	1,127	8.9	1,465	10.2
JUVENILES/ARRESTS BY OFFENSE	1980		1981		1982	
	No.	%	No.	%	No.	%
Total Arrests	5,569	100.0	6,128	100.0	5,165	100.0
Total Alcohol- Related Arrests	1,272	23.0	1,520	24.8	1,489	28.7
Alcohol Related Arrests:						
DUI	91	2.0	97	1.5	123	2.3
Drunkenness	6	1.0	14	.02	0	.0
Liquor Law Viol.	1,175	21.0	1,409	22.9	1,366	26.4

When alcohol-related arrests for the year 1982 are analyzed in terms of the race/ethnic category of the arrestee, it appears that the distribution of arrests for driving under the influence corresponds to the racial/ethnic distribution of the general population of the State, that is, approximately 82 percent of the arrestees were Caucasian; approximately 2 percent were black; and about 15 percent were Alaska Natives (Aleuts and Eskimos), Alaska Indians (Tlingit-Haida and Athabascan Indians), and other minority group members. Data for the three years are very similar; therefore, only 1980 data are presented here. See Table 22.

Table 22. Alcohol-Related Arrests, by Type and by Race/Ethnicity, Number and Percent Distribution, Alaska, 1982.

RACE/ETHNICITY	DRIVING UNDER THE INFLUENCE		LIQUOR LAW VIOLATIONS		TOTAL	
	No.	%	No.	%	No.	%
Caucasian	3,769	82.1	1,236	43.6	5,005	67.4
Black	87	1.9	19	.7	106	1.4
Native	697	15.2	1,568	55.3	2,265	30.5
Other	35	<1.0	10	1.4	45	<1.0
TOTAL	4,588	100.0	2,833	100.0	7,421	100.0

Distribution of liquor law violation offenses among the state's racial/ethnic groups, however, does not correspond at all to the racial/ethnic distribution of the general population. Arrests of Caucasians amounted to only about 44 percent of the total; arrests among Blacks amounted to approximately .7 percent of the total; while arrests of Alaska Natives, Alaska Indians and other minority group members constituted about 55 to 57 percent of these liquor law violation arrests. See Table 22.

NOTE: The Alaska Native (Aleut and Eskimo), Alaska Indian (Tlingit/Haida and Athabascan Indians), and other minority groups (Filipino, Chinese, Japanese, Spanish-surnamed and Other) have been treated in the aggregate here because of a peculiarity in the original raw data, the source of which is the Criminal Justice Planning Agency. Namely arrests data relating to Eskimos have been included in the Criminal Justice Planning Agency "Other" category, even though the Eskimo racial/ethnic group was estimated to have constituted approximately 9.3 percent of the total population of the State of Alaska in 1980, and apparently, constitutes a sizeable proportion of the arrestees in certain offense categories.

This practice, i.e., grouping Eskimos with other minorities, cannot be justified, as the Eskimo group is a major population sub-group, and, needless to say, has limited analysis severely in terms of the Eskimo group itself, and also in terms of the other included minority groups.

The total role of alcohol in crime is underestimated if only crimes with direct alcohol-involvement (by virtue of the definition of the crime charged) are considered; that is, driving under the influence, drunkenness, and liquor law violations. Alcohol can also be involved in the formulation of other crimes, in the commission or in the aggravation of the actual crime committed, for example, crimes such as assault, homicide, rape and property crimes; and alcohol can affect the outcome of the criminal act. Empirical data for Alaska for these other categories of crime which have alcohol involved in their formulation, or commission, are not available now.

There has been data developed by the Alaska Judicial Council that indicate alcohol as being heavily involved in all Alaskan crime. See data below.

REPLICATION OF TABLE VIII. (pg. 47) AND TABLE XVII (pg. 75)
ALASKA FELONY SENTENCES: 1980 ALASKA JUDICIAL COUNCIL DECEMBER 1982

Frequency Of Use Of Drugs And/Or Alcohol At Time Of
Offense For Five Offense Classes*
(Both Urban And Rural Courts---1980)

NOTE: ALL PERCENTAGES ARE COMPUTED ACROSS THE ROWS USING ROW TOTALS AS "N"

Class Of Offense	Total Cases	Used Drugs	Used Drugs and Alcohol	Used Alcohol	No Use
1. MURDER/KIDNAPPING	U = 14 R = 4		21.4% (3)	78.6% (11) 100.0% (4)	
	T = 18		21.4% (3)	83.6% (15)	
2. VIOLENT FELONIES	U = 142 R = 142	2.1% (3) 1.4 (2)	4.2% (6) 4.9% (7)	65.5% (93) 80.1% (113)	28.2% (40) 13.6% (20)
	T = 284	1.8% (5)	4.6% (13)	72.5% (206)	21.1% (60)
3. PROPERTY OFFENSES	U = 195 R = 151	2.6% (5) 2.6% (4)	2.6% (5) 5.3% (8)	46.25 (90) 55.6% (84)	48.6% (95) 36.55 (55)
	T = 346	2.6% (9)	3.8% (13)	50.3% (174)	43.3% (150)
4. FRAUD OFFENSES	U = 24 R = 16		12.5% (3)	12.5% (3) 6.3% (1)	75.0% (6) 93.7% (15)
	T = 40		12.5% (3)	10.0% (4)	52.5% (21)
5. "OTHER" OFFENSES	U = 9 R = 13	11.1% (1)	15.4% (2)	22.2% (2) 46.2% (6)	33.3% (6) 38.4% (5)
	T = 22	11.1% (1)	15.4% (2)	36.4% (8)	50.0% (11)
TOTAL	U = 384 R = 326	2.3% (9) 1.8% (6)	4.4% (17) 5.2% (17)	51.8% (199) 63.8% (208)	38.3% (147) 29.1% (95)
	T = 710	2.1% (15)	4.8% (34)	57.3% (407)	34.1% (242)

U = Urban, R = Rural, T = Total

Alcohol-Related Mortality

Three causes of death are generally regarded as being "directly alcohol-related"; these causes of death are alcoholism, cirrhosis of the liver, and alcoholic psychosis. Alaska data for alcoholism and cirrhosis of the liver will be analyzed in this section.

In 1979 and 1980, both cirrhosis of the liver and alcoholism were included in the ten leading causes of death for Alaska. See Table 24.

Table 24. Deaths Attributable to Cirrhosis of the Liver and Alcoholism, Compared with Other Leading Causes of Death, Alaska, 1979-80.

CAUSE OF DEATH	NO. OF DEATHS		% OF TOTAL		RANK ORDER	
	1979	1980	1979	1980	1979	1980
Accidents	377	348	23.5	20.6	1	2
Heart Disease & Hypertension	338	389	21.1	23.1	2	1
Malignant Neoplasms	272	293	16.9	17.3	3	3
Suicide	53	72	3.3	4.3	6	4
Cerebrovascular Disease	74	64	4.6	3.8	4	7
Diseases of Early Infancy	70	67	4.4	4.0	5	5
CIRRHOSIS OF THE LIVER	42	36	2.6	2.1	8	8
Homicide	48	33	2.9	2.0	7	9
Congenital Abnormalities	30	67	1.9	4.0	9	5
ALCOHOLISM	13	16	.1	.9	10	10
All Other Causes	287	138	17.9	8.1	--	--
TOTAL ALL CAUSES	1,604	1,689	100.0	100.0	--	--

One hundred percent of alcoholism deaths are attributable to excessive alcohol consumption. With respect to cirrhosis of the liver deaths, it has been estimated that approximately 41 to 95 percent of all these deaths are due to excessive alcohol consumption.

NOTE: ICD-9 codes for alcoholism not frequently recorded when appropriate due to family or social pressures and transitory nature of the population.

About 23 percent of all alcoholism deaths in Alaska occurred in the 15 to 44 year old age group during the years 1977, 1978, 1979. See Table 25.

Table 25. Alcoholism Deaths, by Age Group, Number and Percent Distribution, Alaska 1977, 1978, 1979.

AGE GROUP	1977		1978		1979	
	NO.	%	NO.	%	NO.	%
Under 14	0	---	0	---	0	---
15 - 24	0	---	1	5.8	0	---
25 - 34	3	9.7	1	5.8	1	7.6
35 - 44	6	19.4	6	35.6	2	15.4
45 - 54	6	19.4	5	29.4	5	38.5
55 - 64	7	22.6	2	11.7	4	30.8
65+	9	29.0	2	11.7	1	7.6
TOTAL	31	100.0	17	100.0	13	100.0

When alcoholism deaths are analyzed according to the race of the decedent, it appears that Caucasians are underrepresented compared to their representation in the general population, and underrepresented, too, in terms of their share of total resident deaths. See Table 26.

Table 26. Alcoholism Deaths, by Race/Ethnicity, Number and Percent Distribution, Alaska, 1977, 1978, 1979

RACE/ETHNICITY	1977		1978		1979	
	NO.	%	NO.	%	NO.	%
White	12	38.7	7	41.1	4	30.7
Alaska Native and Alaska Indian:	13	41.9	10	58.9	6	46.0
Eskimo	5	16.1	4	23.5	2	15.3
Aleut	1	3.2	1	5.8	2	15.3
Alaska Indian	7	22.6	5	29.6	2	15.3
Other:	6	19.4	0	---	3	23.0
American Indian	4	12.9	0	---	2	15.3
Black	2	6.5	0	---	1	7.7
Other Minorities	0	---	0	---	0	---
TOTAL	31	100.0	17	100.0	13	100.0

Table 27. Total Resident Deaths, by Race/Ethnicity of the Decedent, Alaska, 1977, 1979.

RACE/ETHNICITY	1 9 7 7		1 9 7 8		1 9 7 9	
	ABSOLUTE FREQUENCY	RELATIVE FREQUENCY	ABSOLUTE FREQUENCY	RELATIVE FREQUENCY	ABSOLUTE FREQUENCY	RELATIVE FREQUENCY
White	1,090	67.9	1,186	69.8	1,074	67.0
Eskimo	197	12.3	230	13.5	244	15.2
Aleut	50	3.1	48	2.8	53	3.3
Alaska Indian	148	9.2	135	8.0	159	9.9
Amer. Indian	52	3.2	14	.8	4	0.2
Black	50	3.1	46	2.6	31	1.9
Chinese	1	0.1	1	.1	0	---
Japanese	1	0.1	7	.4	6	0.4
Filipino	9	0.6	9	.5	4	0.2
Other	5	0.3	6	.4	6	0.4
Not Stated	3	0.2	4	.2	9	0.6
TOTAL	1,606	100.0	1,686	99.1	1,590	100.0

NOTE: It should always be remembered that reporting of causes of death on death certificates can be inaccurate in the sense that there may be a reluctance to report certain causes of death on the certificates which have other legal uses different from, and in addition to, their vital statistics function. Alcoholism may be considered as one of the causes of death which may not be reported in all cases with 100 percent accuracy.

Cirrhosis of the Liver Mortality

The liver is the organ most significantly involved with processing alcohol in the body, and, therefore, is often most seriously damaged by heavy drinking and alcohol abuse. Alaska's death rate from cirrhosis of the liver is lower than that of the United States. This lower rate is, in part, a function of the younger age of the Alaska population, which means lower death rates for chronic illnesses, including cirrhosis of the liver. Nevertheless, cirrhosis of the liver was the eighth leading cause of death in Alaska in 1977 and 1979.

Cirrhosis of the liver deaths are concentrated most heavily in the 35-64 year old age group. See Table 28.

Table 28. Cirrhosis of the Liver Deaths, by Age Group, Number and Percent Distribution, Alaska, 1977, 1978, 1979, 1980, 1981

AGE GROUP	1 9 7 7		1 9 7 8		1 9 7 9		1 9 8 0		1 9 8 1	
	NO.	%	NO.	%	NO.	%	NO.	%	NO.	%
14 and Under	0	---	1	2.5	0	---	0	---	0	---
15 - 24	0	---	0	0	1	2.4	0	---	0	---
25 - 34	2	5.4	3	7.6	7	16.6	3	8.3	5	13.2
35 - 44	7	18.9	11	28.2	9	21.4	7	19.4	7	18.4
45 - 54	16	43.2	9	23.1	5	11.9	15	41.6	10	26.3
55 - 64	11	29.7	13	33.3	2	28.6	8	22.2	7	18.4
65+	1	2.7	2	5.1	8	19.0	3	8.3	9	23.7
TOTAL	37	100.0	39	100.0	42	100.0	36	100.0	38	100.0

As in alcoholism deaths, members of the Caucasian group appear to be slightly underrepresented in cirrhosis of the liver deaths, as compared to their representation in the general population of the state, and in comparison to their share of total resident deaths. See Table 29.

Table 29. Cirrhosis of the Liver Deaths, by Race/Ethnicity, Number and Percent Distribution, Alaska, 1978-1980.

RACE/ETHNICITY	1978		1979		1980	
	NO.	%	NO.	%	NO.	%
White	25	65.0	26	62.0	22	61.0
Alaska Native & Alaska Indian	1	2.5	NR	NR	1	3.0
Other	13	32.5	16	38.0	13	36.0
Total	39		42		36	

Non-white women appear to be a population sub-group particularly at risk: liver cirrhosis has been one of the categories of alcohol-related diseases and death in which these women are dying approximately the same numbers as men. For 1978-1980 data, see Table 30.

Table 30. Deaths Attributable to Cirrhosis of the Liver, by Sex, Alaska 1978-1980.

YEAR	RACE	MALE	FEMALE
1980	White	16	6
	All Other	8	6
	TOTAL	24	12
1979	White	18	8
	All Other	4	12
	TOTAL	22	20
1978	White	18	8
	All Other	8	6
	TOTAL	26	14

Table 30 shows that it is non-white women who are causing the high mortality figures for members of the female sex; furthermore, in absolute numbers, it appears that there were more non-white women than non-white men dying of cirrhosis of the liver during these years.

Other Alcohol-Related Mortality

Many other deaths may be directly or indirectly due to excessive alcohol use. These deaths include suicides, homicides, accidents of all sorts, and other acute and chronic diseases, for example, cardiovascular and gastrointestinal disease, and cancer.

The proportion of these deaths which can be attributed to alcohol use has not been determined for all categories of death, but an effort has been made to discover the involvement of alcohol in several of the categories of accidental death, for the years 1977-1981. The categories of accidental death which have been selected for study are 1) exposure to environmental factors -- deaths from excessive cold, and 2) fire deaths.

Exposure to Environmental Factors: Deaths from Alcohol and Excessive Cold

Alaska is famous for the extremely cold climate in its northern regions. Unfortunately, alcohol in combination with this excessive cold is taking its toll in terms of human life. See Table 31.

Table 31. Accidental Deaths Due to Natural and Environmental Factors and Deaths Due to Excessive Cold, and Alcohol-Related Excessive Cold Deaths, Alaska, 1977, 1978, 1979, 1980.

	1977	1978	1979	1980
Total Deaths Due to Natural and Environmental Factors	16	14	18	14
Total Deaths Due to Excessive Cold	12	8	17	8
Number of Alcohol-Related Excessive Cold Deaths, Natural and Environmental Factor	14	6	8	4

NOTES: NATURAL AND ENVIRONMENTAL FACTORS = excessive cold, exposure, hunger, animal bites, etc.

EXCESSIVE COLD = includes exhaustion, exposure to cold, freezing, and frostbite.

Accidental Death: Fire Fatalities and Alcohol

Nationally, it is believed that a considerable portion of the loss of life caused by fires may be attributed to the misuse of alcohol. It is alcohol's impairment of sensory, judgmental, and physical functions, and its resultant negligent conduct, that causes it to be a major cause of fire deaths. Furthermore, the failure of alcohol-impaired parents, and other adults, in the home, to be able to perceive, and respond to, a fire emergency, or the failure of parents/other adults, when drinking outside the home in which there are children, to leave children attended by an adult, or some other responsible persons, are considered as alcohol-related fire fatalities.

For Alaska, the State Fire Marshal's best current estimate of alcohol-involvement in Alaska fire fatalities is that approximately 85 percent of all fire fatalities during a prior three-year period (unspecified years) were alcohol related.

Turning to the three years of specific data available from the Fire Marshal's office, it appears that alcohol was involved in 46 percent of all fire fatalities in 1979, in 48 percent of all fire fatalities in 1979, and in 48 percent in 1981. See Table 32.

Table 32. Total Number of Deaths by Fire, and Number of Deaths by Fire Which Were Alcohol-Related, Alaska, 1979-1981.

YEAR	TOTAL NUMBER OF DEATHS BY FIRE	ALCOHOL-RELATED DEATHS BY FIRE
1979	26	12
1980	23	11
1981	27	13

Alaska's fire fatality rate, per 1,000,000 population is the highest in the nation, and, is triple the United States rate. See Table 33.

Table 33. Fire Fatalities per 1,000,000 Population, Alaska and United States, 1981.

Area	FIRE FATALITIES PER MILLION POPULATION
Alaska	65.85
United States	19

It is entirely possible that Alaska's extremely high estimated alcohol-involvement in fire fatalities, i.e., approximately 50 percent of all fire fatalities on the average annually, for the past two years, is partially, or entirely, the reason for the excessive fire fatality rate, per 1,000,000 population, as compared to the United States rate.

Direct Social Response to Alcohol and Drug Problems: Alcohol and Drug Treatment Programs.

Approximately 13004 admissions were submitted by thirty-five alcohol and drug programs to the Office of Alcoholism and Drug Abuse during the one year period from October 1, 1982 to September 30, 1983. These records represent 9681 unduplicated clients. Many of the duplicated client intakes are for detoxification and emergency services. The provision of these services are mandated by the statutes establishing the State Office of Alcohol and Drug Abuse and by their nature will result in a high number of duplicated services. When the data are examined on the Health Systems agency level, there appeared to be a slightly disproportionate distribution of client admissions across the State. It appeared that Southeast is over-represented, that Southcentral is under-represented, and that parity exists in Northern Alaska.

See Table 34 for distribution of population by region compared to client admissions by region.

Table 34. Statewide Populations by Regions and Total Admissions by Region Compared to Client Admissions by Region. 1982-1983.

	Population		Admissions	
		%		%
Southeast	59201	12.8	2224	17.1
Southcentral	318477	69.1	8272	63.6
Northern	83159	18.1	2508	19.3
TOTAL	460837	100	13004	100

About 74% of all admissions were males, and about 2.6% were females. This 2.8 to 1 ratio of males to females was consistent throughout the State. By comparison, the composition of the total State resident population, was 54% male and 4.6% female. See Table 35.

Table 35. Total Clients by Sex.

	Male		Female	
		%		%
1. Statewide	9597	74%	3414	26%
2. Southeast	1644	74%	589	26%
3. Southcentral	6093	73%	2155	27%
4. Northern	1860	74%	670	26%

Approximately 51% of the client population was composed of Alaska Natives (Eskimo, Aleut, Tlingit, Haida, Athabaskan, and American Indians) about 44% of the clients were White and 1% were Black. These percentages reflect client population composition on a Statewide basis, there was considerable variation in the racial/ethnic composition of the clientele on a regional basis. This corresponds to the distribution of the various racial/ethnic groups across the State. See Table 36.

Table 36. Total Admissions by Race/Ethnicity.

	Caucasian		Alaska Indian		Eskimo		Black		Other		Total
1. Statewide	5711	44%	2914	22%	3812	29%	180	1%	387	4%	13004
2. Southeast	1089	49%	1004	45%	26	1%	9	4%	96	4%	2224
3. Southcentral	3682	45%	991	12%	3215	40%	147	2%	237	3%	8272
4. Northern	940	38%	919	37%	571	23%	24	1%	54	2%	2508

It appears from this data that Alaska Natives are significantly over-represented (51%) in the client population of alcoholism and drug treatment relative to their representation (18%) in the State's total resident population.

During this period 72% of the clients were between the ages of 18 to 40, whereas only 43% of the State's resident population falls into this age classification. About 3% of the client population was aged 61 years and older, while at the other end of the age scale 4% of the client population was in the 17 years and younger age group. See Table 37.

Table 37. Total Clients by Age.

	17 & Under		18-25		26-40		41-60		61+	
1. Statewide	508	4%	3459	27%	5798	45%	2642	20%	385	3%
2. Southeast	113	5%	691	31%	921	41%	410	18%	52	2%
3. Southcentral	331	4%	2180	269%	3686	45%	1636	20%	240	3%
4. Northern	64	3%	588	23%	1191	48%	596	24%	93	4%

On the basis of 12438 admission records, approximately 44% of them were recorded as readmissions to alcohol and drug programs. This readmission rate indicates that a number of clients were admitted to treatment more than once. This high readmission rate is greatly affected by detoxification components of programs, and is less typical of other components.

Table 38. Total Admissions by New Client and Client Readmission

	New Client Admissions		Client Readmissions		Total	
1. Statewide	6996	56%	5442	44%	12438	100%
2. Southeast	1193	56%	882	44%	2075	100%
3. Southcentral	4564	58%	3380	42%	7944	100%
4. Northern	1239	50%	1240	50%	2480	100%

There were also 12438 clients for whom level of educational attainment was reported, 40% had a high school education, or an equivalency degree, i.e., G.E.D. Another 48% had not attained the level of a high school education, while approximately 12% had had some college, or had received a college degree. The educational levels for clients was consistent for the regions as shown in Table 39.

Table 39. Percent of admissions and terminations by years of education and occupation. Statewide and Regionally.

Education Years	Statewide Percent	Southeast Percent	Southcentral Percent	Northern Percent
9 or Less	17%	11%	18%	20%
10-11	31%	34%	31%	31%
12	28%	27%	25%	28%
13-14	8%	9%	9%	7%
15-16	3%	4%	3%	2%
17+	1%	1%	1%	1%
GED	12%	15%	13%	11%

The majority of clients for whom present occupation was reported (N=12438) stated that they were "blue collar" workers, that is, by occupation, they were employed in crafts, labor, fishing, logging and farming. See Table 40.

Table 40. Clients by Occupation.

Occupation	Statewide	Southeast	Southcentral	Northern
Technical/Professional	12%	9%	8%	9%
Sales	2%	2%	2%	2%
Craftsman/Clerical	19%	17%	12%	15%
Transport/Operators	6%	5%	3%	7%
Laborers	23%	18%	14%	28%
Fishing/Logging/Farming	13%	19%	9%	1%
Services	12%	11%	8%	11%
Substance	2%	1%	1%	4%
Student	5%	4%	3%	4%
Military	1%	1%	1%	1%
Homemaker	4%	5%	4%	3%

Based upon 12,883 admissions for which legal status was determined at admission it appears that approximately 38% of admissions are as the result of involvement with the Alaska legal system. Further 34% of those admitted had been or were incarcerated immediately prior to treatment. See Table 41.

Table 41. Admissions by Legal Status Statewide.

NO Involvement	Deferred Prosecution	Sentance Deferred	Probation Parole	Furlough Rehab./Leave
4,635 36%	333 3%	503 4%	3,448 27%	98 1%

Involuntary Committment	Incarcerated	Status Unknown	Total
131 1%	321 2%	3,414 26%	12,883 100%

Of the 12711 admissions for which primary problem and severity of problem were determined, alcohol was clearly identified as the leading primary problem in 94% of admissions. The only other substances to exceed 1% of the admissions were cocaine, marijuana/Hashish each accounting for 2%. In only 11% of the admissions was the severity identified as non-dependent. The severity was rated as dependent in 37% and as episodic in 37% of admissions.

Table 42. Statewide Admissions by Primary Problem. (N= 12711)

Substance	Number	%	Substance	No.	%	Substance	No.	%
Alcohol	11886	94%	Barbituates	8	=	Amphetamines	11	=
Heroin	99	1%	Tranquilizers	11	=	Cocaine	234	2%
Methadone	1	=	Sedatives/Hypnotics	8	=	Marijuana/Hashish	265	2%
Other Opiates	109	1%	Inhalents	3	=	Hallucinogens	6	=
PCP	0	=	Over the Counter	4	=	Poly Drug	59	=

= Less than 1 percent

Table 43. Severity of Problems.

	Non Dependent	Dependent	Episodic	Psyfunctional	Unknown
Number	1358	4716	4736	798	1170
%	11	37	37	6	9

Indirect Social Response to Alcohol Problems: Mental Health Community

Mental Health Centers

Community Mental Health Centers (CMHCs) are state-operated mental health centers which serve Alaska's population on an outpatient basis at the community level. Community services include diagnosis, rehabilitation, prevention and education.

In FY 1981, there were 4,089 admissions to CMHCs and in 1982 there were 5,033. According to the Division of Mental Health and Developmental Disabilities, increased utilization of alternative resources in the community, including community alcoholism treatment programs, is reflected in the current leveling-off trend in CMHC admissions.

Upon admission, the mental health professional involved a patient's case reports the principal reason why the patient is seeking the services of the CMHC. The following table indicates the relative importance of "alcohol abuse" as a factor contributing to CMHC admissions. It appears from these data that "alcohol abuse" is the third leading factor contributing to all CMHC admissions in Alaska. See Table 44.

Table 44. Presenting Problem at Admission, Community Mental Health Centers, Alaska, FY 81 and FY 82.

PRESENTING PROBLEM	CMHC ADMISSIONS FY 81		CMCH ADMISSIONS FY 82	
	NUMBER	% OF TOTAL	NUMBER	% OF TOTAL
Life Crisis	2,852	74.5	3,582	71.1
Mental Illness	610	15.9	531	10.5
Alcohol Abuse	246	6.4	324	6.4
Mental Retardation	32	0.8	40	0.7
Drug Abuse	32	0.8	34	0.6
Not Stated	317	8.0	522	8.3
TOTAL	4,089	100.0	5,033	100.0

NOTES: (1) Each category of presenting problem is defined by the American Psychiatric Association (APA) Diagnostic Codes. (2) "Mental Illness" should be viewed as a specific mental disorder, while "life crisis" is a reaction to a given situation which does not necessarily have psychiatric implications.

In addition to "presenting problem" specification, a provisional diagnosis, according to APA Diagnostic Codes, is made for each patient at admission. "Alcohol disorders" constituted 6.4 percent of all such provisional diagnoses in FY 1981. "Alcohol disorder" diagnoses were assigned to 14 percent male admissions, and to 4 percent of female admissions in FY 1981 and to 14.6 percent of males and 6.3 percent of females in 1982. The numbers of individuals admitted to CMHCs, by race and sex, with a provisional diagnosis of "alcohol disorder" is set forth in the following table. See Table 45.

Table 45. Provisional Diagnosis of Alcohol Disorder, by Race and Sex, Community Mental Health Centers, Alaska, 1981-82.

RACE/ETHNICITY	1981			1982		
	TOTAL ADM.	ALCOHOL DISORDER		TOTAL ADM.	ALCOHOL DISORDER	
		NUMBER	PERCENT		NUMBER	PERCENT
MALE						
Caucasian	1,102	92	9.0	1,133	126	11.1
Indian, Eskimo, Aleut	263	101	39.0	256	79	37.1
Black	29	0	0	29	2	6.9
Other	16	0	0	31	6	19.4
TOTAL	1,410	198	14.0	1,449	213	14.6
FEMALE						
Caucasian	1,579	38	3.0	1,481	68	4.6
Indian, Eskimo, Aleut	226	39	18.0	285	48	16.8
Black	41	0	0	38	0	0
Other	27	0	0	55	2	3.6
TOTAL	1,873	77	4.1	1,859	118	6.3

NOTE: "Alcohol Disorder" diagnoses as percentage of all admission diagnoses, for each racial/ethnic group, and for total admissions, by sex.

More male than female admissions to CMHCs fell into the "alcohol disorder" diagnostic category. Members of the Alaska Native, i.e., Eskimos, Aleuts, and Alaska Indian, groups were admitted to CMHCs with the provisional diagnosis "alcohol disorder" more frequently, on a more proportionate basis, than were Caucasians, and this was true for both sexes.

Bush/Non-Bush CMHCs

When CMHCs are classified as "bush" or "non-bush" programs, differences appear as between the two types of programs with respect to "alcohol abuse" as a presenting problem, and "alcohol disorder" as a discharge diagnosis. ("Bush", in Alaska, means the vast area outside of cities which encompasses most of the State.)

"Bush" programs include the following CMHCs: Kotzebue, McGrath, Tanana Chiefs (serving Fort Yukon, Bettles, and Galena), Bethel, Dillingham, and Nome. "Non-bush" programs include CMHCs in Juneau, Ketchikan, Sitka, Fairbanks, Anchorage, Copper Center, Cordova, Homer, Kenai, Kodiak and Seward.

"Drug disorders" constituted .8 percent of all provisional diagnosis for FY 1981 and .6 percent in 1982. Drug disorder diagnosis were assigned to 1.7% of males and .7% of females in FY 1981 and to 2.9% of males in FY 1982. This is illustrated in Table 45A.

Table 45A. Provisional Diagnosis of Drug Disorder
by Race and Sex, CMHC, FY 80-82.

Race/Ethnicity	Total Adm.	1980		Total Adm.	1981	
		Drug Disorder Number	%		Drug Disorder Number	%
Male						
Caucasian	1102	18	1.6	1133	35	3.1
Indian, Eskimo	263	6	2.3	256	6	2.3
Aleut						
Black	29	0	0	29	1	3.4
Other	16	0	0	31	0	0
Total	1410	24	1.7	1431	42	2.9
Female						
Caucasian	1379	11	.7	1481	19	1.3
Indian, Eskimo	226	1	.4	285	6	2.1
Aleut						
Black	41	1	2.4	38	1	2.6
Other	27	0	0	55	0	0
Total	1873	13	.7	1859	26	1.4

More male than female admissions to CHMCS fell into the "drug disorder" diagnostic category. Members of the male group were admitted at a higher rate as were blacks.

State Mental Hospital and Community Mental Health Center Data

A state's mental hospital(s), and community mental health centers, as well as its drug treatment programs, deal directly with drug users by providing specific treatment for drug addiction and/or supportive medical services for drug-associated physical illnesses.

The Alaska Psychiatric Institute (API), the State's one public mental hospital, is a state mental inpatient facility in Anchorage that provides services not available on a community level, i.e., not available at local Community Mental Health Centers. The Alaska Psychiatric Institute, which has a statewide catchment area, provides inpatient care to persons who are mentally ill, who are a danger to themselves, or who require 24-hour intensive psychiatric treatment.

An individual's condition is diagnosed by a mental health professional following admission to API. Admission data for API supplied by the Alaska Division of Mental Health and Developmental Disabilities indicate that twenty-nine (29), or 2.6 percent, of the 1087 people admitted to API in FY 82 (July 1, 1981 to June 30, 1982) were given a provisional diagnosis of drug abuse. There were 131 admissions for alcohol abuse, or 12.1 percent of total admissions.

Analysis of these data is limited, in the Division's statistical output, to sex and race variables; these drug abuse diagnoses are not classified by drug type, or by age group. Of these admissions for drug abuse, 16 (66 percent) were male, and 13 (44 percent) were female. Caucasian males constituted by far the largest proportion of drug abuse provisional diagnoses. Caucasian females were the next largest group.

Of the admissions for alcohol abuse, 93 (or 71 percent) were male and 38 (29 percent) were female. Caucasian and Native males were the group most highly represented. See Table 48.

Table 48. API Provisional Diagnosis of Alcohol/Drug Abuse by Sex and Race, FY 1982.

Race			Total		% of API Admits			Total		% of API Admits
	Male	Female	No.	%		Male	Female	No.	%	
Caucasian	9	7	16	55	1.4	66	20	86	63	7.9
Alaska Native	5	4	9	31	.8	23	18	51	36	4.7
Black	2	0	2	7	.1	3	0	3	.2	---
Other	0	2	2	7	.1	1	0	1	.1	---
Total	16	13	29	100	2.8	93	38	111	100	12.9

Criminal Justice - Drug Arrests

Narcotic arrests increased in absolute numbers and increased as a proportion of total arrests between 1977 and 1982. As a percentage of total arrests, narcotics arrests increased 28 percent between the periods 1977 and 1982. In 1977-79, narcotics arrests accounted for 11.6 percent of all drug arrests, while in 1981-82 this category constituted 25 percent of total drug arrests.

Table 49. Narcotics Arrests 1977-1982.

OFFENSE	1977	1978	1979	1980	1981	1982
Possession	60	56	47	30	66	129
Sale	47	35	56	30	45	209
TOTAL	107	91	103	60	111	338
Total Drug Arrests	969	884	740	533	669	998
Narcotics as % of Total	11.0	10.3	13.9	11.2	16.5	33.9

NOTE: The drug included in the narcotic category are opium, cocaine, heroin or its derivatives. The recent popularity of cocaine has had a substantial affect on the increase in this category.

The age group accounting for a major proportion of drug arrests is the 18 and under year old age group, 55 percent of all arrests in 1980 involved members of this group, and 57.5 percent of all arrests in 1981 involved members of this age group. See Table 50.

Table 50. All Drug Arrests, By Age Group, 1980 and 1981.

1980	Under 18	18	30-35	36-40	41+	TOTAL
Male	245	166	38	5	9	412
Female	51	19	0	0	0	69
TOTAL	296	185	38	5	9	533
% of Total	68.0	29.0	1.0	1.0	2.0	100.0
<u>1981</u>						
Male	296	192	36	9	9	542
Female	87	33	4	2	1	127
Total	385	225	40	11	10	669
% of Total	57.5%	33.6%	5.9%	1.6%	1.4%	100%

Most persons arrested for narcotics violations were in the 20-29 year old age group; this group had 50 percent of all narcotics arrests in 1980, and 56 percent in 1981. During the period 1980-1981, 6 percent to 3.6 percent of the narcotics arrests involved persons 40 years of age and older. About 19 percent of the narcotics arrests occurred among the youngest age group, those up to the age of 19 years. See Table 51.

Table 51. Narcotics Arrests, By Age Group, 1981.

1980	18 AND UNDER	19-29	30-35	36-40	41+	TOTAL
Male	10	35	17	1	4	67
Female	5	4	2	0	0	11
TOTAL	15	39	19	1	4	78
% of Total	20.0	50.0	25.0	2.0	6.0	100.0

1981						
Male	15	51	17	4	3	90
Female	6	12	2	0	1	21
Total	21	63	19	4	4	111
% of Total	18.9	56.7	17.1	3.6	3.6	100

In 1981, 79 percent of drug arrests involved Caucasians; 12.5 percent of all drug arrests involved "Indians" (Criminal Justice Planning Agency designation); 3.5 percent involved Blacks; and 4.6 percent involved other racial/ethnic groups. In 1980, the proportions were roughly the same: 69 percent Caucasian; 27 percent Indian; 3.2 percent Black; and 0 percent Other Groups. The proportion of arrests attributable to the Caucasian group is comparable to the proportion of Caucasians in the general population, i.e., 78 percent.

Blacks are underrepresented in drug arrests in terms of their representation in the population at large, i.e., 2 to 4 percent of all drug arrests during 1980-81, compared to a little less than 5 percent of the total population.

When drug arrests by race are compared to total arrests by race, some interesting differences appear. In 1980, Whites accounted for 69 percent of the drug arrests, but only 60 percent of total arrests; on the other hand, Indians comprised 36 percent of total arrests, but only 27 percent of drug arrests. Black arrests were 3.5 percent of total arrests and 3.2 percent of drug arrests. There is a similar pattern in the 1981 drug arrest data. See Table 52.

Table 52. Total Arrests, By Race, 1980, 1981.

1980

ARREST CATEGORY	WHITE	INDIAN	BLACK	OTHER	TOTAL
-----------------	-------	--------	-------	-------	-------

Total Arrests

Number	9,693	5,797	579	33	16,102
% (Row)	60.0	36.0	3.5	0.4	100.0

Drug Arrests

Number	373	143	17	0	533
% (Row)	69.0	26.8	3.2	0.0	100.0

1981

Total Arrests

Number	11,376	3,497	790	3,162	18,825
% (Row)	60.4	18.5	4.1	16.7	100

Drug Arrest

Number	530	84	24	31	669
% (Row)	79.3	12.5	3.5	4.6	100

When the data are analyzed in terms of race and age, few noticeable differences appear. However, this examination does show that while Indians constituted only 8.5 percent of total arrests for the 18 years of age and under group, they accounted for 19 percent of total drug arrests in the older than 18 years of age group in 1981. For the other racial/ethnic groups, analysis by age variable showed no significant differences. See Table 53.

Table 53. Total Drug Arrests, by Race and Age, 1980, 1981.

RACE	1980		1981	
	NUMBER	PERCENT	NUMBER	PERCENT
Under 18 Years:				
White	256	87.0	296	84.9
Black	12	4.0	11	3.1
Indian	28	10.0	30	8.5
Other	0	0.0	12	3.4
TOTAL	296	100.0	352	100.0
18 Years Plus:				
White	184	78.0	234	73.1
Black	6	3.0	13	4.0
Indian	47	19.0	54	19.0
Other	0	0.0	19	5.9
TOTAL	237	100.0	320	100.0

DRUG USAGE SURVEY INFORMATION

Community Survey

To obtain information about drug taking in Alaskan communities, a survey of seven cities was conducted by the Center for Alcohol and Addiction studies and sponsored by the State Office of Alcoholism and Drug Abuse. The survey results provide data on the prevalence and extent of drug use as reported by residents in Barrow, Kotzebue, Bethel, Nome, Sitka, Juneau, Fairbanks and Anchorage.

The major purpose of this research was to develop an accurate assessment of current patterns of drug-taking behavior in Alaska. The results of the survey of over 1,000 Alaska residents 18 years of age and older disclose high lifetime prevalence levels for opportunities to try and experience mood altering drugs. Although it is not known whether the sample respondents have used are the "real thing" as opposed to "look alike" or substitute drugs, the important fact is that they think they have tried certain drugs.

Despite the high level of lifetime experiences most of the experiences have been experimental and only a small percentage of the sample take drugs regularly. Marijuana, cocaine and stimulants appear to be the most "popular" drugs as reported by respondents in this survey.

Drug taking behavior was found to be age related in Alaska as the prevalence rates for the 18-25 year age group were approximately double those of the 25+ age group. It was also found that higher proportions of males, overall, have had greater experience with drugs than females. First experiences with drugs vary with the drug being taken and the age of the person trying them. The predominate ages for first experiences ranged from 16 to 20, but first experiences continued well into the mid-to-late 20's and early 30's. The three primary reasons given why people try/take drugs were:

1. to relieve stress and to overcome unwanted feelings and emotions;
2. to enhance social or peer relationships; and
3. to experience the effects which drugs induce.

The following two tables contain summary data for incidence and prevalence.

TABLE I

TOTAL COMMUNITY SAMPLE

LIFETIME EXPERIENCE WITH DRUGS BY AGE GROUP AND GENDER *
(N = 1007)

Drug/Gender	All Ages (N = 1007) Percent Who: Ever Tried	18-25 Years (N = 212) Percent Who: Ever Tried	26+ Years (N = 795) Percent Who: Ever Tried
<u>Marijuana</u>			
Total	57.3	82.5	49.9
Male	58 *	86	58
Female	56	76	41
<u>Cocaine</u>			
Total	23.9	43.4	18.1
Male	28	48	25
Female	19	38	10
<u>hallucinogens</u>			
Total	16.7	26.9	13.6
Male	20	34	19
Female	12	18	8
<u>Stimulants</u>			
Total	27.6	43.9	22.8
Male	29	47	28
Female	25	40	18
<u>Depressants</u>			
Total	12.1	20.8	9.4
Male	14	22	14
Female	10	10	5
<u>heroin</u>			
Total	2.1	0.5	2.5
Male	3	1	4
Female	1	0	1
<u>Other Opiates</u>			
Total	9.0	9.9	8.7
Male	11	12	13
Female	6	8	4
<u>Inhalants</u>			
Total	8.4	16.0	6.2
Male	11	24	9
Female	5	8	3
<u>Tranquilizers</u>			
Total	10.0	12.3	9.4
Male	10	15	10
Female	10	9	3

* Percentages for Male/Female are approximations

TABLE II
TOTAL COMMUNITY SAMPLE
EXPERIENCE WITH DRUGS DURING PAST YEAR, PAST 30 DAYS
(N = 1007)

	<u>% of Sample Using in Last 12 Months</u>	<u>% of Sample Using in Last 12 Months</u>
Marijuana	25.2	15.9
Cocaine	12.9	4.5
halloicinogens	3.8	1.1
Stimulants	6.7	2.1
Depressents	2.7	0.6
heroin	.2	0
Other Opiates	1.1	0.4
Inhalents	1.6	0.3
Tranquilizers	1.9	0.6

School Survey

This data represents the findings from a study conducted by the Center for Alcohol and Addiction Studies of the University of Alaska, Anchorage. The research sponsored by the State Office of Alcoholism and Drug Abuse, surveyed 3,609 students in grades 7-12 in the school districts in eight locations in the state: Anchorage, Barrow, Bethel, Kotzebue, Fairbanks, Juneau, Nome and Sitka. The project was designed to obtain information on the use or nonuse of a broad spectrum of chemical substances.

The major findings of the study can be summarized as follows.

Half the students sampled have reported experiences with one or more illicit mood-altering drugs. A substantial proportion of these experiences involved marijuana. After marijuana, the other drugs experienced reflect the following order of lifetime prevalence: stimulants, cocaine, inhalants, depressants, tranquilizers, hallucinogens and heroin.

The level of lifetime experiences with psychoactive drugs among students is high. The extent to which drugs have been tried/taken among Alaska's students is illustrated vividly when the present findings are compared to results of a national survey of drug use among a sample of 12-17 year olds. Although the ages of the two samples are not exactly comparable, the national data nevertheless provides a "baseline" which helps to achieve a perspective on drug use by Alaska's youth.

Although many students have tried drugs, the majority of such use has been chiefly experimental. Only a small percent of students have taken drugs with any consistency or regularity. Marijuana, however, is the exception, with about 4% of the sample using it once or more a day.

Slightly higher proportions of males than females are involved in taking/trying drugs.

Most students who do not try drugs report that it is because of concern that drugs would "hurt" their minds, and because of fear that drugs would also cause physical harm.

Of those who have tried/taken drugs, the reasons for stopping are also mainly because of concern over psychological and physical harm.

More students who have tried drugs express a need for drug education than those who did not try drugs.

The following tables contain basic prevalence and incidence data from the school survey;

TABLE I
LIFETIME EXPERIENCES WITH PSYCHOACTIVE DRUGS

	Total Sample Alaskan Students Grades 7-12 (N = 3609)	1982 National Survey of 12-17 Year Olds (N = 1581)	Alaskan Jr. high Grades 7-9 (N = 1950)	Alaskan Sr. high Gds. 10-12 (N = 1567)	National Survey of High Sch. Seniors (N = 17500)	Alaskan Males Gds. 7-12 (N = 1770)	Alaskan Females Gds. 7-12 (N = 1732)
Marijuana	49.5	26.7	36.7	65.9	58.7	51.1	48.3
Hallucinogens	8.7	5.2	5.4	13.0	12.5	10.5	8.7
Cocaine	18.3	6.5	10.2	28.7	16.0	19.8	17.0
Heroin	2.2	6.1	1.6	2.9	1.2	3.2	1.2
Inhalents	16.5	no data	14.8	18.5	18.0	17.9	15.1
Stimulants	27.2	6.7	17.6	39.4	27.9	26.3	28.2
Depressants	14.3	5.8	10.6	19.4	15.2	15.4	13.6
Tranquilizers	11.5	4.9	7.7	16.3	14.0	12.4	10.9
Alcohol	71.7	65.2	no data	no data	no data	no data	no data
Tobacco	55.0	49.5	no data	no data	no data	no data	no data

TABLE II
FREQUENCY OF TAKING DRUGS:

Past Year Experiences

Total Schools
Junior h.S./Senior h.S.
(N = 1953) (N = 1567)

Drug	Percent of Jr. h. S. Students Who Have Tried Up to 3 Times a Month	Percent of Jr. h. S. Students Who Have Taken Once a Week or More	Percent of Sr. h. S. Students Who Have Tried Up to 3 Times a Month	Percent of Sr. h. S. Students Who Have Taken Once a Week or More
Marijuana	24.5	11.9	35.9	24.2
hallucinogens	4.5	0.7	9.9	1.4
Cocaine	10.6	1.4	23.1	3.5
heroin	2.0	0.4	2.3	1.1
Inhalents	11.0	2.1	9.9	1.8
Stimulants	13.6	3.5	26.8	8.5
Depressants	8.9	1.8	14.8	2.9
Tranquilizers	6.9	1.4	12.7	2.7

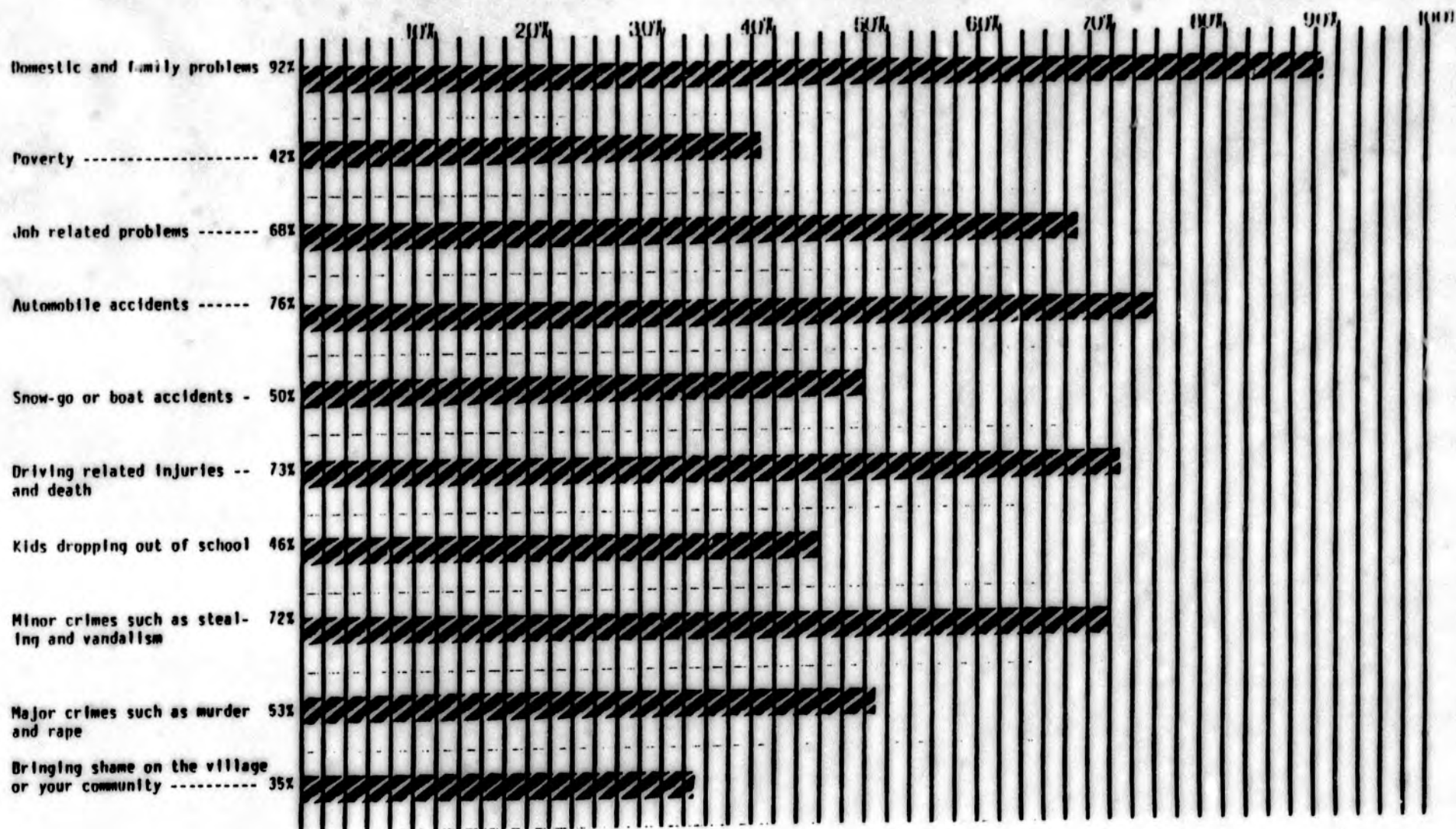
Community Survey

During July and August of 1983, the State Office of Alcoholism and Drug Abuse conducted an objective survey concerning alcohol and drug abuse in Alaska. A compilation of the results is contained in the following pages. Over 4,800 color coded surveys were mailed out to 1) all local officials listed in the municipal league directory, 2) all holders of on and off premise liquor licenses, 3) nurses selected at random from the State Register of Nurses, 4) all members of the Governor's boards and commissions, 5) all members of the Alaska Peace Officer's Association and State Troopers, and 6) all attendees of the Annual Summer School on Addictions.

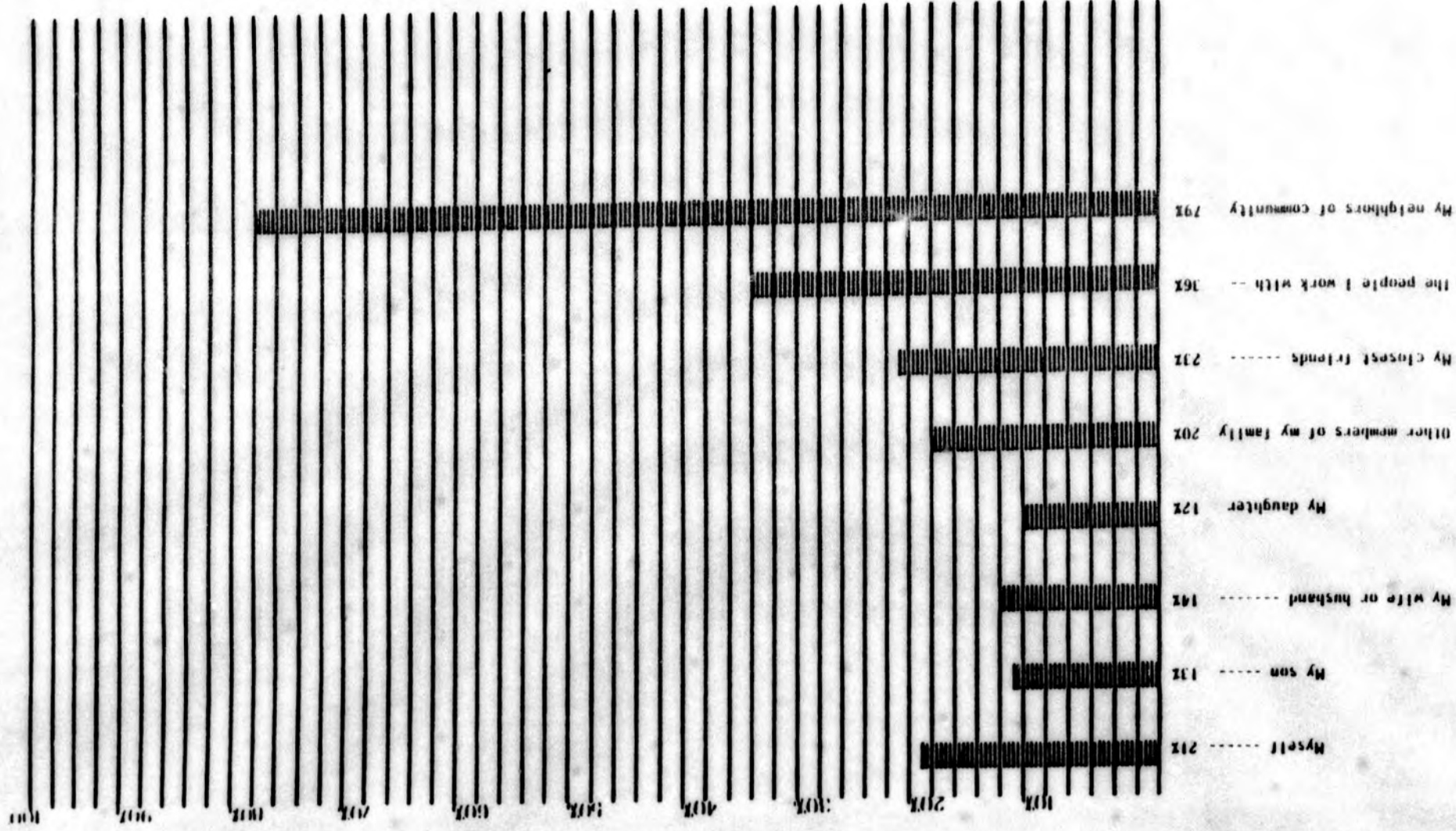
There were 1513 surveys returned (over 31%) that were scored. The results are displayed in graphic form showing the frequency response given by all groups to each question. It should be noted that this information represents the opinion of the respondents at a given point in time. The volume of the responses provides a sufficient basis for utilizing this information as a subjective assessment of the problems and service need.

The respondents were allowed to select as many choices as they thought appropriate for questions 1,2 and 9. They were limited to one choice for questions 3,4, 7 and 10, and to three choices for questions 5 and 6. For question 8 we asked those surveyed to list and rank the five most important human services problems for their community. The responses for all groups have been included to better show the nature of the problem perceptions.

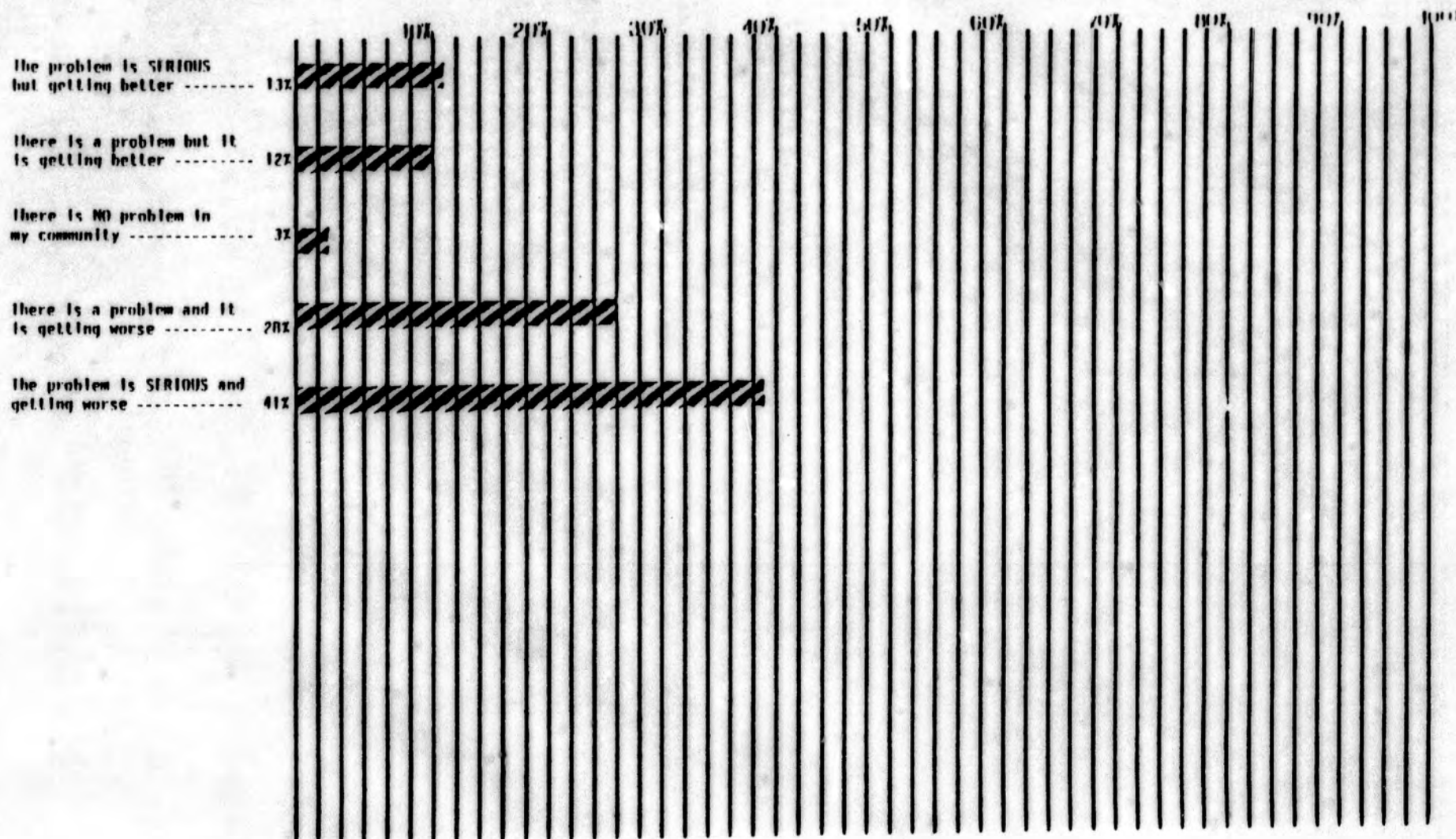
1. What types of problems does alcohol and drug abuse cause in your community?



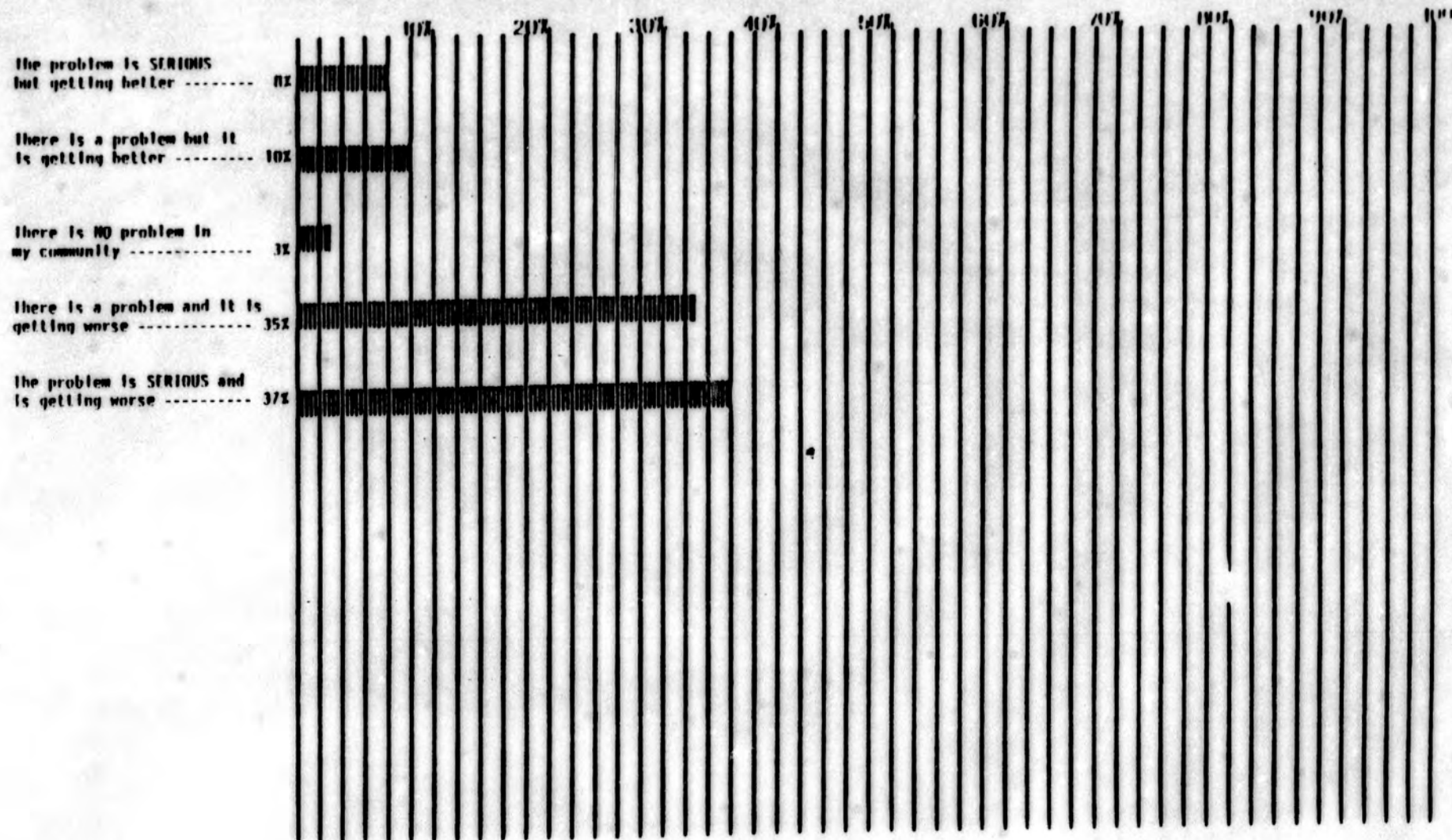
2. Who are most affected by the above problems?



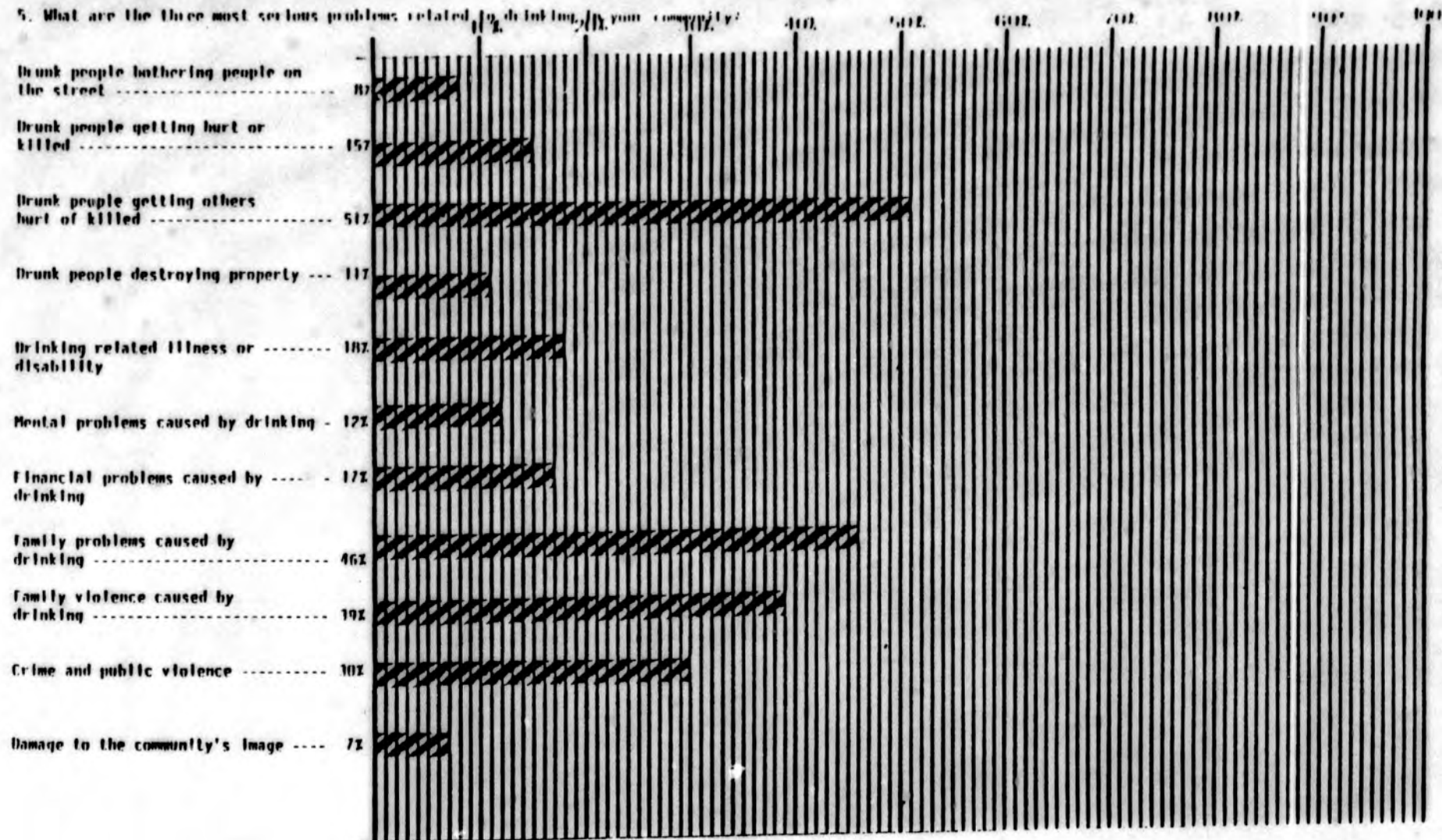
1. Please describe the extent of your community's drinking problem?



4. Please describe the extent of your community's drug abuse problem?



5. What are the three most serious problems related to drinking by your community?



6. What are the three most serious problems related to drug abuse in your community?

Drug users bothering people
on the street 41%

Drug users getting themselves
killed 71%

Drug users getting others
killed 19%

Drug abuse related illness and
disability 9%

Mental problems caused
by drug abuse 30%

Financial problems
caused by drug abuse 33%

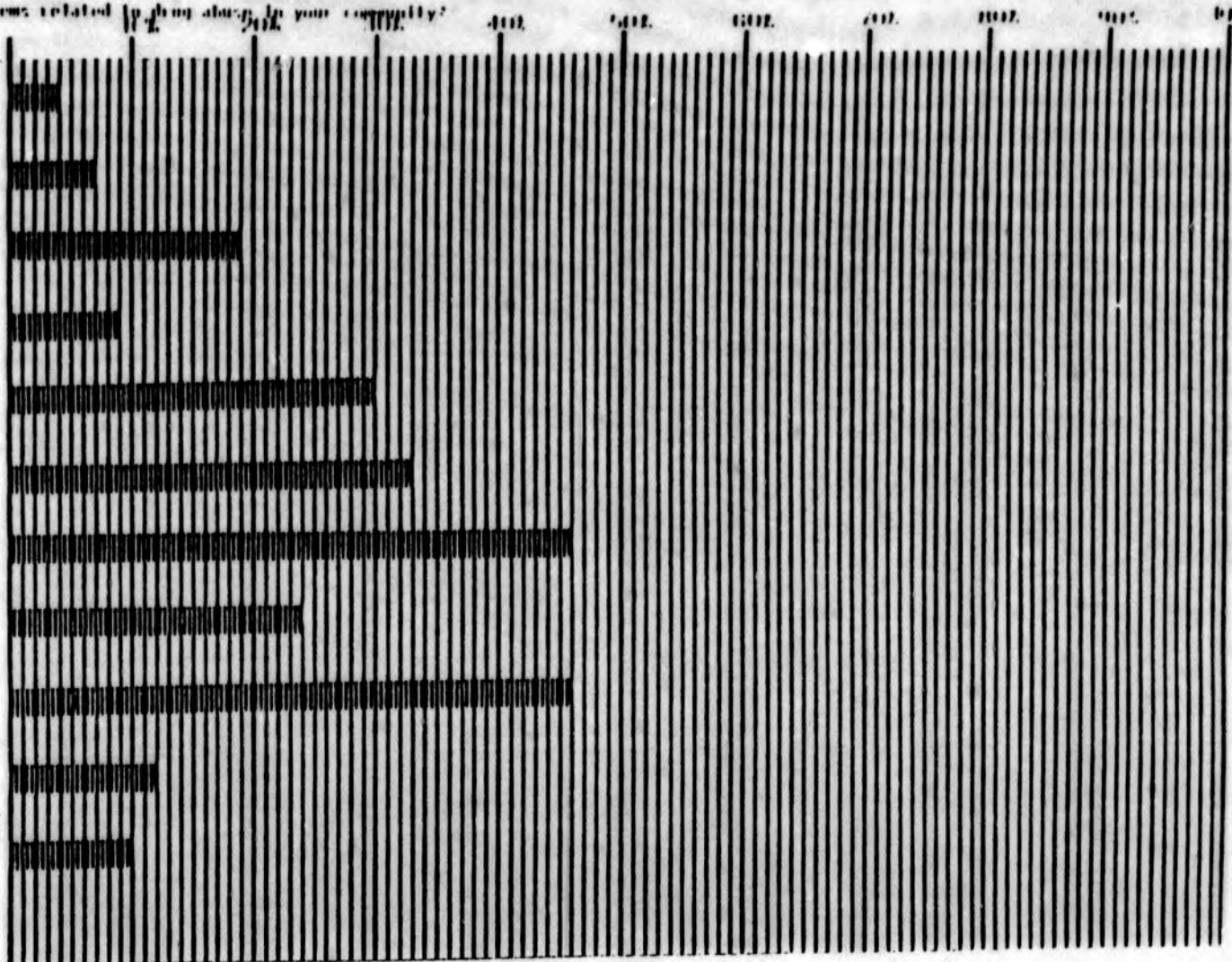
Family problems caused by drug abuse 46%

Family violence caused by
drug abuse 24%

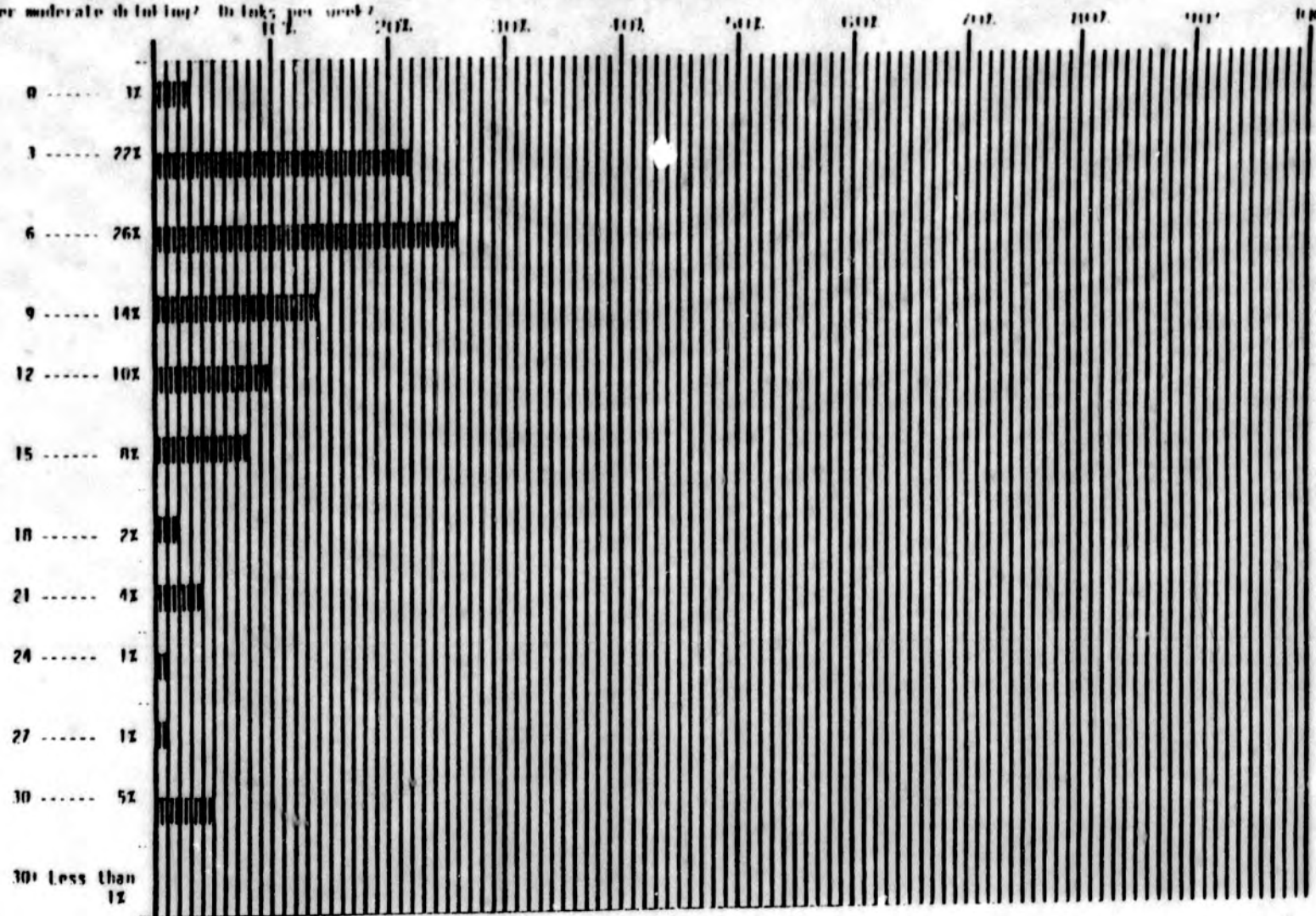
Crime and public violence 46%

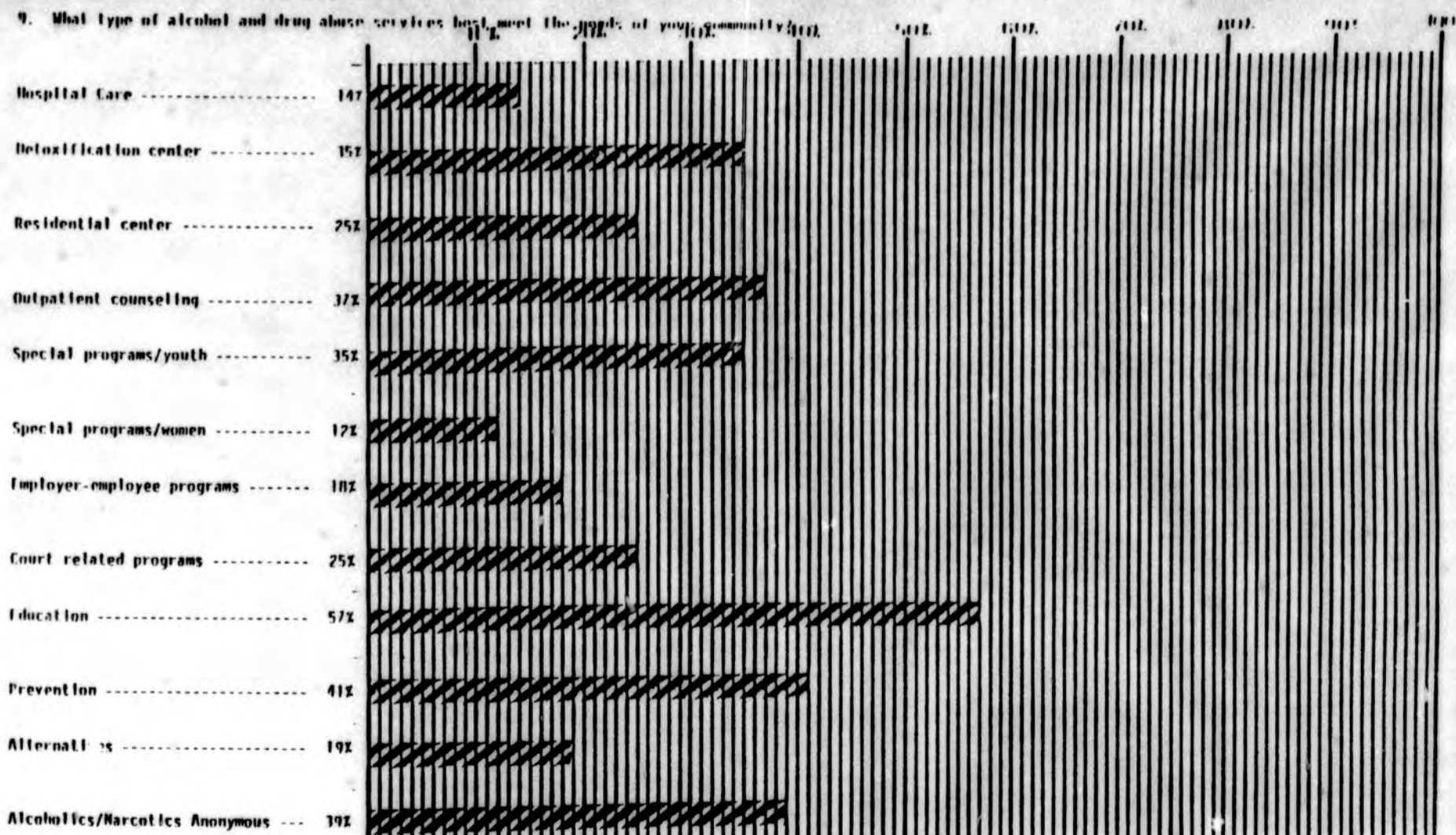
Damage to the community's image 7%

Drug overdose deaths 5%

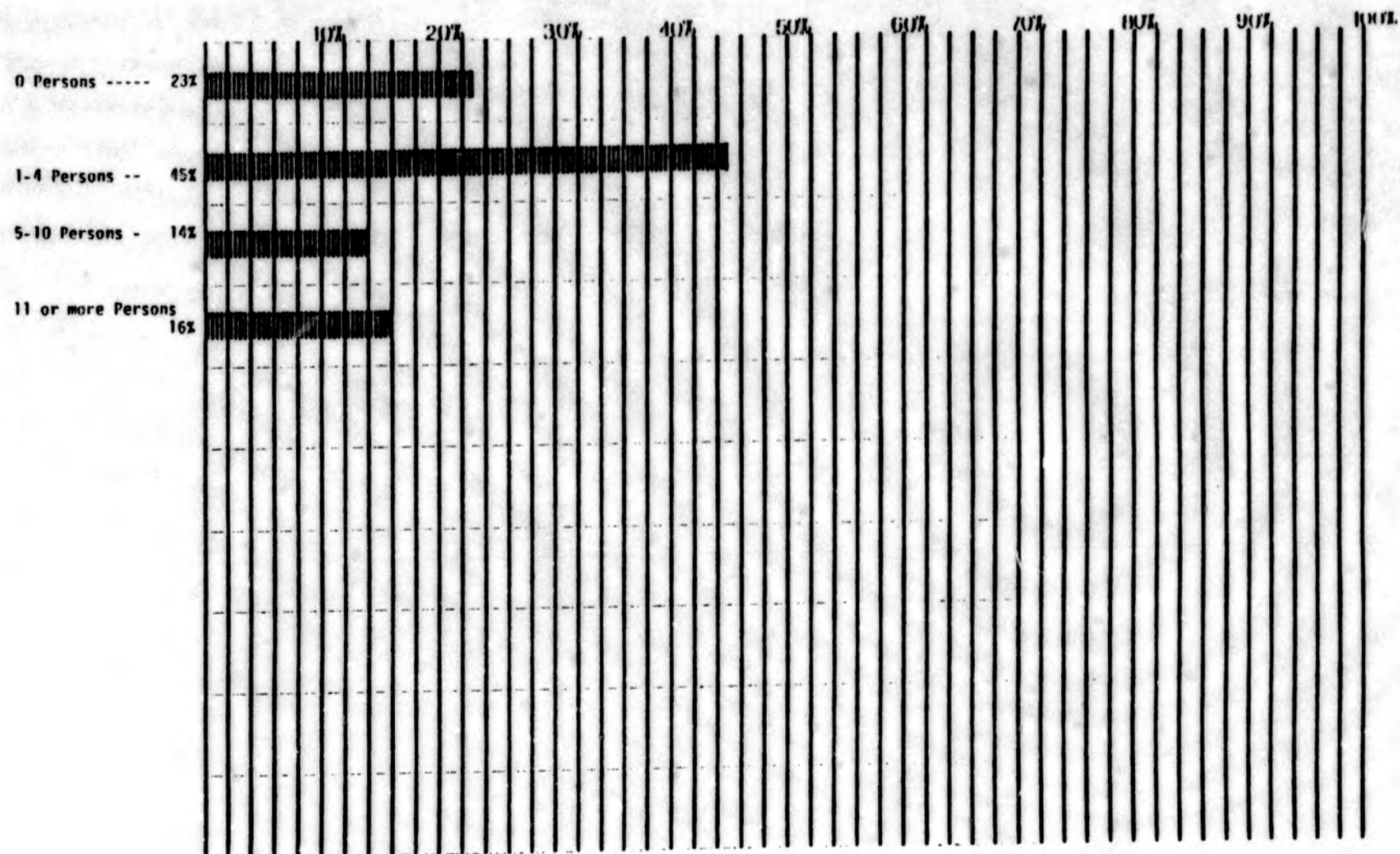


7. What do you consider moderate drinking? Drinks per week?





10. Do you know anyone who has benefitted from alcohol or drug treatment?



APPENDIX - B

ALASKA STATUTE (AS) 47.37

Chapter 37. Uniform Alcoholism and Intoxication Treatment Act.

Section	Section
10. Declaration of policy	170. Treatment and services for intoxicated persons and persons incapacitated by alcohol
20. Office of alcoholism	180. Emergency commitment
30. Powers of office	190. Involuntary commitment of alcoholics
40. Duties of office	200. Hearing on petition for involuntary commitment of alcoholics
50. Interdepartmental coordinating committee	210. Records of alcoholics and intoxicated persons
60. Advisory board on alcoholism	220. Visitation and communication of patients
70. Composition	230. Establishment of emergency service patrol
80. Qualifications of board members	240. Payment for treatment
90. Term of office	250. Nonapplicability
100. Compensation, per diem, or expenses	260. Application of Administrative Procedure Act
110. Duties	270. Definitions
120. Alcoholism program coordinator	
130. Comprehensive program for treatment; regional facilities	
140. Public and private treatment facilities	
150. Acceptance for treatment	
160. Voluntary treatment of alcoholics	

Revisor's note. — In ch. 207, SLA 1972, AS 47.37.070 — 47.37.270 were designated AS 47.37.062 — 47.37.210.

Sec. 47.37.010. Declaration of policy. It is the policy of the state that alcoholics and intoxicated persons should not be criminally prosecuted for their consumption of alcoholic beverages and that they should be afforded a continuum of treatment so they may lead normal lives as productive members of society. (§ 1 ch 207 SLA 1972)

§ 47.37.020 WELFARE, SOCIAL SERVICES AND INSTITUTIONS § 47.37.030

Cross reference. — For other provisions concerning the treatment of alcoholics, see AS 47.30.470 — 47.30.500.

Purpose of the legislature in enacting this chapter. — See Peter v. State, Sup. Ct. Op. No. 1112 (File No. 2185), 531 P.2d 1263 (1975).

The purpose of this chapter is to afford alcoholics and intoxicated persons a continuum of treatment, rather than subject them to criminal prosecution. Abraham v. State, Sup. Ct. Op. No. 1747 (File No. 3407), 585 P.2d 526 (1978).

This chapter establishes a comprehensive program for the treatment of alcoholism as a disease. Peter v. State, Sup. Ct. Op. No. 1112 (File No. 2185), 531 P.2d 1263 (1975).

Public drunkenness should not be made the subject of criminal sanctions. — See Peter v. State, Sup. Ct. Op. No. 1112 (File No. 2185), 531 P.2d 1263 (1975).

This chapter does not make drunkenness a defense to criminal liability for nonalcoholic substantive offenses committed by one under the influence of

liquor. Peter v. State, Sup. Ct. Op. No. 1112 (File No. 2185), 531 P.2d 1263 (1975); Walton v. State, Sup. Ct. Op. No. 1488 (File No. 2736), 568 P.2d 981 (1977).

One addicted to heroin is afflicted with an illness as much as is one addicted to alcohol. Huff v. State, Sup. Ct. Op. No. 1493 (File No. 3201), 568 P.2d 1014 (1977).

This chapter repealed by implication 13 AAC 02.175(c), which prohibits a person from being upon or along a highway while under the influence of an intoxicating liquor. Peter v. State, Sup. Ct. Op. No. 1112 (File No. 2185), 531 P.2d 1263 (1975).

There is an irreconcilable conflict between this chapter, a principal purpose of which is to decriminalize public drunkenness, and 13 AAC 02.175(c), making it a misdemeanor to appear upon or along a highway or street in an intoxicated condition. Peter v. State, Sup. Ct. Op. No. 1112 (File No. 2185), 531 P.2d 1263 (1975).

Quoted in In re S.D., Sup. Ct. Op. No. 1255 (File No. 2530), 549 P.2d 1190 (1976).

Sec. 47.37.020. Office of alcoholism. An office of alcoholism is established in the department. The office shall be headed by a co-ordinator appointed by the commissioner. The coordinator shall be a qualified professional who has training and experience in the organization and administration of treatment services for persons with medical-social problems. The coordinator is in the classified service. (§ 1 ch 207 SLA 1972)

Sec. 47.37.030. Powers of office. The office may

(1) plan, establish, and maintain treatment programs as appropriate;
(2) make contracts and award grants necessary or incidental to the performance of its duties and the execution of its powers, including contracts with and grants to public and private agencies, organizations, and individuals, to pay them for services rendered or furnished to alcoholics or intoxicated persons; to the maximum extent possible, contracts and grants shall be for a period of two years;

(3) solicit and accept for use a gift of money or property or a grant of money, services, or property from the federal government, the state, or a political subdivision of it or a private source, and do all things necessary to cooperate with the federal government or any of its agencies in making an application for a grant;

(4) administer or supervise the administration of the provisions relating to alcoholics and intoxicated persons of any state plan submitted for federal funding under federal health, welfare, or treatment legislation;

(5) coordinate its activities and cooperate with alcoholism programs in this and other states, and make contracts and other joint or cooperative

arrangements with state, local, or private agencies for the treatment of alcoholics and intoxicated persons and for the common advancement of alcoholism programs in this and other states;

(6) keep records and engage in research and the gathering of relevant statistics;

(7) do other acts necessary to implement the authority expressly granted to it;

(8) acquire, hold, or dispose of real property or any interest in it, and construct, lease, or otherwise provide treatment facilities for alcoholics and intoxicated persons; however, the office shall encourage local initiative, involvement and financial participation under grants-in-aid whenever possible in preference to the construction or operation of facilities directly by the office. (§ 1 ch 207 SLA 1972; am § 1 ch 117 SLA 1978)

Effect of amendment. — The 1978 amendment, in paragraph (2), inserted "and award grants" and "and grants to" and added "to the maximum extent possible, contracts and grants shall be for a period of two years" to the end.

Legislative history report. — For report on ch. 117, SLA 1978 (SB 542), see 1978 Senate Journal, p. 761.

Sec. 47.37.040. Duties of office. The office shall

(1) develop, encourage, and foster statewide, regional, and local plans and programs for the prevention of alcoholism and treatment of alcoholics and intoxicated persons in cooperation with public and private agencies, organizations, and individuals, and provide technical assistance and consultation services for these purposes;

(2) coordinate the efforts and enlist the assistance of all public and private agencies, organizations, and individuals interested in prevention of alcoholism and treatment of alcoholics and intoxicated persons;

(3) cooperate with the division of corrections in establishing and conducting programs to provide treatment for alcoholics and intoxicated persons in or on parole from penal institutions;

(4) cooperate with the Department of Education, school boards, schools, police departments, courts, and other public and private agencies, organizations and individuals in establishing programs for the prevention of alcoholism and treatment of alcoholics and intoxicated persons, and preparing curriculum materials for use at all levels of school education;

(5) prepare, publish, evaluate, and disseminate educational material dealing with the nature and effects of alcohol;

(6) develop and implement, as an integral part of treatment programs, an educational program for use in the treatment of alcoholics and intoxicated persons which includes the dissemination of information concerning the nature and effects of alcohol;

(7) organize and foster training programs for all persons engaged in treatment of alcoholics and intoxicated persons and establish standards for training paraprofessional alcoholism workers;

§ 47.37.050 WELFARE, SOCIAL SERVICES AND INSTITUTIONS § 47.37.050

(8) sponsor and encourage research into the causes and nature of alcoholism and treatment of alcoholics and intoxicated persons, and serve as a clearinghouse for information relating to alcoholism;

(9) specify uniform methods for keeping statistical information by public and private agencies, organizations, and individuals, and collect and make available relevant statistical information, including number of persons treated, frequency of admission and readmission, and frequency and duration of treatment;

(10) advise the governor in the preparation of a comprehensive plan for treatment of alcoholics and intoxicated persons;

(11) review all state health, welfare, and treatment plans to be submitted for federal funding, and advise the commissioner on provisions to be included relating to alcoholism and intoxicated persons;

(12) assist in the development of, and cooperate with, alcohol education and treatment programs for employees of state and local governments and businesses and industries in the state;

(13) utilize the support and assistance of interested persons in the community, particularly recovered alcoholics, to encourage alcoholics to voluntarily undergo treatment;

(14) cooperate with the Department of Public Safety and the Department of Highways in establishing and conducting programs designed to deal with the problem of persons operating motor vehicles while intoxicated;

(15) encourage hospitals and other appropriate health facilities to admit without discrimination alcoholics and intoxicated persons and to provide them with adequate and appropriate treatment;

(16) encourage all health and disability insurance programs to include alcoholism as a covered illness;

(17) submit to the legislature an annual report covering the activities of the office;

(18) develop and implement a training program on alcoholism for employees of state and municipal governments, and private institutions;

(19) develop curriculum materials on drug and alcohol abuse for use in grades kindergarten through 12, as well as a course of instruction for teachers to be charged with presenting the curriculum.

(§ 1 ch 207 SLA 1972; am §§ 2, 4 ch 117 SLA 1973)

Effect of amendment. — The 1978 amendment added "and establish standards for training paraprofessional alcoholism workers" to the end of paragraph (7) and added paragraphs (18) and (19).

Legislative history report. — For report on ch. 117, SLA 1978 (SB 542), see 1978 Senate Journal, p. 761.

Sec. 47.37.050. Interdepartmental coordinating committee. (a) An interdepartmental coordinating committee is created, composed of the coordinator and the commissioners of health and social services, education, highways, labor and public safety. The committee shall meet

at least twice annually at the call of the commissioner of health and social services who is its chairman. The committee shall provide for the coordination and exchange of information on all programs relating to alcoholism, and act as a permanent liaison among state departments engaged in activities affecting alcoholics and intoxicated persons. The committee shall assist the commissioner of health and social services and the coordinator in formulating a comprehensive plan for prevention of alcoholism and for treatment of alcoholics and intoxicated persons.

(b) In exercising its coordinating functions, the committee shall assure that the appropriate state agencies

(1) provide all necessary medical, social, treatment, and educational services for alcoholics and intoxicated persons and for the prevention of alcoholism, without unnecessary duplication of services;

(2) cooperate in the use of facilities and in the treatment of alcoholics and intoxicated persons;

(3) adopt approaches for the prevention of alcoholism and the treatment of alcoholics and intoxicated persons consistent with the policy of this chapter. (§ 1 ch 207 SLA 1972)

Sec. 47.37.060. Advisory board on alcoholism. There is established in the Department of Health and Social Services an advisory board on alcoholism. (§ 1 ch 207 SLA 1972)

Sec. 47.37.070. Composition. The advisory board on alcoholism consists of nine members appointed by the governor. (§ 1 ch 207 SLA 1972)

Revisor's note. — In ch. 207, SLA 1972, AS 47.37.070 — 47.37.270 were designated AS 47.37.062 — 47.37.310.

Sec. 47.37.080. Qualifications of board members. Of the nine members

(1) two shall be persons who are licensed to practice medicine in the state, one of whom shall be certified in psychiatry by the American Board of Psychiatry and Neurology or eligible for that certification, except that if a psychiatrist is not available a clinical psychologist may be appointed;

(2) one shall be a practicing attorney who has been admitted to the practice of law by the state supreme court;

(3) two shall be persons who have evidenced an interest in the problems of alcoholism and who have knowledge of the social problems encountered in the rehabilitation of alcoholics;

(4) one shall be a public health nurse;

(5) one shall be a representative of the liquor industry;

(6) one shall be from the public at large;

(7) one shall be a social worker. (§ 1 ch 207 SLA 1972; am § 1 ch 72 SLA 1976)

§ 47.37.090 WELFARE, SOCIAL SERVICES AND INSTITUTIONS § 47.37.130

Effect of amendment. — The 1976 amendment rewrote this section.

Sec. 47.37.090. Term of office. (a) The members of the board initially appointed under AS 47.37.080(a) serve terms of four years.

(b) The member initially appointed under AS 47.37.080(b) serves a term of three years.

(c) The member initially appointed under AS 47.37.080(c) serves a term of two years.

(d) The members initially appointed under AS 47.37.080(d) — (h) serve terms of four years. Subsequent terms for all board members are four years.

(e) A vacancy occurring in the membership of the board shall be filled by appointment of the governor for the unexpired portion of the vacated term.

(f) Board members serve at the pleasure of the governor. (§ 1 ch 207 SLA 1972)

Sec. 47.37.100. Compensation, per diem, or expenses. Members of the advisory board on alcoholism are not entitled to a salary, but are entitled to per diem, reimbursement for travel and other expenses authorized by law for other boards. (§ 1 ch 207 SLA 1972)

Sec. 47.37.110. Duties. The board shall act in an advisory capacity to the commissioner in the following matters:

(1) special problems affecting mental health which alcoholism may present;

(2) educational and research activities conducted by the office in respect to the problems presented by alcoholism;

(3) social problems which affect rehabilitation of alcoholics;

(4) legal processes which affect the treatment and rehabilitation of alcoholics;

(5) a program of public relations concerning the problem of alcoholism conducted by a department of the state government or by an organized group whose purpose is the rehabilitation of alcoholics. (§ 1 ch 207 SLA 1972)

Sec. 47.37.120. Alcoholism program coordinator. The alcoholism program coordinator shall carry out the development and implementation of a comprehensive program dealing with the treatment of, research on and education concerning alcoholic problems as they affect the state. (§ 1 ch 207 SLA 1972)

Sec. 47.37.130. Comprehensive program for treatment; regional facilities. (a) The office shall establish a comprehensive and coordinated program for the treatment of alcoholics and intoxicated persons. Subject to the approval of the commissioner, the coordinator may divide the state into appropriate regions to conduct the program and establish standards for the development of the program on the regional level. In establishing

the regions, consideration shall be given to the city and borough lines and population concentrations and when feasible, programs shall be established with maximum local community involvement.

(b) The program of the office shall include

(1) emergency treatment provided by a facility affiliated with or part of the medical service of a general hospital;

(2) inpatient treatment;

(3) intermediate treatment; and

(4) outpatient and follow-up treatment.

(c) The office shall provide adequate and appropriate treatment for alcoholics and intoxicated persons admitted under AS 47.37.160 — 47.37.190 within the limits of available state and federal funds.

(d) The office shall maintain, supervise and control all facilities operated by it subject to the regulations of the department. The administrator of each facility shall make an annual report of its activities to the coordinator in the form and manner the coordinator specifies.

(e) If possible, the office shall coordinate the activities of the program with all appropriate public and private resources.

(f) The coordinator shall prepare, publish, and distribute annually a list of all approved public and private treatment facilities.

(g) The office may contract for the use of any facility as an approved public treatment facility if the coordinator, subject to the regulations of the department, considers this an effective and economical course to follow. (§ 1 ch 207 SLA 1972)

Sec. 47.37.140. Public and private treatment facilities. (a) The office shall establish standards for facilities (these standards may vary in their requirements and stringency according to the population, price level, remoteness, access to transportation, and availability of ancillary services of the area to be served) and shall fix the fees to be charged for the required inspections of those facilities. Every facility shall meet the applicable standards before it is approved as a public or private treatment facility. The standards shall be enacted in a manner that will provide protection of the health, safety and well-being of clients of the affected programs and protection for the affected programs from exposure to malpractice and liability actions.

(b) The office shall inspect, on a regular basis, approved public and private treatment facilities at reasonable times and in a reasonable manner.

(c) The office shall maintain a list of approved public and private treatment facilities.

(d) Each approved public and private treatment facility shall file with the office on request, data, statistics, schedules, and information which the office reasonably requires. An approved public or private treatment facility that without good cause fails to furnish any data, statistics, schedules, or information as requested, or files fraudulent returns of them, shall be removed from the list of approved treatment facilities.

§ 47.37.150 WELFARE, SOCIAL SERVICES AND INSTITUTIONS § 47.37.160

(e) The coordinator, after holding a hearing under the provisions of the Administrative Procedure Act (AS 44.62), may suspend, revoke, limit, restrict, or refuse to grant an approval for a treatment facility, for failure to meet its standards.

(f) Upon petition of the office and after a hearing held upon reasonable notice to the facility, the district court may issue a warrant to an officer or employee of the office authorizing him to enter and inspect at reasonable times, and examine the books and accounts of an approved public or private treatment facility refusing to consent to inspection or examination by the office or which the office has reasonable cause to believe is operating in violation of this chapter. (§ 1 ch 207 SLA 1972; am § 2 ch 105 SLA 1978)

Effect of amendment. — The 1978 amendment rewrote subsection (a).

Editor's note. — Section 1, ch. 105, SLA 1978, provides: "Recognizing the standards for rural alcohol treatment facilities

currently employed by the Department of Health and Social Services are not entirely appropriate, it is the intent of the legislature that standards more responsive to rural needs and conditions be adopted."

Sec. 47.37.150. Acceptance for treatment. The coordinator shall promulgate regulations for the admission of persons into the treatment program, considering available treatment resources and facilities, for the purpose of early and effective treatment of alcoholics and intoxicated persons. In establishing the regulations the coordinator shall be guided by the following standards:

(1) if possible a patient shall be treated on a voluntary rather than an involuntary basis;

(2) a patient shall be initially assigned or transferred to outpatient or intermediate treatment, unless he is found to require inpatient treatment;

(3) a person shall not be denied treatment solely because he has withdrawn from treatment against medical advice on a prior occasion or because he has relapsed after earlier treatment;

(4) an individualized treatment plan shall be prepared and maintained on a current basis for each patient;

(5) provision shall be made for a continuum of coordinated treatment services, so that a person who leaves a facility or a form of treatment will utilize other appropriate treatment and facilities. (§ 1 ch 207 SLA 1972)

Sec. 47.37.160. Voluntary treatment of alcoholics. (a) An alcoholic may voluntarily apply for treatment directly to an approved public treatment facility.

(b) Subject to regulations promulgated by the coordinator, the administrator in charge of an approved public treatment facility may determine who shall be admitted for treatment. If a person is refused admission to an approved public treatment facility, the administrator

shall, if possible, refer the person to another approved public treatment facility.

(c) When a patient receiving inpatient care leaves an approved public treatment facility, he shall be encouraged to consent to appropriate outpatient or intermediate treatment. If it appears to the administrator in charge of the treatment facility that the patient is an alcoholic who requires help, the office shall arrange for assistance in obtaining supportive services and residential facilities. (§ 1 ch 207 SLA 1972)

Sec. 47.37.170. Treatment and services for intoxicated persons and persons incapacitated by alcohol. (a) An intoxicated person may come voluntarily to an approved public treatment facility for emergency treatment. A person who appears to be intoxicated in a public place and to be in need of help or a person who appears to be intoxicated in or upon a licensed premise where intoxicating liquors are sold or consumed who refuses to leave upon being requested to leave by the owner, an employee or a peace officer may be taken into protective custody and assisted by a peace officer or a member of the emergency service patrol to his home, an approved public treatment facility, an approved private treatment facility, or another appropriate health facility. If all of the preceding facilities, including the person's home, are determined to be unavailable, a person taken into protective custody and assisted under this subsection may be taken to a state or municipal detention facility in the area.

(b) A person who appears to be incapacitated by alcohol in a public place shall be taken into protective custody by a peace officer or a member of the emergency service patrol and immediately brought to an approved public treatment facility, an approved private treatment facility, or another appropriate health facility or service for emergency medical treatment. If no treatment facility or emergency medical service is available, a person who appears to be incapacitated by alcohol in a public place shall be taken to a state or municipal detention facility in the area, if that appears necessary for the protection of the person's health or safety.

(c) A person who voluntarily appears or is brought to an approved public treatment facility shall be examined by a licensed physician as soon as possible. After the examination, he may be admitted as a patient or referred to another health facility. The approved public treatment facility which refers him shall arrange for his transportation.

(d) No person who, after medical examination, is found to be incapacitated by alcohol at the time of his admission or to have become incapacitated at any time after his admission, may be detained at a facility after he is no longer incapacitated by alcohol. No person may be detained at a facility if he remains incapacitated by alcohol for more than 48 hours after admission as a patient, unless he is committed under AS 47.37.180. A person may consent to remain in the facility as long as the physician in charge considers it appropriate.

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(e) A person who is not admitted to an approved public treatment facility, is not referred to another health facility, and has no funds, may be taken to his home, if any. If he has no home, the approved public treatment facility shall assist him in obtaining shelter.

(f) If a patient is admitted to an approved public treatment facility, his family or next of kin shall be promptly notified. If an adult patient who is not incapacitated requests that there be no notification of next of kin, his request shall be granted.

(g) Peace officers or members of the emergency service patrol who comply with this section are acting in the course of their official duty and are not criminally or civilly liable for it.

(h) If the physician in charge of the approved public treatment facility determines it is for the patient's benefit, an attempt shall be made to encourage the patient to submit to further diagnosis and appropriate voluntary treatment.

(i) A person taken to a detention facility under (a) or (b) of this section may be detained only (1) until a treatment facility or emergency medical service is made available, or (2) until he is no longer intoxicated or incapacitated by alcohol, or (3) for a maximum period of 12 hours, whichever occurs first. A detaining officer or a detention facility official may release a person who is detained under (a) or (b) of this section at any time to the custody of a responsible adult. A peace officer or a member of the emergency service patrol, in detaining a person under (a) or (b) of this section and in taking him to a treatment facility, an emergency medical service or a detention facility, is taking him into protective custody and he shall make reasonable efforts to provide for and protect the health and safety of the detainee. In taking a person into protective custody under (a) and (b) of this section, a detaining officer, a member of the emergency service patrol or a detention facility official may take reasonable steps to protect himself, including a full protective search of the person of a detainee. Protective custody under (a) and (b) of this section does not constitute an arrest and no entry or other record may be made to indicate that the person detained has been arrested or charged with a crime, except that a confidential record may be made which is necessary for the administrative purposes of the facility to which the person has been taken or which is necessary for statistical purposes where the person's name may not be disclosed.

(j) For purposes of (b) of this section, "incapacitated by alcohol" means a person who, as the result of consumption of alcohol, is rendered unconscious or has his judgment or physical mobility so impaired that he cannot readily recognize or extricate himself from conditions of apparent or imminent danger to his health or safety. The definition in AS 47.37.270(8) applies to other portions of this chapter. (§ 1 ch 207 SLA 1972; am §§ 1—4 ch 101 SLA 1976)

Effect of amendment. — The 1976 amendment substituted the language beginning "or a person who appears to be intoxicated" and ending "taken into protective custody and assisted" for "if he consents, may be assisted" and inserted "a member of" preceding "the emergency service patrol" in the second sentence of subsection (a), added the third sentence of that subsection, rewrote subsection (b), and added subsections (i) and (j).

Legislative history report. — For report on ch. 101, SLA 1976 (CSSSB 336 am H), see 1976 House Journal, p. 555.

Constitutionality. — For case holding that this section as it existed prior to the 1977 amendment, which among other things rewrote subsection (b), did not countenance an unreasonable search in violation of the 4th amendment to the United States Constitution, see *Peter v. State*, Sup. Ct. Op. No. 1112 (File No. 2185), 531 P.2d 1263 (1975).

Sec. 47.37.180. Emergency commitment. (a) An intoxicated person who (1) has threatened, attempted to inflict, or inflicted physical harm on another or is likely to inflict physical harm on another unless committed, or (2) is incapacitated by alcohol, may be committed to an approved public treatment facility for emergency treatment. A refusal to undergo treatment does not constitute evidence of lack of judgment as to the need for treatment.

(b) The certifying physician, spouse, guardian, or relative of the person to be committed, or any other responsible person, may make a written application for commitment under this section, directed to the administrator of the approved public treatment facility. The application shall state facts to support the need for emergency treatment and be accompanied by a physician's certificate supporting the need for emergency treatment and stating that the physician has examined the person sought to be committed within two days before the certificate's date.

(c) Upon approval of the application by the administrator in charge of the facility, the person may be brought to the facility by a peace officer, a health officer, a member of the emergency service patrol, the applicant for commitment, the patient's spouse, the patient's guardian, or any other interested person. The person shall be retained at the facility to which he was admitted, or transferred to another appropriate public or private treatment facility, until discharged under (e) of this section. However, no person may be detained under this section for more than 48 hours unless a district or superior court judge has reviewed and approved the commitment application.

(d) The administrator in charge of an approved public treatment facility may refuse an application if in his opinion the application and certificate fail to sustain the grounds for commitment.

(e) When on the advice of his medical staff the administrator determines that the grounds for commitment no longer exist, he shall discharge a person committed under this section. No person committed under this section may be detained in a treatment facility for more than five days. If a petition for involuntary commitment under AS 47.37.190 has been filed within the five days and the administrator in charge of an

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approved public treatment facility finds that grounds for emergency commitment still exist, he may detain the person until the petition has been heard and determined, but no longer than 10 days after filing the petition.

(f) A copy of the written application for commitment and of the physician's certificate, and a written explanation of the person's right to legal counsel, shall be given to the person within 24 hours after commitment by the administrator, who shall provide a reasonable opportunity for the person to consult with legal counsel. (§ 1 ch 207 SLA 1972)

Sec. 47.37.190. Involuntary commitment of alcoholics. (a) After a hearing initiated by petition of his spouse or guardian, a relative, the certifying physician, or the administrator in charge of an approved public treatment facility, a person may be committed to the custody of the office by the superior court. The petition shall allege that the person is an alcoholic who habitually lacks self-control in using alcoholic beverages and that he (1) has threatened, attempted to inflict, or inflicted physical harm on another and that unless committed is likely to inflict physical harm on another; or (2) is incapacitated by alcohol. A refusal to undergo treatment does not constitute evidence of lack of judgment as to the need for treatment. The petition shall be accompanied by a certificate of a licensed physician who has examined the person within two days before submission of the petition, unless the person whose commitment is sought has refused to submit to a medical examination, in which case the fact of refusal shall be alleged in the petition. The certificate shall set out the physician's findings in support of the allegations of the petition.

(b) After the petition is filed, the court shall fix a date for a hearing no later than 10 days after the date the petition was filed. A copy of the petition and of the notice of the hearing, including the date fixed by the court, shall be served on (1) the petitioner; (2) the person whose commitment is sought; (3) the next of kin of the person whose commitment is sought; (4) the administrator in charge of the approved public treatment facility in which the committed person has been committed for emergency care, and any other person the court considers appropriate. A copy of the petition and certificate shall be delivered to each person notified.

(c) If, not less than two days before the date fixed for the hearing, the person sought to be committed or his counsel or advisor files a written request with the superior court, the court shall summon and impanel a jury of six adult residents of the judicial district in which the court officiates, preferably from the court's jury list or the last voters list, if available, to hear and consider evidence concerning the condition of the person sought to be committed. (§ 1 ch 207 SLA 1972)

Sec. 47.37.200. Hearing on petition for involuntary commitment of alcoholics. (a) At the hearing required under AS 47.37.190(b), the court or the jury, if requested under AS 47.37.190(c), shall hear all relevant testimony, including, if possible, the testimony of at least one licensed physician who has examined the person whose commitment is sought. The person whose commitment is sought shall be present unless the court believes that his presence is likely to be injurious to him, in which case the court shall appoint a guardian ad litem to represent him throughout the proceeding. The court may examine the person in open court, or if advisable, examine him out of court. If the person has refused to be examined by a licensed physician, he shall be given an opportunity to request examination by a court-appointed licensed physician. If he fails to request a medical examination and there is sufficient evidence to believe that the allegations of the petition are true, or if the court believes that more medical evidence is necessary, the court may issue a temporary order committing him to the office for a period of not more than five days for purposes of a diagnostic examination.

(b) If after hearing all relevant evidence, including the results of any diagnostic examination by the office, the court or the jury finds that grounds for involuntary commitment have been clearly established, the court shall issue an order of commitment to the office. No court may order the commitment of a person unless it determines that the office is able to provide adequate and appropriate treatment for him.

(c) A person committed under AS 47.37.190 — 47.37.200 shall remain in the custody of the office for treatment for a period of up to 30 days. At the end of the 30-day period, he shall be discharged automatically unless the office, before the expiration of the period, obtains a court order for his recommitment upon the grounds set out in AS 47.37.190(a) for a further period of up to 90 days. If a person has been committed because he is an alcoholic likely to inflict physical harm on another, the office shall apply for recommitment if after examination it is determined that the likelihood still exists.

(d) A person recommitted under (c) of this section who has not been discharged by the office before the end of the 90-day period shall be discharged at the expiration of that period unless the office, before expiration of the period, obtains a court order on the grounds set out in AS 47.37.190(a) for recommitment for a further period not to exceed 90 days. If a person has been committed because he is an alcoholic likely to inflict physical harm on another, the office shall apply for recommitment if after examination it is determined that the likelihood still exists. No more than two recommitment orders may be permitted under (c) and (d) of this section.

(e) Upon the filing of a petition for recommitment under (c) or (d) of this section, the court shall fix a date for hearing no later than 10 days after the date the petition was filed. A copy of the petition and of the notice of hearing, including the date fixed by the court, shall be served

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on (1) the petitioner; (2) the person whose commitment is sought; (3) the next of kin of the person whose commitment is sought; (4) the original petitioner under AS 47.37.190(a), if different from the petitioner for recommitment; (5) any other person the court considers appropriate. AS 47.37.180(c) applies to hearings for recommitment under this section. At the hearing the court or the jury shall proceed as provided in (a) of this section.

(f) The office shall provide adequate and appropriate treatment for a person in its custody. The office may transfer a person in its custody from one approved public treatment facility to another if the transfer is medically advisable.

(g) A person committed to the custody of the office for treatment shall be discharged at any time before the end of the period for which he has been committed if either of the following conditions is met:

(1) when an alcoholic committed on the grounds of likelihood of infliction of physical harm on another is no longer considered an alcoholic or the likelihood of his infliction of physical harm no longer exists; or

(2) when, in the case of an alcoholic committed on the grounds of the likelihood of infliction of physical harm on another, either

(A) further treatment will not be likely to bring about significant improvement in the person's condition, or

(B) treatment is no longer adequate or appropriate.

(h) The court shall inform the person whose commitment or recommitment is sought of his right to contest the application, be represented by counsel at every stage of the proceedings relating to his commitment and recommitment, to have counsel appointed by the court or provided by the court, if he is unable to obtain counsel, and to a jury trial, if requested, as specified in AS 47.37.190(c). If the court believes that the person needs the assistance of counsel, the court shall require, by appointment if necessary, counsel for him regardless of his objection. The person whose commitment or recommitment is sought shall be informed of his right to be examined by a licensed physician of his choice. If the person is unable to obtain a licensed physician and requests examination by a physician, the court shall employ a licensed physician for the examination.

(i) If a private treatment facility agrees with the request of a competent patient or his parent, sibling, adult child, or guardian to accept the patient for treatment, the administrator of the public treatment facility shall transfer him to the private treatment facility.

(j) A person committed under this chapter may at any time seek discharge from commitment by writ of habeas corpus under AS 12.75. (§ 1 ch 207 SLA 1972)

Sec. 47.37.210. Records of alcoholics and intoxicated persons. (a) Except as required by AS 28.35.030(b), the registration and other records of treatment facilities shall remain confidential and are privileged to the patient.

(b) Notwithstanding (a) of this section, the coordinator may make available information from patient's records for purposes of research into the causes and treatment of alcoholism. No information may disclose a patient's name. (§ 1 ch 207 SLA 1972; am § 4 ch 152 SLA 1978)

Effect of amendment. — The 1978 AS 28.35.030(b)" to the beginning of amendment added "Except as required by subsection (a).

Sec. 47.37.220. Visitation and communication of patients. (a) Patients in any approved treatment facility under this chapter shall be granted reasonable opportunities for adequate consultation with counsel, and for continuing contact with family and friends including the use of telephone facilities, consistent with an effective treatment program.

(b) No mail or other communication to or from a patient in any approved treatment facility may be intercepted, read, or censored. (§ 1 ch 207 SLA 1972)

Sec. 47.37.230. Establishment of emergency service patrol. (a) The office and cities and boroughs may establish emergency service patrols. An emergency service patrol consists of persons trained to give assistance in public places to persons who are intoxicated. Members of an emergency service patrol shall be capable of providing first aid in emergency situations and shall be capable of transporting intoxicated persons to their homes and to and from public treatment facilities.

(b) The coordinator shall promulgate regulations for the establishment, training, and conduct of emergency service patrols. (§ 1 ch 207 SLA 1972)

Sec. 47.37.240. Payment for treatment. (a) A patient in an approved treatment facility, or the person obligated to provide for the cost of treatment of a person committed under this chapter, is liable to the office for the cost of maintenance and treatment of the patient in accordance with rates established by the coordinator.

(b) The coordinator shall promulgate regulations governing financial ability that take into consideration the income, savings, and other personal and real property of the person liable for the cost and maintenance of the patient. (§ 1 ch 207 SLA 1972).

Sec. 47.37.250. Nonapplicability. (a) Nothing in this chapter affects a statute, ordinance, or regulation relating to (1) drunken driving, driving under the influence of alcohol, or other similar offenses involving alcohol and the operation of a vehicle, aircraft, boat, machinery, or other equipment, (2) the sale, purchase, dispensation, possession, or use of alcoholic beverages at specified times and places or by a particular class of persons, including prohibitions against drinking intoxicating beverages in specified public places, (3) being upon the traveled portion of a highway so as to be a hazard to the motoring public.

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(b) Nothing in this chapter affects AS 11.70.030, relating to the defense of voluntary intoxication. (§ 1 ch 207 SLA 1972; am § 1 ch 186 SLA 1976)

Effect of amendment. — The 1976 amendment deleted "or" from the end of clause (1), added "including prohibitions against drinking intoxicating beverages in specified public places, or" to the end of clause (2), and added clause (3).

This section refers only to the sale, purchase, dispensation or use of alcoholic beverages. *Peter v. State*, Sup. Ct. Op. No. 1112 (File No. 2185), 531 P.2d 1263 (1975).

And not to being intoxicated at "specific times and places". — See *Peter v. State*, Sup. Ct. Op. No. 1112 (File No. 2185), 531 P.2d 1263 (1975).

A construction to expand the nonapplicability section to include anyone intoxicated on a highway would have the effect of emasculating the statute. *Peter v. State*, Sup. Ct. Op. No. 1112 (File No. 2185), 531 P.2d 1263 (1975).

Sec. 47.37.260. Application of Administrative Procedure Act. Except as otherwise provided in this chapter, the Administrative Procedure Act (AS 44.62) applies to and governs all administrative action taken by the coordinator under this chapter. (§ 1 ch 207 SLA 1972)

Sec. 47.37.270. Definitions. In this chapter

(1) "alcoholic" means a person who habitually lacks self-control in using alcoholic beverages, or uses alcoholic beverages to the extent that his health is substantially impaired or endangered, or his social or economic function is substantially disrupted;

(2) "approved private treatment facility" means a private agency meeting the standards prescribed in AS 47.37.140(a) and approved under AS 47.37.140(c);

(3) "approved public treatment facility" means a treatment agency operating under the direction and control of the office or providing treatment under this chapter through a contract with the office under AS 47.37.130(g) or through a grant awarded under AS 47.30.475, and meeting the standards prescribed in AS 47.37.140(a) and approved under AS 47.37.140(c);

(4) "commissioner" means the commissioner of health and social services;

(5) "coordinator" means the coordinator of the office of alcoholism;

(6) "department" means the Department of Health and Social Services;

(7) "emergency service patrol" means a patrol established under AS 47.37.230;

(8) "incapacitated by alcohol" means a person who is unconscious or has his judgment otherwise so impaired that he is incapable of realizing and making a rational decision with respect to his need for treatment, as evidenced objectively by extreme physical debilitation, physical harm or threats of harm to others or chronic inability to hold regular employment;

(9) "incompetent person" means a person who has been adjudged incompetent by the appropriate court;

(10) "intoxicated person" means a person whose mental or physical functioning is substantially impaired as a result of the use of alcohol;

(11) "office" means the office of alcoholism within the Department of Health and Social Services;

(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. (§ 1 ch 207 SLA 1972; am § 4 ch 116 SLA 1978)

Effect of amendment. — The 1978 amendment inserted "or through a grant awarded under AS 47.30.475" in paragraph (3).

Quoted in *Peter v. State*, Sup. Ct. Op. No. 1112 (File No. 2185), 581 P.2d 1263 (1975).

APPENDIX - C

REVIEW BOARD ON ALCOHOLISM - BY LAWS

BY-LAWS
REVIEW BOARD
ON ALCOHOLISM

ARTICLE I NAME

The name of the organization shall be the Review Board on Alcoholism, hereinafter referred to as the Board.

ARTICLE II PURPOSE

The Board's purpose, as delineated in Alaska Statutes, subject to amendment, shall be to act in an advisory capacity to the Commissioner of Health and Social Services in the following matters:

1. Special problems affecting mental health which alcoholism may present;
2. Educational and research activities conducted by the office in respect to the problems presented by alcoholism;
3. Social problems which affect rehabilitation of alcoholics;
4. Legal processes which affect the treatment and rehabilitation of alcoholics;
5. A program of public relations concerning the problem of alcoholism conducted by a department of state government or by an organized group whose purpose is the rehabilitation of alcoholics.

ARTICLE III MEMBERSHIP

Section 1. - Composition

- A. Two members shall be persons who are licensed to practice medicine

in the State, one of whom shall be certified in psychiatry by the American Board of Psychiatry and Neurology or is eligible for that certification, except that if a psychiatrist is not available, a clinical psychologist may be appointed.

- B. One member shall be a practicing attorney who has been admitted to the practice of law by the Supreme Court of the State of Alaska.
- C. Two shall be persons who have evidenced an interest in the problems of alcoholism and who have knowledge of the social problems encountered in the rehabilitation of alcoholics;
- D. One shall be a public health nurse;
- E. One shall be a representative of the liquor industry;
- F. One shall be from the public at large;
- G. One shall be a social worker. (§ 1 ch 207 1972; am § 1 ch 72)

Section 2. - Term of Office

- A. Three members of the Board initially appointed under Section 1 (A-B) shall serve of three years.
- B. Three members initially appointed under Section 1 shall serve terms of two years.
- C. Three members initially appointed under Section 1 shall serve terms of one year.
- D. Subsequent terms for all Board members shall be three years.
- E. A vacancy occurring in the membership of the Board shall be

filled by appointment of the Governor for the unexpired portion of the vacated term.

F. Board members serve at the pleasure of the Governor.

Section 3. - Attendance

A. Participation in the affairs of the Board is expected. Any member failing to attend three consecutive meetings of the Board shall be asked to resign unless the composite Board determines otherwise for justifiable cause. The Executive Secretary will notify the Board any time a member is in violation of this section.

B. The Governor shall replace any members who by poor attendance demonstrate their ineffectiveness as Board members.

ARTICLE IV MEETINGS

Section 1. - Regular Meetings

There shall be at least four regular meetings at least one of which will be held in a rural area where a program is located or where there is interest in establishing a program or a problem exists. Written notice of the meeting shall be sent to members of the Board not less than thirty (30) days prior to the meeting dates. The agenda for the meeting will be sent to members of the Board not less than fourteen (14) days before the meeting. The time and place for the next regular meeting shall be determined before adjournment of each meeting. Meetings shall be conducted according to Roberts Rules of Order and the order of business shall be specified in the agenda. With the consent of the Chairman and Board, other matters may be added to the agenda at any time.

Section 2. - Annual Meeting

One of the regular meetings shall be held between May and July each year and shall be designated as the Annual Meeting for purposes of election of officers and other business.

Section 3. - Special Meetings

Special meetings may be called by the Chairman, Coordinator of the State Office of Alcoholism/Drug Abuse, or on petition of five members. Written notice of such meetings including the agenda, shall be sent to all members at least fourteen (14) days prior to a special meeting.

Section 4. - Executive Session

- A. All meetings of the Board shall be public with the exception only of the following subjects which may be discussed in executive session:
 - 1. Matters, the immediate knowledge of which would adversely affect the finances of the government unit;
 - 2. Subjects that tend to prujudice the reputation and character of any person, provided the person may request a public discussion.
 - 3. Matters by which law, municipal charter, or ordinances are required by be confidential.
- B. Such exceptions are to be discussed at a public Board meeting and the question of holding an executive session shall be determined by a majority vote of the body. The reason for an executive session shall be announced publicly before the session is convened. No subject may be considered at the exectuive session except those mentioned in the motion calling for the session unless auxillary

to the main question. No action may be taken at the executive session.

C. Action taken contrary to this section is void by Alaska State Law.

Section 5. - Quorum

A quorum at any meeting of the Board shall consist of a simple majority of the current Board members. The Board may adjourn from time to time during these sessions; and the loss of a quorum at any continuation of the session shall not affect the power of the Board to act.

Section 6. - Voting

Only duly appointed members in person at a meeting can vote. A proxy vote shall not be permitted. All decisions made by a simple majority vote of those present constituting a quorum unless otherwise specified by these By-laws.

Section 7. - Minutes

Minutes of all meetings shall be kept, transcribed, and distributed to the membership by the State Office of Alcoholism and Drug Abuse within thirty (30) days following the meeting.

Section 8. - Board Action

All recommendations to the Commissioner of Health and Social Services shall be made in writing along with a request for a report of any action taken pursuant to recommendations.

ARTICLE V OFFICERS

Section 1. - Officers

The officers of the Board shall be a Chairman and Vice Chairman elected

annually.

Section 2. - Executive Secretary

The Coordinator of the State Office of Alcoholism and Drug Abuse shall be designated Executive Secretary to the Board, shall be responsible for providing secretarial and administrative functions for the Board. He functions as an ex-officio member of the Board.

Section 3. - Qualifications

Any voting member of the Board is eligible to become an officer.

Section 4. - Term of Office

All officers shall serve a term beginning at the adjournment of the Annual Meeting at which elected, and ending with the adjournment of the next Annual Meeting.

Section 5. - Duties

The Chairman shall preside at all meetings of the Board and provide all functions usually attendant with the chair. He shall have the right to vote in all cases. He shall make all committee appointments subject to the approval of the composite membership unless otherwise indicated by these By-laws.

The Vice Chairman shall perform the duties of the Chairman whenever the Chairman shall be unable to do so.

Section 6. - Vacancies

If a majority of the composite Board membership determines that the Chairman is unable to continue the duties of his office, the Vice Chairman shall succeed him for the remainder of the unexpired term. If there is no current Vice

Chairman, an election shall be held at the current session in which the vacancy occurs or at the next scheduled session of the Board.

ARTICLE VI PARLIAMENTARY PROCEDURE

The rules contained in Robert's Rules of Order, Revised, shall govern the Board in all cases to which they are applicable, and in which they are not inconsistent with these By-laws, special rules or pertinent State or Federal statutes.

ARTICLE VII AMENDMENTS

The By-laws, as adopted, may be amended, altered, repealed, or added to at any duly convened meeting of the Board providing that written notice detailing the proposed changes has been sent to each Board member at least thirty (30) days before the meeting. Such changes shall become effective upon a two-thirds vote of those present at the meeting.

APPENDIX - D

REVIEW BOARD ON ALCOHOLISM - MEMBERSHIP

REVIEW BOARD ON ALCOHOLISM - REV. 11/27/84

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APPENDIX - E

ALASKA STATUTE (AS) 44.29

Article 3. Advisory Board on Drug Abuse.

Section	Section
100. Advisory board on drug abuse	140. Duties
110. Composition	150. Drug abuse program coordinator
120. Term of office	
130. Compensation, per diem, and expenses	

Sec. 44.29.100. Advisory board on drug abuse. There is established in the Department of Health and Social Services an advisory board on drug abuse. (§ 1 ch 198 SLA 1972)

Sec. 44.29.110. Composition. The advisory board on drug abuse shall consist of 12 members, broadly representative of all drug-related fields, who are known for their experience or interest in drug abuse and who shall be appointed by the governor. (§ 1 ch 198 SLA 1972)

Sec. 44.29.120. Term of office. (a) Members of the advisory board on drug abuse shall be appointed for overlapping terms of three years.

(b) Of the 12 initial appointees four shall be appointed for one-year terms, four for two-years terms, and four for three-year terms.

(c) Subsequent terms for all board members are three years.

(d) A vacancy occurring in the membership of the board shall be filled by appointment of the governor for the unexpired portion of the vacated term.

(e) Board members serve at the pleasure of the governor.

(f) The governor shall replace any members who by poor attendance or lack of contribution to the board's work demonstrate their ineffectiveness as board members. (§ 1 ch 198 SLA 1972)

Sec. 44.29.130. Compensation, per diem, and expenses. Members of the advisory board on drug abuse are not entitled to a salary, but are entitled to per diem, reimbursement for travel and other expenses authorized by law for other boards. (§ 1 ch 198 SLA 1972)

Sec. 44.29.140. Duties. The board shall act in an advisory capacity to the commissioner of health and social services in the following matters:

(1) special problems affecting mental health which drug abuse or addiction may present;

(2) educational research and public informational activities conducted by the Department of Health and Social Services and others in respect to the problems presented by drug abuse;

(3) social problems which affect rehabilitation of drug users and addicts;

(4) legal processes which affect the treatment and rehabilitation of drug users and addicts;

(5) development of programs of prevention, treatment and rehabilitation for drug abusers and addicts;

(6) review of applications and subsequent recommendations to the commissioner of health and social services on use of funds for grants for local drug abuse projects and programs;

(7) evaluation of effectiveness of drug abuse programs in the state. (§ 1 ch 198 SLA 1972)

Sec. 44.29.150. Drug abuse program coordinator. The drug abuse program coordinator shall carry out the development and implementation of a comprehensive program to prevent and treat the use and abuse of drugs as they affect the people in Alaska. The comprehensive program may include educational activities, research, grants for treatment centers, or any other activities considered effective for prevention or treatment. The drug abuse coordinator is appointed by the governor. (§ 1 ch 198 SLA 1972)

APPENDIX - F

ADVISORY BOARD ON DRUG ABUSE - MEMBERSHIP

ADVISORY BOARD ON DRUG ABUSE - REV. 10/30/84

Constance L. Munro
Advisory Board on Drug Abuse
120 West Ninth Street
Juneau, Alaska 99801

Peggy Colletta
Advisory Board on Drug Abuse
20 53rd Street
Gulf Port, Mississippi 39506

Ben J. Esch, Chairperson
Advisory Board on Drug Abuse
3223 West 31st Avenue
Anchorage, Alaska 99503

Julie K. Perkins
Advisory Board on Drug Abuse
Box 813
Nome, Alaska 99762

Alexander P. Shadura
Advisory Board on Drug Abuse
P.O. Box 3907
Kenai, Alaska 99611

Roberta J. Wallace
Advisory Board on Drug Abuse
480 University Ave.
Fairbanks, Alaska 99701

Kathleen Toomey M.D.
Advisory Board on Drug Abuse
Kotzebue Hospital
Kotzebue, Alaska 99752

APPENDIX - G

FY'85 GRANT REVIEW CRITERIA

OFFICE OF ALCOHOLISM AND DRUG ABUSE
FY 85 GRANT
REVIEW CRITERIA

I. Budget Detail and Narrative Review (one to be completed per program)

A. Does the budget narrative state who is responsible for the fiscal management of this grant.

* If an accounting service/bookkeeping firm is used is the firms address and phone number listed in the budget narrative?

B. Does the budget narrative describe:

* Program director's management responsibility?

* Board of director's management responsibility?

C. Does the budget narrative state when the last private audit was completed?

D. Does the budget narrative state when the last DH&SS audit was completed?

* Are findings of audit discussed?

* Is there a discussion of status of refund and/or relief?

E. Is there a recent financial statement (such as the balance sheet from the last private audit of the agency) attached to budget narrative?

F. In reviewing the Budget Detail and the Budget Narrative:

* Category 100

1. Are wages, salaries reasonable and are salary levels well discussed in budget narrative?

2. Are new positions clearly identified and discussed in the narrative?

3. Are job description and attached resumes of key administrative and counseling staff in the application?

4. Are fringe benefits detailed and allowable?

* Category 200

1. Is client travel requested and readily identifiable in budget detail and computation basis discussed in narrative?

2. Is local mileage identifiable in budget detail and computation basis discussed in narrative?

3. Are training costs (travel and tuition) identifiable in budget detail and discussed in narrative?
4. Are other travel costs listed in budget detail and discussed in narrative?

* Category 300

1. Is name of the owner of any facility that is rented or leased named in narrative?
2. Is narrative explanatory about what is included in rental cost?
3. Who is responsible for repair or maintenance; for major renovations; liability insurance; property insurance?
4. Are other costs detailed in budget and discussed in narrative?

* Category 400

1. Are supply costs discussed in narrative with regards to program necessity?
2. Are miscellaneous household supplies costed out over \$300? If so, are they detailed in the budget narrative?

* Category 500

1. Are conditions of acquisition clear in respect to purchase, lease, lease to buy, and rental?
2. Are unit prices stated in each instance?
3. Are maintenance/repair costs reasonable/adequate? (Check with duplication with Category 300.)

* Category 600

1. For all consultants listed on budget detail, does the budget narrative address:
 - name of firm,
 - rate of compensation,
 - extent of service to be performed?

If above is unknown, does narrative explain basis used to determine cost listed on detail budget page?

2. Is adequate insurance provided for?
 - a. Bonding
 - b. Liability
 - c. Malpractice
 - d. Check for duplication with Category 100.
3. Are subscriptions, dues, printing, and advertising fees/costs reasonable/allowable?
4. For all subcontracts listed in the budget detail, does the budget narrative list each one and describe what direct service will be provided by the sub-contractor?
5. For all subcontractors listed in the budget detail, are there separate budgets and budget narratives as required?

* Category 700

1. Does the proposal package contain a federally negotiated indirect cost agreement?
 - a. Is a detail description of services provided for in the indirect cost rate? (Check for duplication.)
2. When was indirect cost rate most recently negotiated?

II. Program Narrative Review (one to be completed per program)

A. Agency and Board Apparatus

1. Does the history of the organization/agency demonstrate capability of providing quality services?
 - a. Past provider of alcohol and drug abuse services?
 - b. Past provider of other human services?
 - c. Is the stated purpose of the organization appropriate?
2. Does the organization provide a clear and reasonable organizational structure delineated in program and budget narrative?
 - a. Does staffing described correspond to organizational structure delineated in program and budget narrative?
 - b. Are lines of authority well defined with organization and in relation to subcomponents?
3. Is the relationship of the project director to the organization/board clearly defined?
 - a. Is only the director responsible for reporting to the board?
 - b. Is the project director's resume commensurate with job description?
 - c. Does the board appear in compliance with guidelines, Part III A-J (departmental guidelines, mailed to programs)?
 - d. Does the description of the board include:
 1. Composition
 2. Functions
 3. Standing Committees
 4. Frequency of meetings
 5. Policy/advisory relationships
 6. Representation (age, ethnic, sex, etc.)
 7. Number of members
 8. Vacancies
 - e. Are Board minutes attached? (Last six months.)

PROGRAM NAME: _____

COMPONENT: _____

8. Proposed Components of Service (one to be completed for each component)

1. For each component of service proposed, the following must be provided:
 - a. Is the identified need for the services proposed described in detail?
 - b. Is the process that was utilized in determining the identified need described in detail?
 - c. Philosophy of approach (prevention, treatment, etc.) that guides each component of service.
 - d. Is there a description of how each proposed component of service is linked to identified need?
 - e. Are the set of goals and objectives that are proposed measurable/quantifiable and timed?
 - f. Are the particular target group(s) to be reached by each proposed component of service listed clearly?
 - g. Is the identity of other agencies providing similar services detailed in the proposal?
 - h. Is the method to be used to evaluate activities, review goals and objectives, and how they are to be shared with governing authority and community clearly stated and reasonable given the stated goals and objectives?
2. Does the proposal describe how each component of service is linked to other components of services proposed in this application?
3. Are copies of Memorandums of Agreement with other provider agencies provided?
4. Do the components of services proposed in this application appear to be consistent with, and does the proposal discuss relationship to local/regional/State plans?
 - a. State Alcoholism/Drug Abuse Plan?
 - b. State Health Plan?
 - c. HSA Plans?
 - d. State Manpower and Training Plan?
 - e. Tribal Specific Health Plans?
5. How is the community support evidenced in the applications?

III. Prior Experience (one to be completed per program, not one per component).

- A. Prior Experience (this portion to be completed during grant staffing)
 - 1. Has the agency been responsive to recommendations and required corrective action plan resulting from on-site evaluations? (If not, please list areas needing corrective action.)
 - 2. Were corrective actions timely, adequate, and appropriate?
 - 3. Has the program shown responsiveness to the special conditions attached to the Notice of Grant Award for previous years?
 - 4. During the most recent on-site, were community perceptions of the program measured? If so, describe method and results and whether this was addressed in the on-site report.
- B. Does the plan for treatment services as described in each of the proposed components insure provision for continuity of services?
- C. Does this proposal insure that all services are provided either directly or through Memorandum of Agreement?

APPENDIX - H

M.I.S. PROGRAM SUMMARY REPORTS

① PROGRAM NAME: AKEELA HOUSE

② PROGRAM SUMMARY DATA: COVERING PERIOD: FROM: 7/1/83 TO: 2/29/84

③ * CLIENT DATA *

④ CLIENT ACTIVITY

ACTIVE BEG. OF PERIOD: 213	SEX ⑤	NO.	PERCENT	PROBLEM/LEGAL	NO.	RACE ⑧	NO.	%	AGE ⑨
NEW ADMISSIONS: 467	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	73	10%	<= 17 YRS OLD
READMISSIONS: 87	582	76.3 %	MALE	PRIMARY PROB ⑥	660	87% CAUCASIAN	337	44%	18-25 YRS OLD
TERMINATIONS 506	181	23.7 %	FEMALE	ALCOHOL	40	5% AK NATIVE	34	4%	26-40 YRS OLD
ACTIVE END OF PERIOD 261				LEGAL INVOLV ⑦	66	8% ALL OTHER	1	0%	41-60 YRS OLD
									>= 61 YRS OLD

RESOURCE UTILIZATION DATA

⑩ OMP. NO.	⑪ COMPONENT NAME	⑫ TOTAL STAFF HRS	⑬ NUMBER ADMITTED OF CLIENTS SERVED	⑭ LEVEL OF ACTIVITY (# PEOPLE)	⑮ % BED UTILIZATION	⑯ % HRS CLIENT PRE/POST (1)	⑰ % STAFF HOURS SPENT IN "100" SERIES	⑱ "200" SERIES	⑲ "300"/"400" SERIES
010	MANAGEMENT & SUPPORT SERVICES	10,558	N/A	301	N/A	0.0%	0.0%	96.3%	3.7%
020	EVALUATION	1,681	50	1,002	N/A	70.0%	6.3%	15.2%	78.5%
030	OUTREACH	1,176	N/A	1,384	N/A	.3%	0.0%	75.2%	24.8%
040	INTERMEDIATE CARE	16,312	113	910	86.2%	63.9%	63.0%	35.3%	1.7%
051	OUTPATIENT WOMEN	1,264	156	158	N/A	64.5%	53.2%	30.3%	16.5%
052	OUTPATIENT ADULT	3,710	445	475	N/A	52.5%	43.2%	31.2%	25.6%
053	OUTPATIENT YOUTH	2,134	78	3,613	N/A	42.9%	15.9%	25.9%	58.2%
054	JAIL	466	N/A	1,161	N/A	84.2%	.8%	8.5%	90.7%
055	OUTPATIENT SCHOOLS	146	5	61	N/A	12.1%	6.7%	20.5%	72.8%
056	AFTERCARE	1,010	68	560	N/A	49.5%	38.9%	39.1%	22.0%
	TOTAL	38,457	709	9,625			OVERALL: 34.9%	51.0%	14.1%

COMMENTS:

(1) INCLUDES ACTIVITY
CODES 101-180,
300-303, 307,
326-328, 406.

PROGRAM SUMMARY DATA

The Program Summary Sheet is designed to give program managers, directors, board members and other policy makers a one-page look at the activities reported to the Office of Alcoholism & Drug Abuse Management Information System (MIS). This report is prepared using data from several of the production reports routinely generated by the system. At this time, the report itself is not computer generated, therefore we plan to prepare it manually on a quarterly basis. 1/

Following are definitions/explanations for the various items included on the summary report.

- 1) Program Name: The name of the grantee reporting entity.
- 2) Report Period: Time period covered by the report.
- 3) Client Data: This section of the report is completed for those programs with formal treatment components. The demographic data contained in this section is taken from the Client Admission Form.
- 4) Client Activity: This section contains client flow information. The number of active clients at the beginning of the report period, the number of first-time admissions, the number of re-admissions, the number of terminations and the number of active clients on file at the end of the reporting period. The active clients at the beginning of the period plus the new admissions plus re-admissions, minus the terminations equals the clients on file at the end of the period.
- 5) Sex: The number and percentage of males and females admitted during the report period.
- 6) Primary Problem Alcohol: The number and percentage of admissions listing alcohol as the primary substance abuse problem. For those programs primarily listing other substances as the primary problem a breakdown of numbers and percentages by substance is provided in the comments section.
- 7) Legal Involvement: The number and percentage of admissions entering the program as a direct result of involvement with the criminal justice system.

-
- 1/ Rpt. # 2300 is used to complete (5), (7), (8), (9)
Rpt. # 2325 is used to complete (6)
Rpt. # 2310 is used to complete (4)
Rpt. # 2205 is used to complete (10), (11), (12), (13), (14), (16), (17),
(18), (19)
Rpt. # 2335 is used to complete (15)

Summary Sheet Definitions (cont.)

- 8) Race: The number and percent of clients listing their race/ethnicity as caucasian, Alaska native, or other. A much more detailed breakdown of demographic characteristics is available by program, region and statewide using routine production reports.
- 9) Age: The number and percent of admissions broken out by age group.

Resource Utilization Data

This section summarizes staff hours expended by component. Source for the data is the Component Services Report (2505) and the Bed Utilization Report (2335). Staff report hours via the Staff Activity Log.

- 10) Component Number: The number assigned to the component of service. These components generally follow the state standards (i.e., intermediate care, aftercare, outpatient, etc.). The first two digits of the component number indicate the type of component. The third digit allows the grantee to separate free-standing components within a like type of service (example: 041, 042 would be used for short-term intermediate care and a halfway house).
- 11) Component Name: The name assigned by the grantee to the component, such as "Aurora's Watch" for the halfway house in Sitka.
- 12) Total Staff Hours: The total staff hours (rounded) reported within the component for the report period.
- 13) Number of Admitted Clients Served: The number of unique client numbers receiving services within the component during the report period. This number refers to formally admitted clients receiving "100" series client-specific services.
- 14) Level of Activity (# people): This figure gives the total number of "participants" from all the non-client specific activities listed during the report period. For example, the Alaska Council reports its "Here's Looking At You" kindergarten through 12th grade education program under a separate component number. As they complete staff log entries for items such as code 314 (student education presentation) staff will enter the number of events and participants. A figure of, for example, 3000 would indicate that 3000 people attended these presentations. Other "300" or "400" series codes (the non-client specific codes) also note events and participants. The figure listed on this summary report adds all the participants from all the different "300" and "400" codes listed. For a detailed breakdown, the reader would want to review the Component Services Report for the grantee of interest.
- 15) Bed Utilization (percentage): Lists the bed utilization rate of each separate residential component for the report period. This figure is

Summary Sheet Definitions (cont.)

taken from the Bed Utilization Report (2335) which is built from the Residential/Detox Log. Bed Utilization rate is a basic mathematical calculation that multiplies the number of calendar days in the report period by the number of beds ("available bed days"). Then the computer sums the "occupied bed days" from the residential logs and divides this sum by the "available bed days" to arrive at the bed utilization rate.

- 16) % Hours Client & Pre/Post Client: This column lists the percentage of total staff hours for each component (12) that were spent in direct contact with individuals who are clients, who may become clients, or have completed the formal treatment plan and have been terminated from the active roles of the program. This column includes all of the "100" series codes, Codes "300 - 303", "307", "326-328", and "406".
- 16) (cont.) "300" = Services to Former Client
"301" = Pre-client Contact
"302" = Crisis Intervention
"303" = Client Follow-up
"307" = Urinalysis Testing
"326" = Non-client specific Screening & Assessment
"327" = Non-client specific Group Counseling
"328" = Non-client specific Individual Counseling
"406" = Working with Individuals Who May Become Clients (village counselors only)
- 17) % Hours Spent in "100" series. Percentage of total staff hours (12) recorded against "100" series codes. *** (Client specific activities, must include an active client)
- 18) % Hours Spent in "200" series. Percentage of total staff hours (12) recorded against "200" series codes. *** (Administrative, includes all activities related to maintenance of client files)
- 19) % Hours Spent in "300/400" series. Percentage of total staff hours (12) recorded against "300" or "400" series codes. *** (300 - non-client specific activities - prevention, pre/post client, training, etc. 400 - Bush programs)

Program Totals: The totals under column (12), Total Staff Hours and column (14) Level of Activity are numeric sums of the individual component figures.

Number of Admitted Clients (13). Since a client may move from one component of care to another during treatment, the total unique client numbers served is recalculated at the program level to provide a more accurate figure.

% Staff hours Spent in "100, 200, 300/400" Series (columns 17, 18, & 19) are recalculated based on the total staff hours at the program level.

PROGRAM NAME: ALEUTIAN-PRIBILOF ISLAND ASSOCIATION (STARTED ON MIS 11/1/83)

PROGRAM SUMMARY DATA: COVERING PERIOD: FROM: 7/1/83 TO: 6/30/84

```

*****
* CLIENT DATA *
*****
CLIENT ACTIVITY      SEX      PROBLEM/LEGAL      RACE      NO.      %      AGE
ACTIVE BEG. OF PERIOD: 0      NO. PERCENT      NO. %      NO. %      NO. %      NO. %
NEW ADMISSIONS:      55      *****      *****      *****      *****      *****      *****
READMISSIONS:      0      42 76.4 % MALE      PRIMARY PROB.      17      31% CAUCASIAN      28      51% 26-40 YRS
TERMINATIONS      22      13 23.6 % FEMALE      ALCOHOL      35      64% AK NATIVE      11      20% 41-60 YRS
ACTIVE END OF PERIOD 34      17 31% LEGAL INVOLV.      3      5% ALL OTHER      1      2% >= 61 YRS
*****

```

```

*****
RESOURCE UTILIZATION DATA
*****
COMP. NO. COMPONENT      TOTAL STAFF HRS      NUMBER ADMITTED CLIENTS SERVED      LEVEL OF ACTIVITY (# PEOPLE)      % BED UTILIZATION      % HRS CLIENT & PRE/POST CLIENT (1)      % STAFF HOURS SPENT IN "100" SERIES      "200" SERIES      "300"/"400" SERIES
*****
000 COMMUNITY PROGRAM      3,743      51      817      --      9.7%      6.2%      44.7%      49.1%
TOTAL      3,743      51      817      OVERALL:      6.2%      44.7%      49.1%

```

COMMENTS:

(1) INCLUDES ACTIVITY
CODES 101-180,
300-303,307,
326-328, 406.

PROGRAM NAME: ALASKA COUNCIL ON PREVENTION OF ALCOHOLISM & OTHER DRUG ABUSE

PROGRAM SUMMARY DATA: COVERING PERIOD: FROM: 7/1/83 TO: 6/30/84

 * CLIENT DATA *

CLIENT ACTIVITY	SEX	PROBLEM/LEGAL	RACE	AGE
ACTIVE BEG. OF PERIOD: ---	NO. PERCENT	NO. %	NO. %	NO. %
NEW ADMISSIONS: ---	****	****	****	---
READMISSIONS: ---	----	----	----	---
TERMINATIONS: ---	----	----	----	---
ACTIVE END OF PERIOD: ---	----	----	----	---

 RESOURCE UTILIZATION DATA

COMP. NO.	COMPONENT NAME	TOTAL STAFF HRS	NUMBER ADMITTED CLIENTS SERVED	LEVEL OF ACTIVITY (# PEOPLE)	% BED UTILIZATION	% HRS CLIENT & PRE/POST CLIENT (1)	% STAFF HOURS SPENT IN "100" SERIES	"200" SERIES	"300"/"400" SERIES
010	ADMINISTRATION	11,722	--	1,027	-- %	-- %	-- %	98.2%	1.8%
070	OUTREACH EMP. ASSIST. PRGM.	1,165	--	423	-- %	-- %	-- %	76.2%	23.8%
090	STATEWIDE PREVENTION COORD.	1,937	--	4,398	-- %	-- %	-- %	28.9%	71.1%
101	COMMUNITY DEV/SPECIAL PROJ.	274	--	48	-- %	-- %	-- %	64.8%	35.2%
102	HERE'S LOOKING AT YOU	9,932	--	25,150	-- %	-- %	-- %	52.4%	47.6%
103	PUBLIC INFORMATION	2,509	--	12,385	-- %	-- %	-- %	65.8%	34.2%
104	NORTH STAR PROJECT	2,827	--	3,118	-- %	-- %	-- %	68.8%	31.2%
105	HIGHWAY SAFETY PLANNING	1,298	--	7,284	-- %	-- %	-- %	63.6%	36.4%
TOTAL		31,664	N/A	53,833			OVERALL:	N/A	71.9%

COMMENTS:

(1) INCLUDES ACTIVITY
 CODES 101-180,
 300-303, 307,
 326-328, 406.

PROGRAM NAME: AKEELA HOUSE

PROGRAM SUMMARY DATA: COVERING PERIOD: FROM: 7/1/83 TO: 6/30/84

```

*****
* CLIENT DATA *
*****
CLIENT ACTIVITY    SEX    PROBLEM/LEGAL    RACE    NO.    %    AGE
ACTIVE BEG. OF PERIOD: 213    NO.    PERCENT    NO.    %    NO.    %    112    10%    <= 17 YRS
NEW ADMISSIONS:    746    *****    *****    *****    *****    419    39%    18-25 YRS
READMISSIONS:    104    820    77.0 % MALE    PRIMARY PROB.    917    86%    CAUCASIAN    466    44%    26-40 YRS
TERMINATIONS    775    242    23.0 % FEMALE    648    61%    ALCOHOL    55    5%    AK NATIVE    64    6%    41-60 YRS
ACTIVE END OF PERIOD 291    606    57%    LEGAL INVOLV.    93    9%    ALL OTHER    3    1%    >= 61 YRS
*****

```

```

*****
RESOURCE UTILIZATION DATA
*****
COMP. NO.    COMPONENT    TOTAL STAFF HRS    NUMBER ADMITTED OF CLIENTS SERVED    LEVEL OF ACTIVITY (# PEOPLE)    % BED UTILIZATION    % CLIENT PRE/POST (1)    % STAFF HOURS SPENT IN "100" SERIES    "200" SERIES    "300"/"400" SERIES
*****
010    MANAGEMENT & SUPPORT SERVICES    15,612    N/A    333    N/A    0.0%    /-    0.0%    96.2%    3.8%
020    EVALUATION    2,589    115    1,668    N/A    68.8%    11.9%    14.2%    73.9%
030    OUTREACH    1,904    N/A    11,645    N/A    0.3%    0.0%    70.6%    29.4%
040    INTERMEDIATE CARE    24,080    133    2,353    85.7%    26.4%    25.4%    72.9%    1.7%
051    OUTPATIENT WOMEN    1,739    221    271    N/A    67.3%    52.6%    26.8%    20.6%
052    OUTPATIENT ADULT    6,696    657    874    N/A    47.8%    38.8%    33.4%    27.8%
053    OUTPATIENT YOUTH    3,531    136    5,043    N/A    47.5%    21.4%    25.1%    53.5%
054    OUTPATIENT JAIL    610    2    2,149    N/A    83.0%    0.7%    8.2%    91.1%
055    OUTPATIENT SCHOOLS    161    6    102    N/A    20.0%    6.0%    13.6%    75.4%
056    AFTERCARE    1,502    77    560    N/A    54.5%    47.4%    37.2%    15.4%
*****
TOTAL    58,424    1,001    24,998    /-    OVERALL:    19.5%    71.0%    9.5%
*****

```

COMMENTS:

AKEELA HOUSE LISTED PRIMARY PROBLEM AT ADMISSION AS FOLLOWS:
 648 (61.0%) ALCOHOL
 24 (2.2%) OPIATES/SYNTHETIC OPIATES
 7 (0.7%) DEPRESSANTS
 160 (15.0%) STIMULANTS
 152 (14.0%) MARIJUANA
 15 (1.4%) OTHER

(1) INCLUDES ACTIVITY CODES 101-180, 300-303, 307, 326-328, 406.

PROGRAM NAME: AMOUAK CENTER

PROGRAM SUMMARY DATA: COVERING PERIOD: FROM: 7/1/83 TO: 6/30/84

***** CLIENT DATA *****

CLIENT ACTIVITY		SEX	PROBLEM/LEGAL		RACE	AGE	
ACTIVE BEG. OF PERIOD:	34	NO.	PERCENT	NO.	%	NO.	%
NEW ADMISSIONS:	102	****	*****	****	*****	51	33%
READMISSIONS:	18	101	68.2 % MALE	1	1% CAUCASIAN	82	53%
TERMINATIONS	117	47	31.8 % FEMALE	149	96% AK NATIVE	21	14%
ACTIVE END OF PERIOD	39			68	46% LEGAL INVOLV.	5	3% ALL OTHER

***** RESOURCE UTILIZATION DATA *****

COMP. NO.	COMPONENT NAME	TOTAL STAFF HRS	NUMBER ADMITTED CLIENTS SERVED	LEVEL OF ACTIVITY (# PEOPLE)	% BED UTILIZATION	% HRS CLIENT & PRE/POST CLIENT (1)	% STAFF HOURS SPENT IN		
							"100" SERIES	"200" SERIES	"300"/"400" SERIES
040	INTERMEDIATE CARE UNIT *	6,413	58	3	39.6%	69.3%	69.0%	29.6%	1.4%
050	OUTPATIENT	6,968	76	346	N/A	28.6%	20.0%	56.6%	23.4%
TOTAL		13,381	148	349			OVERALL: 43.5%	43.6%	12.9%

COMMENTS:

*CLOSED

(1) INCLUDES ACTIVITY
CODES 101-180,
300-303,307,
326-328, 406.

6/30/84 10:01

* CLIENT DATA *									
CLIENT ACTIVITY									
SEX									
PROBLEM/LEGAL									
RACE									
NO. %									
AGE									
ACTIVE BEG. OF PERIOD: 72									
NO. PERCENT									
NEW ADMISSIONS: 43									
READMISSIONS: 1									
TERMINATIONS: 98									
ACTIVE END OF PERIOD 18									
1 1% LEGAL INVOLV.									
4 12									
86% CAUCASIAN									
16 33% <= 17 YRS									
19 30% 18-25 YRS									
34 7% 26-40 YRS									
8 7% 41-60 YRS									
18 16% >= 61 YRS									
4 ALL OTHER									
10% AK NATIVE									
99 92% ALCOHOL									
100 92% FEMALE									
53 46.1% MALE									
PRIMARY PROB.									

[illegible]

(1) INCLUDES ACTIVITY
CODES 101-180,
300-303, 307,
326-328, 406.

PROGRAM NAME: ANTI

PROGRAM SUMMARY DATA: COVERING PERIOD: FROM: 7/1/83 TO: 6/30/84

```
*****
* CLIENT DATA *
*****
CLIENT ACTIVITY SEX PROBLEM/LEGAL RACE NO. % AGE
ACTIVE BEG. OF PERIOD: --- NO. PERCENT NO. % --- --% <= 17 YRS
NEW ADMISSIONS: --- **** ***** **** ***** --- --% 18-25 YRS
READMISSIONS: --- ---- --% MALE ---- --% PRIMARY PROB. --- --% CAUCASIAN --- --% 26-40 YRS
TERMINATIONS --- ---- --% FEMALE ---- --% ALCOHOL --- --% AK NATIVE --- --% 41-60 YRS
ACTIVE END OF PERIOD --- ---- --% LEGAL INVOLV. --- --% ALL OTHER --- --% >= 61 YRS
*****
```

```
*****
RESOURCE UTILIZATION DATA
*****
COMP. COMPONENT TOTAL NUMBER LEVEL % % HRS /- % STAFF HOURS SPENT IN
NO. NAME STAFF ADMITTED OF BED CLIENT & /- "100" "200" "300"/
***** ***** ***** ***** ***** ***** /- SERIES SERIES SERIES
100 CONSULTATION & EDUCATION 2,274 N/A 517 -- -- -- 56.0% 44.0%
***** ***** ***** ***** ***** /- ***** ***** *****
TOTAL 2,274 N/A 517 OVERALL: N/A% 56.0% 44.0%
(UNDUPLICATED)
```

COMMENTS:

ANTI RECORDED 80 SOADA TRAINING
EVENTS WITH A TOTAL OF 401 PARTICIPANTS.

(1) INCLUDES ACTIVITY
CODES 101-130,
300-303, 307,
326-328, 406.

PROGRAM NAME: VOLUNTEERS OF AMERICA/ARCH

PROGRAM SUMMARY DATA: COVERING PERIOD: FROM: 7/1/83 TO: 6/30/84

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*****
* CLIENT DATA *
*****
CLIENT ACTIVITY    SEX    PROBLEM/LEGAL    RACE    NO.    %    AGE
ACTIVE BEG. OF PERIOD: 21    NO.    PERCENT    NO.    %    NO.    %    47 100% <= 17 YRS
NEW ADMISSIONS: 26    ****    *****    ****    *****    ****    *****    0 0% 18-25 YRS
READMISSIONS: 1    35    74.5 % MALE    PRIMARY PROB.    36    77% CAUCASIAN    0 0% 26-40 YRS
TERMINATIONS 32    12    25.5 % FEMALE    *10 21% ALCOHOL    8 17% AK NATIVE    0 0% 41-60 YRS
ACTIVE END OF PERIOD 16    40 85% LEGAL INVOLV.    3 6% ALL OTHER    0 0% >= 61 YRS
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*****
RESOURCE UTILIZATION DATA
*****
COMP. NO.    COMPONENT NAME    TOTAL STAFF HRS    NUMBER ADMITTED CLIENTS SERVED    LEVEL OF ACTIVITY (# PEOPLE)    % BED UTILIZATION    % CLIENT & PRE/POST CLIENT (1)    % STAFF HOURS SPENT IN "100" SERIES    "200" SERIES    "300"/"400" SERIES
*****
010    MANAGEMENT & SUPPORT SERVICES    11,336    N/A    537    N/A    1.7%    0.0%    92.2%    7.3%
040    INTERMEDIATE CARE    22,965    41    6    91.3%    99.6%    99.3%    .4%    .3%
TOTAL    34,301    48    543    OVERALL:    66.5%    30.7%    2.8%

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COMMENTS:

*PRIMARY PROBLEM:

10 (21%) ALCOHOL
1 (2%) DEPRESSANTS
35 (75%) MARIJUANA/HASHISH
1 (2%) POLYDRUG USE

(1) INCLUDES ACTIVITY
CODES 101-180,
300-303,307,
326-328, 406.

PROGRAM NAME: BBAHC - DILLINGHAM

PROGRAM SUMMARY DATA: COVERING PERIOD: FROM: 7/1/83 TO: 6/30/84

* CLIENT DATA *

CLIENT ACTIVITY	SEX	PROBLEM/LEGAL	RACE	AGE
ACTIVE BEG. OF PERIOD: 53	NO. PERCENT	NO. %	NO. %	NO. %
NEW ADMISSIONS: 63	****	****	****	46 34% 18-25 YRS
READMISSIONS: 21	105 77.2 % MALE	PRIMARY PROB.	18 13% CAUCASIAN	63 46% 26-40 YRS
TERMINATIONS 108	31 22.8 % FEMALE	ALCOHOL	118 87% AK NATIVE	25 20% 41-60 YRS
ACTIVE END OF PERIOD 29		85 63% LEGAL INVOLV.	0 0% ALL OTHER	1 0% >= 61 YRS

RESOURCE UTILIZATION DATA

COMP. NO.	COMPONENT NAME	TOTAL STAFF HRS	NUMBER ADMITTED CLIENTS SERVED	LEVEL OF ACTIVITY (# PEOPLE)	% BED UTILIZATION	% HRS CLIENT & PRE/POST CLIENT (1)	% STAFF HOURS SPENT IN	"100" SERIES	"200" SERIES	"300"/"400" SERIES
000	OUTPATIENT	10,854	108	2,746	--	12.2%	8.1%	68.1%	23.8%	
070	DILLINGHAM ASAP	2,078	N/A	285	--	5.2%	0.0%	85.4%	14.6%	
	TOTAL	12,932	122	3,031			OVERALL: 6.8%	70.9%	22.3%	

COMMENTS: (UNDUPLICATED)

(1) INCLUDES ACTIVITY
CODES 101-180,
300-303,307,
326-328, 406.

PROGRAM NAME: CENTER FOR ALCOHOL & ADDICTION STUDIES

PROGRAM SUMMARY DATA: COVERING PERIOD: FROM: 7/1/83 TO: 6/30/84

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*****
* CLIENT DATA *
*****
CLIENT ACTIVITY    SEX    PROBLEM/LEGAL    RACE    NO.    %    AGE
ACTIVE BEG. OF PERIOD: --- NO. PERCENT    NO. %    NO. %    --- --% <= 17 YRS
NEW ADMISSIONS: --- **** ***** **** ***** **** ***** --- --% 18-25 YRS
READMISSIONS: --- ---- --% MALE    PRIMARY PROB. --- --% CAUCASIAN --- --% 26-40 YRS
TERMINATIONS --- ---- --% FEMALE --- --% ALCOHOL --- --% AK NATIVE --- --% 41-60 YRS
ACTIVE END OF PERIOD --- --- --% LEGAL INVOLV. --- --% ALL OTHER --- --% >= 61 YRS
*****

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*****
RESOURCE UTILIZATION DATA
*****
COMP. NO.    COMPONENT NAME    TOTAL STAFF HRS    NUMBER ADMITTED CLIENTS SERVED    LEVEL OF ACTIVITY (# PEOPLE)    % BED UTILIZATION    % HRS CLIENT & PRE/POST CLIENT (1)    % STAFF HOURS SPENT IN "100" SERIES    "200" SERIES    "300"/"400" SERIES
*****
900    CAAS    2,122    N/A    580    --%    --%    /-    0.0%    64.7%    35.3%
*****
TOTAL    2,122    N/A    580    OVERALL:    0.0%    64.7%    35.3%
*****
COMMENTS:
(UNDUPLICATED)

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(1) INCLUDES ACTIVITY
CODES 101-180,
300-303, 307,
326-328, 406.

PROGRAM NAME: COOK INLET COUNCIL ON ALCOHOLISM

PROGRAM SUMMARY DATA: COVERING PERIOD: FROM: 7/1/83 TO: 6/30/84

* CLIENT DATA *									
CLIENT ACTIVITY		SEX		PROBLEM/LEGAL		RACE		AGE	
ACTIVE BEG. OF PERIOD:	106	NO.	PERCENT	NO.	%	NO.	%	NO.	%
NEW ADMISSIONS:	251	324	78.6 % MALE	350	85% ALCOHOL	379	92% CAUCASIAN	36	9% <= 17 YRS
READMISSIONS:	56	88	21.4 % FEMALE	258	63% LEGAL INVOLV.	22	5% AK NATIVE	98	24% 18-25 YRS
TERMINATIONS	273					11	3% ALL OTHER	211	51% 26-40 YRS
ACTIVE END OF PERIOD	140							57	14% 41-60 YRS
								10	2% >= 61 YRS

RESOURCE UTILIZATION DATA									
COMP. NO.	COMPONENT NAME	TOTAL STAFF HRS	NUMBER ADMITTED OF CLIENTS SERVED	LEVEL OF ACTIVITY (# PEOPLE)	% BED UTILIZATION	% HRS CLIENT & PRE/POST CLIENT (1)	% STAFF HOURS SPENT IN		
							"100" SERIES	"200" SERIES	"300"/"400" SERIES
000	COMMUNITY PROGRAM	2,493	0	5,422	--	12.5%	0.0%	54.6%	45.4%
010	MANAGEMENT & SUPPORT SERVICES	6,893	N/A	195	--	-- %	0.0%	93.8%	6.2%
051	OUTPATIENT HOMER	1,784	116	1,430	--	38.0%	24.7%	44.1%	31.2%
052	OUTPATIENT KENAI	1,841	247	3,440	--	75.7%	61.0%	11.0%	28.0%
071	ASAP HOMER	2,066	--	854	--	16.0%	0.0%	78.4%	21.6%
072	ASAP KENAI	2,125	--	571	--	31.3%	0.0%	60.1%	39.9%
090	YOUTH OPTIONS	2,139	--	3,116	--	7.1%	.1%	76.9%	23.0%
	TOTAL	19,341	387	15,028			OVERALL: 8.1%	69.0%	22.9%

COMMENTS:

(1) INCLUDES ACTIVITY
CODES 101-180,
300-303, 307,
326-328, 406.

PROGRAM NAME: CORDOVA MENTAL HEALTH & ALCOHOLISM CLINIC

PROGRAM SUMMARY DATA: COVERING PERIOD: FROM: 7/1/83

TO: 6/30/84

* CLIENT DATA *

CLIENT ACTIVITY		SEX	PROBLEM/LEGAL		RACE		AGE	
ACTIVE BEG. OF PERIOD:	27	NO.	PERCENT	NO.	%	NO.	%	4 5% <= 17 YRS
NEW ADMISSIONS:	45	***	*****	***	*****	***	*****	31 35% 18-25 YRS
READMISSIONS:	17	63	71.6 % MALE		PRIMARY PROB.	56	64% CAUCASIAN	39 44% 26-40 YRS
TERMINATIONS	72	25	28.4 % FEMALE	82	93% ALCOHOL	24	27% AK NATIVE	12 14% 41-60 YRS
ACTIVE END OF PERIOD	17			44	50% LEGAL INVOLV.	8	9% ALL OTHER	2 2% >= 61 YRS

RESOURCE UTILIZATION DATA

COMP. NO.	COMPONENT NAME	TOTAL STAFF HRS	NUMBER ADMITTED OF CLIENTS SERVED	LEVEL OF ACTIVITY (# PEOPLE)	% BED UTILIZATION	% HRS CLIENT & PRE/POST CLIENT (1)	% STAFF HOURS SPENT IN "100" SERIES	"200" SERIES	"300"/"400" SERIES
000	COMMUNITY SERVICES	2,399	71	1,679	--	48.5%	31.0%	42.5%	26.5%
TOTAL		2,399	71	1,679	OVERALL:		31.0%	42.5%	26.5%

COMMENTS:

(UNDUPLICATED)

(1) INCLUDES ACTIVITY
CODES 101-180,
300-303, 307,
326-328, 406.

PROGRAM NAME: CRAIG YOUTH CENTER

PROGRAM SUMMARY DATA: COVERING PERIOD: FROM: 7/1/83 TO: 6/30/84

 * CLIENT DATA *

CLIENT ACTIVITY	SEX	PROBLEM/LEGAL	RACE	AGE
ACTIVE BEG. OF PERIOD: ---	NO. PERCENT	NO. %	NO. %	NO. %
NEW ADMISSIONS: ---	****	****	****	---
READMISSIONS: ---	----	---	---	---
TERMINATIONS: ---	----	----	----	----
ACTIVE END OF PERIOD: ---	----	----	----	----

 RESOURCE UTILIZATION DATA

COMP. NO.	COMPONENT NAME	TOTAL STAFF HRS	NUMBER ADMITTED OF CLIENTS SERVED	LEVEL OF ACTIVITY (# PEOPLE)	% BED UTILIZATION	% HRS CLIENT & PRE/POST CLIENT (1)	% STAFF HOURS SPENT IN
090	YOUTH ALTERNATIVES	1,666	N/A	7,092	---	---	0.0% 19.2% 80.8%
TOTAL		1,666	N/A	7,092	OVERALL: 0.0% 19.2% 80.8%		

 COMMENTS:
 BEGAN REPORTING ON THE MIS 11/1/83
 (UNDUPLICATED)

(1) INCLUDES ACTIVITY
 CODES 101-180,
 300-303, 307,
 326-328, 406.

PROGRAM NAME: COPPER RIVER MENTAL HEALTH & SUBSTANCE ABUSE

PROGRAM SUMMARY DATA: COVERING PERIOD: FROM: 7/1/83 TO: 6/30/84

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*****
* CLIENT DATA *
*****
CLIENT ACTIVITY SEX PROBLEM/LEGAL RACE NO. % AGE
ACTIVE BEG. OF PERIOD: 38 NO. PERCENT NO. % NO. %
NEW ADMISSIONS: 45 **** ***** **** ***** **** ***** 26 31% 18-25 YRS
READMISSIONS: 1 65 78.3 % MALE PRIMARY PROB. 24 29% CAUCASIAN 34 42% 26-40 YRS
TERMINATIONS 76 18 21.7 % FEMALE *51 61% ALCOHOL 54 65% AK NATIVE 19 23% 41-60 YRS
ACTIVE END OF PERIOD 8 64 77% LEGAL INVOLV. 5 6% ALL OTHER 2 2% >= 61 YRS
*****

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*****
RESOURCE UTILIZATION DATA
*****
COMP. COMPONENT TOTAL NUMBER LEVEL % % HRS /- % STAFF HOURS SPENT IN
NO. NAME STAFF ADMITTED OF BED CLIENT & /- "100" "200" "300"/
***** ***** ***** ***** ***** ***** ***** ***** *****
000 COMMUNITY PROGRAM 4,974 84 2,098 -- 28.7% 26.2% 48.0% 25.8%
TOTAL 4,974 84 2,098 OVERALL: 26.2% 48.0% 25.8%

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COMMENTS:

*'PRIMARY PROBLEM' NOT PROVIDED ON
CLIENT ADMISSION FORM 24% OF THE TIME. WE ESTIMATE
ACTUAL PERCENT "ALCOHOL AS PRIMARY PROBLEM" TO BE OVER 95%

(1) INCLUDES ACTIVITY
CODES 101-180,
300-303,307,
326-328, 406.

PROGRAM NAME: CENTER FOR DRUG PROBLEMS - MUNICIPALITY OF ANCHORAGE

PROGRAM SUMMARY DATA: COVERING PERIOD: FROM: 7/1/83 TO: 6/30/84

 * CLIENT DATA *

CLIENT ACTIVITY		SEX	PROBLEM/LEGAL		RACE	AGE	
ACTIVE BEG. OF PERIOD:	NO.	PERCENT	NO.	%	NO.	%	%
NEW ADMISSIONS:	57	105	2*	1%	126	80%	1% <= 17 YRS
READMISSIONS:	46	66.5 % MALE	1	ALCOHOL	5	3% AK NATIVE	14% 18-25 YRS
TERMINATIONS	101	33.5 % FEMALE	27	17% LEGAL INVOLV.	27	17% ALL OTHER	78% 26-40 YRS
ACTIVE END OF PERIOD	58						1% >= 61 YRS

 RESOURCE UTILIZATION DATA

COMP. NO.	COMPONENT NAME	TOTAL STAFF HRS	NUMBER ADMITTED CLIENTS SERVED	LEVEL OF ACTIVITY (# PEOPLE)	% BED UTILIZATION	% HRS CLIENT & PRE/POST CLIENT (1)	% STAFF HOURS SPENT IN "100" SERIES	"200" SERIES	"300"/"400" SERIES
010	MANAGEMENT & SUPPORT SERVICES	7,936	18**	846	--	3.0%	.3%**	88.0%	11.7%
050	OUTPATIENT DRUG FREE	180	37	6	--	97.0%	88.9%	2.8%	8.3%
060	OUTPATIENT METHADONE	4,474	114	206	--	95.8%	93.9%	3.6%	2.5%
TOTAL		12,590	137	1,058			OVERALL: 34.8%	56.8%	8.4%

COMMENTS:

* 158 ADMISSIONS STATED PRIMARY PROBLEM AS FOLLOWS: 143 (91%) OPIATES,
 1 SYNTHETIC OPIATES
 6 DEPRESSANTS
 2 STIMULANTS
 2 MARIJUANA/HASHISH

** SHOULD NOT REPORT CLIENT-SPECIFIC ACTIVITIES IN 010 COMPONENT.

(1) INCLUDES ACTIVITY CODES 101-180, 300-303, 307, 326-328, 406.

PROGRAM NAME: FAIRBANKS NATIVE ASSOCIATION C A P

PROGRAM SUMMARY DATA: COVERING PERIOD: FROM: 7/1/83 TO: 6/30/84

* CLIENT DATA *

CLIENT ACTIVITY	SEX	PROBLEM/LEGAL	RACE	NO.	%	AGE
ACTIVE BEG. OF PERIOD: 483	NO. PERCENT	NO. %	NO. %	58	3%	<= 17 YRS
NEW ADMISSIONS: 815	1668	78.0 % MALE	PRIMARY PROB.	1044	49%	CAUCASIAN 1075 51% 26-40 YRS
READMISSIONS: 847	1601	22.0 % FEMALE	ALCOHOL	975	46%	AK NATIVE 497 23% 41-60 YRS
TERMINATIONS	544	951	44%	LEGAL INVOLV.	117	5% ALL OTHER 70 3% >= 61 YRS
ACTIVE END OF PERIOD						

RESOURCE UTILIZATION DATA

COMP. NO.	COMPONENT NAME	TOTAL STAFF HRS	NUMBER ADMITTED CLIENTS SERVED	LEVEL OF ACTIVITY (# PEOPLE)	% BED UTILIZATION	% HRS CLIENT PRE/POST CLIENT (1)	% STAFF HOURS SPENT IN "100" SERIES	"200" SERIES	"300"/"400" SERIES
010	MANAGEMENT & SUPPORT SERVICES	18,248	N/A	6	N/A %	N/A %	N/A %	99.6%	.4%
021	DETOX	9,208	591	5	66.4%	83.2%	83.1%	16.1%	.8%
022	COMMUNITY SERVICES PATROL	3,476	N/A	3,584	N/A %	N/A %	N/A %	7.2%	92.8%
041	SHORT TERM INTERMEDIATE CARE	11,894	276	442	73.2%	73.5%	70.8%	24.7%	4.5%
042	LONG TERM INTERMEDIATE CARE	6,372	75	27	62.6%	41.2%	40.3%	58.1%	1.6%
050	OUTPATIENT-AFTERCARE SERVICES	7,947	777	949	N/A %	52.7%	50.4%	37.4%	12.2%
051	INCARCERATED 310 1/2 FIRS	1,443	142	1,321	N/A %	69.4%	61.2%	12.3%	25.9%
070	FBKS ASAP MISDEMEANOR SERVICES	6,644	114	693	N/A %	12.9%	1.9%	81.8%	16.3%
090	YOUTH D/A PREVENTION PROGRAM	6,930	N/A	8,450	N/A %	.3%	.1%	42.5%	57.4%
100	PUBLIC EDUCATION PREV. PROGRAM	5,608	10	13,859	N/A %	16.9%	.1%	47.6%	52.3%
900	REGIONAL TRAINING	3,157	N/A	459	N/A %	N/A %	N/A %	5.4%	94.6%
TOTAL		80,927	1,329	29,795	OVERALL: 29.3% 50.5% 20.2%				

COMMENTS:

(UNDUPLICATED)

(1) INCLUDES ACTIVITY CODES 101-180, 300-303, 307, 326-328, 406.

PROGRAM NAME: GALENA - YK MENTAL HEALTH PROGRAM

PROGRAM SUMMARY DATA: COVERING PERIOD: FROM: 7/1/83 TO: 6/30/84

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*****
* CLIENT DATA *
*****
CLIENT ACTIVITY    SEX    PROBLEM/LEGAL    RACE    NO.    %    AGE
ACTIVE BEG. OF PERIOD: 61    NO.    PERCENT    NO.    %    NO.    %    <= 17 YRS
NEW ADMISSIONS: 26    ****    *****    ****    *****    ****    *****    20    22%    18-25 YRS
READMISSIONS: 5    40    44.4 % MALE    PRIMARY PROB.    1    1% CAUCASIAN    44    49%    26-40 YRS
TERMINATIONS 75    50    55.6 % FEMALE    *67    74% ALCOHOL    89    99% AK NATIVE    18    20%    41-60 YRS
ACTIVE END OF PERIOD 17    11    12% LEGAL INVOLV.    0    0% ALL OTHER    5    6%    >= 61 YRS
*****

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*****
* RESOURCE UTILIZATION DATA *
*****
COMP. NO.    COMPONENT NAME    TOTAL STAFF HRS    NUMBER ADMITTED CLIENTS SERVED    LEVEL OF ACTIVITY (# PEOPLE)    % BED UTILIZATION    % HRS CLIENT & PRE/POST CLIENT (1)    % STAFF HOURS SPENT IN "100" SERIES    "200" SERIES    "300"/"400" SERIES
*****
000    Y-K MENTAL HEALTH PROGRAM    3,773    44    910    --    8.5%    4.3%    83.0%    12.7%
TOTAL    3,773    44    910    OVERALL:    4.3%    83.0%    12.7%

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COMMENTS:

* 'PRIMARY PROBLEM' NOT PROVIDED ON
CLIENT ADMISSION FORM 26% OF THE TIME.
WE ESTIMATE "PRIMARY PROBLEM OF ALCOHOL" TO BE
OVER 95%

(1) INCLUDES ACTIVITY
CODES 101-180,
300-303, 307,
326-323, 406.

PROGRAM NAME: ALCOHOL & DRUG ABUSE CENTRAL AGENCY (JUNEAU)

PROGRAM SUMMARY DATA: COVERING PERIOD: FROM: 7/1/83

TO: 6/30/84

* CLIENT DATA *									
CLIENT ACTIVITY	SEX	PROBLEM/LEGAL	RACE	NO.	%	AGE			
ACTIVE BEG. OF PERIOD: 284	NO.	PERCENT	NO.	%	NO.	%	33	3%	<= 17 YRS
NEW ADMISSIONS: 444	***	*****	***	*****	***	*****	322	31%	18-25 YRS
READMISSIONS: 311	826	78.3 MALE	991	94%	665	63% CAUCASIAN	468	45%	26-40 YRS
TERMINATIONS 732	230	21.7 FEMALE	542	51% LEGAL INVOLV.	330	31% AK NATIVE	204	19%	41-60 YRS
ACTIVE END OF PERIOD 325					61	6% ALL OTHER	29	2%	>= 61 YRS

RESOURCE UTILIZATION DATA									
COMP. NO.	COMPONENT NAME	TOTAL STAFF HRS	NUMBER ADMITTED CLIENTS SERVED	LEVEL OF ACTIVITY (# PEOPLE)	% BED UTILIZATION	% HRS CLIENT & PRE/POST CLIENT (1)	% STAFF HOURS SPENT IN "100" SERIES	"200" SERIES	"300"/"400" SERIES
010	MANAGEMENT & SUPPORT SERVICES	1,905	N/A	N/A	N/A	N/A	0.0%	96.1%	3.9%
021	DETOXIFICATION	5,218	313	81	127.9%	94.1%	93.7%	3.2%	3.1%
022	COMMUNITY SERVICES PATROL	981	N/A	1,523	N/A	95.6	0.0%	4.4%	95.6%
030	INPATIENT	27,544	278	463	74.3%	35.7%	35.5%	55.5%	9.0%
041	INTERMEDIATE CARE	3,037	74	3	76.1%	33.2%	28.3%	53.7%	18.0%
042	LONG TERM INTERMEDIATE CARE	260	24	1	81.3%	62.5%	47.3%	16.6%	36.1%
050	OUTPATIENT/AFTERCARE	7,936	428	889	N/A	41.9%	38.5%	50.0%	11.5%
071	ALCOHOL SAFETY ACTION PROGRAM	2,932	N/A	349	N/A	25.9	0.0%	73.9%	26.1%
072	OUTREACH/REFERRAL	5	N/A	0	N/A	N/A	0.0%	70.0%	30.0%
090	YOUTH ALTERNATIVES	2,277	N/A	21,360	N/A	5.3	0.0%	46.2%	53.8%
100	CONSULTATION & EDUCATION	1,960	69	9,985	N/A	1.5%	0.0%	74.9%	25.1%
TOTAL		51,055	863 (UNDUPLICATED)	34,654	OVERALL:		36.7%	48.2%	15.1%

(1) INCLUDES ACTIVITY CODES 101-180, 300-303, 307, 326-328, 406.

COMMENTS:

PROGRAM NAME: KETCHIKAN ALCOHOLISM PROGRAM

PROGRAM SUMMARY DATA: COVERING PERIOD: FROM: 7/1/83

TO: 6/30/84

* CLIENT DATA *

CLIENT ACTIVITY	SEX	PROBLEM/LEGAL	RACE	NO.	%	AGE
ACTIVE BEG. OF PERIOD: 94	NO. PERCENT	NO. %	NO. %	47	12%	<= 17 YRS
NEW ADMISSIONS: 203	****	****	****	110	32%	18-25 YRS
READMISSIONS: 108	298 73.8 % MALE	PRIMARY PROD.	236	58% CAUCASIAN	158	39% 26-40 YRS
TERMINATIONS 274	106 26.2 % FEMALE	ALCOHOL	139	34% AK NATIVE	67	17% 41-60 YRS
ACTIVE END OF PERIOD 131		LEGAL INVOLV.	29	8% ALL OTHER	2	0% >= 61 YRS

RESOURCE UTILIZATION DATA

COMP. NO.	COMPONENT NAME	TOTAL STAFF HRS	NUMBER ADMITTED OF CLIENTS SERVED	LEVEL OF ACTIVITY (# PEOPLE)	% BED UTILIZATION	% HRS PRE/POST CLIENT (1)	% STAFF HOURS SPENT IN
							"100" SERIES
010	MANAGEMENT & SUPPORT SERVICES	4,838	N/A	115	N/A %	1.6%	1.5%
040	STRUCTURED RESIDENTIAL	4,458	42	47	26.1%	54.6%	38.0%
050	OUTPATIENT CARE	5,934	359	1,185	N/A %	29.4%	41.5%
071	ALCOHOL SAFETY ACTION PROGRAM	3,402	N/A	268	N/A %	8.1%	87.8%
072	OUTPATIENT/REFERRAL SERVICES	761	26	549	N/A %	19.5%	37.8%
073	PRINCE OF WALES ALCOHOLISM SVC	495	13	83	N/A %	15.2%	62.3%
100	CONSULTATION & EDUCATION	1,065	6	2,226	N/A %	3.8%	24.2%
	TOTAL	20,953	381	4,473			OVERALL: 18.8%

COMMENTS:

(UNDUPLICATED)

(1) INCLUDES ACTIVITY
CODES 101-180,
300-303, 307,
326-328, 406.

PROGRAM NAME: KILA, INC. FSAC

PROGRAM SUMMARY DATA: COVERING PERIOD: FROM: 7/1/83 TO: 6/30/84

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*****
* CLIENT DATA *
*****
      CLIENT ACTIVITY      SEX      PROBLEM/LEGAL      RACE      NO.      %      AGE
ACTIVE BEG. OF PERIOD: 21  NO.  PERCENT      NO.  %      NO.  %      NO.  %      AGE
NEW ADMISSIONS: 143  ****  *****      ****  *****      ****  *****      39  23%  18-25  YRS
READMISSIONS: 8  124  72.5 % MALE      PRIMARY PROB.  142  83%  CAUCASIAN  58  34%  26-40  YRS
TERMINATIONS 108  47  27.6 % FEMALE  *44  28%  ALCOHOL  8  5%  AK NATIVE  9  5%  41-60  YRS
ACTIVE END OF PERIOD 64  64  37%  LEGAL INVOLV.  21  12%  ALL OTHER  1  1%  >= 61 YRS
*****

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*****
* RESOURCE UTILIZATION DATA *
*****
      TOTAL      NUMBER      LEVEL      %      % HRS      /-      % STAFF HOURS SPENT IN
COMP.  COMPONENT      STAFF      ADMITTED      OF      BED      CLIENT &      /-      "100"      "200"      "300"/
NO.  NAME      HRS      SERVED      (# PEOPLE)      UTILI-      PRE/POST      /-      SERIES      SERIES      SERIES
*****  *****  *****  *****  *****  *****  *****  /-  *****  *****  *****
000  KILA, INC, FSAC      8,334      154      1,873      --      31.8%      /-      29.1%      49.8%      21.1%
      TOTAL      8,334      154      1,873      OVERALL:  29.1%      49.8%      21.1%

```

COMMENTS:

KILA REPORTED PRIMARY PROBLEM AT ADMISSION
AS FOLLOWS:
44 (28%) ALCOHOL
31 (19%) OPIATES/SYNTHETIC OPIATES
1 (<1%) DEPRESSANTS
36 (23%) STIMULANTS
38 (24%) MARIJUANA/HASHISH
8 (5%) POLYDRUG
1 (<1%) OTHER

(1) INCLUDES ACTIVITY
CODES 101-180,
300-303,307,
326-328, 406.

PROGRAM NAME: KUSKOKWIM NATIVE ASSOCIATION COMMUNITY COUNSELING

PROGRAM SUMMARY DATA: COVERING PERIOD: FROM: 7/1/83 TO: 6/30/84

* CLIENT DATA *

CLIENT ACTIVITY	SEX	PROBLEM/LEGAL	RACE	AGE
ACTIVE BEG. OF PERIOD: 14	NO. PERCENT	NO. %	NO. %	4 9% <= 17 YRS
NEW ADMISSIONS: 29	****	****	****	13 28% 18-25 YRS
READMISSIONS: 4	33 71.7 % MALE	PRIMARY PROB.	0 0% CAUCASIAN	26 57% 26-40 YRS
TERMINATIONS: 21	13 28.3 % FEMALE	ALCOHOL	46 100% AK NATIVE	2 4% 41-60 YRS
ACTIVE END OF PERIOD: 26		27 59% LEGAL INVOLV.	0 0% ALL OTHER	1 2% >= 61 YRS

RESOURCE UTILIZATION DATA

COMP. NO.	COMPONENT NAME	TOTAL STAFF HRS	NUMBER ADMITTED OF CLIENTS SERVED	LEVEL OF ACTIVITY (# PEOPLE)	% BED UTILIZATION	% CLIENT PRE/POST	% STAFF HOURS SPENT IN
000	COMMUNITY PROGRAM	7,672	45	8,251	--	13.1%	"100" SERIES 4.6%
	TOTAL	7,672	45	8,251			"200" SERIES 58.2%
							"300"/"400" SERIES 37.2%
							OVERALL: 4.6% 58.2% 37.2%

COMMENTS:

(UNDUPLICATED)

(1) INCLUDES ACTIVITY
CODES 101-180,
300-303, 307,
326-328, 406.

PROGRAM NAME: KODIAK COUNCIL ON ALCOHOLISM

PROGRAM SUMMARY DATA: COVERING PERIOD: FROM: 7/1/83

TO: 6/30/84

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*****
* CLIENT DATA *
*****
CLIENT ACTIVITY      SEX      PROBLEM/LEGAL      RACE      NO.      %      AGE
ACTIVE BEG. OF PERIOD: 133  NO.  PERCENT      NO.  %      NO.  %      NO.  %      <= 17 YRS
NEW ADMISSIONS: 257  ****  *****      ****  *****      ****  *****      95  24%  18-25 YRS
READMISSIONS: 31  316  76.0% MALE      PRIMARY PROB.  285  68% CAUCASIAN  207  51%  26-40 YRS
TERMINATIONS 342  100  24.0% FEMALE      ALCOHOL  105  25% AK NATIVE  69  17%  41-60 YRS
ACTIVE END OF PERIOD 79  232  56% LEGAL INVOLV.  28  7% ALL OTHER  6  1%  >= 61 YRS
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*****
RESOURCE UTILIZATION DATA
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COMP. NO.	COMPONENT NAME	TOTAL STAFF HRS	NUMBER ADMITTED CLIENTS SERVED	LEVEL OF ACTIVITY (# PEOPLE)	% BED UTILIZATION	% HRS CLIENT \$ PRE/POST CLIENT (1)	% STAFF HOURS SPENT IN	"100" SERIES	"200" SERIES	"300"/"400" SERIES
000	KODIAK NATIVE ASSOCIATION	331	11	270	N/A	30.0%	8.2%	41.8%	50.0%	
010	MANAGEMENT & SUPPORT SERVICES	9,369	N/A	14,217	N/A	.1%	0.0%	83.3%	16.7%	
040	INTERMEDIATE CARE	9,289	132	862	68.0%	34.2%	32.6%	54.8%	12.6%	
050	OUTPATIENT CARE	2,938	260	643	N/A	43.6%	36.2%	37.3%	26.5%	
070	ALCOHOL SAFETY ACTION PROGRAM	1,979	N/A	2,096	N/A	40.6%	.1%	59.0%	40.9%	
080	AFTERCARE	649	22	0	N/A	43.4%	35.9%	45.8%	18.3%	

TOTAL	*****	*****	*****	*****	OVERALL:	*****	*****	*****
24,555	*****	401	18,088	*****	17.7%	63.5%	18.8%	*****

COMMENTS:

(1) INCLUDES ACTIVITY
CODES 101-180,
300-303,307,
326-328, 406.

PROGRAM NAME: KETCHIKAN YOUTH SERVICES

PROGRAM SUMMARY DATA: COVERING PERIOD: FROM: 7/1/83

TO: 6/30/84

* CLIENT DATA *

CLIENT ACTIVITY	SEX	PROBLEM/LEGAL	RACE	NO.	%	AGE
ACTIVE BEG. OF PERIOD: ---	NO. PERCENT	NO. %	NO. %	---	---	<= 17 YRS
NEW ADMISSIONS: ---	****	****	****	---	---	18-25 YRS
READMISSIONS: ---	----	----	----	---	---	26-40 YRS
TERMINATIONS: ---	----	----	----	---	---	41-60 YRS
ACTIVE END OF PERIOD: ---	----	----	----	---	---	>= 61 YRS

RESOURCE UTILIZATION DATA

COMP. NO.	COMPONENT NAME	TOTAL STAFF HRS	NUMBER ADMITTED OF CLIENTS SERVED	LEVEL OF ACTIVITY (# PEOPLE)	% BED UTILIZATION	% HRS CLIENT PRE/POST CLIENT (1)	% STAFF HOURS SPENT IN "100" SERIES	"200" SERIES	"300"/"400" SERIES
090	S/A PREVENTION, ALTERNATIV ACT	10,302	N/A	19,220	--	--	--	45.4%	54.6%
TOTAL		10,302	N/A	19,220	OVERALL: N/A 45.4% 54.6% *				

COMMENTS:

* CODE 304 (ALTERNATIVE ACTIVITIES) WAS REPORTED 43.9% OF THE TIME WITH 207 EVENTS AND 17,030 PARTICIPANTS.

(1) INCLUDES ACTIVITY CODES 101-180, 300-303, 307, 326-328, 406.

PROGRAM NAME: NORTHWEST REGIONAL ALCOHOLISM PROGRAM-MANIILAQ

PROGRAM SUMMARY DATA: COVERING PERIOD: FROM: 7/1/83 TO: 6/30/84

 * CLIENT DATA *

CLIENT ACTIVITY		SEX		PROBLEM/LEGAL		RACE		AGE	
ACTIVE BEG. OF PERIOD:	71	NO.	PERCENT	NO.	%	NO.	%	NO.	%
NEW ADMISSIONS:	115	115	71.0 % MALE	254	98%	9	3% CAUCASIAN	110	42% 18-25 YRS
READMISSIONS:	75	184	71.0 % MALE	254	98%	244	96% AK NATIVE	40	15% 26-40 YRS
TERMINATIONS	173	75	29.0 % FEMALE	120	46%	2	1% ALL OTHER	5	2% 41-60 YRS
ACTIVE END OF PERIOD	88								2% >= 61 YRS

 RESOURCE UTILIZATION DATA

COMP. NO.	COMPONENT NAME	TOTAL STAFF HRS	NUMBER ADMITTED CLIENTS SERVED	LEVEL OF ACTIVITY (# PEOPLE)	% BED UTILIZATION	% HRS CLIENT & PRE/POST CLIENT (1)	% STAFF HOURS SPENT IN
							"100" SERIES
010	MANAGEMENT & SUPPORT SERVICES	6,630	11*	2,208	N/A%	1.4%	92.4%
040	INTERMEDIATE CARE UNIT	11,992	92	732	79.2%	76.9%	17.2%
050	OUTPATIENT	2,223	136	628	N/A%	37.3%	45.2%
071	KASAP (ALCOHOL SAFETY ACTION)	490	N/A	21	N/A%	3.3%	84.2%
072	OUTREACH	7,190	36	20,587	N/A%	3.6%	24.6%
100	NWRAP/EDUCATION	11	N/A	58	N/A%	0.0%	100.0%
	TOTAL	28,536	220	24,234			35.8%

 OVERALL: 35.8% 39.9% 24.3%

COMMENTS:

*SHOULD NOT RECORD CLIENT-SPECIFIC ACTIVITIES IN THE "010" COMPONENT

(1) INCLUDES ACTIVITY CODES 101-180, 300-303, 307, 326-328, 406.

PROGRAM NAME: MAT-SU COUNCIL ON ALCOHOLISM

PROGRAM SUMMARY DATA: COVERING PERIOD: FROM: 7/1/83 TO: 6/30/84

* CLIENT DATA *

CLIENT ACTIVITY	SEX	PROBLEM/LEGAL	RACE	AGE
ACTIVE BEG. OF PERIOD: 98	NO. PERCENT	NO. %	NO. %	NO. %
NEW ADMISSIONS: 331	*** *****	*** *****	*** *****	33 7% <= 17 YRS
READMISSIONS: 40	322 69.0 % MALE	PRIMARY PROB. 425	91% CAUCASIAN	225 49% 18-25 YRS
TERMINATIONS 321	145 31.0 % FEMALE	ALCOHOL 431	6% AK NATIVE	89 19% 26-40 YRS
ACTIVE END OF PERIOD 148		290 62% LEGAL INVOLV.	3% ALL OTHER	9 2% 41-60 YRS

RESOURCE UTILIZATION DATA

COMP. NO.	COMPONENT NAME	TOTAL STAFF HRS	NUMBER ADMITTED CLIENTS SERVED	LEVEL OF ACTIVITY (# PEOPLE)	% BED UTILIZATION	% HRS CLIENT & PRE/POST CLIENT (1)	% STAFF HOURS SPENT IN	"100" SERIES	"200" SERIES	"300"/"400" SERIES
*****	*****	*****	*****	*****	*****	*****	*****	*****	*****	*****
010	MANAGEMENT & SUPPORT SVCIES	7,391	N/A	4,294	--	.2	.2%	94.5%	5.3%	
051	REGULAR OUTPATIENT	6,280	380	2,567	--	44.5%	38.3%	23.7%	38.0%	
052	ACTION PHASE I - OUTPATIENT	2,299	219	69	--	82.5%	80.2%	12.7%	7.1%	
070	ASAP MISDEMEANOR SERVICES	2,298	N/A	1,355	--	21.3%	0.0%	60.9%	39.1%	
	TOTAL	18,268	457	8,285		OVERALL:	23.3%	55.6%	21.1%	

COMMENTS:

(UNDOPLI-CATED)

(1) INCLUDES ACTIVITY
CODES 101-180,
300-303,307,
326-328, 406.

PROGRAM NAME: MCGRATH - ANVIK COMMUNITY PROGRAM

PROGRAM SUMMARY DATA: COVERING PERIOD: FROM: 7/1/83 TO: 6/30/84

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*****
* CLIENT DATA *
*****
CLIENT ACTIVITY    SEX    PROBLEM/LEGAL    RACE    NO.    %    AGE
ACTIVE BEG. OF PERIOD: 3    NO.    PERCENT    NO.    %    NO.    %    1    2% <= 17 YRS
NEW ADMISSIONS:    11    ****    *****    ****    *****    ****    *****    2    4% 18-25 YRS
READMISSIONS:    37    19    38.0 % MALE    PRIMARY PROB.    1    2% CAUCASIAN    26    52% 26-40 YRS
TERMINATIONS    39    31    62.0 % FEMALE    48    96% ALCOHOL    49    98% AK NATIVE    19    38% 41-60 YRS
ACTIVE END OF PERIOD 12    1    2% LEGAL INVOLV.    0    0% ALL OTHER    2    4% >= 61 YRS
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*****
RESOURCE UTILIZATION DATA
*****
COMP. NO.    COMPONENT NAME    TOTAL STAFF HRS    NUMBER ADMITTED OF ACTIVITY (# PEOPLE)    LEVEL OF ACTIVITY    % BED UTILIZATION    % HRS CLIENT PRE/POST    % STAFF HOURS SPENT IN "100" SERIES    "200" SERIES    "300"/"400" SERIES
*****
000    COMMUNITY PROGRAM    2,929    19    491    --    3.6%    1.6%    85.0%    13.4%
*****
TOTAL    2,929    19    491
*****
OVERALL:    1.6%    85.0%    13.4%
*****

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COMMENTS:

(1) INCLUDES ACTIVITY
CODES 101-180,
300-303,307,
326-328, 406.

(UNDUPLICATED)

PROGRAM SUMMARY DATA: COVERING PERIOD: FROM: 10/1/83 TO: 6/30/84 (PGM STARTED ON HIS 10/1/83)

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* CLIENT DATA *

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CLIENT ACTIVITY		SEX		PROBLEM/LEGAL		RACE		AGE	
ACTIVE BEG. OF PERIOD:	15	NO.	PERCENT	NO.	%	NO.	%	NO.	%
NEW ADMISSIONS:	61	***	*****	***	*****	***	*****	3	3%
READMISSIONS:	13	66	75.0 % MALE			2	2% CAUCASIAN	28	32%
TERMINATIONS	40	22	25.0 % FEMALE	86	98% ALCOHOL	84	96% AK NATIVE	35	40%
ACTIVE END OF PERIOD	49			39	44% LEGAL INVOLV.	2	2% ALL OTHER	20	23%

[illegible]

RESOURCE UTILIZATION DATA

[illegible]

COMP. NO.	COMPONENT NAME	TOTAL STAFF HRS	NUMBER ADMITTED CLIENTS SERVED	LEVEL OF ACTIVITY (# PEOPLE)	% BED UTILIZATION	% HRS CLIENT 1 PRE/POST CLIENT (1)	% STAFF HOURS SPENT IN	"100" SERIES	"200" SERIES	"300"/"400" SERIES
000	OUTPATIENT PROGRAM	3,808	79	524	--	20.2%	18.2%	59.2%	22.6%	
	TOTAL	3,808	79	524		OVERALL:	18.2%	59.2%	22.6%	

COMMENTS:

(UNDUPLI-
CATED)

(1) INCLUDES ACTIVITY
CODES 101-120,
300-303, 307,
326-328, 406.

PROGRAM NAME: ALASKA COUNCIL - EAP MUNI OF ANCHORAGE

PROGRAM SUMMARY DATA: COVERING PERIOD: FROM: 7/1/83

TO: 6/30/84

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*****
* CLIENT DATA *
*****
CLIENT ACTIVITY      SEX      PROBLEM/LEGAL      RACE      NO.      %      AGE
ACTIVE BEG. OF PERIOD: --- NO. PERCENT      NO. %      NO. %      --- --% <= 17 YRS
NEW ADMISSIONS:      --- **** *****      **** *****      **** *****      --- --% 18-25 YRS
READMISSIONS:      --- ---- --% MALE      PRIMARY PROB.      --- --% CAUCASIAN      --- --% 26-40 YRS
TERMINATIONS      --- ---- --% FEMALE      ALCOHOL      --- --% AK NATIVE      --- --% 41-60 YRS
ACTIVE END OF PERIOD --- ---- --% LEGAL INVOLV.      --- --% ALL OTHER      --- --% >= 61 YRS
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*****
RESOURCE UTILIZATION DATA
*****
COMP. NO. COMPONENT      TOTAL STAFF HRS      NUMBER ADMITTED OF CLIENTS SERVED      LEVEL OF ACTIVITY (# PEOPLE)      % BED UTILIZATION      % CLIENT & PRE/POST CLIENT (1)      % STAFF HOURS SPENT IN "100" SERIES      "200" SERIES      "300"/"400" SERIES
*****
070 EAP MUNI OF ANCHORAGE      1,350      N/A      551      --      --      0.0%      85.8%      14.2%
*****
TOTAL      1,350      N/A      551      OVERALL:      0.0%      85.8%      14.2%
*****
COMMENTS:
(UNDUPLICATED)

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(1) INCLUDES ACTIVITY
CODES 101-180,
300-303, 307,
326-328, 406.

PROGRAM NAME: NORTH SLOPE BOROUGH - BARROW

PROGRAM SUMMARY DATA: COVERING PERIOD: FROM: 7/1/83

TO: 6/30/84

* CLIENT DATA *

CLIENT ACTIVITY		SEX		PROBLEM/LEGAL		RACE		AGE	
ACTIVE BEG. OF PERIOD:	53	NO.	PERCENT	NO.	%	NO.	%	NO.	%
NEW ADMISSIONS:	70	****	*****	****	*****	****	*****	58	38%
READMISSIONS:	31	104	68.0 % MALE			18	12% CAUCASIAN	71	46%
TERMINATIONS	113	49	32.0 % FEMALE	124	81% ALCOHOL	128	86% AK NATIVE	13	8%
ACTIVE END OF PERIOD	41			103	69% LEGAL INVOLV.	3	2% ALL OTHER	1	1%

RESOURCE UTILIZATION DATA

COMP. NO.	COMPONENT NAME	TOTAL STAFF HRS	NUMBER ADMITTED OF CLIENTS SERVED	LEVEL OF ACTIVITY (# PEOPLE)	% BED UTILIZATION	% HRS CLIENT PRE/POST CLIENT (1)	% STAFF HOURS SPENT IN
							"100" SERIES
010	MANAGEMENT & SUPPORT SERVICES	2,511	N/A	5	--	.6%	.3%
040	HALFWAY HOUSE	763	18	323	1.8%	9.6%	4.7%
050	OUTPATIENT	2,514	75	101	--	16.8%	13.1%
071	ALCOHOL SAFETY ACTION PROGRAM	70	2	57	--	12.9%	7.1%
072	FRIENDSHIP HOUSE OUTREACH	1,544	50	894	--	11.6%	8.5%
	TOTAL	7,402	137	1,380			6.9%

OVERALL: 6.9% 79.5% 13.6%

COMMENTS:

(UNDUPLICATED)

(1) INCLUDES ACTIVITY
CODES 101-180,
300-303, 307,
326-328, 405.

PROGRAM NAME: NORTON SOUND COMPREHENSIVE ALCOHOLISM PROGRAM

PROGRAM SUMMARY DATA: COVERING PERIOD: FROM: 7/1/83 TO: 6/30/84

* CLIENT DATA *									
CLIENT ACTIVITY	SEX	PROBLEM/LEGAL	RACE	NO.	%	AGE			
ACTIVE BEG. OF PERIOD: 124	NO.	PERCENT	NO.	%	NO.	%	2	1%	<= 17 YRS
NEW ADMISSIONS: 102	****	*****	****	*****	****	*****	9	4%	18-25 YRS
READMISSIONS: 42	161	61.7 % MALE	18	7%	7% CAUCASIAN	92	37%	26-40 YRS	
TERMINATIONS 240	100	38.3 % FEMALE	245	84%	ALCOHOL	114	46%	41-60 YRS	
ACTIVE END OF PERIOD 28			2	1%	ALL OTHER	31	12%	>= 61 YRS	

RESOURCE UTILIZATION DATA									
COMP. NO.	COMPONENT NAME	TOTAL STAFF HRS	NUMBER ADMITTED CLIENTS SERVED	LEVEL OF ACTIVITY (# PEOPLE)	% BED UTILIZATION	% HRS CLIENT PRE/POST	% STAFF HOURS SPENT IN	"100" SERIES	"200" SERIES
010	MANAGEMENT & SUPPORT SERVICES	3,263	N/A	1,056	N/A	.2%		.1%	90.8%
040	INTERMEDIATE CARE	9,431	88	115	77.3%	75.0%		74.3%	23.5%
050	OUTPATIENT	2,609	127	439	N/A	38.4%		36.0%	43.5%
071	ALCOHOL SAFETY ACTION PROGRAM	2,094	N/A	1,492	N/A	33.6%		0.0%	58.5%
080	AFTERCARE	1,159	40	294	N/A	20.0%		11.3%	62.9%
100	CONSULTATION & EDUCATION	1,077	N/A	1,297	N/A	0.0%		0.0%	85.9%
	TOTAL	19,633	239	4,693			OVERALL:	41.2%	46.8%

(1) INCLUDES ACTIVITY
CODES 101-180,
300-303,307,
326-328, 405.

PROGRAM NAME: NUGEN'S RANCH

PROGRAM SUMMARY DATA: COVERING PERIOD: FROM: 7/1/83 TO: 6/30/84

* CLIENT DATA *

CLIENT ACTIVITY		SEX		PROBLEM/LEGAL		RACE		AGE	
ACTIVE BEG. OF PERIOD:	35	NO.	PERCENT	NO.	%	NO.	%	NO.	%
NEW ADMISSIONS:	70	***	*****	***	*****	***	*****	4	4% 18-25 YRS
READMISSIONS:	6	92	83.6 % MALE			45	41% CAUCASIAN	48	44% 26-40 YRS
TERMINATIONS	81	18	16.4 % FEMALE	102	97% ALCOHOL	63	57% AK NATIVE	42	37% 41-60 YRS
ACTIVE END OF PERIOD	30			7	6% LEGAL INVOLV.	2	2% ALL OTHER	16	15% >= 61 YRS

RESOURCE UTILIZATION DATA

COMP. NO.	COMPONENT NAME	TOTAL STAFF HRS	NUMBER ADMITTED OF CLIENTS SERVED	LEVEL OF ACTIVITY (# PEOPLE)	% BED UTILIZATION	% HRS CLIENT PRE/POST CLIENT (1)	% STAFF HOURS SPENT IN "100" SERIES	% STAFF HOURS SPENT IN "200" SERIES	% STAFF HOURS SPENT IN "300"/"400" SERIES
010	MANAGEMENT & SUPPORT SERVICES	21,472	33*	1,332	0.0%	1.8%	.4%	93.4%	6.2%
040	INTERMEDIATE CARE	12,042	90	13	83.0%	98.7%	98.4%	1.3%	.3%
011	PAID WORK THERAPY	4,367	N/A	N/A	N/A	N/A	0.0%	100.0%	0.0%
	TOTAL	37,881	112	1,345			OVERALL: 31.5%	64.9%	3.6%

COMMENTS:

(UNDUPLICATED)

(1) INCLUDES ACTIVITY
CODES 101-130,
300-303, 307,
326-328, 406.

PROGRAM NAME: PHILLIPS ALCOHOLISM TREATMENT CENTER

PROGRAM SUMMARY DATA: COVERING PERIOD: FROM: 7/1/83 TO: 6/30/84

 * CLIENT DATA *

 CLIENT ACTIVITY SEX PROBLEM/LEGAL RACE NO. % AGE
 ACTIVE BEG. OF PERIOD: 694 NO. PERCENT NO. % 29 3% <= 17 YRS
 NEW ADMISSIONS: 150 **** ***** **** ***** **** ***** 284 28% 18-25 YRS
 READMISSIONS: 182 814 79.5 % MALE PRIMARY PROB. 20 2% CAUCASIAN 432 42% 26-40 YRS
 TERMINATIONS 871 210 20.5 % FEMALE 1005 98% ALCOHOL 994 97% AK NATIVE 227 22% 41-60 YRS
 ACTIVE END OF PERIOD 155 113 11% LEGAL INVOLV. 7 1% ALL OTHER 46 5% >= 61 YRS

 RESOURCE UTILIZATION DATA

COMP. NO.	COMPONENT NAME	TOTAL STAFF HRS	NUMBER ADMITTED CLIENTS SERVED	LEVEL OF ACTIVITY (# PEOPLE)	% BED UTILIZATION	% HRS CLIENT PRE/POST CLIENT (1)	% STAFF HOURS SPENT IN "100" SERIES	"200" SERIES	"300"/"400" SERIES
010	MANAGEMENT & SUPPORT SERVICES	9,085	N/A	330	N/A %	.3%	0.0%	97.1%	2.9%
021	DETOX (TERMINATED)	3,592	394	23	CLSD%	69.3%	69.3%	30.3%	.4%
022	COMMUNITY SERVICE PATROL	961	N/A	1,171	N/A %	0.0%	0.0%	1.0%	99.0%
040	INTERMEDIATE CARE	7,760	111	659	93.7%	53.5%	51.1%	34.2%	14.7%
050	OUTPATIENT CARE	3,573	86	684	N/A %	32.4%	21.5%	56.6%	21.9%
070	ALCOHOL SAFETY ACTION PROGRAM	2,055	7	2,304	N/A %	2.6%	.1%	83.6%	16.3%
100	CONSULTATION & EDUCATION	1,601	N/A	72	N/A %	0.0%	0.0%	93.2%	6.8%
	TOTAL	28,627	830	5,243			OVERALL: 25.2%	62.2%	12.6%

COMMENTS:

(UNDUPLICATED)

(1) INCLUDES ACTIVITY
 CODES 101-180,
 300-303, 307,
 326-328, 406.

PROGRAM NAME: PETERSBURG COUNCIL ON ALCOHOLISM

PROGRAM SUMMARY DATA: COVERING PERIOD: FROM: 7/1/83 TO: 6/30/84

* CLIENT DATA *

CLIENT ACTIVITY	SEX	PROBLEM/LEGAL	RACE	NO.	%	AGE
ACTIVE BEG. OF PERIOD: 39	NO.	PERCENT	NO.	%	NO.	%
NEW ADMISSIONS: 23	51	75.0 % MALE	41	60% CAUCASIAN	23	33% 26-40 YRS
READMISSIONS: 7	17	25.0 % FEMALE	21	31% AK NATIVE	21	30% 41-60 YRS
TERMINATIONS: 23			6	9% ALL OTHER	9	12% >= 61 YRS
ACTIVE END OF PERIOD: 46						

RESOURCE UTILIZATION DATA

COMP. NO.	COMPONENT NAME	TOTAL STAFF HRS	NUMBER ADMITTED OF CLIENTS SERVED	LEVEL OF ACTIVITY (# PEOPLE)	% BED UTILIZATION	% HRS CLIENT & PRE/POST CLIENT (1)	% STAFF HOURS SPENT IN
010	MANAGEMENT & SUPPORT SERVICES	987	N/A	3,997	--	0.0%	"100" SERIES
050	OUTPATIENT	3,699	65	38,782	--	40.5%	"200" SERIES
	TOTAL	4,686	65	42,779			"300" SERIES
COMMENTS:			(UNDUPLICATED)				

(1) INCLUDES ACTIVITY
CODES 101-180,
300-303, 307,
326-328, 406.

PROGRAM NAME: PETERSBURG YOUTH PROGRAM

PROGRAM SUMMARY DATA: COVERING PERIOD: FROM: 7/1/83 TO: 6/30/84

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*****
* CLIENT DATA *
*****
CLIENT ACTIVITY    SEX    PROBLEM/LEGAL    RACE    NO.    %    AGE
ACTIVE BEG. OF PERIOD: --- NO. PERCENT    NO. %    NO. %    --- --% <= 17 YRS
NEW ADMISSIONS: --- **** *****    **** *****    **** *****    --- --% 18-25 YRS
READMISSIONS: --- ---- --% MALE    PRIMARY PROB.    --- --% CAUCASIAN    --- --% 26-40 YRS
TERMINATIONS --- ---- --% FEMALE    --% ALCOHOL    --- --% AK NATIVE    --- --% 41-60 YRS
ACTIVE END OF PERIOD --- ---- --% LEGAL INVOLV.    --- --% ALL OTHER    --- --% >= 61 YRS

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*****
RESOURCE UTILIZATION DATA
*****
COMP. NO.    COMPONENT    TOTAL STAFF HRS    NUMBER ADMITTED CLIENTS SERVED    LEVEL OF ACTIVITY (# PEOPLE)    % BED UTILIZATION    % CLIENT PRE/POST CLIENT (1)    % STAFF HOURS SPENT IN "100" SERIES    "200" SERIES    "300"/"400" SERIES
*****
090    YOUTH ALTERNATIVES    6,179    N/A    11,937    --    --    --    *****    48.2%    51.8%
TOTAL    6,179    N/A    11,937    OVERALL:    N/A    48.2%    51.8%

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COMMENTS:

CODE 304 (ALTERNATIVE ACTIVITIES) WAS
RECORDED 15% OF THE TIME FOR 416 EVENTS AND 4,123
PARTICIPANTS.

(1) INCLUDES ACTIVITY
CODES 101-180,
300-303, 307,
326-328, 406.

PROGRAM NAME: RURAL CAP ALCOHOLISM/DRUG ABUSE PREVENTION

PROGRAM SUMMARY DATA: COVERING PERIOD: FROM: 7/1/83 TO: 6/30/84

M CLIENT DATA M

CLIENT ACTIVITY	SEX	PROBLEM/LEGAL	RACE	AGE
ACTIVE BEG. OF PERIOD: ---	NO. PERCENT	NO. %	NO. %	---
NEW ADMISSIONS: ---	****	****	****	---
READMISSIONS: ---	----	----	----	---
TERMINATIONS: ---	----	----	----	---
ACTIVE END OF PERIOD: ---	----	----	----	---

RESOURCE UTILIZATION DATA

COMP. NO.	COMPONENT NAME	TOTAL STAFF HRS	NUMBER ADMITTED OF CLIENTS SERVED	LEVEL OF ACTIVITY (# PEOPLE)	% BED UTILIZATION	% HRS CLIENT PRE/POST (1)	% STAFF HOURS SPENT IN
100	CONSULTATION & EDUCATION	4,209	N/A	10,564	--	--	75.9%
TOTAL		4,209	N/A	10,564	OVERALL: N/A 75.9%		

COMMENTS:

82 OUTREACH, COMMUNITY DEVELOPMENT, EDUCATION PRESENTATIONS RECORDED WITH 7,650 PARTICIPANTS.

(1) INCLUDES ACTIVITY CODES 101-180, 300-303, 307, 326-328, 406.

PROGRAM NAME: SALVATION ARMY COMPREHENSIVE ALCOHOLISM PROGRAM

PROGRAM SUMMARY DATA: COVERING PERIOD: FROM: 7/1/83 TO: 6/30/84

***** CLIENT DATA *****									
CLIENT ACTIVITY		SEX		PROBLEM/LEGAL		RACE		AGE	
ACTIVE BEG. OF PERIOD:	422	NO.	PERCENT	NO.	%	NO.	%	NO.	%
NEW ADMISSIONS:	739	***	*****	***	*****	***	*****	450	15%
READMISSIONS:	1219	1779	74.8 %	MALE	PRIMARY PROB.	1277	54%	CAUCASIAN	1222 51% 18-25 YRS
TERMINATIONS	2131	600	25.2 %	FEMALE	ALCOHOL	952	40%	AK NATIVE	613 26% 26-40 YRS
ACTIVE END OF PERIOD	249			725	30%	LEGAL INVOLV.	150	6%	ALL OTHER 52 2% >= 61 YRS

***** RESOURCE UTILIZATION DATA *****									
COMP. NO.	COMPONENT NAME	TOTAL STAFF HRS	NUMBER ADMITTED CLIENTS SERVED	LEVEL OF ACTIVITY (# PEOPLE)	% BED UTILIZATION	% HRS CLIENT & PRE/POST CLIENT (1)	% STAFF HOURS SPENT IN		
							"100" SERIES	"200" SERIES	"300"/"400" SERIES
010	MANAGEMENT & SUPPORT SERVICES	43,466	N/A	1,424	N/A	.9%	N/A	94.6%	5.4%
021	DETOXIFICATION	35,738	860	13,129	78.9%	84.4%	63.1%	13.1%	23.8%
022	COMMUNITY SERVICE PATROL	17,412	N/A	10,094	N/A	88.0%	0.0%	10.8%	89.2%
041	INTERMEDIATE CARE UNIT	25,310	345	2,048	93.4%	68.6%	65.2%	29.7%	5.1%
042	TRANSITIONAL CARE UNIT	1,963	80	294	83.6%	57.6%	48.0%	42.3%	9.7%
043	REFLECTIONS	12,987	207	1,289	70.7%	70.7%	63.7%	27.2%	9.1%
044	EXTENDED CARE UNIT	8,713	50	64	61.6%	77.1%	76.7%	20.8%	2.5%
051	OUTPATIENT/AFTERCARE	14,534	633	4,892	N/A	46.4%	36.3%	49.8%	13.9%
052	OUTPATIENT/CORRECTIONS (CLOSED)	25	N/A	11	N/A	16.3%	6.1%	83.7%	10.2%
053	OUTPATIENT/DAY TREATMENT	623	105	20	N/A	58.9%	55.8%	32.1%	12.1%
	TOTAL	160,771	1,615	33,265			OVERALL: 37.7%	42.8%	19.5%

COMMENTS:

(UNDUPLICATED)

(1) INCLUDES ACTIVITY CODES 101-180, 300-303, 307, 326-328, 406.

PROGRAM NAME: SEARHC SUBSTANCE ABUSE PROGRAM

PROGRAM SUMMARY DATA: COVERING PERIOD: FROM: 7/1/83 TO: 6/30/84

* CLIENT DATA *

CLIENT ACTIVITY	SEX	PROBLEM/LEGAL	RACE	NO.	%	AGE
ACTIVE BEG. OF PERIOD: 54	NO. PERCENT	NO. %	NO. %	6	5%	<= 17 YRS
NEW ADMISSIONS: 56	****	****	****	45	39%	18-25 YRS
READMISSIONS: 23	78 59.5 % MALE	PRIMARY PROB.	21 17% CAUCASIAN	40	35%	26-40 YRS
TERMINATIONS 90	53 40.5 % FEMALE	ALCOHOL	98 77% AK NATIVE	18	16%	41-60 YRS
ACTIVE END OF PERIOD 43		39 30% LEGAL INVOLV.	8 6% ALL OTHER	6	5%	>= 61 YRS

RESOURCE UTILIZATION DATA

COMP. NO.	COMPONENT NAME	TOTAL STAFF HRS	NUMBER ADMITTED CLIENTS SERVED	LEVEL OF ACTIVITY (# PEOPLE)	% BED UTILIZATION	% HRS CLIENT & PRE/POST CLIENT (1)	% STAFF HOURS SPENT IN	"100" SERIES	"200" SERIES	"300"/"400" SERIES
000	COMMUNITY PROGRAM	9,296	117	4,170	--	19.1%	12.5%	53.9%	33.6%	
TOTAL		9,296	117	4,170			OVERALL: 12.5%	53.9%	33.6%	

COMMENTS:

(UNDUPLICATED)

(1) INCLUDES ACTIVITY
CODES 101-180,
300-303, 307,
326-328, 406.

PROGRAM NAME: SEWARD LIFE ACTION COUNCIL

PROGRAM SUMMARY DATA: COVERING PERIOD: FROM: 7/1/83 TO: 6/30/84

* CLIENT DATA *

CLIENT ACTIVITY		SEX	PROBLEM/LEGAL		RACE		AGE	
ACTIVE BEG. OF PERIOD:	43	NO.	PERCENT	NO.	%	NO.	%	2 1% <= 17 YRS
NEW ADMISSIONS:	106	****	*****	****	*****	****	*****	73 39% 18-25 YRS
READMISSIONS:	38	139	74.7 % MALE		PRIMARY PROB.	127	68% CAUCASIAN	79 42% 26-40 YRS
TERMINATIONS	148	47	25.3 % FEMALE	*156	84% ALCOHOL	52	28% AK NATIVE	29 16% 41-60 YRS
ACTIVE END OF PERIOD	39			115	62% LEGAL INVOLV.	7	4% ALL OTHER	3 2% >= 61 YRS

RESOURCE UTILIZATION DATA

COMP. NO.	COMPONENT NAME	TOTAL STAFF HRS	NUMBER ADMITTED CLIENTS SERVED	LEVEL OF ACTIVITY (# PEOPLE)	% BED UTILIZATION	% HRS CLIENT PRE/POST CLIENT (1)	% STAFF HOURS SPENT IN	"100" SERIES	"200" SERIES	"300"/"400" SERIES
010	MANAGEMENT & SUPPORT SERVICES	6,232	N/A	1,068	--	.3%	.1%	89.6%	10.3%	
050	OUTPATIENT	3,318	168	2,374	--	61.3%	33.2%	23.2%	43.6%	
	TOTAL	9,550	168	3,442			OVERALL: 11.6%	66.5%	21.9%	

COMMENTS:

*'PRIMARY PROBLEM' NOT PROVIDED ON 12% OF CLIENT ADMISSION FORMS. WE ESTIMATE ACTUAL "PRIMARY PROBLEM ALCOHOL" TO BE OVER 95%

(UNDUPLICATED)

(1) INCLUDES ACTIVITY CODES 101-180, 300-303, 307, 326-328, 406.

PROGRAM NAME: SITKA COUNCIL ON ALCOHOLISM AND OTHER DRUG ABUSE

PROGRAM SUMMARY DATA: COVERING PERIOD: FROM: 7/1/83 TO: 6/30/84

* CLIENT DATA *

CLIENT ACTIVITY		SEX		PROBLEM/LEGAL		RACE		AGE	
ACTIVE BEG. OF PERIOD:	77	NO.	PERCENT	NO.	%	NO.	%	NO.	%
NEW ADMISSIONS:	206	****	*****	****	*****	****	*****	152	39%
READMISSIONS:	110	302	77.2 % MALE		PRIMARY PROB.	93	24% CAUCASIAN	157	40% 18-25 YRS
TERMINATIONS	328	89	22.8 % FEMALE	340	97% ALCOHOL	285	72% AK NATIVE	63	16% 26-40 YRS
ACTIVE END OF PERIOD	65			190	49% LEGAL INVOLV.	14	4% ALL OTHER	8	2% 41-60 YRS

RESOURCE UTILIZATION DATA

COMP. NO.	COMPONENT NAME	TOTAL STAFF HRS	NUMBER ADMITTED CLIENTS SERVED	LEVEL OF ACTIVITY (# PEOPLE)	% BED UTILIZATION	% HRS CLIENT PRE/POST CLIENT (1)	% STAFF HOURS SPENT IN	"100" SERIES	"200" SERIES	"300"/"400" SERIES
010	MANAGEMENT & SUPPORT SERVICES	7,957	4*	985	N/A %	.1%	.1%	96.0%	3.9%	
030	ALCOHOLISM THERAPY SERVICES	16,577	171	2,279	73.0%	52.7%	47.5%	40.2%	12.3%	
040	AURORA'S WATCH	5,722	87	451	64.7%	31.0%	29.1%	65.5%	5.4%	
050	OUTPATIENT REFERRAL UNIT	4,870	127	1,123	N/A %	29.0%	20.1%	57.8%	22.1%	
070	SITKA COURT SERVICES	3,027	N/A	271	N/A %	8.3%	0.0%	87.1%	12.9%	
101	COMMUNITY EDUCATION & PREV.	3,825	N/A	2,108	N/A %	0.0%	0.0%	72.2%	27.3%	
900	REGIONAL TRAINING	3,541	N/A	683	N/A %	0.0%	0.0%	68.9%	31.1%	
	TOTAL	45,519	326	7,900			OVERALL:	23.1%	63.1%	13.8%

COMMENTS:

(UNDUPLICATED)

(1) INCLUDES ACTIVITY
CODES 101-180,
300-303,307,
326-328, 406.

PROGRAM NAME: SOUTH KATCHEMAK INC. CAP

PROGRAM SUMMARY DATA: COVERING PERIOD: FROM: 7/1/83 TO: 6/30/84

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* CLIENT DATA *
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CLIENT ACTIVITY    SEX    PROBLEM/LEGAL    RACE    NO.    %    AGE
ACTIVE BEG. OF PERIOD: 9    NO.    PERCENT    NO.    %    NO.    %    11    13% <= 17 YRS
NEW ADMISSIONS:    75    *****    *****    *****    25    29% 18-25 YRS
READMISSIONS:      2    55    64.7 % MALE    PRIMARY PROB.    17    20% CAUCASIAN    32    38% 26-40 YRS
TERMINATIONS       49    30    35.3 % FEMALE    ALCOHOL    66    78% AK NATIVE    15    18% 41-60 YRS
ACTIVE END OF PERIOD 37    30    35% LEGAL INVOLV.    2    2% ALL OTHER    2    2% >= 61 YRS
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RESOURCE UTILIZATION DATA
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COMP. NO.    COMPONENT    TOTAL STAFF HRS    NUMBER ADMITTED OF ACTIVITY (# PEOPLE)    LEVEL    %    % HRS    /-    % STAFF HOURS SPENT IN    "100"    "200"    "300"/
*****    *****    *****    *****    *****    *****    *****    *****    /-    SERIES    SERIES    SERIES
000    COMMUNITY PROGRAM    5,623    70    3,504    --    15.7%    13.8%    55.9%    30.3%
TOTAL    5,623    70    3,504    (UNDUPLICATED)    OVERALL:    13.8%    55.9%    30.3%
COMMENTS:

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(1) INCLUDES ACTIVITY
CODES 101-180,
300-303, 307,
326-328, 406.

PROGRAM NAME: SITKA TEEN CLUB

PROGRAM SUMMARY DATA: COVERING PERIOD: FROM: 7/1/83 10: 2/29/84

* CLIENT DATA *

CLIENT ACTIVITY	SEX	PROBLEM/LEGAL	RACE	NO.	%	AGE
ACTIVE BEG. OF PERIOD: ---	NO. PERCENT	NO. %	NO. %	---	---	---
NEW ADMISSIONS: ---	----	----	----	----	----	----
READMISSIONS: ---	----	----	----	----	----	----
TERMINATIONS ---	----	----	----	----	----	----
ACTIVE END OF PERIOD ---	----	----	----	----	----	----

RESOURCE UTILIZATION DATA

COMP. NO.	COMPONENT NAME	TOTAL STAFF HRS	NUMBER ADMITTED CLIENTS SERVED	LEVEL OF ACTIVITY (# PEOPLE)	% BED UTILIZATION	% HRS CLIENT & PRE/POST CLIENT (1)	% STAFF HOURS SPENT IN "100" SERIES	"200" SERIES	"300"/"400" SERIES
090	YOUTH ALTERNATIVES PREVENTION	4,741	--	6,085	--	--	--%	76.5%	23.5%
092	TV PRODUCTION	24	--	15	--	--	--%	0.0%	100.0%
093	NATURAL HELPERS	285	--	313	--	--	--%	0.0%	100.0%
094	HOSPITAL VOLUNTEERS	710	--	46	--	--	--%	0.0%	100.0%
095	WORD PROCESSOR TRAINING	196	--	365	--	--	--%	0.0%	100.0%
096	YOUTH EMPLOYMENT	5,133	--	487	--	--	--%	0.0%	100.0%
097	PARENTING CLASS	28	--	59	--	--	--%	0.0%	100.0%
098	STUDENT OPTIONS	99	--	196	--	--	--%	0.0%	100.0%

TOTAL

11,216 N/A 7,566

OVERALL: N/A 32.3% 67.7%

COMMENTS:

(UNDUPLICATED)

(1) INCLUDES ACTIVITY
CODES 101-180,
300-303, 307,
326-328, 406.

PROGRAM NAME: TCC REGIONAL PREVENTION

PROGRAM SUMMARY DATA: COVERING PERIOD: FROM: 7/1/83 TO: 6/30/84

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*****
* CLIENT DATA *
*****
CLIENT ACTIVITY    SEX    PROBLEM/LEGAL    RACE    NO.    %    AGE
ACTIVE BEG. OF PERIOD: --- NO. PERCENT    NO. %    NO. %    --- --% <= 17 YRS
NEW ADMISSIONS: --- **** *****    **** *****    **** *****    --- --% 18-25 YRS
READMISSIONS: --- ---- --% MALE    PRIMARY PROB.    --- --% CAUCASIAN    --- --% 26-40 YRS
TERMINATIONS --- ---- --% FEMALE    --% ALCOHOL    --- --% AK NATIVE    --- --% 41-60 YRS
ACTIVE END OF PERIOD --- ---- --% LEGAL INVOLV.    --- --% ALL OTHER    --- --% >= 61 YRS
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RESOURCE UTILIZATION DATA
*****
COMP. NO.    COMPONENT NAME    TOTAL STAFF HRS    NUMBER ADMITTED OF CLIENTS SERVED    LEVEL OF ACTIVITY (# PEOPLE)    % BED UTILIZATION    % HRS CLIENT & PRE/POST CLIENT (1)    % STAFF HOURS SPENT IN "100" SERIES    "200" SERIES    "300"/"400" SERIES
*****
000    COMMUNITY PROGRAM    2,323    N/A    64    --    --    --    --    30.6%    69.4%
*****
TOTAL    2,323    N/A    64    OVERALL:    --    30.6%    69.4%
*****
COMMENTS:
(CUNDUPLI--
CATED)

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(1) INCLUDES ACTIVITY
CODES 101-180,
300-303,307,
326-328, 406.

PROGRAM NAME: UPPER TANANA ALCOHOLISM PROGRAM

PROGRAM SUMMARY DATA: COVERING PERIOD: FROM: 7/1/83

TO: 6/30/84

* CLIENT DATA *

CLIENT ACTIVITY	SEX	PROBLEM/LEGAL	RACE	NO.	%	AGE
ACTIVE BEG. OF PERIOD: 25	NO. PERCENT	NO. %	NO. %	NO. %	NO. %	2 3% <= 17 YRS
NEW ADMISSIONS: 43	****	****	****	****	****	24 33% 18-25 YRS
READMISSIONS: 5	56 78.9 % MALE	67 94% PRIMARY PROB.	21 30% CAUCASIAN	29 40% 26-40 YRS		
TERMINATIONS 50	15 21.1 % FEMALE	67 94% ALCOHOL	47 66% AK NATIVE	14 20% 41-60 YRS		
ACTIVE END OF PERIOD 23		59 83% LEGAL INVOLV.	3 4% ALL OTHER	3 4% >= 61 YRS		

RESOURCE UTILIZATION DATA

COMP. NO.	COMPONENT NAME	TOTAL STAFF HRS	NUMBER ADMITTED OF CLIENTS SERVED	LEVEL OF ACTIVITY (# PEOPLE)	% BED UTILIZATION	% HRS CLIENT & PRE/POST CLIENT (1)	% STAFF HOURS SPENT IN	"100" SERIES	"200" SERIES	"300"/"400" SERIES
000	COMMUNITY PROGRAM	11,816	53	2,166	--	14.7%	3.4%	43.8%	52.8%	
	TOTAL	11,816	53	2,166			OVERALL: 3.4%	43.8%	52.8%	

COMMENTS:

(UNDUPLICATED)

(1) INCLUDES ACTIVITY
CODES 101-180,
300-303, 307,
326-328, 406.

PROGRAM NAME: UPPER YUKON BEHAVIORAL HEALTH SERVICE

PROGRAM SUMMARY DATA: COVERING PERIOD: FROM: 7/1/83 TO: 6/30/84

 * CLIENT DATA *

CLIENT ACTIVITY	SEX	PROBLEM/LEGAL	RACE	AGE
ACTIVE BEG. OF PERIOD: 23	NO. PERCENT	NO. %	NO. %	NO. %
NEW ADMISSIONS: 13	51 83.6 % MALE	61 97% ALCOHOL	0 0% CAUCASIAN	7 11% 18-25 YRS
READMISSIONS: 28	10 16.4 % FEMALE	13 21% LEGAL INVOLV.	63 100% AK NATIVE	36 57% 26-40 YRS
TERMINATIONS: 56			0 0% ALL OTHER	17 27% 41-60 YRS
ACTIVE END OF PERIOD: 8				1 2% >= 61 YRS

 RESOURCE UTILIZATION DATA

COMP. NO.	COMPONENT NAME	TOTAL STAFF HRS	NUMBER ADMITTED OF CLIENTS SERVED	LEVEL OF ACTIVITY (# PEOPLE)	% BED UTILIZATION	% HRS CLIENT & PRE/POST CLIENT (1)	% STAFF HOURS SPENT IN
							"100" "200" "300" / SERIES SERIES SERIES
000	COMMUNITY PROGRAM	2,832	40	155	--	17.2%	3.8% 52.3% 43.9%
TOTAL		2,832	40	155	OVERALL: 3.8% 52.3% 43.9%		

 COMMENTS: (UNDUPLICATED)

(1) INCLUDES ACTIVITY
 CODES 101-180,
 300-303, 307,
 326-328, 406.

PROGRAM NAME: VALDEZ COUNSELING CENTER

PROGRAM SUMMARY DATA: COVERING PERIOD: FROM: 7/1/83

TO: 6/30/84

* CLIENT DATA *

CLIENT ACTIVITY	SEX	PROBLEM/LEGAL	RACE	NO.	%	AGE	
ACTIVE BEG. OF PERIOD: 41	NO.	PERCENT	NO.	%	NO.	%	
NEW ADMISSIONS: 69	***	*****	***	*****	35	29% <= 17 YRS	
READMISSIONS: 8	93	79.5 % MALE	111	95% CAUCASIAN	51	44% 18-25 YRS	
TERMINATIONS: 66	24	20.5 % FEMALE	2	2% AK NATIVE	27	23% 26-40 YRS	
ACTIVE END OF PERIOD: 52		98	84% LEGAL INVOLV.	4	3% ALL OTHER	2	2% >= 61 YRS

RESOURCE UTILIZATION DATA

COMP. NO.	COMPONENT NAME	TOTAL STAFF HRS	NUMBER ADMITTED OF CLIENTS SERVED	LEVEL OF ACTIVITY (# PEOPLE)	% BED UTILIZATION	% HRS CLIENT & PRE/POST CLIENT (1)	% STAFF HOURS SPENT IN	"100" SERIES	"200" SERIES	"300"/"400" SERIES
010	MANAGEMENT & SUPPORT SERVICES	1,357	N/A	154	--	--	0.0%	98.1%	1.9%	
050	OUTPATIENT	1,701	109	3,527	--	53.3%	45.5%	34.5%	20.0%	
070	OUTREACH/ASAP	95	N/A	19	--	32.1%	0.0%	67.9%	32.1%	
	TOTAL	3,153	109	3,700			OVERALL: 24.5%	62.9%	12.6%	

COMMENTS:

(UNDUPLICATED)

(1) INCLUDES ACTIVITY
CODES 101-180,
300-303, 307,
326-328, 406.

PROGRAM NAME: WRANGELL COUNCIL ON ALCOHOLISM

PROGRAM SUMMARY DATA: COVERING PERIOD: FROM: 7/1/83 TO: 6/30/84

***** CLIENT DATA *****

CLIENT ACTIVITY	SEX	PROBLEM/LEGAL	RACE	AGE
ACTIVE BEG. OF PERIOD: 120	NO. PERCENT	NO. %	NO. %	NO. %
NEW ADMISSIONS: 84	XXXX XXXXXXXXXXXX	XXXX XXXXXXXXXXXX	XXXX XXXXXXXXXXXX	66 29% <= 17 YRS
READMISSIONS: 26	131 57.2 % MALE	PRIMARY PROB.	124 54% CAUCASIAN	70 31% 18-25 YRS
TERMINATIONS 132	98 42.8 % FEMALE	221 97% ALCOHOL	95 42% AK NATIVE	32 14% 26-40 YRS
ACTIVE END OF PERIOD 98		100 44% LEGAL INVOLV.	10 4% ALL OTHER	4 2% >= 61 YRS

***** RESOURCE UTILIZATION DATA *****

COMP. NO.	COMPONENT NAME	TOTAL STAFF HRS	NUMBER ADMITTED OF CLIENTS SERVED	LEVEL OF ACTIVITY (# PEOPLE)	% BED UTILIZATION	% HRS CLIENT & PRE/POST CLIENT (1)	% STAFF HOURS SPENT IN
000	COMMUNITY PROGRAM	5,867	207	7,835	--	39.5%	"100" SERIES 37.8%
	TOTAL	5,867	207	7,835			"200" SERIES 50.8%
			(UNDUPLICATED)				"300"/"400" SERIES 11.4%
						OVERALL:	37.8% 50.8% 11.4%

(1) INCLUDES ACTIVITY
CODES 101-180,
300-303,307,
326-328, 406.

PROGRAM NAME: YAKUTAI ALCOHOLISM PROGRAM

PROGRAM SUMMARY DATA: COVERING PERIOD: FROM: 7/1/83 TO: 6/30/84

* CLIENT DATA *									

CLIENT ACTIVITY									
SEX	NO.	PERCENT	NO.	%	PROBLEM/LEGAL	RACE	NO.	%	AGE
ACTIVE DEG. OF PERIOD: 6									
NEW ADMISSIONS: 1									
READMISSIONS: 5									
TERMINATIONS: 9									
ACTIVE END OF PERIOD 3									
***** RESOURCE UTILIZATION DATA *****									

NUMBER LEVEL % % % %									
ADMITTED	OF	BED	CLIENT &	/-	% STAFF HOURS SPENT IN				
SERVED	CLIENTS	ACTIVITY	UTILI-	/-	"100"				
543	11	543	11	543	11				

TOTAL 3,886									
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PROGRAM NAME: YUKON-KUSKOKWIM HEALTH CORPORATION ALCOHOLISM PROGRAM

PROGRAM SUMMARY DATA: COVERING PERIOD: FROM: 7/1/83 TO: 6/30/84

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*****
* CLIENT DATA *
*****
CLIENT ACTIVITY    SEX    PROBLEM/LEGAL    RACE    NO.    %    AGE
ACTIVE BEG. OF PERIOD: 52    NO.    PERCENT    NO.    %    NO.    %    14    12%    <= 17 YRS
NEW ADMISSIONS:      53    *****    *****    *****    *****    36    30%    18-25 YRS
READMISSIONS:        17    98    80.9 % MALE    PRIMARY PROB.    1    1%    CAUCASIAN    55    45%    26-40 YRS
TERMINATIONS         82    23    19.1 % FEMALE    ALCOHOL    120    99%    AK NATIVE    16    13%    41-60 YRS
ACTIVE END OF PERIOD 40    79    65%    LEGAL INVOLV.    0    0%    ALL OTHER    0    0%    >= 61 YRS
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* RESOURCE UTILIZATION DATA *
*****
COMP. NO.    COMPONENT NAME    TOTAL STAFF HRS    NUMBER ADMITTED CLIENTS SERVED    LEVEL OF ACTIVITY (# PEOPLE)    % BED UTILIZATION    % HRS CLIENT PRE/POST    % STAFF HOURS SPENT IN "100" SERIES    "200" SERIES    "300"/"400" SERIES
*****
000    REGIONAL ALCOHOL/DRUG ABUSE    23,476    88    27,192    --    14.1%    4.3%    49.6%    46.1%
900    SOUTHWEST REGIONAL TRAINING    4,108    N/A    2 137    --    0.0%    0.0%    77.0%    23.0%
*****
TOTAL    27,584    88    29,329    OVERALL:    3.7%    53.6%    42.7%

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COMMENTS:

(UNDUPLICATED)

(1) INCLUDES ACTIVITY
CODES 101-180,
300-303, 307,
326-328, 406.

APPENDIX - I

DIRECTORY OF STATE APPROVED PROGRAMS 1984

DRAFT

DRAFT

ALASKA

DIRECTORY OF STATE APPROVED ALCOHOLISM AND DRUG ABUSE SERVICES

AUGUST 1984

DRAFT

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Behavioral Health Division
825 L Street
Anchorage, Alaska 99501

ANCHORAGE, MOA/BHD

Phone - 264-4744

Contact person - Jim Parsons

Services - Monitoring of subcontractors providing alcohol and drug treatment services in Anchorage area.

Fees - Sliding fee scales

Eligibility - Anyone in need of treatment for substance abuse.

Akeela House, Inc.
2804 Bering Street - Residential
504 W. 25th - Outpatient/Administration
Anchorage, Alaska 99503

ANCHORAGE, MOA/BHD

Phone - 561-5405

Contact person - C. Joe DiMatteo, Director

Services - Provides a residential facility for abusers as an alternative to incarceration in addition to self referrals and agency referrals; provides vocational training for re-entry into the community. Provides alcohol information, outreach and referral information for the Anchorage area. Outpatient services are provided for adults and families.

Fees - sliding fee scale

Eligibility - Anyone in need of substance abuse treatment services.

Cook Inlet Native Association
670 W. Fireweed Lane
Anchorage, Alaska 99503

ANCHORAGE, MOA/BHD

Phone - 278-4641

Contact person - Doug Modig, Director

Services - Referral services for CINA area villages and Anchorage area
Provides intermediate residential care and outpatient/aftercare services.

Fees - None

Eligibility - Natives Statewide in need of intermediate and outpatient care.

Center for Drug Problems
520 East 4th Avenue, Suite 102
Anchorage, Alaska 99501

ANCHORAGE, MOA/BHD

Phone - 276-6430

Contact person - Cynthia Aiken, Director

Services - Individual and group counseling, methadone maintenance, detoxification, drug-free and social survival skill training.

Fees - Counseling - free, methadone maintenance - \$35.00/month, methadone detoxification - \$50.00, one time.

Eligibility - Methadone maintenance - proven 2 year addiction to opiates, detoxification - currently addicted to narcotics, over age 18.

Salvation Army Clitheroe Center
Comprehensive Services
P.O. Box 6567
Anchorage, Alaska 99502

ANCHORAGE, MOA/BHD

Phone - 243-1181 (intake and referral) or 276-2989 (outpatient)

Contact Person - Dr. Ray Dexter, Director

Services - Outpatient aftercare, individual and group counseling, long-term residential care (120-180 days), short-term residential care (5-6 weeks), emergency medical services, detoxification, specially equipped van, community service patrol.

Fees - Sliding fee scale

Eligibility - Anyone in need of alcohol treatment services

Salvation Army
Comprehensive Out-Patient/DWI Unit
Alcohol Services
2501 Blueberry
Anchorage, Alaska 99503

ANCHORAGE, MOA/BHD

Phone - AC 907-276-2898

Contact person - Noni Turvil, Unit Supervisor

Services - Outpatient group, family and individual counseling, aftercare, and vocational rehabilitation, court referral specialist, and community seminars.

Fees - Sliding fee based on ability to pay.

Eligibility - Alcoholism primary problem, problem drinkers as well as alcoholics

Volunteers of America
Hiland Road
Eagle River, Alaska 99577

ANCHORAGE, MOA/BHD

Phone - 694-3336

Contact Person - Jeeni Swyter, Director

Services - Provides Adolescent Residential Center for Help (ARCH) for youth, ages 12-17, who have a substance abuse problem, outpatient and aftercare.

Fees - Sliding fee scale

Eligibility - Youth desiring help with a substance abuse problem.

Alaska Council on Prevention
7521 Old Seward Hwy., Suite A
Anchorage, Alaska 99502

ANCHORAGE

Phone - 349-6602

Contact person - Barbara Bailey, Director

Services - Serves as an information and education service agency for alcoholism in Alaska through programs such as, "Here's Looking at You", Employee Assistance, Media Development, and Alcohol Awareness Week, Information and Education.

Fees - None

Eligibility - Open to the Public

Aleutian/Pribilof Islands Association, Inc.
1689 C Street
Anchorage, Alaska 99501

ANCHORAGE

Phone - 276-2700

Contact person - Kathy Sutcliffe, Director

Fees - Sliding Scale

Eligibility - Resident of the Aleutian/Pribilof Area

Aleutian/Pribilof Islands Association, Inc. (Continued)

Services:

The Aleutian/Pribilof Islands Association proposes to develop and implement a regional alcoholism program aimed at prevention and early intervention. A/PIA will provide an alcoholism intervention specialist, to be located in Unalaska at the Aleutian Counseling Center.

A/PIA is also providing training, travel and associated costs for one community paraprofessional from each community in the region. The trained individuals will return to their homes and provide outreach, consultation and education services to individuals, families and the community.

A/PIA also will provide for referral and transportation services from the Chain to Anchorage for individuals suffering from acute problems related to alcohol abuse and in need of emergency treatment.

The Center for Alcohol and Addiction Studies
University of Alaska, Anchorage
3211 Providence Ave.
Anchorage, Alaska 99504

ANCHORAGE

Phone - 786-1801

Contact person - Tom Lonner, Ph.D., Director
Ken Duff, Training Coordinator

Services:

1. Training and Education
Coordination of efforts toward Statewide University System delivery of certification-linked substance abuse counselor training; Statewide Annual School on Addiction Studies. Continuing education and training programs. Member of State Training Agency Network.
2. Research and Evaluation
Conduct research projects to gain knowledge about substance abuse in Alaska and to help reduce the impact of substance abuse. Current research involves; 1) identification of current trends in drug use as they relate to demographic, attitudinal and personality characteristics, and to identify the frequency, quantity, context and consequences of drug use; and 2) assess the potential social impacts of the use and abuse of alcohol and other drugs which may be associated with major construction projects in the state. Assists substance abuse programs in developing more useful and valid program procedures.

Fees:

1. Training and Education - based on designated registration costs and availability of academic credits.
2. Research and Evaluation - dependent on nature and extent of services requested.

Alcohol Safety Action Programs
ASAP Misdemeanor Services
941 West 4th Avenue, Room 209
Anchorage, Alaska 99501

ANCHORAGE

Phone - 274-8611 x 735

Contact person - Emily McKenzie

Services - Provides for court liaison, screening, diagnosis, referral and follow-up services as a diversion program for first time offenders and misdemeanor referral from court to treatment.

Fees - None

RurAL CAP
P.O. Box 3-3908
Anchorage, Alaska 99501

ANCHORAGE

Phone - 279-2511

Contact person - Joan Cannelos

Services - Include continuing use of the LearnAlaska network; publication of a newsletter and revision/distribution of handbooks and resource list; education, consultation and technical assistance to individual villages on request; and continued coordination and cooperation with regional alcohol/drug abuse staff and other prevention grantees. Responsibility for cost sharing and planning activities will continue to be shifted to village participants, with RurAl CAP staff providing technical assistance, coordination and administration.

Fees - Determined on Individual Basis

Eligibility - Rural Community

North Pacific Rim
903 W. Northern Lights Blvd.
Suite 203
Anchorage, Alaska 99503-2496

ANCHORAGE

Phone - 276-2121

Contact person - Joanie Cleary

Services - Coordinate and provide prevention and education activities in rural communities.

Fees - None

Eligibility - Communities of Tatitlek and Chenega.

Kuskokwim Native Association
Community Counseling Center
Box 106
Aniak, Alaska 99557

ANIAK

Phone - 675-4445

Contact - Susan Soule

Services - Prevention education, emergency services, assessment and referral, intensive outpatient program, alcohol abuse groups, aftercare/follow-up, support services.

Fees - None

Eligibility - Open to all: targeted for episodic binge drinkers, chronic drinkers, women ages 14-30, parents of abused and neglected children.

Ikayugtut, Inc.
P.O. Box 730
Barrow, Alaska 99723

BARROW

Phone - 852-6569

Contact person - Reverend James Armstrong

Services - Outpatient counseling services, aftercare, consultation, treatment, family therapy.

Fees - Information not available.

Eligibility - Available to all.

North Slope Borough/Substance Abuse Treatment Services
Box 69
Barrow, Alaska 99723

BARROW

Phone - 852-4673

Contact - Phyllis Brister, Acting Program Coordinator

Services - Alcohol education, information, and referral. Also, sober fellowship, individual, and group outpatient counseling; outreach to the P.H.S. hospital, Barrow Court system and Department of Public Safety. Additionally, E.A.P. (Employee Assistance Program) coordination, and substance abuse prevention. These services are provided in Barrow and the North Slope Borough villages.

Fees - Sliding fee schedule for services, based on income, family size and ability to pay.

Eligibility - Available to all who are concerned about substance use, abuse, addiction.

Phillips Alcoholism Treatment Center (PATC)

BETHEL

P.O. Box 388 (Location behind courthouse bldg. on Airport Rd. in downtown Bethel)
Bethel, Alaska 99559

Phone - 543-2129

Contact person - George Ives, Director

Services - Outpatient counseling, aftercare coordination, drug abuse information and counseling, court liaison, 30 day residential program, A.I.S.

Hours - Outpatient - Monday through Friday at 12:00 noon to 9:00 p.m. Other times by special appointment.

Fees - Services will be provided to everyone regardless of their ability to pay. The Veterans' Administration has approved our rate schedule of \$40.70 per out-patient counseling visit. The V.A. will be billed at that rate for each eligible veteran. Others will be billed according to the approved sliding fee schedule.

Eligibility - Services are provided to all who need or request them.

Yukon-Kuskokwim Health Corp. Alcoholism Program

BETHEL

Box 528

Bethel, Alaska 99559

Phone - 543-3321

Contact - Carl Berger, Director; Louie Andrew, Regional Technical Assistant.

Services - Provides technical assistance, such as proposal writing, to new area alcoholism programs seeking funds: Referral, early intervention, outpatient, aftercare, prevention and education services provided in several villages.

Fees - None

Eligibility - Available to all

Southwestern Regional Training Program

BETHEL

Yukon-Kuskokwim Health Corporation

Box 528

Bethel, Alaska 99559

Phone - 543-3321

Contact person - Carl Berger, Health Director; Laurie Marum, Trainer

Services - Level I, II Counselor Certification-linked Training, training plan assistance, internship program development for Southwestern Communities funded by Office of Alcoholism and Drug Abuse and Family Violence programs. Member of State Training Agency Network.

Fees - Based on Credits offered and credit level.

Eligibility - Counselors pursuing Alcoholism and Drug Abuse Certification from SOADA funded programs, family violence programs, and other human services.

Cordova Mental Health and Alcohol Clinic
Cordova Community Hospital
P.O. Box 160
Cordova, Alaska 99574

CORDOVA

Phone - 424-7131

Contact - John Crowley, Hospital Administrator

Services - Information, counseling, consultation, education, and substance abuse awareness, outpatient treatment, aftercare, outreach and prevention education consultation.

Fees - Sliding scale based on income.

Eligibility - The general public, all ages.

Copper River Mental Health & Substance Abuse Services
Drawer H
Copper Center, Alaska 99574

COPPER CENTER

Phone - 822-5241 Ext. 227

Contact person - Roy White/Paula Miller

Services - Combined Mental Health and Alcohol program offering referral, outpatient, outreach, crisis intervention, aftercare, information/education.

Fees - Based on ability to pay.

Eligibility - Open to all interested persons.

Craig Youth Center
P.O. Box 184
Craig, Alaska 99921

CRAIG

Phone - 826-3243

Contact - Wendy Swearingen, Director

Services - Structured and recreational activities will be offered to all area youth between the ages of 6-18. Consultative and educational information will be targeted to all area youths identified as "at risk" concerning alternatives to substance abuse. Consultative services and improving parenting skills presentations will be targeted to all area youth and their families who are identified as "at risk".

Craig Youth Center (Continued)

The proposed service strategies for structured and recreational activities include woodcarving, metalwork, macrame, silk screening, cooking, native culture, small engine repair, upholstery, basketweaving, art, preservative making, building small tables, etc. and various other kinds of structured learning activities. Recreational activities will include dances, tournaments, pool, foosball, softball, volleyball, pajama parties, board games, fund-raising events and many other activities.

Fees - None

Eligibility - Area Youth

Bristol Bay Area Health Corporation Alcohol Program
P.O. Box 10235
Dillingham, Alaska 99576

DILLINGHAM

Phone - 842-5266 or 842-5267

Contact Person - Bob Wallman, Alcohol Program Coordinator

Services - Outpatient, outreach, aftercare, follow-up, court diversion, referral, alternative activities, prevention/education, Alcohol Information School, and technical assistance to Dillingham and 31 other communities in the Bristol Bay Region.

Fees - Sliding fee scale, based on ability to pay for outpatient services. Alcohol Information School - \$50.00 flat fee.

Eligibility - Anyone with an alcohol problem or drug problem, including family members.

Fairbanks Native Association, Inc.
Regional Center for Alcohol and Other
Addictions
310 1/2 First Ave.
Fairbanks, Alaska 99701

FAIRBANKS

Phone - 452-1648

Contact person - Banarsi Lal, Director, Alcohol & Drug Abuse Services

Services - Administrative Office (452-1648); Detox (Short and Long-Term) Intermediate (456-1053 or 456-1045); Halfway House (452-8761); Drop-In Center (456-7948); Youth Drug Abuse Prevention Program (452-5085); Outpatient/Aftercare Services (456-1101 or 456-1041); Fairbanks Alcohol Safety Action Program (452-6144); Community Services (456-1041); Substance Abuse Counselor Training (452-7045)

Fairbanks Native Association, Inc. (Continued)

Fees - Detoxification - \$73.34 per bed/day
Short-Term (30 Day) Care - \$46.79 per bed/day
Long-Term Care - \$21.32 per bed/day
Diagnostic Evaluation - \$25.00 per person
Alcohol Information School - \$25.00 per person
Outpatient - \$60.00 (six counseling sessions)

Eligibility - Sincere desire for sobriety.

KILA, Inc.

FAIRBANKS

Fairbanks Substance Abuse Center
Treatment Division
Education/Prevention Division
Outreach/Training Division
3098 Airport Way
Fairbanks, Alaska 99701

Phone - 452-5715

Contact person - Barbara Breedon, Program Manager

Services - Drug related counseling, communication training, discussion groups, parent effectiveness training, youth effectiveness, school presentations, health curriculum consultation, alternatives to drug use methadone program, outpatient, drug abuse/detoxification, referral, outreach.

Fees - \$50.00 initially for complete laboratory and psychological work-up.
\$15.00 per week for counseling/treatment.

Eligibility - Treatment Division 1) methadone - current physiological addiction to an opiate; 2) other drug - addiction or previous abuse; 3) incarceration on a drug related charge, Education/Prevention Division and Outreach/Training Division - interested persons.

Tanana Chiefs Conference - Regional Prevention

FAIRBANKS

201 First Avenue
Fairbanks, Alaska 99701

Phone - 452-2446

Contact person - Mark Mattaini, Director

Services - The TCC Regional Prevention Project provides information, education and prevention services in the northern region. This year the project is divided into five separate program components: Youth Prevention, Broadcast Services, Fetal Alcohol Syndrome Prevention, Village Local Option Support, and Provider Conferences.

Fees - None

Eligibility - Request for Services

Upper Yukon Alcoholism Program
P.O. Box 21
Ft. Yukon, Alaska 99740

FT. YUKON

Phone - 662-2526

Contact - Evelyn Wiszincka.

Services - In addition to services provided to the city of Fort Yukon, six villages are also served on an itinerant basis. The program delivers services on an outpatient basis only. The following services are provided: Prevention, Out-reach, Treatment, Referral, Consultation/Education, and Follow-up.

Fees - Sliding Scale

Eligibility - Residents of Yukon Flats Subregion

Yukon-Koyukuk M.H./Drug & Alcohol Program
Box 17
Galena, Alaska 99741

GALENA

Phone - 656-1266

Contact person - Director, Under recruitment
Kathleen Esmailkas, Alcoholism Coordinator

Services - Alcohol Counseling, prevention, consultation, treatment, family therapy.

Fees - Sliding Scale

Eligibility - Open clinic, willingness to participate.

Alcoholism and Drug Abuse Central Agency
210 Admiral Way
Juneau, Alaska 99801

JUNEAU

Phone - 586-5280

Contact person - Richard Miller, Director
William Platt, Treatment Director

Services - Inpatient treatment services, individual and group therapy, films, step study detoxification, 24 hour care, crisis line, outreach, alcohol information school (AIS), emergency, intermediate, long term and outreach care services; also aftercare, and prevention education.

Fees - \$75.00 - outpatient services; sliding scale for other services.

Eligibility - Desire to get sober.

National Council on Alcoholism - Juneau
147 S. Franklin
Juneau, Alaska 99801

JUNEAU

Phone - 586-1688

Contact Person - Karen Lawfer

Services - Individual/vocational/educational counseling, A.A., education, referral, EAP (ASAP) Alcohol Safety Action Program.

Fees - Sliding Scale

Eligibility - Anyone desiring sobriety.

Gastineau Manor Halfway House
306 W. 8th St.
Juneau, Alaska 99801

JUNEAU

Phone - 586-3536

Contact person - Betty Tompkins, Director

Service - Intermediate care, group and individual counseling, vocational education. Halfway House.

Fees - \$350/month and up, depending on income level.

Eligibility - Over 18, with alcohol problem.

Alcohol Safety Action Programs
Alaska Highway Safety Planning Agency
Pouch N
Juneau, Alaska 99811

JUNEAU

Phone - 465-4374

Contact - T. Michael Lewis

Services - Provides for court liaison, screening, diagnosis, referral and follow-up services as a diversion program for first time offenders and misdemeanor referral from court to treatment.

Fees - None

Eligibility - Programs are currently operating in Anchorage, Fairbanks, Juneau, Kodiak, Sitka, Wasilla, Ketchikan, Kenai, Homer, Valdez, Tok, Bethel, Dillingham, Kotzebue, Nome, Barrow.

Southeast Alaska Regional Health Corp.

JUNEAU

Niles Cesar, Director

P.O. Box 2800

Juneau, Alaska 99803

Contact Person: David Bond

Phone - 789-2131

Services - Outpatient counseling, outreach, aftercare, and community information/education, referral, crisis intervention, alcohol information school. Programs in Angoon, Haines, Hoonah, Hydaburg, Kake, Klukwan.

Fees - Free or sliding scale

Eligibility - anyone.

Cook Inlet Council on Alcohol and Drug Abuse

KENAI

P.O. Box 882

Kenai, Alaska 99611

Phone 283-3658

Contact person - Kevin Murphy, Director

Services - outpatient, aftercare, AIS, ASAP, outreach, referrals, follow-up, prevention education services. Provider to Kenai, Soldotna, and Homer.

Fees - Based on sliding fee scale.

Eligibility - Interested or referred persons.

Gateway Mental Health Program

KETCHIKAN

Wesley Terwilliger, Director

Ketchikan Comprehensive Alcohol Program

3134 Tongass Ave.

Ketchikan, Alaska 99901

Phone - 225-4154

Contact person - Charlie Laub

Services - The program has three components: A quarter way, intensive, 30-day facility, a halfway house and an information and referral office. Provides individual, group, and family counseling with A.A. involvement. Detox available and 24 hour hotline.

Fees - Vary according to ability to pay.

Eligibility - Open, individuals must be sober to stay in houses during treatment.

Ketchikan Youth Services

KETCHIKAN

Box 7202

Ketchikan, Alaska 99901

Phone - 225-2540

Contact person - Paul Young, Director

Services - Provide recreational alternatives, prevention education, consultation and referral.

Fees - None

Eligibility - Open to youth ages 12 thru 18

Kodiak Council on Alcoholism

KODIAK

Box 497

Kodiak, Alaska 99615

Phone - 486-3535 Office

486-5382 Hope House Treatment Center

Contact persons - Mr. Bob Aldrich, Executive Director

Services - Information and Education, film and literature library, individual and group outpatient counseling, family consultations, referral services, 30 day inpatient problems, diagnostic screening, alcohol information school, residential treatment.

Fees - sliding scale

Eligibility - Persons or families adversely affected by substance abuse.

Northwest Regional Alcoholism Program

KOTZEBUE

Manilaq Association

Marie Schwind, Director

P.O. Box 256

Kotzebue, Alaska 99752

Phone - 442-3311

Contact - Dan Thomas, Director

Services - Emergency care, outreach, outpatient care, aftercare, alternatives, residential treatment, prevention education and referral in surrounding villages.

Fees - None

Eligibility - None

McGrath-Anvik Educational Mental Health Association
P.O. Box 167
McGrath, Alaska 99627

McGRATH

Phone - 524-3781

Contact person - Susan Rogge, Director

Services - Community education, individual, group and family counseling, crisis intervention, mental health and public health Antabuse Program, outpatient treatment, after care, outreach, prevention.

Fees - Sliding scale based on income and family size.

Eligibility - Anyone

Norton Sound Health Corporation
Comprehensive Alcohol Program
P.O. Box 966
Nome, Alaska 99762

NOME

Phone - 443-5411

Contact person - Betty Hannigan, Director, Community Services

Services - Emergency & Medical detox; 9-bed 45-day intermediate residential center (3-bed halfway); individual, family, and group outpatient; outreach; program-wide aftercare; village volunteer counselors; correspondence alcohol education course; teen group; court diversion (ASAP); community prevention education; technical assistance for village program development; 24-hour crisis intervention; jail services; employment assistance program.

Fees - Sliding scale, no charge if low income, third party is encouraged.

Eligibility - Open to all (residential center - 18 and older)

Petersburg Council on Alcoholism & Drug Abuse
215 Indian St.
Box 1066
Petersburg, Alaska 99833

PETERSBURG

Phone - 772-3552

Contact person - Larry Blank, Director 772-4557

Services - Information and referral, outpatient counseling, group counseling, Alcohol Information School, public school presentations, films, lectures, literature, outreach, aftercare, prevention/education, and OMVI diversion, DROP-IN center, "Alternative to Drinking Club Room".

Fees - Alcohol Information School - \$30.00 for 4 sessions. Mortimer-Filkins testing - \$50.00 per person. All other fees are on a sliding scale, according to income. No one will be refused services because of inability to pay.

Eligibility - Anyone with an alcohol or drug abuse problem, or anyone affected by an alcohol or drug abuse problem.

Petersburg Youth Services

PETERSBURG

212 Indian St.

P.O. Box 842

Petersburg, Alaska 99833

Phone - 772-4422

Contact person - Denise Perlich, Director

Services - Prevention, drop-in center, community recreation activities.

Fees - None

Eligibility - Available to all youth.

S. Kachemak, Inc. Alcoholism Program

SELDOVIA

P.O. Box 197

Seldovia, Alaska

Phone - 234-7807

Contact Person - Edith-Helen Hilts, Director

Services - Community education, out patient, aftercare, outreach

Fees - Ability to pay

Eligibility - Alaskan natives of the area

Seward Life Action Council

SEWARD

P.O. Box 1045

Seward, Alaska 99664

Phone - 224-5257 or 24 hour crisis line 224-3027

Contact person - , Executive Director

Services - Combined Mental Health and Alcoholism/Drug Abuse Program. Out-patient services, outreach, aftercare, information and referral, prevention education, 24 hour on-call crisis intervention services, consultation, Employee Assistance Program (EAP), and brief stay detoxification and recovery component, Alcohol Information School (AIS) and ASAP screening.

Fees - Based on sliding scale. ASAP screening \$30.00/AIS - \$75.00

Eligibility - no specific requirements.

Sitka Council on Alcoholism and Other Drug Abuse, Inc.
Information, Referral, and Outpatient Office (IRO)
207 Moller Street
Sitka, Alaska 99835

SITKA

Phone - 747-3636

Contact person - Mac Armstrong

Services - Information, community education, group and individual counseling, emergency care, outpatient and intermediate care, outreach, aftercare, prevention education and court diversion.

Fees - A sliding scale based on income.

Eligibility - All people having alcohol or other drug related social and personal problems.

Sitka Council on Alcoholism and Other Drug Abuse, Inc.
Alcoholism Therapy Services (ATS) - Hopital Mt. Edgecumbe
P.O. Box 4310
Mt. Edgecumbe, Alaska 99835

SITKA

Phone - 966-2438

Contact person - Mac Armstrong (747-3636)

Services - Sixteen bed facility for inpatient care.

Fees - No fee for eligible participants.

Eligibility - Clients must be admitted by a physician and eligible under IHS, PHS, or VA guidelines.

Sitka Council on Alcoholism and Other Drug Abuse, Inc.
Aurora's Halfway House
207 Moller
Sitka, Alaska 99835

SITKA

Phone - 966-2435

Contact person - Mac Armstrong (747-3636)

Services - Provides a sheltered environment for up to 14 persons.

Fees - Room and board \$337.00/month, adjusted on basis of in-kind services.

Eligibility - Preference given to those recently discharged from ATS or other treatment programs, limited space available for persons requiring support in crisis situations.

Southeastern Regional Training Program
Sitka Council on Alcoholism and Drug Abuse
207 Moller Street
Sitka, Alaska 99835

SITKA

Phone - 747-3636

Contact person - John Sullivan

Services: Level I, II Counselor Certification linked training, training plan assistance, internship program development for Southeastern Communities funded by Office of Alcoholism and Drug Abuse and family Violence programs. Member State Training Agency Network.

Fees: Based on credits offered and credit level.

Eligibility: Counselors pursuing Alcoholism and Drug Abuse Certification from SOADA funded programs, family violence and other human service programs.

Sitka Teen Club
P.O. Box 1034
Sitka, Alaska 99835

SITKA

Phone - 747-3500

Contact person - Under Recruitment

Services - Social and recreational activities, tutoring, counseling, job opportunities, referrals, workshops, weekly group meeting for affected youth.

Fees - N.A.

Eligibility - All teenagers and their families.

Upper Tanana Alcoholism Program
P.O. Box 83
Tok, Alaska 99780

TOK

Phone - 888-5185

Contact Person - , Program Coordinator

Services - Outpatient, outreach, referral, criminal justice diversion and prevention and education. Operates service network of rural counselors in several locations.

Fees - Sliding scale

Eligibility - Open to the public

Valdez Counseling Center

VALDEZ

P.O. Box 307

Valdez, Alaska 99686

Phone - 835-2838

Contact - David H. Hoxworth, Director

Services - Outpatient, outreach, aftercare, follow-up, 24 hr. emergency telephone service, alcohol education/prevention services, ASAP, AIS.

Fees - Based on sliding fee scale.

Eligibility - None - open to all persons.

Alaska Alcohol Rehabilitation Services

WASILLA

Nugen's Ranch

P.O. Box 1545

Wasilla, Alaska 99687

Phone - 376-4534

Contact person - Leonard Nugen, Director

Services - Long term care for chronic alcoholics

Fees - Based on ability to pay

Eligibility - Extensive eligibility requirements based on long term chronic abuse of alcohol.

Mat-Su Council on Alcoholism

WASILLA

Box 2270

Wasilla, Alaska 99687

Phone - 376-4001

Contact person - Andy Brennan, Director

Services - Outpatient counseling, outreach, aftercare, referrals, ASAP, AIS school, prevention, education, intensive outpatient treatment, and court intervention program.

Fees - Sliding scale; plus intensive treatment fee scale.

Eligibility - Open to all interested persons.

Wrangell Council on Alcoholism & Related Drug Dependencies

WRANGELL

P.O. Box 1108

Wrangell, Alaska 99929

Phone - 874-3338

Contact Person - Merry Warner, Director

Services - Information and referral, individual and group outpatient, after care, outreach, family counseling, Alcohol Information School (AIS) ASAP screening, youth education, emergency care, employee assistance, and prevention education.

Fees - Sliding Fee scale.

Eligibility - Any person in need of services.

Yakutat Alcoholism Program

YAKUTAT

Box 6

Yakutat, Alaska 99689

Phone - 784-3775

Contact person - Vivian Lewis, Director

Services - Information referral, outreach, outpatient counseling, and aftercare.

Fees - None

Eligibility - Anyone

PRIVATE SECTOR PROVIDERS

Charter North Hospital
2530 DeBarr Road
Anchorage, Alaska 99504

Phone - 338-7575

Services - The alcoholism and substance abuse component of the Charter North Hospital is composed of a six bed detoxification unit, thirty alcoholism and substance abuse beds, and four drug abuse beds. The alcoholism and substance abuse program is structured for rehabilitation, beginning with detoxification and continuing through a twenty-eight day program of education and counseling. The program utilizes an open medical staff model with patients admitted by and under the care of the individual patient's physician who defines the specific treatment regime customized to address the therapeutic needs of the individual.

Fees - Contact hospital for more information.

Eligibility - Anyone.

Veterans Administration
Alcohol Treatment Unit
Outpatient Clinic Annex
801 B Street, Suite 203
Anchorage, Alaska 99502

Phone - 279-0627

Services - A full range of counseling services including Social Work Services, vocational counseling, and job club. Outpatient medical care is also offered by the unit. Groups are held Monday through Thursday evenings. The Monday night group focuses on the first time D.W.I. offender, and includes the realities of drinking and driving, with the legislation and consequences of a D.W.I.; family and social roles surrounding drinking; alternatives to drinking; and the medical psychological and social problems that result from drinking.

Group counseling is augmented by individual sessions, which gives the veteran an opportunity to discuss the material that he is learning with his primary counselor. A typical treatment plan is from twelve to fourteen weeks long, in order to give the client time to work out his or her specific problems and needs.

There is no cost to eligible veterans, and in most cases the family may also be counseled at no cost. Hours of operation are from 7 a.m. to 8 p.m. by appointment. Additional information may be obtained by calling the number listed above or coming to our offices.

Employee Assistance Consultants of Alaska
4790 Business Park Boulevard, Bldg. D, Suite 7
Anchorage, Alaska 99503

Phone - 562-2812

Contact person - Darryl Logan

Services - A private firm that contracts to provide counseling programs for employees throughout the state. Our Employee Assistance Program offers confidential personal problem evaluation, counseling and referral services for all employers and family members. Services available to employees cover counseling and referral in the following areas: alcohol/drug, educational, legal, financial, marital/family, medical, psychiatric, and psychological.

Fees - Contact program for more information

Human Affairs, Inc.
3601 'C' Street
Suite 300
Anchorage, Alaska 99503

Phone - 562-0794

Contact Person - Pat Wilson, Director

Services - This private Corporation provides Employee Assistance Programming for business, industry, State and local governments. Services range from Evaluation and referral through ongoing long term counseling. Management consultation by request. Company employee population served range from 13 to 3400.

Fees - Contact program for more information

Northpoint, Inc.
406 West Fireweed Lane, Suite 103
Anchorage, Alaska 99503

Phone - 338-7686

Contact Person - Obed Nelson

Services - Northpoint's primary outpatient treatment program is a six-week program involving three days per week for three hours each day. The primary program is followed by a six-month program of weekly aftercare sessions.

Fees - Contact program for more information

Eligibility - Anyone

Genesis, Inc.

1569 South Bragaw Street
Anchorage, Alaska 99508

Phone - 338-2116

Contact Person - Brian Kelly

Services - Genesis is a private treatment agency that provides intensive outpatient care for five weeks, plus aftercare for six (6) months. Treatment consists of a combination of education sessions, individuals therapy, group therapy, and related activities provided to detoxified alcoholics and their families. Their goal is total abstinence.

Fees - Contact program for more information.

Eligibility - None

Integrated Counseling Service

1st National Executive Center
100 Cushman Street, Suite 310 H
Fairbanks, Alaska 99701

Phone - 452-5230

Contact Person - Pat Malloy, Ph.D.

Services - Community wide service provider for individuals and families seeking to redirect their energies in achieving a new life style. Areas of expertise include marriage, family and child counseling, employee assistance programs, alcohol information programs, alcohol and drug abuse counseling, and pre-sentence evaluations for the court system. The spiritual/religious aspects of recovery are integrated into the individualized treatment planning.

Fees - Dependent on type of program required.

Eligibility - Client's willingness to participate.

Far North Recovery Center

P.O. Box 873349
58 1/2 Mile Parks Highway
Houston, AK 99687

Phone - 892 - 7529

Contact - David L. Davis, Executive Director

Services - Far North is a private non-profit community centered organization that provides residential intermediate care. They have targeted people who are in crisis through the courts, referral agencies, crisis centers and voluntary admissions.

Fees - Contact program for more information.

YOUTH SUBSTANCE ABUSE PROGRAMS INITIATED OCTOBER 1984

Aleutian/Pribilof Islands Association, Inc.
1689 C Street
Anchorage, Alaska 99501

ANCHORAGE

Phone - 276-2700

Contact Person - Kathy Sutcliffe

Services - Will develop and implement a Natural Helper program in four villages.

Kuskokwim Native Association
Community Counseling Center
Box 106
Aniak, Alaska 99557

ANIAK

Phone - 675-4445

Contact - Susan Soule

Services - The project will hire two local youth to establish a youth education/prevention program in the village of Aniak.

Yukon Kuskokwim Health Corporation
Box 528
Bethel, Alaska 99559

BETHEL

Phone - 543-3321

Contact - Carl Berger

Services - Will provide for a prevention worker to team with an existing Village Alcohol Education Counselor in one village.

Bristol Bay Area Health Corporation
P.O. Box 10235
Dillingham, Alaska

DILLINGHAM

Phone - 842-5266 or 842-5267

Contact - Bob Wallman

Services - Will provide intensified substance abuse education in the schools and community. Education will be aimed at involving youth in community activities and increasing community knowledge and ability to make appropriate steps towards local solutions.

McGrath-Anvik Educational Mental Health Association
P.O. Box 167
McGrath, Alaska 99627

McGRATH

Phone - 524-3781

Contact - Susan Rogge

Services - The project will provide for a substance abuse counselor to deliver education, refusal skills training, modified natural helpers, and a student assistance project to four schools in the Iditerod School District.

Minto Village Council
Box 29
Minto, Alaska 99758

MINTO

Phone - 798-7112

Contact - Carlos Frank

Services - The project provides for the establishment and operation of a Teen Center for information, education, peer counseling and coordination of youth activities in Minto.

City of Tanana
P.O. Box 181
Tanana, Alaska 99777

TANANA

Phone - 366-7159

Contact - Anne M. Lilley

Services - To operate a Teen Center in Tanana to provide a drug free setting for an education and peer counseling program.

Cook Inlet Council on Alcohol and Drug Abuse (Tyonek)
Tyonek, Alaska 99682

TYONEK

Phone - 583-2201

Contact - Peter Mikuliak

Services - The project will permit further development of the teenage Peer Counselors to be used in the implementation of a village Community School program.

REVIEW BOARD ON ALCOHOLISM

3331489-TE31485
Annie S. Bowen, Chairperson
Review Board on Alcoholism
8431 E. 17th Avenue
Anchorage, Alaska 99504

2796661-TE31487
Ose Matsutani, Director
Review Board on Alcoholism
Alaska Native Medical Center
P.O. Box 7-741
Anchorage, Alaska 99501

2252975-TE31485
Arlene W. Nelson
Review Board on Alcoholism
Box 3147
Ketchikan, Alaska 99901

4863237-TE31486
R. Holmes Johnson
Review Board on Alcoholism
Holmes Johnson Clinic
P.O. Box 1727
Kodiak, Alaska 99615

2834639-TE31487
Christine Martin
Review Board on Alcoholism
P.O. Box 1298
Kenai, Alaska 99611

9668368-TE31487
Frank O. Williams, Jr.
Review Board on Alcoholism
P.O. Box 4050
Mt. Edgecumbe, Alaska 99835

4243272-TE31487
Margy Johnson
Review Board on Alcoholism
Box 1309
Cordova, Alaska 99574

ADVISORY BOARD ON DRUG ABUSE

5866806-TE21586
Constance L. Munro
Advisory Board on Drug Abuse
120 West Ninth Street
Juneau, Alaska 99801

3453272-TE31585
Peggy Colletta
Advisory Board on Drug Abuse
SRA Box 1458-K
Anchorage, Alaska 99502

2433857-TE7186
Ben J. Esch, Chairperson
Advisory Board on Drug Abuse
3223 West 31st Avenue
Anchorage, Alaska 99503

4435434-TE21585
Julie K. Perkins
Advisory Board on Drug Abuse
Box 813
Nome, Alaska 99762

2834955-TE31585
Alexander P. Shadura
Advisory Board on Drug Abuse
P.O. Box 3907
Kenai, Alaska 99611

GLOSSARY

Aftercare -

The process of providing continued contact which will support and increase the gains made to date in the treatment process.

Education -

The dissemination of relevant information specifically aimed at increasing the awareness, receptivity, and sensitivity of the community and stimulating social action to increase the services provided for people with problems associated with the use of alcohol.

Inpatient Care -

The process of providing care to persons who require twenty-four hour supervision in a hospital or other suitably equipped medical setting as a result of acute or chronic medical and/or psychiatric illnesses associated with alcohol abuse and/or alcoholism.

Intermediate Care -

The process of providing alcoholism treatment services in a full, twenty-four hour residential milieu therapy setting, or a partial (less than twenty-four hours) residential milieu therapy setting.

Medical Care -

Those diagnostic and treatment services that, under the laws of the jurisdiction in which the program is located, can only be provided by a licensed physician.

Outpatient Care -

The process of providing nonresidential diagnostic and alcoholism treatment services on both a scheduled and a nonscheduled basis.

Outreach -

The process of reaching into a community systematically for the purposes of identifying persons in need of services, alerting persons and their families to the availability of services, locating needed services, and enabling persons to enter and accept the service delivery system.

Prevention -

- A. Primary Prevention: includes activities designed to alter societal conditions and address the needs of potential substance abusers before abuse begins and its negative consequences occur. Thus, primary prevention as the term is used in this section, refers to strategies which address the problem of substance abuse before the identifiable development of the problem.
- B. Secondary Prevention: includes early intervention activities designed to address problems of substance abuse early in their development and before addiction or other severe consequences occur.
- C. Tertiary Prevention: includes treatment and rehabilitation services, focused upon the smaller numbers of people already experiencing the negative consequences of alcohol and/or other drug abuse.