

ALASKA LEGISLATURE SPECIAL COMMITTEE / SUBJECT FILE 8672

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Population

Alaska's population in 1982 was estimated at 460,837; this represents a jump of 160,000 people since the 1970 census. Alaska has a relatively large military population, amounting to 23,000 in 1982; the military establishment is concentrated in Anchorage, Fairbanks, and the Aleutian Islands. The population is 54.4% male and 45.6% female. Alaska has a young population--the median age is 26.1 years compared to a national average of 30 years. On the other hand, the proportion of older people in Alaska's population is much smaller than in the U.S. population, perhaps because of the vicissitudes of life and high cost of living in Alaska, which cause many to leave the State at retirement age. See Table I.

Table 1. POPULATION BY AGE GROUP, HSA, ALASKA, US
1982

AGE	SEHSA	NHSA	SHSA	ALASKA	US
0-14	29.2	32.4	26.9	26.9	22.7
15-24	21.9	23.5	20.5	20.5	18.7
25-34	12.6	16.3	22.6	22.6	16.4
35-54	23.1	18.7	21.9	21.9	21.8
54+	13.3	9.0	8.0	8.0	20.9

The categories for the analysis of Alaska's racial composition are: 1) white, 2) non-white, which includes Natives, Blacks, Chinese, Japanese, Filipino, Hispanic, etc. Whites constitute the major part of Alaska's population. About seventy-seven percent of the population is Caucasian, and about sixteen percent is Native (Alaska Native and Alaska Indian). About five percent of the population is Black. The remaining one percent is composed of Other Minorities, including Filipino, Chinese, Japanese and other minorities.

The population distribution, by race, for 1982, is shown in Table 2.

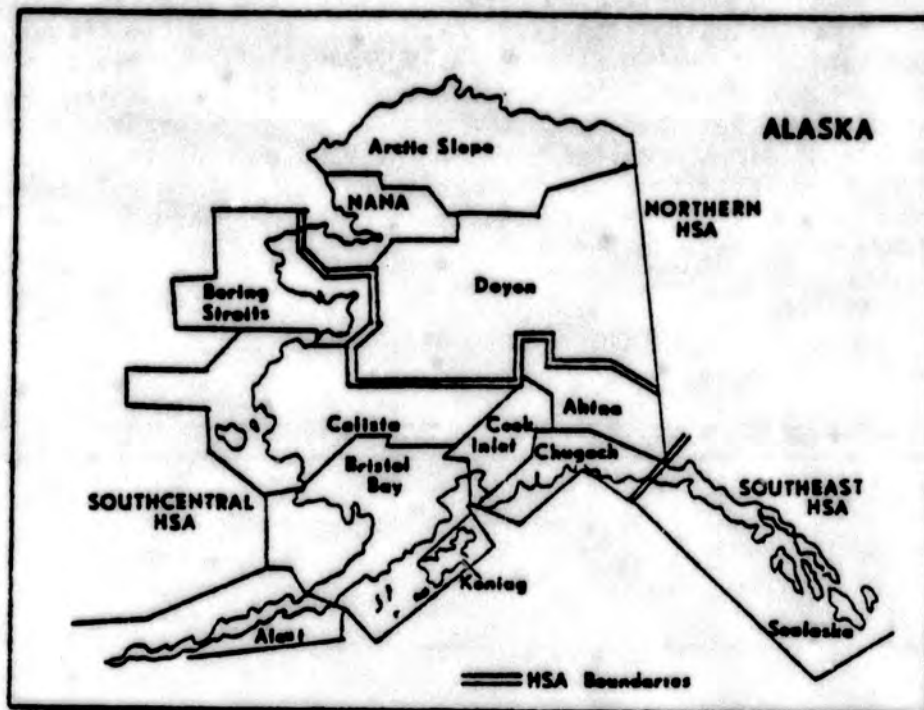
Table 2. POPULATION DISTRIBUTION BY RACE
ALASKA '82

RACE	NUMBER	PERCENT
WHITE	354,475	76.92
NON-WHITE	106,352	23.08
TOTAL	460,837	100.00

Health Systems Agencies and Native Regional Corporations

Three Health Systems Agencies (HSAs) have been established in Alaska, the Southeast Alaska Health Systems Agency, Southcentral Health Planning and Development, Inc., and the Northern Alaska Health Resources Association, Inc. Map 2.

Map 2. Health Systems Agencies and Native Regional Corporations, Alaska



Total population, and cumulative population change between 1970-1977-82 for each HSA is shown in Table 3.

Table 3. TOTAL RESIDENT POPULATION, BY HSA AND STATEWIDE AND POPULATION CHANGE ALASKA 1970-77-82

AREA	1970 Pop.	1977 Pop.	1970-1977 Cumulative Pop. Change	1982 Pop.	Cumulative Pop. in 1980 Change From	
					1970	1977
NORTHERN	64,630	74,014	+14.52	83,159	+28.66	+12.35
SOUTHEAST	42,565	53,162	+24.90	59,201	+39.08	+11.35
SOUTHCENTRAL	195,166	284,035	+45.54	318,477	+63.18	-12.12
TOTAL	302,361	411,211	+36.00	460,837	+36.12	-12.06

The State's Native Regional Corporations number twelve. Their locations and boundaries, and their relationship to the three HSAs, are shown in Map 2.

Density of Population

Despite Alaska's recent rapid rate of population growth, the State is still very sparsely settled. For purposes of comparison, Alaska's sparsity of population in 1980 resembled that of the Mountain States (Montana, Idaho, Wyoming, Utah, and Colorado) in the 1870s and 1880s. The 1960 census showed a population density of only 0.40 persons per square mile for Alaska, compared with the United States average of 60.0 persons per square mile. The 1970 census enumeration showed a population density of about 0.53 persons per square mile, while in 1980 (based on the most current population estimate), population density was only 0.70 persons per square mile for the state as a whole. See Table 4, which illustrates the quite marked differences in population density among various regions.

Table 4. POPULATION DENSITY PER SQUARE MILE, BY HSA AND TOTAL ALASKA
1980

AREA	AREA SQ. MILES	POPULATION	DENSITY PER SQ. MILE
NORTHERN HSA	320,000	76,656	.24
SOUTHEAST HSA	32,000	53,794	1.60
SOUTHCENTRAL HSA	218,000	270,126	1.24
	570,300	400,481	.70

Urbanization and Population Growth

Urbanization has been an important trend in Alaska, as it has been elsewhere in the United States; however, the pattern and timing of urbanization in Alaska have been somewhat different than in the rest of the nation.

In 1890, there was no urban population in Alaska, by 1900, there was a substantial urban population (for example, in Nome) as a result of the gold rush. As the gold rush subsided, the urban population declined, but by 1920 it had begun to increase again. Urban population has increased steadily since the 1920s and more rapidly, since the 1950s. In the 1950 census enumeration, 26.6% of Alaska's population lived in urban areas; by the 1960 census, the urban segment of the population amounted to 37.9% of the total; and, by the 1970 census, 48.4% of the population was classed as urban. (NOTE: "Urban" is defined as places of 2,500 or more).

The distribution of Alaska's total population by size of place in 1950, 1960, and 1970 is shown in Table 5. In 1950, nearly 62% of the total population resided in places of less than 1000 persons. By 1960, this percentage had dropped to 52%. By 1980, the percentage of the total population residing in places of less than 1000 persons had declined even further, to 27%.

Table 5. DISTRIBUTION OF TOTAL ALASKA POPULATION BY SIZE OF PLACE
1950 - 1980

SIZE OF PLACE	1950		1960		1970		1980	
	POP.	% of Pop.	POP.	% of Pop.	POP.	% of Pop.	POP.	% of Pop.
<1,000	79,394	61.7	116,446	51.5	117,017	38.4	108,625	27.1
1,000 - 1,500	3,575	2.8	12,444	5.5	15,170	5.1	3,487	.8
1,500 - 2,000	7,190	5.6	7,032	3.1	6,918	2.3	10,201	2.5
2,000 - 2,250	4,222	3.3	4,478	2.0	15,765	5.2	15,416	3.8
2,500 - 5,000	5,976	4.6	5,865	2.6	21,355	7.1	25,914	6.5
5,000 - 10,000	17,032	13.2	22,354	9.9	43,268	14.4	20,233	5.1
10,000 - 25,000	11,254	8.7	13,311	5.9	32,860	10.9	42,173	10.5
25,000 - MORE	0	0	44,237	19.6	48,029	16.0	174,431	43.7

The major peaks in Alaska's population growth were caused by the gold rush at the turn of the century, resource development, expansion of the military presence, and, most recently, the construction of the trans-Alaska Oil Pipeline. The latter event, occurring in the mid-1970s caused population fluctuations, which were primarily in-migrational in nature, all along the 800 mile route of the pipeline, from Prudhoe Bay on the North Slope, south to Valdez on the Prince William Sound, and caused economic and social reverberations throughout the State.

Despite trends of urbanization and population growth, which have intensified since the beginning of the construction of the Trans-Alaska Pipeline, it is clear that Alaska is, even in 1979, significantly rural in character, compared to the Lower 48.

B. ALCOHOL ABUSE INDICATORS

The best available method we have for estimating the extent of alcohol abuse is through the analysis of indirect "indicators," or quantifiable measures, of alcohol abuse.

These indicators are believed to be related to alcohol abuse in such a way that changes in the indicators correspond to changes in actual alcohol abuse patterns. If a number of indicators are analyzed together, and if consistent patterns are observed, over time, then these indirect indicators may be assumed to provide a reasonably reliable indication of the nature and extent of alcohol abuse, and alcohol related problems, within a state. It must be emphasized that no one indicator alone can be used to quantify the extent of alcohol abuse within an area or state.

The indicators selected for this Needs Assessment, their sources, the rationale for the use of each, and the limitations of each as an indicator, are described below.

Per Capita Sales of Alcoholic Beverages

Source:	Department of Revenue
Rationale:	Relative measure, over time, of per capita amount of alcoholic beverages sold in the State. Useful for comparison with other states', and national, per capita sales data.
Limitations:	If used as a measure of "apparent consumption," many assumptions are necessary to relate per capita sale to per capita "apparent consumption."

Prevalence Estimates:

Source:	Demographic data/mortality data used in conjunction with standard prevalence estimate formulas (Marden procedure; modified Jellinek procedure).
Rationale:	To provide estimates of population "at risk," and in need of alcoholism treatment services.
Limitations:	Procedures are standard methodologies which are not Alaska-specific, and they do not take account of unique population-specific factors.

Alcohol and Highway Safety

Source: Department of Public Safety

Rationale: To provide an estimate of alcohol involvement in a major cause of preventable death. Assists in identification of populations particularly at risk.

Limitations: Data may understate actual alcohol-involvement.

Arrests for Alcohol-Related Offenses

Source: Department of Public Safety

Rationale: May assist in identifying high risk populations.

Limitations: Local law enforcement activities/policies may vary without relationship to actual extent of alcohol-related offenses. Arrest data indicate alleged offenses only. Only directly alcohol-related offenses can be quantified with these data.

Alcohol-Related Mortality

Source: Department of Health and Social Services, Office of Information Systems

Rationale: Health indicator which is directly related to actual prevalence of alcohol abuse.

Limitations: There is a potential for underreporting due to reluctance to attribute death to alcohol-related causes.

Other Alcohol-Related Mortality

Source: Department of Health and Social Services, Office of Information Systems, and death certificate data submitted to Bureau of Vital Statistics.

Rationale: Data concerning accidental deaths which are directly related to prevalence of alcohol abuse.

Limitations: There is a potential for underreporting due to differences in reporting practices by medical examiners and/or fire officials.

Alcoholism Treatment Programs

Source: Department of Health and Social Services,
Office of Alcoholism and Drug Abuse, Information System.

Rationale: Reporting on individual clients allows study of specific populations. Demographic characteristics may be used as a tool in identifying high risk populations.

Limitations: Necessary assumption: that characteristics of those persons seeking treatment at public treatment programs are representative of the entire alcohol abusing population.
Voluntary/involuntary entry bias.
Unavoidable internal problems with information system during 1978.

Mental Health

Source: Department of Health and Social Services,
Division of Mental Health and Developmental Disabilities.

Rationale: Demographic characteristics of patients may be used to identify high risk populations.

Limitations: There is a potential for underreporting due to misdiagnosis of alcohol problems.

Child Abuse and Child Neglect

Source: Department of Health and Social Services,
Division of Family and Youth Services.

Rationale: Indicates the consequences for the family unit of alcohol abuse.

Limitations: Exact nature of the correlation between child abuse/child neglect and alcohol abuse by a family member has not been determined. Potential for underreporting of child abuse/child neglect cases because some cases never come to the attention of Division of Social Services.

Analysis of Alcohol Abuse Patterns

Per Capita Sales of Alcoholic Beverages

Note on Terminology

The amount of legal alcoholic beverages sold, per capita, is sometimes referred to as "apparent consumption" of alcoholic beverages. Some of the more important assumptions necessary to relate sales to actual consumption, as "apparent consumption," are: 1) All the alcoholic beverages sold in a state are consumed by the resident population; 2) All alcoholic beverages consumed are legally purchased (and, thus, all are included in government reports of alcoholic beverages sold/distributed; and 3) Persons who abstain from alcohol consumption do not constitute a significant proportion of the drinking age population (and, therefore, the drinking age population figure is not adjusted downward to reflect the existence of an abstaining sub-population group).

In fact, these assumptions should be questioned, or at least, taken into account, when "apparent consumption" data are presented. For example, an unknown number of non-residents -- tourists and other visitors -- purchase and consume alcoholic beverages while visiting this State; failing to account for their presence in the population tends to inflate "apparent consumption" figures. Also, illegally manufactured alcoholic beverages may contribute significantly to the amount of alcohol consumed in the state. And, as no current survey information concerning the proportion of abstainers in the population exists for Alaska, it is impossible to make valid adjustments in the size of the "drinking age" population which would take these abstainers into account. Failure to make allowances for the latter two factors results in understatement of "apparent consumption" of alcoholic beverages in the State. Furthermore, the definition of "drinking age" population, if unrealistic in terms of a state's drinking habits and practices, can result in distortion of the actual relationship of sales to consumption.

Hence, we have avoided "apparent consumption" terminology here because so many assumptions have to be made to relate alcoholic beverage sales data to actual consumption of alcoholic beverages; we will use instead the terminology "per capita sales" in this section. What is meant by "per capita sales" is this: if all legally sold alcoholic beverages were divided equally among all persons who could legally purchase such beverages, then the average amount sold to each person would be expressed as per capita sales of alcoholic beverages.

At best, sales of alcoholic beverages, when expressed as an amount per

capita, can be used as a comparative or relative measure: 1) to show trends or changes, over time, in the per capita amount of alcoholic beverages sold in the State; 2) to compare state trends with national trends, or to compare trends among several states; and 3) because sales data are presented with regional breakdowns, those data can be used to compare per capita sales of alcoholic beverages among sub-state regions.

TRENDS IN PER CAPITA SALES OF ALCOHOLIC BEVERAGES, ALASKA, 1958 - 82

When per capita sales, by beverage type, are analyzed, for the period 1958-1982, it appears that there has been a significant decrease in sales of distilled spirits, with corresponding increases in sales of beer and wine. The proportionate share of distilled spirits in total per capita sales fell from 58 percent in 1958, to 43 percent in 1982, on the other hand, the share of beer increased from 35 percent in 1958 to 43 percent in 1982, while the proportion of total per capita sales accounted for by wine rose more noticeably from 7 percent in 1958 to 14 percent in 1982. See Table 6.

Table 6. Sale/Distribution of Legal Alcoholic Beverages, Percent in each Beverage Class, and Per Capita Sale/Distribution Expressed as Gallons of Absolute Alcohol, for Persons 19 Years of Age and Older¹, Alaska, FY 76-82.

Year	PERCENTAGE OF ALC. BEV. SOLD			Absolute Alcohol in Gallons
	Distilled Spirits	Wine	Beer	
1982	43%	14%	43%	4.58
1981	44%	13%	43%	4.48
1980	45%	13%	42%	3.93
1979	46%	13%	41%	3.72
1978	47%	12%	41%	3.79
1977	49%	11%	40%	3.87
1976	51%	11%	38%	3.94
1958	58%	7%	35%	2.52

¹Drinking Age Population.

Comparison of Trends in Per Capita Sales of Alcoholic Beverages, United States and Alaska, 1958-1977

For the nation as a whole, per capita sales of alcoholic beverages rose during the 1960's, increasing by approximately 26 percent during the decade. There has been virtually no change in U.S. per capita sale during the 1970's; per capita sales have remained at the peak level reached during the early 1970's. Increased per capita sales during the past two decades

generally are believed to be due to liberalization of alcohol control laws, in combination with a larger proportion of young people in the total population, and a larger number of women who drink alcohol. Alaska's per capita sale of alcoholic beverages for the period 1958-1977 is very high relative to the national average.

This same trend, with Alaska per capita sales greatly exceeding those of the United States, has continued in 1980. See Table 7 for comparative data.

Table 7. Per Capita Sale of Legal Alcoholic Beverages, U.S. Gallons of Absolute Alcohol Per Person, 18 Years of Age and Older, Alaska and United States, 1980.

AREA	U.S. GALLONS OF ABSOLUTE ALCOHOL			
	Distilled Spirits	Wine	Beer	Total
ALASKA	1.75	0.51	1.67	3.93
UNITED STATES (NAT'L VALUE)	1.13	0.38	1.69	3.20

On the national level, beer is the leading class among alcoholic beverages in per capita sales, whereas, in Alaska, the leading beverage class is distilled spirits.

When compared to other states, on a state-by-state basis, Alaska's per capita sales figure is ranked fourth in the nation, behind Nevada, the District of Columbia, and New Hampshire. With respect to interstate comparisons, various reasons for extremely high rates of per capita sales (or, "apparent consumption") have been offered in the national literatures for each of the top three states. High amounts attributed to the District of Columbia are explained by the facts that (1) there is no balance between urban and rural areas there - the District is a metropolis where a high rate of sales "is expected"; (2) it is also a tourist and convention center, which "implies a high drinking rate"; and (3) its low prices attract a vast suburban and transient population to purchase their supplies there. The high rates in Nevada are explained generally entirely in terms of vacationers, tourists, and convention-goers, while the high per capita sales in New Hampshire are attributed to that state's status as a vacation state, and to the lower prices of alcoholic beverages there compared to neighboring states. Alaska's high level of per capita sales has not been explained in the explanatory literature, but presumably, at least the tourism cause for high level per capita sales applies to Alaska.

Table 8 presents a summary of per capita sales, in terms of beverage alcohol and absolute alcohol, of all alcoholic beverages, and by beverage class, for persons 19 years of age and older, in the State of Alaska, for the years 1976 through 1982.

Table 8. Per Capita Sales, Total Sales and Sales by Beverage Class, Beverage Alcohol and Absolute Alcohol, for Persons 19 Years of Age and Older, Alaska, 1976-1982.

YEAR	BEVERAGE CLASS	GALLONS PER CAPITA		19 YRS. & OLDER POPULATION Estimated 81/82
		Volume of Beverage Alcohol	Volume of Absolute Alcohol	
1982	Distilled Spirits	4.81	1.98	272,796
	Wine	4.92	.63	
	Beer	43.69	1.97	
	TOTAL	---	4.58	
1981	Distilled Spirits	4.83	1.99	259,806
	Wine	4.65	.60	
	Beer	42.05	1.89	
	TOTAL	---	4.48	
1980	Distilled Spirits	4.26	1.75	264,991
	Wine	3.92	.51	
	Beer	37.13	1.67	
	TOTAL	---	3.93	
1979	Distilled Spirits	4.17	1.71	271,439
	Wine	3.62	.47	
	Beer	34.15	1.54	
	TOTAL	---	3.72	
1978	Distilled Spirits	4.39	1.80	269,570
	Wine	3.51	.45	
	Beer	34.21	1.54	
	TOTAL	---	3.79	
1977	Distilled Spirits	4.63	1.90	271,546
	Wine	3.44	.44	
	Beer	34.03	1.53	
	TOTAL	---	3.87	
1976	Distilled Spirits	4.83	1.99	263,876
	Wine	3.28	.42	
	Beer	33.89	1.53	
	TOTAL	---	3.44	

Source: Alcohol sales - Department of Revenue.
Population - Department of Labor.

Calculated with the following percentages of absolute alcohol:
Distilled spirits: 0.43; wine: 0.14; beer: 0.045.

Relationship of State Law to Per Capita Sales

The legal framework provided for the sale of alcoholic beverages in the State of Alaska does nothing to inhibit high volume per capita sales of alcoholic beverages.

Retail Distribution: Liquor Store Licenses

In terms of retail distribution, by-the-bottle, through liquor stores, Alaska is a "license" state, i.e., there are privately owned liquor stores licensed by the State for distribution of alcoholic beverages, rather than a "control" state in which there are government-owned liquor stores. In 1970, there were 319 retail licenses for liquor store sales by the bottle for off-premises consumption. In 1979, there were 424 retail licenses. In 1982, there were 458 retail licenses.

Total Licenses for Sale of Alcoholic Beverages

In 1970 there were 915 beverage dispensary licenses in the State of Alaska; this included 596 licenses for on-premises sale of liquor by-the-drink, and 319 liquor store licenses for sales by-the-bottle for off-premises consumption. That was 3.03 licenses per 1000 population, which, relative to the other states, was by far the highest ratio of licenses to population in the United States. In 1970, the national average for the ratio of liquor licenses to each 1000 population was 1.2. In 1982 the Alaska ratio of liquor licenses to each 1000 population rose to 3.68.

In 1982, there were 1474 liquor licenses in the State of Alaska. By category, these licenses were distributed among the available liquor license types as follows:

Table 9. Total Number of Licenses by Type,¹ by Year, Alaska
1978 - 1982.*

	1978	1979	1980	1981	1982
Beverage Dispensary Club	483	583	592	624	629
Commercial Carrier	51	61	62	66	66
Restaurant	64	78	79	83	84
Retail	181	218	222	234	236
Pub	351	424	431	454	458
Total	1	1	1	1	1
	1,131	1,365	1,387	1,462	1,474
On-Premise	780	941	956	1,008	1,016
Off-Premise	351	424	431	454	458

1. Department of Revenue: Alcohol Beverage Control Board

* The total number of Liquor License's was made available by the ABC Board. The distribution of license's by type was based on the percentage breakout for 1981 a year for which data on number of each type of license was available. Data on the exact type breakout for previous years was unavailable.

DEFINITIONS OF LICENSE TYPES:

Pub License - may sell beer and wine for consumption at a designated location on the premises of a campus of an accredited university or college.

Beverage Dispensary License - may sell for cash, or serve on the premises, beer, wine, and hard liquors for consumption on the premises only.

Club License - clubs, fraternal organizations and patriotic organizations that have state/national charter have the right to sell intoxicating liquor to members and families, but only in club rooms.

Common Carrier - may sell intoxicating liquors for consumption aboard a boat, aircraft or a railroad buffet car while in transit, and may sell intoxicating liquors while stationary if not prohibited by local ordinance.

Restaurant License - may sell beer and wine only, with meals.

Excluding wholesale licenses, there were 1474 liquor licenses in the State of Alaska in 1982. This amounts to 1 license for every 185 persons 19 years of age or older or 1 license for every 283 persons in Alaska.

Table 9a. Number of persons per license, Alaska , 1978-1982

	1978	1979	1980	1981	1982
ON PREMISE LICENSE'S	780	941	956	1008	1016
19+ Population	345	288	277	271	291
State Population	525	431	418	426	452
OFF PREMISE LICENSE'S	351	424	431	454	458
19+ Population	766	639	614	603	646
State Population	1168	957	928	947	1004
TOTAL LICENSE'S	1131	1365	1387	1462	1474
19+ Population	237	198	191	187	200
State Population	363	297	288	294	312
STATE POP. (000's) ¹					
19+ years 2	269	271	265	274	296
State Pop. 3	410	406	400	430	460

1. Department of Labor: Annual Population Statistics.
2. The number of state population aged 19 and over.
3. The entire state population.

Long Hours of Sale

Alaska statutes provide that "no person may consume, sell or give.... any liquor on any licensed premises between the hours of 5 A.M. and 8 A.M." Thus, liquor sale is permitted, at the maximum level, for twenty-one hours per day. These are some of the longest hours of sale in the entire United States. NOTE: Hours may be shortened by local option. Also, the sale of liquor is on a local-option basis, and may be prohibited in a given area altogether. Bar hours have been shortened by local vote in Juneau, Anchorage, Sitka, Kenai-Soldotna, Fairbanks and other communities.

No Prohibited Days of Sale

Except during the hours noted, liquor may be sold on any day of the week, including Sunday, except on election day, and then, liquor may be sold after the polls have closed.

Age Requirement

Alaska has reduced the age requirement for buying and consuming alcoholic beverages (beer, wine and distilled spirits) to nineteen years. The age requirement was raised to 21 effective January 1, 1984. A part of the legislation raising the drinking age allowed those who were 19 on or before January 1, 1984 to retain their drinking privilege.

Other

- Liquor advertising and advertising of liquor stores is permitted.
- Meals do not have to be served with alcoholic beverages, or on premises where alcoholic beverages are sold.
- Sale of alcoholic beverages in containers of any available size is allowed.
- Revised Title 04 permits local communities to reduce or limit availability of beverage alcohol.

Prevalence of Alcohol Abuse: Estimates of Persons with Alcohol-Related Problems, Problem Drinkers, and Alcoholics

Prevalence estimates attempt to quantify (1) the size of alcoholic population, or (2) the size of the population at risk of abusing alcohol, and who constitute, therefore, at risk of experiencing alcohol-related problems and alcohol-related disabilities (physical, mental or psychological, or social problems). Prevalence estimate procedures are based on such medical or social indicators as incidence of cirrhosis of the liver, alcoholism and cirrhosis of the liver mortality data, suicides, beverage alcohol consumption, alcohol-related arrests or alcohol-related accidents, and alcoholism treatment program client loads.

Two prevalence estimate procedures have been selected for use here, in order to make estimates based on current data of the "at-risk-population", and of need for alcoholism treatment services in Alaska. The first estimation procedure selected is the Marden method, which seeks to identify the number of persons with alcohol-related problems. The second estimation procedure selected is a modified version of the Jellinek formula, which seeks to identify the number of alcoholics in a discrete population. An estimate of problem drinkers, both adult and juvenile, based upon national problem drinker estimates, is included in this section, too.

A summary of the several prevalence estimates derived by these methods for the State of Alaska is set forth in Table 10.

Table 10. Prevalence Estimates, Alaska

ESTIMATED NO. OF ALCOHOLICS	ADULTS		TOTAL ADULTS
	Male	Female	
MURDEN FORMULA Persons with Alcohol - Related Problems, 1982	29262	6002	35282
JELLINEK FORMULA Alcoholics, 1980	11516	1968	13484

Before proceeding to the actual prevalence estimates, it is necessary to define the different groups to which these estimations relate.

PERSONS WITH ALCOHOL-RELATED PROBLEMS: Persons with alcohol-related problems are persons who are prospective clients of alcoholism treatment programs, because of the various problems they may be having with alcohol or which are caused by drinking alcohol.

ALCOHOLISM. Alcoholism is an addiction to alcohol. It is also defined as alcohol dependence syndrome by the World Health Organization and in the ninth revision of the International Classification of Diseases. Alcoholism is characterized by a compulsion to take alcohol on a continuous or periodic basis to experience is psychological and physical effects, and sometimes to avoid the discomfort of its absence. Tolerance may or may not be present.

PROBLEM DRINKER. A problem drinker is a person who drinks alcohol to an extent, or in any manner, that an alcohol-related disability is manifested. Therefore, the term problem drinker generally is applied to those who demonstrate problems in relation to drinking alcohol.

ALCOHOL-RELATED DISABILITY. Alcohol-related disability is a broad term that includes alcoholism but doesn't require that alcoholism be present. An alcohol-related disability exists when there is an impairment in the physical, mental or social functioning of an individual, so that it may be reasonably inferred that alcohol is part of the cause of that disability. Impairment includes actual health problems related to a specific drinking bout; offensive behavior caused by heavy drinking; injuries, death and property loss caused by accidents related to drinking; failure of the chronic excessive drinker to fulfill his or her roles in family or on the job; and mental problems such as depression and anxiety, related to drinking.

Marden Procedure for Estimation of Prevalence of Persons with Alcohol-Related Problems

The Marden procedure provides estimates of the probability of persons in various population sub-groups (sub-groupings by age, race, sex, or occupation, for example) of having a problem with alcoholism or alcohol abuse, i.e., the probability of occurrence of problem drinking for a given population segment. Actual population data for a discrete locale or area are classified according to the sub-groups for whom probability estimates are available, and the probabilities provided by the Marden method are applied to this population data. The method yields an estimate of the number of drinkers with alcohol-related problems in a given area, and for the various sub-populations included in the estimate. A modified version of the Marden method, which is based upon only the age and sex distribution of the population (race/ethnicity, and occupation, not being taken into account) is used here. Use of this version of the Marden procedure will necessarily reduce the precision of the estimate derived because socio-economic status (which is derived from occupational status in this method), and race/ethnicity, will not be considered; the results, however, will be more exacting than those obtained when the total population of an area is multiplied by a single figure.

MATRIX A
POPULATION 1982

AGE GROUP	MALE	FEMALE
0-19	84,574	81,089
20-29	55,577	50,406
30-39	45,911	39,449
40-49	26,580	21,916
50-59	16,914	15,314
60-69	7,249	6,575
70+	4,835	4,382
TOTAL	241,640	219,160

MATRIX B
PROBABILITIES FOR PROBLEM DRINKING (AGE-SEX ONLY)

AGE GROUP	MALE	FEMALE
0-19	.000	.000
20-29	.248	.020
30-39	.164	.079
40-49	.174	.068
50-59	.127	.019
60-69	.116	.012
70+	.014	.004

MATRIX C
NUMBER OF PERSONS WITH ALCOHOL-RELATED PROBLEMS IN POPULATION - 1982

AGE GROUP	MALE	FEMALE	TOTAL
0-19	0	0	0
20-29	13,783	1008	14,791
30-39	7,529	3,116	10,645
40-49	4,625	1,490	6,115
50-59	2,418	291	2,709
60-69	840	79	919
70+	67	18	85
TOTAL	29,262	6,002	35,282

Thus, the total prevalence estimate of persons with alcohol-related problems derived by the Marden procedure is 35,282.

Among other things, the Marden method assumes that there are no "drinkers with problems" in the under 20 year old population. This directly contradicts recent evidence on the rising amount of alcohol abuse among young people. According to Marden, the reason for his assumption in his prevalence estimation procedure is that no solid figures were available upon which to base probability estimates for young people, hence they were omitted from the procedure.

Finally, Marden has cautioned that the number produced in Matrix C should be interpreted in the light of several factors, which are unique to particular populations, or areas, and which can influence the quantitative estimates derived from the method, as follows: 1) youthful drinkers and drinking practices in a community or geographic region; 2) ethnicity -- there may be varying ethnic drinking practices in a community or region; 3) unemployment; 4) areas of rapid growth in a region, and in-migration of young persons in those age groups for which there is a high incidence of alcohol-related problems; and 5) urban/rural distribution of the population.

Modified Jellinek Procedure for Estimation of Alcoholics

The second procedure selected is a modified Jellinek estimation formula, which estimates, separately, the number of male alcoholics and the number of female alcoholics.

The Jellinek formula, as it originally appeared in the 1940's was

$$A = \left(\frac{PD}{R} \right) R, \text{ where}$$

A = total number of alcoholics alive in a given year

D = number of reported deaths from liver cirrhosis in given year

P = percentage of liver cirrhosis deaths attributable to alcoholism
(a presumed constant: .515 for males and .177 for females)

K = percentage of all alcoholics with medical complications who die of
cirrhosis of the liver (a presumed constant: .00694)

R = ratio of all alcoholics to those alcoholics with medical complications
(in the original Jellinek formula, R = 4)

In the version of the Jellinek formula adopted here, several of the constants
have been revised, as follows:

P = .628 for males This represents an increased percentage of
 = .216 for females the contribution of alcoholism to total
 deaths from cirrhosis of the liver.

R = 5.3 This represents a decreased proportion of
 alcoholics with medical complications.

The other constant factors remain as they were in the original formula.

Applied to Alaska data for six years -- 1975 to 1981 -- for which years
cirrhosis of the liver mortality data, by sex, is available, this version
of the modified Jellinek formula produces the following series of preval-
ence estimates:

Table 11. Cirrhosis Mortality, by Sex, and Estimated Number of
Alcoholics, Alaska, 1975-1981.

YEAR	CIRRHOSIS MORTALITY		NUMBER OF ALCOHOLICS		
	MALE	FEMALE	MALE	FEMALE	TOTAL
1975	25	24	11,990	3,956	15,946
1976	31	18	14,892	2,978	17,879
1977	16	18	7,637	2,978	10,615
1978	26	14	12,410	2,296	14,706
1979	22	20	10,500	3,280	13,780
1980	24	12	11,516	1,968	13,484
1981	20	18	9,597	2,978	12,575

Alcohol and Highway Safety

Motor vehicle traffic accidents are the largest cause of violent death in the United States today, and, at the national level, approximately one-half of the fatalities resulting from traffic accidents are alcohol-related. In addition, about one-third of the injuries resulting from motor vehicle traffic accidents show alcohol involvement.

Alcohol consumption causes degeneration of driving skills and impairment of good driving judgment, generally. Alcohol also impairs the visual function of glare recovery, and reduces the ability to detect objects in the peripheral visual field. These detrimental effects of alcohol are particularly hazardous for the driver under the influence of alcohol.

Alcohol-Involvement in Motor Vehicle Traffic Fatality Accidents, Alaska, 1975-1981.

Alcohol-involvement in motor vehicle fatality accidents has ranged from 45 percent to 73 percent during the past seven reported years (1975-1981). (MOTOR VEHICLE TRAFFIC ACCIDENT means all reported accidents involving a motor vehicle, or motor vehicles, and which occur on a trafficway, or which occur after the motor vehicle or vehicles ran off the trafficway, but before events are stabilized). See Table 12.

Table 12. Total Motor Vehicle Traffic Fatality Accidents, and Total Fatalities, and Motor Vehicle Traffic Fatality Accidents with Indication of Alcohol for One or More Drivers, Alaska, 1975 - 1982.

Year	1975	1976	1977	1978	1979	1980	1981	1982
Total Fatal Accidents	100	111	130	112	81	86	90	98
Accidents with Indication of Alcohol for one or more drivers: ⁽¹⁾								
Number.....	45	67	64	54	57	58	66	51
Percentage of Total	45.0	60.4	49.2	48.2	70.3	67.4	73.3	52.0
Total Motor Vehicle Traffic Fatalities	114	127	138	127	91	95	100	107
Alcohol Involvement in Fatalities	34	86	104	93	66	64	76	53

Table: 13 JUVENILE INVOLVEMENT IN FATAL ACCIDENTS/FATALITIES
AND ALCOHOL INVOLVMENT 1979-82

Driver Age	Fatal Accidents	Alcohol Accidents	Fatalities	Alcohol Fatalities
1979				
all ages	81 (23%)	57 = 70%	91 (25%)	69 = 75%
0 - 18	<u>17</u>	<u>11</u> = 64%	<u>20</u>	<u>13</u> = 65%
19	2	2 = 100%	2	2 = 100%
20	9	6 = 66%	11	8 = 72%
0 - 20	<u>28</u>	<u>19</u> = 67%	<u>32</u>	<u>23</u> = 71%
0 - 20 as % of all ages	34%	33%	35%	33%
1980				
all ages	86 (8%)	58 = 67%	95 (8%)	64 = 67%
0 - 18	<u>10</u>	<u>5</u> = 50%	<u>11</u>	<u>6</u> = 54%
19	2	1 = 50%	4	1 = 25%
20	3	1 = 33%	3	1 = 33%
0 - 20	<u>15</u>	<u>7</u> = 46%	<u>18</u>	<u>8</u> = 44%
0 - 20 as % of all ages	17%	12%	18%	12%
1981				
all ages	90 (26%)	66 = 73%	100 (23%)	76 = 76%
0 - 18	<u>13</u>	<u>11</u> = 84%	<u>18</u>	<u>16</u> = 88%
19	4	4 = 100%	4	4 = 100%
20	2	2 = 100%	3	3 = 100%
0 - 20	<u>19</u>	<u>17</u> = 89%	<u>25</u>	<u>23</u> = 92%
0 - 20 as % of all ages	21%	25%	25%	30%
1982				
all ages	98 (9%)	51 = 52%	107 (8%)	53 = 49%
0-18	<u>2</u>	<u>2</u> = 100%	<u>2</u>	<u>2</u> = 100%
19	5	5 = 100%	5	5 = 100%
20	2	2 = 100%	2	2 = 100%
0 - 20	<u>9</u>	<u>9</u> = 100%	<u>9</u>	<u>9</u> = 100%
0 - 20 as % of all ages	9%	17%	8%	16%
4 YEAR TOTAL				
all ages	355 (15%)	232 = 65%	393 (16%)	262 = 66%
0-18	<u>42</u>	<u>29</u> = 69%	<u>51</u>	<u>37</u> = 73%
19	13	12 = 92%	15	12 = 80%
20	16	11 = 69%	19	14 = 74%
0-20	<u>61</u>	<u>52</u> = 85%	<u>85</u>	<u>63</u> = 74%
0-20 as % of all ages	17%	22%	21%	24%

(%) = Of the total for all ages the % involving alcohol affected youth.

Total 1/7/83
Licensed Drivers 281,841

0 - 20
Licensed Drivers 8081 = 2.9%

Source: Highway Safety Planning Agency

Table 14. Total Arrests for Alcohol-Related Offenses, Alaska, 1979-1982

ARRESTS FOR ALCOHOL-RELATED OFFENSES	1979		1980		1981		1982	
	¹ NO.	%	¹ NO.	%	¹ NO.	%	¹ No.	%
Driving under the Influence	3,006	16.0	2,575	16.0	3,481	18%	4,988	26
Drunkenness	585	3.1	181	2.0	139	.1%	0	0
Liquor Law Violations	2,429	12.9	2,346	15.0	2,536	13%	2,781	14
Total Arrests for Alcohol-Related Offenses	6,020	32.1	5,102	32.9	6,156	34%	7,769	40
TOTAL ARRESTS, ALL OFFENSES	18,698	100.0	16,102	100.0	18,825	100%	19,485	100.0

¹ Percentage of Total Arrests, All Offenses.

Arrests for these directly alcohol-related offenses have increased approximately 30 percent during the four-year period 1979-1982 (from 6020 to 7769). The category which has shown the greatest increase is the liquor law violation arrests category. See Table 15.

Table 15. Alcohol-Related Offenses, Percentage Increase or Decrease, by Category, 1978-81.

OFFENSE CATEGORY	PERCENTAGE INCREASE OR DECREASE IN ARRESTS 1978-1981
Driving under the Influence	+ 6%
Drunkenness	-78%
Liquor Law Violations	+20%
TOTAL	+ 3%

Data is available for 1981 that allows the determination of fatal accident and fatality rates per 100 million miles driven. The fatal accident rate for Alaska is 3.40 compared to the national rate of 2.84. The fatality rate for Alaska is 3.74 compared to 3.74 compared to 3.18 for the national rate. Alaska's fatality accident and fatality rates per 100 million vehicle miles are 20% and 18% higher than the national averages. There are probably several factors affecting these higher rates alcohol certainly being one of them.

The Department of Public Safety, which is the source of all traffic safety information, also collects data on the circumstances, or factors, which have contributed to motor vehicle traffic fatalities (not accidents). Up to four factors may be reported by investigating officers as being contributory circumstances for any fatality. For the period 1979-1982 alcohol-involvement was the most frequently reported contributing circumstance in fatality accidents. See Table 13.

During the years 1979 - 1982, there were 355 fatal highway accidents resulting in 393 fatalities. Data from the Highway Safety Planning Agency shows that 65% or 232 of the fatal highway accidents were alcohol related, and 66% or 262 of the highway fatalities were alcohol related.

The proportion of alcohol relatedness for the 0-20 age group was significantly higher than the overall rate. The 0-20 age group was involved in 61 fatal accidents, 52 or 85% of which were alcohol related.

The 19 year old age group showed a markedly higher rate for the four periods than the other groups, 92% (12 of 13) of the fatal accidents and 80% (12 of 15) of the fatalities were alcohol related. The legal age for drinking during this period was also 19.

While accounting for only 2.9% of licensed drivers the 0-20 drivers were involved in 17% of fatal accidents, 22% of fatal alcohol related accidents, and in 21% of fatalities, 24% of alcohol related fatalities.

ALCOHOL AND CRIMINAL ACTIVITY

On the national level, criminal offenses which are, by definition, directly related to alcohol consumption -- driving under the influence, drunkenness, and liquor law violations -- accounted for 27 percent of all FBI-reported crime in 1977, 29 percent in 1978, 32 percent in 1979, 33 percent in 1980, and 34 percent in 1981. The largest number of these arrests were in the driving under the influence category (17%-18%), with liquor law violations as the next largest category of arrests (9%-13%). See Table 16

Table 16. Selected FBI Arrest Data, Alcohol-Related Offenses
Computed as a Percentage of All Reported Arrests,
United States, 1977-1982.

YEAR	DRIVING UNDER THE INFLUENCE	DRUNKEN- NESS	LIQUOR LAW VIOLATIONS	TOTAL
1982	24%	0%	7%	31%
1981	18%	.1%	15%	34%
1980	16%	2%	15%	33%
1979	16%	3%	13%	32%
1978	16%	3%	10%	29%
1977	17%	.9%	9%	27%

NOTE: Under the Uniform Crime Reporting Program of the FBI, the definition of alcohol-related offense in the three categories, above, are as follows:

DRIVING UNDER THE INFLUENCE: operating any motor vehicle or common carrier while drunk or under the influence of alcohol or narcotics.

DRUNKENNESS: all offenses of drunkenness or intoxication, with the exception of "driving under the influence."

LIQUOR LAW VIOLATIONS: state or local liquor law violations with the exception of "drunkenness" and "driving under the influence."

In Alaska, too, arrests for alcohol-related offenses constituted almost one-third of all reported arrests. At the state level, arrests in these three categories accounted for about 29 percent of all FBI-reported criminal arrests in 1978, about 32 percent in 1979, about 33 percent in 1980, 34 percent in 1981, and 31% in 1982. See Table 15.

In 1980, these liquor law violation arrests were distributed across the state as follows, see Table 17 A.

Table 17 A. Liquor Law Violations, by selected towns, Alaska, 1980

LIQUOR LAW VIOLATIONS BY TOWN	ARRESTS			PERCENTAGE
	ADULT	JUVENILE	TOTAL	
Anchorage	79	81	160	16%
Kodiak	56	11	67	7%
Sitka	29	84	113	11%
Juneau	94	166	260	26%
Soldotna	6	10	16	2%
Fairbanks	265	120	375	38%
TOTAL	529	472	991	100%

In 1981, offenses directly related to alcohol use constituted 37.5 percent of all male arrests; the comparable percentages for 1980 and 1979 were 32 percent and 32.3 percent, respectively. A similar proportion of female arrests were for directly alcohol-related offenses, amounting to 36.4 percent of all female arrests in 1981; 34 percent in 1980; and 31.3 percent in 1979. See Table 19.

For the period 1979-1981, about 18 percent of all male arrests were for the offense of driving under the influence; by comparison, only about 13 percent of all female arrests were for this offense. Equal proportions of male arrests and female arrests were for drunkenness, although the absolute number of male arrests in this category was much larger than the absolute number of female arrests, as was the case in the other alcohol-related offense categories. Of the three classes of directly alcohol-related offenses, the proportionately largest, for females, was the liquor law violation category, with arrests ranging from 14 percent to 21 percent of all female arrests for the period 1979-1981. See Table 19.

Table 19. Total Arrests, and Alcohol-Related Offenses, by Category and by Sex, Number and Percent of Total, Alaska, 1979-1981.

MALES/ARREST CATEGORY	1979		1980		1981	
	No.	%	No.	%	No.	%
Total Arrests	15,504	100.0	13,214	100.0	15,443	100.0
Total Alcohol-Related Arrests	5,019	32.3	4,129	32.0	5,795	37.5
Alcohol Related Arrests:						
DUI	2,599	16.7	2,240	17.0	3,012	19.5
Drunkenness	453	2.9	144	1.0	99	.6
Liquor Law Viol.	1,967	12.6	1,745	14.0	1,811	11.7
FEMALES/ARREST CATEGORY	1979		1980		1981	
	No.	%	No.	%	No.	%
Total Arrests	3,197	100.0	2,888	100.0	3,382	100.0
Total Alcohol-Related Arrests	1,001	31.3	973	34.0	1,234	36.4
Alcohol Related Arrests:						
DUI	407	12.7	335	12.0	469	13.8
Drunkenness	132	4.1	37	2.0	40	1.1
Liquor Law Viol.	462	14.4	601	21.0	725	21.4

DUI = Driving under the Influence

When alcohol-related arrests are analyzed in terms of the adult or juvenile status of the arrestee, noticeable age-related differences can be noted. For each year during the period 1979-1982, approximately 97 percent of all driving under the influence arrests occurred among adults. Most drunkenness arrests involved adults, too; the proportion of drunkenness arrests varied from 92 percent in 1979 to 99 percent in 1981. Arrests for liquor law violations were more equally distributed between adults and juveniles; juveniles accounted for roughly one-half of all the liquor law violation arrests over this period. See Table 20.

Table 21. Total Arrests, and Alcohol-Related Offenses, by Adult/Juvenile Status, Number and Percent of Total, Alaska, 1980-1982.

ADULTS/ARRESTS BY OFFENSE	1980		1981		1982	
	No.	%	No.	%	No.	%
Total Arrests	10,533	100.0	12,697	100.0	14,320	100.0
Total Alcohol- Related Arrests	3,830	37.0	4,636	36.5	5,970	41.4
Alcohol Related Arrests:						
DUI	2,484	24.0	3,384	26.6	4,465	31.2
Drunkenness	175	.2	125	.1	0	0.0
Liquor Law Viol.	1,171	12.0	1,127	8.9	1,465	10.2
JUVENILES/ARRESTS BY OFFENSE	1980		1981		1982	
	No.	%	No.	%	No.	%
Total Arrests	5,569	100.0	6,128	100.0	5,165	100.0
Total Alcohol- Related Arrests	1,272	23.0	1,520	24.8	1,489	28.7
Alcohol Related Arrests:						
DUI	91	2.0	97	1.5	123	2.3
Drunkenness	6	1.0	14	.02	0	.0
Liquor Law Viol.	1,175	21.0	1,409	22.9	1,366	26.4

When alcohol-related arrests for the year 1982 are analyzed in terms of the race/ethnic category of the arrestee, it appears that the distribution of arrests for driving under the influence corresponds to the racial/ethnic distribution of the general population of the State, that is, approximately 82 percent of the arrestees were Caucasian; approximately 2 percent were black; and about 15 percent were Alaska Natives (Aleuts and Eskimos), Alaska Indians (Tlingit-Haida and Athabascan Indians), and other minority group members. Data for the three years are very similar; therefore, only 1980 data are presented here. See Table 22.

Table 22. Alcohol-Related Arrests, by Type and by Race/Ethnicity, Number and Percent Distribution, Alaska, 1982.

RACE/ETHNICITY	DRIVING UNDER THE INFLUENCE		LIQUOR LAW VIOLATIONS		TOTAL	
	NO.	%	NO.	%	NO.	%
Caucasian	3,769	82.1	1,236	43.6	5,005	67.4
Black	87	1.9	19	.7	106	1.4
Native	697	15.2	1,568	55.3	2,265	30.5
Other	35	<1.0	10	1.4	45	<1.0
TOTAL	4,588	100.0	2,833	100.0	7,421	100.0

Distribution of liquor law violation offenses among the state's racial/ethnic groups, however, does not correspond at all to the racial/ethnic distribution of the general population. Arrests of Caucasians amounted to only about 44 percent of the total; arrests among Blacks amounted to approximately .7 percent of the total; while arrests of Alaska Natives, Alaska Indians and other minority group members constituted about 55 to 57 percent of these liquor law violation arrests. See Table 22.

NOTE: The Alaska Native (Aleut and Eskimo), Alaska Indian (Tlingit/Haida and Athabascan Indians), and other minority groups (Filipino, Chinese, Japanese, Spanish-surnamed and Other) have been treated in the aggregate here because of a peculiarity in the original raw data, the source of which is the Criminal Justice Planning Agency. Namely arrests data relating to Eskimos have been included in the Criminal Justice Planning Agency "Other" category, even though the Eskimo racial/ethnic group was estimated to have constituted approximately 9.3 percent of the total population of the State of Alaska in 1980, and apparently, constitutes a sizeable proportion of the arrestees in certain offense categories.

This practice, i.e., grouping Eskimos with other minorities, cannot be justified, as the Eskimo group is a major population sub-group, and, needless to say, has limited analysis severely in terms of the Eskimo group itself, and also in terms of the other included minority groups.

The total role of alcohol in crime is underestimated if only crimes with direct alcohol-involvement (by virtue of the definition of the crime charged) are considered; that is, driving under the influence, drunkenness, and liquor law violations. Alcohol can also be involved in the formulation of other crimes, in the commission or in the aggravation of the actual crime committed, for example, crimes such as assault, homicide, rape and property crimes; and alcohol can affect the outcome of the criminal act. Empirical data for Alaska for these other categories of crime which have alcohol involved in their formulation, or commission, are not available now.

There has been data developed by the Alaska Judicial Council that indicate alcohol as being heavily involved in all Alaskan crime. See data below.

REPLICATION OF TABLE VIII. (pg. 47) AND TABLE XVII (pg. 75)
ALASKA FELONY SENTENCES: 1980 ALASKA JUDICIAL COUNCIL DECEMBER 1982

Frequency Of Use Of Drugs And/Or Alcohol At Time Of
Offense For Five Offense Classes*
(Both Urban And Rural Courts---1980)

NOTE: ALL PERCENTAGES ARE COMPUTED ACROSS THE ROWS USING ROW TOTALS AS "N"

Class Of Offense	Total Cases	Used Drugs	Used Drugs and Alcohol	Used Alcohol	No Use
1. MURDER/KIDNAPPING	U = 14 R = 4		21.4% (3)	78.6% (11) 100.0% (4)	
	T = 18		21.4% (3)	83.6% (15)	
2. VIOLENT FELONIES	U = 142 R = 142	2.1% (3) 1.4 (2)	4.2% (6) 4.9% (7)	65.5% (93) 80.1% (113)	28.2% (40) 13.6% (20)
	T = 284	1.8% (5)	4.6% (13)	72.5% (206)	21.1% (60)
3. PROPERTY OFFENSES	U = 195 R = 151	2.6% (5) 2.6% (4)	2.6% (5) 5.3% (8)	46.25 (90) 55.6% (84)	48.6% (95) 36.55 (55)
	T = 346	2.6% (9)	3.8% (13)	50.3% (174)	43.3% (150)
4. FRAUD OFFENSES	U = 24 R = 16		12.5% (3)	12.5% (3) 6.3% (1)	75.0% (6) 93.7% (15)
	T = 40		12.5% (3)	10.0% (4)	52.5% (21)
5. "OTHER" OFFENSES	U = 9 R = 13	11.1% (1)	15.4% (2)	22.2% (2) 46.2% (6)	33.3% (6) 38.4% (5)
	T = 22	11.1% (1)	15.4% (2)	36.4% (8)	50.0% (11)
TOTAL	U = 384 R = 326	2.3% (9) 1.8% (6)	4.4% (17) 5.2% (17)	51.8% (199) 63.8% (208)	38.3% (147) 29.1% (95)
	T = 710	2.1% (15)	4.8% (34)	57.3% (407)	34.1% (242)

U = Urban, R = Rural, T = Total

Alcohol-Related Mortality

Three causes of death are generally regarded as being "directly alcohol-related"; these causes of death are alcoholism, cirrhosis of the liver, and alcoholic psychosis. Alaska data for alcoholism and cirrhosis of the liver will be analyzed in this section.

In 1979 and 1980, both cirrhosis of the liver and alcoholism were included in the ten leading causes of death for Alaska. See Table 24.

Table 24. Deaths Attributable to Cirrhosis of the Liver and Alcoholism, Compared with Other Leading Causes of Death, Alaska, 1979-80.

CAUSE OF DEATH	NO. OF DEATHS		% OF TOTAL		RANK ORDER	
	1979	1980	1979	1980	1979	1980
Accidents	377	348	23.5	20.6	1	2
Heart Disease & Hypertension	338	389	21.1	23.1	2	1
Malignant Neoplasms	272	293	16.9	17.3	3	3
Suicide	53	72	3.3	4.3	6	4
Cerebrovascular Disease	74	64	4.6	3.8	4	7
Diseases of Early Infancy	70	67	4.4	4.0	5	5
CIRRHOSIS OF THE LIVER	42	36	2.6	2.1	8	8
Homicide	48	33	2.9	2.0	7	9
Congenital Abnormalities	30	67	1.9	4.0	9	5
ALCOHOLISM	13	16	.1	.9	10	10
All Other Causes	287	138	17.9	8.1	--	--
TOTAL ALL CAUSES	1,604	1,689	100.0	100.0	--	--

One hundred percent of alcoholism deaths are attributable to excessive alcohol consumption. With respect to cirrhosis of the liver deaths, it has been estimated that approximately 41 to 95 percent of all these deaths are due to excessive alcohol consumption.

NOTE: ICD-9 codes for alcoholism not frequently recorded when appropriate due to family or social pressures and transitory nature of the population.

About 23 percent of all alcoholism deaths in Alaska occurred in the 15 to 44 year old age group during the years 1977, 1978, 1979. See Table 25.

Table 25. Alcoholism Deaths, by Age Group, Number and Percent Distribution, Alaska 1977, 1978, 1979.

AGE GROUP	1977		1978		1979	
	NO.	%	NO.	%	NO.	%
Under 14	0	---	0	---	0	---
15 - 24	0	---	1	5.8	0	---
25 - 34	3	9.7	1	5.8	1	7.6
35 - 44	6	19.4	6	35.6	2	15.4
45 - 54	6	19.4	5	29.4	5	38.5
55 - 64	7	22.6	2	11.7	4	30.8
65+	9	29.0	2	11.7	1	7.6
TOTAL	31	100.0	17	100.0	13	100.0

When alcoholism deaths are analyzed according to the race of the decedent, it appears that Caucasians are underrepresented compared to their representation in the general population, and underrepresented, too, in terms of their share of total resident deaths. See Table 26.

Table 26. Alcoholism Deaths, by Race/Ethnicity, Number and Percent Distribution, Alaska, 1977, 1978, 1979

RACE/ETHNICITY	1977		1978		1979	
	NO.	%	NO.	%	NO.	%
White	12	38.7	7	41.1	4	30.7
Alaska Native and Alaska Indian:	13	41.9	10	58.9	6	46.0
Eskimo	5	16.1	4	23.5	2	15.3
Aleut	1	3.2	1	5.8	2	15.3
Alaska Indian	7	22.6	5	29.6	2	15.3
Other:	6	19.4	0	---	3	23.0
American Indian	4	12.9	0	---	2	15.3
Black	2	6.5	0	---	1	7.7
Other Minorities	0	---	0	---	0	---
TOTAL	31	100.0	17	100.0	13	100.0

Table 27. Total Resident Deaths, by Race/Ethnicity of the Decedent, Alaska, 1977, 1979.

RACE/ETHNICITY	1 9 7 7		1 9 7 8		1 9 7 9	
	ABSOLUTE FREQUENCY	RELATIVE FREQUENCY	ABSOLUTE FREQUENCY	RELATIVE FREQUENCY	ABSOLUTE FREQUENCY	RELATIVE FREQUENCY
White	1,090	67.9	1,186	69.8	1,074	67.0
Eskimo	197	12.3	230	13.5	244	15.2
Aleut	50	3.1	48	2.8	53	3.3
Alaska Indian	148	9.2	135	8.0	159	9.9
Amer. Indian	52	3.2	14	.8	4	0.2
Black	50	3.1	46	2.6	31	1.9
Chinese	1	0.1	1	.1	0	---
Japanese	1	0.1	7	.4	6	0.4
Filipino	9	0.6	9	.5	4	0.2
Other	5	0.3	6	.4	6	0.4
Not Stated	3	0.2	4	.2	9	0.6
TOTAL	1,606	100.0	1,686	99.1	1,590	100.0

NOTE: It should always be remembered that reporting of causes of death on death certificates can be inaccurate in the sense that there may be a reluctance to report certain causes of death on the certificates which have other legal uses different from, and in addition to, their vital statistics function. Alcoholism may be considered as one of the causes of death which may not be reported in all cases with 100 percent accuracy.

Cirrhosis of the Liver Mortality

The liver is the organ most significantly involved with processing alcohol in the body, and, therefore, is often most seriously damaged by heavy drinking and alcohol abuse. Alaska's death rate from cirrhosis of the liver is lower than that of the United States. This lower rate is, in part, a function of the younger age of the Alaska population, which means lower death rates for chronic illnesses, including cirrhosis of the liver. Nevertheless, cirrhosis of the liver was the eighth leading cause of death in Alaska in 1977 and 1979.

Cirrhosis of the liver deaths are concentrated most heavily in the 35-64 year old age group. See Table 28.

Table 28. Cirrhosis of the Liver Deaths, by Age Group, Number and Percent Distribution, Alaska, 1977, 1978, 1979, 1980, 1981

AGE GROUP	1 9 7 7		1 9 7 8		1 9 7 9		1 9 8 0		1 9 8 1	
	NO.	%	NO.	%	NO.	%	NO.	%	NO.	%
14 and Under	0	---	1	2.5	0	---	0	---	0	---
15 - 24	0	---	0	0	1	2.4	0	---	0	---
25 - 34	2	5.4	3	7.6	7	16.6	3	8.3	5	13.2
35 - 44	7	18.9	11	28.2	9	21.4	7	19.4	7	18.4
45 - 54	16	43.2	9	23.1	5	11.9	15	41.6	10	26.3
55 - 64	11	29.7	13	33.3	2	28.6	8	22.2	7	18.4
65+	1	2.7	2	5.1	8	19.0	3	8.3	9	23.7
TOTAL	37	100.0	39	100.0	42	100.0	36	100.0	38	100.0

As in alcoholism deaths, members of the Caucasian group appear to be slightly underrepresented in cirrhosis of the liver deaths, as compared to their representation in the general population of the state, and in comparison to their share of total resident deaths. See Table 29.

Table 29. Cirrhosis of the Liver Deaths, by Race/Ethnicity, Number and Percent Distribution, Alaska, 1978-1980.

RACE/ETHNICITY	1978		1979		1980	
	NO.	%	NO.	%	NO.	%
White	25	65.0	26	62.0	22	61.0
Alaska Native & Alaska Indian	1	2.5	NR	NR	1	3.0
Other	13	32.5	16	38.0	13	36.0
Total	39		42		36	

Non-white women appear to be a population sub-group particularly at risk: liver cirrhosis has been one of the categories of alcohol-related diseases and death in which these women are dying approximately the same numbers as men. For 1978-1980 data, see Table 30.

Table 30. Deaths Attributable to Cirrhosis of the Liver, by Sex, Alaska 1978-1980.

YEAR	RACE	MALE	FEMALE
1980	White	16	6
	All Other	8	6
	TOTAL	24	12
1979	White	18	8
	All Other	4	12
	TOTAL	22	20
1978	White	18	8
	All Other	8	6
	TOTAL	26	14

Table 30 shows that it is non-white women who are causing the high mortality figures for members of the female sex; furthermore, in absolute numbers, it appears that there were more non-white women than non-white men dying of cirrhosis of the liver during these years.

Other Alcohol-Related Mortality

Many other deaths may be directly or indirectly due to excessive alcohol use. These deaths include suicides, homicides, accidents of all sorts, and other acute and chronic diseases, for example, cardiovascular and gastrointestinal disease, and cancer.

The proportion of these deaths which can be attributed to alcohol use has not been determined for all categories of death, but an effort has been made to discover the involvement of alcohol in several of the categories of accidental death, for the years 1977-1981. The categories of accidental death which have been selected for study are 1) exposure to environmental factors -- deaths from excessive cold, and 2) fire deaths.

Exposure to Environmental Factors: Deaths from Alcohol and Excessive Cold

Alaska is famous for the extremely cold climate in its northern regions. Unfortunately, alcohol in combination with this excessive cold is taking its toll in terms of human life. See Table 31.

Table 31. Accidental Deaths Due to Natural and Environmental Factors and Deaths Due to Excessive Cold, and Alcohol-Related Excessive Cold Deaths, Alaska, 1977, 1978, 1979, 1980.

	1977	1978	1979	1980
Total Deaths Due to Natural and Environmental Factors	16	14	18	14
Total Deaths Due to Excessive Cold	12	8	17	8
Number of Alcohol-Related Excessive Cold Deaths, Natural and Environmental Factor	14	6	8	4

NOTES: NATURAL AND ENVIRONMENTAL FACTORS = excessive cold, exposure, hunger, animal bites, etc.

EXCESSIVE COLD = includes exhaustion, exposure to cold, freezing, and frostbite.

Accidental Death: Fire Fatalities and Alcohol

Nationally, it is believed that a considerable portion of the loss of life caused by fires may be attributed to the misuse of alcohol. It is alcohol's impairment of sensory, judgmental, and physical functions, and its resultant negligent conduct, that causes it to be a major cause of fire deaths. Furthermore, the failure of alcohol-impaired parents, and other adults, in the home, to be able to perceive, and respond to, a fire emergency, or the failure of parents/other adults, when drinking outside the home in which there are children, to leave children attended by an adult, or some other responsible persons, are considered as alcohol-related fire fatalities.

For Alaska, the State Fire Marshal's best current estimate of alcohol-involvement in Alaska fire fatalities is that approximately 85 percent of all fire fatalities during a prior three-year period (unspecified years) were alcohol related.

Turning to the three years of specific data available from the Fire Marshal's office, it appears that alcohol was involved in 46 percent of all fire fatalities in 1979, in 48 percent of all fire fatalities in 1979, and in 48 percent in 1981. See Table 32.

Table 32. Total Number of Deaths by Fire, and Number of Deaths by Fire Which Were Alcohol-Related, Alaska, 1979-1981.

YEAR	TOTAL NUMBER OF DEATHS BY FIRE	ALCOHOL-RELATED DEATHS BY FIRE
1979	26	12
1980	23	11
1981	27	13

Alaska's fire fatality rate, per 1,000,000 population is the highest in the nation, and, is triple the United States rate. See Table 33.

Table 33. Fire Fatalities per 1,000,000 Population, Alaska and United States, 1981.

Area	FIRE FATALITIES PER MILLION POPULATION
Alaska	65.85
United States	19

It is entirely possible that Alaska's extremely high estimated alcohol-involvement in fire fatalities, i.e., approximately 50 percent of all fire fatalities on the average annually, for the past two years, is partially, or entirely, the reason for the excessive fire fatality rate, per 1,000,000 population, as compared to the United States rate.

Direct Social Response to Alcohol and Drug Problems: Alcohol and Drug Treatment Programs.

Approximately 13004 admissions were submitted by thirty-five alcohol and drug programs to the Office of Alcoholism and Drug Abuse during the one year period from October 1, 1982 to September 30, 1983. These records represent 9681 unduplicated clients. Many of the duplicated client intakes are for detoxification and emergency services. The provision of these services are mandated by the statutes establishing the State Office of Alcohol and Drug Abuse and by their nature will result in a high number of duplicated services. When the data are examined on the Health Systems agency level, there appeared to be a slightly disproportionate distribution of client admissions across the State. It appeared that Southeast is over-represented, that Southcentral is under-represented, and that parity exists in Northern Alaska.

See Table 34 for distribution of population by region compared to client admissions by region.

Table 34. Statewide Populations by Regions and Total Admissions by Region Compared to Client Admissions by Region. 1982-1983.

	Population		Admissions	
		%		%
Southeast	59201	12.8	2224	17.1
Southcentral	318477	69.1	8272	63.6
Northern	83159	18.1	2508	19.3
TOTAL	460837	100	13004	100

About 74% of all admissions were males, and about 2.6% were females. This 2.8 to 1 ratio of males to females was consistent throughout the State. By comparison, the composition of the total State resident population, was 54% male and 4.6% female. See Table 35.

Table 35. Total Clients by Sex.

	Male		Female	
		%		%
1. Statewide	9597	74%	3414	26%
2. Southeast	1644	74%	589	26%
3. Southcentral	6093	73%	2155	27%
4. Northern	1860	74%	670	26%

Approximately 51% of the client population was composed of Alaska Natives (Eskimo, Aleut, Tlingit, Haida, Athabaskan, and American Indians) about 44% of the clients were White and 1% were Black. These percentages reflect client population composition on a Statewide basis, there was considerable variation in the racial/ethnic composition of the clientele on a regional basis. This corresponds to the distribution of the various racial/ethnic groups across the State. See Table 36.

Table 36. Total Admissions by Race/Ethnicity.

	Caucasian		Alaska Indian		Eskimo		Black		Other		Total
1. Statewide	5711	44%	2914	22%	3812	29%	180	1%	387	4%	13004
2. Southeast	1089	49%	1004	45%	26	1%	9	4%	96	4%	2224
3. Southcentral	3682	45%	991	12%	3215	40%	147	2%	237	3%	8272
4. Northern	940	38%	919	37%	571	23%	24	1%	54	2%	2508

It appears from this data that Alaska Natives are significantly over-represented (51%) in the client population of alcoholism and drug treatment relative to their representation (18%) in the State's total resident population.

During this period 72% of the clients were between the ages of 18 to 40, whereas only 43% of the State's resident population falls into this age classification. About 3% of the client population was aged 61 years and older, while at the other end of the age scale 4% of the client population was in the 17 years and younger age group. See Table 37.

Table 37. Total Clients by Age.

	17 & Under		18-25		26-40		41-60		61+	
1. Statewide	508	4%	3459	27%	5798	45%	2642	20%	385	3%
2. Southeast	113	5%	691	31%	921	41%	410	18%	52	2%
3. Southcentral	331	4%	2180	269%	3686	45%	1636	20%	240	3%
4. Northern	64	3%	588	23%	1191	48%	596	24%	93	4%

On the basis of 12438 admission records, approximately 44% of them were recorded as readmissions to alcohol and drug programs. This readmission rate indicates that a number of clients were admitted to treatment more than once. This high readmission rate is greatly affected by detoxification components of programs, and is less typical of other components.

Table 38. Total Admissions by New Client and Client Readmission

	New Client Admissions		Client Readmissions		Total	
1. Statewide	6996	56%	5442	44%	12438	100%
2. Southeast	1193	56%	882	44%	2075	100%
3. Southcentral	4564	58%	3380	42%	7944	100%
4. Northern	1239	50%	1240	50%	2480	100%

There were also 12438 clients for whom level of educational attainment was reported, 40% had a high school education, or an equivalency degree, i.e., G.E.D. Another 48% had not attained the level of a high school education, while approximately 12% had had some college, or had received a college degree. The educational levels for clients was consistent for the regions as shown in Table 39.

Table 39. Percent of admissions and terminations by years of education and occupation. Statewide and Regionally.

Education Years	Statewide Percent	Southeast Percent	Southcentral Percent	Northern Percent
9 or Less	17%	11%	18%	20%
10-11	31%	34%	31%	31%
12	28%	27%	25%	28%
13-14	8%	9%	9%	7%
15-16	3%	4%	3%	2%
17+	1%	1%	1%	1%
GED	12%	15%	13%	11%

The majority of clients for whom present occupation was reported (N=12438) stated that they were "blue collar" workers, that is, by occupation, they were employed in crafts, labor, fishing, logging and farming. See Table 40.

Table 40. Clients by Occupation.

Occupation	Statewide	Southeast	Southcentral	Northern
Technical/Professional	12%	9%	8%	9%
Sales	2%	2%	2%	2%
Craftsman/Clerical	19%	17%	12%	15%
Transport/Operators	6%	5%	3%	7%
Laborers	23%	18%	14%	28%
Fishing/Logging/Farming	13%	19%	9%	1%
Services	12%	11%	8%	11%
Substance	2%	1%	1%	4%
Student	5%	4%	3%	4%
Military	1%	1%	1%	1%
Homemaker	4%	5%	4%	3%

Based upon 12,883 admissions for which legal status was determined at admission it appears that approximately 38% of admissions are as the result of involvement with the Alaska legal system. Further 34% of those admitted had been or were incarcerated immediately prior to treatment. See Table 41.

Table 41. Admissions by Legal Status Statewide.

NO	Deferred	Sentance	Probation	Furlough
Involvement	Prosecution	Deferred	Parole	Rehab./Leave
4,635	333	503	3,448	98
36%	3%	4%	27%	1%

Involuntary	Status		
Committment	Incarcerated	Unknown	Total
131	321	3,414	12,883
1%	2%	26%	100%

Of the 12711 admissions for which primary problem and severity of problem were determined, alcohol was clearly identified as the leading primary problem in 94% of admissions. The only other substances to exceed 1% of the admissions were cocaine, marijuana/Hashish each accounting for 2%. In only 11% of the admissions was the severity identified as non-dependent. The severity was rated as dependent in 37% and as episodic in 37% of admissions.

Table 42. Statewide Admissions by Primary Problem. (N= 12711)

Substance	Number	%	Substance	No.	%	Substance	No.	%
Alcohol	11886	94%	Barbituates	8	=	Amphetamines	11	=
Heroin	99	1%	Tranquilizers	11	=	Cocaine	234	2%
Methadone	1	=	Sedatives/Hypnotics	8	=	Marijuana/Hashish	265	2%
Other Opiates	109	1%	Inhalents	3	=	Hallucinogens	6	=
PCP	0	=	Over the Counter	4	=	Poly Drug	59	=

= Less than 1 percent

Table 43. Severity of Problems.

	Non Dependent	Dependent	Episodic	Psyfunctional	Unknown
Number	1358	4716	4736	798	1170
%	11	37	37	6	9

Indirect Social Response to Alcohol Problems: Mental Health Community

Mental Health Centers

Community Mental Health Centers (CMHCs) are state-operated mental health centers which serve Alaska's population on an outpatient basis at the community level. Community services include diagnosis, rehabilitation, prevention and education.

In FY 1981, there were 4,089 admissions to CMHCs and in 1982 there were 5,033. According to the Division of Mental Health and Developmental Disabilities, increased utilization of alternative resources in the community, including community alcoholism treatment programs, is reflected in the current leveling-off trend in CMHC admissions.

Upon admission, the mental health professional involved a patient's case reports the principal reason why the patient is seeking the services of the CMHC. The following table indicates the relative importance of "alcohol abuse" as a factor contributing to CMHC admissions. It appears from these data that "alcohol abuse" is the third leading factor contributing to all CMHC admissions in Alaska. See Table 44.

Table 44. Presenting Problem at Admission, Community Mental Health Centers, Alaska, FY 81 and FY 82.

PRESENTING PROBLEM	CMHC ADMISSIONS FY 81		CMCH ADMISSIONS FY 82	
	NUMBER	% OF TOTAL	NUMBER	% OF TOTAL
Life Crisis	2,852	74.5	3,582	71.1
Mental Illness	610	15.9	531	10.5
Alcohol Abuse	246	6.4	324	6.4
Mental Retardation	32	0.8	40	0.7
Drug Abuse	32	0.8	34	0.6
Not Stated	317	8.0	522	8.3
TOTAL	4,089	100.0	5,033	100.0

NOTES: (1) Each category of presenting problem is defined by the American Psychiatric Association (APA) Diagnostic Codes. (2) "Mental Illness" should be viewed as a specific mental disorder, while "life crisis" is a reaction to a given situation which does not necessarily have psychiatric implications.

In addition to "presenting problem" specification, a provisional diagnosis, according to APA Diagnostic Codes, is made for each patient at admission. "Alcohol disorders" constituted 6.4 percent of all such provisional diagnoses in FY 1981. "Alcohol disorder" diagnoses were assigned to 14 percent male admissions, and to 4 percent of female admissions in FY 1981 and to 14.6 percent of males and 6.3 percent of females in 1982. The numbers of individuals admitted to CMHCs, by race and sex, with a provisional diagnosis of "alcohol disorder" is set forth in the following table. See Table 45.

Table 45. Provisional Diagnosis of Alcohol Disorder, by Race and Sex, Community Mental Health Centers, Alaska, 1981-82.

RACE/ETHNICITY	1981			1982		
	TOTAL ADM.	ALCOHOL DISORDER NUMBER	PERCENT	TOTAL ADM.	ALCOHOL DISORDER NUMBER	PERCENT
MALE						
Caucasian	1,102	92	9.0	1,133	126	11.1
Indian, Eskimo, Aleut	263	101	39.0	256	79	37.1
Black	29	0	0	29	2	6.9
Other	16	0	0	31	6	19.4
TOTAL	1,410	198	14.0	1,449	213	14.6
FEMALE						
Caucasian	1,579	38	3.0	1,481	68	4.6
Indian, Eskimo, Aleut	226	39	18.0	285	48	16.8
Black	41	0	0	38	0	0
Other	27	0	0	55	2	3.6
TOTAL	1,873	77	4.1	1,859	118	6.3

NOTE: "Alcohol Disorder" diagnoses as percentage of all admission diagnoses, for each racial/ethnic group, and for total admissions, by sex.

More male than female admissions to CMHCs fell into the "alcohol disorder" diagnostic category. Members of the Alaska Native, i.e., Eskimos, Aleuts, and Alaska Indian, groups were admitted to CMHCs with the provisional diagnosis "alcohol disorder" more frequently, on a more proportionate basis, than were Caucasians, and this was true for both sexes.

Bush/Non-Bush CMHCs

When CMHCs are classified as "bush" or "non-bush" programs, differences appear as between the two types of programs with respect to "alcohol abuse" as a presenting problem, and "alcohol disorder" as a discharge diagnosis. ("Bush", in Alaska, means the vast area outside of cities which encompasses most of the State.)

"Bush" programs include the following CMHCs: Kotzebue, McGrath, Tanana Chiefs (serving Fort Yukon, Bettles, and Galena), Bethel, Dillingham, and Nome. "Non-bush" programs include CMHCs in Juneau, Ketchikan, Sitka, Fairbanks, Anchorage, Copper Center, Cordova, Homer, Kenai, Kodiak and Seward.

"Drug disorders" constituted .8 percent of all provisional diagnosis for FY 1981 and .6 percent in 1982. Drug disorder diagnosis were assigned to 1.7% of males and .7% of females in FY 1981 and to 2.9% of males in FY 1982. This is illustrated in Table 45A.

Table 45A. Provisional Diagnosis of Drug Disorder
by Race and Sex, CMHC, FY 80-82.

Race/Ethnicity	Total Adm.	1980		Total Adm.	1981	
		Drug Disorder Number	%		Drug Disorder Number	%
Male						
Caucasian	1102	18	1.6	1133	35	3.1
Indian, Eskimo	263	6	2.3	256	6	2.3
Aleut						
Black	29	0	0	29	1	3.4
Other	16	0	0	31	0	0
Total	1410	24	1.7	1431	42	2.9
Female						
Caucasian	1379	11	.7	1481	19	1.3
Indian, Eskimo	226	1	.4	285	6	2.1
Aleut						
Black	41	1	2.4	38	1	2.6
Other	27	0	0	55	0	0
Total	1873	13	.7	1859	26	1.4

More male than female admissions to CHMCS fell into the "drug disorder" diagnostic category. Members of the male group were admitted at a higher rate as were blacks.

State Mental Hospital and Community Mental Health Center Data

A state's mental hospital(s), and community mental health centers, as well as its drug treatment programs, deal directly with drug users by providing specific treatment for drug addiction and/or supportive medical services for drug-associated physical illnesses.

The Alaska Psychiatric Institute (API), the State's one public mental hospital, is a state mental inpatient facility in Anchorage that provides services not available on a community level, i.e., not available at local Community Mental Health Centers. The Alaska Psychiatric Institute, which has a statewide catchment area, provides inpatient care to persons who are mentally ill, who are a danger to themselves, or who require 24-hour intensive psychiatric treatment.

An individual's condition is diagnosed by a mental health professional following admission to API. Admission data for API supplied by the Alaska Division of Mental Health and Developmental Disabilities indicate that twenty-nine (29), or 2.6 percent, of the 1087 people admitted to API in FY 82 (July 1, 1981 to June 30, 1982) were given a provisional diagnosis of drug abuse. There were 131 admissions for alcohol abuse, or 12.1 percent of total admissions.

Analysis of these data is limited, in the Division's statistical output, to sex and race variables; these drug abuse diagnoses are not classified by drug type, or by age group. Of these admissions for drug abuse, 16 (66 percent) were male, and 13 (44 percent) were female. Caucasian males constituted by far the largest proportion of drug abuse provisional diagnoses. Caucasian females were the next largest group.

Of the admissions for alcohol abuse, 93 (or 71 percent) were male and 38 (29 percent) were female. Caucasian and Native males were the group most highly represented. See Table 48.

Table 48. API Provisional Diagnosis of Alcohol/Drug Abuse by Sex and Race, FY 1982.

Race			Total		% of API Admits			Total		% of API Admits
	Male	Female	No.	%		Male	Female	No.	%	
Caucasian	9	7	16	55	1.4	66	20	86	63	7.9
Alaska Native	5	4	9	31	.8	23	18	51	36	4.7
Black	2	0	2	7	.1	3	0	3	.2	---
Other	0	2	2	7	.1	1	0	1	.1	---
Total	16	13	29	100	2.8	93	38	111	100	12.9

Criminal Justice - Drug Arrests

Narcotic arrests increased in absolute numbers and increased as a proportion of total arrests between 1977 and 1982. As a percentage of total arrests, narcotics arrests increased 28 percent between the periods 1977 and 1982. In 1977-79, narcotics arrests accounted for 11.6 percent of all drug arrests, while in 1981-82 this category constituted 25 percent of total drug arrests.

Table 49. Narcotics Arrests 1977-1982.

OFFENSE	1977	1978	1979	1980	1981	1982
Possession	60	56	47	30	66	129
Sale	47	35	56	30	45	209
TOTAL	107	91	103	60	111	338
Total Drug Arrests	969	884	740	533	669	998
Narcotics as % of Total	11.0	10.3	13.9	11.2	16.5	33.9

NOTE: The drug included in the narcotic category are opium, cocaine, heroin or its derivatives. The recent popularity of cocaine has had a substantial affect on the increase in this category.

The age group accounting for a major proportion of drug arrests is the 18 and under year old age group, 55 percent of all arrests in 1980 involved members of this group, and 57.5 percent of all arrests in 1981 involved members of this age group. See Table 50.

Table 50. All Drug Arrests, By Age Group, 1980 and 1981.

1980	Under 18	18	30-35	36-40	41+	TOTAL
Male	245	166	38	5	9	412
Female	51	19	0	0	0	69
TOTAL	296	185	38	5	9	533
% of Total	68.0	29.0	1.0	1.0	2.0	100.0
<u>1981</u>						
Male	296	192	36	9	9	542
Female	87	33	4	2	1	127
Total	385	225	40	11	10	669
% of Total	57.5%	33.6%	5.9%	1.6%	1.4%	100%

Most persons arrested for narcotics violations were in the 20-29 year old age group; this group had 50 percent of all narcotics arrests in 1980, and 56 percent in 1981. During the period 1980-1981, 6 percent to 3.6 percent of the narcotics arrests involved persons 40 years of age and older. About 19 percent of the narcotics arrests occurred among the youngest age group, those up to the age of 19 years. See Table 51.

Table 51. Narcotics Arrests, By Age Group, 1981.

1980	18 AND UNDER	19-29	30-35	36-40	41+	TOTAL
Male	10	35	17	1	4	67
Female	5	4	2	0	0	11
TOTAL	15	39	19	1	4	78
% of Total	20.0	50.0	25.0	2.0	6.0	100.0

1981						
Male	15	51	17	4	3	90
Female	6	12	2	0	1	21
Total	21	63	19	4	4	111
% of Total	18.9	56.7	17.1	3.6	3.6	100

In 1981, 79 percent of drug arrests involved Caucasians; 12.5 percent of all drug arrests involved "Indians" (Criminal Justice Planning Agency designation); 3.5 percent involved Blacks; and 4.6 percent involved other racial/ethnic groups. In 1980, the proportions were roughly the same: 69 percent Caucasian; 27 percent Indian; 3.2 percent Black; and 0 percent Other Groups. The proportion of arrests attributable to the Caucasian group is comparable to the proportion of Caucasians in the general population, i.e., 78 percent.

Blacks are underrepresented in drug arrests in terms of their representation in the population at large, i.e., 2 to 4 percent of all drug arrests during 1980-81, compared to a little less than 5 percent of the total population.

When drug arrests by race are compared to total arrests by race, some interesting differences appear. In 1980, Whites accounted for 69 percent of the drug arrests, but only 60 percent of total arrests; on the other hand, Indians comprised 36 percent of total arrests, but only 27 percent of drug arrests. Black arrests were 3.5 percent of total arrests and 3.2 percent of drug arrests. There is a similar pattern in the 1981 drug arrest data. See Table 52.

Table 52. Total Arrests, By Race, 1980, 1981.

1980

ARREST CATEGORY	WHITE	INDIAN	BLACK	OTHER	TOTAL
-----------------	-------	--------	-------	-------	-------

Total Arrests

Number	9,693	5,797	579	33	16,102
% (Row)	60.0	36.0	3.5	0.4	100.0

Drug Arrests

Number	373	143	17	0	533
% (Row)	69.0	26.8	3.2	0.0	100.0

1981

Total Arrests

Number	11,376	3,497	790	3,162	18,825
% (Row)	60.4	18.5	4.1	16.7	100

Drug Arrest

Number	530	84	24	31	669
% (Row)	79.3	12.5	3.5	4.6	100

When the data are analyzed in terms of race and age, few noticeable differences appear. However, this examination does show that while Indians constituted only 8.5 percent of total arrests for the 18 years of age and under group, they accounted for 19 percent of total drug arrests in the older than 18 years of age group in 1981. For the other racial/ethnic groups, analysis by age variable showed no significant differences. See Table 53.

Table 53. Total Drug Arrests, by Race and Age, 1980, 1981.

RACE	1980		1981	
	NUMBER	PERCENT	NUMBER	PERCENT
Under 18 Years:				
White	256	87.0	296	84.9
Black	12	4.0	11	3.1
Indian	28	10.0	30	8.5
Other	0	0.0	12	3.4
TOTAL	296	100.0	352	100.0
18 Years Plus:				
White	184	78.0	234	73.1
Black	6	3.0	13	4.0
Indian	47	19.0	54	19.0
Other	0	0.0	19	5.9
TOTAL	237	100.0	320	100.0

DRUG USAGE SURVEY INFORMATION

Community Survey

To obtain information about drug taking in Alaskan communities, a survey of seven cities was conducted by the Center for Alcohol and Addiction studies and sponsored by the State Office of Alcoholism and Drug Abuse. The survey results provide data on the prevalence and extent of drug use as reported by residents in Barrow, Kotzebue, Bethel, Nome, Sitka, Juneau, Fairbanks and Anchorage.

The major purpose of this research was to develop an accurate assessment of current patterns of drug-taking behavior in Alaska. The results of the survey of over 1,000 Alaska residents 18 years of age and older disclose high lifetime prevalence levels for opportunities to try and experience mood altering drugs. Although it is not known whether the sample respondents have used are the "real thing" as opposed to "look alike" or substitute drugs, the important fact is that they think they have tried certain drugs.

Despite the high level of lifetime experiences most of the experiences have been experimental and only a small percentage of the sample take drugs regularly. Marijuana, cocaine and stimulants appear to be the most "popular" drugs as reported by respondents in this survey.

Drug taking behavior was found to be age related in Alaska as the prevalence rates for the 18-25 year age group were approximately double those of the 25+ age group. It was also found that higher proportions of males, overall, have had greater experience with drugs than females. First experiences with drugs vary with the drug being taken and the age of the person trying them. The predominate ages for first experiences ranged from 16 to 20, but first experiences continued well into the mid-to-late 20's and early 30's. The three primary reasons given why people try/take drugs were:

1. to relieve stress and to overcome unwanted feelings and emotions;
2. to enhance social or peer relationships; and
3. to experience the effects which drugs induce.

The following two tables contain summary data for incidence and prevalence.

TABLE I

TOTAL COMMUNITY SAMPLE

LIFETIME EXPERIENCE WITH DRUGS BY AGE GROUP AND GENDER *
(N = 1007)

Drug/Gender	All Ages (N = 1007) Percent Who: Ever Tried	18-25 Years (N = 212) Percent Who: Ever Tried	26+ Years (N = 795) Percent Who: Ever Tried
<u>Marijuana</u>			
Total	57.3	82.5	49.9
Male	58 *	86	58
Female	56	76	41
<u>Cocaine</u>			
Total	23.9	43.4	18.1
Male	28	48	25
Female	19	38	10
<u>hallucinogens</u>			
Total	16.7	26.9	13.6
Male	20	34	19
Female	12	18	8
<u>Stimulants</u>			
Total	27.6	43.9	22.8
Male	29	47	28
Female	25	40	18
<u>Depressants</u>			
Total	12.1	20.8	9.4
Male	14	22	14
Female	10	10	5
<u>heroin</u>			
Total	2.1	0.5	2.5
Male	3	1	4
Female	1	0	1
<u>Other Opiates</u>			
Total	9.0	9.9	8.7
Male	11	12	13
Female	6	8	4
<u>Inhalants</u>			
Total	8.4	16.0	6.2
Male	11	24	9
Female	5	8	3
<u>Tranquilizers</u>			
Total	10.0	12.3	9.4
Male	10	15	10
Female	10	9	3

* Percentages for Male/Female are approximations

TABLE II
TOTAL COMMUNITY SAMPLE
EXPERIENCE WITH DRUGS DURING PAST YEAR, PAST 30 DAYS
(N = 1007)

	<u>% of Sample Using in Last 12 Months</u>	<u>% of Sample Using in Last 12 Months</u>
Marijuana	25.2	15.9
Cocaine	12.9	4.5
halloicinogens	3.8	1.1
Stimulants	6.7	2.1
Depressents	2.7	0.6
heroin	.2	0
Other Opiates	1.1	0.4
Inhalents	1.6	0.3
Tranquilizers	1.9	0.6

School Survey

This data represents the findings from a study conducted by the Center for Alcohol and Addiction Studies of the University of Alaska, Anchorage. The research sponsored by the State Office of Alcoholism and Drug Abuse, surveyed 3,609 students in grades 7-12 in the school districts in eight locations in the state: Anchorage, Barrow, Bethel, Kotzebue, Fairbanks, Juneau, Nome and Sitka. The project was designed to obtain information on the use or nonuse of a broad spectrum of chemical substances.

The major findings of the study can be summarized as follows.

Half the students sampled have reported experiences with one or more illicit mood-altering drugs. A substantial proportion of these experiences involved marijuana. After marijuana, the other drugs experienced reflect the following order of lifetime prevalence: stimulants, cocaine, inhalants, depressants, tranquilizers, hallucinogens and heroin.

The level of lifetime experiences with psychoactive drugs among students is high. The extent to which drugs have been tried/taken among Alaska's students is illustrated vividly when the present findings are compared to results of a national survey of drug use among a sample of 12-17 year olds. Although the ages of the two samples are not exactly comparable, the national data nevertheless provides a "baseline" which helps to achieve a perspective on drug use by Alaska's youth.

Although many students have tried drugs, the majority of such use has been chiefly experimental. Only a small percent of students have taken drugs with any consistency or regularity. Marijuana, however, is the exception, with about 4% of the sample using it once or more a day.

Slightly higher proportions of males than females are involved in taking/trying drugs.

Most students who do not try drugs report that it is because of concern that drugs would "hurt" their minds, and because of fear that drugs would also cause physical harm.

Of those who have tried/taken drugs, the reasons for stopping are also mainly because of concern over psychological and physical harm.

More students who have tried drugs express a need for drug education than those who did not try drugs.

The following tables contain basic prevalence and incidence data from the school survey;

TABLE I
LIFETIME EXPERIENCES WITH PSYCHOACTIVE DRUGS

	Total Sample Alaskan Students Grades 7-12 (N = 3609)	1982 National Survey of 12-17 Year Olds (N = 1581)	Alaskan Jr. high Grades 7-9 (N = 1950)	Alaskan Sr. high Gds. 10-12 (N = 1567)	National Survey of High Sch. Seniors (N = 17500)	Alaskan Males Gds. 7-12 (N = 1770)	Alaskan Females Gds. 7-12 (N = 1732)
Marijuana	49.5	26.7	36.7	65.9	58.7	51.1	48.3
Hallucinogens	8.7	5.2	5.4	13.0	12.5	10.5	8.7
Cocaine	18.3	6.5	10.2	28.7	16.0	19.8	17.0
Heroin	2.2	6.1	1.6	2.9	1.2	3.2	1.2
Inhalents	16.5	no data	14.8	18.5	18.0	17.9	15.1
Stimulants	27.2	6.7	17.6	39.4	27.9	26.3	28.2
Depressants	14.3	5.8	10.6	19.4	15.2	15.4	13.6
Tranquilizers	11.5	4.9	7.7	16.3	14.0	12.4	10.9
Alcohol	71.7	65.2	no data	no data	no data	no data	no data
Tobacco	55.0	49.5	no data	no data	no data	no data	no data

TABLE II
FREQUENCY OF TAKING DRUGS:

Past Year Experiences

Total Schools
Junior h.S./Senior h.S.
(N = 1953) (N = 1567)

Drug	Percent of Jr. h. S. Students Who Have Tried Up to 3 Times a Month	Percent of Jr. h. S. Students Who Have Taken Once a Week or More	Percent of Sr. h. S. Students Who Have Tried Up to 3 Times a Month	Percent of Sr. h. S. Students Who Have Taken Once a Week or More
Marijuana	24.5	11.9	35.9	24.2
hallucinogens	4.5	0.7	9.9	1.4
Cocaine	10.6	1.4	23.1	3.5
heroin	2.0	0.4	2.3	1.1
Inhalents	11.0	2.1	9.9	1.8
Stimulants	13.6	3.5	26.8	8.5
Depressants	8.9	1.8	14.8	2.9
Tranquilizers	6.9	1.4	12.7	2.7

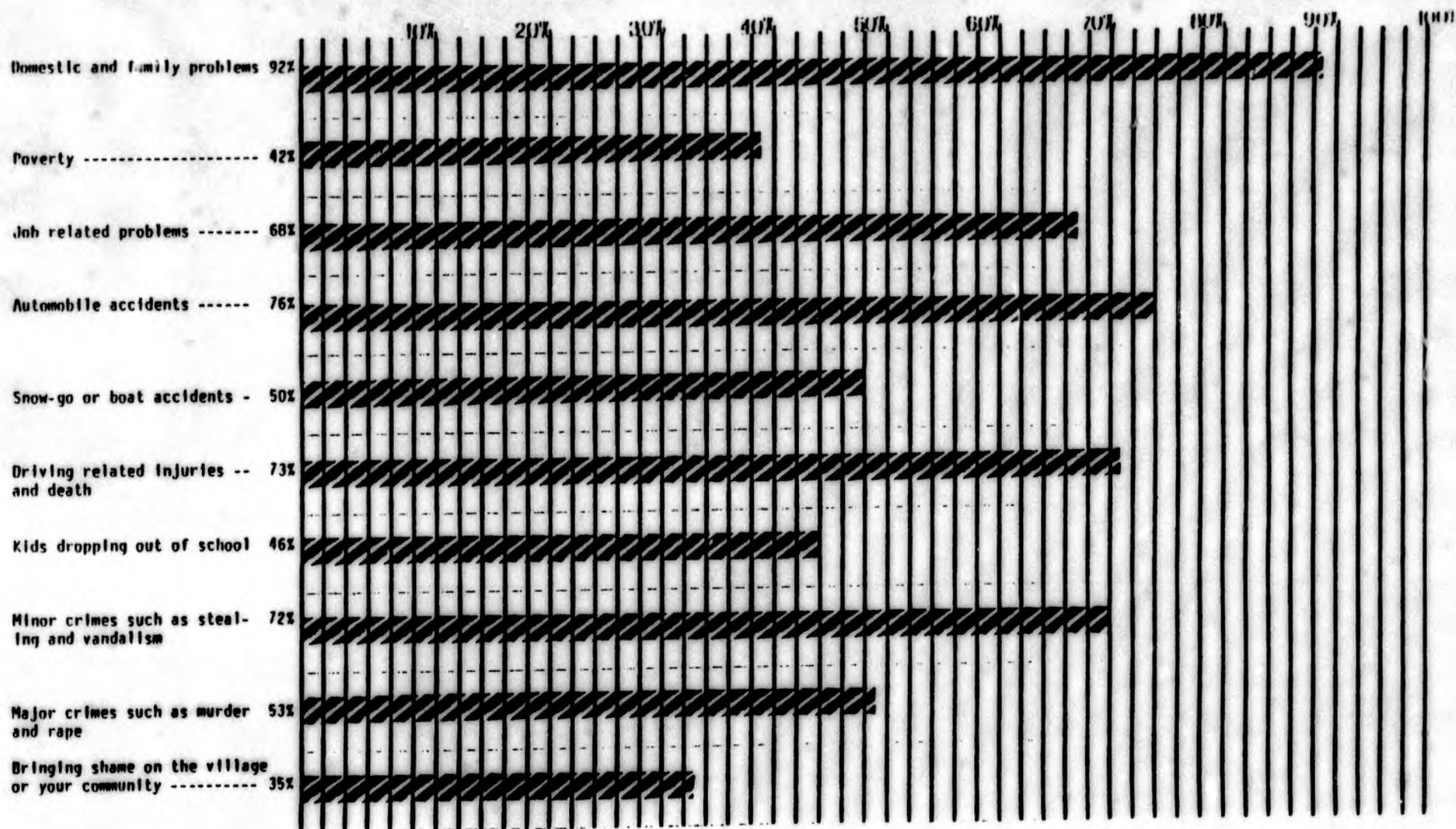
Community Survey

During July and August of 1983, the State Office of Alcoholism and Drug Abuse conducted an objective survey concerning alcohol and drug abuse in Alaska. A compilation of the results is contained in the following pages. Over 4,800 color coded surveys were mailed out to 1) all local officials listed in the municipal league directory, 2) all holders of on and off premise liquor licenses, 3) nurses selected at random from the State Register of Nurses, 4) all members of the Governor's boards and commissions, 5) all members of the Alaska Peace Officer's Association and State Troopers, and 6) all attendees of the Annual Summer School on Addictions.

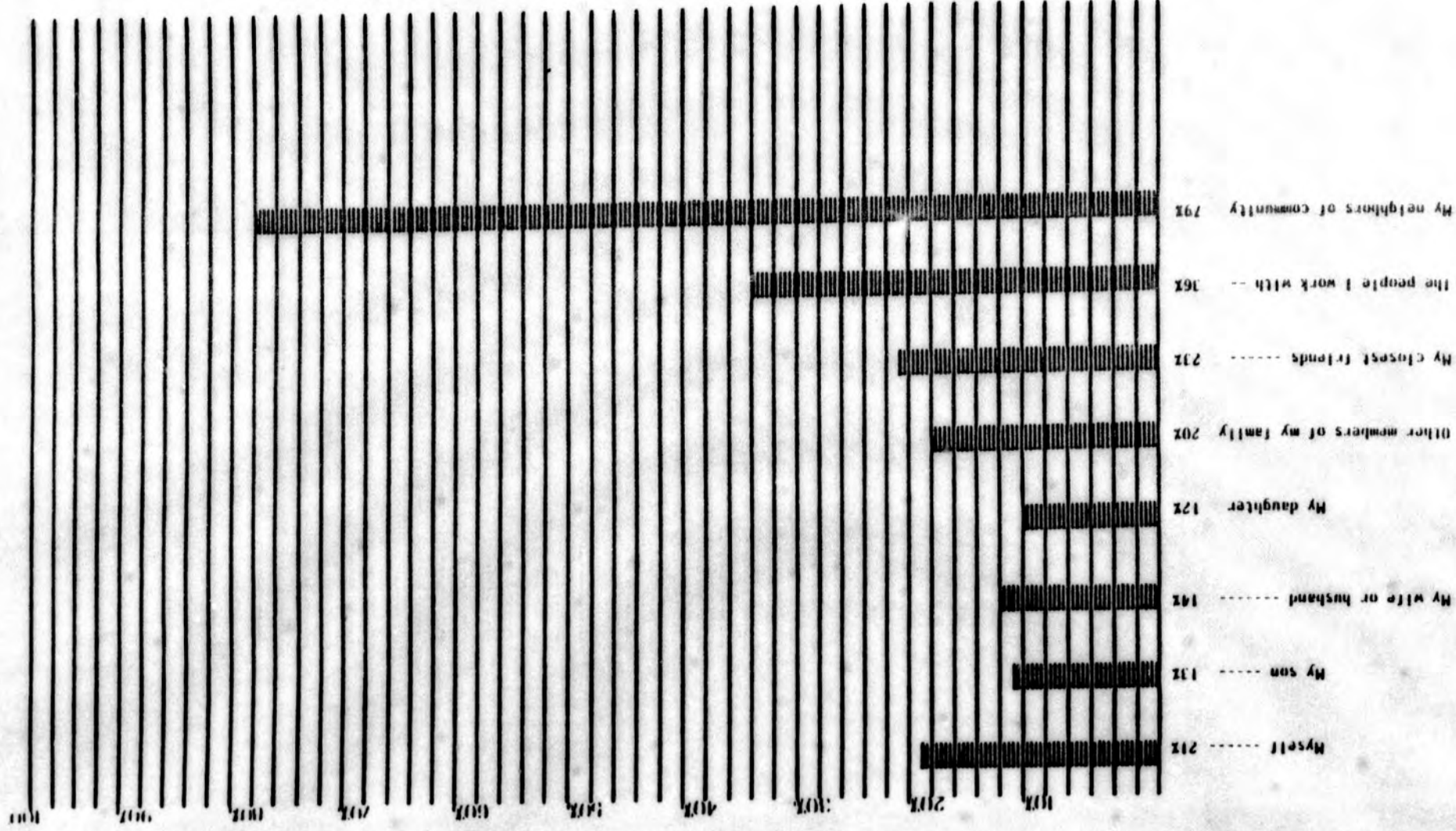
There were 1513 surveys returned (over 31%) that were scored. The results are displayed in graphic form showing the frequency response given by all groups to each question. It should be noted that this information represents the opinion of the respondents at a given point in time. The volume of the responses provides a sufficient basis for utilizing this information as a subjective assessment of the problems and service need.

The respondents were allowed to select as many choices as they thought appropriate for questions 1,2 and 9. They were limited to one choice for questions 3,4, 7 and 10, and to three choices for questions 5 and 6. For question 8 we asked those surveyed to list and rank the five most important human services problems for their community. The responses for all groups have been included to better show the nature of the problem perceptions.

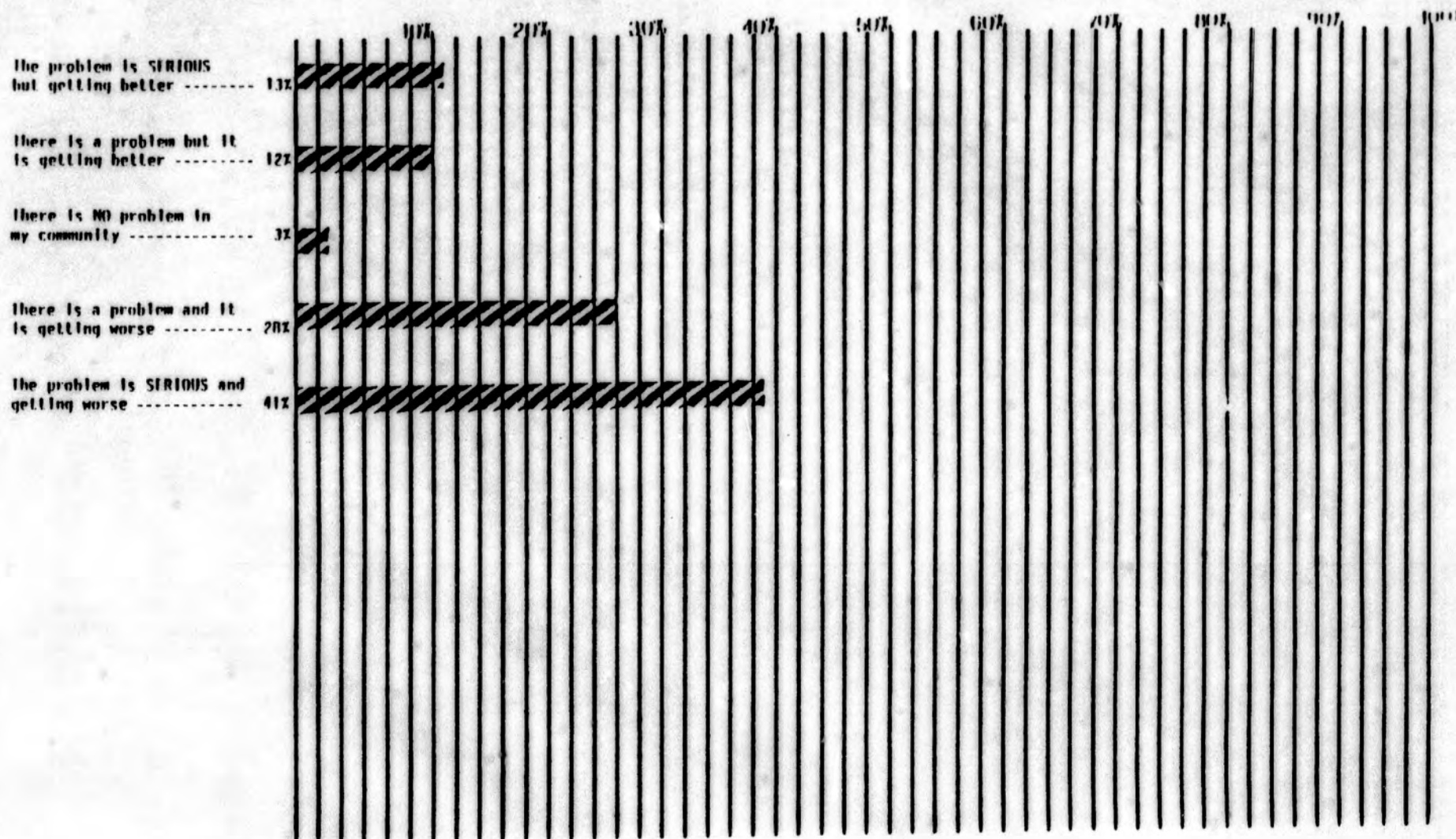
1. What types of problems does alcohol and drug abuse cause in your community?



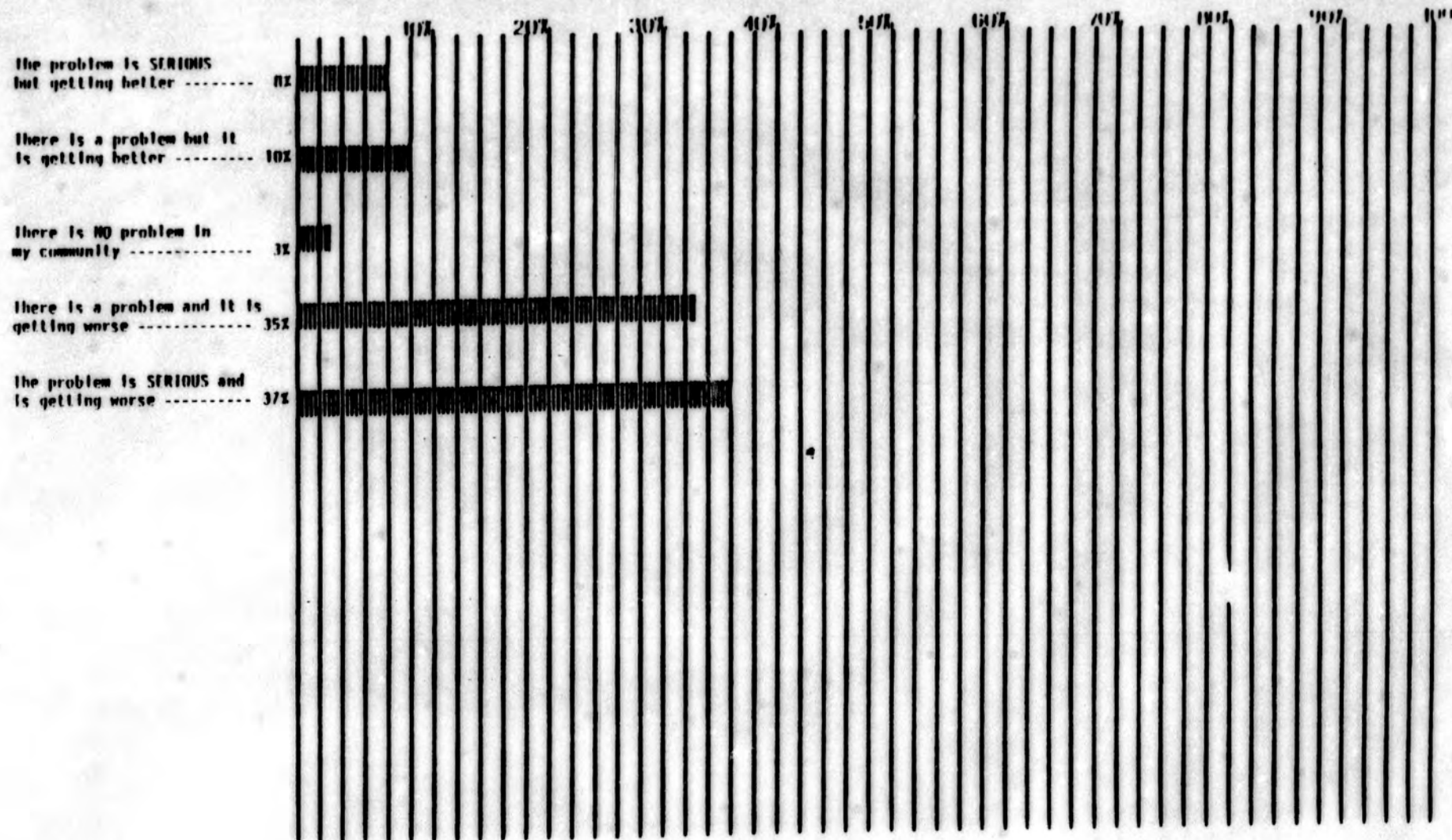
2. Who are most affected by the above problems?



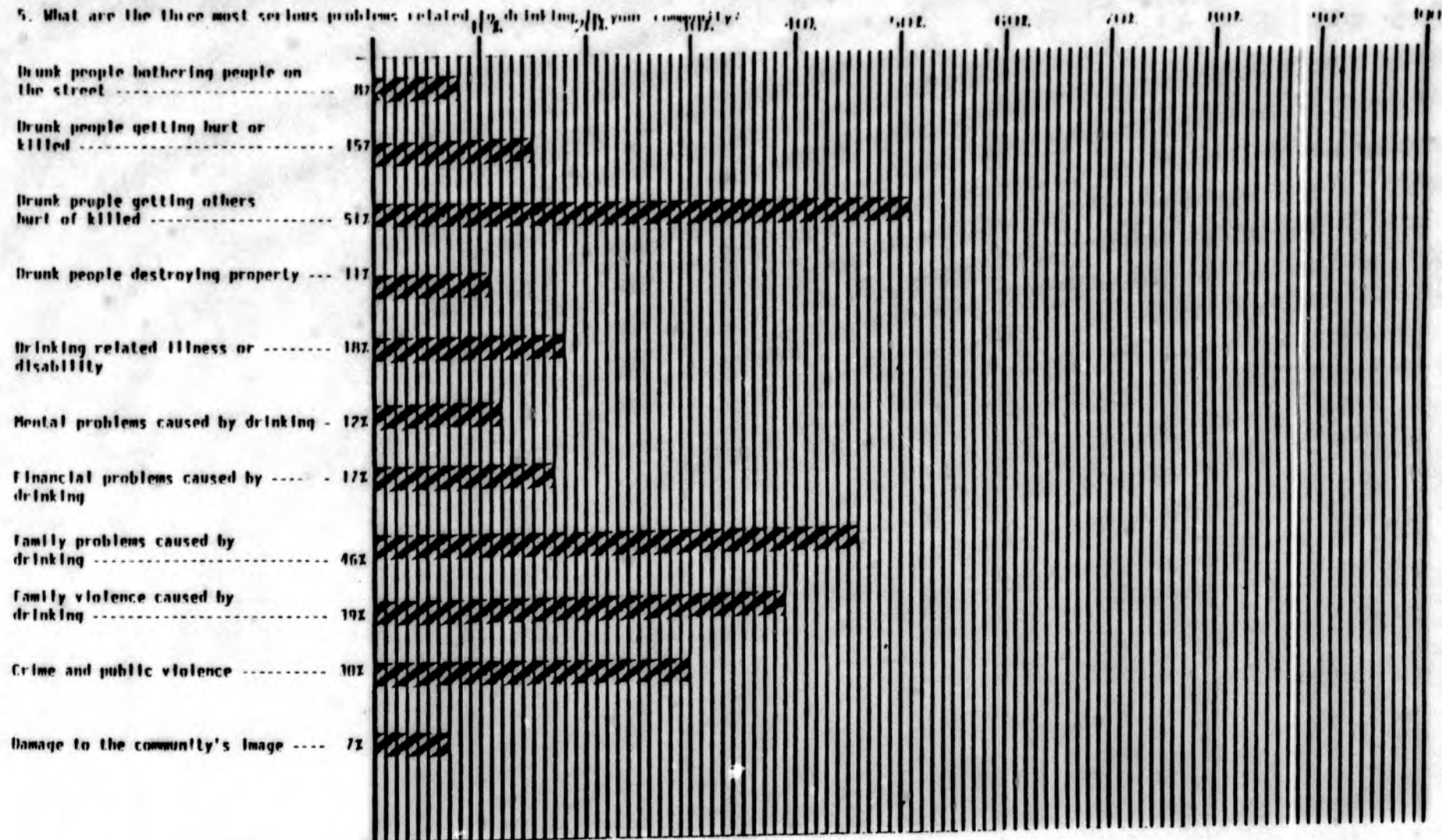
1. Please describe the extent of your community's drinking problem?



4. Please describe the extent of your community's drug abuse problem?



5. What are the three most serious problems related to drinking by your community?



6. What are the three most serious problems related to drug abuse in your community?

Drug users bothering people
on the street 41%

Drug users getting themselves
killed 71%

Drug users getting others
killed 19%

Drug abuse related illness and
disability 9%

Mental problems caused
by drug abuse 30%

Financial problems
caused by drug abuse 33%

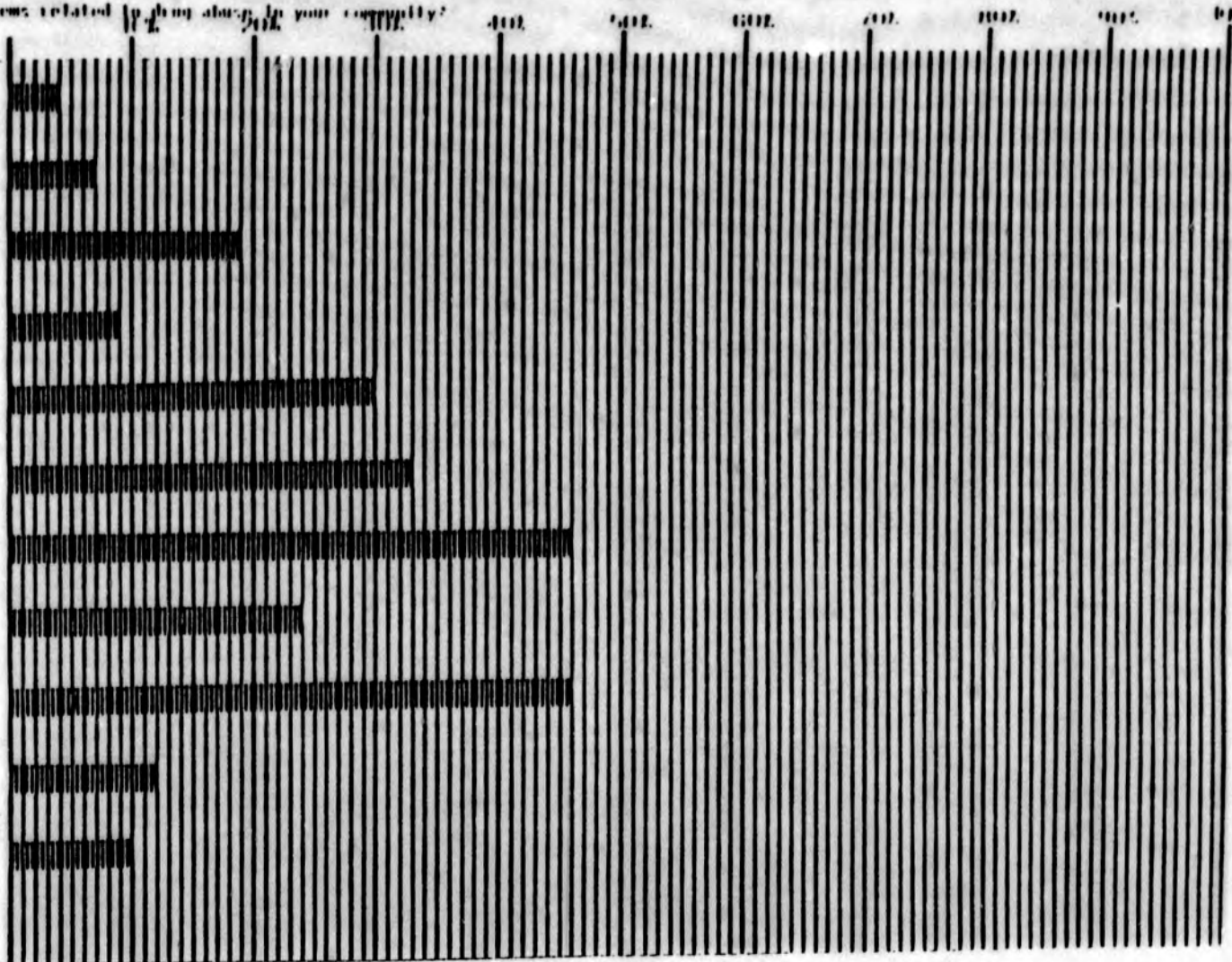
Family problems caused by drug abuse 46%

Family violence caused by
drug abuse 24%

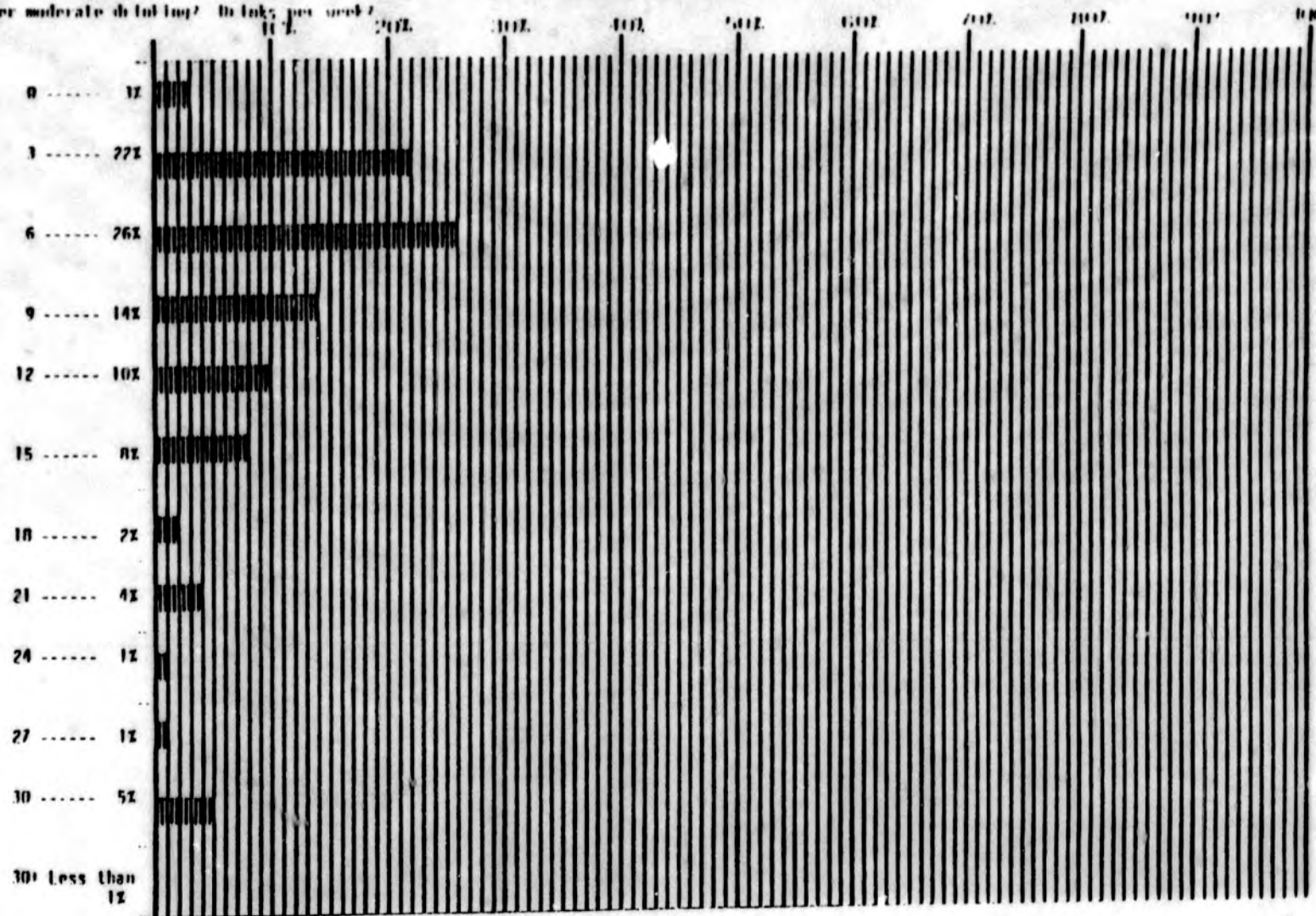
Crime and public violence 46%

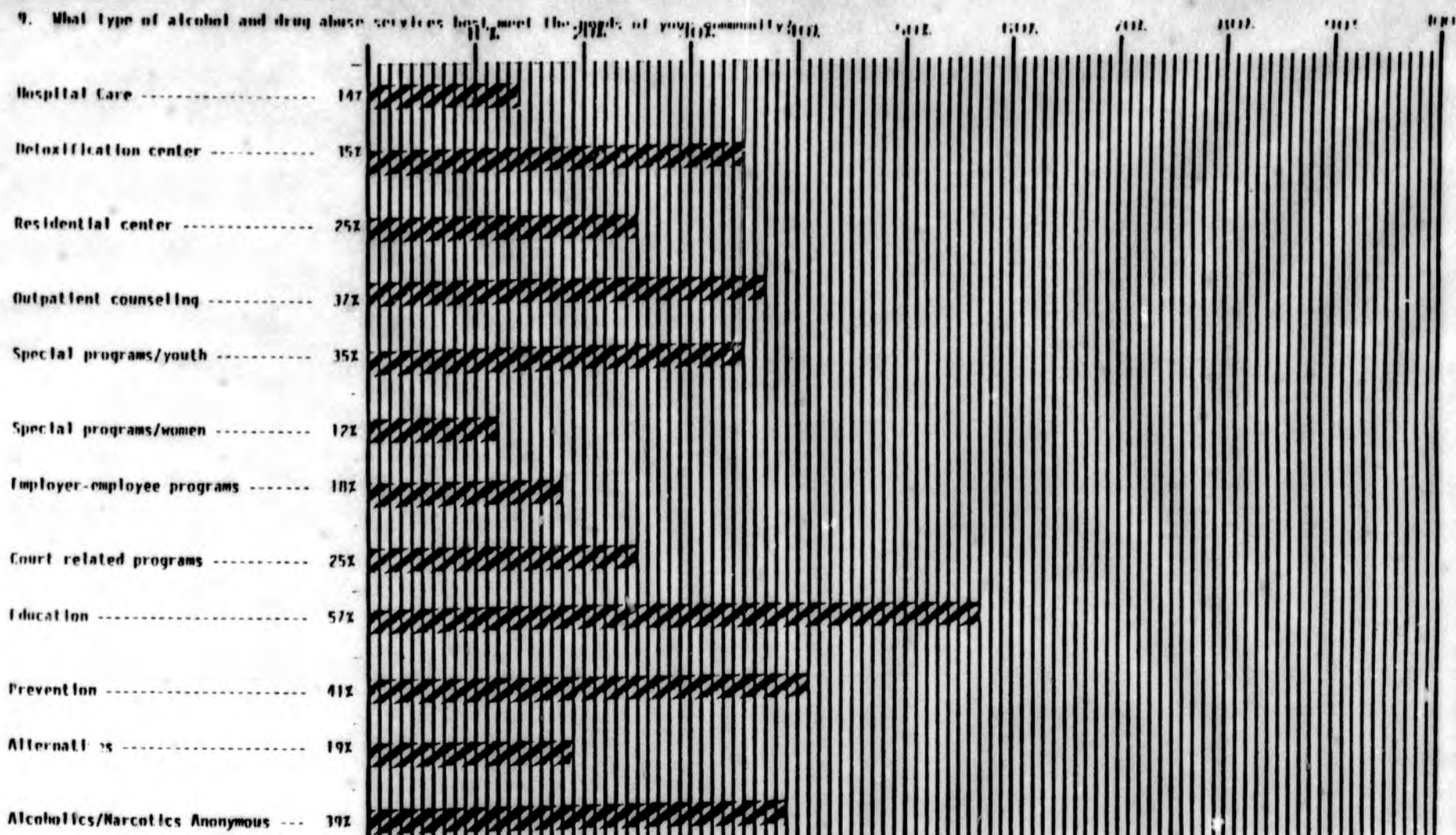
Damage to the community's image 7%

Drug overdose deaths 5%

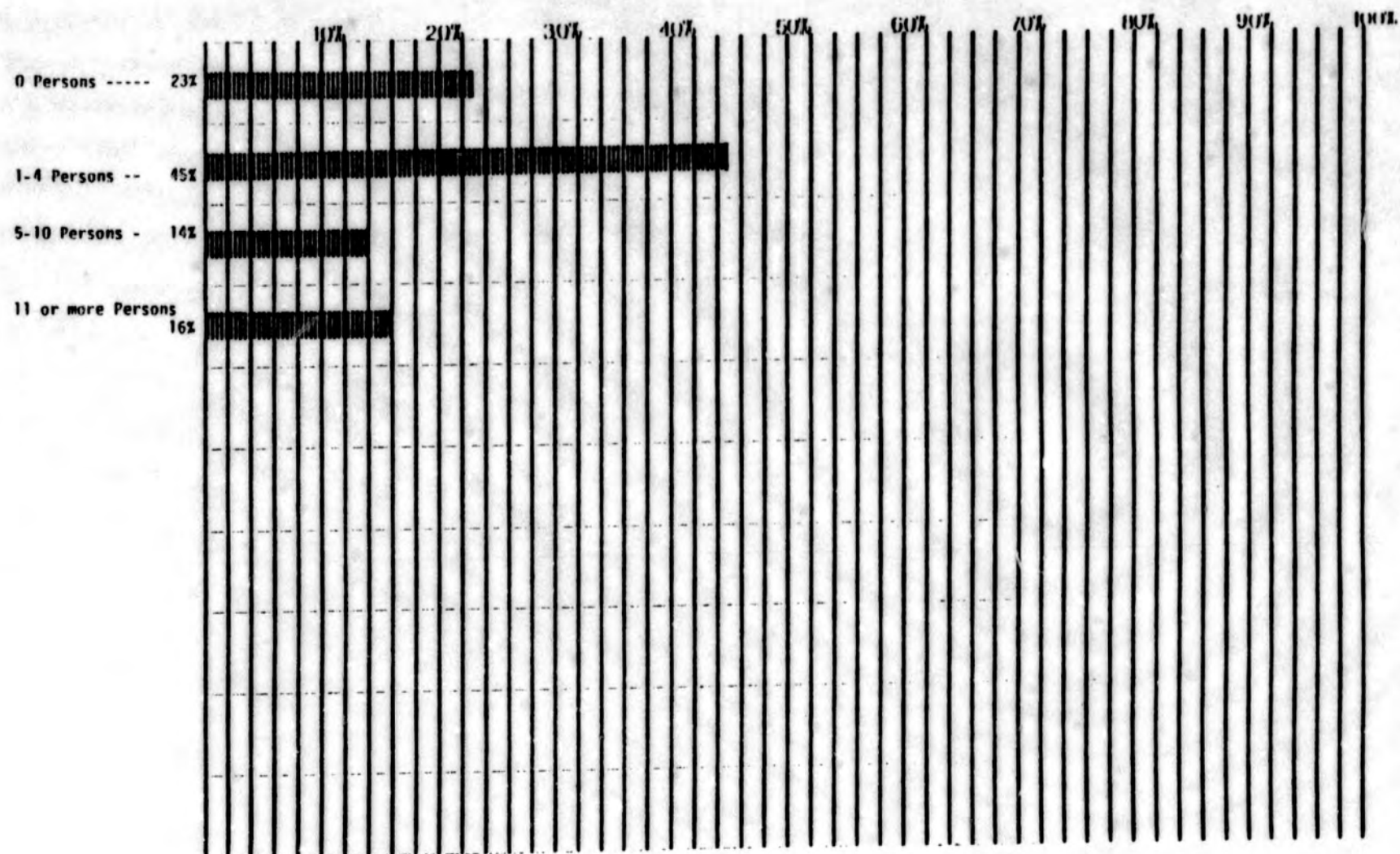


7. What do you consider moderate drinking? Drinks per week?





10. Do you know anyone who has benefitted from alcohol or drug treatment?



APPENDIX - B

ALASKA STATUTE (AS) 47.37

Chapter 37. Uniform Alcoholism and Intoxication Treatment Act.

Section	Section
10. Declaration of policy	170. Treatment and services for intoxicated persons and persons incapacitated by alcohol
20. Office of alcoholism	180. Emergency commitment
30. Powers of office	190. Involuntary commitment of alcoholics
40. Duties of office	200. Hearing on petition for involuntary commitment of alcoholics
50. Interdepartmental coordinating committee	210. Records of alcoholics and intoxicated persons
60. Advisory board on alcoholism	220. Visitation and communication of patients
70. Composition	230. Establishment of emergency service patrol
80. Qualifications of board members	240. Payment for treatment
90. Term of office	250. Nonapplicability
100. Compensation, per diem, or expenses	260. Application of Administrative Procedure Act
110. Duties	270. Definitions
120. Alcoholism program coordinator	
130. Comprehensive program for treatment; regional facilities	
140. Public and private treatment facilities	
150. Acceptance for treatment	
160. Voluntary treatment of alcoholics	

Revisor's note. — In ch. 207, SLA 1972, AS 47.37.070 — 47.37.270 were designated AS 47.37.062 — 47.37.210.

Sec. 47.37.010. Declaration of policy. It is the policy of the state that alcoholics and intoxicated persons should not be criminally prosecuted for their consumption of alcoholic beverages and that they should be afforded a continuum of treatment so they may lead normal lives as productive members of society. (§ 1 ch 207 SLA 1972)

§ 47.37.020 WELFARE, SOCIAL SERVICES AND INSTITUTIONS § 47.37.030

Cross reference. — For other provisions concerning the treatment of alcoholics, see AS 47.30.470 — 47.30.500.

Purpose of the legislature in enacting this chapter. — See Peter v. State, Sup. Ct. Op. No. 1112 (File No. 2185), 531 P.2d 1263 (1975).

The purpose of this chapter is to afford alcoholics and intoxicated persons a continuum of treatment, rather than subject them to criminal prosecution. Abraham v. State, Sup. Ct. Op. No. 1747 (File No. 3407), 585 P.2d 526 (1978).

This chapter establishes a comprehensive program for the treatment of alcoholism as a disease. Peter v. State, Sup. Ct. Op. No. 1112 (File No. 2185), 531 P.2d 1263 (1975).

Public drunkenness should not be made the subject of criminal sanctions. — See Peter v. State, Sup. Ct. Op. No. 1112 (File No. 2185), 531 P.2d 1263 (1975).

This chapter does not make drunkenness a defense to criminal liability for nonalcoholic substantive offenses committed by one under the influence of

liquor. Peter v. State, Sup. Ct. Op. No. 1112 (File No. 2185), 531 P.2d 1263 (1975); Walton v. State, Sup. Ct. Op. No. 1488 (File No. 2736), 568 P.2d 981 (1977).

One addicted to heroin is afflicted with an illness as much as is one addicted to alcohol. Huff v. State, Sup. Ct. Op. No. 1493 (File No. 3201), 568 P.2d 1014 (1977).

This chapter repealed by implication 13 AAC 02.175(c), which prohibits a person from being upon or along a highway while under the influence of an intoxicating liquor. Peter v. State, Sup. Ct. Op. No. 1112 (File No. 2185), 531 P.2d 1263 (1975).

There is an irreconcilable conflict between this chapter, a principal purpose of which is to decriminalize public drunkenness, and 13 AAC 02.175(c), making it a misdemeanor to appear upon or along a highway or street in an intoxicated condition. Peter v. State, Sup. Ct. Op. No. 1112 (File No. 2185), 531 P.2d 1263 (1975).

Quoted in In re S.D., Sup. Ct. Op. No. 1255 (File No. 2530), 549 P.2d 1190 (1976).

Sec. 47.37.020. Office of alcoholism. An office of alcoholism is established in the department. The office shall be headed by a co-ordinator appointed by the commissioner. The coordinator shall be a qualified professional who has training and experience in the organization and administration of treatment services for persons with medical-social problems. The coordinator is in the classified service. (§ 1 ch 207 SLA 1972)

Sec. 47.37.030. Powers of office. The office may

(1) plan, establish, and maintain treatment programs as appropriate;
(2) make contracts and award grants necessary or incidental to the performance of its duties and the execution of its powers, including contracts with and grants to public and private agencies, organizations, and individuals, to pay them for services rendered or furnished to alcoholics or intoxicated persons; to the maximum extent possible, contracts and grants shall be for a period of two years;

(3) solicit and accept for use a gift of money or property or a grant of money, services, or property from the federal government, the state, or a political subdivision of it or a private source, and do all things necessary to cooperate with the federal government or any of its agencies in making an application for a grant;

(4) administer or supervise the administration of the provisions relating to alcoholics and intoxicated persons of any state plan submitted for federal funding under federal health, welfare, or treatment legislation;

(5) coordinate its activities and cooperate with alcoholism programs in this and other states, and make contracts and other joint or cooperative

arrangements with state, local, or private agencies for the treatment of alcoholics and intoxicated persons and for the common advancement of alcoholism programs in this and other states;

(6) keep records and engage in research and the gathering of relevant statistics;

(7) do other acts necessary to implement the authority expressly granted to it;

(8) acquire, hold, or dispose of real property or any interest in it, and construct, lease, or otherwise provide treatment facilities for alcoholics and intoxicated persons; however, the office shall encourage local initiative, involvement and financial participation under grants-in-aid whenever possible in preference to the construction or operation of facilities directly by the office. (§ 1 ch 207 SLA 1972; am § 1 ch 117 SLA 1978)

Effect of amendment. — The 1978 amendment, in paragraph (2), inserted "and award grants" and "and grants to" and added "to the maximum extent possible, contracts and grants shall be for a period of two years" to the end.

Legislative history report. — For report on ch. 117, SLA 1978 (SB 542), see 1978 Senate Journal, p. 761.

Sec. 47.37.040. Duties of office. The office shall

(1) develop, encourage, and foster statewide, regional, and local plans and programs for the prevention of alcoholism and treatment of alcoholics and intoxicated persons in cooperation with public and private agencies, organizations, and individuals, and provide technical assistance and consultation services for these purposes;

(2) coordinate the efforts and enlist the assistance of all public and private agencies, organizations, and individuals interested in prevention of alcoholism and treatment of alcoholics and intoxicated persons;

(3) cooperate with the division of corrections in establishing and conducting programs to provide treatment for alcoholics and intoxicated persons in or on parole from penal institutions;

(4) cooperate with the Department of Education, school boards, schools, police departments, courts, and other public and private agencies, organizations and individuals in establishing programs for the prevention of alcoholism and treatment of alcoholics and intoxicated persons, and preparing curriculum materials for use at all levels of school education;

(5) prepare, publish, evaluate, and disseminate educational material dealing with the nature and effects of alcohol;

(6) develop and implement, as an integral part of treatment programs, an educational program for use in the treatment of alcoholics and intoxicated persons which includes the dissemination of information concerning the nature and effects of alcohol;

(7) organize and foster training programs for all persons engaged in treatment of alcoholics and intoxicated persons and establish standards for training paraprofessional alcoholism workers;

§ 47.37.050 WELFARE, SOCIAL SERVICES AND INSTITUTIONS § 47.37.050

(8) sponsor and encourage research into the causes and nature of alcoholism and treatment of alcoholics and intoxicated persons, and serve as a clearinghouse for information relating to alcoholism;

(9) specify uniform methods for keeping statistical information by public and private agencies, organizations, and individuals, and collect and make available relevant statistical information, including number of persons treated, frequency of admission and readmission, and frequency and duration of treatment;

(10) advise the governor in the preparation of a comprehensive plan for treatment of alcoholics and intoxicated persons;

(11) review all state health, welfare, and treatment plans to be submitted for federal funding, and advise the commissioner on provisions to be included relating to alcoholism and intoxicated persons;

(12) assist in the development of, and cooperate with, alcohol education and treatment programs for employees of state and local governments and businesses and industries in the state;

(13) utilize the support and assistance of interested persons in the community, particularly recovered alcoholics, to encourage alcoholics to voluntarily undergo treatment;

(14) cooperate with the Department of Public Safety and the Department of Highways in establishing and conducting programs designed to deal with the problem of persons operating motor vehicles while intoxicated;

(15) encourage hospitals and other appropriate health facilities to admit without discrimination alcoholics and intoxicated persons and to provide them with adequate and appropriate treatment;

(16) encourage all health and disability insurance programs to include alcoholism as a covered illness;

(17) submit to the legislature an annual report covering the activities of the office;

(18) develop and implement a training program on alcoholism for employees of state and municipal governments, and private institutions;

(19) develop curriculum materials on drug and alcohol abuse for use in grades kindergarten through 12, as well as a course of instruction for teachers to be charged with presenting the curriculum.

(§ 1 ch 207 SLA 1972; am §§ 2, 4 ch 117 SLA 1973)

Effect of amendment. — The 1978 amendment added "and establish standards for training paraprofessional alcoholism workers" to the end of paragraph (7) and added paragraphs (18) and (19).

Legislative history report. — For report on ch. 117, SLA 1978 (SB 542), see 1978 Senate Journal, p. 761.

Sec. 47.37.050. Interdepartmental coordinating committee. (a) An interdepartmental coordinating committee is created, composed of the coordinator and the commissioners of health and social services, education, highways, labor and public safety. The committee shall meet

at least twice annually at the call of the commissioner of health and social services who is its chairman. The committee shall provide for the coordination and exchange of information on all programs relating to alcoholism, and act as a permanent liaison among state departments engaged in activities affecting alcoholics and intoxicated persons. The committee shall assist the commissioner of health and social services and the coordinator in formulating a comprehensive plan for prevention of alcoholism and for treatment of alcoholics and intoxicated persons.

(b) In exercising its coordinating functions, the committee shall assure that the appropriate state agencies

(1) provide all necessary medical, social, treatment, and educational services for alcoholics and intoxicated persons and for the prevention of alcoholism, without unnecessary duplication of services;

(2) cooperate in the use of facilities and in the treatment of alcoholics and intoxicated persons;

(3) adopt approaches for the prevention of alcoholism and the treatment of alcoholics and intoxicated persons consistent with the policy of this chapter. (§ 1 ch 207 SLA 1972)

Sec. 47.37.060. Advisory board on alcoholism. There is established in the Department of Health and Social Services an advisory board on alcoholism. (§ 1 ch 207 SLA 1972)

Sec. 47.37.070. Composition. The advisory board on alcoholism consists of nine members appointed by the governor. (§ 1 ch 207 SLA 1972)

Revisor's note. — In ch. 207, SLA 1972, AS 47.37.070 — 47.37.270 were designated AS 47.37.062 — 47.37.310.

Sec. 47.37.080. Qualifications of board members. Of the nine members

(1) two shall be persons who are licensed to practice medicine in the state, one of whom shall be certified in psychiatry by the American Board of Psychiatry and Neurology or eligible for that certification, except that if a psychiatrist is not available a clinical psychologist may be appointed;

(2) one shall be a practicing attorney who has been admitted to the practice of law by the state supreme court;

(3) two shall be persons who have evidenced an interest in the problems of alcoholism and who have knowledge of the social problems encountered in the rehabilitation of alcoholics;

(4) one shall be a public health nurse;

(5) one shall be a representative of the liquor industry;

(6) one shall be from the public at large;

(7) one shall be a social worker. (§ 1 ch 207 SLA 1972; am § 1 ch 72 SLA 1976)

§ 47.37.090 WELFARE, SOCIAL SERVICES AND INSTITUTIONS § 47.37.130

Effect of amendment. — The 1976 amendment rewrote this section.

Sec. 47.37.090. Term of office. (a) The members of the board initially appointed under AS 47.37.080(a) serve terms of four years.

(b) The member initially appointed under AS 47.37.080(b) serves a term of three years.

(c) The member initially appointed under AS 47.37.080(c) serves a term of two years.

(d) The members initially appointed under AS 47.37.080(d) — (h) serve terms of four years. Subsequent terms for all board members are four years.

(e) A vacancy occurring in the membership of the board shall be filled by appointment of the governor for the unexpired portion of the vacated term.

(f) Board members serve at the pleasure of the governor. (§ 1 ch 207 SLA 1972)

Sec. 47.37.100. Compensation, per diem, or expenses. Members of the advisory board on alcoholism are not entitled to a salary, but are entitled to per diem, reimbursement for travel and other expenses authorized by law for other boards. (§ 1 ch 207 SLA 1972)

Sec. 47.37.110. Duties. The board shall act in an advisory capacity to the commissioner in the following matters:

(1) special problems affecting mental health which alcoholism may present;

(2) educational and research activities conducted by the office in respect to the problems presented by alcoholism;

(3) social problems which affect rehabilitation of alcoholics;

(4) legal processes which affect the treatment and rehabilitation of alcoholics;

(5) a program of public relations concerning the problem of alcoholism conducted by a department of the state government or by an organized group whose purpose is the rehabilitation of alcoholics. (§ 1 ch 207 SLA 1972)

Sec. 47.37.120. Alcoholism program coordinator. The alcoholism program coordinator shall carry out the development and implementation of a comprehensive program dealing with the treatment of, research on and education concerning alcoholic problems as they affect the state. (§ 1 ch 207 SLA 1972)

Sec. 47.37.130. Comprehensive program for treatment; regional facilities. (a) The office shall establish a comprehensive and coordinated program for the treatment of alcoholics and intoxicated persons. Subject to the approval of the commissioner, the coordinator may divide the state into appropriate regions to conduct the program and establish standards for the development of the program on the regional level. In establishing

the regions, consideration shall be given to the city and borough lines and population concentrations and when feasible, programs shall be established with maximum local community involvement.

(b) The program of the office shall include

(1) emergency treatment provided by a facility affiliated with or part of the medical service of a general hospital;

(2) inpatient treatment;

(3) intermediate treatment; and

(4) outpatient and follow-up treatment.

(c) The office shall provide adequate and appropriate treatment for alcoholics and intoxicated persons admitted under AS 47.37.160 — 47.37.190 within the limits of available state and federal funds.

(d) The office shall maintain, supervise and control all facilities operated by it subject to the regulations of the department. The administrator of each facility shall make an annual report of its activities to the coordinator in the form and manner the coordinator specifies.

(e) If possible, the office shall coordinate the activities of the program with all appropriate public and private resources.

(f) The coordinator shall prepare, publish, and distribute annually a list of all approved public and private treatment facilities.

(g) The office may contract for the use of any facility as an approved public treatment facility if the coordinator, subject to the regulations of the department, considers this an effective and economical course to follow. (§ 1 ch 207 SLA 1972)

Sec. 47.37.140. Public and private treatment facilities. (a) The office shall establish standards for facilities (these standards may vary in their requirements and stringency according to the population, price level, remoteness, access to transportation, and availability of ancillary services of the area to be served) and shall fix the fees to be charged for the required inspections of those facilities. Every facility shall meet the applicable standards before it is approved as a public or private treatment facility. The standards shall be enacted in a manner that will provide protection of the health, safety and well-being of clients of the affected programs and protection for the affected programs from exposure to malpractice and liability actions.

(b) The office shall inspect, on a regular basis, approved public and private treatment facilities at reasonable times and in a reasonable manner.

(c) The office shall maintain a list of approved public and private treatment facilities.

(d) Each approved public and private treatment facility shall file with the office on request, data, statistics, schedules, and information which the office reasonably requires. An approved public or private treatment facility that without good cause fails to furnish any data, statistics, schedules, or information as requested, or files fraudulent returns of them, shall be removed from the list of approved treatment facilities.

§ 47.37.150 WELFARE, SOCIAL SERVICES AND INSTITUTIONS § 47.37.160

(e) The coordinator, after holding a hearing under the provisions of the Administrative Procedure Act (AS 44.62), may suspend, revoke, limit, restrict, or refuse to grant an approval for a treatment facility, for failure to meet its standards.

(f) Upon petition of the office and after a hearing held upon reasonable notice to the facility, the district court may issue a warrant to an officer or employee of the office authorizing him to enter and inspect at reasonable times, and examine the books and accounts of an approved public or private treatment facility refusing to consent to inspection or examination by the office or which the office has reasonable cause to believe is operating in violation of this chapter. (§ 1 ch 207 SLA 1972; am § 2 ch 105 SLA 1978)

Effect of amendment. — The 1978 amendment rewrote subsection (a).

Editor's note. — Section 1, ch. 105, SLA 1978, provides: "Recognizing the standards for rural alcohol treatment facilities

currently employed by the Department of Health and Social Services are not entirely appropriate, it is the intent of the legislature that standards more responsive to rural needs and conditions be adopted."

Sec. 47.37.150. Acceptance for treatment. The coordinator shall promulgate regulations for the admission of persons into the treatment program, considering available treatment resources and facilities, for the purpose of early and effective treatment of alcoholics and intoxicated persons. In establishing the regulations the coordinator shall be guided by the following standards:

(1) if possible a patient shall be treated on a voluntary rather than an involuntary basis;

(2) a patient shall be initially assigned or transferred to outpatient or intermediate treatment, unless he is found to require inpatient treatment;

(3) a person shall not be denied treatment solely because he has withdrawn from treatment against medical advice on a prior occasion or because he has relapsed after earlier treatment;

(4) an individualized treatment plan shall be prepared and maintained on a current basis for each patient;

(5) provision shall be made for a continuum of coordinated treatment services, so that a person who leaves a facility or a form of treatment will utilize other appropriate treatment and facilities. (§ 1 ch 207 SLA 1972)

Sec. 47.37.160. Voluntary treatment of alcoholics. (a) An alcoholic may voluntarily apply for treatment directly to an approved public treatment facility.

(b) Subject to regulations promulgated by the coordinator, the administrator in charge of an approved public treatment facility may determine who shall be admitted for treatment. If a person is refused admission to an approved public treatment facility, the administrator

shall, if possible, refer the person to another approved public treatment facility.

(c) When a patient receiving inpatient care leaves an approved public treatment facility, he shall be encouraged to consent to appropriate outpatient or intermediate treatment. If it appears to the administrator in charge of the treatment facility that the patient is an alcoholic who requires help, the office shall arrange for assistance in obtaining supportive services and residential facilities. (§ 1 ch 207 SLA 1972)

Sec. 47.37.170. Treatment and services for intoxicated persons and persons incapacitated by alcohol. (a) An intoxicated person may come voluntarily to an approved public treatment facility for emergency treatment. A person who appears to be intoxicated in a public place and to be in need of help or a person who appears to be intoxicated in or upon a licensed premise where intoxicating liquors are sold or consumed who refuses to leave upon being requested to leave by the owner, an employee or a peace officer may be taken into protective custody and assisted by a peace officer or a member of the emergency service patrol to his home, an approved public treatment facility, an approved private treatment facility, or another appropriate health facility. If all of the preceding facilities, including the person's home, are determined to be unavailable, a person taken into protective custody and assisted under this subsection may be taken to a state or municipal detention facility in the area.

(b) A person who appears to be incapacitated by alcohol in a public place shall be taken into protective custody by a peace officer or a member of the emergency service patrol and immediately brought to an approved public treatment facility, an approved private treatment facility, or another appropriate health facility or service for emergency medical treatment. If no treatment facility or emergency medical service is available, a person who appears to be incapacitated by alcohol in a public place shall be taken to a state or municipal detention facility in the area, if that appears necessary for the protection of the person's health or safety.

(c) A person who voluntarily appears or is brought to an approved public treatment facility shall be examined by a licensed physician as soon as possible. After the examination, he may be admitted as a patient or referred to another health facility. The approved public treatment facility which refers him shall arrange for his transportation.

(d) No person who, after medical examination, is found to be incapacitated by alcohol at the time of his admission or to have become incapacitated at any time after his admission, may be detained at a facility after he is no longer incapacitated by alcohol. No person may be detained at a facility if he remains incapacitated by alcohol for more than 48 hours after admission as a patient, unless he is committed under AS 47.37.180. A person may consent to remain in the facility as long as the physician in charge considers it appropriate.

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(e) A person who is not admitted to an approved public treatment facility, is not referred to another health facility, and has no funds, may be taken to his home, if any. If he has no home, the approved public treatment facility shall assist him in obtaining shelter.

(f) If a patient is admitted to an approved public treatment facility, his family or next of kin shall be promptly notified. If an adult patient who is not incapacitated requests that there be no notification of next of kin, his request shall be granted.

(g) Peace officers or members of the emergency service patrol who comply with this section are acting in the course of their official duty and are not criminally or civilly liable for it.

(h) If the physician in charge of the approved public treatment facility determines it is for the patient's benefit, an attempt shall be made to encourage the patient to submit to further diagnosis and appropriate voluntary treatment.

(i) A person taken to a detention facility under (a) or (b) of this section may be detained only (1) until a treatment facility or emergency medical service is made available, or (2) until he is no longer intoxicated or incapacitated by alcohol, or (3) for a maximum period of 12 hours, whichever occurs first. A detaining officer or a detention facility official may release a person who is detained under (a) or (b) of this section at any time to the custody of a responsible adult. A peace officer or a member of the emergency service patrol, in detaining a person under (a) or (b) of this section and in taking him to a treatment facility, an emergency medical service or a detention facility, is taking him into protective custody and he shall make reasonable efforts to provide for and protect the health and safety of the detainee. In taking a person into protective custody under (a) and (b) of this section, a detaining officer, a member of the emergency service patrol or a detention facility official may take reasonable steps to protect himself, including a full protective search of the person of a detainee. Protective custody under (a) and (b) of this section does not constitute an arrest and no entry or other record may be made to indicate that the person detained has been arrested or charged with a crime, except that a confidential record may be made which is necessary for the administrative purposes of the facility to which the person has been taken or which is necessary for statistical purposes where the person's name may not be disclosed.

(j) For purposes of (b) of this section, "incapacitated by alcohol" means a person who, as the result of consumption of alcohol, is rendered unconscious or has his judgment or physical mobility so impaired that he cannot readily recognize or extricate himself from conditions of apparent or imminent danger to his health or safety. The definition in AS 47.37.270(8) applies to other portions of this chapter. (§ 1 ch 207 SLA 1972; am §§ 1—4 ch 101 SLA 1976)

Effect of amendment. — The 1976 amendment substituted the language beginning "or a person who appears to be intoxicated" and ending "taken into protective custody and assisted" for "if he consents, may be assisted" and inserted "a member of" preceding "the emergency service patrol" in the second sentence of subsection (a), added the third sentence of that subsection, rewrote subsection (b), and added subsections (i) and (j).

Legislative history report. — For report on ch. 101, SLA 1976 (CSSSB 336 am H), see 1976 House Journal, p. 555.

Constitutionality. — For case holding that this section as it existed prior to the 1977 amendment, which among other things rewrote subsection (b), did not countenance an unreasonable search in violation of the 4th amendment to the United States Constitution, see *Peter v. State*, Sup. Ct. Op. No. 1112 (File No. 2185), 531 P.2d 1263 (1975).

Sec. 47.37.180. Emergency commitment. (a) An intoxicated person who (1) has threatened, attempted to inflict, or inflicted physical harm on another or is likely to inflict physical harm on another unless committed, or (2) is incapacitated by alcohol, may be committed to an approved public treatment facility for emergency treatment. A refusal to undergo treatment does not constitute evidence of lack of judgment as to the need for treatment.

(b) The certifying physician, spouse, guardian, or relative of the person to be committed, or any other responsible person, may make a written application for commitment under this section, directed to the administrator of the approved public treatment facility. The application shall state facts to support the need for emergency treatment and be accompanied by a physician's certificate supporting the need for emergency treatment and stating that the physician has examined the person sought to be committed within two days before the certificate's date.

(c) Upon approval of the application by the administrator in charge of the facility, the person may be brought to the facility by a peace officer, a health officer, a member of the emergency service patrol, the applicant for commitment, the patient's spouse, the patient's guardian, or any other interested person. The person shall be retained at the facility to which he was admitted, or transferred to another appropriate public or private treatment facility, until discharged under (e) of this section. However, no person may be detained under this section for more than 48 hours unless a district or superior court judge has reviewed and approved the commitment application.

(d) The administrator in charge of an approved public treatment facility may refuse an application if in his opinion the application and certificate fail to sustain the grounds for commitment.

(e) When on the advice of his medical staff the administrator determines that the grounds for commitment no longer exist, he shall discharge a person committed under this section. No person committed under this section may be detained in a treatment facility for more than five days. If a petition for involuntary commitment under AS 47.37.190 has been filed within the five days and the administrator in charge of an

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approved public treatment facility finds that grounds for emergency commitment still exist, he may detain the person until the petition has been heard and determined, but no longer than 10 days after filing the petition.

(f) A copy of the written application for commitment and of the physician's certificate, and a written explanation of the person's right to legal counsel, shall be given to the person within 24 hours after commitment by the administrator, who shall provide a reasonable opportunity for the person to consult with legal counsel. (§ 1 ch 207 SLA 1972)

Sec. 47.37.190. Involuntary commitment of alcoholics. (a) After a hearing initiated by petition of his spouse or guardian, a relative, the certifying physician, or the administrator in charge of an approved public treatment facility, a person may be committed to the custody of the office by the superior court. The petition shall allege that the person is an alcoholic who habitually lacks self-control in using alcoholic beverages and that he (1) has threatened, attempted to inflict, or inflicted physical harm on another and that unless committed is likely to inflict physical harm on another; or (2) is incapacitated by alcohol. A refusal to undergo treatment does not constitute evidence of lack of judgment as to the need for treatment. The petition shall be accompanied by a certificate of a licensed physician who has examined the person within two days before submission of the petition, unless the person whose commitment is sought has refused to submit to a medical examination, in which case the fact of refusal shall be alleged in the petition. The certificate shall set out the physician's findings in support of the allegations of the petition.

(b) After the petition is filed, the court shall fix a date for a hearing no later than 10 days after the date the petition was filed. A copy of the petition and of the notice of the hearing, including the date fixed by the court, shall be served on (1) the petitioner; (2) the person whose commitment is sought; (3) the next of kin of the person whose commitment is sought; (4) the administrator in charge of the approved public treatment facility in which the committed person has been committed for emergency care, and any other person the court considers appropriate. A copy of the petition and certificate shall be delivered to each person notified.

(c) If, not less than two days before the date fixed for the hearing, the person sought to be committed or his counsel or advisor files a written request with the superior court, the court shall summon and impanel a jury of six adult residents of the judicial district in which the court officiates, preferably from the court's jury list or the last voters list, if available, to hear and consider evidence concerning the condition of the person sought to be committed. (§ 1 ch 207 SLA 1972)

Sec. 47.37.200. Hearing on petition for involuntary commitment of alcoholics. (a) At the hearing required under AS 47.37.190(b), the court or the jury, if requested under AS 47.37.190(c), shall hear all relevant testimony, including, if possible, the testimony of at least one licensed physician who has examined the person whose commitment is sought. The person whose commitment is sought shall be present unless the court believes that his presence is likely to be injurious to him, in which case the court shall appoint a guardian ad litem to represent him throughout the proceeding. The court may examine the person in open court, or if advisable, examine him out of court. If the person has refused to be examined by a licensed physician, he shall be given an opportunity to request examination by a court-appointed licensed physician. If he fails to request a medical examination and there is sufficient evidence to believe that the allegations of the petition are true, or if the court believes that more medical evidence is necessary, the court may issue a temporary order committing him to the office for a period of not more than five days for purposes of a diagnostic examination.

(b) If after hearing all relevant evidence, including the results of any diagnostic examination by the office, the court or the jury finds that grounds for involuntary commitment have been clearly established, the court shall issue an order of commitment to the office. No court may order the commitment of a person unless it determines that the office is able to provide adequate and appropriate treatment for him.

(c) A person committed under AS 47.37.190 — 47.37.200 shall remain in the custody of the office for treatment for a period of up to 30 days. At the end of the 30-day period, he shall be discharged automatically unless the office, before the expiration of the period, obtains a court order for his recommitment upon the grounds set out in AS 47.37.190(a) for a further period of up to 90 days. If a person has been committed because he is an alcoholic likely to inflict physical harm on another, the office shall apply for recommitment if after examination it is determined that the likelihood still exists.

(d) A person recommitted under (c) of this section who has not been discharged by the office before the end of the 90-day period shall be discharged at the expiration of that period unless the office, before expiration of the period, obtains a court order on the grounds set out in AS 47.37.190(a) for recommitment for a further period not to exceed 90 days. If a person has been committed because he is an alcoholic likely to inflict physical harm on another, the office shall apply for recommitment if after examination it is determined that the likelihood still exists. No more than two recommitment orders may be permitted under (c) and (d) of this section.

(e) Upon the filing of a petition for recommitment under (c) or (d) of this section, the court shall fix a date for hearing no later than 10 days after the date the petition was filed. A copy of the petition and of the notice of hearing, including the date fixed by the court, shall be served

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on (1) the petitioner; (2) the person whose commitment is sought; (3) the next of kin of the person whose commitment is sought; (4) the original petitioner under AS 47.37.190(a), if different from the petitioner for recommitment; (5) any other person the court considers appropriate. AS 47.37.180(c) applies to hearings for recommitment under this section. At the hearing the court or the jury shall proceed as provided in (a) of this section.

(f) The office shall provide adequate and appropriate treatment for a person in its custody. The office may transfer a person in its custody from one approved public treatment facility to another if the transfer is medically advisable.

(g) A person committed to the custody of the office for treatment shall be discharged at any time before the end of the period for which he has been committed if either of the following conditions is met:

(1) when an alcoholic committed on the grounds of likelihood of infliction of physical harm on another is no longer considered an alcoholic or the likelihood of his infliction of physical harm no longer exists; or

(2) when, in the case of an alcoholic committed on the grounds of the likelihood of infliction of physical harm on another, either

(A) further treatment will not be likely to bring about significant improvement in the person's condition, or

(B) treatment is no longer adequate or appropriate.

(h) The court shall inform the person whose commitment or recommitment is sought of his right to contest the application, be represented by counsel at every stage of the proceedings relating to his commitment and recommitment, to have counsel appointed by the court or provided by the court, if he is unable to obtain counsel, and to a jury trial, if requested, as specified in AS 47.37.190(c). If the court believes that the person needs the assistance of counsel, the court shall require, by appointment if necessary, counsel for him regardless of his objection. The person whose commitment or recommitment is sought shall be informed of his right to be examined by a licensed physician of his choice. If the person is unable to obtain a licensed physician and requests examination by a physician, the court shall employ a licensed physician for the examination.

(i) If a private treatment facility agrees with the request of a competent patient or his parent, sibling, adult child, or guardian to accept the patient for treatment, the administrator of the public treatment facility shall transfer him to the private treatment facility.

(j) A person committed under this chapter may at any time seek discharge from commitment by writ of habeas corpus under AS 12.75. (§ 1 ch 207 SLA 1972)

Sec. 47.37.210. Records of alcoholics and intoxicated persons. (a) Except as required by AS 28.35.030(b), the registration and other records of treatment facilities shall remain confidential and are privileged to the patient.

(b) Notwithstanding (a) of this section, the coordinator may make available information from patient's records for purposes of research into the causes and treatment of alcoholism. No information may disclose a patient's name. (§ 1 ch 207 SLA 1972; am § 4 ch 152 SLA 1978)

Effect of amendment. — The 1978 AS 28.35.030(b)" to the beginning of amendment added "Except as required by subsection (a).

Sec. 47.37.220. Visitation and communication of patients. (a) Patients in any approved treatment facility under this chapter shall be granted reasonable opportunities for adequate consultation with counsel, and for continuing contact with family and friends including the use of telephone facilities, consistent with an effective treatment program.

(b) No mail or other communication to or from a patient in any approved treatment facility may be intercepted, read, or censored. (§ 1 ch 207 SLA 1972)

Sec. 47.37.230. Establishment of emergency service patrol. (a) The office and cities and boroughs may establish emergency service patrols. An emergency service patrol consists of persons trained to give assistance in public places to persons who are intoxicated. Members of an emergency service patrol shall be capable of providing first aid in emergency situations and shall be capable of transporting intoxicated persons to their homes and to and from public treatment facilities.

(b) The coordinator shall promulgate regulations for the establishment, training, and conduct of emergency service patrols. (§ 1 ch 207 SLA 1972)

Sec. 47.37.240. Payment for treatment. (a) A patient in an approved treatment facility, or the person obligated to provide for the cost of treatment of a person committed under this chapter, is liable to the office for the cost of maintenance and treatment of the patient in accordance with rates established by the coordinator.

(b) The coordinator shall promulgate regulations governing financial ability that take into consideration the income, savings, and other personal and real property of the person liable for the cost and maintenance of the patient. (§ 1 ch 207 SLA 1972).

Sec. 47.37.250. Nonapplicability. (a) Nothing in this chapter affects a statute, ordinance, or regulation relating to (1) drunken driving, driving under the influence of alcohol, or other similar offenses involving alcohol and the operation of a vehicle, aircraft, boat, machinery, or other equipment, (2) the sale, purchase, dispensation, possession, or use of alcoholic beverages at specified times and places or by a particular class of persons, including prohibitions against drinking intoxicating beverages in specified public places, (3) being upon the traveled portion of a highway so as to be a hazard to the motoring public.

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(b) Nothing in this chapter affects AS 11.70.030, relating to the defense of voluntary intoxication. (§ 1 ch 207 SLA 1972; am § 1 ch 186 SLA 1976)

Effect of amendment. — The 1976 amendment deleted "or" from the end of clause (1), added "including prohibitions against drinking intoxicating beverages in specified public places, or" to the end of clause (2), and added clause (3).

This section refers only to the sale, purchase, dispensation or use of alcoholic beverages. *Peter v. State*, Sup. Ct. Op. No. 1112 (File No. 2185), 531 P.2d 1263 (1975).

And not to being intoxicated at "specific times and places". — See *Peter v. State*, Sup. Ct. Op. No. 1112 (File No. 2185), 531 P.2d 1263 (1975).

A construction to expand the nonapplicability section to include anyone intoxicated on a highway would have the effect of emasculating the statute. *Peter v. State*, Sup. Ct. Op. No. 1112 (File No. 2185), 531 P.2d 1263 (1975).

Sec. 47.37.260. Application of Administrative Procedure Act. Except as otherwise provided in this chapter, the Administrative Procedure Act (AS 44.62) applies to and governs all administrative action taken by the coordinator under this chapter. (§ 1 ch 207 SLA 1972)

Sec. 47.37.270. Definitions. In this chapter

(1) "alcoholic" means a person who habitually lacks self-control in using alcoholic beverages, or uses alcoholic beverages to the extent that his health is substantially impaired or endangered, or his social or economic function is substantially disrupted;

(2) "approved private treatment facility" means a private agency meeting the standards prescribed in AS 47.37.140(a) and approved under AS 47.37.140(c);

(3) "approved public treatment facility" means a treatment agency operating under the direction and control of the office or providing treatment under this chapter through a contract with the office under AS 47.37.130(g) or through a grant awarded under AS 47.30.475, and meeting the standards prescribed in AS 47.37.140(a) and approved under AS 47.37.140(c);

(4) "commissioner" means the commissioner of health and social services;

(5) "coordinator" means the coordinator of the office of alcoholism;

(6) "department" means the Department of Health and Social Services;

(7) "emergency service patrol" means a patrol established under AS 47.37.230;

(8) "incapacitated by alcohol" means a person who is unconscious or has his judgment otherwise so impaired that he is incapable of realizing and making a rational decision with respect to his need for treatment, as evidenced objectively by extreme physical debilitation, physical harm or threats of harm to others or chronic inability to hold regular employment;

(9) "incompetent person" means a person who has been adjudged incompetent by the appropriate court;

(10) "intoxicated person" means a person whose mental or physical functioning is substantially impaired as a result of the use of alcohol;

(11) "office" means the office of alcoholism within the Department of Health and Social Services;

(12) "treatment" means the broad range of emergency, outpatient, intermediate, and inpatient services and care which may be extended to alcoholics and intoxicated persons, including diagnostic evaluation, medical, psychiatric, psychological, and social service care, vocational rehabilitation and career counseling. (§ 1 ch 207 SLA 1972; am § 4 ch 116 SLA 1978)

Effect of amendment. — The 1978 amendment inserted "or through a grant awarded under AS 47.30.475" in paragraph (3).

Quoted in *Peter v. State*, Sup. Ct. Op. No. 1112 (File No. 2185), 581 P.2d 1263 (1975).

APPENDIX - C

REVIEW BOARD ON ALCOHOLISM - BY LAWS