

ALASKA LEGISLATURE SPECIAL COMMITTEE / SUBJECT FILE 8672

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showed a pattern of alcohol-related arrests more evenly divided among DWI, disorderly conduct and liquor law violations, whereas male alcohol-related arrests were very definitely concentrated on the DWI offense.

For juvenile arrests for alcohol-related offenses, about two-thirds were for liquor law violations. Liquor law violations and assaults together accounted for 85% of all juvenile arrests for alcohol-related offenses.

Although there is not enough data to adequately address the impact of alcohol-related arrests on the court and corrections components of the criminal justice system, it appears that misdemeanors would again be emphasized. Forty-eight to 75% of all misdemeanor cases filed with the district court were for alcohol-related offenses in 1975. Also, 42% to 78% of all misdemeanor convictions were for alcohol-related offenses.

During the period from 1971 to 1975, the number of releases for jail sentences of ten days or longer for alcohol-related offenses decreased by 72%, most likely in relation to the decriminalization of public drunkenness provided in the Uniform Act (1972). Also, during 1975, more than 50% of all served sentences fewer than ten days were for alcohol-related offenses. In addition, the recidivism rate for alcohol-involved offenses was established to be about 43%.

Limitations on available data most certainly restricted this section of the analysis of the impact of excessive drinking on the

court and corrections components of the criminal justice system. Certainly additional investigation is necessary.

Alcohol and Traffic Safety

The misdemeanor offense of driving-while-intoxicated is the offense category that accounts for the largest number of arrests annually. Drunk drivers are one of the primary concerns for the problem of traffic safety.

In Alaska, as elsewhere, most people killed after drinking and driving have a very high blood alcohol concentration. During 1975, 46% of the motor vehicle fatalities involved alcohol. Most drivers convicted for DWI have very high BAC's. The average BAC for DWI drivers in the state is almost twice the statutory legal limit of impairment. Even this level of .10% blood alcohol concentration is too high for safe driving when one considers the scientific and medical evidence of the extent of impaired judgment and ability indicated by the various ranges of blood alcohol concentration. Additional research information clearly demonstrates the increasing probability of involvement in any kind of crash with increasing BAC levels, as well as the increasing likelihood of responsibility for the crash with increasing BAC's. The probability for crash involvement begins to increase appreciably above .05% BAC. The presumptive limit for intoxication for conviction for OMVI is .10% BAC. The average BAC of arrested DWI drivers in 1975 was .18%. Ninety-two percent of all DWI arrests recorded BAC's above .10%.

The greatest majority of drivers have generally clear driving records, a very low rate of previous crash involvements, and account for very few of the crashes and traffic convictions. The great majority of drivers--80%-90%--also register no measurable BAC; about 3%-5% show BAC levels above .10%. This contrasts very sharply with both the subpopulations of drivers involved in crashes and drivers convicted of DWI. The average BAC level of these drivers is almost twice that of the limit of legal impairment. They account for an extremely disproportionate number of prior DWI convictions, as well as other serious and minor traffic violations and involvement in accidents. Given the array of information available about these drivers, it is logical and valid to conclude that the great majority were indeed drunk, independent of one's precise definition of the term. While the conclusion seems obvious, the information available also allows the inference that a very high proportion of these drivers also qualify for the label of "problem-drinker" or "alcoholic drinker". As such, these problem-drinker-drivers are valid clients for alcoholism treatment and rehabilitation as well as for the judicial-correctional system.

This group of people is generally well known to the courts, accounting as they do for so many traffic violations and accidents. In Alaska, about 22% of all adult arrests are for OMVI. Of those convicted, two out of ten had at least one prior OMVI conviction, 18 of 20 had at least one prior major traffic violation (reckless or negligent driving, etc.), and 13 out of 20 had one or more traffic accidents. Drivers

convicted of OMVI tend to be younger, between 18 and 39 years old, non-Native, and male.

The general trends of increasing consumption in Alaska, along with increasing numbers of licensed drivers, roadways, and vehicle miles driven, can be expected to continue. Given the nature of the increases--a younger population, more drivers, less driving experience, increasing consumption, and increased recreational, nighttime driving, the extent of alcohol involvement in crashes will probably increase.

Alcohol Abuse and Health and Social Services

There are also a number of other indicators of the impact of excessive drinking that comprise the general category of reported morbidity, including both diseases and trauma. This category represents the incidence of various adverse events as reported in the utilization of inpatient and outpatient health services and other social services. This information needs to be approached with a great deal of caution, since the inadequacies of the reporting systems, combined with the differing philosophical, financial and administrative practices of the various health and social service agencies, aggregate to mainly underrepresent the impact on this category of service. Further, this information does not reflect the nature or extent of the need for services in the population, but rather the nature and extent of the reported utilization by the agencies.

The findings mainly point to the lack of inclusion of the effects of alcoholism and alcohol abuse in the reporting systems of the agencies that concern themselves with alcohol-related health and social service consequences. In spite of the inadequacy of the reporting systems, the limited information did show a system wide impact that can be felt in inpatient and outpatient hospital services, emergency room services, mental health services, alcoholism and drug programs, and in field services provided by public health nurses, as well as in reported cases of child abuse and neglect. In addition, some of the very limited client data available hints that there seems to be some interesting disparities in the characteristics of the theoretical subpopulations at risk, and the subpopulations of clients that obtain health and social services. Much more investigation is needed.

Generally, it can be expected that the existing minimal indications of the already pervasive impact of alcoholism and alcohol abuse on health and social services will increase dramatically in the near future. This will probably be the combined result of not only better reporting systems (and changes in third party reimbursement regulations) but also the result of real increases related to the patterns of increasing average annual consumption of beverage alcohol in the state.

C. CONCLUSION

The information presented in this Volume, along with supplemental information in the other Volumes, has provided a description of the

nature and the extent of alcohol problems in the state. In general, the presentation and analysis only serves to reinforce what Alaskans have perceived now for several years--alcoholism and alcohol abuse constitute the greatest social problem facing the state. But more specifically, the ambiguous term "alcoholism and alcohol abuse" have been replaced with specific problems. The specification of the alternative configuration of alcohol problems is by no means complete. But this initial effort has produced outcomes that now allow not only the definition of the needs for more precise research, but it provides critical baseline information for the development of coordinated social policy, and the definition of specific programs for the reduction and prevention of designated alcohol problems.

The thrust of this Volume was on the measurable indicators of the impact of alcohol-related problems. This approach, of course, is necessary in order to develop a clear identification of the character or nature of the problems to be attacked. However, it is clearly understood that compiling only measurable indicators omits from immediate consideration some types of problematic behaviors that have not been, or cannot be measured. Nonetheless, the number and diversity of events that can be measured serve to more clearly reflect the actual state of affairs, and also serve to focus problem solving efforts on events and social and institutional response rather than vague notions about alcoholism or alcohol abuse.

Out of the many findings in this Volume, two particular notions emerge that deserve special attention. First, the population of the state of Alaska qualifies, without question, as a high consuming population, with regard to beverage alcohol. Further, and most important, there appears to be a very high degree of correspondence between the increasing average annual consumption of beverage alcohol in the state, and the nature and extent of individual public health and social problems associated with the current use of beverage alcohol. This notion directs attention to factors that control levels of population consumption.

The second notion of particular import, though not so certain as the first, is the appearance of discrepancies in the characteristics of the target populations at risk, and the characteristics of the sub-populations receiving treatment services for alcoholism and alcohol abuse. This last notion raises the question of the effective and efficient distribution of treatment resources.

There are many different views about the interplay of the various factors involved in each and all of the alternative configurations of specific alcohol problems. It seems that these views are also influenced by differing sociocultural and personal value systems as well as by evidence from actual research evidence. There also exists a diversity of organizations--official, voluntary, and professional, that all play important and interrelated roles in efforts to reduce and prevent alcohol problems. Because of this diversity of views and organizations, it is extremely important that there be general agreement on the part of those

involved as to the goals and objectives to be achieved and a mutual understanding of the approaches and methods to be used. If such agreement and understanding are not achieved, then the actions taken by the various groups may be discordant and ineffectual, or even counterproductive.

**THE
ALASKA
STATE
ALCOHOLISM
& DRUG ABUSE
PLAN
1984 - 1986**

STATE OF ALASKA

ALCOHOLISM AND DRUG ABUSE STATE PLAN

1984 - 1986

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The National Conference of Commissioners on Uniform State Laws, in 1971, approved the Uniform Alcoholism and Intoxication Treatment Act and agreed to recommend its adoption by every State. Since that time several States have adopted this model law or legislation very similar to it, removing public-intoxication from criminal justice systems and providing for the treatment of alcoholism by the public health and community service agencies. Legislators in many other States agree that such statutes should be enacted but hesitate because of the cost entailed in this sweeping change of policy.

The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Amendments of 1973 (S. 1125), which was passed by the Senate on June 21, 1973, includes a section providing for special grants of \$100,000 plus 10% of its formula allotment for alcoholism program to each state which adopts the Uniform Action or legislation substantially similar to it. A nearly identical provision is included in a similar bill (H.R. 10019) now under consideration in the House of Representatives.

I consider the adoption by the State of the Uniform Alcoholism and Intoxication Treatment Act an important step toward providing enlightened treatment for the millions who suffer from alcoholism. I am therefore pleased to make copies of the Act available for distribution.

Harrison A. Williams, Jr.
Chairman, Committee on Labor and Public Welfare.

U.S. SENATE,
COMMITTEE ON LABOR AND PUBLIC WELFARE,
Washington, D.C., September 28, 1973.

Hon. Harrison A. Williams, Jr.
Chairman, Committee on Labor and Public Welfare,
U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: In 1971 the National Conference of Commissioners on Uniform State Laws approved the Uniform Alcoholism and Intoxication Treatment Act and encouraged its introduction in the State legislatures. The then Secretary of Health, Education, and Welfare, Elliot Richardson, wrote me on November 3, 1971 concerning this draft and stated: "For too long, public intoxication has been the responsibility of the criminal justice system. Experience has demonstrated that existing laws and existing ways of handling alcoholic persons only helped to perpetuate human misery and suffering and to create burdens for their families, local communities, police departments, courts and other agencies. The failure to provide for the medical and social needs of alcoholic persons on the other hand has contributed to high rates of recidivism and the evolution of a revolving door system of ineffectiveness."

Several States have already adopted this or similar legislation but most have not done so because of the cost. In order to encourage the remaining States to take this action a provision was included in the Comprehensive Alcoholism Prevention, Treatment and Rehabilitation Amendments of 1973 (S. 1125) which was passed by the Senate on June 21, for a special grant to States which adopt this act. I am convinced that every effort should be made to encourage this action by the States. Consequently, I am transmitting a copy of the Uniform Act to you, together with notes and comments thereon, with the recommendation that the document be made available for distribution by the Committee.

Sincerely yours,

Harold E. Hughes,
Chairman, Subcommittee on Alcoholism and Narcotics.

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ACRONYMS

AA	- Alcoholics Anonymous
A-95	- Governor's Statewide Clearinghouse for Program Coordination
AANHSA	- Alaska Area Native Health Service
ABC	- Alcohol Beverage Control Board
ACC/ALL	- Anchorage Community College/Adult Literacy Lab
ABE	- Adult Basic Education
ACOPADA	- Alaska Council on Prevention of Alcoholism & Other Drug Abuse
ADACA	- Alcoholism/Drug Abuse, Mental Health Administration
AS	- Alaska Statute
ASAP	- Alcohol Safety Action Program
ATA	- Alcohol Treatment Center (NAPIS)
APU	- Alaska Pacific University
BBAHC	- Bristol Bay Area Health Corp. (Dillingham)
BIA	- Bureau of Indian Affairs
CAAS	- Center for Alcohol & Addiction Studies
CHAMPUS	- Civilian Health & Medical Program of the Uniformed Services
CMHC	- Community Mental Health Center
COA	- Council on Alcoholism
C&RA	- Department of Community & Regional Affairs
CRNA	- Copper River Native Association
D/A	- Drug Abuse
DAIS	- Drivers Alcohol Information School
DAWN	- Drug Abuse Warning Network (DEA-NIDA)
DEA	- Drug Enforcement Administration (Department of Justice)
DHSS	- Department of Health & Social Services
DOT	- Department of Transportation
DPC	- Data Processing Center
DPS	- Department of Public Safety
EAP	- Employee Assistance Program
EMS	- Emergency Medical Services
FAS	- Fetal Alcohol Syndrome
FDA	- Food & Drug Administration (concerned with use of methadone in treatment of narcotic addiction)
FDTC	- Fairbanks Drug Treatment Center
FFA	- Federal Funding Agency
FFC	- Federal Funding Criteria
FMIS	- Financial Management Information System
FNA-CAP	- Fairbanks Native Association-Comprehensive Alcoholism Program
FY	- Fiscal Year (State of Alaska's is July 1 - June 30, FY 85 is July 1, 1984 - June 30, 1985)
HLAY	- "Here's Looking At You" (school-based education program)
HSA	- Health Systems Agency
HSP	- Health Systems Plan
H&SS	- Department of Health & Social Services
ICC	- Interdepartmental Coordinating Committee
IHS	- Indian Health Service
J	- Joint Commission on Accreditation of Hospitals
JCAH	- Joint Commission on Accreditation of Hospitals

K-12	- Kindergarten through Twelfth Grade
KANA	- Kodiak Area Native Association
KILA, Inc.	- Composed of a treatment/counseling program (FDIC) and a prevention/education component.
LEAA	- Law Enforcement Assistance Administration
M/H	- Mental Health
MIS	- Management Information System
MOA	- Municipality of Anchorage
NAHRA	- Northern Alaska Health Resources Association
NA	- Native Association
NAPIS	- National Alcoholism Program Information System
NASADAD	- National Association of State Alcohol & Drug Abuse Directors
NCA	- National Council on Alcoholism
NCA-AR	- National Council on Alcoholism - Alaska Region
NDATC	- National Drug Abuse Training Center
NDATUS	- National Drug Abuse Treatment Utilization Survey (NIDA)
NGA	- Notice of Grant Award
NIAAA	- National Institute on Alcohol abuse & Alcoholism
NIDA	- National Institute on Drug Abuse
NIMH	- National Institute of Mental Health
NSHC	- Norton Sound Health Corp. (Nome)
OPPM	- Operating Policies & Procedures Manual
PHS	- Public Health Service
PL	- Public Law (federal)
QPR	- Quarterly Progress Report (SOADA)
RHC	- Regional Health Corporation
RFP	- Request for Proposals
RSA	- Reimbursable Services Agreement (between State agencies)
Rural CAP	- Rural Alaska Community Action Program
SAA	- State Alcoholism Authority (NIAAA)
SACAS	- Salvation Army Comprehensive Alcoholism Services (Anchorage)
SAPIS	- State Alcohol Profile Information System (NIAAA)
SCRO	- South Central Regional Office (SOADA)
SCHPD	- South Central Health Planning & Development Inc. (HSA)
SEAGSA	- Southeast Alaska Health Systems Agency
SEARCH	- Southeast Alaska Regional Health Corp.
SHCC	- State Health Coordinating Council
SHPDA	- State Health Planning & Development Agencies
SOADA	- State Office on Alcoholism & Drug Abuse
SPD	- State plan Development
SPSS	- Statistical Package for the Social Services
T/A	- Technical Assistance
TASC	- Treatment Alternatives to Street Crime
T/C	- Therapeutic Community
TCC	- Tanana Chiefs Conference
U of A	- University of Alaska
UTRCA	- Upper Tanana Regional council on Alcoholism (Tok, AK)
UCR	- Uniform Crime Reports
VA	- Veterans Administration
YKHC	- Yukon-Kuskokwim Health Corporation

CHAPTER I
INTRODUCTION AND BACKGROUND

CHAPTER I INTRODUCTION AND BACKGROUND

HISTORY AND STATUTORY AUTHORITY OF THE STATE OFFICE OF ALCOHOLISM AND DRUG ABUSE

The Alaska State Office of Alcoholism and Drug Abuse (SOADA) is a separate office within the State's Department of Health and Social Services. On July 1, 1977, the former State Office of Drug Abuse was merged with the Office of Alcoholism. Since that time, the SOADA has functioned as the Single State Agency for implementation of both Public Law 91-616 and Public Law 92-255. Alaska Statutes 47.37, 47.30.470-500, and 44.29.100-150 defines the powers and duties of the Office of Alcoholism and Drug Abuse.

Alaska Statute 47.37 incorporates in its Declaration of Policy the Uniform Alcoholism and Intoxication Treatment Act of 1972: 1) "It is the policy of the state that alcoholics and intoxicated persons should not be criminally prosecuted for their consumption of alcoholic beverages and that they should be afforded a continuum of treatment so they may lead normal lives as productive members of society." (sec. 1 ch. 207 SLA 1972). The legislation details the duties of the office with regard to developing and maintaining a comprehensive program of services for the prevention of alcoholism and treatment of alcoholics and intoxicated persons. Alaska Statute 44.29 establishes that "the drug abuse program coordinator shall carry out the development and implementation of a comprehensive program to prevent and treat the use and abuse of drugs as they affect the people of Alaska." (sec. 1 ch. 198 SLA 1972). Alaska Statute 47.30.470-500 sets for the grant-in-aid program through which this comprehensive program is funded. This statute details what information shall be considered when reviewing grants as well as the review process itself.

The Governor's Review Board on Alcoholism

The statewide citizens' advisory council for alcoholism programming in Alaska is the Review Board on Alcoholism. The Board was established under the provisions of AS 47.37.060-110. Nine members are appointed by the Governor to serve four year terms. Alaska Statute 47.37, included as Attachment A, details the composition of the Board and its duties. Bylaws adopted by the Board establish that a Chairperson and Vice-Chairperson will be elected for one-year terms, and the Coordinator of the State Office will serve as Executive Secretary. See Attachment B. Additionally, the Board now serves as a standing committee to the Statewide Health Coordinating Council (SHCC) under HB 830 passed in 1980.

The Governor's Advisory Board on Drug Abuse

The statewide citizens' advisory council for drug abuse in Alaska is the Governor's Advisory Board on Drug Abuse. The Board was established under the provisions of AS 44.29. Nine members are appointed by the Governor to serve four-year terms. Alaska Statute 44.29, included as Attachment D, details the composition of the Board and its duties, and Attachment E lists the current membership.

Legislative Policy (Alcohol abuse and alcoholism)

Alaska Statute 47.37.130(a) sets forth the policy of the State of Alaska as it relates to treatment services.

"Comprehensive program for treatment; regional facilities.

- (a) The office shall establish a comprehensive and coordinated program for the treatment of alcoholics and intoxicated persons. Subject to the approval of the commissioner, the coordinator may divide the state into appropriate regions to conduct the program and establish standards for the development of the program on a regional level. In establishing the regions, consideration shall be given to the city and borough lines and population concentrations and, when feasible, programs shall be established with maximum local community involvement.
- (b) The program of the office shall include:
 - (1) emergency treatment provided by a facility affiliated with or part of the medical service of a general hospital;
 - (2) inpatient treatment;
 - (3) intermediate treatment; and
 - (4) outpatient and follow-up treatment.

There are equally detailed statute citations that deal with prevention services.

AS.47.37.040 The office shall:

- (1) develop, encourage and foster statewide, regional and local plans and programs for the prevention of alcoholism....;
- (2) coordinate the efforts and enlist the assistance of all public and private agencies, organizations, and individuals interested in prevention of alcoholism and treatment of alcoholics and intoxicated persons;

Statements related to prevention of alcoholism can be found throughout Alaska Statute 47.37., as well as in AS 44.29.100-150, and AS 17.30.140.

The Legislative session of 1980 produced a major increase in funds available for alcoholism services. Along with this monetary increase came a major statement of intent. The House Finance Committee produced a report entitled "Special Efforts in Response to Alcoholism and Alcohol Abuse Problems." This document states in part:

"The provisions of the Uniform Act* are reaffirmed.....Special attention is hereby directed to the rapid and intensive development of the full range of comprehensive alcoholism and alcohol services on a statewide basis which are equally available and accessible within the three primary health service regions of the state.

Single State Agency

The single state agency is directed to undertake special efforts during the next five years to develop and coordinate prevention, treatment, research and administrative programs that are commensurate with the high prevalence and incidence of alcohol problems in the state."

For the past four fiscal years (FY'81 through FY'84) AS 47.37 and the House Finance Committee document and the subsequent state plans have guided the development of alcoholism services in Alaska.

Legislative Policy (Drug Abuse)

The legislative directives around drug abuse have not been as extensive nor as firm. Alaska Statute 44.29 sets forth the composition and duties of an Advisory Board on Drug Abuse. The duties of the Board are to act as an advisor to the commissioner of the Department of Health and Social Services (AS 44.29.140) in regard to:

- (3) social problems which affect rehabilitation of drug users and addicts;
- (5) development of programs of prevention, treatment and rehabilitation for drug abusers and addicts;
- (7) evaluation of effectiveness of drug abuse programs in the state.

AS 44.29.150 states:

"The drug abuse program coordinator shall carry out the development and implementation of a comprehensive program to prevent and treat the use and abuse of drugs as they affect the people in Alaska.

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

The Legislative session of 1982 produced a major revision of Alaska's laws regarding controlled substances. The changes brought Alaska law closer to federal law and the criminal penalties were revised to reflect the most recent criminal code. However, this major revision did not produce a clarification of state policy. In almost every instance where treatment is an issue the law states that a court may consider treatment as part of a criminal penalty or that treatment may be considered in probation or parole decisions.

The legislation did, however, add to the clarity regarding prevention. AS 17.30.140 states:

- (a) The commissioner of health and social services shall provide for educational programs designed to prevent and deter the abuse of controlled substances.

Philosophy of the Office of Alcoholism and Drug Abuse

From the above legislative directives it is clear that SOADA's mission is to create and maintain a comprehensive program of prevention, intervention and treatment for all Alaskans that may be affected by alcohol and drug abuse.

The mission of this agency has its roots in both federal and state law that recognizes the need for and legitimate place of prevention and treatment as the appropriate response to recognized alcohol and drug problems. Alaska Statute 47.37.010 states that alcoholics and intoxicated persons should be afforded a continuum of treatment and not be criminally prosecuted for their consumption of alcohol alone. AS. 11.71.305 states that a person convicted of violating the law in regard to controlled substances, when such violation relates to personal use may be ordered to receive treatment. These citations are rooted in research and law that substance abuse is preventable and treatable.

Alcoholism, drug addiction, substance abuse, substance abuser, drug abuse, alcohol abuse, chemical addiction, and/or problem drinker are all terms that are often used and widely misused by many. It is often unclear whether whether the terms are describing a physical condition, defining a behavior, labeling a person or a combination of these items. To complicate the issue further, the term poly-drug abuse or abuser when there is confusion regarding who or what is the problem. These terms are not the issues that must be addressed as this office strives to meet the mission set forth in statute. The categorizing of addicted individuals or the etiology of disease is secondary to reducing the human devastation of chemical dependency.

At issue is how this office defines alcoholism and drug abuse. The Office of Alcoholism and Drug Abuse supports the reality that alcoholism and drug abuse are diseases for which there are effective treatment and rehabilitation modes. Alcoholism and drug abuse have an effect on and interfere with the physical, social, psychological and spiritual aspects of a person's life. Alcoholism and drug abuse can be diagnosed, can be subjected to an intervention process, and can be treated.

Alcoholism and drug abuse require divergent treatment modalities due to the multi-faceted ways in which the disease affects the individual. Not everyone who suffers this disease consumes the same drug(s) in the same manner or in the same setting. Not everyone is the same age, sex, race, or has the same marital or economic status when the disease becomes apparent to significant others or to themselves.

At the core of any or all treatment modalities there must be the basic belief that:

Use of alcohol and/or other drugs in a manner that repeatedly interferes with the major life functions of the individual (e.g. health, work, family, etc.) is defined as alcoholism/ alcohol abuse or drug abuse.

If this definition is used, the primary goal of any treatment program is to encourage and support the individual to become and remain abstinent from alcohol and other drugs. The Office of Alcoholism and Drug Abuse supports the idea that lasting changes in an individual's physical, social, psychological or spiritual health must take place in order for lasting abstinence to be achieved. However, no changes in an individual's life/ health style can take place as long as alcohol and/or drug taking is still present. Therefore, abstinence remains the base response to recovery.

There still remains the question of those persons who use alcohol and/or other drugs and do not now and may never fit the above definition. How does this person fall within the mission of this agency? Drunk or drugged behavior can often be obnoxious, embarrassing and sometimes damaging. An inexperienced drinker, driving while drunk, is a danger to him or herself as well as everyone nearby. Overconsumption of alcohol or drugs in any situation that calls for accurate thinking or physical coordination can cause problems for all concerned. Alcohol abuse or drug misuse remains as an important health risk concern as alcoholism.

Drinking during pregnancy has been shown to have effects on the unborn fetus. Fetal Alcohol Syndrome (FAS) research has yet to define if any alcohol consumption is safe. Therefore, the general medical advice recommended is that if a person is planning to become pregnant or is pregnant that drinking alcohol should stop. It is common medical practice that, during pregnancy, all drug taking should be done only under a physician's orders. Fetal alcohol syndrome becomes a special office health priority in light of the state per capita consumption statistics.

During adolescence, research has shown that the body is still growing and developing. Even more important is that potential or actual intellectual growth is enormous. Research has demonstrated that alcohol and/or other drug abuse can affect that ability to learn. Nutrition, good health, and exercise are all established prerequisites for proper adolescent growth. The point that alcohol or drug taking behavior interferes with this process mandates that education and information about these dangers be offered at a young age.

There are also many drugs that serve a beneficial medical purpose. These controlled substances can also be abused and the potential for abuse is a prime concern as to the amount of control exercised. The medically approved, therapeutic use of these drugs is not abuse and would not fit the above definition. Even so, warnings about driving, operating machinery or doing detailed manual work while using these drugs are given by doctors and pharmacists. It is crucial that consumers be aware of these consequences or, at least, educated enough to ask their doctor or pharmacist about possible restrictions or potential for abuse and addiction.

School education (K-12), public education, advertising, public information campaigns and other educational efforts are vitally important in developing an educated populace. Education about effects of alcohol and drugs, about the legal issue of the use of alcohol and drugs, and education about alternative behaviors are a major part of this effort.

The provision of addictions counseling inside correctional facilities is being provided by community programs in those cities where state correctional facilities exist. It has been found that offenders have extremely high rates of addiction and substance abuse. The in-facility programs are specifically designed to lower recidivism rates for offenders while providing an opportunity to initiate changes in physical, social, psychological and spiritual health.

Early identification of persons who may be having problems due to alcohol and/or drug use is a proven capability. Education and information programs have the effect of making persons look at their drug use. Employee Assistance Programs and Alcohol Safety Action Programs are based on the premises that poor work performance or drunk driving or misdemeanor violation may be related to alcoholism and/or drug abuse. If not, then other issues may arise, but if alcoholism and/or drug abuse are at the root of the problem then treatment can be started.

It is the belief of the Office of Alcoholism and Drug Abuse that alcoholism and drug abuse is a disease that is primary, progressive, chronic and fatal. If it is not prevented, it must be treated. If the disease is not treated, the person suffering the disease will die from it or a related cause. Even after long periods of abstinence, if the drinking or drug taking resume so will the symptoms of the disease.

Alcoholism and drug abuse is a disease that can present multiple symptoms at varying stages of the disease. These symptoms may mask other problems or may be masked by other problems (e.g. mental illness, mental retardation, physical problems, or other diseases, etc.).

For these reasons, the systematic responses to alcoholism and drug abuse must be varied and must be comprehensive. A full range of services must be included.

SOADA Structure and Organization

Since the last plan there have been some significant changes in SOADA's operational abilities. Due to budget reductions beginning in FY'83 (July 1, 1982), the SOADA staff was reduced from 25 positions to 19. This resulted in the loss of the trainer position and two grants administrators.

As a result, several staff persons have taken on additional duties.

The SOADA over the past two years has developed and has operationalized the automated Management Information System. This has greatly aided us in providing much needed current data. The M.I.S. has also added to the workload; thus, two additional staff positions have been reclassified to provide the necessary support to this major endeavor. (see next page for current organizational chart)

The loss of staff persons and the reclassification of others has had an impact. This impact has been both negative and positive. There has been a loss in ability to provide all requested technical assistance. Training has not been as visible, although still at existing levels. Our planning and policy capabilities have been reduced. On the positive side has been a better communication among staff; the M.I.S. is operational and very useful, and grantee programs are operating better each year.

The election of a new governor and the appointment of a new commissioner has changed the structure of the Department of Health and Social Services. SOADA has been placed under a Deputy Commissioner for Health along with the Division of Mental Health and Developmental Disabilities and the Division of Public Health. A separate arena in the Department is Social Services which has a separate Deputy Commissioner.

Funding for Alcohol and Drug Abuse Services

Funding for alcohol and drug abuse grants are appropriated by the State Legislature. Ideally, this funding is reflective of identified need and the tools (financial) to implement legislative policy. Funding has been anything but stable over the past six fiscal years.

FUNDING BY FISCAL YEAR (In Thousands)

	<u>Administration</u>	<u>Alcohol Grants</u>	<u>Drug Grants</u>	<u>Total</u>
FY'79	708.1	2471.0	872.1	4051.2
FY'80	1379.3	2739.3	1085.3	5203.9
FY'81	2009.3	9346.9	1183.0	17444.0
FY'82	2368.6	15697.9	1550.0	19616.5
FY'83	1593.9	14865.7	1550.0	18009.6
FY'84	1534.4	12513.2	1550.0	15597.6
FY'85	1374.0	11680.4	2082.0	15136.4

Contributing to this funding pattern have been federal budget actions. The major jump in FY'81 was in response to the afore-mentioned House Finance Committee report that heralded a very detailed legislative policy change. Changes in funding since that time have been relective of lower state revenues and a change of legislative policy.

While the SOADA cannot predict future legislative appropriations there is evidence that state revenues will stabilize at current levels or lower. We must anticipate less state revenues.

Summary

The task of this plan is simple. We must document the need for alcohol and drug abuse services. Using statutory and policy directives, we must describe a comprehensive prevention, intervention, and treatment strategy. Finally, we must define the parameters as to how the Department of Health and Social Services intends to invest its funding.

CHAPTER II

SUBSTANCE ABUSE

GOALS, PRINCIPLES, OBJECTIVES AND SERVICES

The plan by which the State Office of Alcoholism and Drug Abuse translates the mandate to provide substance abuse prevention, rehabilitation and treatment services into action is comprised of a series of policies, principles and objectives encompassing the various service components. The policies, principles and objectives have been developed as part of the office's annual budget preparation and ongoing planning process and are derived from: (1) a review of the performance in meeting goals in the 1981 to 1983 plan; (2) an analysis of major need indicators relevant to alcohol and drug abuse problems in the State; (3) input from field operations staff regarding feedback from survey reports and field observations; (4) data available via the Management Information System (MIS) concerning service population and treatment system characteristics; (5) specifics outlined in State statutes establishing the office; and (6) an analysis of data received from a needs assessment questionnaire distributed statewide.

The organization of this section consists of a listing of three policy statements that serve to drive the following component principles and objective statements. These statements reflect the overall policy and philosophy of the office regarding its efforts to positively affect substance abuse problems. A discussion of target groups follows that identifies specific recipients of increased prevention and treatment services outlined in the general plan for services. The component principles represent the office's philosophy and policy regarding specific components of service and illustrates what is deemed to be appropriate for service delivery in Alaska. The objectives and strategies are statements that delineate specific programmatic responses the office has selected as being integral for the operation of a comprehensive service delivery system. A set of program measures has been included that provides quantitative projections of service levels consistent with the goals and objectives of the plan. This constitutes the overall plan for service delivery that the State office has determined should be emphasized for its planning and future decision making. Therefore, to express SOADA's mission the following three overall policy statements have been developed.

POLICY STATEMENTS

Maintain and continue to improve the delivery of alcohol and drug abuse services by developing a long range strategic service delivery system that will allow the accomplishment of statutory mandates and the governor's policies in the most efficient and cost effective manner.

To develop, encourage, and foster statewide, regional, and local responses and programs for the prevention of alcohol and drug abuse and the treatment of alcoholics and substance abusers in cooperation with public and private organizations, and individuals.

To increase the provision of therapeutic and cost effective alternatives to the more costly criminal justice system responses to both alcohol- and drug-related offenders.

TARGET GROUPS

Based on a review of the needs assessment data, and the experience of the SOADA staff, the following target groups have been identified. The groups are women, rural and Native Alaskans, youth and alcohol and drug related offenders. The estimated number of alcoholics and problem drinkers in Alaska in 1983 was 13,484 and 35,282 respectively. Adult problem drinkers are estimated at about 83% male. Arrests for offenses directly related to alcohol consumption constituted about 34% of reported arrests during 1979-1981, and the rate is increasing. These arrests were 85% to 89% male except for liquor law violations which were only about 72% males. The mortality rates related to alcoholism and alcohol abuse are much higher than rates in the rest of the nation, and Native Alaskans are overrepresented in these mortality data. Given the rates cited above and information from the following, four groups are being specifically targeted for service due to their problems and underserved status.

Women

It has been estimated that women constitute one-fourth of the alcoholics and one-fifth of the problem drinkers in Alaska's population. The data concerning substance abuse outcomes shows that the number of women dying from cirrhosis is equal to that of men in Alaska. Both the alcoholism and Community Mental Health Center treatment service data indicate an over representation of women among their clients. They represent 26% of alcoholism program admissions and 35% of community mental health admissions for alcohol disorder. It is, also, the sense of the community and local service providers that many female problem drinkers are in need of services but are not receiving them through criminal justice referrals and are not seeking them themselves. Furthermore, the effect of maternally ingested alcohol on a fetus can be described as a "pickling" effect. This toll on a future generation of health and social care costs and lost human productivity is a tremendous burden. The SOADA needs to increase the attractiveness of treatment services to this group and raise public awareness of this problem and of the availability of services for women. Additionally, training and prevention efforts are needed.

Rural and Native Alaskans

Native Alaskans are overrepresented on a variety of alcohol abuse indicators. It is unclear at this time as to whether Natives do, in fact, have greater difficulty with alcohol or if the perception of alcoholism as a Native problem has caused them to be identified at a greater level than their representation in the general population. In the general population Native Alaskans account for 18% of the total. In the category of alcohol related arrests,

Natives were cited for 30% of the total and 55% of the liquor law violations. It is interesting that they only represent 15% of driving while intoxicated arrests. The low percentage of DWI arrests could be the result of either a low rate of ownership of vehicles by Natives, or the necessity of having to gain a positive breathalyzer for DWI arrest. Native Alaskans also account for 49% of the alcoholism deaths and 28% of the cirrhosis deaths during the average year. Current alcoholism treatment services are heavily overrepresented by Native Alaskan clients who make up 51% of the caseload. The same is true for diagnosis of alcohol disorder in community mental health centers where Natives represent 38% of the clients. It is clear that SOADA needs to continue its efforts of increased outreach and community development/advocacy in rural areas where most Native Alaskans reside.

Youth

There are three areas of substance abuse indicators in which Alaskan youth are overrepresented. The most dramatic is juvenile involvement in fatal accidents. It was shown that over a four year period youth were responsible for 22% of fatal alcohol accidents and 24% of alcohol accident fatalities while comprising 9.2% of all drivers. Youth also represented over one half of those arrested for liquor law violations. The drug arrest data indicates that juveniles were arrested in 62% of all drug cases, most commonly for possession of marijuana. The treatment data for SOADA programs show that youth are treated in less numbers than their representation in the general population. Data from a school drug usage survey showed that while one time usage or experimentation with drugs is much higher than the national average, prevalence is about equal.

Alcohol and Drug Related Offenders

In 1981, offenses directly related to alcohol (DUI, Drunkenness, Liquor Law Violations) constituted 37.5 percent of all male arrests and 36.4 percent of female arrests. Males were arrested more often for driving under the influence and females were arrested for liquor law violations most often. During the same period 41.4 percent of all adult arrests were for these alcohol related crimes compared with 28.7 percent of juvenile crime. While drug arrests represent only 4.3 percent of all arrests, they include a heavy overrepresentation of juveniles. More than half of the annual drug arrests are for juvenile possession of marijuana. As the number of arrests in Alaska is growing annually, the impact of the substance abusing offender is becoming a greater burden on the criminal justice system. The referral of clients to substance abuse treatment is currently recognized as an effective method of easing this burden...

* Support data for all target group statements can be located in Appendix A.

PREVENTION

Prevention is those activities that are designed to prevent individuals and groups from becoming dependent on the regular use of alcohol and/or other drugs. Prevention Services may vary widely but are generally associated with information, education, alternatives, literature distribution, media campaigns, clearinghouse activities, speakers' bureau, and school or peer group situations. These services may be directed at any segment of the population.

The fundamental objective of prevention is to assist Alaskan citizens to develop into and continue being healthy and productive members of society. Prevention involves professionals, lay-persons, family members and friends in a process that enables Alaskan citizens to create and maintain positive attitudes, values, behaviors, skills and lifestyles in which alcohol abuse and/or drug abuse is considered unacceptable. The desired outcome of this prevention process is the reduction of behavior that distracts Alaskan citizens from achieving the goal of being healthy and productive individuals.

There are varied methods by which the prevention process can operate. Among them are organizational change strategies, school education, alcohol and drug free alternatives, public information, community action strategies and cultural/heritage strategies.

COMMUNITY DEVELOPMENT

Under the prevention definition, services targeted to the community as a whole are termed "Community Development" There are several methods of service delivery that could be considered. Specifically, the Office of Alcoholism and Drug Abuse considers the following methods appropriate, productive and supportable.

1. "Institutional Change Strategies"

This method is the systematic development and implementation of activities designed to change the institutional structure of the community. Such activities could include: school alcohol and drug use suspension policies; insurance coverage for alcoholism and drug abuse treatment; alcohol or drug free social and/or recreational events for the community; community awareness of and support for current limitations of alcohol use or drug use (e.g. smoking in public places, hours of alcohol sales, underage consumption); and community activities that will change current limitations on alcohol use or drug use as permitted by Alaska statutes.

<u>Objective</u>	<u>Strategies</u>	<u>Measure</u>
Support and encourage an annual meeting focusing on the needs of rural substance abuse problems to promote the planning and development of services.	Sponsor an annual meeting of rural providers.	Number of annual meetings. Number of rural programs attending
Increased coordination with the Department of Education and with local school districts to ensure the development and implementation of school substance abuse policies consistent with the public health model.	Establish a joint policy development group with the Department of Education. Require local programs to provide assistance to their school districts in developing substance abuse policies.	Number of meetings. Completed draft of model school policies. Number of meetings. Number of local districts adopting policies.

Quantitative Measures

To increase the community participation in the area of program responses to youth drug usage and abuse through a 5% increase in activity by the several youth alternative programs above the FY'84 level.

	FY'84	FY'85	FY'86
*Number of hours spent by staff	16852	19000	21000
*Number of activities	3587	4000	4200
*Number of youth participants	41413	42000	42000
*Number of referrals from youth alternative programs into drug treatment programs	N/M	100	114
*Number of parent groups	N/M	3	4

2. "Community Response Strategies"

This method encompasses activities which impact and involve the community as a whole. Impact on the individual may also occur as the result of community action.

Activities such as speakers' bureaus, community action committees-volunteer development and other activities designed to encourage community members to actively participate in confronting and changing unacceptable attitudes and behaviors around alcohol abuse, drug abuse and alcoholism.

<u>Objective</u>	<u>Strategies</u>	<u>Measures</u>
To increase community substance abuse awareness and alternatives, by increasing the number of SOADA sponsored local activities in rural communities.	To fund, monitor and evaluate annually rural programs and their informational, outreach and early intervention efforts.	Number of local activities.
Provide technical assistance to any group that desires to accept responsibility for the control of substance abuse in their community.	Maintain financial support for a mix of programs designed to enable communities to develop freedom from abuse and promote self-sufficiency.	Number of grant awarded to providers for community action projects.

Quantitative Measures

To increase the number of local staff hours spent in rural communities to develop and increase community substance abuse awareness and alternatives.

FY'84

FY'85

FY'86

*Number of staff hours

3687

3800

4000

To increase the number of hours spent working with other community agencies on drug prevention strategies to better involve the whole community.

*Number of staff hours working with other agencies

14614

15000

15000

3. "Cultural/Heritage Strategies"

Alaska is unique in that there is a cultural diversity that many individuals feel should be maintained. Such diversity is a part of both institutional and individual identities. Activities that explore cultural values, attitudes, behaviors and lifestyles as they relate to unacceptable alcohol abuse or drug abuse are beneficial.

Such activities that involve cultural leaders, helpers and/or healers, that involve the examination of cultural identity (past and future) and activities which provide a base for community attitudes regarding alcohol abuse and drug abuse are also supported.

Activities are encouraged that define traditional cultural beliefs so as to aid in the development of and effective integration of current lifestyle expectations in such a manner that alcohol abuse and drug abuse are not the barriers to a healthy and productive life.

<u>Objective</u>	<u>Strategies</u>	<u>Measures</u>
To increase by 10% from the FY'84 level the number of Alaska Native counselors currently employed in state-funded programs who have received Alcohol/Drug Abuse Counselor Certification.	To provide a system of training programs reaching rural Alaska and to provide assistance to the establishment and maintenance of an objective state-wide Counselor Certification process.	Number passing exam. % passing exam. Number of Alaska Natives passing exam. % of Alaska Natives passing exam Number with Certification. Number of alaska Natives with Certification.
Improve the interface between regional trainers and cultural/traditional leaders.	Incorporate participation by cultural/traditional leaders into training activities.	Number of training activities incorporating traditional or cultural leaders

SCHOOL EDUCATION

School education is defined as approaches that focus on skill building through the use of a well defined and structured affective learning process and the production and distribution of accurate and objective information in a school based setting. School education can be delivered to all students in grades K-12 through utilization of curriculums that are already available. Examples of skills that are to be developed or enhanced include values clarification, problem solving, decision making, coping, and cultural values and identities of the local (regional) community.

Examples of information giving activities including pamphlet distribution, health fairs, as well as using school children in the actual development of and distribution of the information.

<u>Objectives</u>	<u>Strategies</u>	<u>Measures</u>
Provide the K-12 program to all school districts state-wide.	To increase by 10% the level of knowledge of youth grades kindergarten through 12th grade in substance use and abuse as measured by inference from the performance study entitled: "An Evaluation of the Statewide Alcohol Education Project Years 1, 2, and 3".	Number of teachers trained. Number of students receiving curriculum. Calculation of the change in knowledge as formulated in the study.
To increase by 10% the number of educational presentations to teachers in the schools.	Provide mechanisms making K-12 training available to all teachers in the state.	Number of presentations for whom teachers are the target group. Number of community outreach for whom teachers were the target group.
Continue to support school education programs which include curriculum for defensive driving and material addressing drunk driving.	Provide material and training for those districts wanting to provide this curriculum.	Number of districts given support.

Quantitative Measures

To increase the level of knowledge
of youth, grades K thru 12, in
substance use and abuse.

	FY'84	FY'85	FY'86
*Number of teachers trained	345	370	400
*Number of students receiving curriculum	45454	45500	47000

ALCOHOL AND DRUG ABUSE ALTERNATIVE ACTIONS

Alternative strategies include approaches that provide growth-inducing experiences through which individuals develop increased levels of confidence and self-reliance. The primary focus of these programs is the prevention of substance abuse, this focus represents the sole purpose of the programs. Enhancement in these areas is provided through social, occupational, esthetic, affective, and cognitive experiences. Alternatives-based activities are designed to provide exposure to a variety of rewarding activities that offer positive alternative to alcohol and drug taking behavior. Activities should be specific to age and culture but are not limited by same. Youth or elderly populations have a need for alternative activities but these activities are not identical. Families may also need alternatives that involve the entire family or community at the same time, place and event. Alternative actions can be delivered on a non-scheduled, continual, or special events basis appropriate to the activity or target group.

<u>Objectives</u>	<u>Strategies</u>	<u>Measures</u>
To increase the community participation in the area of program responses to youth drug usage and abuse through a 5% increase in activity by the several youth alternative programs above the FY'84 level.	Provide on-site technical assistance as requested. Continue to support youth alternative programs.	Number of hours spent by staff. Number of activities. Number of youth participants. Number of referrals from youth alternative programs into drug treatment programs. Number of parent groups.
Emphasize skill and knowledge building activities geared towards substance abuse to motivate youth toward responsible behaviors.	Continue to encourage the development/or identification and adoption of new activities.	Number of activities selected for use in programs. Number of programs adoption new activities.

PUBLIC INFORMATION

Public information is the dissemination of accurate and objective information specifically aimed at increasing the awareness, receptivity, and sensitivity of the community and individuals regarding problems associated with alcohol abuse or drug abuse.

Activities can be in the form of a materials clearinghouse, newsletters, alcohol/drug awareness weeks, press releases, participation in health/state fairs or information given through media outlets such as radio, newspapers, and television.

Information giving can also take the form of documentaries, poster development or other methods of information dispersal used in the particular area.

<u>Objectives</u>	<u>Strategies</u>	<u>Measures</u>
To increase by 10% the number of referrals to substance abuse treatment programs.	To provide intensive substance use and abuse informational campaigns and to intensify the local out-reach efforts.	Number of referrals. Number self-referrals. Number of family referrals. Number of API referrals. Number of educational facility referrals. Number of non-criminal justice related referrals. Number of staff hours spent in information referral services.
To increase by 10% the number of educational presentations to parents in the community.	Provide support for prevention components of local programs. Provide programs with technical assistance and information.	Number of presentations for whom parents are the target group. Number of community outreach.
Continue to support special events such as alcohol action week and drug prevention month.	Provide funding and support for special events. Provide coordination and leadership to programs in sponsoring events.	Number of special events. Number of communities holding special events.

Quantitative Measures

To increase the number of educational presentations to parents in the community.

FY'84

FY'85

FY'86

*Number of presentations for whom parents are the target group

411

475

575

INTERVENTION

Intervention is actively and systematically working within a community for the purposes of identifying persons in need of services, alerting persons and their families to the availability of services, locating needed services, and enabling persons to enter and accept the service delivery system. Outreach needs to facilitate procurement and availability of alcoholism and drug abuse services, and to alert all public and private human service agencies who serve the same target population, to the importance of early identification and easy access to the service delivery system.

The outreach function is the most visible service of the program to the local community. It is very important that the advisory board, other agencies and the general public be given a voice in the review of this service to ensure acceptability. It is essential that the outreach process involve as many organizations and individuals as may be in contact with various parts of the treatment delivery system.

COURT/JUSTICE SYSTEM SERVICES

The Alcohol Safety Action Program (ASAP) is a systematic means of evaluating and referring persons convicted of alcohol and drug abuse related offenses by the District Court of the State of Alaska. ASAP is viewed as a means of differentiating the effect of the drinking problems and referring them to appropriate agencies for treatment depending on the client's needs. It is seen as a very structured system that is governed by a set of predetermined standards designed to assist in diagnosing problem levels of clients involved with the system.

The goal of each community ASAP is to provide reliable and continuous early identification and appropriate intervention services for DWI and other alcohol or drug related misdemeanor cases. The services that an ASAP program would typically make are referrals to an outpatient counseling and/or alcohol/ drug information school.

These services are based on the premise that early identification and intervention of persons with alcohol/drug related problematic behavior increases the likelihood of success of education and treatment, and that less intensive and extensive resources are, therefore, required and can more easily be provided in each community.

Objectives

To increase by 10% the number of persons entering treatment programs as a result of the criminal justice system responses to alcohol related offenders and to maintain the cost effectiveness of this type of response.

Strategies

Maintain the Alcohol Safety Action Program in a state-wide system. Fund substance abuse counselors at the major state-operated corrections institutions.

Measures

Number of ASAP programs.
Number of persons whose legal status at time of admission is probation/parole and DUI/OMVI conviction.
Average cost for clients with single OMVI convictions.
Average cost for clients with multiple OMVI convictions.
Average cost for clients on probation.
Cost per client served in ASAP.

Provide substance abuse programming and counseling at state-operated corrections institutions.

Fund substance abuse counselors at the major state-operated corrections institutions.

Number of counselors at correctional institutions.
Number of hours of counseling at correctional institutions.

To decrease by 10% the number of clients readmitted to treatment programs as referrals from the criminal justice system from FY'84 levels.

To continue funding for court diversion programs.
To provide support for treatment programs in urban areas.

Number of clients referred and readmitted to treatment from criminal justice system.

Conduct a review and make appropriate revisions of all policies, procedures and criteria related to referral mechanisms for receiving clients from the Criminal Justice system into the Alcohol and Drug treatment system.

Conduct and review of the referral process to treatment from the following programs:
A: Pre-Trial Diversion
B: A.S.A.P.
C: Misdemeanant Probation
D: Felony Probation
E: Suspended Imposition of Sentence
F: Corrections Furlough

Number of Clients Referred from:
A: Pre-Trial Diversion
B: A.S.A.P.
C: Misdemeanant Probation
D: Felony Probation
E: Suspended Imposition of Sentence
F: Corrections Furlough

Objectives

To increase by 10% the number of persons entering drug treatment programs as a result of the criminal justice system responses to drug related offenders and to maintain the cost effectiveness of the type of response from 1984 levels.

Services

Continue to support court diversion programs.
Continue to support drug treatment programs.
Provide coordination of effort with other involved department at state level.
Complete on-site evaluation for each program.

Actions

Number of persons admitted to a drug treatment program as a result of involvement with the criminal justice system.
Cost per client in the drug treatment.
Number of counselors at correctional institutions.
Number of hours of counseling at correctional institutions.
Average cost for clients with single drug-related convictions.
Average cost for clients with multiple drug-related convictions.

Quantitative Measures

To increase the number of persons persons entering treatment programs as a result of criminal justice system responses to alcohol related offenders and to maintain the cost effectiveness of this type of response.

	FY'84	FY'85	FY'86
*Number of ASAP programs	10	10	12
*Number of persons whose legal status at time of admission is probation/parole and DUI/OMVI conviction	N/M	2500	2830
*Cost per client served in ASAP	N/M	Estimate not yet available	
*Number of counselors at correctional institutions		3 FTE's	
*Number of hours counseling at correctional institutions	N/M	4900	5561

To decrease the number of clients readmitted to treatment programs from the criminal justice system.

*Number of clients referred and readmitted to treatment from criminal justice system

N/M

500

570

*(Measure illustrates a measure in readmission that is less than overall client increase.)

CORRECTIONS BASED

Persons confined in youth and adult correctional facilities are often identified as an at risk population in need of alcoholism and drug abuse services. Systematic approaches to identification, screening, assessment, and referral of incarcerated persons for services is a high priority strategy. Services aimed at a reduction of recidivism such as on and off site treatment, referrals, and release planning are acceptable activities. Training for correctional officers, probation and parole officers, and other corrections personnel, likewise is a desirable activity.

Objectives

To increase by 40% the number of clients completing their treatment plans in youth adult correctional settings.

Strategies

To provide treatment services in correctional setting to those seeking them or required to receive them as part of sentence.

Measures

Number of persons treated in youth or adult correctional settings
Number completing treatment plan
% completing treatment plan

EMPLOYEE ASSISTANCE PROGRAMS

The purpose of Employee Assistance Programs is to improve the productivity of public and private sector employees and their dependents. The work place is an excellent environment for the early identification and referral of alcoholics and drug abusers. Strategies such as marketing programs, training supervisors, screening, assessment, referral, and follow-up are acceptable Employee Assistance Program activities. To the maximum extent possible, employee assistance programs should maintain separate identities to ensure maximum utilization within the community.

<u>Objective</u>	<u>Services</u>	<u>Actions</u>
To continue to support at current levels the development of employee assistance programs and coordinating with existing employee assistance programs.	Provide support to employee assistance program referral project. Provide support to programs to conduct employee assistance coordination.	Number of EAP programs in operation Number of clients served by EAP programs Number of referrals between programs

STUDENT ORIENTED PROGRAMS Youth are often identified as a high at risk group that can benefit from alcoholism and drug abuse services. Close cooperation with school administrators is essential for success with this target group. Strategies such as teacher training, assist programs similar to employee assistance programs, use of natural helpers, family involvement, parent groups, tutoring, and alternatives to suspension efforts are example of acceptable approaches.

Ohjectives

Increase the number of student assistance programs in the State by 50% over the FY'84 level.

Strategies

Continue to support the development of student assistance programs.
Provide school groups and districts with technical assistance and information.

Measures

Number of student assistance programs

SYSTEMS COORDINATION

The alcoholic or drug abuser often comes in contact with related agencies that can assist in the process of ensuring that persons in need of alcohol or drug abuse treatment are afforded care. Therefore, specific and systematic identification, screening, assessment, and referral services offered to related health, social service and allied agencies sharing target group clients are beneficial.

<u>Objectives</u>	<u>Strategies</u>	<u>Measures</u>
To continue coordination with private sector providers by sponsoring joint needs review and committee meetings.	Provide support to employee assistance program referral project. Continue to provide on-site evaluations for private treatment facilities.	Trip Reports/meetings. Memorandum of Agreement written among provider.
To continue the number of hours spent working with other community agencies on drug prevention strategies to better involve the whole community.	Provide support to local programs to conduct coordinative activities.	Number of staff hours working with other agencies. Number of cooperative efforts mentioned in quarterly narrative reports.
To increase by 10% the number of referrals from community agencies and other non-treatment programs to drug treatment programs.	Provide technical assistance on improving referral capabilities.	Number of referrals. Number of self-referrals. Number of family referrals. Number of church referrals. Number of friends referrals. Number of hours spent in I&R services.
Continue coordination with Indian Health Service and with state agencies for the purpose of ensuring quality and comprehensiveness of care.	Provide leadership for the Interagency Coordinating Committee Continue to hold joint policy and review meetings with IHS.	Number of meetings with federal agencies. Number of meetings with state agencies.

Quantitative Measures

	FY'84	FY'85	FY'86
To increase the number of agency, community and self referrals to alcohol and other substance abuse programs			
*Number of referrals	9000	9500	10100
To increase the number of referrals from community agencies and other non-treatment programs to drug treatment programs.			
*Number of referrals	N/M	1300	1430
*Number of hours spent in I&R services	N/M	600	640

TREATMENT PRINCIPLES

Treatment is the formal and organized provision of services for persons who have abused alcohol and/or drugs, and is designed to alter specific physical, mental, social and spiritual problems caused by such abuse.

The primary functions of any alcoholism or drug abuse treatment program are to identify, evaluate, and treat persons who experience problems related to alcohol or drug abuse. Through the process of needs identification and evaluation of a client, the appropriate treatment milieu is identified. The alcoholism or drug abuse program staff evaluation of each client's needs is used to establish a written treatment plan for each client. The modality of treatment shall be based upon known, demonstrable and/or generally accepted methods of treatment and directed towards the specific needs of the clients.

To deal with the complex problems related to the use of alcohol or drugs, multiple theories and modes of clinical evaluation and treatment should be considered. Planning for treatment shall take into account the physical, social, cultural, educational, vocational, spiritual and psychological needs of each client. The patient's progress and outcome shall be reviewed in the light of the objectives of the individualized treatment plan.

The comprehensive and state approved treatment components are: emergency care, inpatient care, intermediate residential care, outpatient care and aftercare.

EMERGENCY CARE

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

Emergency care comprises a network of services that provides all persons having acute problems related to alcohol or drug use and abuse immediate diagnosis and care, as well as appropriate referral for continuing care after emergency treatment. Primary emergency services in Alaska are community service patrols, and medical or social detoxification.

In cases of severe acute intoxication, detoxification is to be provided utilizing one of three modes: medical detoxification or short term treatment usually less than 10 days, during which medication (i.e., prescription drugs) may be used; social detoxification or non-medical treatment in a caring and supervised environment; and outpatient methadone detoxification may combine counseling and medication in an outpatient setting.

<u>Objectives</u>	<u>Strategies</u>	<u>Measures</u>
To increase from 9,000 (FY'84 level) to at least 10,000 vehicle transports for severely intoxicated persons who are in a life endangering situation as a result of alcohol or other substance abuse.	To provide funding for community service patrols.	Number of transportees (level of activity). Number of patrol trips.
To increase the rate of referral to treatment by 10% above FY'84 level from Emergency Care Services	To provide emergency care and services to 400 persons having acute problems with substance use and abuse.	Number of beds available for emergency use and services. Number of persons admitted to detox. Number of persons discharged & referred vs terminated + %.

Quantative Measure

	FY'84	FY'85	FY'86
To increase vehicle transports for severely intoxicated persons who are in a life endangering situation as a result of alcohol abuse or other substance abuse.			
*Number of Transportees (level of activity)	12500	13000	13000
To increase the rate of referral to treatment from detoxification.			
*Number of beds available for emergency use and services	33	33	33
*Number of persons admitted to detox	2916	3000	3100
*Number and percentage of persons discharged to treatment vs. terminated.	$\frac{725}{25\%}$	$\frac{750}{25\%}$	$\frac{775}{25\%}$

HOSPITAL CARE (INPATIENT)

The process of providing care to persons who require 24-hour medical supervision in a hospital or other suitably equipped medical setting as a result of acute or chronic medical, social, cultural, spiritual and psychological problems associated with alcohol abuse, drug abuse and/or alcoholism. The average planned length of stay in these units is twenty-eight days and incorporates intoxicant-free therapy and shall promote involvement with available aftercare planning and community support resources.

Objectives

To continue the number of persons who have completed the treatment plan in a 24 hour hospital or other suitably equipped medical setting who are in such a program as a result of acute or chronic substance abuse.

To continue the number of persons completing individualized treatment plans in a residential setting who are in such a program as a result of substance abuse.

Strategies

To provide funding for inpatient substance abuse treatment.

Provide technical on-site assistance as requested.
Continue to support residential setting programs for drug abusers in urban areas.
Complete on-site evaluations of each program.
Provide assistance to improve outreach and referral capabilities of programs.

Measures

Number of beds available.
Number of persons treated inpatient
Number of persons completing treatment plan.
% completing treatment plan.
Number referred to other components of care at discharge.
% referred to other components of care at discharge.

Number of beds available.
Number of clients treated in the residential drug free setting.
Number of clients completing intermediate care treatment plan.
% completing intermediate care treatment plan.
Number of intermediate care clients referred to outpatient care.
% referred to outpatient care.
Average length of stay.

INTERMEDIATE RESIDENTIAL CARE

Intermediate care shall be designed to facilitate the rehabilitation of the alcohol or drug abusing persons by placing them in an organized therapeutic environment in which they may receive diagnostic services, counseling, vocational rehabilitation and/or work therapy while benefiting from the support which a full 24-hour or partial, less than 24-hour, residential setting can provide.

1. Short term intermediate residential care is the provision of counseling and social adjustment services to persons who require 24-hour supervision as a result of alcohol or drug abuse. This process is more intensive than other forms of intermediate care with an average length of stay of twenty-eight days. This process is similar to inpatient care without the medical staff and the hospital setting.
2. Transitional care is delivered in Halfway Houses and involves a one to six months length of stay. At the start of transitional care, the client spends most of their time at the house in a therapeutic and support environment. As they advance through treatment, more time may be spent on habilitation or rehabilitation until re-entry into the community is made. Most individuals will enter this care from some other component of service.

3. Long term care is a long term therapeutic environment for a period of six months to two years. Each of the clients is required to assist in the upkeep and operation of the facility as well as attending the therapeutic activities conducted. Such care may be rather intense (e.g. in a Therapeutic Community or TC) or be closer to transitional care in treatment intensity.

Objective

To increase by 10% from the FY'84 level, the number of persons completing the individualized treatment plan in a 24 hour or less-than-24 hour residential setting who are in such a program as a result of alcohol/drug abuse.

Strategies

To provide funding for community-based intermediate care substance abuse treatment facilities and one long-term care facility.

Measures

Number of beds available short-term.
Number treated short-term.
Number completing short-term intermediate treatment plan.
% completing short-term intermediate care treatment plan.
Number of beds available long-term.
Number treated long-term.
Number completing long-term intermediate care treatment plan.
% completing long-term intermediate care treatment plan.
Number of short-term intermediate care clients referred to outpatient care.
% of short-term intermediate care clients referred to outpatient care.
Average length of stay - long-term care.

INTERMEDIATE CARE (cont)

Quantitative Measures

To increase the number of persons completing the individualized treatment plan in a 24 hour or less than 24 hour residential setting who were in such a program as a result of alcohol/drug abuse.

*Number of beds available short-term	145	133	135
*Number treated short-term	1250	1300	1350
*Number completing short-term intermediate treatment plan	852	975	1000
*% completing short-term intermediate care treatment plan	68%	75%	75%
*Number of beds available long-term	169	169	169
*Number treated long-term	639	650	670
*Number completing long-term intermediate treatment plan	146	325	390
*% completing long-term intermediate care treatment plan	23%	50%	60%

OUTPATIENT CARE SERVICES

Outpatient care services provide non-residential, diagnostic and primary alcoholism and drug abuse treatment services on both a scheduled and a nonscheduled basis.

Outpatient counseling can be provided through various modalities deemed appropriate for alcohol or drug abuse treatment, such as but not limited to, individual counseling, group counseling, family counseling, intensive, antabuse, or methadone maintenance.

Intensive outpatient care may be a combination of the outlined activities but is offered to the client in a more compressed time frame. Antabuse therapy shall only be administered by a licensed physician. Education and didactic activities may be a part of any outpatient care services. Methadone maintenance shall only be provided in state and federally approved programs.

Objectives

To increase the number of persons completing their treatment plans in a non-residential, substance-free setting.

To increase by 10% the number of clients discharged from methadone maintenance by increasing by 10% the clients referred to drug free outpatient treatment from FY'84 levels.

Strategies

To provide out-patient care to those seeking such assistance.
Complete on-site evaluations of each program.
Provide technical on-site assistance as requested.
Continue to support non-residential treatment programs.

Inform users of changes in state and federal regulations.
Provide technical on-site assistance as requested.
Facilitate coordination between methadone maintenance and drug free outpatient programs.
Complete on-site evaluation of program.

Measures

Number treated.
Number completing treatment plan.
% completing treatment plan.
Number of clients admitted to drug free outpatient care.
Methadone detox.
Methadone maintenance.

Number of clients discharged from methadone maintenance.
Number of referrals from methadone maintenance to drug free outpatient.

Quantitative Measures

To increase the number of persons completing their treatment plans in a non-residential, substance-free setting.

	FY'84	FY'85	FY'86
*Number treated	9164	9200	9300
*Number completing treatment plan	1632	3200	3250
*% completing treatment plan	18%	25%	35%

To continue the number of persons completing their treatment plans in methadone maintenance and methadone detox

	FY'84	FY'85	FY'86
*Number treated	136	136	136
*Number completing treatment plan	21	28	28
*% completing treatment plan	15%	20%	20%

To decrease the number of clients readmitted to treatment programs as referrals from the criminal justice system from FY'84 levels.

	FY'84	FY'85	FY'86
*Number of clients referred and readmitted to treatment from criminal justice system	N/M	60	68
*Number of hours of counseling at correctional institutions	N/M	1170	1328
*Average cost for clients with single drug-related convictions	*Baseline to be established		
*Average cost for clients with multiple drug-related convictions	*Baseline to be established		

To increase by the number of persons entering treatment programs as a result of criminal justice systems responses to alcohol or drug related offenders and to maintain the cost effectiveness of these programs.

*Number of persons admitted to a drug treatment program as a result of involvement with the criminal justice system

N/M

700

795

*Cost per client in the drug treatment

*Baseline to be established

AFTERCARE

Aftercare provides care to patients who have progressed sufficiently through emergency, inpatient, intermediate and/or outpatient services to a point in their recovery where they will benefit from a level of continued contact which will support and increase the gains made to date in the treatment process. Aftercare must be delivered through the development of an individualized aftercare plan developed between the aftercare counselor and the client. In a sense, aftercare could be termed self care under the general guidance of the aftercare counselor.

<u>Objective</u>	<u>Strategies</u>	<u>Measures</u>
To increase by 20% the persons receiving continued aftercare services for the purpose of providing support and increasing the gains made during the treatment process.	To provide funds for after-care services at the community level.	Number of formal after-care programs. Number of persons treated in aftercare. Number of staff hours provided to former treatment clients.
Increase substance abuse clients exposure and referral to Alcoholic Anonymous and Narcotic Anonymous prior to discharge from the program.	Maintain as a grant condition the utilization of AA and NA concepts as an integral part of the program delivery.	Number of programs utilizing AA and NA principles.
Provide at least 50% of all client with an AA or NA sponsor prior to discharge.	Require treatment programs to maintain referral networks with AA and NA groups.	Number of programs with referral network with AA or NA group.

Quantitative Measures

	FY'84	FY'85	FY'86
To increase the number of persons receiving aftercare services.			
*Number of formal after-care programs	N/M	25	25
*Number of persons treated in after-care	1000	1000	1000
*Number of staff hours provided to former treatment clients	40546	41000	43000

ADMINISTRATIVE SUPPORT SERVICES

Among central office functions, highest priority is accorded to those which enhance the State's ability to identify and meet client needs, especially the functions of data acquisition, analysis and planning, and those administrative functions by which the Office assures accountability and costeffectiveness in existing uses of public money for substance abuse services, especially grant/contract administration, monitoring and evaluation, technical assistance, training and research. Additionally, in fulfilling its mandate to develop comprehensive prevention programs, the SOADA cannot ignore the important role of the legal and institutional systems responsible for identifying and controlling substance abuse. The office therefore, assumes a strong advocacy posture toward those key elements outside its authority and assumes a leadership role in coordination. The SOADA's advocacy efforts focus on 1) legislative change, 2) performance quality in regulatory and enforcement systems, and 3) special needs of substance abusers in other service delivery systems.

PROGRAM MONITORING

This procedure includes all activities that relate to the review of and assistance to Grantees with respect to their conformance to the conditions of their grant. The procedures focus on the planning for and the conduct of onsite reviews of programs and facilities by Field Operations staff.

<u>Objectives</u>	<u>Strategies</u>	<u>Measures</u>
To increase the aggregate evaluation scores of each program by 5% from the FY'84 aggregate level in FY'85. Evaluations will be based upon the State standards.	Base Health Facilities Surveyors in Anchorage to evaluate all State funded substance abuse programs. To provide intensive, strategic programmatic assistance to improve local community-based programs. To annually conduct one on-site evaluation and follow-up of each program receiving State A/DA funds. To provide one technical assistance contact for each program meeting the State standards and two such contacts for programs not meeting the State standards.	Average evaluation scores. Number of programs meeting state standards level. Number of programs failing to meet state standards level. Number of on-sites. Number of follow-ups. Number of T.A. on-sites to each type of program.
To develop improved State standards for alcoholism programs to more appropriately address the uniqueness of urban and rural programs by the end of FY'86.	Provide program managers and advisory board with mechanism to give input in State standard revision process. Form a standards review committee to meet four times, holding public hearings in 10 communities.	Number of sets of minutes of Review Committee Meetings. Number of sets of minutes of public hearings. Revised Standards developed in draft by June 1985.

Quantitative Measures

To increase the aggregate evaluation score of each program. Evaluations will be based on state standards.

*Average evaluation score	N/M	82%	85%
*Number of programs meeting state standards	35	38	39
*Number of on-sites	53	53	53
*Number of follow-ups	43	43	43
*Number of T.A. visits	30	30	30

To continue the development of state standards for drug and alcohol abuse programs.

*Number of meetings	N/M	3	3
*Number of hearings	N/M	3	3

FISCAL MONITORING

This procedure includes all activities that relate to the handling of Grantee requests for funds and the monitoring of these requests for conformance to the Grant or Contract conditions. The procedures focus on the activities of the Administrative Officer.

Objectives

To decrease the in-house request for payment turn-around time to three working days.

To decrease the request for line item budget revision turn-around time to fourteen days.

To increase the utilization of alternative funding mechanisms by 10% over FY'84 levels by identification and promotion of strategies.

Strategies

Maintain the Central Office administrative staff and to fund training for the same.

To provide budgetary technical assistance to grantees.

Research, analyze and experimentally implement alternative State funding mechanisms.

Measures

Payment turn-around time in days (mean).

Turn-around time in days (mean).

Produce report of strategies and analysis of their utility to the Commissioner.
Revise statute to match requirements.

Quantitative Measures

To audit 23 FY'85 grants in FY'86.

*Number of audits

FY'84

FY'85

FY'86

23

23

23

PLANNING AND RESEARCH

This procedure includes all activities that relate to the development, review and approval of both the Drug Abuse and the Alcoholism State Plans. The procedure focuses on the activities of the planners and the review of the Draft State Plans with various review and approval groups.

<u>Objectives</u>	<u>Strategies</u>	<u>Measures</u>
To continue to support a variety of special evaluation projects specific to the subject of substance abuse or system components.	Provide support for special evaluation projects as directed by advisory board.	Contract file -- Number of contracts in aggregation.
To continue the distribution of publications by State office to the legislature, Department and field over 20% FY'84 level.	Publish: Four newsletters, One Annual Report, One Alaska Services Directory, Four Quarterly Performance Reports.	Number of newsletters. Annual Report to Legislature. Alaska Services Directory. Quarterly Performance Reports.
To increase the number of meetings of the Review Board on Alcoholism and the Advisory Board on Drug Abuse from two to three per year to accept plans and to make funding recommendations.	Provide staff, technical and financial assistance to the Alcoholism and Drug Abuse Boards.	Minutes of Board Meetings. Number of meetings.
Establish a free-standing board to be responsible for the review of applications and certification of substance abuse counselors.	Provide coordination and start up funding for a non-profit organization to provide this service.	Establishment of board.
Continue to assess the scope of youth substance abuse needs for outpatient and residential treatment.	Review appropriateness of present treatment responses and investigate the cost effectiveness of alternative approaches	Prepare a document assessing the scope of youth needs and describing cost effective alternatives.

Quantitative Measures

To continue the distribution
of publications.

FY'84

FY'85

FY'86

*Number of newsletters

4

4

4

*Annual Report

1

1

1

*Alaska State Directory

1

1

1

*Quarterly Performance reports

4

4

4

To continue the number of
meetings of the Review Board
on Alcoholism and the Advisory
Board on Drug Abuse.

*Number of meetings

3

3

3

To increase coordination
with private sector
treatment agencies.

*Number of on-sites

5

9

10

*Number of joint meetings

0

3

5

GRANT APPLICATIONS

This procedure includes all activities that relate to the solicitation, review, and final negotiation and approval of grant proposals from prospective program operators. The procedures focus on the review activities of all SOADA staff and the review and approvals with the Alcoholism and Drug Abuse Boards and the Commissioner of Department of Health and Social Services respectively.

Objective

To decrease volume of material required and duplication of previous year information from the office's grant application package future grant cycles.

Strategies

Review and analyze the office's grant application procedures.

Measures

Development and distribution of a new grant application.

TRAINING

Training activities are comprised of all procedures directed towards increasing the knowledge, skills or competency of those providing substance abuse treatment services. The primary delivery of training services is accomplished through the regional training network and directed towards counselor trainee attainment of level I or level II certification. The delivery of training is also provided through the support of special purpose conferences, symposiums and schools.

<u>Objective</u>	<u>Strategies</u>	<u>Measures</u>
To increase the number of Alaska Native counselors employed in state funded programs who have received Alcohol/Drug Abuse Counselor Certification.	Provide funds to regional programs with intent of targeting Natives. Actively recruit Native counselors.	Number of Native trainees Number of Natives taking test Number of Native counselors
Continue to conduct addictions school and prevention symposium annually.	Provide funds for addictions school and prevention symposium.	Number of attendees at Addictions School Prevention Symposium
Maintain regional training system the three health service areas	Provide funding for regional training network.	Number of regional training programs Number of students in training programs

APPENDIX - A

NEEDS ASSESSMENT

Appendix A Index

Pages 1-6	A. Description of State and Demographic Data
7-9	B. Alcohol/Drug Abuse indicators intro
9-16	Per Capita Sales
16-20	Prevalence of alcohol abuse
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APPENDIX A

NEEDS ASSESSMENT

This section of the State Plan consists of an analysis of statistical data to illustrate the extent of alcohol/drug abuse problems in Alaska. The three parts of this Needs Assessment are: A.) a description of the State and demographic data, B.) an analysis of alcohol abuse indicators, C.) an analysis of drug abuse indicators.

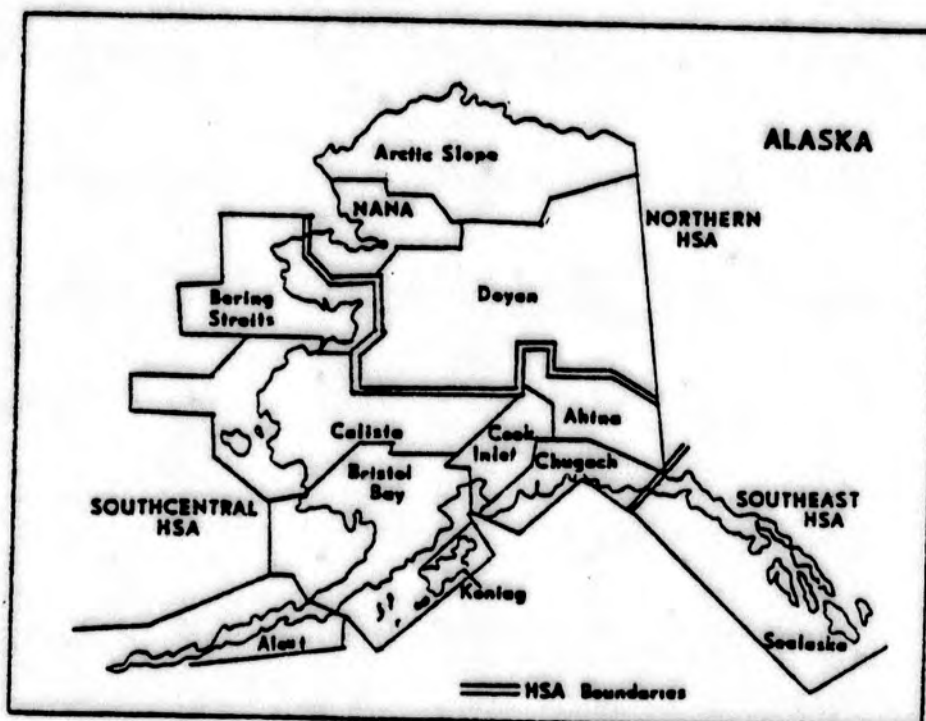
A. DESCRIPTION OF THE STATE AND DEMOGRAPHIC DATA

Regions of Alaska

The 586,400 square mile territory of Alaska is one-fifth the size of the entire Lower 48 states, because of its sub-continental size, Alaska is not a single, homogeneous region, but consists of several distinct regions, each with differing climate, physical features and population.

For purposes of demographic statement and analysis, the State can meaningfully be divided into three large regions. These are Southeast Alaska, Southcentral Alaska, and Northern Alaska.

Map 1. Alaska by Major Regions.



The Southeast, Alaska's "Panhandle", is a thin strip of coastline which is separated from the rest of the State by Canadian territory, the Malaspina Glacier, and the St. Elias Range. Juneau, the capitol, is located in the Southeast, and, with an estimated population of 24,000, is this region's largest city.

Central and Interior Alaska is the area south of the Brooks Range and east of longitude 151°W. This region includes Kodiak Island, Cook Inlet, and the Copper, Susitna, Tanana and Upper Yukon River Basins. The major towns in this region are Anchorage, in Central Alaska, and Fairbanks, in Interior Alaska. Anchorage, with an estimated population of 197,000 is Alaska's largest city; Fairbanks, population estimated at 54,000, is the State's second largest city. This region is divided into distinct coastal and interior units by the Alaska Range, but it is tied together by the Alaska Railroad, a highway system, and installations of the defense establishment, which give both sub-areas a similar economic and social character.

The third region of the State is Northern and Western Alaska, which includes the remaining portions of the State to the west and north. The area of this region is approximately 330,000 acres, and it is characterized by sparse population, isolated and remote centers of settlement, and an undeveloped economy. The region has no cities; its largest towns are Kotzebue, Barrow, Nome and Bethel. Populations of these towns range from 2300 to 3000.

Land and Climate

Alaska is a land of superlatives and extremes, having the country's highest point (Mt. McKinley, 20,320 feet); the nation's northernmost point (Point Barrow, 71°23' north); 33,000 miles of coastline; some of the world's largest and most easily accessible glaciers (the largest, the Malaspina Glacier, measures 2937 square miles, almost as large as the states of Delaware and Rhode Island combined); the nation's largest national forest, and largest national park and monument (Tongass National Forest, 16 million acres; Glacier Bay National Monument, 2.8 million acres); 1800 named islands and thousands more which have never been given official names; and the famous Midnight Sun, that period during the summer months when there is daylight round the clock -- for up to three months in Barrow and for shorter periods of time in other parts of northern Alaska.

In terms of weather and climate, Alaska, contrary to popular opinion, has it all -- hot and cold, wet and dry. Temperatures can range from 100° to -80°F. Average annual rainfall in the rain forests of the Southeast is 200 inches while the Arctic North has desert-like dry conditions. The most snowfall in one season was 974.5 inches at Thompson Pass, just east of Valdez, in 1952-1953.

Transportation is important in Alaska, and often takes unusual, or unique forms. Dog sleds, snow machines, automobiles, state-run ferry boats, commercial and private airplanes (float-and ski-equipped) and helicopters, trains, trucks, and boats are all vital modes of transportation. Air travel is more unpredictable, time consuming, and expensive than in the Lower 48. Nevertheless, air travel is perhaps the most important, because so many areas of the State--especially isolated coastal towns and remote "bush" communities in the Interior--are inaccessible by other means.