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HB 340 cont.,

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

D. Drinking Age

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

*Williams et al. "The Legal Minimum Drinking Age and Fatal Motor Vehicle Crashes," 197
**Whitehead et al. "The Impact of the Change in the Drinking Age on the Collission

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

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

AGE AND OMVI ARRESTS IN ALASKA, 1975

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

*From Uniform Crime Report, 1975
**From Division of Motor Vehicles, effective 12/31/75

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

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

E. Closing Hours

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

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

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

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

PROHIBITED HOURS OF SALE FIXED BY STATE LAW**

License States	On-Premise Consumption (Bars, Restaurants, etc.)	Off-Premise Consumption (Package Stores)	No. Hours Closure On-Premise	No. Hours Closure Off-Premi
Alaska	5 am - 8 am	5 am - 8 am	3	3
Arizona	1 am - 6 am	1 am - 6 am	5	5
Arkansas	1 am - 7 am	1 am - 7 am	6	6
California	2 am - 6 am	2 am - 6 am	4	4
*Colorado	2 am - 7 am	Midnight - 8 am	5	8
*Connecticut	1 am - 9 am	8 pm - 8 am	8	12
Delaware	1 am - 9 am	1 am - 9 am	8	8
*D.C.	2 am - 8 am	9 pm - 10 am	6	13
Florida	Midnight - 7 am	Midnight - 7 am	7	7
Indiana	3 am - 7 am	3 am - 7 am	4	4
Kansas	11 pm - 9 am	11 pm - 9 am	10	10
Kentucky	Midnight - 8 am	Midnight - 8 am	8	8
Louisiana	None	None	0	0
*Maryland	2 am - 6 am	Midnight - 6 am	4	6
*Minnesota	1 am - 8 am	10 pm - 8 am	7	10
*Mississippi	Midnight - 10 am	10 pm - 10 am	10	12
Missouri	1:30 am - 6 am	1:30 am - 6 am	4 1/2	4 1/2
Nebraska	1 am - 6 am	1 am - 6 am	5	5
Nevada	None	None	0	0
New Mexico	2 am - 7 am	2 am - 7 am	5	5
*New York	3 am - 8 am	Midnight - 8 am	5	8
North Dakota	1 am - 8 am	1 am - 8 am	7	7
Oklahoma	10 pm - 10 am	10 pm - 10 am	12	12
South Carolina	Sundown - Sunrise	Sundown - Sunrise	12	12
South Dakota	2 am - 7 am	2 am - 7 am	5	5
*Tennessee	3 am - 8 am	11 pm - 8 am	5	9
*Texas	2 am - 7 am	9 pm - 10 am	5	13
*Wisconsin	2 am - 8 am	9 pm - 8 am	6	11
Wyoming	2 am - 6 am	2 am - 6 am	4	4
		Average of States Listed Above	6	7
Other License States				
Georgia	Fixed Locally	Midnight - 8 am	-	8
Hawaii	Hrs. Set By Counties	Hrs. Set By Counties	-	-
Illinois	Fixed Locally	Fixed Locally	-	-
Massachusetts	Fixed Locally	Fixed Locally	-	-
New Jersey	Fixed Locally	Fixed Locally	-	-
Rhode Island	1 am - 6 am	Fixed Locally	5	-

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

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

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

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

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

significant effect in those areas where bootlegging is currently common.

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

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

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

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

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

G. Limitation on Possession in a Dry Community

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

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

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

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

II. Middle Option - "Semi-Dry"

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

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

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

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

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

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

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

I. OMVI Statutes

1. Medical evidence exists to demonstrate the validity of blood alcohol concentrations as an index of level of impairment due to alcohol. Further, both medical and associated scientific research information demonstrates the reliability of the blood, urine, and breath testing procedure to ascertain blood concentrations.

2. According to research tests, the risk of a person becoming involved in an automobile accident begins to increase at .05% BAC. At .10% a person is approximately seven times more likely to be involved in a crash than if sober, and at .15% BAC the risk of accident involvement is increased 25 times.*

3. Additional research findings and demonstration programs show that persons identified as problem drinker-drivers as a result of conviction for OMVI and presentence investigation are primary candidates for alcohol treatment and rehabilitation systems as well as for the criminal justice system. Further, recent treatment rehabilitation evaluation information shows that the recovery rate for persons treated as problem drinker-drivers is much higher than the conventional treatment rate for voluntary self-admissions to treatment programs. This result is considered to be due to the increased potential of treatment when problem drinker-drivers are identified early in the progressive cycle of alcoholism. The important contribution of screening all convicted drunk drivers is the early identification of

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

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

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

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

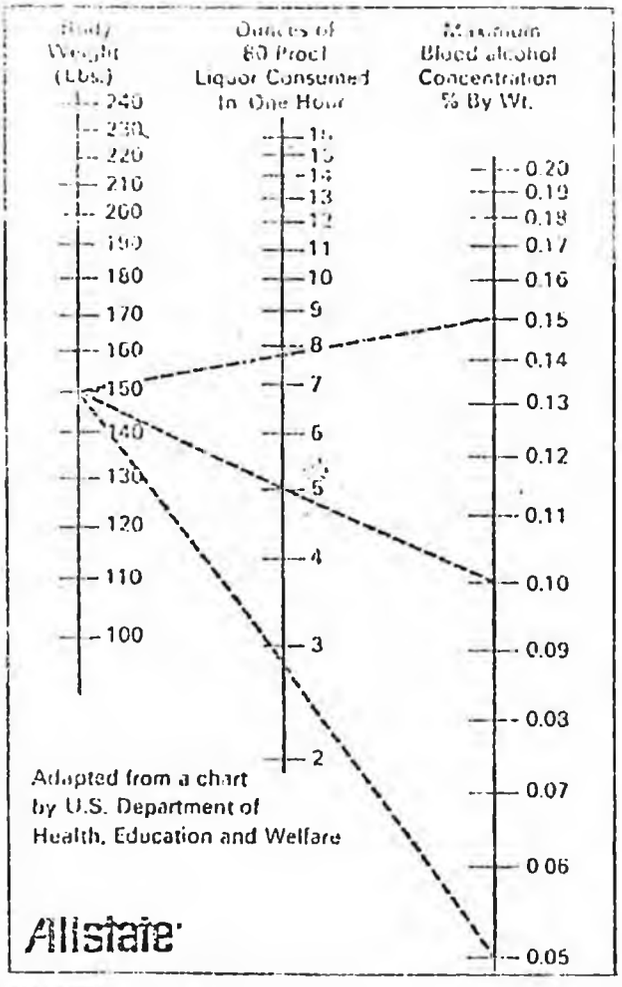
J. Public Education

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

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

"EMPTY STOMACH"

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

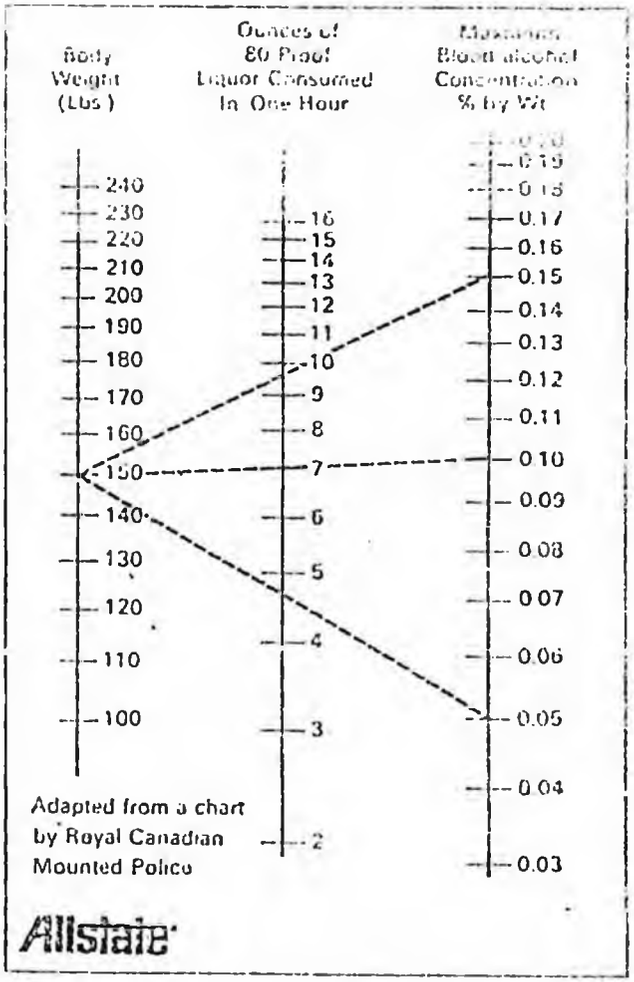


Adapted from a chart by U.S. Department of Health, Education and Welfare

Allstate

"FULL STOMACH"

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



Adapted from a chart by Royal Canadian Mounted Police

Allstate

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

To determine the approximate average number of ounces of 80 proof liquor needed in a one-hour period to reach 0.10%, draw a line from BODY WEIGHT to 0.10%. The line will intersect the average number of ounces needed to produce 0.10%. Follow the same procedure to determine the amount of liquor needed to reach other blood-alcohol concentrations, such as 0.05%, 0.15%, etc.

Charts show *rough averages only*. Many factors affect the rate of alcohol absorption into the bloodstream. Amount of food consumed, kind of food and drink consumed, and percentage of fatty tissue in the body, for examples, can vary blood-alcohol concentration values.

*The rate of elimination of alcohol from the bloodstream is approximately 0.015% per hour. Therefore, subtract 0.015% from blood-alcohol concentration indicated on above charts for each hour after the start of drinking.

11 20

REPORT OF THE

I.C.C. SUB-COMMITTEE ON THE

PRIMARY PREVENTION OF ALCOHOL-ASSOCIATED

PROBLEMS THROUGH EDUCATION

October 14, 1976

4.29

GOAL

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

CONSIDERATIONS

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

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

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

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

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

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

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

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

RECOMMENDATIONS

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

I. TOWARD THE EDUCATION OF THE GENERAL PUBLIC

GOALS

1. The public will be made aware of the true extent of the socio-economic problems at State, community, family and individual levels, which emerge from the current levels and patterns of alcohol consumption use.

2. The public will be aware of the concept that alcohol is a drug in the true sense of the definition, that intoxication means being functionally incapacitated to some degree, and that such a state is not to be approached with impunity or humor.

3. The public will be disabused of the traditional misconceptions associated with alcohol.

4. The public will be aware of alternatives to drinking which are more rewarding and less physically dangerous.

5. The public will be aware of the purpose and direction of counter-media campaigns originated by the alcohol beverage industry.

6. The general public will sustain a measurable decrease in over-all consumption of alcoholic beverages.

Project A

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

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

1. TIME FRAME

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

2. RESPONSIBILITY BASE

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

3. FUNDING SOURCE

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

4. LEGISLATIVE BACK-UP

Support budget requests of involved State Departments.

Project B

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

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

1. TIME FRAME

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

2. RESPONSIBILITY BASE

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

3. FUNDING SOURCES

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

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

4. LEGISLATIVE NEED

a. Legislation which will provide authorization for a new category for alcohol education under the municipal revenue-sharing plan.

b. Legislation which will provide State personnel positions and funding for three community preventive education specialists.

Project C

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

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

1. TIME FRAME

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

2. RESPONSIBILITY BASE

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

3. FUNDING SOURCES

The Office of the Governor.

4. LEGISLATIVE NEED

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

Project D

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

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

1. TIME FRAME

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

2. RESPONSIBILITY BASE

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

3. FUNDING SOURCES

Department of Health and Social Services.

4. LEGISLATIVE NEED

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

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

GOALS

By completion of the elementary grades:

1. Students will know and demonstrate the importance of asking a responsible adult before eating or drinking anything unknown; and know dangers of putting foreign objects into mouth or other body orifices.

2. Students will be able to identify substances commonly used by individuals that may modify mood and behavior (e.g., candy, soft drinks, tea, coffee, cigarettes, alcohol); and know there are differences between alcoholic beverages and other beverages.

3. Medicines are helpful for maintaining health and should be treated with respect.

4. Medicines and other substances that are commonly used can be harmful if misused; know a variety of conditions which contribute to the misuse of medicines; are able to identify substances that can be harmful if misused; know dangers resulting from use of combinations of drugs.

5. Misuse of drugs often starts early in life. Individuals react differently to alcohol and other drugs. One can live a normal, full and happy life without misusing drugs. Personal goals and practices established early in life (e.g., self-respect for one's body, healthy standards of behavior and sound personal decisions) can help one to avoid the misuse of drugs. A positive self-image can be a factor in finding alternatives to the abuse of alcohol and other drugs.

6. Students will know some sources and results of authoritative research concerning the effects of alcohol use on the body; identify reasons individuals drink or refrain from drinking and ways that drinking can affect the performance of an athlete, hunter or fishing person, and know some of the ways alcohol advertising contributes to the use of alcohols.

7. Well-adjusted individuals are able to interact with others in a variety of situations. Various behaviors can produce various good and bad feelings in others. People react in different ways to various situations. Other people can affect one's self-image.

8. Students will be able to identify the qualities in themselves which they appreciate and those they would like to change; will be able to analyze their own feelings of pride; and will be able to describe ways to improve qualities and how to maintain those they value.

9. Students will be able to recognize and disscuss effects of emotions on behavior; will be able to identify alternative methods of dealing with stress in one's own culture.

By the completion of junior high:

1. Students will know general physiological and psychological effects of drugs; know about alcohol, its history, nature, uses and abuses, and physical effects on the individual, the family and society; know reasons why individuals refrain from drinking; and can identify cultural similarities and differences in our society and how this pertains to alcoholism. Students can identify dynamics of decision making concerning use of alcohol and are able to list sources of social pressures which affect decisions; are able to evaluate alternate solutions to such problems and to name legal, psychological and physical consequences of given incidents involving use and abuse of alcohol. Students will know methods of discouraging illegal alcohol and other drug suppliers and ways in which individuals can be influential in the control of alcohol and other drug usage.

2. Alcohol and other drugs may cause immediate and harmful long-range effects. Many major health problems may be aggravated by misuse of these substances. Students know effects on pregnant women and new-born infants. Students know some social and economic problems resulting from substance misuse.

3. Students know basic physiological and psychological needs of human beings and are able to list ways substances have been used and misused to meet basic needs; know ways of avoiding alcohol and other drug abuse.

4. Students will understand that anxiety, fatigue, frustration and mild depression are normal tolerable parts of everyday life; know ways in which pressures can help or hinder behavior; know ways that the effects of pressure can be re-channeled; know ways in which trust in one's self and in others can serve as relief from anxiety; know how a crisis situation may affect the individual; and that individuals vary in their abilities to adjust to the demands of living.

5. Self-acceptance and acceptance of one's cultural framework is fundamental to sound health; knows socially appropriate ways of meeting one's own emotional needs that will be well regarded by others, both within immediate peer or cultural group and within the larger society, and ways of meeting those needs that will not be so regarded. Self-respect is built upon complex factors, including the concept of self in relation to "important others" and is related to the ability to accept success, failure and/or criticism.

6. Students will demonstrate basic steps in dealing with a problem; know ways in which feelings such as anger and fear may affect an individual's ability to cope with problems; will be able to identify acceptable ways in society to release and deal with hostility and anxiety; and know local resources that can assist individuals in solving complex problems.

7. Students will know ways in which self-discipline helps to adjust behavior and regulate emotions in a manner acceptable to oneself and to one's own culture.

By the completion of high school:

1. Students will know the historical background, characteristics and scope of the substance abuse problem in their immediate family, village or city, state, nation and world.

2. Various treatments and sources that are available for substance abuses will be known.

3. Students will be able to analyze alcohol and drug advertising for such qualities as subtle inferences, scientific accuracy and emotional appeal.

4. The essences of major state, federal and international laws and regulations relating to alcohol and other drugs will be known.

5. Students will be able to identify defense mechanisms which they and others use in adjusting and adpating to situations and experiences; will identify defense mechanisms which may be used in maladjustive behavior.

6. Values include the beliefs, ideals, rules and standards which guide one's actions. Influences in one's physical or social environment which help shape one's values are recognizable. Values influence human behavior in many ways.

7. Vocational and avocational interests and activities can fulfill psychological and creative needs.

8. Students will know ways in which major changes (e.g., changing jobs, marrying, having children, death in the family) can affect the individual's overall well-being.

Project A

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

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

1. TIME FRAME

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

2. RESPONSIBILITY BASE

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

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

3. FUNDING SOURCES

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

4. LEGISLATIVE NEED

Budgetary support for this special-purpose project.

Project B

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

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

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

1. TIME FRAME

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

2. RESPONSIBILITY BASE

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

3. FUNDING SOURCES

Cooperative State Departmental funding.

4. LEGISLATIVE NEED

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

Project C

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

1. TIME FRAME

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

2. RESPONSIBILITY BASE

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

3. FUNDING SOURCES

No special funding is necessary.

4. LEGISLATIVE NEED

No special legislative back-up is foreseen presently.

SUMMARY

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

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

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

4-1d

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

SUMMARY OF PROPOSAL FOR THE PRIMARY PREVENTION OF
ALCOHOL-ASSOCIATED PROBLEMS THROUGH EDUCATION

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

V. POLICY RECOMMENDATIONS FOR "TREATMENT" AND "TRAINING"

I. Problems

A. The Uniform Act

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

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

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

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

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

B. Data Acquistion and Analysis

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

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

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

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

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

C. The Grant-in-Aid Funding Mechanism

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

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

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

Aniak	Bettles	Ft. Yukon	Kotzebue
Barrow	Cold Bay	Galena	McGrath
Bethel	Dillingham	Glennallen	Nome
			Tok

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

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

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

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

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

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

Project location	State funds	Other Cash or In-Kind	Ratio State/Non-State
Nome	85,430	40,69?	2.09
Dillingham	22,100	9,405	2.35
Kotzebue	36,507	15,719	2.32
Juneau	90,360	233,864	0.39
Wrangell	26,860	8,980	2.99
Unalaska	33,800	66,110	0.51

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

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

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

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

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

X = Funded

-- = Not Funded

D. Other Problems

1. Manpower and Staff development

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

2. Administrative and Fiscal Management of Programs

State Office of Alcoholism program evaluations and DHSS fiscal audits

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

3. Public attitude and awareness

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

a. The acceptance of alcoholism as a treatable illness.

b. The success of alcoholism treatment programs in reducing the number of visible alcoholics.

c. The fundamental nature, limitations and capabilities of treatment programs for the alcoholic.

d. The distinction between the alcoholic and the alcohol abuser and the treatment modalities appropriate to each.

II. Basic treatment and rehabilitation components

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

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

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

A. Emergency care: Shall provide for twenty-four hour availability of the following services to all persons and their families with problems related to alcohol use and abuse: (1) immediate medical evaluation and care; (2) supervision of persons by properly trained staff until they are no longer incapacitated by the effects of alcohol; (3) evaluation of medical, psychological, and social needs, leading to the development of a plan for continuing care; and (4) effective transporation services.

B. Inpatient care: Shall provide twenty-four hour supervised care under the direction of a physician in a hospital or other suitably equipped medical setting designed for the diagnosis and/or treatment of medical and/or psychiatric illnesses derived from or associated with alcohol abuse and/or alcoholism.

C. Intermediate care: Shall be designed to facilitate the rehabilitation of the alcoholic person by placing him in an organized therapeutic environment in which he may receive diagnostic services, counseling, vocational rehabilitation and/or work therapy while benefiting from the support which a full or partial residential setting can provide.

D. Outpatient care: Shall be designed to provide a variety of diagnostic and primary alcoholism services on both a scheduled basis and nonscheduled basis in a nonresidential setting to alcoholic persons and their families whose physical and emotional status allows them to function in their usual environment.

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

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

above (A-D).

A. Emergency Care

1. Emergency Medical Services

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

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

2. Sleep-Off Center

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

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

B. Inpatient care

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

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

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

C. Intermediate Care

1. Thirty-day residential rehabilitation and treatment services.

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

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

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

2. Halfway house services

A halfway house unit is a community-based intermediate residential

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

The list of existing halfway house programs is as follows:

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

D. Outpatient care

1. Outpatient services

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

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

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

2. Information and Referral services

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

3. Education

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

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

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

E. Long-term Domiciliary Care

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

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

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

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

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

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

III. Recommendations

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

* Amend the Uniform Alcoholism and Intoxication Treatment Act (AS 47.37.010-270) for the purposes of: distinguising more adequately between the alcoholic and intoxicated individual (alcohol abuser); establishing separate policies for the alcoholic and the alcohol abuser; defining the responsibility of the State Office of Alcoholism and the service providers with whom the office contracts with regard to the treatment of the alcoholic and the alcohol abuser; and simplifying the court procedure for involuntary commitment of alcoholics to inpatient treatment for 30 to 180 days after sleep-off. (The present Uniform Act contains provisions which are fare too costly, cumbersome and unwieldy with regard to involuntary commitment. Consequently, there have been considerable problems with implementation of this provision by the Courts.)

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

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

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

* Recommend use of local sales taxes (either current possible or raised from a special tax) to provide increasing amounts of local support for programs.

* Require that communities receiving revenue-sharing money from the Department of Community and Regional Affairs for "alcoholism program beds" match their SGF Office of Alcoholism Grant with an amount of cash equivalent to that revenue sharing support.

* Allow an amount equivalent to 10% of the State's grant as "in-kind" match, for all years of State Grant-in-Aid financial support to local programs,to help offset local indirect cost expenses for local management of grants.

* Alter existing Title XIX, Private Insurance and Vocational Rehabilitation regulations, to provide coverage for treatment of alcoholism.

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

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

FY 78 60% State; 40% Other (cash)

FY 79 40% State; 60% Other (cash)

FY 80 . 25% State; 75% Other (cash)

FY 81 State fee for service support only for those patients not covered by other resources.

* Fund new programs at the following schedule:

Year 1 75% State; 25% Other

Year 2 60% State; 40% Other

Year 3 40% State; 60% Other

Year 4 25% State; 75 % Other

Year 4 State "fee for service" support only for those patients not covered by other resources

C. Emergency Care

1. Emergency Medical Services

The present Uniform Act requires that persons be afforded a continuum

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

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

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

2. Sleep-off Center Services

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

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

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

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

* Require an initial medical examination within 24 hours.

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

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

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

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

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

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

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

Capital Expenditures = $439,050 (estimated)

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

(includes total staffing of 117)

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

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

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

probable utilization of a sleep-off facility.

Source of funding

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

A. For Capital Expenditures: State General Fund

B. For Operating Expenses:

1. Poverty area communities: renewable yearly grant-in-aid, 90/10 State to local cash ratio.

2. Non-poverty area communities: progressively decreasing State/local grant-in-aid for four years (75/25; 60/40; 40/60; 25/75) and "fee for service" reimbursement starting at year five for those clients not covered by other resources.

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

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

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

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

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

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

These recommendations are made in view of the following considerations:

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

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

alcoholism, will be a continuing recidivism risk.

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

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

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

2. Inpatient Care

A. Medical detoxification

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

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

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

3. Intermediate Care

A. Thirty day residential treatment services

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

rely primarily on reimbursement for services given.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

FY 78 75% State; 25% Other

FY 79 50% State; 50% Other

FY 80 25% State; 75% Other

FY 81 0% State; 100 Other

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

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

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

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

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

Outpatient Care:

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

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

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

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

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

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

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

Information and referral services

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

* The State should function as a clearing-house for research, treatment, and training information pertinent to alcoholism.

* Existing local community alcoholism programs should provide information and referral services on an ongoing basis as part of their normal activities.

* Existing local community alcoholism programs should be required to develop formal referral networks with all health, social services, judicial and law enforcement agencies in their local catchment area.

Long Term Care

* The State should fund, and initially operate, a long-term domiciliary care and rehabilitation facility for the chronic public inebriate.

* The primary client population for this program should be the court committed chronic public inebriate and/or those addicted individuals in need of long-term in-residence care who chose to commit themselves voluntarily for a period of 90 days or longer.

* The State should initiate and operate this facility for a period of at least five years.

RATIONALE:

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

1. Trained management personnel will have to be recruited.

2. Other personnel will have to be trained.

3. Close cooperation will have to be maintained with the Alaska Court System. A state operated facility could more easily accomodate court referrals.

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

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

RATIONALE:

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

1. The availability of third-party reimbursements for cost of care for a program of this sort.

2. The direct and indirect costs likely to be incurred by various state agencies (e.g., Vocational Rehabilitation, Public Safety, Corrections, Judicial System) in using the services of this facility.

3. The willingness and capability of a community agency to effectively operate such a facility and to provide the required administrative and fiscal management.

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

RATIONALE:

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

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

RATIONALE:

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

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

$7,000/month.

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

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

REVENUE PROJECTIONS FOR LOCAL COMMUNITY ALCOHOLISM PROGRAM

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

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

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

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

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

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

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

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

Funding Source	FY 76	FY 77	FY 78
Federal Grants	$ 485,190	$ 607,821	$ 668,603
Local Govt.	502,076	693,522	762,874
Community	10,000	122,753*	135,028
Sub-Total	995,266	1,424,096	1,566,505
In-Kind	383,244	252,410	277,651
Total	1,378,490	1,676,506	1,844,156

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

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

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

VOLUME/SALES (1975)*

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

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

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

	1975 Gallons Volume	Est. 1975 Retail Sales (Millions)	Local Sales Tax Revenues (Projected in Millions) 1%	2%	3%
Liquor	1,236,976	$66.7	0.670	1.330	2.001
Wine	801,665	$14.9	0.149	0.298	0.447
Beer	8,451,841	$59.2	0.592	1.184	1.776
Total	10,490,482	$140.8	$1.411	$2.812	$4.224

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

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

	%Inc	Est. 1976 Gallons Volume	Est 1976 Retail Sales (Millions)	Sales Tax Revenues (Projected in Millions) @1%	@2%	23%
Liquor	(21%)	1,496,741	$81.07	0.8107	1.609	2,420
Wine	(32.7%)	1,063,809	19.8	0.198	0.395	0.593
Beer	(22%)	10,311,246	72.2	0.722	1.444	2.167
		12,871,796	$173.07	$1.7307	$3.448	$5.180

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

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

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

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

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

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

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

E. Troubled Employees Program

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

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

implemented.

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

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

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

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

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

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

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

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

1. Constructive Confrontation

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

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

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

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

2. Employee Assistance Counselor

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

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

A. Academic background - basic course work in the social sciences.

B. Area of experience - social work pastoral counseling, counseling psychology, personnel counseling, and experience in a public or

private occupational program.

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

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

3. Community Resources

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

4. Policy Statement

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

RATIONALE:

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

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

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

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

Counselor Training and Counselor Certification

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

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

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

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

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

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

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

1. Knows the interrelated physical, psychological, social, and spiritual dynamics of addiction-alcoholism and drug dependency as they relate to individual clients and the family social structure, and general approaches to the tasks of prevention and treatment.

2. Knows the "continuum of care" concept as a prevention and treatment strategy for addressing the problems of addiction and substance abuse in the community and in the overall State system, including specific treatment modalities, and is committed to using and expanding his knowledge.

3. Knows and can apply the basic principles and techniques of intervention, assessment (diagnostic) interviewing, and referral within the "continuum of care".

4. Knows the legal, ethical, and confidentiality considerations involved in the treatment of alcohol-(and drug) dependent clients and the processes relating to same.

5. Knows and can apply the principles and techniques of individual and group counseling within the alcoholism (and drug-dependency) treatment program.

6. Knows and can apply the principles and techniques of family (significant other) counseling.

7. Knows and can apply interpersonal communication principles and techniques in relation to bicultural (Eskimo, Indian, and Aleut) populations.

8. Knows and can apply written communication principles and skills in relation to developing client treatment plans, progress notes, and discharge summaries.

9. Knows and can apply oral communication principles and skills in relation to clients and other human service professionals.

10. Knows one's personal attitudes in relation to the alcoholism and drug-dependency treatment system and the clients it serves; knows how to develop effective attitudes and approaches and is committed to being an effective worker.[2]

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

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

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

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

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

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

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

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

VI. POLICY RECOMMENDATIONS FOR MANAGEMENT

A. MANAGEMENT PROBLEMS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Management Recommendations:

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

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

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

* Alter the composition of the Interdepartmental Coordinating Committee: The following persons should be members:

Commissioner of Health and Social Services

Director of Division of Policy Development and Planning

Director of Budget and Management

Commissioner of Administration

Commissioner of Public Safety

Commissioner of Community and Regional Affairs

Commissioner of Education

Commissioner of Revenue

Commissioner of Labor

Director of Criminal Justice Planning Agency

Department of Law

Representative from the Alaska Court System

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

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

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

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

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

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

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

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

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

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

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

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

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

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