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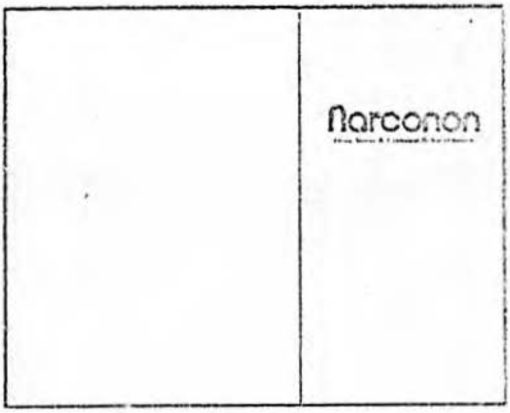

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WHAT IS NARCONON:

Narconon (meaning non-narcosis or the absence of stupor or insensibility) is an effective drug and criminal rehabilitation program that works to reduce drug abuse and drug-related crime. Narconon utilizes the very workable technology of American writer and humanitarian L. Ron Hubbard.

WHAT TYPES OF SERVICE DOES NARCONON OFFER:

- A special "Study Course" to help your client get a better education.
- Rehabilitation from drugs and crime.
- Individual, one-on-one counseling.
- Specialized youth counseling.
- Employment assistance.
- Education about drugs and their use.
- Helps your client get back into the community.
- Assist the person in getting the type of vocational training he desires.
- Comfortable living space and recreational activities both on the premises and at the public park less than 2 blocks away.
- 3 hot, well-balanced meals a day with special attention given to supplemental vitamins.
- A drug free, painless withdrawal done with 24 hour supervision, medical liaison and supplemental vitamins.

SUPERVISION:

While Narconon is not a "lock-down" program, there is a limited restriction period, and close supervision thereafter. Close liaison is maintained with you while your client is at Narconon and after he leaves.

NARCONON CAN HELP YOU:

Narconon can take your client under our arrangements with the California Youth Authority, California Department of Corrections (Civil Addict Program) and Ventura County Alcohol and Drug Abuse Placement Service. If your client does not qualify under one of these categories, we will gladly make special arrangements to assist you in any way possible. Narconon cares about your client making it in society.

WITHDRAWAL:

Narconon offers a drug-free, painless withdrawal for those clients who are still on drugs when they are referred to us.

FAMILY:

Whenever possible, Narconon maintains close contact with the client's family in helping them to fully understand his problem and to let them know what progress is being made by the individual. Narconon has good communication with all family members.

WHO DOES NARCONON ACCEPT:

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Narconon has a graduate follow-up program whereby close contact and liaison is maintained with each graduate. Special assistance is given to all Narconon graduates in helping them return to society.

NARCONON LOS ANGELES DIRECTOR JEANNIE JURICH

SUCCESS:

A 1976 survey of all clients handled from 1972-1976 at Narconon Los Angeles showed over 60% to be leading drug free lives. Narconon is an effective program that works.

SUCCESS STORY:

"After more than half my life — 12 years — on different drugs, heroin, barbiturates, morphine, alcohol intensively, I decided to come to NN. I'm very glad I did. I was extremely shy, I had no motivation to understand myself or face my problems. Through just 3 days of the program I have found truth, honesty and friendship within myself and others here at NN. I never realized I could feel happy and positive about just 'being' without the drug-induced state. It's been half my life in the shadows of misfortune, and finally the light is shining through. My mind and body have never been more positive and happy with myself and reality. I urge all of those who are in trouble, and I mean big trouble—'drug dependency'—to help themselves now by at least trying NN. If it can help me, you are a sure winner here at NN.

"Thank you all."

—S.L.

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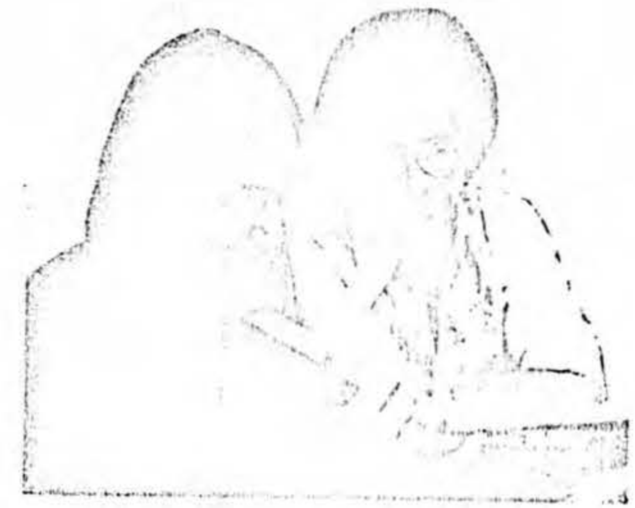

NARCONON COUNSELOR WORKING
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Narconon

Dear Sir:

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Our public lectures include students(Jr. High through College). Narconon L. A. has a "street facility" to handle relatively painless drug withdrawal and concurrent rehab training. No doubt you agree this is a worthwhile alternative to the downward spiral of criminality and insanity so prevalent today.

Our specific appeal to you would be a contribution of

Please know that our combined efforts are creating a safer and saner space to be in.

Sincerely,

Narconon, L.A.

A non-profit corporation founded in 1966 for the reduction of crime and drug abuse

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ALASKA FEDERATION OF NATIVES, INC.

Integrity, Pride in Heritage, Progress

PATTERNS OF MENTAL ILLNESS, ALCOHOL ABUSE, & DRUG ABUSE AMONG ALASKA NATIVES*

Robert Kraus**

* Report prepared under the auspices of the Alaska Federation of Natives, Inc.

** Professor, Medical Science, the Washington/Alaska/Montana/Idaho (WAMI) Program, University of Alaska, and Clinical Professor, Psychiatry, University of Washington.

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The Alaska Native community is struggling with mental health problems of great complexity and severity. The Aleut, Athabascan, Yupik, Inupiat, Tlinget, Haida, and Tsimpshian peoples of the American North, reacting to generations of neglect of their needs in this area, are united in their determination to reverse the steadily increasing tide of mental illness, behavioral disturbance, and social disorder under which they have labored in recent decades. This report, prepared under the auspices of the Alaska Federation of Natives, Inc. (AFN), outlines the scope and severity of the Alaska Native mental health problem. Utilizing a variety of indices it shows that the Alaska Native population suffers under a burden far exceeding that of Alaska non-Native, American Natives, and various other American minority groups. In recent years Native leadership, working closely with State and Federal agencies and with the technical assistance of the Alaska Area Native Health Service (AANHS), has made an outstanding beginning in meeting these problems. It is, however, a beginning. Continuing and increased support is urgently needed. The data in this report do more than outline an urgent health problem. They suggest that a fundamental reordering and rethinking of mental health and public health priorities and models for Alaska are indicated.

ALASKA: THE SETTING AND THE PEOPLE

The Arctic and Subarctic regions make up some 20% of the earths' land mass. They constitute the last great frontier and reservoir of untapped resources and are everywhere undergoing intense exploitation and development. Alaska, the American North, is participating in this worldwide process of socio-cultural and economic change. This fact plus other characteristics of life in Alaska make for unique problems and make models for the delivery of mental health services developed in other States of questionable value. This is especially true of rural Alaska.

Sheer geographical size and distance are a problem. Alaska's 586,000 square miles would enclose three (3) states of Texas. The distance from Shemya in the Aleutians to Ketchikan in the Southeastern panhandle is equivalent to the distance from Los Angeles to Charleston, South Carolina. The distance from Barrow, the northern-most town in the United States, to Kodiak in the Gulf of Alaska is roughly equal to the distance from the Northern Minnesota border to the Arkansas/Louisianna line. Alaska covers four (4) different time zones; when it is 3 p.m. in Anchorage, the State offices in Juneau are closed for the day.

This vast area manifests great ecological diversity. The rain forest of the Southeastern area with its relatively mild climate and abundant natural reservoir constitutes one of the richest and most diverse natural environments in the world. The Alaska Interior, bounded on the North by the Brooks Range and on the South by the Alaska Range is felt by some to constitute one of the harshest environments in the world with winter temperatures ranging to -70^{0} and summer temperatures in the 90's. In contrast, the Aleutian Islands constitute a typical maritime environment which, in turn, is quite distinct from the flat, treeless windswept tundra and frozen coasts of North and West Alaska.

Within this diverse range of ecosystems over thousands of years the Native people of Alaska have developed their distinctive cultural adaptations. "Alaska Native" is fundamentally an administrative term. The Aleuts of the Aleutian Chain, the Athabascans of the Interior, the Tlinget, Haida, and Tsimpshian of the Southeast, the Yupik of West Alaska, and the Inupiat of North Alaska are historically, linguistically, socially and culturally quite distinct. Figure 1 illustrates the traditional geographic distribution of the Native people, a distribution which holds true to a great extent today.

The dotted line across the center of the State demarcates Native from non-Native Alaska. North of the line the population is predominantly rural and Native. South of the line, it is predominantly urban and non-Native with heavy concentrations in Anchorage and Fairbanks.

Alaska Natives are, therefore, widely scattered and live in a wide range of physical environments. Table 1 shows a recent compilation of population figures (Buffler and Kraus, 1977) for the year 1974. The 1977 total figure would probably be in the neighborhood of 64,000. The majority (60%) of Natives live in rural villages. These are remote locations, usually accessible only by airplane, boat, or snowmachine, in which the Native language tends to be spoken and traditional subsistence techniques figure prominently in the way of life. Villages tend to have populations under 500. A smaller number of Natives (approximately 20%) reside in rural predominantly Native towns. These towns tend to have populations of 2,000 or more. English tends to be spoken and there is greater emphasis on a wage and cash economy. Other Natives (approximately 20%) live in the western urban environments of cities such as Anchorage, Fairbanks, and Juneau.

It is clear, therefore, that the patterning of mental illness and the delivery of mental health services in rural Alaska is complicated by a variety of factors that render the application of concepts and models developed elsewhere difficult. Distance which adds enormously to expenses of travel, isolation due to geographical inaccessibility and the vagaries of the weather, problems of communication via radio, wide regional differences in perceived needs, and cultural diversity are only some of the factors which must be taken into account in planning. (Kraus, 1971).

MENTAL HEALTH: THE HISTORICAL DIMENSION

Mental illness has always been a part of Native life just as in all other cultures of the world. The earliest explorers in the Arctic noted the presence of people who appeared to be mentally ill and remarked upon the kindness and compassion with which they were treated in comparison with the abysmal standards of care then prevalent in the Western world. Certainly in precontact and contact times each Native culture had its own concepts of mental illness, its cause, and its effective treatment. Much of this knowledge has been lost in the process of acculturation; however, much persists (Vallee, 1967). The systematic elucidation of Native traditional concepts of mental illness and its treatment should have a high research priority. Such a body of knowledge would be invaluable to both Native and non-Native practicioners.

Until statehood, the only provision for mental health services in Alaska consisted of a contract between the Department of the Interior and Morningside Hospital in Oregon under the terms of which mentally ill Alaskans could be hospitalized. Between January 1, 1904 when the contract was initiated and its termination around the time of Statehood several thousand Alaskans including hundreds of Natives were hospitalized at Morningside (Albrecht, 1948). Statehood with the subsequent contruction of the Alaska Psychiatric Institute and the opening of State clinics in Anchorage, Fairbanks, and Juneau raised the standard of care for non-Natives somewhat but had little impact on Native needs other than providing hospitalization in Anchorage at the Alaska Psychiatric Institute as an alternative to Morningside. In the 1950's and 1960's, mental health services in rural Alaska were provided by an informal network of Indian Health Service personnel, Public Health Nurses, Social Workers, and Clergymen none of whom were trained and all of whom were overburdened with other pressing responsibilities. As recently as 1971, it was possible to State that in all of the Native communities of rural Alaska there was no person, Native or white, professional or non-professional, who was working full-time in the provision of mental health services (Kraus, 1971).

The 1970's have seen two (2) important developments. The first was the Alaska Native Land Claims Settlement which resulted in the formation of 13 Native regional corporations, 12 located in Alaska. Through the Regional Health Corporations of their non-profit components, the Native Regional Corporations began to address themselves to their own health affairs. Mental health and alcohol and drug abuse were early assigned a high priority. For years Native leaders had pointed out the urgency of mental health and alcohol problems to no avail; the Native Health Corporations now provided a structure through which they could take affective action. The second development was the reorganization of the State Department of Menatl Health. Under new and continuir eadership work was completed which led to the passage of community mental he lth center legislation for Alaska, years after the implementation of such legislation in other States. The monies thus made available have ushered in an era of cooperation between the Federal government, the State Department of Mental Health, and the Native Health C porations of benefit to all concerned. Fifteen mental health centers have been set up in Alaska. Five of these have strong Native sponsorship and affiliation.

AN OVERVIEW OF NATIVE MENTAL HEALTH & ALCOHOL PROBLEMS

The encouraging first steps of the Native people and their leaders outlined above offer a note of encouragement in a picture which is otherwise quite serious and alarming. The Alaska Native people suffer under a crushing burden of problems related to mental illness and drug and alcohol abuse. A small number suffer from illnesses of a traditional nature, fully understandable only in terms of their culture. In addition they are subject to all of the standard mental illnesses found worldwide and it would appear that as a population, they are experiencing an increased incidence of these. Also, they are experiencing a variety of behavioral and social disruptions in reaction to the stress an acculturative process which is excruciating in its speed and intensity. Alcohol abuse relates to and exacerbates all of the above and is in all regions of Alaska a major and serious problem. Starting from a baseline which goes back to 1950, the standard indicators of mental disorder and social stress in populations all indicate that Alaska Natives represent cultures that are being heavily stressed. The number of Natives treated on an inpatient and outpatient basis for mental illness and alcohol and drug abuse in Indian Health Service facilities has been rising steadily. Institutionalization of Natives at the Alaska Psychiatric Institute (API) is at a rate 2.6 times that of Caucasians. The first full year of reporting for the Community Mental Health System reveals a Native utilization rate 1½ times that of Caucasians. Suicide attempts in the Native population occur at a high frequency as do non-fatal accidents. Native death rates due to suicide, homicide, accidents and alcohol are high and rising. A variety of indicators show that alcohol abuse problems in both the Native and non-Native populations in Alaska are among the most severe in the nation. The available information suggests that the magnitude of problems experienced by Alaska Natives is far greater than that of Alaska non-Natives or the United States population generally and significantly greater than that of American Natives outside of Alaska.

A DETAILED SURVEY OF NATIVE MENTAL HEALTH & ALCOHOL PROBLEMS

In the next two (2) sections, certain data relevant to mental illness and drug and alcohol abuse in Alaska Natives mentioned briefly above will be reviewed in greater detail. The first section, "Patterns of Utilization" will deal primarily with various mental health service facilities and the rates of utilization of these services by Alaska Natives as compared to other groups.

It should be pointed out that true figures for the incidence and prevalence of mental illnesses and alcohol abuse have not been established with certainty for Alaska Natives or any other major United States population. Judgments concerning Alaskan problems are particularly difficult to make because of the lack of any uniform State health and mental health information system. The development of such a system for the Native population should have a high research priority and would provide information of considerable utility. Establishing the number of people who utilize a service or calculating utilization of service rates for a population is not a direct measure of the frequency of a disorder in that population rather, they are statistics from which it is possible to make inferences about the frequency of the disorder and whether it is increasing or decreasing.

The next section, "Patterns of Mortality", will present certain informative as to mortality patterns in Alaska Natives and other populations with particular references to violent death and discuss these patterns in terms of their mental healt and alcohol abuse significance.

PATTERNS OF UTILIZATION

Background and baseline date as has been noted, epidemiological information concerning the incidence and prevalence of mental illness and alcohol and drug abuse in Alaska Natives has been sadly lacking; therefore, adequate baseline date do not exist. Foulks and Katz (1975) made a limited attempt to survey the problem by analyzing all discharges from the seven Alaska Area Native Health Service General Medical and Surgical (GM & S) hospitals during 1968. The Native Health Service is part of the Indian Hea th Service (IHS) and is the principal provider of health services to Native Alaskans. Foulks and Katz found alcoholism to be the most prevalent mental disorder in all the Native ethnic groups; however, it appeared most common in Athabascan Indians and Aleuts Aleuts appeared to have a low incidence of schizophrenia. Paranoid disorders were most common among the Southeastern Indians who generally lived in larger communities and who had a larger history of contact into white society. Overt depression was most common among Eskimos and was particularly frequent in the larger villages. In fact, all types of mental disorder seemed several times more prevalent in the larger rural Native towns than in the more traditional Native villages. Anxiety neurosis and alcoholism were felt to be most common in the urban environment.

Kontsky (1971) surveyed all admissions to API during the interval 1965-1971. A total of 464 cases were involved. Kontsky commented at length on the difficulties encountered in apply Western psychiatric concepts and techniques across cultural lines, extreme problems of maintaining communication with the distant Native communities from which many of his patients came, and the virtual absence of a follow-up and aftercare system for rural Native patients which resulted in relapse and re-admission for many. He noted that 54% of Native hospital admissions had a history of difficulty with alcohol and 26% of Native patients had a positive history for suicidal behavior. He also noted that both of these percentages were higher than corresponding percentages for the non-Native population.

IHS: GENERAL PATTERNS OF SERVICE

Using this incomplete and superficial information as a baseline an attempt will be made to delineate current trends.

Alaska's seven (7) IHS hospitals and their related outpatient facilities continue to be the principal providers of mental health and alcohol services to Alaska Natives. Tables 2, 3, and 4 show the overall pattern of IHS services during the interval 1971-1976. Table 2 shows admissions to IHS GM & S hospitals and admission rates for the interval. Tables 3 and 4 show outpatient first visits and total visits and respective workload rates. The figures in Tables 2, 3 and 4 illustrate the steadily increasing rates of Native utilization of outpatient services and a corresponding gradual decrease in use of inpatient services, a statistic which reflects the increased amount and quality of outpatient care.

IHS: INPATIENT & OUTPATIENT SERVICES FOR DRUG & ALCOHOL ABUSE

Table 5 shows admissions to IHS hospitals for an admitting diagnosis related to alcohol and drug abuse during the interval 1971-1976. Since 1971, the number of admission diagnoses of drug and alcohol abuse has increased from 334 to 433. The percentage of total admission diagnoses of this type has increased from 3.1% to 4.5% while the admission rate/ 100,000 individuals has increased from 659.4/100,000 to 791.3/100,000.

Table 6 relates also to hospital admissions and shows all diagnoses of drug and alcohol abuse made in IHS hospitals during the interval 1971-1976 regardless of reason for admission.

During the interval, the number of such diagnoses increased from 602 to 818. The percentage of total diagnoses increased from 3.7% to 5.2% and the morbidity rate went from 1188.5/100,000 to 1494.9/100,000.

Table 7 and 8 deal with outpatient or ambulatory care for diagnoses of drug and alcohol abuse in the IHS hospitals. Table 7 shows that first visits for drug and alcohol abuse increased from 1012 to 3712. The percent of total vi its increased from 1.8% to 2.5% and the incidence of such first visits increased from 3972/100,000 to 6783/100,000. Table 8 shows total visits for drug and alcohol diagnoses and total workload rates for the interval in question. It can be seen that the total visits increased from 2985 to 5487. The percent of total visits went from 1.5% to 2.0% while the total workload rate increased from 5892/100,000 to 10,027/100,000.

IHS: INPATIENT & OUTPATIENT SERVICES FOR MENTAL ILLNESS

Table 9 shows the IHS figure for admissions to hospitals with an admitting or first diagnosis of mental illness. The number of such admissions during the interval 1971-1976 has increased from 625 to 773 while the percent of total admission has climbed from 5.7% to 8.1%. The admission rate for persons diagnosed as mentally ill went from 1233/100,000 to 1412/100,000.

Table 10 also deals with hospital care and shows all diagnoses of mental disorder made in IHS hospitals between 1971 and 1976 regardless of reason for admission. The number of such diagnoses has risen from 1171 to 1365 during the interval. The percent of total diagnoses that they comprise has risen from 7.1% to 8.7%. The rate has gone from 2311.8/100,000 to 2494/100,000.

Tables 11 and 12 deal with outpatient care for mental illness in the IHS and show a pattern consistent with the one already described. Table 11 shows that first visits for mental illness have increased from 2180 to 3111 in the interval 1971-1976. The percent of total first visits rose from 2.0 to 2.1 while the rate increased from 4303/100,000 to 5695/100,000. Total outpatient visits for mental illness, as illustrated in Table 12 increased from 5496 to 7886. The percent of total visits has varied between 2.8% and 3.4% being 2.9% in 1976. The total workload rate for mental illness has risen from 10,850/100,000 to 14,411/100,000.

The IHS statistics are worth considering in detail because of the relatively consistant picture they portray. Alaska Natives have been utilizing both outpatient and inpatient services for mental illness and drug and alcohol abuse in steadily increasing numbers since 1971. Treatment of the alcoholic and the mentally ill now comprises a significant percentage of the total workload in these general medical and surgical hospitals. On close examination of the tables decreases will be noted in some areas in the year 1976. Two possible explanations exist which might account for these decreases. The first is the availability of Community Mental Health Services to the Natives for the first time in 1976. An analysis of Native utilization of these services is presented below. Second, the decreare may simply represent a random variation by year since incomplete data for 1977 suggest that utilization is once again rising.

IHS: ACCIDENTS AND ALCOHOL

The incidence of accidents and injuries is commonly held to be an indicator of mental health and degree of stress in a population. Alaska Natives have an extraordinarily high rate of fatal and non-fatal accidents. As will be discussed later, accidents are the leading cause of death for Alaska Natives. Non-fatal accidents and injuries contribute a significant portion of the workload in the IHS system. Table 13 illustrates this phenomenon during the interval 1971-1976. It can be seen that the number of accidents seen went from 10,043 to 12,584 in the interval with 13,543 accidents and injuries seen in 1975. A significant percentage of these ranging from 11.5% to 17.8% were alcohol related.

IHS: SUICIDAL BEHAVIOR

As with accidents, suicide attempts and gestures are considered an index of mental difficulty and stress in a population. Tables 14, 15 and 16 outline this problem with respect to Alaska Natives. Table 14 shows the number of suicide attemptors treated on an outpatient basis each year during the interval 1971-1976. It can be seen that the number of attempt rs has varied from 104 to 161 per year with rates ranging from 205/100,000 one year to 198/100,000 per year. A significant percentage of these suicide attempts ranging from 43.3% to 59.7% in various years were alcohol related. Table 15 outlines another dimension of the problem. It shows the number of Natives hospitalized for suicide attempts during the same interval. The number ranges from 90 to 129 with rates ranging from a low of 164.5/100,000 per year to 250.9/100,000 per year. It is worth noting that if one combines the outpatient and inpatient rates for the year 1973, a year in which suicidal attempts seemed quite frequent, a combined rate of 518/100,000 per year is obtained. This is a questionable procedure since there is probably some overlap between the two populations with a small number of hospitalized attempters not being admitted directly as emergencies but being recorded as outpatients first. The combined rate is pointed out only to suggest the magnitude of the problem. Tables 14 and 15 deal only with attempts severe enough to receive medical attention at a hospital. The true incidence of suicidal attempts involves a more comprehensive survey and is more difficult to establish. Such surveys have been attempted of various populations and are summarized in table. Table 16 shows suicide attemptor rates calculated by various investigators for different populations. The city of Los Angeles rate was reported by Mintz (1970) to be 150/100,000 per year. Shore (1972) reported a rate of 450/100,000 per year for a combined Northwest American Indian Reservation population. Miller and Schaenfeld (1971) calculated a rate for Navajo of 89.6/100,000 per year. Kraus (1974) calculated a rate for a rural Alaskan Native town of 1450/100,000 per year and a rate for the Native population of Anchorage of 1000/100,000 per year. Thus, it seems clear that suicidal behavior, much of it alcohol related, is a major and ongoing problem for Alaska Natives and that it is a problem of greater magnitude than is seen in other American Native and non-Native populations. (Kraus, 1972_a, 1972_b)(Kraus & Buffler, 1976).

COMMUNITY MENTAL HEALTH CENTERS

The developing Community Mental Health Center system in Alaska has been mentioned above. 1976 was the first full reporting year for the 15 centers. Table 17 summarizes Native and Caucasian utilization of the services of the various centers statewide. 617 Natives were seen in Community Mental Health Centers in 1976 for a rate of 1011/100,000 per year. 1993 Caucasians were seen in Community Mental Health Centers for a rate of 664/100,000 per year. These low and preliminary figures show that Alaska Natives are being treated in Centers at a rate 1½ times that of Caucasians.

ALASKA PSYCHIATRIC INSTITUTE

The Alaska Psychiatric Institute (API), the States only psychiatric hospital, plays a significant role in offering mental health services to Natives. Rates of admission to psychiatric hospitals have long been one of the classical indices of the mental health of a population as well as a measure of the quality of alternative modes of treatment available. Table 18 shows Alaska Native and Caucasion admissions to the API by number of patients, admission rates, and fiscal year 1973-1976. It can be seen that Native admissions have ranged from 184 to 227 with admission rates falling between 325/100,000 per year and 381/100,000 per year. Caucasian admissions have numbered between 309 and 481 with rates between 115/100,000 per year and 160/100,000 per year. State and County hospital admission rates have been calculated for various other United States populations and are available for comparison. Table 19 illustrates such a comparison. The combined from year admission rate (1973-1976) for Alaska Natives to the State hospital is 353/100,000 per year. The corresponding rate for Alaska Caucasians in 136/100,000 per year. In 1972, the U.S. total white rate for admission to State and County hospitals was 181.7/100,000 per year. The corresponding rates for U.S. Hispanic/American and U.S. non-white populations are 133.7/100,000 per year and 306.3/100,000 per year respectively. The total U.S. population rate in 1972 was 197.2/100,000 per year. The high admission rate for the non-white population, which is overwhelmingly composed of Black Americans, is a well known statistic and is commonly cited as evidence of the stress experienced by Blacks in our society and of the unavailability to them of treatment alternatives short of hospitalization. The Alaska Native admission rate is higher than that for American Blacks and 2.6 times the rate for Alaska Caucasians.

PATTERNS OF MORTALITY IN ALASKA

People in different populations tend to die at different rates from a variety of causes. The comparison of patterns of mortality of populations gives insight into their health status and the differential stresses which infringe upon them. Violent death, that is, deaths due to accident, homicide, suicide, and alcohol is seen by many as an indicator of the mental health of a population. The stresses which are endured by its members, and its degree of social disorganization. In this section, overall patterns of mortality and patterns of mortality due to violence in Alaska Natives will be presented and compared with other U.S. populations. (Kraus & Buffler, 1977)

OVERALL PATTERNS (1950-1974)

The flow of events in Alaska in recent decades has been accompanied by rather distinctive changes in the patterning of mortality among the various populations in the State. The data presented here represent a synthesis and analysis of a sample of all deaths due to violence in Alaska during the period 1950-1974 as well as relevant data from a variety of sources. (Frederick, 1973) (Iskraat & Johet, 1968) Erhardt & Berlin, 1974).

Figure 2 shows mortality, expressed as percent of total mortality, for the total Alaskan population for selected causes for five year intervals during the period 1950-1974. The general categories for cause of death are: infectious disease; chronic disease, which comprises heart disease, cancer, stroke, and a variety of other chronic diseases usually classified separately; violent, or preventable deaths, which comprise deaths due to accident, suicide, homicide, and alcohol; and deaths due to other causes. It can be seen that deaths due to infectious disease are decreasing and deaths due to chronic disease are increasing although the percentage of deaths due to chronic illness is significantly lower than that of the total U.S. pattern. Violent death is undergoing a steady increase until in the most recent interval it comprises in excess of 30% of the total picture. It should be noted that the total Alaskan population is heavily weighted towards non-Natives. Only 20% of the population is Native.

Figure 3 presents comparable data for the non-Native population of Alaska. This pattern is characterized by an increasing percentage of deaths due to chronic illness although the percentage remains significantly below the United States, all races, percentage. Apparent again is a high percentage of mortality attributable to violent deaths.

Figure 4 illustrates the mortality pattern for the Native population of Alaska. Striking changes over the last 25 years are evident. Deaths due to infectious disease have declined precipitously while deaths due to chronic disease have increased, a phenonmenon due at least in part to greatly improved medical care. Of particular note is the stepwise increase in the percentage of violent deaths. During the interval 1950-1954, the percentage of deaths among Natives due to violence was slightly more than half the percentage for non-Natives even though the Natives, by and large, lived in a more dangerous environment. In the more recent intervals the percentage of violent deaths grew more rapidly for Natives than non-Natives until, in the most recent interval it constitutes slightly in excess of 40% of the total Native mortality.

VIOLENT DEATHS (1950-1974)

Further definition of this emerging problem of death due to violence can be obtained by examining the death rates for each type of violent death-accident, suicide, homicide, and alcohol-for both Natives and non-Natives for the same time period and comparing the rates to those of other United States populations.

Figure 5 shows annual accident death rates for Alaskan non-Natives, Alaskan Natives, total American Indians (including Alaskan Natives), and the U.S., all races. The Alaskan rate seems to be a manifestation of a phenomenon effecting American Indians generally. The Alaskan non-Native rate fell during the interval 1950-1964 and has remained stable although significantly higher than the U.S., all races, rate.

Comparable figures for homicide are summarized in Figure 6. Current Alaskan Native and American Indian homicide rates are high, roughly comparable, and reflect an increasing problem of homicide in the U.S. generally. It is of interest to note that the Alaskan non-Native rate has decreased in each time interval and currently is lower than the United States, all races, rate.

Examination of Figure 7 reveals that the Alaskan Native suicide rate diverged sharply from the American Indian and United States, all races, rates after 1965. As with homicide, the suicide rate for Alaskan non-Natives has decreased steadily since 1950 and is now below the United States, all races, rate.

Deaths due to alcohol present problems of recognition and definition. The alcohol death rates for Alaskan Natives and non-Natives summarized in Figure 8 are based on review and analysis of all alcohol related deaths recorded by the Bureau of Vital Statistics, Alaska, during 1950-1974. Only those cases coded according to the International Statistical Classification of Diseases, Injuring, and Causes of Death as due to alcoholic psychosis, acute alcoholism, chronic alcoholism, alcoholic cirrhosis, or alcohol poisoning as the primary cause of death were utilized. Comparable figures are difficult to obtain because of wide variation in way alcohol mortality statistics are recorded in different areas and health care systems. Deaths due to these causes are increasing in both Natives and non-Natives with the Native increase being more noticeable.

The data presented above concerning overall patterns of mortality and mortality related to violence are summarized in Table 20 which presents figures for the year 1970. The familiar U.S. pattern, mentioned previously, with its large preponderance of deaths due to heart disease, cancer, and stroke is at sharp variance with the Alaskan pattern. Violence, defined as accidents, homicides, suicides, and deaths due to alcohol, is the leading cause of death in Alaska. This is true of both Native and non-Native populations. Among the non-Natives over the last ten years, the pattern has been maintained by a consistently high rate of death by accident and an increasing rate of deaths due to alcohol. Suicide and homicide are decreasing. Among Natives, the pattern of violent death is related to increases in all four categories.

SUMMARY

Although the information incorporated in this report is uneven in quality, incomplete, and drawn only from those health care systems available to Natives which are Statewide in scope, the picture which emerges is clear, ominous, and urgent. Within the various facilities of the Indian Health Service the number of individuals treated both as inpatients and outpatients for mental illness and drug and alcohol abuse rises year by year. Currently over 1/5 of the Native population is treated in a hospital facility for non-fatal accidents and injuries each year and many of these accidents are alcohol related. Suicide and suicide attempts are common; the rates for each of these behaviors far exceed recorded rates for other American Native and non-Native groups. Within the newly developmental health centers, the Native populations are utilizing services at a rate significantly exceeding that of Caucasians despite the fact that all of the best established and larger centers are in predominantly non-Native environments. The institutionalization rate for Natives at the State hospital far exceeds that for Caucasians and is greater than rates recorded for other American minority groups, most notably Blacks, which have long been considered evidence of higher incidence of mental illness and unavailability of an adequate range of services showt of hospitalization. These figures are all the more noteworthy since they are very conservative. It should be remembered that they are derived from a population which has for the most part little or no access to mental health and alcohol services available to them. Also they are derived from a health information system which is at best rudimentary. Review of the documents submitted in conjunction with this report will identify various small, local Native mental health and alcohol programs to be in operation. By and large, the individuals served by these programs are not included in the data surveyed here. Alaska Native rates of violent death are cause for profound concern. For each category of violent death, suicide, homicide, accidents, and alcohol, Alaska Native rates are higher than non-Native, Native, and all races rates and are rising.

Descriptive statistics upon which a report at this level of inclusiveness must rely give the illusion that the problems dealt with are discrete, separable, and specific. They obscure the inter-relatedness and inseparability of the issues. Alcohol abuse, for example, cuts across all the categories covered above. It complicates and exacerbates most mental illnesses in Natives. A majority of the morbidity and mortality due to violence is alcohol related. In addition, however, alcohol abuse produces a host of problems related to family description, child abuse, spouse abuse, physical illness, and behavioral and social deviance which defy precise enumeration. Most clinicians whose practice includes Native patients feel that a significant but unknown increment of physical illnesses among Natives, such as diabetes mellitus, heart disease, certain neoplasms, cirrhosis of the liver, influenza and pneumonia, gonarrhea and other venereal diseases, nutritional disturbances, and complications of pregnancy are caused and/or aggravated by alcohol abuse. A family unit disrupted by alcohol is a fertile breeding ground for a variety of physical, psychological and social disorders.

A single clinical example might serve to develop this point further. In recent years, a Native family received intensive and ongoing psychiatric evaluation. The family consisted of an aged father and nine living adult sons and daughters. The mother and 3 children had died some years prior to the evaluation. At the time of evaluation, the family members were found to have the following history: 20 episodes of hospitalization involving all 10 of the living members, 12 suicide attempts involving five members, 2 homicides, 1 negligent homicide, 11 hospital admissions involving 6 members, 7 divorces involving seven members, 3 cases of severe drug abuse involving 3 members and, 1 accidental death of a member. One member was married to a mentally ill person who required hospitalization. Another member was married to a person who made a living selling drugs. (Richards, Kraus, & Shields, 1977)

This family, of course, is not presented as being representative of Native family life. Rather, it is presented to demonstrate the inter-relationship and concurrence of the problems reviewed in this report. This extreme case highlights the plight of many large, multiproblem, Native families and illustrates the demoralizing impact that mental illness and alcohol abuse has upon them.

The documents submitted by Native organization and various components of the Indian Health Service fill in the local and regional detail which does not emerge in this general summary. Thus, we hear the people of Barrow state that "alcohol stands alone" as the major cause of death and crime on the Slope. The Pacific Rim Corporation states "accidents, acute alcohol intoxication, chronic alcoholism, cirrhosis of the liver, and depressive neurosis occur consistently." Maniilaq states "40% of the 4,995 people in the service area are in need of some mental health services."

The Native people of Alaska and their leaders have mobilized themselves and are determined to meet the crisis in mental health drug and alcohol abuse which confronts them. They are struggling to organize programs which are family oriented, community based, culturally appropriate and which utilize the indigeneous resources of the area. Continued and increased cooperation and support on the State and Federal level are essential. It is a time for fundamental rethinking of mental health priorities in Alaska so as to assign the areas outlined in this report and the accompanying reports the emphasis they deserve. Moreover, it would appear that the overall model for public health priorities and services in Alaska, oriented as it is towards such traditional themes as chronic illness and infectious disease, needs revision in that it seems not to address itself to the primary Public Health problems in the State-Behavioral disturbances and violent death.

TABLES & FIGURES
IN ORDER CITED
IN TEXT

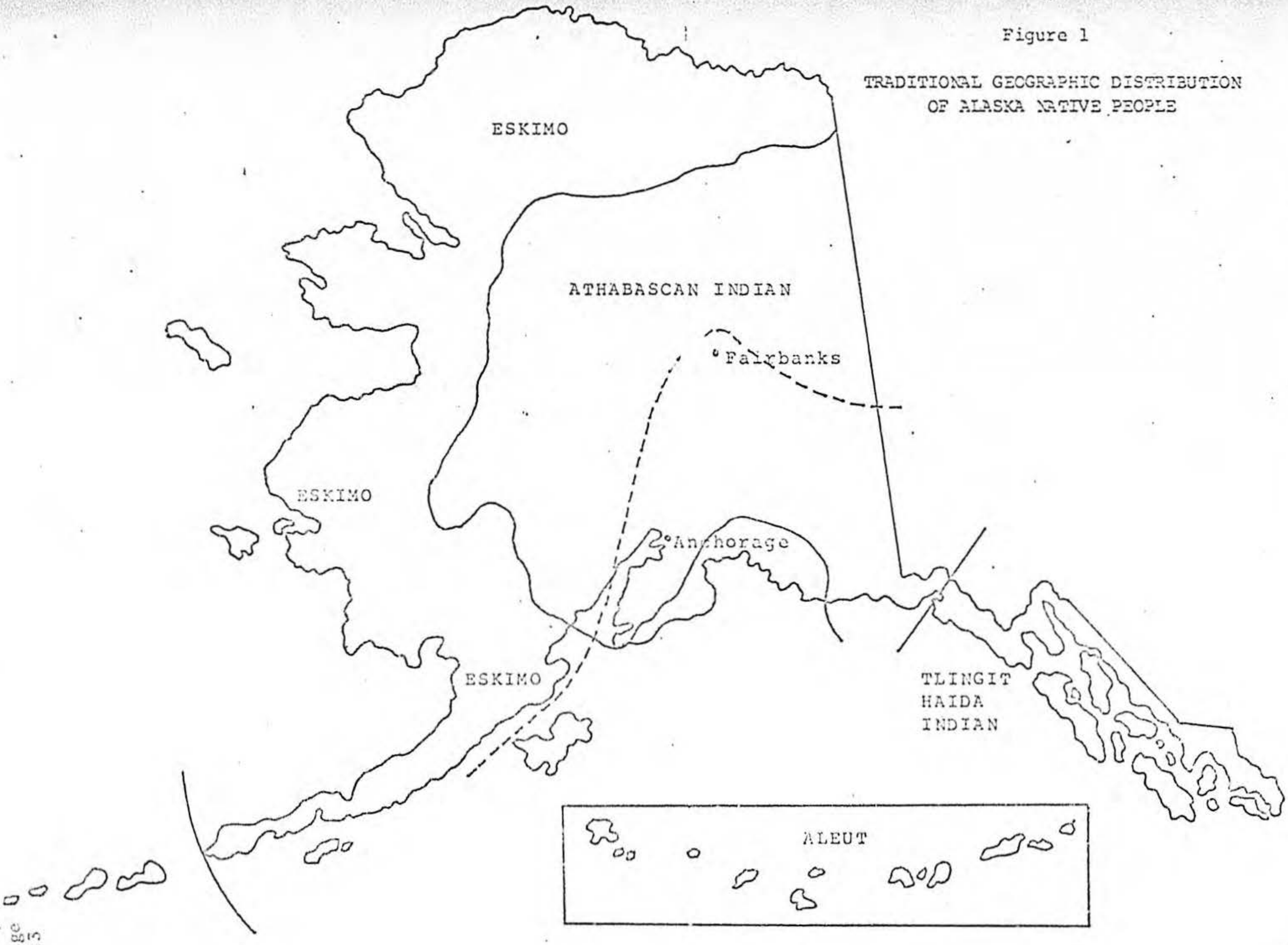

Figure 1

TRADITIONAL GEOGRAPHIC DISTRIBUTION OF ALASKA NATIVE PEOPLE

Table 1

THE POPULATION OF ALASKA, 1974

Natives (N=56,861)	
Northern Eskimo	11,842
Western Eskimo	24,255
Athabascan	7,291
Aleut	2,869
Tlingit, Haida, Tsimpshian Indian	10,604
Non-Native (N=294,214)	
Caucasian	280,215
Black	10,547
Asian American	3,452
Total	351,075

TABLE 2

Alaska Area Native Health Service, Admissions to IHS GM & S Hospitals and Admission Rates by Fiscal Year, 1971-1976

FISCAL YEAR	TOTAL ADMISSIONS	ADMISSION RATE/100,000
1971	10,904	21,526.4
1972	11,396	22,166.5
1973	10,664	20,441.7
1974	10,524	19,821.8
1975	9,677	17,951.6
1976	9,575	17,498.5

Office of Systems Development

TABLE 3

Alaska Area Native Health Service, First Visits and Incidence rates for Ambulatory Patient Care Given in IHS Facilities For All Diagnoses by Fiscal Year, 1971-1976

FISCAL YEAR	FIRST VISITS	RATE/100,000
1971	110,877	218,890
1972	121,187	235,721
1973	141,425	271,095
1974	122,452	230,636
1975	143,645	266,473
1976	149,665	273,515

Office of Systems Development

TABLE 4

Alaska Area Native Health Service, Total Visits and Total Workload Rates for Ambulatory Patient Care Given In IHS Facilities For All Diagnoses, by Fiscal Year, 1971-1976

FISCAL YEAR	TOTAL VISITS	TOTAL WORKLOAD RATE/100,000
1971	199,519	393,886
1972	202,038	392,985
1973	223,954	429,293
1974	246,896	465,025
1975	264,402	490,487
1976	268,409	490,522

Office of Systems Development

TABLE 5

Alaska Area Native Health Service Admissions to IHS - GM & S Hospitals and Admission Rates for Patients Receiving Care For Admission Diagnoses (First Diagnoses) Relating to Alcohol and Drug Abuse by Fiscal Year, 1971-1976

FISCAL YEAR	ADMISSIONS	% OF TOTAL ADMISSIONS	ADMISSION RATE/100,000
1971	334	3.1	659.4
1972	384	3.4	746.9
1973	377	3.5	722.7
1974	476	4.5	896.5
1975	428	4.4	794.0
1976	433	4.5	791.3

Office of Systems Development

TABLE 6

Alaska Area Native Health Service All Diagnoses Related to Drug and Alcohol Abuse of Patients Receiving Care In IHS - GM & S Hospitals Regardless of Reason for Admission by Fiscal Year 1971-1976

FISCAL YEAR	NO. OF DIAGNOSES OF DRUG AND/OR ALCOHOL ABUSE	% OF TOTAL DIAGNOSIS	MORBIDITY RATE/100,000
1971	602	3.7	1188.5
1972	658	3.7	1279.9
1973	711	4.6	1362.9
1974	871	5.6	1640.5
1975	796	5.5	1476.6
1976	818	5.2	1494.9

Office of Systems Development

TABLE 7

Alaska Area Native Health Service First Visits and Incidence Rates for Ambulatory Patient Care Given in IHS Facilities For Diagnoses Relating to Alcohol and Drug Abuse by Fiscal Year, 1971-1976.

FISCAL YEAR	FIRST VISITS	% OF TOTAL VISITS	INCIDENCE RATE/100,000
1971	2,012	1.8	3,972
1972	2,401	2.0	4,670
1973	3,592	2.5	6,885
1974	3,501	2.9	6,594
1975	4,129	2.9	7,659
1976	3,712	2.5	6,783

Office of Systems Development

TABLE 8

Alaska Area Native Health Service Total Visits and Total Workload Rates for Ambulatory Patient Care Given in IHS Facilities For Diagnoses Relating to Alcohol and Drug Abuse by Fiscal Year, 1971-1976

FISCAL YEAR	TOTAL VISITS	% OF TOTAL	WORKLOAD RATE/100,000
1971	2,985	1.5	5,892
1972	3,457	1.7	6,724
1973	4,880	2.2	9,354
1974	5,297	2.1	9,976
1975	5,747	2.2	10,661
1976	5,487	2.0	10,027

Office of Systems Development

TABLE 9

Alaska Area Native Health Service Admissions to IHS - GM & S Hospitals and Admission Rates for Patients Receiving Care For Admission Diagnoses (First Diagnosis) of Mental Illness By Fiscal Year 1971-1976

FISCAL YEAR	ADMISSIONS	% OF TOTAL ADMISSIONS	ADMISSION RATE/100,000
1971	625	5.7	1,233
1972	663	5.8	1,289
1973	659	6.2	1,263
1974	773	7.3	1,455
1975	722	7.5	1,339
1976	773	8.1	1,412

Office of Systems Development

TABLE 10

Alaska Area Native Health Service All Diagnoses of Patients Receiving care in IHS and GM & S Hospitals for Mental Disorders by Fiscal Year 1971-1976

FISCAL YEAR	ALL DIAGNOSES	% of TOTAL DIAGNOSES	MORBIDITY RATE/100,000
1971	1,171	7.1	2,311.8
1972	1,254	7.0	2,439.2
1973	1,177	7.6	2,256
1974	1,365	8.8	2,571
1975	1,324	9.2	2,456
1976	1,365	8.7	2,494

Office of Systems Development

TABLE 11

Alaska Area Native Health Service First Visits and Incidence Rates for Ambulatory Care Given in IHS Facilities for Diagnoses of Mental Disorders by Fiscal Year 1971-1976

FISCAL YEAR	FIRST VISITS	% OF TOTAL FIRST VISITS	INCIDENCE RATE/100,000
1971	2,180	2.0	4,303
1972	2,664	2.2	5,181
1973	3,837	2.7	7,355
1974	2,858	2.3	5,383
1975	3,252	2.3	6,032
1976	3,111	2.1	5,695

Office of Systems Development

TABLE 12

Alaska Area Native Health Service Total Visits and Total Workload Rates for Ambulatory Patient Care Given in IHS Facilities For Diagnoses of Mental Disorders by Fiscal Year 1971-1976

FISCAL YEAR	TOTAL VISITS	% OF TOTAL TOTAL VISITS	TOTAL WORKLOAD RATE/100,000
1971	5,496	2.8	10,850
1972	5,984	3.0	11,639
1973	7,694	3.4	14,748
1974	7,881	3.2	14,843
1975	8,123	3.1	15,068
1976	7,886	2.9	14,411

Office of Systems Development

TABLE 13

Alaska Area Native Health Service Accidents and Injuries
Comparison of Total Accidents and Alcohol Related Accidents
as Defined by Volume of New Cases by Fiscal Year 1971-1976

FISCAL YEAR	TOTAL ACCIDENTS	RATE/ 100,000	ALCOHOL RELATED ACCIDENTS	RATE/ 100,000	% OF TOTAL
1971	10,043	19,826	1,151	2,272	11.5
1972	10,233	19,904	1,358	2,641	13.3
1973	11,388	21,829	1,811	3,471	15.9
1974	11,913	22,438	2,067	3,893	17.4
1975	13,543	25,123	2,415	4,480	17.8
1976	12,584	22,997	2,122	3,878	16.9

Office of Systems Development

TABLE 14

Alaska Area Native Health Service Suicide Attempts Comparison of Total Suicide Attempts and Alcohol Related Suicide Attempts Treated on an Ambulatory Basis as Defined by Volume of New Cases by Fiscal Year 1971-1976

FISCAL YEAR	TOTAL SUICIDE ATTEMPTS	RATE/ 100,000	ALCOHOL RELATED SUICIDE ATTEMPTS	RATE/ 100,000	% OF TOTAL
1971	104	205	45	88	43.3
1972	106	206	39	75	36.8
1973	158	302	63	120	39.9
1974	146	275	83	156	56.8
1975	161	298	86	159	53.4
1976	139	254	83	151	59.7

TABLE 15

Alaska Area Native Health Service Suicide and Self-Injury
Total Suicide attempts with Discharge Rates of Person Treated
in IHS - GM & S Hospitals by Fiscal Year 1971-1976

FISCAL YEAR	NUMBER OF SUICIDE ATTEMPTS	RATE/ 100,000
1971	98	193.5
1972	129	250.9
1973	113	216.6
1974	107	201.5
1975	108	100.3
1976	90	164.5

Office of Systems Development

TABLE 16

Incidence of Suicide Attempts Among Various Alaska Native, American Native, and United States, All Races, Populations

POPULATION	SUICIDE ATTEMPT RATES/100,000
City of Los Angeles (Mintz, 1970)	150
Combined Northwest American Indian Reservation Populations (Shore, 1972)	450
Navajo (Miller & Schoenfeld, 1971)	89.6
Rural Alaska Native Town (Kraus, 1974)	1,450
Native Population of Anchorage, AK (Kraus, 1974)	1,000

TABLE 17

Comparison of Alaska Native and Alaska Caucasian Utilization of Outpatient Community Mental Health Services, Fiscal Year 1976 (Mental Health Information System, 1977)

POPULATION	TOTAL NO. PATIENTS	RATE/100,000
Alaska Native	617	1,011
Alaska Caucasian	1,993	664

TABLE 18

Alaska Native and Caucasian Admissions to the Alaska Psychiatric Institute by Number of Patients, Admission Rates and Fiscal Year 1973-1976

FISCAL YEAR	TOTAL NO. NATIVE ADMISSIONS	RATE/ 100,000	TOTAL NO. CAUCASIAN ADMISSIONS	RATE/ 100,000
1973	184	325	309	115
1974	203	349	372	133
1975	227	381	405	139
1976	218	357	481	160

Analysis of State of Alaska Data (Smith, 1977)

TABLE 19

Comparison of Admission Rates to Alaska Psychiatric Institute for Alaska Native and Caucasians to Admission Rates to State and County Mental Hospitals for Various United States Population.

POPULATION	ADMISSION RATE/100,000
Alaska Natives, API*	353
Alaska Caucasians, API*	136
U.S. Total White Population, 1972 (Meyer, 1974)	181.7
U.S. Spanish American Population, 1972	133.7
U.S. Non-white Population, 1972 (Meyer, 1974)	306.3
Total U.S. Population, 1972 (Meyer, 1974)	197.2

Figure 2

PERCENT OF ALL MORTALITY AMONG TOTAL ALASKAN POPULATION
FROM SELECTED CAUSES FOR FIVE YEAR INTERVALS
1950 - 1974

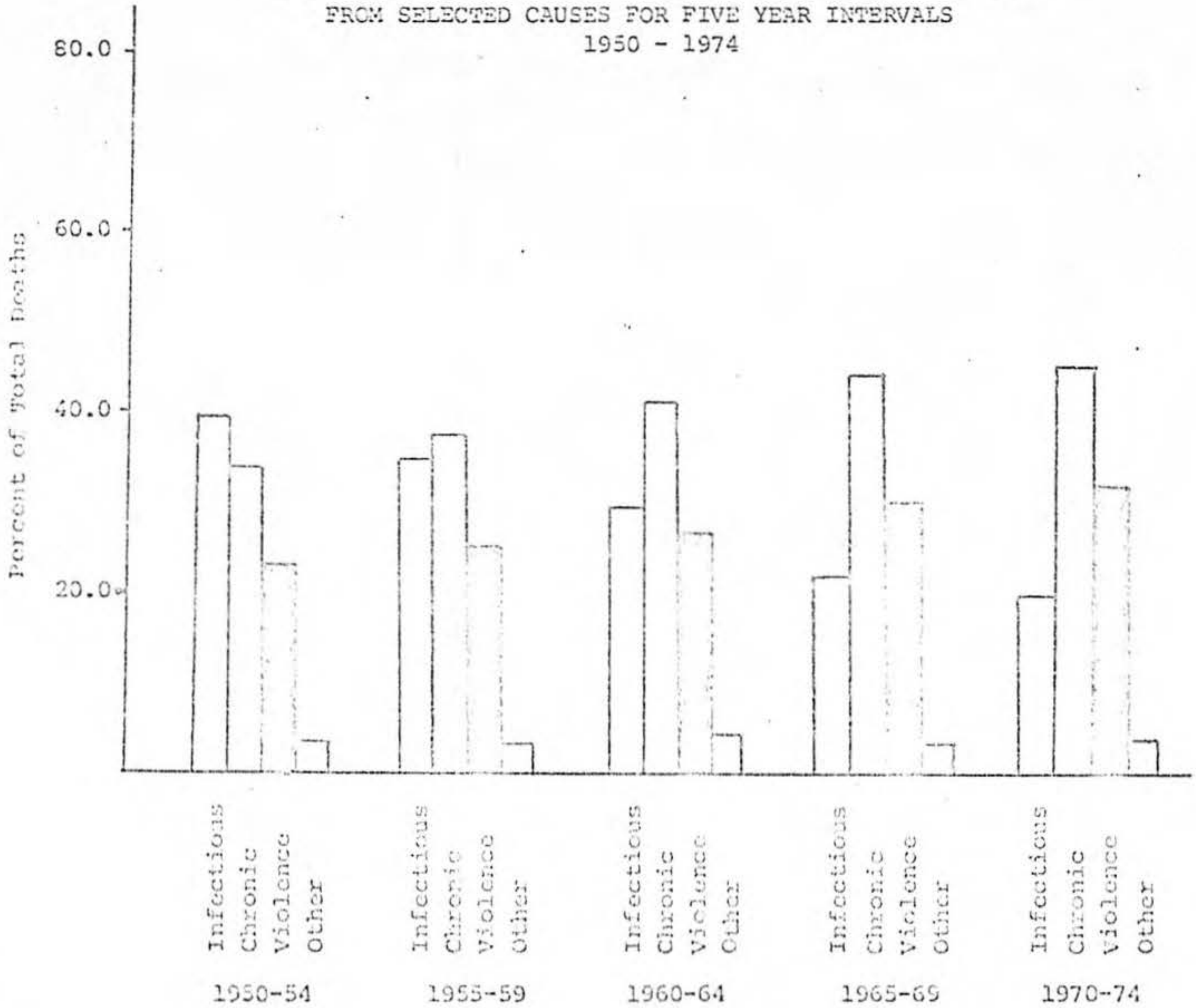

Figure 3

PERCENT OF ALL MORTALITY AMONG NON-NATIVE POPULATION OF ALASKA FROM SELECTED CAUSES BY FIVE-YEAR INTERVALS 1950 - 1974

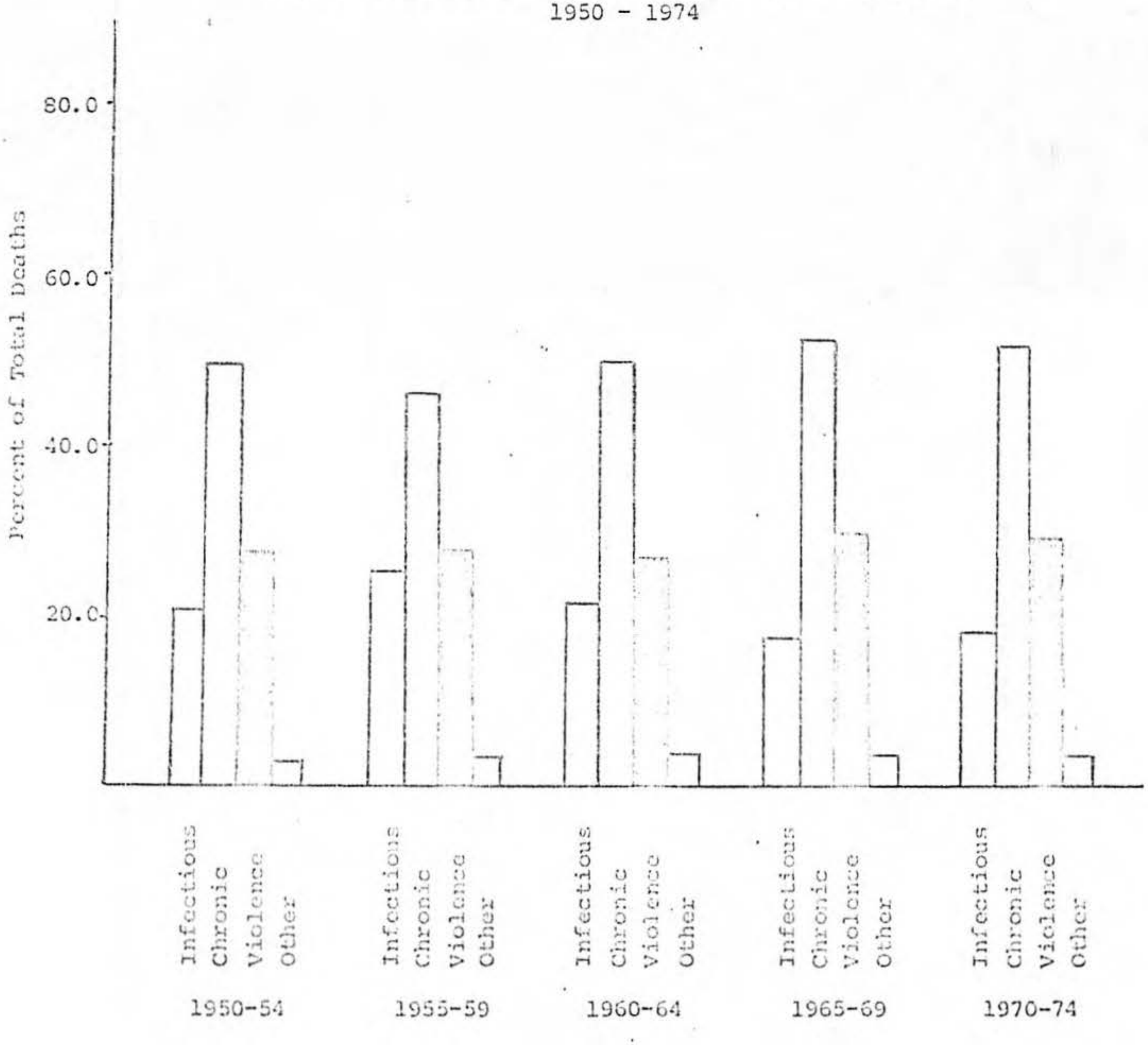

Figure 4

PERCENT OF ALL MORTALITY AMONG ALASKAN NATIVES FROM SELECTED CAUSES FOR FIVE-YEAR INTERVALS, 1950 - 1974

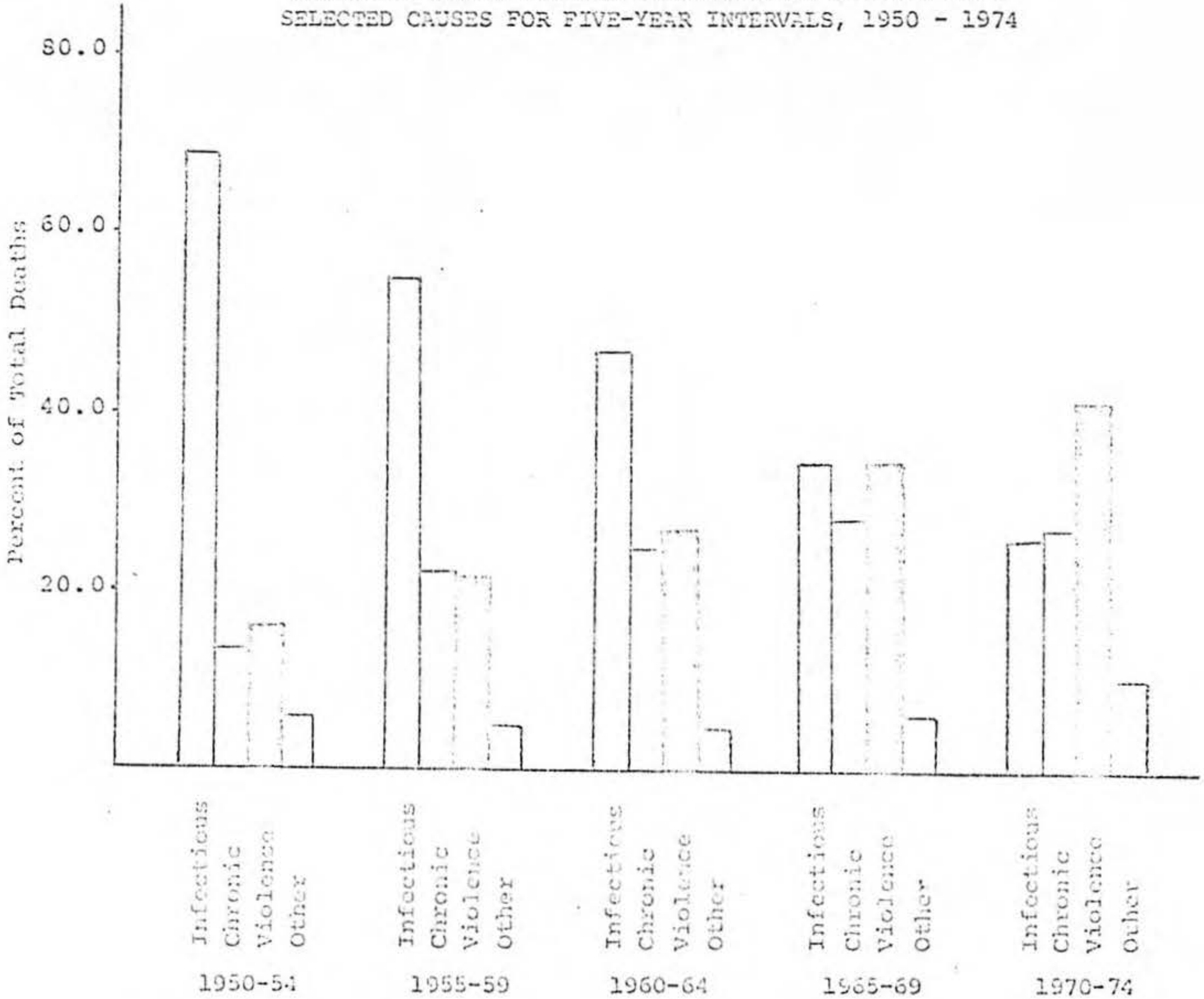

Figure 5

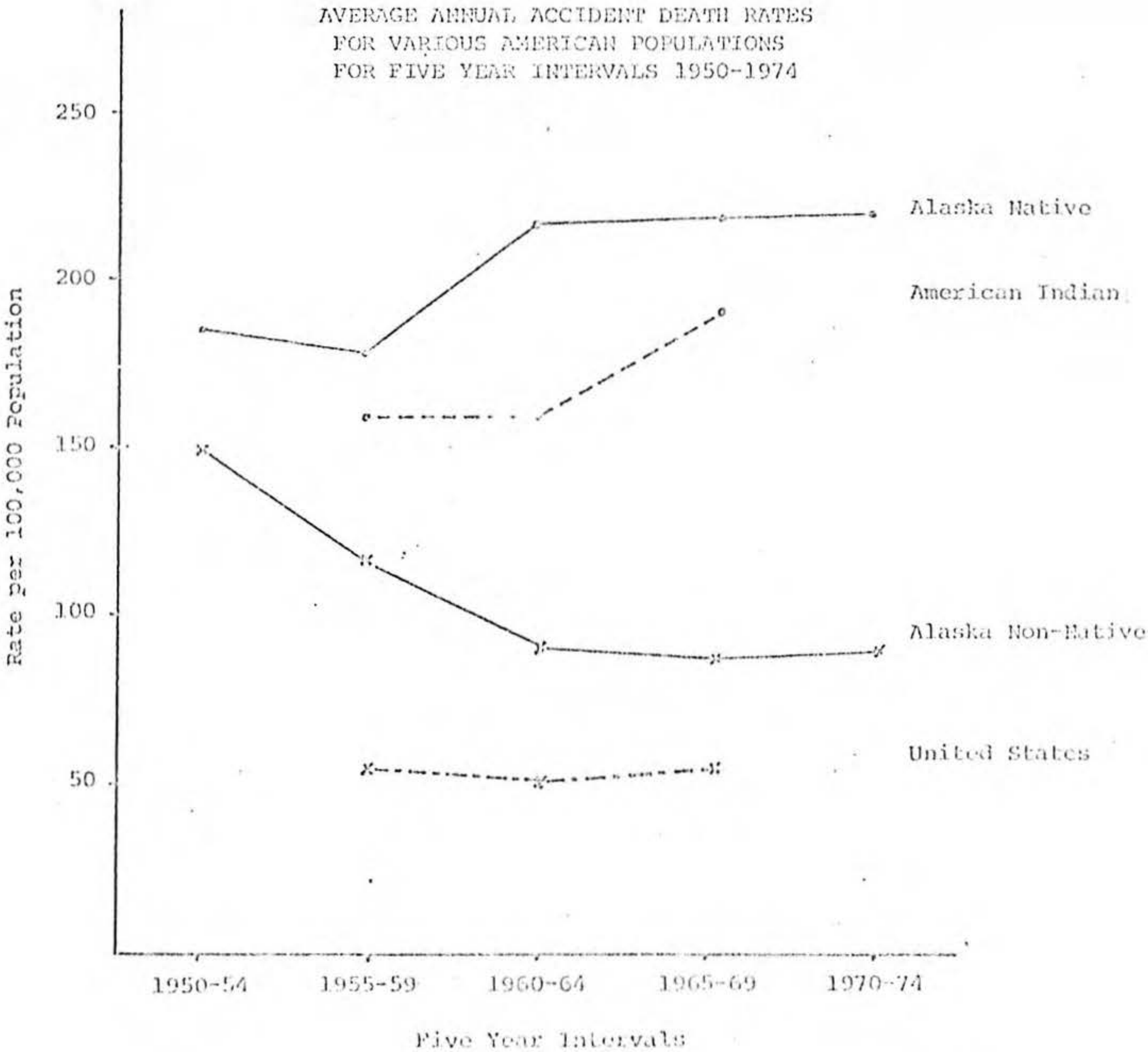
AVERAGE ANNUAL ACCIDENT DEATH RATES
FOR VARIOUS AMERICAN POPULATIONS
FOR FIVE YEAR INTERVALS 1950-1974
250
200
150
100
50
Rate Per 100,000 Population
Alaska Native
American Indian
Alaska Non-Native
United States
1950-54
1955-59
1960-64
1965-69
1970-74
Five Year Intervals

Figure 6

AVERAGE ANNUAL HOMICIDE DEATH RATES
FOR VARIOUS AMERICAN POPULATIONS
FOR FIVE YEAR INTERVALS 1950-1974

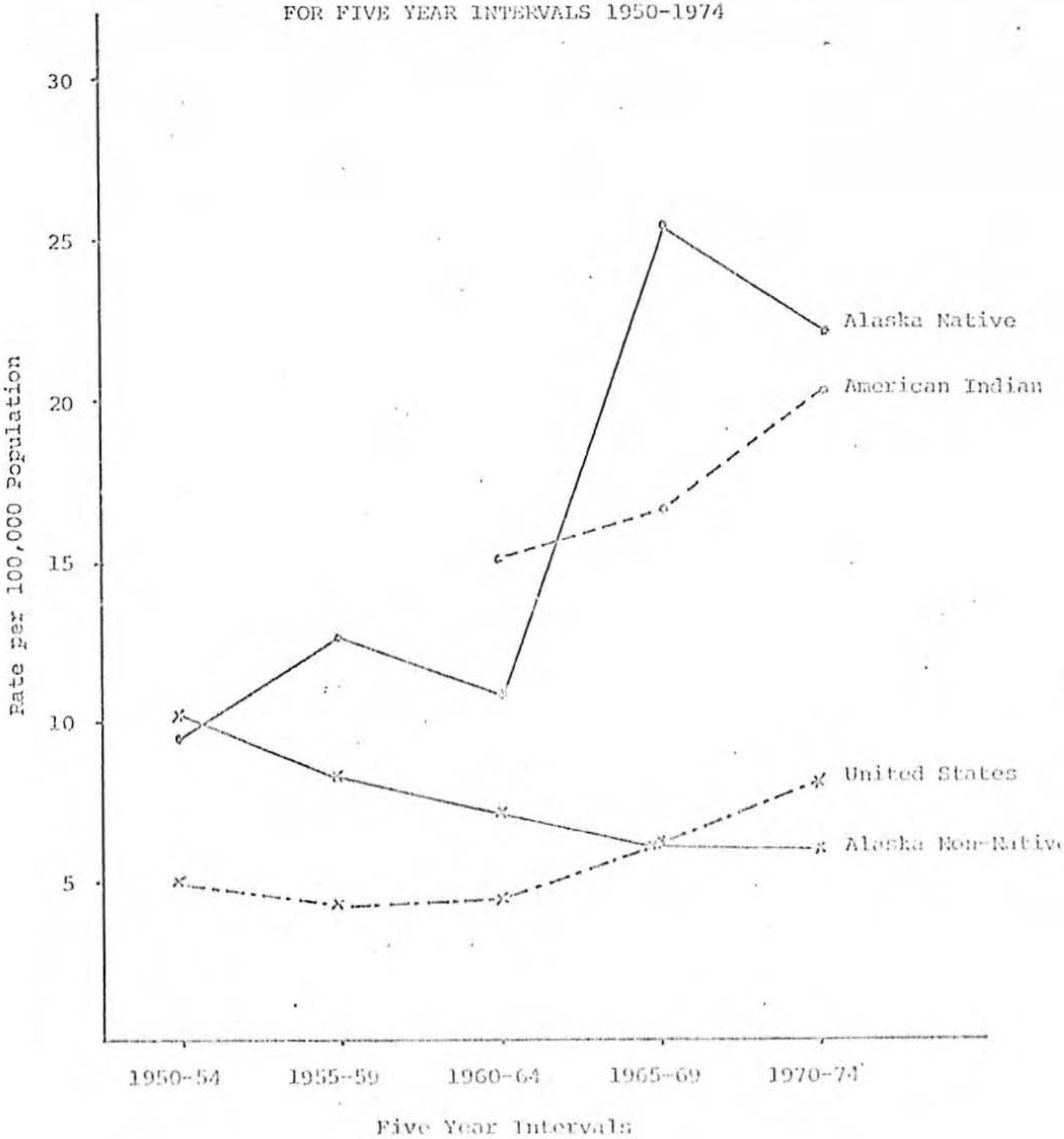

Figure 7

AVERAGE ANNUAL SUICIDE DEATH RATES
FOR VARIOUS AMERICAN POPULATIONS
FOR FIVE YEAR INTERVALS 1950-1974

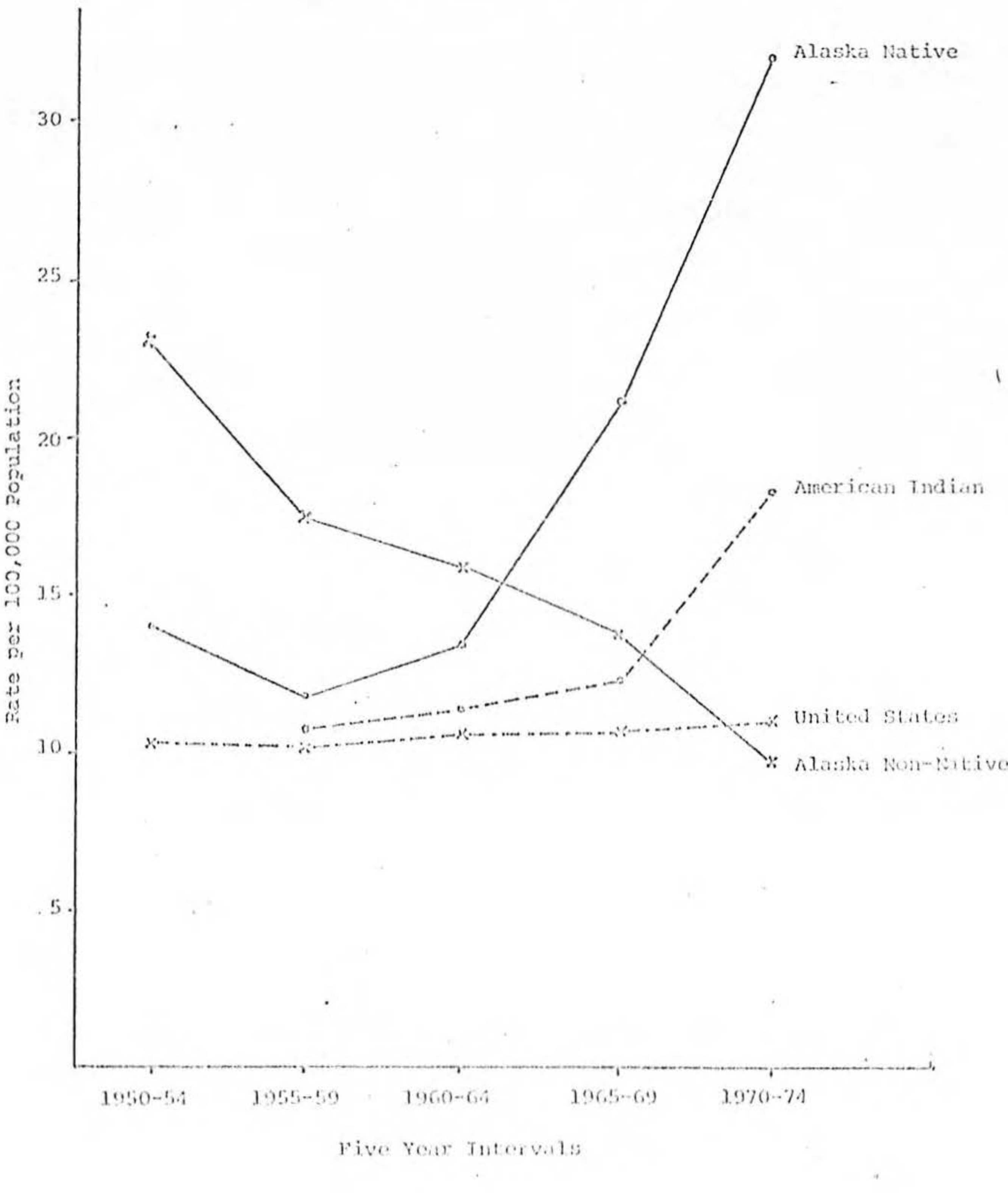

Figure 8

AVERAGE ANNUAL ALCOHOL DEATH RATES
FOR ALASKA NATIVES AND NON-NATIVES
FOR FIVE YEAR INTERVALS 1950-1974

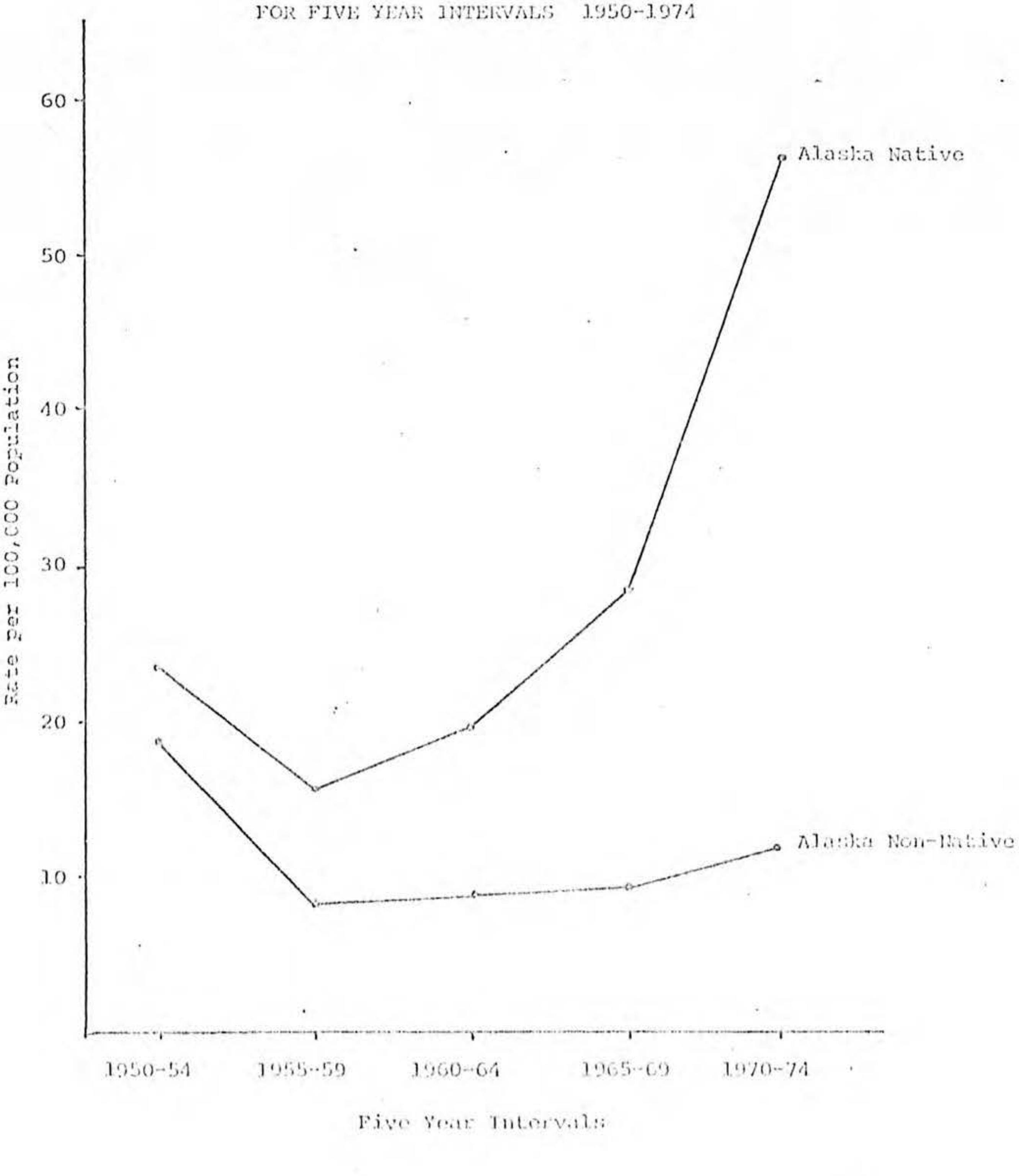

Table 20

LEADING CAUSES OF DEATH AMONG ALASKAN NATIVES, ALL ALASKAN RESIDENTS AND UNITED STATES, 1970

Rank(1)	Cause	Rate per 100,000 Population Alaskan Natives	Alaska Total	United States
1.	Accidents	199.4	116.9	56.4
2.	Dis. of the Heart	73.0	87.4	362.0
3.	Malignant neoplasms	67.1	61.6	162.8
4.	Influenza & Pneumonia	49.3	17.9	30.9
5.	Alcoholism	41.4	10.9	-
6.	Vas. lesions of CNS	35.5	26.2	101.9
7.	Dis. of early infancy	29.6	25.5	21.3
8.	Suicide	29.6	13.2	11.6
9.	Homicide	27.6	10.6	8.3

(1) Ranked by order of importance as a cause of death in Alaska Natives.

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PLEASE NOTE: THE PRECEDING PAGES WERE TREATED AS A UNIT IN THE ORIGINAL DOCUMENT.

SCOMM

#6:35

ALASKA NATIVE COMMISSION ON ALCOHOLISM AND DRUG ABUSE

750 East Fireweed Lane
Anchorage, Alaska 99503

July 13, 1977

Senate Special Committee on Alcoholism
Gerald Abramczyk, Coordinator
Box 2536
Anchorage, Alaska 99510

Dear Gerry:

Enclosed is a brief list of villages and contact people respectively that I would recommend the Committee consider visiting during their itinerary of testimony.

Attached is the present roster of Regional Technical Assistants who should prove to be invaluable to the Committee as resource people and as entré/interpreter as necessary.

Yours truly,

Tom

Thomas L. Stoner, Field Deputy
Office of Technical Assistance

TLS:rrb
Enclosures
cc: Regional Technical Assistants

Put on mailing list

SOA NCAA

VILLAGES	CONTACTS
(LOWER KUSKOKWIM AREA)	
Akiak	Tim Williams Sr.
Akiachuk	William Lomack
Aniak	Richard Romer
Napaskiak	Fred Pete
Hooper Bay	Rudy Smith or Fred Pete
Red Devil	Fred Pete
(CENTRAL INTERIOR)	
Ruby	Donald V. Honea Sr.
Minto	Peter John
Galena	Roger Huntington
(LOWER YUKON)	
Kaltag	Andrew Demoski
Nulato	Andrew Demoski
Holy Cross	Claude Dementieff
(UPPER YUKON)	
Arctic Village	John Titus
Chalkyitsik	Rev. David Samon
Ft. Yukon	Titus Peter
(UPPER TANANA)	
Dot Lake	Chief Andrew Isaac
Eagle Village	Jim Junaby
(SOUTHEAST)	
Angoon	Cy Peck Sr.
Hoonah	Mike Everson (Tlingit & Haida Central Council)
Hydaburg/Craig/Klawock	" " Council)
(COPPER RIVER AREA)	
Copper Center	Stewart Nicolai
(ALEUTIANS)	
Unalaska	Frank Poplawski (Unalaska Alcoholism Program)
Sand Point	
(NORTHWEST)	
Point Hope and Wainwright	Elijah Rock
(NORTH COAST)	
Barrow and Barter Island	Loretta Kenton

Rough Draft.

July 13, 1977

Senate Special Committee
on Alcoholism
Gerry Abramczyk
Box 2536
Anchorage, AK. 99510

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Yours Truly,

Tom Stoner

cc. Regional Technical Assistants -

Villages	Contacts.
(Lower Kuskokwim area)	
Akiak	Tim Williams Sr.
Akiachuk	William Lomack
Aniak	Richard Romer
Napaskiak	Fred Pete
Hooper Bay	Fred Pete (
Red Devil	Fred Pete
(Central Interior)	
Ruby	Donald V. Honea Sr.
Minto	Peter John
Galena	Roger Huntington
~~Kaltag / Nulato~~	~~Andrew Demoski~~
~~[illegible]~~	~~Richard Frank~~
(Lower Yukon)	
Kaltag	Andrew Demoski
Nulato	" "
Holy Cross	Claude Dementieff
(Upper Yukon)	
Arctic Village	John Titus
Chalkyitsik	Rev. David Samon
~~Eagle~~ Ft. Yukon	~~Richard Carroll~~ Titus Peter
(Upper Tanana)	
Dot Lake	Chief Andrew Isaac
Eagle Village	Jim Junaby

Villages	Contacts.
(South east)	
Angoon	Cy Peck Sr.
Hoonah	Mike Iverson T+HCC
Hydaburg/Craig/Klawock	"
(Copper River area)	
Copper Center	Stewart Nicolai
(Aleutians)	
Unalaska	Frank Poplowski
Sand Point	"
(North west)	
Pt. Hope	Elijah Rock
Wainwright	"
(North coast)	
Barrow	Lourretta Kenton
Barter Island	"

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER
OFFICE OF ALCHOHOLISM

POUCH H 05F – JUNEAU 99811

ANCADA File

July 6, 1977

RECEIVED
JUL 8 1977
ANCADA

Thomas Stoner
Field Deputy
Office of Technical Assistance
750 East Firewood Lane
Anchorage, Alaska 99503

Dear Tom:

I am in receipt of my copy of your May 25, 1977 letter to Senator Mike Colletta regarding "Policy Alternatives for Alcohol Control". I found the letter interesting in the extreme and have questions regarding the basis for some of your observations with which I hope you will be able to help.

First of all, could you tell me what you meant by the phrase, "However, the magnitude of such theoretical and data based constructs is somewhat constraining to pragmatic considerations of objective alternatives"? (Last sentence on page 1.) Just prior to that sentence you correctly cite that there is a growing body of scientific evidence to support the "public health thesis" inherent in the Governor's proposed alcohol legislation. How you can then conclude that that evidence is immaterial to "pragmatic considerations of objective alternatives", escapes me.

Secondly, it seems to me that there is some confusion in the next paragraph (top of page 2) when you say that, "The suggestion...that alcoholism can and should be approached as a problem of public health control techniques, rather than as a matter of individual pathologies, is attractive and enlightened." We would agree that our proposal was "attractive and enlightened", however, we would argue that if both alcohol abuse and alcoholism are matters of such great public concern that there is constant reference to them as problems, then government has a responsibility to attempt to deal with both. Alcohol Abuse can be altered, according to the scientific evidence, by control policy. Some Alcoholism can be prevented by that same control policy. Alcoholism, when it emerges in an individual, must be treated on an individual basis. Prevention, on the societal level and treatment on the individual level, are the two necessary components of an overall alcohol abuse policy.

I am confused by one of your next statements on page 2, when you say, "Yet it is far from clear that a concerted policy of reducing alcoholism and alcohol related pathology by controlling the distribution and consumption of alcohol is, at this time, either feasible or desirable". We would argue that the scientific evidence that you accurately cited earlier, definitely bears out that such policy is feasible. Whether it is desirable, we would agree, is a "value question" to be answered by the people. We do have, by the way, a very clear notion of the costs and benefits of our current non-system of controls, presented in Volumes One and Two of Dr. Kelso's work.

I question your statement in the next paragraph on page 2 which asserts that (sic) "Control measures lead to reductions in alcohol related mortality and morbidity in the short run". What is the evidentiary basis for the implication that the effects of control measures are time-limited?

On page 3 you make what appears to be a series of validated statements of fact which I believe are instead, your opinion, and which require some serious work on your part if you are to clarify for your audiences which statements are fact and which opinion.

For example; are you able to support with evidence as solid as that which you quoted earlier (DeLint, et al) the assertion made in your first paragraph on page 3 that "All three strategies have already been implemented ....in the lower United States....and that the rates of both per capita consumption and alcoholism have continued to rise"? The clear implication is that control policies have no effect on rates of per capita consumption or alcohol abuse. Yet I doubt that you can support that implication with sound evidence. All the sound evidence points to the opposite conclusion as you are well aware.

I might agree in part with your comment in the same paragraph that "the remnants of Puritan and Prohibitionist sentiment have encumbered liquor retailers, with restrictions more demanding than those placed on the purveyors of any other legal product", yet I do not agree with you in whole.

First, centuries prior to the evolution of the concept "Puritan" or "Prohibitionist", men were consuming alcohol with both good and bad results. There is evidence that the earliest governments and societies established laws and mores related to the use of alcohol ranging from the very uncontrolled (the Celts and Germanic tribes of Europe, for example) to the very measured and controlled (i.e. the Buddhist, Taoist and Hindu Societies). Therefore, there are much more ancient and generalized human concerns with the use of this potent drug. I believe you do a disservice to stamp all persons who may be interested in the relationship between control measures and alcohol related problems with the emotionalized "Puritan/Prohibitionist" label. Certainly you know may people who fit neither category, who nevertheless maintain an active interest in the control strategies/alcohol problems relationship.

Secondly, you are well aware that ethanol is not a neutral product and that throughout the history of man, some control has been maintained over its use precisely because it is a potent, mind and body altering drug with visible, well-documented potential for abuse. To suggest by implication as you appear to do, that it be treated like any other product, seems to me to ignore the reality of its potent and sometimes lethal properties.

I think you have a responsibility for providing your various audiences for the scientific basis for the following additional assertions on page 3 of your letter to Senator Colletta;

that; "denial of access to alcohol may (does?) displace addictive behavior onto other substances, such as barbituates, with, at best, no net social gain."

that; "those subcultures with relatively small proportions of abstainers tend to have relatively low rates of alcoholism."

that; "Impeding the flow of alcohol to actual or potential alcoholics through the use of control mechanisms, will also impede the flow for (sic) others....in a relatively unequitable manner."

that; "higher rates of alcohol taxation would necessitate(!) that they (the poor) spend a higher proportion of their finite disposable incomes on alcohol".

ESPECIALLY that; "those historical instances adduced by proponents of alcohol control as evidenced that taxation can reduce consumption and alcoholism have tended to be short lived, as increased per capita income soon overtakes the demand-dampened impact on the taxes. Growth in per capita income remains the strongest single prediction of growth in per capita consumption in modern societies". (If that's true, you have just strongly argued our case for an increased excise tax that is designed to co-vary with the Consumer Price Index and levels of per capita income.)

that; "Tax policies have induced shifts in consumption patterns from one type of beverage alcohol to another, but with no obvious effect on Alcoholism." (What about France, Tom?)

Most particularly, I wish to take you to task on all of your assertions on page 4 of your letter to Senator Colletta. On that page you assert, as if it were fact, the following: (sic) "There is no hard evidence on this question that would support the beliefs of the control strategy proponents...The weight of intuitive evidence runs directly opposite"..."Correlations between per capita consumption rates...are too highly aggregated and too subject to ecological fallacy"...."higher taxation would reduce consumption among those whom consumption does good, but no harm, and especially the poor within that group, without it being at all clear whether it would reduce alcoholism"..."given the present state of knowledge about the effectiveness of control mechanisms, greater uniformity (of law) has only neatness to recommend it"...."So promising and straight forward is the simple syllogism of reducing alcoholism by reducing total social consumption that it is painful to realize that there appears to be no way to make it work in the near future"...."The correlations between per capita consumption and alcoholism deaths due to cirrhosis do not prove the causal factors in addictive behavior in a portion of an exposed population..."

Tom, I suggest to you that those assertions are presented by you to me and others as authoritative, objective observations based upon some fairly sophisticated familiarity with the research evidence on the relationships between alcohol control policy and alcohol abuse. Instead, they reflect to me, your own opinion on these matters. While you are entitled to your opinion, I think you owe it to your audiences to present a clear distinction between your personal, subjective, editorial opinion and the presentation of fact based upon validated research. To do otherwise begs the questions you attempt to address and serves to obfuscate and confuse the opportunities for their discussion and rational resolution.

This whole alcohol/control question has served to teach me that every man is indeed "his own Sociologist". We attempted to present the Governor, the people of the State, and their elected representatives, with the best evidence we could find that would allow them to make some potent and informed decisions about how to reduce alcohol abuse in Alaska, if the people chose to.

I would hope that we discharged that duty with responsibility and integrity.

Our policy recommendations would accomplish exactly and precisely what we said they would: lower per capita consumption; less alcohol abuse; some reduction in alcohol-related mortality and morbidity; more local citizen control over how alcohol is used; a better cost/revenue posture for the State General Fund and a more realistic and reasonable body of law that protects the consumer at least as much as it does the industry.

This is overwhelming statistical and visual evidence of the incredibly high and disproportionate human and economic costs of alcohol abuse and alcoholism in Alaska and equally weighty evidence from other countries and jurisdictions that what we proposed, works. We did not promise that the control measures would "eradicate alcoholism" or "abolish alcohol abuse". We said we were confident, based on the evidence, that they would help ease our alcohol-related problems in specific, identifiable ways.

I would close by asking you; "What would you propose as alternatives which, based on scientific evidence, bears such promise for achieving the same ends?"

Very sincerely yours,

Robert L. Cole

Robert L. Cole
Coordinator
Office of Alcoholism and Drug Abuse
State of Alaska

cc: Jay S. Hammond, Governor
Francis Williamson, Commissioner; H&SS
Senator Mike Colletta
Senator William Sumner
Representative Chad Chadderton
Representative Mike Bierne
Gerald S. Abraniczyk, Consultant

ALASKA NATIVE COMMISSION ON ALCOHOLISM AND DRUG ABUSE

750 East Fireweed Lane
Anchorage, Alaska 99503

July 11,1977

Mr. Robert L. Cole,Coordinator
Office of Alcoholism
Pouch H-05-F
Juneau,Alaska 98111

Dear Bob,

I wish to respond to your letter of July 6,1977 and compliment you for some very astute considerations.

My letter to Senator Mike Colletta (May 25,1977),has resulted in an informative dialogue to say the least. It was my intention,to supply Mike Colletta and committee,with both a "pro and con" academic base of information,from which not to draw any conclusion,but rather be sensitized to objectivity while assessing additional information or testimony.However,I have since re-evaluated my letter and the bent with which it itimates.Therefore,I would like to respond to your questions with explanation of some error on my part.

I previously asserted that control measures lead to reductions in alcohol related mortality and morbidity in the short run. As you have appropriately questioned,"What is the evidentiary basis for the implication that the effects of control measures are time-limited",this I believe was the focal point of our difference of understanding.

I must assume full responsibility for being unaware that the proposed increases in excise tax adjustments would equitably follow increases in net per capita income. Growth in per capita income does remain the strongest single predictor of growth in per capita consumption.Therefore,the proposed increase in alcohol excise tax that co-varies with the "Alaskan Consumer Price Index and levels of per capita income",lends itself to a considerable stronger arguement in terms of its feasibility.I therefore,willingly share with you the hope that the recommendations would in identifiable ways,lower per capita consumption,lessen alcohol abuse,demonstrate a reduction in alcohol-related mortality and morbidity (alcohol-related deaths are principle life threatening indicator,not cirrhosis, as I had earlier stated),and provide more local citizen leverage into its use and a cost/revenue posture for the State General fund through a reasonable body of law.

Robert L.Cole

In terms of other narrative assertions you adequately "took me to task" upon, may I simply comment by stating that the entire question of alcohol control beckons"the individual as Sociologist"tendancy within us,and unfortunately can reflect more of an editorial and subjective bent. My apologies!

My primary interest at this point is not of academic departure,for I sincerely feel there is not ethical room for debate on these issues in the areas of intensely "disproportionate human and economic" need.

I propose therefore, that we jointly investigate a means of providing the citizenry of Alaska with some facts that can be related to. With all due respect to Dr.Kelsoe's report,the mere mention of it,is an immediate negative with the Senate committee. Obviously,we are dealing with certain realities,and our strategies will require some finesse.

I believe,that the people of Alaska should have the opportunity to decide the merits of all the issues concerning the proposed alcoholism /alcohol control bills by reforandum and ballot vote. The sponsor of such strategy obviously would have to be from an independant source. I do not believe that the Senate committee could find this convenient.

However,during the two periods of time,that the committee intends to visit village areas,in the interest of gathering testimony,groundwork can be laid to formalize the advent of an Alaska Native Traditional Leadership Conference. Whereby,if viewed as being of significant import,resolutions drafted by such a group coalition,could provide the leverage needed for a ballot vote.

Once each geographical area (region)had an opportunity to make an evaluation of the bills individually, the poll would determine the ultimate merits of any change. One statewide,comprehensive legislative package can not meet the wide diversity of need. I am suggesting then,that each community take a strong posture of ownership in the process of making law. The more subjective interest groups and lobbying efforts would be at bay.

I trust that a cooperative spirit of leadership will be jointly shared by the Senate committee and rural constituents during the next twelve months. The descisions made during this period of time Bob,will effect at least the next twelve years.

Robert, my compliments!

Very Sincerely Yours,

Thomas L.Stoner,Field Deputy
Office of Technical Assistance

ALASKA NATIVE COMMISSION ON ALCOHOLISM AND DRUG ABUSE

750 East Fireweed Lane
Anchorage, Alaska 99503

ANCADA file

July 12, 1977

Ms. Nyda Bailey
New Jersey Alcoholism Association
212 West State Street
Trenton, New Jersey 08618

Dear Ms. Bailey:

I am very interested in obtaining a written report on the recently passed New Jersey legislation providing for in-patient and out-patient insurance coverage in hospitals and alcoholism treatment centers licensed by the state. I understand that there is a unique provision requiring Blue Cross-Blue Shield and commercial carriers to provide coverage up to the normal per diem limitations of the policy with no dollar or treatment day restrictions. It further requires inclusion of alcoholism in individual as well as group insurance contracts.

Alaska is on the threshold of the types of sophisticated program development that is now ongoing in areas such as New Jersey.

Therefore, if it is possible to obtain some documentation of the legislative history of the four recent bills passed regarding coverage, and/or copies of the newly adopted statutes, it will be greatly appreciated and made known.

Sincerely yours,

Thomas L. Stoner, Field Deputy
Office of Technical Assistance

TLS:rrb
cc: Alaska Senate Special Committee on Alcoholism
Robert L. Cole, State Office of Alcoholism

THE ANCADA ANSWER

vol.2, no.7

Monthly Newsletter of the

ALASKA NATIVE COMMISSION ON ALCOHOLISM AND DRUG ABUSE

750 East Fireweed, Suite 2 Anchorage, Alaska 99503 Phone: (907) 274-7435

AUG 77

ANCADA Holds Board Meeting

The board of directors for ANCADA recently held their quarterly board meeting here in Anchorage. The meeting was originally scheduled to be held in Dillingham, Alaska but due to high costs, the meeting was changed to Anchorage.

Regional reports were given from board members representing their regions. A staff financial report and an update report on the Regional Technical Assistance program were also given. George Barril, Executive Director for ANCADA presented his quarterly report to the board along with an update report on the APEP project.

Board members for ANCADA listen on as William Orfitelli, Controller, gives the quarterly financial report.

Marcello Quinto, President of the Board for ANCADA conducted the meeting while regional board memebers gave their reports.

From the left, Joyce Nelson, Peg Benepe and Louie Andrew all RTA's listen to board reports prior to giving local RTA update reports.

B.B.A.H.C. Hires new RTA

Peg Benepe was recently hired as the new local RTA for the Bristol Bay Area Health Corporation. Peg has joined the RTA team bringing with her many years of experience in alcoholism, training and counseling.

Peg has spent seven years working with the AL NON program in Washington. She also organized the local AL NON group in Friday Harbor, Washinton. While living in San Jaun Country, Washington Peg was employed as a psychiatric nurse which involved her in counseling, treatment, in-service training, education and community referral.

Peg earned her Masters of Education with emphasis in counseling from the University of Washington, a B.S. in Psychology and an A.A. in Nursing.

Peg has been stationed in Dillingham, Ak. for the past month getting to know the people, agencies and general feeling of the area. She has plans for an October workshop involving community health aids in her region. Peg has been very busy working with the local people, agencies, high schools, court systems and is presently seeking an Outreach Worker in the Bristol Bay Area Health Corporation region.

If anyone in the Bristol Bay area would like to contact Peg with ideas or suggestions you can write to Peg Benepe, Box 233, Dillingham, Alaska 99576. Or you can call 842-5266. Good luck with future projects Peg and welcome to the RTA team.

ANCADA Drug Proposal Approved

At a recent meeting held in Anchorage, July 15 and 16, the Governor's Advisory Board (GAB) on Drug Abuse approved for funding a drug Information/Counseling grant for ANCADA.

The grant proposes to do training on these topics in the Yukon–Kuskokwim and the Bristol Bay regions. The grant also proposes to do a video tape of the short-term client Systems Counseling course and the pharmacology of drug abuse within the regions in the Yupik language.

Rio Ritha Brown, Administrative Assistant/Trainer will be the project coordinator for this grant. THe $20,000 grant will be implemented as soon as ANCADA receives the award notice.

Yakutat Director Hired

As of July 1, Stella Adams is the new Director of the Alcoholism INformation and Referral Service in Yakutat, replacing Rosemary (Rowsey) Riley who headed the program there for several years.

Yakutat is her home town, but Ms. Adams said she has recently been working for the Sitak Council on Alcoholism as halfway house manager and couselor at its main office.

Commenting on her new position, Ms. Adams said, "It is my goal in this program to go into community education, early intervention, prevention. Alcoholism is such a deadly and complex disease that I believe the community should be educated in the symptoms and progression of the disease in order to combat it. . .I am happy to be back home again and looking forward to starting my new job."

TWO DRINKS A DAY COULD HARM FETUS

Although it has been known for over four years that heavy alcohol use by pregnant women could cause their children to be born with congenital birth defects, a recent study shows that pregnant women who are only moderate drinkers run risks as well.

Dr. Ernest P. Noble, the director for the National Institute on Alcohol Abuse and Alcoholism, has asked the government to warn pregnant women that more than two drinks a day – a total of one ounce of alcohol – might harm their unborn baby.

Dr. Noble told a news conference last June that recent research evidence led him to issue the caution on the dangers of fetal alcohol syndrome. According to Dr. Noble, pregnant women who drink as many as six cans of beer, glasses of wine or mixed drinks per day may have babies with all the symptoms of the syndrome, while those who take more than two drinks a day but less than six may produce children with one or more symptoms.

Symptoms of fetal alcohol syndrome include children born with IQ levels between 60 and 70, hyperactivity, heart murmurs or other cardiac defects, small heads, low-set ears, small eyes, flat noses with upturned nostrils, carp-shaped mouths, poorly developed limbs, joined or otherwise malformed fingers and minor genital abnormalities.

Nobel estimates that 5 percent of the three million women who give birth each year are heavy drinkers, and perhaps one in 100 of their babies a year have the full-blown syndrome, and probably "several fold more" have some of the symptoms.

"Both the risk and the extent of abnormalities appear to be dose related," Noble said, "increasing with higher alcohol intake during the pregnancy period."

Meanwhile, the institute is currently considering a proposal to require a caution label for pregnant women on alcohol bottles and cans, but Noble stressed that this is only in the discussion stage and no such official recommendation is being made at this time.

McGRATH SIGNS RESOLUTION

A group of citizens from McGrath and surrounding villages signed a resolution "that funding be provided to the Anvik/McGrath Mental Health Board for development and implementation of an alcoholism project for the area". After months of planning and correspondence, the resolution was passed at a two-day meeting held on July 19-20 in McGrath.

Tom Stoner, Field Deputy for the Office of Technical Assistance of the Alaska Native Commission on Alcoholism and Drug Abuse (ANCADA), attended the meeting together with Robert Cole, Coordinator of the State Office of Alcoholism and Drug Abuse. Stoner said he and Cole were invited by Leon Kiana of McGrath to attend the gathering of local citizens and to offer their assistance and advice.

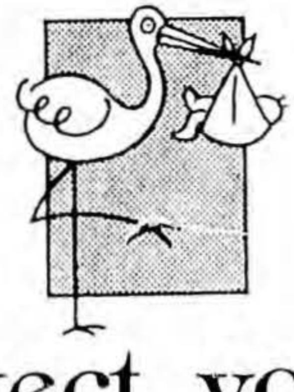
Kiana, who provided the moving force behind the meeting and the writing of the resolution, received go-ahead for his efforts from Mitch Dementieff, executive director of the Tanana Chiefs Conference, Inc., and from Frances Williamson, commissioner of the State Department of Health and Social Services. The Tanana Chiefs Conference had passed their own resolution some months ago noting the high incidence of alcohol-related events in their area, Stoner explained.

The concept paper, which was drafted at the meeting and attached to the resolution, made recommendations for treatment, prevention, training for key village personnel, public education, resource information, and education in schools. It was submitted to ANCADA, the State Office of Alcoholism and Drug Abuse, and the Publice Health Service.

Also considered were alternative recreational education and community schools, and employment alternative such as subsistence, mining, education and health, communications, transportation, and the military, Stoner added.

One of the main objectives to come out of the meeting was a plan for educational workshops for village chiefs, "what small villages can do about alcohol-related problems", Stoner said.

State people at the meeting included Robert Cole, George Mundell, regional program manager, State Office of Alcoholism and Drug Abuse; Jack McCombs, Division of Mental Health; Jeanie Lyerly, Indian Health Service; Jerry Abramczyk, Senate Select Committee on Alcohol Abuse. Attending for the Alaska Native Commission on Alcohol and Drug Abuse (ANCADA) was Tom Stoner, Field Deputy, Office of Technical Assistance.



Protect your unborn baby

CHR's Receive Training

The Kodiak Council on Alcoholism has begun its third in a series of training programs for village-based Community Health Representatives (CHR's) employed by the Kodiak Area Native Association. Gladys Inga of Old Harbor and Ann Squartsoff from Port Lions began their training with KCA.

Gladys grew up in Old Harbor, where she and her husband have made their home and raised three children. Gladys has worked as a teacher's aide with the Head Start Program, and was selected by the Old Harbor Council for theCHR position.

Ann, who was raised in Afognak, has been married for six years. She has served the Port Lions community as a teacher's aide, alternate health aide, and alternate food stamp agent. Ann applied for the CHR position through the Port Lions City Clerk.

Ann and Gladys agree that "nothing else to do" is a major factor in the alcohol-related problems of the villages, and they hope to be able to encourage the development of some constructive alternatives when they return. They also see "knowing where the help is" as vital to their work.

Complying with KANA's new format, which reduces the time the trainees must spend away from their homes and increases their training in other health-related fields, the KCA program has been condensed from ten weeks to two. During that period, on-the-job training will prepare the CHR's to provide assistance, support and appropriate referrals to people and families in need of a variety of alcohol-related services. Trainees will be acquainted with the agency's residential treatment program, group therapy, arts and crafts therapy, intake interviewing techniques, available films and literature, and referral procedures. They will also visit the sleep-off facility, the court in session, the U.S. Coast Guard program, and the hospital detox facilities.

Theory previously taught to the CHR's in a semester of evening classes at Kodiak Community College ("The Functional Approach to Alcoholism") will be condensed by the instructor to an intensive one week seminar.

Of the six outlying villages on Kodiak Island, two (Ouzinkie and Akhiok) already have trained CHR's employed by the Kodiak Area Native Association. Representatives from Larsen Bay and Karluk will begin training with KCA near the end of August, along with a seventh CHR to be stationed in the city of Kodiak. By the end of September, all villages and Kodiak itself will be receiving the services of trained KANA Community Health Representatives.

BLOOD TEST MAY IDENTIFY LONG–TERM BOOZERS

A blood test that could serve as a biochemical marker to identify long-term heavy drinkers and alcoholics has been developed by researchers in New York City.

An elevated ratio of alph-amino-n-buytric acid to leucine, two amino acids in blood plasma (A/L level), is indicative of the presence of alcoholism, report the researchers, Drs. Charles Lieber, Spencer Shaw, and Barry Stimmel of the Bronx Veterans Administration Hospital and the Mount Sinai School of Medicine.

The researchers believe that the A/L ratio is a more reliable marker of alcoholism than blood alcohol levels. The presence of alcohol in the blood is not required for positive test results, since the test reflects prolonged rather than short-term ethanol intake. Positive test results persist for a week or more beyond the long-term drinking period but decrease with prolonged abstinence.

For more information, contact Dr. Charles Lieber, cheif of the Section and Laboratory of Liver Disease, Nutrition, and Alcoholism, Bronx Veterans Administration Hospital, 130 W. Kingbridge Rd., Bronx, New York 10468 (Reprinted from NIAAA Information and Service, # 35, April 27,1977.)

Looking for Involvement?

Plans are being made for the Arctic Rim Conference on Alcoholism to be held May 1 – 5, 1978, in Fairbanks at the University of Alaska. The proposed theme of the conference will be "The Impact of Alcohol on Arctic Consciousness", according to Dr. Peter Schiøler.

Dr. Schiøler, chief advisor to the prime minister and parliament of Denmark on alcohol and drug issues, is representing the International Council on Alcohol and Addictions (ICAA), a co-sponsor of the conference. The Danish alcoholism authority visited Alaska last month on a preliminary planning tour that took him to Anchorage and Fairbanks.

The Alaska co-sponsor of the Arctic Rim Conference is the National Council on Alcoholism - Alaska Region, which will work together with the ICAA on conference details.

Registration fee is $85.00 for the 5-day conference. More information on the conference program and housing arrangement will be forthcoming.

Registration or inquires can be mailed to Suzanne W. Perry, NCA/AR, 4510 International Airport Rd., Suite 1, Anchorage, Ak. 99502, or Archer Tongue, Director, International Council on Alcohol and Addictions, Case postale 140, Lausanne, Switzerland.

Dr. Schiøler encourages Native and Indian peoples of Alaska, Canada, Denmark, Finland, Norway, Soviet Union, and Sweden to get involved and attend the five-day conference.

THE PLACE OF EEDA

On May 27, 1977 the Village Council passed resolution No. 77-9 designating May 27th of each year as "Awareness Day." On this day, the Youth of Tyonek will hold a Memorial Service in memory of five teenagers who died because of alcohol or drugs.

Attending this years services were Roy Peratrovick, Director of the Bureau of Indian Affairs, Joyce Nelson, RTA, Cook Inlet Native Association Alcohol and Drug Abuse Program, Corporal Al Shadle, Alaska State Troopers, and Father Marcarius Tragonsky of the Russian Orthodox Church.

The teenage youth center was dedicated on May 27, 1977 and called " The Place of EEDA", which means Friendship. Bertha Trenton recalls the ceremony by saying, "It was a beautiful ceremony, It's something a person will never forget. I really can't explain how it made me feel, I guess the only way to put it is, it made me feel full of love. . . . . .

May 27, 1977 is a perfect example of what can happen when young people have an idea, a purpose, and support from their parents and friends. By getting involved and making your feelings known, maybe someday there will be many places of EEDA.

CORDOVA
HIRES NEW ALCOHOLISM DIRECTOR

Randy Jones, new director of alcoholism counseling for Cordova Community Services said he is trying to revive the currently inactive Cordova Council on Alcoholism.

Jones, who with his wife, Gretchen, are new to Alaska, commented, "Our impressions so far are that it is truly beautiful. We enjoy the outdoors, hiking and fishing, and try to get out as much as possible."

Being alcoholism counselor in Cordova consists of therapy, education and information, but according to Jones, " So far, I find it very challenging and a lot of work, but an enjoying it very much." His office is located at the Cordova Community Hospital.

The new counselor comes from the Seattle area, and received his B.A. from Washington State University and M.A. from Fuller Theological Seminary in marriage and family counseling. Jones said he received training in alcohol-related couseling from the California Family Studies Center in Burbank, and in private practice with a Seattle Psychiatrist.

"I jumped at the chance to become an alcoholism counselor in Cordova," he added.

ANTI Hires Coordinator

Pictured above is Joyce Nelson, the new Coordinator for the newly established Alaska Native Training Institute.

Joyce is presently in Oregon attending a training session that is being put on by NWITI. Upon completion of her training, Joyce will be traveling to Sitka to hold her first training session for ANTI.

Joyce came to ANTI with eight years experience in the alcohol field. For the past six months, Joyce was the RTA for the Cook Inlet Native Region. While in that position, Joyce helped set-up seminars and training sessions for people in Anchorage, Wasilla, Kenai, Homer and points in between.

Joyce has attended summer seminars in alcohol and alcohol training in Utah, University of Alaska and Seattle University. Joyce has earned an A.A. degree in the area of chemical dependency and a two year degree in Social Science. She just recently finished working on her B.A. degree.

In her new position, Joyce will be responsible for coordinating ANTI seminars and training sessions for rural people. She will be working closely with the twelve regional health corporations and village councils. In addition to the above duties, Joyce will be working with native alcoholism counselors, other allied alcoholism personnel, village couselors, the Judicial System, youth and youth workers and social workers.

If you wish to contact Joyce about information, ideas, or suggestions concerning ANTI, you can contact her by writing to the ANCADA office in care of the Alaska Native Training Institute.

We would like to offer our congratulations to Joyce and we wish her the best of luck in her new position with the Alaska Native Training Institute.

ANCADA AND RURAL CAP join hands

Rural Cap has received notice of grant award for the former "Alcoholism Cultural Heritage Program" project. Working with the regional RTA's, the Rural Cap alcoholism counselors should form a very effective team. Selection and recruitment of counselors will rest with the appropriate regional corporation and will remain employees of Rural Cap. More information will be available as final arrangements are finalized.

Alaska Native Commission on Alcoholism and Drug Abuse

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Anchorage, Alaska 99503

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