

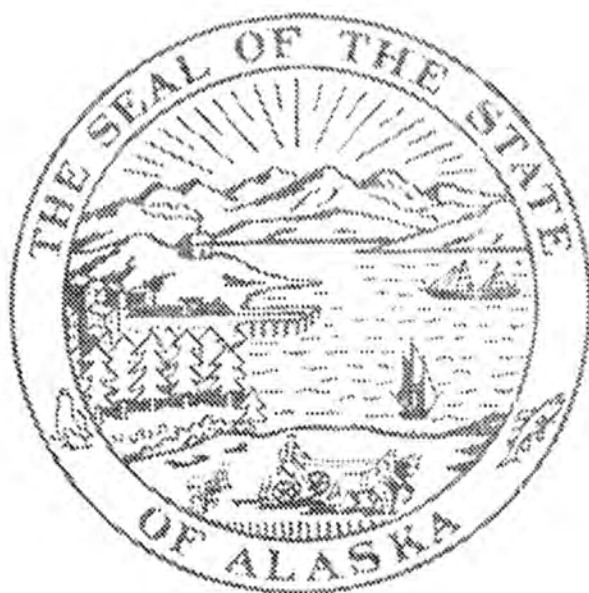
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**18th Alaska Legislature
House of Representatives**

**House Task Force on Alcohol
and Alcohol Abuse**

**Ramona Barnes
Speaker of the House**



**Representative Brian S. Porter, Chairman
Representative Eldon Mulder, Member
Representative Jim Nordlund, Member
Representative Richard Foster, Member
Representative Joe Sitton, Member**

**Task Force Staff:
Eric Musser**

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CREATION OF ALCOHOL TASK FORCE HOUSE OF REPRESENTATIVES 18TH ALASKA LEGISLATURE

"Alcohol policy issues have taken up a great deal of time and attention in our State legislature in the last decade. The problems caused in our society by alcohol abuse have demanded and received consideration from our elected representatives who have adopted legislation on drunk driving, state excise tax rates, fetal alcohol syndrome, alcohol server training, and many other alcohol related issues. But this legislation has been adopted on a piecemeal basis, as a reaction to a perceived individual need of the moment, and indeed, some legislation has never been implemented.

The State of Alaska Alcohol Beverage Control Board is the agency charged with enforcement of our laws dealing with the sale and use of beverage alcohol and yet is currently operating with three fewer investigators than it did in 1977, despite the growth in population and number of licenses in use. Little has been done to address the problem of the repeat drunk driving offender, the cause of most of our alcohol-related highway accidents. Legislation providing for an 'interlock' device that would inhibit a person convicted of DWI from operating a motor vehicle was adopted, but never implemented.

Although we as a society decry the problem of underage drinking, little has been done to curb the use of false identification used to purchase alcohol and unless tragedy results from such an incident, it is often regarded by communities as 'sowing wild oats' and shrugged off as 'a rite of passage - boys will be boys'. During 1990, the State of Alaska spent nearly \$12 million on alcohol abuse treatment, yet the Office of the Ombudsman concluded in a 1993 report that the Division of Alcoholism and Drug Abuse 'fails to insure that the programs it funds are effective.'

Alcohol Abuse is a grave and disturbing dilemma facing our state and deserves to be examined on a broad level, seeking an overview of our existing policies, reconciling the conflicts in our positions, and establishing a strategy for the rational regulation of a legal product and deterrents for the abuse of that product. The Twenty-first Amendment to the US. Constitution reserves to the states the right to regulate alcohol issues and the State of Alaska should assume responsibility for exercising that right in a coordinated, logical manner.

Examination of existing law and policies regarding alcohol as a legal product and the separate issue of laws and policies dealing with alcohol abuse is a method of assuming the State's constitutional right while protecting and promoting the safety and welfare of Alaska's citizens.

Therefore, I am hereby establishing the House Task Force on Alcohol and Alcohol Abuse and appointing Representative Brian Porter, Chair, Representative Richard Foster, Representative Eldon Mulder, Representative Joe Sitton, and Representative Jim Nordlund to serve."

Speaker Ramona Barnes
April 20, 1993

INTRODUCTION

This report contains a review and summary of alcohol abuse related issues as they were presented to the House Alcohol Task Force as established by House Speaker Ramona Barnes on April 20, 1993.

The scope of the task force was to review existing policy, seek public input, find innovative methods to address alcohol and alcohol related problems, find ways to become more efficient, and to make recommendations to the Speaker of the House.

During review of the scope of activities, the House Alcohol Task Force held four regional hearings around the state as follows:

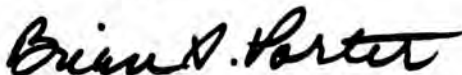
September 21, 1993	Nome
September 23 & 24 1993	Ketchikan
October 4, 1993	Fairbanks
December 1 & 2, 1993	Anchorage

Testimony was offered by treatment providers, prevention specialists, alcohol industry representatives, the Department of Health & Social Services, Division of Alcoholism & Drug Abuse, former and current abusers of alcohol and members of the general public.

I wish to thank all those who took so much of their time to assist us in our review, and to thank the task force members, Representative Eldon Mulder, Representative Jim Nordlund, Representative Richard Foster and Representative Joe Sitton, for their time and work in addressing this critical issue. Also, many thanks go to Eric Musser, my legislative assistant, for his work in assisting the task force with its preparation, research and activities.

Given the overall high incidence of alcohol abuse in our communities and the devastating results, considerable effort is necessary to expand the encouraging beginnings of changing attitudes and values across the state as regards the inappropriate use of alcohol, to improve on the delivery and coordination of services to those in need, and to strengthen law enforcement's ability to establish and maintain the requisite controls.

Sincerely,



Brian S. Porter
Chairman, House Alcohol Task Force

BP:elm

BACKGROUND

A. Policy Relating to Alcohol

AS 47.37.010 declares: *"It is the policy of the state that alcoholics and intoxicated persons should not be criminally prosecuted for their consumption of alcoholic beverages and that they should be afforded a continuum of treatment so they may lead normal lives as productive members of society".*

This policy was adopted after the offense of Drunk in Public was decriminalized as a result of a decision by the U.S. Supreme Court. While the "crime" of Drunk in Public had been used more as a social control protecting the intoxicant and removing his often offensive behavior from public view, the court's decision did not eliminate the more specific criminal violations that are alcohol related such as Driving While Intoxicated and Drunk on a Highway.

B. Alcohol and Health

Alcohol abuse and dependence are serious problems that affect about 10 percent of our national adult population. Adverse social and medical consequences of abusive drinking arise from single bouts of drinking, as well as from prolonged alcohol consumption. Adverse consequences affect not only the drinker, but also others with whom the drinker comes in contact.

According to research, two distinct forms of problematic drinking--alcohol abuse and alcohol dependence--have been identified. Alcohol abuse involves patterns of heavy alcohol intake in non-dependent persons in which health consequences and/or impairment in social functioning are associated. Alcohol dependence is differentiated from alcohol abuse on the basis of such manifestations as craving, tolerance,

and physical dependence that result in changes in the importance of drinking in one's life and in impairment of the ability to exercise restraint over drinking.

In general, alcohol and other drug use is more prevalent among Alaskans than among the national population. Alcohol has historically been and continues to be the most widely available and most frequently used drug in Alaska. According to the Division of Alcoholism and Drug Abuse, about two thirds of Alaskans report that they drink alcoholic beverages and, in aggregate, they drink heavily. Alaska consistently ranks as one of the states with the highest per capita consumption of alcohol at 3.3 - 4.1 gallons per person age 14 or older per year as compared to 2.5 - 2.8 gallons nationally.

C. Status and Trends

According to the Division of Alcoholism and Drug Abuse (ADA), treatment programs serve approximately 7,000 individuals annually with a client profile being male (72%), single (68%), unemployed (45%) and with an annual income below \$10,000. Data further indicate that Alaska's Native people suffer the effects of alcohol and other drugs disproportionately in that while they encompass only 15.6% of Alaska's population, they comprise 47.3% of the clients served through ADA funded programs.

PUBLIC COMMENT

The Task Force conducted four regional teleconferences in the state, seeking comment on the nature and scope of alcohol and alcohol related problems from the public's perspective. These meetings were held in Nome, Ketchikan, Fairbanks and Anchorage.

There appeared to be, at each of the public hearings, considerable support for treatment programs as they currently exist. Emphasis was placed on local control with as few restrictions as possible as most of the respondents felt they were better able to assess and address alcohol related problems within their own community.

There also, at each of the hearings, was general consensus that changes needed to be made in AS 47.37.190, Alaska's involuntary commitment statute. Respondents felt that under several circumstances, particularly related to the public inebriate, that the involuntary commitment was not long enough and should be extended to ensure greater safety to both the public and the individual concerned. It was further mentioned that the procedures for having someone involuntarily committed were too burdensome and cumbersome.

Individual comments taken from each of the sites are highlighted as follows:

- Need more support for rural villages
- More rural half-way houses
- Enact legislation that would increase the excise tax on alcohol
- Utilization of teleconference like network to support AA meetings held in different rural villages

- Send rural residents to treatment in a group to build support network for themselves when they return to their village
- Reduce the Blood Alcohol Content to .08 for presumptive DWI
- Implement that portion of AS 44.29.100 that would establish the Advisory Board on Alcoholism and Drug Abuse
- Enact zero tolerance legislation for minors
- Enact legislation that would mandate the registration of beer kegs

STATE RESPONSES

A. Division of Alcoholism and Drug Abuse

The statutory authority for the Division of Alcoholism and Drug Abuse of the Department of Health, Education & Social Services is found in AS 47.37.040, which lays out the duties and responsibilities of the Division, and lays out the philosophy of the state regarding alcoholism and intoxicated persons.

Within that chapter (AS 47.37.190) is also the involuntary commitment act established for those persons who do not seek treatment on their own and are incapacitated by abuse.

Additionally, AS 44.29.100 provides statutory authority for the establishment of an advisory board on alcoholism and drug abuse.

According to the most recent mission plan of the Division its purpose exists to promote the health and well-being of Alaska's citizens by preventing and treating alcohol, other drug, and inhalant abuse. The Division is responsible for implementing a comprehensive statewide strategy which will demonstrably reduce alcohol, other drug, and inhalant abuse and their harmful consequences:

"To accomplish this mission, the Division of Alcoholism and Drug Abuse (ADA), will provide leadership, advocacy, advice, and assistance to:

1. identify the nature, scope, and effects of alcohol, other drug and inhalant abuse in Alaska; and
2. develop, implement, and support effective community-based programs to prevent and treat alcohol, other drug, and inhalant abuse among Alaska's diverse peoples."

Also within ADA is the Alcohol Safety Action Program (ASAP) program. The basic ASAP function is to provide post disposition case management and accountability for DWI and other alcohol related misdemeanor cases. This involves screening cases referred from the District Court into drinker classification categories, in addition to managing and monitoring the cases throughout treatment.

Most clients are referred directly from the court post-sentence as a condition of a suspended portion of their sentence, although defendants may be assigned as a condition of release prior to conviction or come in as a self referral prior to court.

B. Alcohol Beverage Control Board

The Alcohol Beverage Control Board has its authority under AS 04.06 and is responsible for controlling the manufacture, barter, possession, and sale of alcoholic beverages in the state. The board is vested with the powers, duties, and responsibilities necessary to enforce alcoholic beverage control laws and regulations.

C. Department of Education

The Department of Education is responsible for the administration of the Drug Free Schools and Communities Act. This is a federally funded grant.

D. Department of Public Safety

AS 28.15 establishes the guidelines for administrative actions relating to the issuance, expiration and renewal of driver's licenses, including revocations, disqualification's and reinstatements. Along with local police agencies, this department responds to the adverse effects of alcohol abuse on the highways and in the homes of Alaska.

E. Department of Corrections

The Department of Corrections substance abuse program consists of counseling programs within each of their 13 institutions as well as 38 community treatment beds in the state. The Inmate Substance Abuse Treatment Program's (ISAP) mission is to accurately assess the treatment needs of those individuals who are eligible for community placements. In addition, inmates serving lengthy sentences should be provided the substance abuse treatment they need in order to lead a healthier quality of life during and after confinement.

The ISAP program offers comprehensive services to approximately 85% of their inmate population with substance abuse problems.

FUNDING

The FY 94 authorized budget for the Division of Alcoholism & Drug Abuse is \$23.149 million dollars. State appropriations constitute approximately 85% of this funding for alcohol and other drug prevention and treatment services provided through ADA. 87% of the state appropriation (\$17.2 million) comes from the Mental Health Trust Income Account while unrestricted GF dollars equate to \$2.76 million. Federal funds (\$3.1 million) in Substance Abuse Prevention and Treatment Block Grant funds make up 13.6% of the Division's budget. Included in the overall funding for ADA is the Alcohol Safety Action Program, administration and competitive, designated and CAASA grants.

Further, the Department of Education receives approximately \$2.0 million for administration and operation of the Drug Free Schools and Communities Act.

Department of Corrections Substance Abuse Program funds authorized for FY 94 were \$1,411,100. Of this total, 55.3% (\$781,300) is from the Mental Health Trust Income Account and the balance 45.7% (\$629,800) is unrestricted GF.

The Governor's office received for FY 94 \$465,000 in federal funds through the Drug Free Schools and Communities Act.

The Departments of Health, Education and Social Services and Public Safety each have approximately 3% of their budgets specifically identified for alcohol programs. This totals \$2,851,000 for the Department of Public Safety. Each department believes, though, that a considerable portion of their remaining budget responds to alcohol related problems.

Therefore, identifiable funding for alcohol and drug abuse services in Alaska total \$29,875,100 for FY 94.

RECOMMENDATIONS

As a result of input from the public hearings, other interviews, and the general experience and individual research of Task Force members and staff, the following recommendations are offered:

A. Coordinating Activities

1. The Task Force Believes the Practice of Bootlegging Alcoholic Beverages Needs to be Studied In-Depth and Stopped.

Bootlegging of alcoholic beverages throughout rural Alaska is out of control, according to testimony presented to the Task Force. Bootlegging leads to the unsupervised sale of alcoholic beverages to minors and persons known to be intoxicated.

The Task Force recommends that the Department of Public Safety, Attorney General, the ABC board, legislature and Federal Bureau of Alcohol, Tobacco and Firearms form a joint committee to study new approaches to control bootlegging, such as resource issues, needs for legislation and other proposals to address this problem.

2. The Task Force Supports Legislation Which Will Encourage Minors To Avoid Drinking.

It is the public policy of Alaska, to prohibit the sale of liquor to minors under the age of 21 years. During the first session of the 18th legislature, SB 84 was enacted which would revoke the driver's license of a minor who used an altered driver's license to purchase alcohol. This law also provides that the Alaska Driver's License will be produced in such a way as to discourage alteration

attempts and will have "UNDER 21" prominently displayed thereon.

However, the Task Force believes further legislation needs to be Enacted which would suspend the driver's license of any minor who uses any type of false or altered identification for the purchase of alcoholic beverages. Zero tolerance legislation should be Enacted to send a clear and convincing message that consumption of alcoholic beverages by minors is unacceptable, especially as it relates to driving. To accomplish this goal, HB 299 was introduced and should be enacted into law to address these problems. Additionally, the Task Force supports the passage of HB 28, SB 221 or HB 344, and HB 195, all designed to discourage minors from drinking.

3. The Task Force Believes a Traffic Safety Commission Should be Created.

The Task Force urges the Legislature to create a Traffic Safety Commission consisting of legislators, the Attorney General, Department of Public Safety, Department of Health, Education & Social Services, Department of Transportation and the Alaska Association of Chiefs of Police.

The purpose of the Commission would be to coordinate traffic safety activities. For example, several agencies spend money on alcohol abuse and DWI prevention campaigns which could be more effective if the agencies adopted a unified strategy that included media and public involvement. The Commission would also give traffic safety issues, particularly DWI, higher visibility and priority within state government.

4. The Enforcement Division of the Alcoholic Beverage Control Board (ABC) Should Be Expanded and Coordinate Its Activity with the Department of Public Safety.

The Task Force finds that proactive enforcement of liquor laws is imperative and should be coordinated with the enforcement and public awareness of Alaska's DWI enforcement efforts.

Further, the staffing levels of ABC investigators are inadequate. With 1,810 liquor licenses issued statewide, the maximum time available to monitor the compliance of each license is approximately 3 hours per license.

The Task Force recommends that the staffing levels of ABC investigators be increased to a minimum of six and that this investigation unit and the Criminal Investigation Bureau of the Alaska State Troopers continue to coordinate their activities dealing with alcohol violations.

PREVENTION

1. **Local Newspapers Should Publish the Names of Those Arrested For DWI in their Communities and the Penalties the Offenders Receive When Convicted.**

The Task Force found that several Alaskan newspapers, including the *Juneau Empire*, *Fairbanks Daily News Miner*, and others, publish the names of those convicted of DWI in their particular community. It notes that in Anchorage the names of all those arrested for DWI were published on the front page of the paper in the mid-eighties. This was a part of a coordinated DWI prevention program that was highly successful.

The Task Force believes that this is an effective public awareness strategy that has a significant deterrent effect and brings attention to the serious penalties resulting from conviction.

2. **The Sale of Alcoholic Beverages Should be Accompanied by a Strong Anti-DWI Message.**

The Task Force believes that every location which sells alcoholic beverages should post in a prominent place, for example, next to the cash register, an anti-DWI message.

3. **The Task Force Urges All Wholesale Liquor Distributors to Help Increase Alcohol Abuse Awareness by Funding Programs in Alaska.**

The Task Force believes programs like the Designated Driver Program, in which a driver receives free soft drinks and discounts on food from a liquor retailer in exchange for being named the designated driver of a group and refraining from drinking would increase public awareness of the hazards and consequences of drinking and driving and should be continued and expanded.

4. Youth Alcohol Awareness Initiatives In Our Schools Should Be Expanded.

A 1988 University of Alaska Anchorage, Center for Alcohol and Addiction Studies found that approximately 74% of students in grades 7 through 12 had consumed an alcoholic beverage during their lifetime, and close to two-thirds (58%) had consumed at least one alcoholic beverage during the last year.

Currently, there are four operating alcohol education initiatives for minors. These initiatives are undertaken through the City of Barrow, Mat-Su Council for the Prevention of Alcoholism and Drug Abuse, and the City of Wrangell and City of North Pole Police Departments. Two of these programs are Project DARE programs.

The Task Force believes that the Community Action Against Substance Abuse Grant Fund established under AS 47.37.045, presently authorized at \$178.4 thousand for FY 94, should be substantially increased with priority given to funding Police-In-School Liaison Programs or youth alcohol awareness initiatives.

ENFORCEMENT

It is generally accepted and has been shown in Alaska that a potential criminal offender is deterred from committing a crime in direct proportion to his/her belief in the likelihood of discovery and apprehension. The Task Force believes that all persons and entities, especially the media, should recognize this fact and promote it.

1. **With the Advent of Cellular Technology, Alaska Should Begin a Statewide "Report Every Drunk Driver Immediately" (REDDI) Program.**

Alaska is the largest state in land mass and 7th in per capita income. As a consequence, there are not enough resources to adequately police all of the state's roads. According to national statistics from the Advocates for Auto and Highway Safety, fewer than two percent of those who drink and drive are arrested.

Alaska presently has the remnants of a REDDI program started several years ago by the Seward Police Department. REDDI addresses DWI problems by educating private citizens about a special number (e.g., 1-800 BEAT DWI) which they can call to report those who drive drunk. A police dispatcher takes down the time, location of the suspected drunk driver, color of vehicle, license plate number and direction of travel and notifies troopers or other police officers in the vicinity.

REDDI is based on the same concept as the "Neighborhood Watch" program, which actively involves citizens in safeguarding lives and property in their communities. The Task Force believes that most people will be as willing to report a drunk driver as a prowler.

Colorado, Idaho, Kansas, Nebraska, Oregon and Washington all report success with the program. The National Transportation Safety Board issued a safety recommendation to all 50 states encouraging adoption of REDDI - type programs.

The principal advantages of the REDDI program are; first, REDDI empowers private citizens who currently feel helpless to combat DWI. Second, REDDI supports law enforcement by giving the police extra sets of eyes trained on suspected drunk drivers. Third, REDDI prevents drinking and driving by enhancing the perceived risk of apprehension.

To increase public awareness of the REDDI program, advertisements could be placed on municipal transit vehicles (where available) in a manner suggested below.

2. The Task Force Recommends That the legislature Reduce the Presumption of Intoxication from .10 to .08 BAC.

A recently released National Highway Traffic Safety Administration (NHTSA) study of California's .08 law, which went into effect on January 1, 1990 found that the .08 law, and the publicity surrounding its enactment, had been a major factor in reducing alcohol-related traffic fatalities by 12 percent in California in 1990.

Some people have argued that lowering the presumed intoxication level to .08 would further burden an already overburdened court system. However, California's experience has been that a .08 law does not increase the number of DWI defendants pleading guilty, requesting jury trials or appealing convictions. The reduced fatality levels and the absence of an increase in the volume of cases may be explained by the success of the .08 law in deterring drinking and driving behavior by increasing the perceived risk of apprehension for lower intoxication levels.

The Task Force recommends the passage of HB 61, lowering the BAC to .08.

3. **Police Departments Should Use Sobriety Checkpoints.**

Sobriety checkpoints are used by police as a visible deterrent to drunk driving. Stopping a predetermined sequence of cars, at a selected location, generally on a weekend night, officers conduct a brief interview to determine if the driver is impaired by alcohol. Sobriety checkpoints have been shown to be effective in deterring drinking and driving because they also serve to increase the perception that detection and arrest are likely to occur.

The Task Force recommends that sobriety checkpoints be conducted on Friday and Saturday nights around graduation time and on major holidays but also periodically indiscriminately to avoid predictability.

TREATMENT

Those people who can neither be prevented nor deterred from impaired driving tend to have serious substance abuse problems. They are also the most likely candidates to become repeat DWI offenders and to become involved in the myriad other criminal and social tragedies that cost our state so much in monetary and personal loss. Yet, information from the Division of Alcoholism and Drug Abuse (ADA) is relatively non-existent as to the effectiveness of treatment provided throughout Alaska for these clients.

1. **Outcome Evaluations and Follow-up Should be a Mandatory Component of Grant Fund Allocation to Treatment Facilities.**

AS 47.37.040(9) mandates ADA shall "*specify uniform methods for keeping statistical information by public and private agencies, organizations, and individuals, and collect and make available relevant statistical information, including number of persons treated, frequency of admission and readmission, and frequency and duration of treatment.*"

The Task Force finds that while ADA has, to the extent possible, fulfilled its legislative mandates, there exists deficiencies in the statistical information available to adequately measure program success.

The Task Force recommends that AS 47.37 be strengthened to ensure that outcome evaluations and follow-up information is reported to ADA before a recipient may continue to receive grant funding from the state and that ADA continue and complete the process begun with New Standards, Inc. in Minnesota to develop and implement appropriate program measurements.

2. **Fund Source Restrictions May Handicap ADA's Ability to Respond to Changing Societal Norms.**

Since 1990, a greater proportion of state funding for ADA activities has come from the Mental Health Trust Income Account (MHTIA). These funds may restrict ADA's ability to respond effectively to changing circumstances as MHTIA funds have restrictions on their uses. MHTIA funds are restricted to uses supporting services for mental health trust beneficiaries. This excludes prevention services, treatment services for adolescents, some drug addicts and early intervention services such as Alcohol Safety Action Programs and Employee Assistance programs.

Similarly, federal funds are increasingly contingent on use of their funds to carry out Federal initiatives which define distribution formulas, target specific populations, and mandate specific services and activities.

The Task Force finds that the trend toward categorization limits the flexibility to alter service configurations or initiate innovations in service delivery to respond to changing needs and to allow community based responses that recognize the diverse cultures and needs of our citizens.

GENERAL POLICY RECOMMENDATIONS

1. Recognize the need to promote the positive aspects and values of responsible alcohol consumption and the negativeness of alcohol abuse so as to encourage and support responsible drinking.
2. Recognize that the outcomes and success of prevention and treatment services in Alaska should be measured by the elimination or significant reduction of the universally recognized adverse results of alcohol abuse and alcoholism. At a minimum this would include those objectives found in the Healthy People 2000 initiative of the Federal government as adopted by the Department of Health and Social Services.
3. Find ways to support post-treatment aftercare programs, especially in the smaller communities of the state.
4. Recognize the need to review in its entirety AS.47.37.190-200 "involuntary commitment" so as to make this process more manageable and effective.

CONCLUSIONS

A. Funding

The Task Force recognizes the projected declines in revenue and the shortage of new funds to implement or alter existing programs. The Division of Motor Vehicles has estimated however, that there are approximately 10,000 driver's license revocations statewide each year. Presently, the license reinstatement fee for all classes is \$100.

The Task Force recommends, therefore, that to accomplish its goals, legislation should be enacted that would amend AS 28.15.211(c) and (d) to increase the driver's license reinstatement fee to \$250. This increase would generate approximately \$1,357,000 new dollars annually. The Task Force also believes these funds should be held in reserve until FY 95 budget caps have been established by the Finance Committee. Following the establishment of the budget caps, then these funds should be programmed in with \$678,500 being appropriated to the Department of Public Safety and \$678,500 being appropriated to the Department of Health and Social Services, Division of Alcoholism and Drug Abuse, to accomplish the recommendations of the Task Force.

The Task Force has also recommended that the ABC Board's investigation positions be increased. We believe existing program receipts should be used for this purpose. The fees received from liquor licenses and permits should be used to address the needs and responsibilities of the agency that assesses and collects them. This, undoubtedly, was the intent when they were first established. The ABC Board received \$1,792,100 in program receipts and had an authorized budget of \$626,000 in FY 94.

B. Observations

As the old joke goes, there seems to be good news and bad news. The "bad news" is, as we've acknowledged within this report, the resources available

now and in the future to address the gigantic challenges of alcohol abuse in Alaska appear to be diminishing. While this will require innovation and more private sector participation, it also will hopefully result in state dollars being expended for only those efforts that can demonstrate successes.

The "good news" is that the attitudes and values associated with the past "last frontier" approach to excessive alcohol consumption seem also to be diminishing. Several things seem to be coming together simultaneously that can only result in improvement. The liquor industry is sponsoring responsible drinking, anti-DWI programs and endorsing such things as an increase in ABC investigator positions.

A singular "good news" item is the impetus of the Alaska Federation of Natives "Sobriety Movement". This comprehensive approach to Native drinking problems holds tremendous promise for positive impact.

While the Task Force recognizes the fact that Alaska is still a leader in alcohol related problems, the perception that these problems are undesirable and either treatable or avoidable, is spreading rapidly. As often occurs, we hope this perception become's reality.

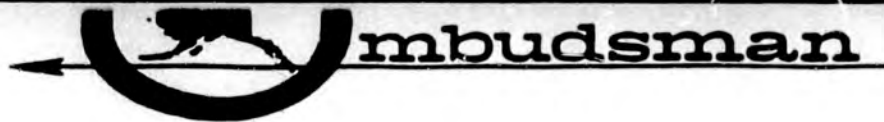
DEPARTMENT OF HEALTH AND SOCIAL SERVICES
ALCOHOL AND DRUG ABUSE PROGRAMS

	FY83	FY84	FY85	FY86	FY87	FY88	FY89	FY90	FY91	FY92	FY93	FY94
PROGRAM AREA												
Administration	1,517.3	1,613.1	1,221.1	1,441.5	1,425.4	1,118.1	1,263.3	1,417.3	1,515.7	1,476.1	1,632.3	1,643.9
ASAP						963.1	992.6	1,005.1	1,104.2	1,066.7	1,082.4	1,096.5
Grants												
Competitive	15,318.7	12,658.2	14,030.9	14,050.1	11,703.3	12,010.1	12,122.7	14,609.6	18,364.0	19,811.9	17,942.8	17,477.8
Designated		553.6	1,329.7	1,574.1	1,341.7	1,377.7	1,840.4	1,925.4	1,988.3	2,759.0	2,752.4	2,752.4
CAASA										400.0	178.4	178.4
Total	16,836.0	14,824.9	16,581.7	17,065.7	14,470.4	15,469.0	16,219.0	18,957.4	22,972.2	25,513.7	23,588.3	23,149.0
FUND SOURCE												
General Fund	14,041.3	13,220.8	15,094.5	15,169.7	12,570.1	13,030.6	13,200.1	13,578.3	2,897.5	3,067.7	2,729.8	2,322.8
General Fund/Mental Health								1,037.8	14,364.5	17,398.8	16,844.9	17,222.9
General Fund/Program Rcpts								59.0	75.1	65.3	81.2	95.3
Total General Fund	14,041.3	13,220.8	15,094.5	15,169.7	12,570.1	13,030.6	13,200.1	14,675.1	17,337.1	20,531.8	19,655.9	19,641.0
Federal Funds	2,794.7	1,604.1	1,487.2	1,501.0	1,504.4	2,032.2	2,184.0	3,245.9	4,759.4	4,198.5	3,568.0	3,163.1
Interagency Receipts				395.0	395.9	406.2	834.9	1,036.4	875.7	781.4	362.4	342.9
Alcohol/Drug RLF										2.0	2.0	2.0
POSITIONS												
PFT	19	19	18	18	28	26	27	28	28	27	27	28
PPT					2	3	3	3	2	1	1	1

Note: FY83 - FY92 represents actual expenditures. FY 93 and FY 94 are authorized amounts.

Responsibility for the Alcohol Safety Action Program (ASAP) was transferred from the Court System in FY87. Funds to support ASAP appear in Administration in FY87 and then placed in its own component in FY88.

Legislative Finance Division



**STATE OF ALASKA
OFFICE OF THE OMBUDSMAN**

INVESTIGATIVE REPORT

**Department of Health and Social Services
Division of Alcoholism and Drug Abuse
Ombudsman Complaint F89-0072**

February 4, 1993

**Duncan C. Fowler
Ombudsman**

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INVESTIGATIVE REPORT

Final Finding and Closure

Ombudsman Complaint F89-0072

February 4, 1993

BACKGROUND

Allegation development

On February 3, 1989, Dr. Frank A. Gold entered a complaint against the Division of Alcoholism and Drug Abuse (ADA). The allegation was that the division fails to implement alternative alcohol abuse programs for the treatment, education and prevention of alcohol abuse. Investigation was completed by Assistant Ombudsman April Crosby with assistance from Deputy Ombudsman Michael Hostina.

According to Dr. Gold, the division's decisions regarding which programs receive state funds are based on outdated theories of alcoholism and its treatment. He alleged the division ignores current research on treatment effectiveness which should form the context for their funding decisions. In fact, he alleged, proposals based on state-of-the-art research are dismissed as noncomplying. Specifically, according to Dr. Gold, the single treatment model used by the state is the disease model of alcoholism, whereas empirical scientific evidence shows that other models are client and cost effective. Basically, the original allegation took issue with the underlying treatment philosophy or conceptual framework upon which division funding decisions are based.

In December 1989 then-Ombudsman Regional Director Michael Hostina clarified with Dr. Gold and with then-Commissioner of Health and Social Services Myra Munson, that he had narrowed the investigation to the following question:

Is the department's selection of alcohol treatment programs based on improper or irrelevant grounds?

This focus accomplished two things. First, Dr. Gold's interest was with treatment programs and not prevention and education programs. Second, it narrowed the investigation to the central question of whether the division funded only programs which were based on compatible philosophical assumptions rather than on empirical studies of treatment effectiveness.

However, after considerable review of technical and professional literature, the ombudsman made a further decision not to evaluate the philosophical underpinnings of various models for treating substance abuse. This decision was made because there is continuing professional debate about the efficacy of treatment based on the disease model of substance abuse. The ombudsman was not prepared to interject his office into this ongoing professional dialogue.

Instead, the allegation was reformulated to address the complainant's concerns regarding whether ADA's funding decisions were reasonable. This changed the focus of the investigation from the validity of an underlying philosophical orientation toward

treatment, to a review of what information ADA uses to make its funding decisions. Therefore, per AS 24.55.150 (4) the allegation under investigation is:

ADA unreasonably fails to ensure that the programs it funds effectively further the division's mission.

Reasons for accepting the complaint for investigation

The complexity of this complaint and understaffing in the Fairbanks office resulted in long delays in completion of this investigation. Despite these problems the ombudsman pressed for completion of this investigation for several reasons.

The first of these reasons is that ADA receives significant state funds at levels which have increased dramatically since the division began funding local alcohol programs. In 1971, alcohol treatment programs were funded with \$270,000 and in 1990, 19 years later, they received a little over \$11,996,000. This is an increase of significantly over 4,000 percent. Since the state population and state revenues also increased during this period, an increase in funding is not surprising. The amount of increase, however, illustrates that substantial state resources are allocated to these programs.

A second reason for investigating this complaint is the rising social cost to Alaskans -- beyond funding the programs themselves -- from the negative effects of alcohol abuse. The positive correlation between alcohol abuse and social ills such as domestic violence, child abuse, suicides, traffic accidents and violations, probation and parole violations, and fire and other accidents, is well documented. ADA's annual reports, required by AS 47.37, are chock full of statistical summaries of indicators from health services, public safety records and the criminal justice system which illustrate alcohol-related social and economic costs.

The division's 1986 report on the costs of alcohol abuse and alcoholism to the state (AK/DHSS/SOADA/89-1 and -2) characterized the situation as a "fiscal crisis." One source of revenue for these programs is the alcohol excise tax, but, according to the report, in 1986 the state incurred \$12.60 in costs for every tax dollar collected. Three years later, Alaska collected less revenue from this tax (perhaps due to declining population) but spent even more per dollar collected because the problems increased despite the declining population.

Another example of program costs compared to available revenues is the role of federal funding. According to the division's most recent Request for Proposals, the program for services to women of child-bearing age are relatively highly subsidized by the federal government, receiving almost 34 percent, or \$300,000 from that source. These programs had a total of \$843,800 available for FY93. However, according to Chart 23 in the ADA Plan, the cost to Alaska of alcohol-related birth defects and fetal alcohol syndrome was over \$14,000,000 in 1988 alone.

The shocking Alaska Federation of Natives' 1989 report, "A Call for Action," on the status of Alaska's Native population, very effectively illustrates the numerous and profound ways these Alaskans pay for this problem. Most of the statistics documenting high suicide, homicide, accidental death and injury and crime and incarceration rates are also correlated with alcohol abuse. Calling alcohol "the fuel that fires the cycle of violence and self-destruction," the report makes clear that the greatest toll is on young Native adults, unborn infants and abused children. Whether in jails or health facilities, the costs associated with these alcohol-affected populations are tremendous.

A third reason for pursuing this investigation is the extent of public interest involved. Alcohol-related problems affect the general population, beyond the abusers themselves, in ways not immediately apparent even from social ills considered above. For

example, the presence of fetal alcohol syndrome-affected children in public schools places an inordinate burden on special education programs and staff in the Department of Education. Another example is the concern expressed by private businesses and individuals who contact the Division of Alcoholism and Drug Abuse or even the Division of Tourism regarding the disturbing effect of public inebriates on their potential customers. Even more profound -- and more difficult to assess -- is the tremendous loss of human and cultural resources associated with Native alcohol abuse.

Given the documented prevalence of alcoholism and alcohol-related problems, the tremendous economic and social costs associated with these problems, and a history of increasing problems despite various population trends, the question of whether state funds are effectively allocated in combating these costly problems is an important one. Since Alaska can anticipate decreasing state revenues, perhaps accompanied by decreasing employment, and, probably, the subsequent increase in social problems which usually accompanies recessionary periods, the question is especially timely. It is important that these critical state dollars fund programs most likely to succeed in reducing Alaska's alcohol related problems.

INVESTIGATION

The issues

It is reasonable that the Division of Alcoholism and Drug Abuse would fund those treatment programs which are most effective in achieving the division's mission. To do this, the funding criteria must pertain to the prospective programs' ability to achieve that mission. And, to determine this ability, some means of measuring program effectiveness must be included in the program evaluation process. The questions for investigation and analysis in this report are, therefore:

- What is ADA's mission, is it appropriately formulated, and does it effectively guide the funding process for treatment programs?
- Does ADA adequately evaluate programs to determine their effectiveness in achieving the division's mission?
- What process is used by ADA for its program funding decisions and does it reasonably ensure progress toward accomplishing ADA's mission?

History of ADA's statutory mandate

The state of Alaska first funded services to help combat alcohol abuse in 1969. In 1972, the Uniform Alcoholism and Intoxication Treatment Act (AS 47.37) removed responsibility for public intoxication from the criminal justice system and provided for treatment of public inebriates by public health and community service agencies.¹ The following year federal funds became available to state alcoholism programs through the Federal Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Amendment.

In 1980-81, the Alaska legislature significantly increased state funds available to respond to alcohol abuse problems, enabling the development of a comprehensive statewide alcoholism and drug abuse program. In 1987, the state office of alcoholism and drug abuse (SOADA) increased its jurisdiction by assuming responsibility for offenders

¹ Although public intoxication is no longer a crime in Alaska, significant numbers of Alaskans incapacitated by alcohol are taken into protective custody and housed temporarily in jail cells due to insufficient sleep off beds.

arrested for "driving under the influence" of alcohol and controlled substances. In 1990, the office became a full-fledged division of alcoholism and drug abuse (ADA). The enabling statute incorporates a declaration of policy from the Uniform Alcoholism and Intoxication Treatment Act of 1972:

AS 47.37.010 Declaration of policy. It is the policy of the state that alcoholics and intoxicated persons should not be criminally prosecuted for their consumption of alcoholic beverages and that they should be afforded a continuum of treatment so they may lead normal lives as productive members of society.

AS 47.37.040 establishes a broad, 19-point list of the division's duties, ranging from planning and establishing various kinds of prevention and treatment programs for alcohol and other substance abusers, and coordinating with state, private and nonprofit agencies and schools and private enterprises to educate and/or treat substance abusers, to conducting research and providing guidance and reports to state government.

AS 47.37.130 directs the division to "establish a comprehensive and coordinated program for the treatment of alcoholics, intoxicated persons, drug abusers, and inhalant abusers." It further specifies that the division's program must include essential components: emergency treatment affiliated with medical service, and inpatient, intermediate, outpatient and follow-up treatment. It charges the division with ensuring that "adequate and appropriate treatment is provided" in its approved public treatment facilities; and that the division "shall maintain, supervise and control all facilities operated by it."

What is ADA's mission pertaining to substance abuse and treatment?

Apart from governing statutes, there are several sources from which to learn the division's mission. One is the State of Alaska Alcoholism and Drug Abuse Plan for 1990-92.

Mission

According to page four of the plan, the division's mission, "as clearly defined by legislation," is "to create and maintain a comprehensive program of prevention, intervention and treatment for all Alaskans that may be affected by alcohol and drug abuse." On page 10, citing statutory authority and legislative mandates, the plan states

The primary purpose of the ADA, is, therefore, to ensure the provision of a comprehensive and coordinated program of substance abuse prevention and treatment services, and to ensure that the administration and management of all alcohol and drug abuse programs follow state standards and meet the treatment and prevention needs of all Alaskans.

Loren A. Jones, director of ADA, interprets "comprehensive" to mean that a variety of programs be available to people throughout the state.

The plan expands this mission statement by grouping ADA's statutory duties into three efforts:

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

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

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

Goals and objectives

Chapter II. E. of the plan contains the division's goals and objectives. According to Mr. Jones, these are organized by target populations identified by ADA due to their need for services, i.e., chronic alcoholics, Native/rural populations, high-risk AIDS and fetal alcohol syndrome populations, youths and inmates.

Of these target populations, chronic alcoholics are the state's highest priority for treatment. Chapter I.C. of the plan, entitled ADA Policy, states:

The ADA has placed the highest priority for services on meeting the needs of abusers who are in the greatest immediate danger of death and those with serious illness or injury and accompanying social and functional damage due to alcoholism or drug use.

During a conversation on June 23, 1992, Director Jones confirmed that "the public's role" is to serve "the most severely debilitated." These are the people whose abuse patterns are so severe that they very likely have no job, no car, and possibly no family and no home: the public inebriates.

When asked why this target population has highest priority, Mr. Jones gave several reasons. First, they cost the most in that they are most likely to use emergency medical facilities, homeless services and other services for the indigent. People with mild to moderate impairment are more likely able to pay for treatment with insurance coverage or other personal resources. Mr. Jones doubted that "the state should [treat] the market that the private sector can handle."

Second, he said ADA receives pressure to treat this population because

... when the tourists are in town and the business people [object to public inebriates] they come to the state. They don't go to private programs. And when people are in jail on some alcohol-related crime, [the public] doesn't want those people getting out without having received some treatment. ... [We receive few complaints about] people who drink too much at a Chamber of Commerce luncheon. [They are not the cause of] people who go to the legislature about severe alcohol problems.

Mr. Jones explained that people with serious impairment are most often referred to a treatment program by the court system. Public safety officers often attempt to get inebriates off the streets by arresting them for a misdemeanor (although the courts get overwhelmed with such cases) and, after numerous arrests, a judge may order the person to a treatment program.

Third, Mr. Jones stated that sound public sector fiscal policy requires that funds go where the needs are greatest. When comparing the serious debilitation of public inebriates or the plight of some rural villages where on any given day a significant proportion of the residents are intoxicated, it is hard to justify funding programs for people who are drinking

a little too much because of a brief personal setback, or for high schoolers who get caught the first time they drink and drive.

Mr. Jones pointed out that over the years program emphases change, reflecting new developments. For example, there are years when the division is pressured to focus on prevention programs for youth. In other years, the pressure reflects interest in pregnant women or populations at high risk for HIV infection. At this time and when the 1990-92 plan was written, the highest treatment priority is the most severely impaired.

Among the plan's goals and objectives, there are other goals pertaining to certain programs such as prevention programs, employee assistance programs (EAP), the Alcohol Safety Action Programs (ASAP) and training programs in alcohol-related parenting skills and in identifying and reducing inhalant users. Goals are also specified regarding coordination with for-profit agencies and training substance abuse professionals. Goals for the Data, Policy, Planning and Program Development section are listed elsewhere, at Chapter I. E. 2. Management Responsibilities: Organizational Structure.

When asked why there are no goals in the plan specifying desired outcomes of treatment programs, Mr. Jones said that the providers themselves establish the treatment goals. The division's goals pertain to establishing and maintaining a delivery system for comprehensive treatment programming, but, since ADA does not provide treatment directly, they do not formulate treatment goals.

While no treatment outcome goals are explicitly stated in the plan, Chapter I.B of the plan, Addiction and Abuse Defined, indicates that the goal of any treatment program funded by the division is abstinence. Excerpting from this section, the treatment goal is stated as follows:

The ADA holds . . . that alcohol and other drug abuse is the number one health problem in Alaska.

. . . alcoholism . . . is a primary, progressive, chronic and fatal disease. If it is not prevented, it must be treated. To be treated, intervention must often take place. If the disease is not treated, the person suffering the disease will die from it or a related cause.

Because alcoholism . . . ha[s] such a profound effect on . . . the physical, social, psychological and spiritual aspects of a person's life, the primary goal of any treatment program is to encourage and support the individual to become and remain abstinent. [ADA] supports the philosophy that abstinence is the basis for any lasting change. . . .

The division's annual Request For Proposals (RFPs) to private service providers are a final source for learning the division's goals. These documents state somewhat different purposes or goals for each funding program, primarily in terms of the population targeted by each funding source. For example, the funding guidelines for the program for intravenous drug users begins, "These grants are designed to reduce or eliminate the intravenous use of illegal drugs and the spread of communicable diseases. . . ."

According to the FY92 and FY93 RFPs, the division allocates the bulk of state funds to the Community Alcoholism and Drug Abuse Prevention programs. The goal for these programs, according to the FY92 RFP, is "to prevent and treat the effects of alcohol and other drug abuse in the community." In the FY93 RFP, this goal reads, "to prevent, reduce or eliminate the abuse of alcohol and other drugs in Alaskan communities." RFP instructions indicate that applicants must develop program goals and objectives in terms of this statement of purpose.

Does ADA evaluate these programs to determine their effectiveness in achieving these goals?

Although program evaluation is not mentioned explicitly in statute, ADA's responsibility for evaluation is implied by AS 47.37.130 (d), which authorizes the division to provide "adequate and appropriate treatment." AS 47.37.140, .150 and .210 authorize the division to establish standards for, among other things, program facilities, admission and client treatment plans, and for the availability of program reports.

With the adoption of 7 AAC 29.030, the division established such standards for every program it funds by adopting alcohol program accreditation standards from the Joint Commission on Accreditation of Hospitals (JCAH). Standard 1. G requires that programs evaluate their performance in terms of their goals and objectives and that evaluation results become part of a continuing planning process. It is therefore ADA's responsibility to ensure that each program follows through on evaluation and that its contribution to future planning is sustained.

Evaluation methods

Mr. Jones referred to treatment as a "black box" and noted that asking how it works engenders intense debate. ADA's quality assurance program is implemented through annual site visits, during which ADA staff, using a detailed check list, monitor compliance with the JCAH standards. In addition to reviewing the physical facilities, staff pull sample client records to check for such things as whether the treatment plan matches problem assessment information, whether treatment plans are updated regularly, whether clients leave prior to completion and why, and whether the program personnel performing various tasks are appropriately trained.

In addition to site visits, the division monitors the programs it funds by requesting a series of reports. 7 AAC 28.040 authorizes ADA to require record keeping by funded programs. Part of it reads:

In addition to financial records, the projects shall keep records regarding the persons served by the project which shall include personal histories in such detail as required of the projects by the department for the purpose of data collection and evaluation of project effectiveness. Quarterly reports shall be submitted according to the format prescribed.

The first component of grantee reporting requirements is quarterly reports. These reports, which "detail how the grantee is in compliance with the terms of the grant" instruct grantees to "identify specific progress as it relates to the grant's goals and objectives." The Quarterly Progress Report Format contains two sections asking for indications of progress toward the programs goals and objectives.

The third evaluation method required of all programs is the evaluation plan. These plans must show how progress toward goals and objectives a program sets for itself will be measured.

Both quarterly reports and a program's evaluation plan are self-evaluation tools which judge the program in terms of its stated goals and objectives. Since the formulation of goals and objectives is central to implementing program evaluation, it is worth looking at how they are written.

Guidelines to grant applicants for writing goals and objectives vary between the FY92 RFP and the RFP for the most recent FY93 funding cycle. The earlier instructions read:

C. 4.a. Program goals and objectives provide organizational direction as well as a basis for evaluating progress. The applicant should therefore develop a set of goals and objectives that clearly illustrate how and when the identified problems and needs will be addressed.

Program objectives should be written as activities and end results detailing **who is going to do what, when and how much**. This section must also include information about how each objective will be measured. [Emphasis in original.]

The same section in the FY93 RFP reads:

Project goals and objectives provide organizational direction as well as a basis for evaluating performance and progress toward overall program goals. The applicant organization must develop a set of goals and objectives that clearly illustrates what will be achieved to address identified problems and needs, the targets [sic] levels for performance, and how and when actions leading to the targets will be accomplished.

Project goals should be written as the outcomes, or end results the project is designed to bring about. Project objectives should be written as targets resulting from activities designed to bring about the goals. Objectives should identify **who is going to do what, when, and how much** will be achieved - the level of performance planned. Target levels for objectives are usually measured from some baseline. Performance targets clarify how each objective will be measured and the minimal level the respondent believes can be achieved. [Emphasis in original.]

According to ADA Director Jones, ADA's evaluation methods focus on whether a program's procedures and activities are in order. Mr. Jones stated that as long as program procedures included certain mainstream methods or themes, the desired outcomes would follow. Therefore, he said, it is reasonable to fund programs on the basis of the presence of these treatment themes. The themes, explained Mr. Jones, include that alcoholism is a chronic, degenerative disease, that the ill person admits to a problem and connects it to negative consequences, and that getting well requires sobriety and a recovery plan for the rest of one's life. The themes also include the probable necessity of participation in a self-help and follow-up group after primary treatment. Treatment evaluation focuses on whether these methods are used. Such "process evaluation" makes up 95 percent of ADA's evaluation efforts.

The rest of ADA's evaluation, about 5 percent, monitors program "outcomes" or success in terms of the "end results the project is designed to bring about." Mr. Jones stated that such follow up is frequent but informal and not recorded. For example, some programs request that clients return postcards periodically to let the program know how they are doing. Some programs get reports from client family members or from social service agencies regarding client behavior. Other programs have alumni groups. Finally, sometimes program staff report seeing former clients sober or under the influence of alcohol.

As a result, ADA does not officially track whether the clients of any given treatment program successfully change their behavior over time, in accord with whatever treatment goals were established by ADA, the program, and/or the client. Mr. Jones said

In our defense, neither do the public health nurses or the mental health people or vocational rehabilitation people do long-term follow-up. Most people come in and get some episodic treatment . . . six months later a mental health program can't tell you where their clients are . . . how many

kids are in jail today who were in DFYS foster homes 20 years ago? The state doesn't do this kind of research.

One exception was the 1981 study by ALTAM Associates, Inc., which ADA commissioned, according to the report, "to evaluate the effects of state-funded alcoholism treatment on the functioning of clients." Mr. Jones said the project took three years (the final report was issued in 1984) and cost \$300,000, resources of a magnitude that the division no longer has and does not expect to have in the foreseeable future.

Generally though, according to Mr. Jones, such outcome studies are not done in the public sector. ADA's rationale for not doing outcome evaluation includes that it is too expensive and that very few publicly-funded programs do this sort of research outside of a research hospital setting. Finally, Mr. Jones stated that such evaluation isn't necessary in order to have confidence in the high quality of Alaska's substance abuse treatment programs because ADA's treatment processes are "mainstream" and commonly accepted as effective.²

One result of Alaska's choice not to do treatment outcome studies is that ADA has no system for tracking recidivism among its programs' clients. ADA cannot tell whether a person treated in one program returns to it or to another program at a future time or modifies their drinking behavior after completing the program.

Another result is that ADA does not have the information necessary for strategic planning. ADA does not have a comprehensive plan for what programs are offered where, compared to what sorts of treatment are needed by certain groups. He indicated that ADA knows what private programs offer, and has in the past requested, for example, more evening programs or less individual therapy from its public programs. Within funding constraints, the division tries to respond when waiting lists in some areas overwhelm available services. But the division does not, generally, recruit certain types of programs based on a needs assessment for the state as a whole. The state plan does not include a needs assessment and ADA does not direct state funds based on empirical data about the nature and location of existing problems.

Mr. Jones offered two reasons for this. First, ADA does not have funds for epidemiology studies which would assess how many people in which locations present what sorts of symptoms of various levels of impairment. Second, he said the RFPs function best if they remain general and the professional providers tell ADA the best way to provide treatment. This allows the programs to be community driven, an important aspect of ADA's commitment. Local providers are judged to be in the best position to identify and plan for local needs.

Mr. Jones was confident that a good mix of treatment programs is generally available. This is partly because most programs tailor treatment plans to individuals depending on assessment and diagnosis. Also programs are known to refer clients among themselves, in the best interests of the client. If a preferred treatment is not available in a remote area, or a client has already tried a local program, he or she is referred to somewhere else. The question of programs keeping clients out of economic self interest does not generally arise due to the fact that the need for treatment exceeds supply and most programs have waiting lists.

² Judging from a review of professional literature in the alcohol abuse treatment field, Mr. Jones' statement that ADA's treatment methods are commonly accepted as effective is true. However, it is also true that some treatment professionals dispute the effectiveness of treatment methods such as ADA uses and the basic tenets on which they are based. See Appendix A for a brief summary of this debate.

In 1982 the division implemented a fully automated management information system (MIS). According to the plan this is a major planning tool and Mr. Jones said the intention was to collect client identifying information in order to track them across social services agencies. Programs receiving state funds are required to provide data to the MIS as specified by regulation and reporting requirements of the Special Conditions of their grant awards. ADA/MIS provides forms for required information.

According to 7 AAC 28.150, the MIS is

a necessary major part of the overall research and evaluation system of the office. The intent . . . is to collect, process and provide to program administrators and staff relevant programmatic and client information, as well as to provide programmatic information to the public and the legislature.

7 AAC 28.040 Required Records states:

In addition to financial records the projects shall keep records regarding the persons served by the project which shall include personal histories in such detail as required of the projects by the department for the purpose of data collection and evaluation of project effectiveness.

According to Mr. Jones, the only reliable way to track individuals is use of social security numbers, as names and spellings of names change and birth dates are subject to error. However, social security numbers may be used for research only when given voluntarily, and ADA was precluded from using social security numbers by a lawsuit filed by service providers. Following this, ADA elected not to attempt client tracking by other identifying information.

Hence, the MIS system collects a great deal of information about total numbers of clients served in state programs and client transfer and referral among these programs, but the system does not contain information about relapse, recidivism or the conditions of repeat program usage.

However, according to Neil O'Keefe, director of marketing for the Chemical Abuse/Addiction Treatment Outcome Registry (CATOR), a private evaluation research firm in Minnesota, they have used social security numbers to track program completers and noncompleters for 14 years and 35 states. They obtain client consent and if it is not obtained they do not track that particular client. Also, they cannot redisclose any of their data.

A special case: the Alcohol Safety Action Program

Loren Jones and Emily McKenzie, coordinator of the Alcohol Safety Action Program (ASAP), discussed with ombudsman investigators the fact that monitoring recidivism might be possible in Ms. McKenzie's program. Transferred in 1987 from the court system to ADA, ASAP is designed to be a neutral link between the criminal justice system and the substance abuse treatment system.

Judges refer defendants whose offenses are alcohol related to ASAP for an initial screening designed to determine if the person has an alcohol problem. If a problem warranting treatment is detected, the person is referred to a list of approved programs, each of which provides a variety of treatment options, from which he or she may choose. Since program compliance and completion are court ordered, and since, if the person is arrested again, there is a record of previous treatment, tracking ASAP clients would be possible.

Ms. McKenzie acknowledged that ASAP statistics are collected for the purposes of tracking employee workload, not client behavior or program outcomes. She said ASAP knows how many assignments or reassignments (when one referral doesn't work out and a client changes programs) they make, but not how many individuals or cases they manage. Ms. McKenzie commented, "What you'd like is discreet to the person or the case and so many of the statistics we keep at this point have to do with just the flow of work as opposed to research. You can have one person floating in any number of places here."

Mr. Jones said that, other than periodically trying to interest a university researcher in follow-up studies, ADA had not considered such research recently. He attributed this to insufficient resources.

He acknowledged that it would be possible to track whether alcohol-related offenders who are referred to treatment by ASAP are rearrested for subsequent alcohol-related offenses. Which treatment programs they completed and when could be tracked. He stated that information gained this way would be only a "gross level" indicator regarding program effectiveness but that it would be a beginning. He emphasized, however, that ASAP does not have the staff to analyze any data gained.

Are outcome evaluation methods used by other public agencies?

Dennis Kelso, co-author of the ALTAM Associates, Inc. study and now an administrator with San Diego county alcohol and drug programs in California, agreed that outcome studies by state agencies have not been the norm. However, based on information from several states, outcome monitoring is increasing and may become the rule rather than the exception for several reasons.

According to Susan Niesenbaum, manager of the research and policy analysis branch in the Department of Alcohol and Drug Programs in California, that state has increased the requirement for outcome evaluation from the programs it funds. The purpose of the requirement is to improve service delivery. In some programs, clients who are judged not to have made adequate progress are flagged and followed, often through association with other social service agencies, for longer-term help and monitoring. Program funding is not reduced based on such clients but technical assistance is provided to strengthen the program.

California's evaluation requirements also reflect the state legislature's growing demands for data. According to Ms. Niesenbaum, no contracts are awarded "unless the research department gets what they need to respond to the legislature." She said that treatment programs are getting used to evaluation requirements as the standards are developed and put in place.

California applies the evaluation data to a very comprehensive statewide planning effort designed to maximize treatment effectiveness and eliminate duplicated services. The planning model acts as a net which catches alcohol problems in the myriad forms they assume. Recognizing that alcohol-related problems are presented in various ways, the social, educational and health service systems as well as the criminal justice system are viewed as the settings where problems appear and treatment should occur. The agencies which both identify and address the problems may be federal, state, local or community organizations. Finally, the treatment strategies by any of the agencies within the various settings include prevention, treatment, enforcement, research and evaluation, and planning for public policy.

Thus, as information about their programs accumulates, California is able to place effective treatment strategies in the most appropriate organization in the most effective setting. The planning model also identifies holes in treatment effectiveness, not only

geographically, but in terms of whether programs are pervasive enough and are optimally designed to make the statewide net of services as effective and efficient as possible.

According to William Burnett, director of treatment programs for alcohol and drug abuse in South Carolina, outcome evaluation is necessary to "know what we are getting. Are these programs doing what they claim to do and can we improve them?" He felt research on program effectiveness was necessary before the state could do additional planning or propose new initiatives. To this end, South Carolina contracted two years ago with the Chemical Abuse/Addiction Treatment Outcome Registry (CATOR), the Minnesota research firm, for an outcome-oriented follow-up study of several of their program sites.

Mr. Burnett endorsed the credibility and usefulness of CATOR research, as did Charles Roundy, Community Treatment Services coordinator in the same organization. Mr. Roundy emphasized that policy and planning staff will use the study results to improve existing programs. The aim, he said, is to find out who's still sober, why they are when others aren't, and what about their program might be responsible for the difference. Then, he said, the state may be able to raise the likelihood of someone else improving, based on the experience of those whose treatment was successful.

Mr. Roundy illustrated with the consideration of whether or not a program informs a client's employer about treatment. He said that generally, clients don't want employers to know. However, research may show that the time of day a program is held makes a critical difference in program effectiveness. If a client is more likely to attend during the day than after a long day at work, the program should be during the day. To do that, the client may need "flex time" or other support from the workplace. This illustrates how outcome research might be used to improve a state's offerings, said Mr. Roundy.

Mr. Burnett offered that public substance abuse programs are mistaken when they think outcome evaluation requires a "heavy duty research component" as an add-on to what they already do. Rather, he said, follow-up evaluation should be built into every program up front. Currently, in South Carolina state funding is contingent upon outcome evaluation being an integral part of treatment programs. Mr. Burnett said that "performance-based funding" is the trend in his state and at the federal level.

Mr. Burnett recommended standards from the Commission on Accreditation of Rehabilitation Facilities (CARF) for programs wanting to integrate outcome evaluation "up front" rather than as an additional, research component. CARF standards require that programs do their own evaluation rather than use research consultants and the CARF accreditation process gives programs several years to get a program evaluation model in place.

According to Dennis Lewelling, program field representative in the Oklahoma Department of Mental Health and Substance Abuse Programs, that state has also moved toward outcome evaluation. Several years ago they purchased an evaluation package from CATOR but eventually declared the results invalid when they realized that, due to insufficient funding, the people hired to conduct the survey were inadequately trained. Since then, however, Oklahoma invited all providers to participate in developing an outcome evaluation tool. The resulting one-page survey, which has adult and adolescent versions, requests information on criminal involvement, employment status, health, living situation and other indicators of alcohol-related social problems. It is now required of all certified programs and will be administered at three- and twelve-month intervals by the providers themselves.

Again due to funding constraints, Oklahoma decided to administer this survey by mail, fully recognizing the low return rate they may receive. However, what information they do gather will be integrated with the law enforcement community's computerized

information system and with the mental health programs' follow-up system which tracks admissions, discharges and presenting problems for each mental health agency. Mr. Lewelling said the next step is to tie in hospital records. Such records are not kept by client identifying information but by agency and program.

The motivation for gathering this information, according to Mr. Lewelling, was threefold. First, the department had been unable to obtain additional funds from the state legislature. The department recognized that, in order to justify its budget requests, it needed to provide legislators with statistical analyses showing that their programs make a difference. Second, they wanted to improve their treatment programs. Staff from more effective programs will be asked to train program staff from less effective programs. Mr. Lewelling specified that low outcome results will not be used to determine program funding levels. Third, he had "heard federal rumblings" that outcome studies would be required for receipt of block grant funds.

Gib Sudbeck, director of the Division of Alcohol and Drug Abuse in South Dakota, had also heard these rumblings. He said there is now a federal mandate that every state receiving block grant funds must have applied for a needs assessment grant by 1995. He said this is the writing on the wall, and surely the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) will next mandate measurement of progress on states' substance abuse problems.

Partially to get ahead of the game, Mr. Sudbeck said, South Dakota contracted with CATOR to do an outcome study with a sample taken from "across the board" of state-funded programs. He thought South Dakota was the only state to do a statewide study.

His other reason for this decision echoed the experience of other states. One reason was that his efforts to expand state programs were met with questions from the legislature regarding how effective the state's effort was currently. South Dakota had never done outcome evaluation of the services it purchased so there was no data with which to respond.

The third reason was for program improvement. He said almost every program had developed its own model of treatment and no one had identified the most effective among these. He was interested in which programs were most effective so he can replicate successful components.

There is definite risk in this decision, he said. The only common denominator among the clients affected is their inability to pay, or the fact that they are in publicly funded programs. In sampling all populations, they may learn they are very effective with some clients but minimally effective with others. But the three-year study, with a sample of 500 clients in a state with a population of 700,000, cost approximately \$40,000, which he found very reasonable. He thought the risk and the expense were warranted to learn how to allocate future funds more effectively.

Neil O'Keefe at CATOR said that contrary to the assumption that only private programs can afford outcome evaluation, CATOR now does 17 - 20 percent of its research for the public sector. In addition to states, they contract with individual agencies and counties and they are negotiating with major military providers such as Veterans Administration programs. He said CATOR has also worked with Canadian provincial governments, especially regarding treatment effectiveness with Native populations.

According to Mr. O'Keefe, CATOR is developing a large body of data on public treatment programs to which other programs can be compared. Data from other states or similar client categories serves as control groups, which allows CATOR to work with fairly small samples in some cases. The South Dakota contract illustrates this. It was

important to Mr. Sudbeck that he have some information to take to the legislature as soon as seven months after the study started in July 1992. By January or February he will be able to report to the legislature comparable outcome effectiveness from other states with client populations similar to his. That is, he will have a norm to which South Dakota results can be compared as soon as their data is available. In this way, he said, CATOR's existing databases and variety of evaluation instruments help speed results and lower costs.

When asked why public agencies are turning to such research now, Mr. O'Keefe stated that public programs were perceived as being behind in the use of placement, assessment and diagnostic instruments and when a push for accountability arrived, they had to catch up. The push came when federal block grant funds became more competitive.

Mr. Jones stated that ADA gave some thought to using CATOR a few years ago. CATOR was invited as a presenter at the division's Tri-Discipline conference, the annual professional training program, two years ago. He said that providers' general response to the evaluation process described in CATOR's workshop was first, that they could afford such assessment only if the state paid for it; and second, that CATOR's use of telephone follow up probably wouldn't work well in rural Alaska because of the lack of telephones and their transient population.

According to Herman Diesenhaus, acting chief of the Services Analysis Branch, Office of Science and Evaluation at the Center for Substance Abuse Treatment, U. S. Department of Health and Human Services, the suspicion that evaluation will be more important is warranted. He said that at the federal level, the "policy environment is that we don't know what our money is buying us and 60 percent of the states don't know either. Those that do know use idiosyncratic evaluation systems so we can't compare across states. We want to change that."

When states failed to promulgate national treatment standards themselves, federal administrators sought to mandate the treatment outcome monitoring which had been voluntary in the past. The 1992 Alcohol, Drug Abuse, and Mental Health Administration Reorganization Act, implemented in October 1992, requires a prevention and treatment plan, including outcome monitoring, from any state hoping to keep its block grant funding at the present level. A national development plan for all state programs includes that each state locally implements the national drug control strategies, which include treatment and prevention outcome evaluation.

Mr. Diesenhaus anticipated that the states will have two primary concerns about this development, the cost of such evaluation and how to do it. He said that money would be available for outcome monitoring so that the effort is not funded from already limited administrative funds.

Regarding evaluation methods, he said it was his job to "demystify" the idea of outcome monitoring. Accountability, he said, is a normal part of quality assurance. As a manufacturer invests a percentage of funds in some sampling technique for quality control, so must states monitor the performance of their providers. He felt any state was deficient which certified providers or purchased services with no continuous quality improvement. ADAMHA is working toward an evaluation model which would accommodate differential data from different states regarding the nature of the clients they start with, what resources they have and what outcome targets are realistic. To implement such models, states will be encouraged to set up committees for establishing acceptable performance levels from among their providers.

Mr. Diesenhaus said the purpose of the outcome monitoring is to identify those states which need help to be more effective. However, he also said the Office of National Drug Control Policy is leaning away from block grant monies being awarded according to

a formula based on population and toward a formula based on need. Further, he said that if a state normally gets \$10 million but is only getting 60 percent utilization from their funds, 40 percent of those funds might be transferred to a needy state which is using its funds more efficiently.

Closer to home, the Division of Mental Health and Developmental Disabilities has implemented outcome evaluation for services to the developmentally disabled in Alaska. Northern Community Resources, health care consultants, recently completed work on program standards that include outcome evaluation requirements.

Karen Purdue, consultant and former deputy commissioner of the Department of Health and Social Services, said that the evaluation model is aimed at determining "whether the person was affected, what was the impact," rather than "what did the program do." Interview teams go to the consumer and the community to see how he or she has been affected, to see if the consumer's "quality of life" has changed in the way that the program goals said they would.

Developmental Disabilities Program Administrator Mike Renfro indicated that 50 percent of a program surveyor's time will now be spent with the consumer of state-funded services, rather than just reviewing program sites and files and interviewing providers. Mr. Renfro noted that the change is part of the division's move away from funding "categorical services" such as group homes, and toward a voucher system for more individualized services based on what the consumer wants and needs. He stated that the results have enabled the division to provide more services to more people at less cost.

What is ADA's funding process?

The proposal review process

The process for proposal review and grant awards is spelled out at 7 AAC 28.030 and in the RFPs. It is, roughly, a four step process.

(1) division staff screen proposals and forward complete proposals to the Advisory Board for consideration;

(2) the Proposal Evaluation Committee (Advisory Board) holds a public meeting and prepares recommendations on the basis of the proposals, comments at the hearing and staff comments;

(3) the division director forwards the division's and the board's recommendations to the commissioner; and

(4) the commissioner makes the final award decisions.

There is also an appeal procedure.

Reviewers use a worksheet to score each proposal. According to Suzanne Perry, ADA's regional program coordinator in Juneau, the same Grant Review Criteria form as was used for the last time in FY92 for reviewing proposals, had been used for a long time, she thought a minimum of five years.

However, through FY92, division staff used it during their preliminary reviews but the Advisory Board did not. Through the FY92 funding cycle there was no formalized way in which Advisory Board members recorded their proposal evaluation responses.

The Grant Review Criteria form was revised for the FY93 funding cycle and, this year, the staff did not use the form but the board did. This year, staff members reviewed

proposals only for completeness and forwarded complete applications to the Advisory Board as "responsive."

During the board's first experience with the proposal review form, it was used "as a guideline only" due to a misunderstanding about its use. Ms. Perry explained that while it was clear that new applicants would not receive points from the section on prior performance with a grant, it was not clear that previously funded applicants were not required to resubmit information requested in the section on organizational structure. When discrepancies in the form's use among board members became apparent the board decided not to be totally subject to the resulting numeric scores. Ms. Perry said, "We learned a lot about its use."

Review criteria

Criteria for reviewing applications are spelled out in regulations at 7 AAC 78.100. Criteria for Application Review. These criteria include:

- management and financial capability,
- identification and justification of need;
- prior experience with providing effective similar services;
- community support for the program,
- appropriateness of program objectives and whether they can be measured;
- feasibility of the service plan;
- accessibility to clients;
- reliable client confidentiality;
- reliable aftercare and follow up,
- coordination with related organizations;
- reasonableness of the proposed budget;
- compatibility with department's objectives and planning;
- a plan for training staff if necessary,
- an evaluation plan with outcome indicators;
- an acceptable record regarding previous audits; and
- the applicant's status as a political subdivision of the state.

Several program areas have review criteria specific to them which are dictated by their funding sources or other considerations. The Alcohol Safety Action Program is a good example. Because of its role as a link between the criminal justice system and the treatment delivery system, ASAP funding criteria include items like the number of alcohol-related court cases in the area, proximity of the program to a court facility and the amount of support the program has from criminal justice system personnel. The ASAP RFP is so specialized that until FY92 it was a separate RFP from that issued for all other programs.

Review of ASAP proposals does not include use of the division's more generic Grant Review Criteria.

The FY92 Grant Review Criteria form had three criteria pertaining to organizational structure and history, nine on the design of services proposed, 29 on budget and financial management and four covering any previous experience between the state and the applicant agency. None reflected the regulatory requirement of outcome evaluation. For each criterion, proposal reviewers had the option to judge the proposal "Very Complete", "Complete", "Minimal" or "Not Address[ed]".

For FY93 the form was revised in several ways which more closely reflect the criteria listed in regulation. For example, one criterion from 7 AAC 78.100 reads:

(14) the existence of a service evaluation proposal employing clear outcome indicators.

In the earlier RFP's review form, this regulatory concern for program evaluation is addressed by:

I.B.9. Is the method to be used to evaluate activities, review goals and objectives, and how they are to be shared with governing authority and community clearly stated and reasonable, given the stated goals and objectives? [sic]

whereas, in the revised form, it reads:

IV.J. The proposal contains a clear and systematic plan for evaluating project performance, including data to be collected and processes for analyzing the data to measure achievement of goals and objectives.

The revised form is also more closely tied to the regulatory criteria in that its criteria are more evenly balanced among areas of concern in the regulations, i.e., five pertain to understanding the problem and target population; seven to goals and objectives; 10 to the method for service delivery; four to organizational structure and qualifications; eight to budget and financial management; and five to previous experience with the applicant agency.

Second, instead of the incremental choices mentioned above as possible reviewer responses for each criterion, the 1993 form requires evaluators to assign points to each consideration. Different sections are weighted, although each question within each section is not. The sections on goals and objectives and the delivery methodology are most heavily, and evenly, weighted; and the budget receives the next highest number of possible points. Remaining points are evenly divided among understanding the problem and target population, organizational structure and qualifications, and prior performance with a grant. Points are tallied for each section and are totaled.

For example, the section assessing whether the applicant understands the problem and target population receives a possible total of 30 points among four different considerations, whereas the section assessing qualifications and experience receives a possible 30 points among six considerations. Also, the section on goals and objectives has fewer considerations but more total points than the section on budget.

Third, two criteria under the goals and objectives section also address evaluation, in that they refer to baseline data and outcomes:

III. A. Project goals identify outcomes/results to be achieved by the project and by each component of the project which will change the condition of the target population.

III. G. Target performance levels are measured from a baseline and

ANALYSIS

To analyze whether an agency's actions are reasonable, the standard of reasonableness must be kept in mind. The ombudsman's manual states:

An administrative act may be unreasonable in those situations in which the complaint suggests that a procedure adopted and followed by an agency in the management of a program is inconsistent with, or fails to achieve, the purposes of the program.

The mission

Whether ADA's funding procedures aid or obstruct the agency in achieving its purpose, or mission, depends in large part on what that mission is. Perhaps the best way to illustrate this point is by using an extreme analogy. If the Air Force should determine that its mission is to fly 200 hours per aircraft per month, the goals and objectives it would set to achieve that mission and the criteria used to judge success would be quite different than if its mission were to destroy ground targets.

This example may also be used to illustrate goal-mission confusion. Assuming that the mission is destruction of ground targets, it may well be that the Air Force must reach the goal of flying 200 hours per aircraft per month to effectively carry out the mission. But ultimately, effectiveness cannot be measured in terms of hours flown, nor may it be assumed because a goal has been met. If the targets are not destroyed, the agency must reformulate its goals to better accomplish its mission, perhaps by grounding some aircraft so that others may fly more hours.

A clear statement of purpose helps an agency separate the ends, its purpose, from the means, its goals, in its decision making (Bryson, Strategic Planning for Organizations, Jossey-Bass, Inc. 1988). Without a clear and carefully implemented mission statement an agency such as the Air Force may find that those with vested interests in certain goals, e.g. pilots who love to fly, may be able to subvert the decision making process to the detriment of the mission.

As these examples show, implementation of a clear mission statement is far from an exercise in semantics. Nor is the work done when the mission statement is crafted. The mission not only guides development of goals, but also enables and requires evaluation of whether those goals are helping the agency accomplish the mission.

In the case of an agency such as ADA, only those programs which hold promise for achieving the mission should be funded; those programs which evaluation shows do not fulfill that promise should not be funded again. Unfortunately, ADA's mission statement is not clearly articulated. As a result it does not clearly guide the funding process or serve as a benchmark for evaluating the effectiveness of programs which are funded.

It should be noted here that this sort of a statement -- that ADA's mission is not clear enough to provide good guidance for division decision-makers -- almost assures a "justified" finding when the allegation is framed in terms of the "reasonableness" of those managers' decisions. The ombudsman's manual defines administrative acts as "unreasonable" if the agency adopts and follows procedures "which are inconsistent with

or fail to achieve, the purposes of the program." Clearly, if the purposes of a program are unclear, it will be difficult to demonstrate that procedures are consistent with them. By the same token, though, it is equally difficult to demonstrate that procedures are inconsistent with the purposes.

That point constitutes the thrust of the following analysis. The point is not that ADA's funding decisions were clearly wrong or that the programs ADA funded were clearly ineffective. The point of analysis in terms of "reasonable" or "unreasonable" decisions is that, given the division's statutory framework and its interpretation in the 1990-92 plan, it would be almost impossible for division managers to evaluate ADA's or specific programs' performance. Given ADA's unclear mission, there was little chance that anyone could measure whether it was being accomplished. The analysis explains why this was so and how it could be changed.

The division's plan defines its mission in terms of the creation and maintenance of programs. However, programs are potentially a means of achieving the division's mission and should not be confused with the mission itself. Doing so creates at least the theoretical danger that the mission will be sacrificed for the means, i.e. that funding certain types of programs, or simply processing people through those programs, might become the division's focus rather than preventing or reducing the abuse of alcohol and drugs or the effects of such abuse.

Clearly, funding ineffective programs would not accomplish ADA's mission. Nor does this report suggest that effectiveness is not of concern to ADA. Mr. Jones notes that ADA only funds programs with "mainstream" approaches which are accepted as effective. The effort ADA does make in terms of evaluation predominantly goes toward ensuring that those approaches are in fact implemented.

While the division seeks to fund effective programs it does not require evidence of effectiveness. ADA does not set outcome goals or require outcome evaluation. Statistical analysis overwhelmingly emphasizes number of patients served rather than the effect of programming on those patients. The division makes no formal effort to determine whether in fact programming has the desired outcome.

In addition, the division does not formally determine local needs or solicit specific programming to meet those needs. Instead, the division relies on potential grantees to identify those needs and provide appropriate services. While ADA must obtain local input in planning, both because of federal funding requirements and to ensure that it funds relevant programs, the division has an obligation to coordinate the statewide network of services and to impose quality control measures. It is possible that appropriate programming will result from the process used by ADA, but it is also possible that providers will request grants for services which they are equipped to provide, rather than those which may be most appropriate.

The fact that the division defines its mission in terms of providing programs, does not set outcome goals or require evidence of effectiveness, and does not formally determine specific local needs suggest that means-end confusion is occurring at the division.

There are any number of ways for ADA to formulate its mission statement. However, a basic assumption of this report is that the mission must be defined in terms of reduction of drug and alcohol abuse, or reduction of the social effects of that abuse, rather than providing programs or serving clients. To do otherwise is to spend state dollars with no objective benchmark for success or failure.

AS 47.37.010 suggests that restoring all alcoholics and intoxicated persons to normalcy may be ADA's mission. On the other hand, ADA currently uses factors such as

need, severity of illness and social cost to determine who receives services. Statements by ADA Director Loren Jones raise the valid point that the state has a greater interest in intervention when alcoholism, drug addiction or intoxication creates a high social cost. He explained:

If just drinking happened, rarely would an individual come to the attention of a program. Something happened around that drinking episode. He . . . wrecked his car . . . [or started domestic violence]. In gross terms, something else happened besides the fact that he used alcohol . . . the person has to do something out of the ordinary that brought them to [the state's] attention.

The division also directs services to the most severely impaired based in part on the determination that the social cost of their affliction is extremely high. These approaches suggest that ADA might well cast its mission not in terms of restoring individuals to normalcy but in terms of reducing the social cost of drug and alcohol abuse.

Should the division choose to implement a mission to reduce the social costs of alcohol and drug abuse, at a minimum it would have to:

- (1) formally identify those abuser groups which pose the highest social cost;
- (2) from those high cost groups, identify those groups for whom intervention will most likely succeed³; and
- (3) develop evaluation methods to determine whether social costs are reduced as a result of intervention.

Whether because of new federal requirements or otherwise, ADA appears to be moving toward an impact or outcome formulation of its mission in its FY93 RFP for Community Alcohol and Drug Abuse Prevention Programs. These programs are designed to "prevent, reduce or eliminate the abuse of alcohol and other drugs in Alaskan communities." Nevertheless, ADA has not yet implemented methods for measuring its effectiveness in achieving that mission.

Is ADA's program evaluation adequate?

Evaluation provides the feedback necessary for an agency to determine whether the goals and objectives it has formulated are in fact helping to accomplish its mission. The information obtained allows for continued refinement of goals and improvement in overall effort. As a steward of public monies, ADA has an obligation to ensure that the programs it funds are effective. Treatment outcome evaluation is the clearest way to demonstrate effectiveness. While outcome evaluation is not explicitly required in statute, ADA's regulations lay the foundation for requiring such feedback in program reporting requirements. 7 AAC 28.040 states in part that

. . . In addition to financial records, the projects shall keep records regarding the persons served which shall include personal histories in such detail as required of the projects by the department for the purpose of data collection and evaluation of the project effectiveness. . . .

³ At least some of the literature in the field suggests that those most severely disabled by alcohol, the division's highest priority abuser group, are least likely to benefit from treatment. Unless the mission adopted by the division includes caretaking, this group may pose a dilemma for the division since any outcome-oriented mission statement will require that the group served be likely to benefit.

ADA's regulations also indicate that provision of outcome information is an important consideration in funding. Yet, ADA has not enforced reporting requirements for program results. Until this last funding cycle it has required only that goals and objectives be defined as activities. The only way to evaluate an activity, with no purpose or outcome explicitly expected, is to note if and how many times it happened. This is the "who, what, when and how much" of RFP instructions. It is also the "process" on which ADA programs have been evaluated for years.

Mr. Jones gave two reasons why ADA does not do outcome evaluation. The first of these is that ADA cannot do it. The second reason suggests that ADA does not need to do outcome evaluation.

Barriers to outcome evaluation are falling

The belief that publicly funded programs cannot and do not conduct outcome evaluation due to lack of funds and/or expertise is no longer true. Willing to risk that reliable outcome research justifies front-end costs with increased effectiveness and efficiency in the future, several states have taken the lead in doing this kind of program evaluation in the publicly funded arena.

Other states have found ways to begin this important component of providing high quality treatment. Regardless of whether these factors function as carrots or sticks, the three factors motivating other states also pertain to Alaska. These are federal pressure for accountability, local legislative scrutiny and the promise of continuous program quality improvement.

Mr. Jones may be correct that many other kinds of social service agencies within and outside the state do not do long-term follow up. However, programs within his own department have determined that it is both necessary and cost effective to do such evaluation. In any event, as state revenues in Alaska shrink, any available federal dollars will become even more important. If Alaska hopes to remain competitive in the scramble for federal funds, outcome evaluation is mandatory and there is no reason to believe that delay will either save the state this effort or minimize it in any way.

While Alaskans may argue that our population is unique and poses special difficulties to an evaluation process, it is worth noting that Mr. Sudbeck in South Dakota specifically mentioned the few telephones available for follow-up contact among clients of some South Dakota programs. He mentioned the option of using local interviewers for follow-up contacts, a method Mr. O'Keefe also mentioned as particularly useful for some populations. This method will be employed by the Developmental Disabilities Division.

Both Mr. Jones and Ms. McKenzie stated that when funds are scarce, evaluation is usually the first program component to be sacrificed. Whether this has been true in the past or not, the legislature will need solid criteria for its own funding decisions as state revenues decline. As South Dakota chose to get ahead of the game when the federal government looked for accountability, the Division of Alcohol and Drug Abuse could strengthen its ability to compete for funds with an initiative for evaluating itself for effectiveness.

Mr. Jones' arguments also fail to address the fact that there are two types of outcome evaluation, statewide evaluation of ADA's efforts, such as the ALTAM study, and outcome evaluation of individual programs. Investigation indicates that evaluation does not need to be a separate big-ticket component of the division. It may be built in "up

front" as part of funding requirements.⁴ Alternatively, outside evaluation can be done at less cost than the division seems to imply. While it doesn't follow from this analysis that ADA should necessarily contract with CATOR or a comparable firm, it does seem clear that outcome evaluation doesn't need to be done from the ground up each time. Evaluation models, tools and baseline data are already available.

While evaluation costs may be far less than ADA implies, they will still be significant. However, given the experience of other states and the direction of federal funding programs, it seems reasonable to assume that the costs of not doing outcome evaluation will be even greater.

Finally, Alaska's motivation to improve treatment is certainly as compelling as in other states. Given the high toll of substance abuse on Alaskans and the fact that treatment of alcohol abuse is less costly than dealing with all the negative social and economic impacts of its abuse, the improvement of treatment programs should have high priority in the division's plan and goals. The position that, due to low funding, ADA cannot do the evaluation necessary to make its program more efficient for each dollar spent, is untenable.

Outcome evaluation is needed at both program and statewide levels

The second reason Mr. Jones gave for not doing outcome evaluation, in addition to its cost, was that it isn't necessary. He was confident that ADA programs successfully target abusers posing the highest public cost and that these people are as effectively treated as possible.

Mr. Jones' confidence is based on two assumptions. The first of these is explicit and holds that treatment processes based on the disease model of alcoholism⁵ are the most effective in creating successful treatment outcomes for all individuals treated by division funded programs. However, review of relevant research indicates considerable debate and little or no controlled research on the effectiveness of programs using these very themes. While the literature does indicate that well implemented programs based on the disease model will work for some people, it also indicates that different methods may be more appropriate for others.

The second assumption is unstated but seems to be that all programs using the same themes are equally effective in creating successful treatment outcomes. While the division evaluates to make sure that programs are following accepted treatment themes, it is important to remember that there are human factors on both the program and recipient sides of a treatment plan. As Mr. Jones acknowledges with his "black box" comments, treatment is far less scientific or predictable than this assumption would seem to imply. Programs based on the same basic principles may vary widely in terms of their specific approach and the skill of their staff. It follows that they may have very different success rates.

To put it in concrete terms using our previous analogy, ADA's position on evaluation is comparable to the Air Force deciding that it need only evaluate a particular squadron on whether it flew its missions using proven tactics rather than actually measuring how many targets the squadron destroyed.

⁴ In fact, ADA wrote outcome evaluation requirements into its FY93 RFP. Unfortunately, as will be explored further in the next section of this report, ADA has failed to insist that programs implement these requirements.

⁵ Treatment funded by ADA is all based on the disease model of alcoholism, according to Mr. Jones.

Mr. Jones alluded to the growth of self-help groups in Alaska as evidence that "something is working . . . it has made a difference in this state." He cited the growth in Juneau's Alcoholics Anonymous (AA) group from five-six participants a week in 1975 to 800 currently active participants.

It is notoriously difficult to study the effectiveness of self-help programs like Alcoholics Anonymous, partly because participation in them is usually confidential. However, arguing that more participants in AA meetings means that they are effective is like arguing that a higher bed occupancy rate means that hospitals work. It is possible that is the case but it is far from the only, or even the likely, explanation. That statement also ignores the fact that not all current AA members have been through ADA programs, and the "something" which may be working may not be ADA programs.

Th ADA's argument also fails to explain the fact that, as the number of presumably sober AA participants rises, so do statistics reflecting economic and social costs of alcohol abuse in Alaska, despite a fluctuating state population and a decreasing per capita alcohol consumption rate.

Mr. Jones acknowledged that he does not fully understand this situation. He offered increased sensitivity by police, more likely court action and the efficacy of groups like Mothers Against Drunk Drivers as possible reasons for at least those statistics indicating an increase in alcohol-related arrests. That may in fact be the case, but the point is, without individual outcome evaluation there is no way to be sure that the monies spent are having a positive effect. Even assuming a positive effect, there is no mechanism to selectively fund the most effective programs.

Under these circumstances the division cannot demonstrate either that individual programs or its statewide strategy are working. Which brings us to a second point. Even if the division imposes meaningful outcome evaluation on individual programs it still needs to evaluate its own overall effectiveness in reducing substance abuse or its social effects. This is the case because even if individual programs are completely effective, i.e. they meet their goals, these programs, taken as a group, may not be effective in achieving ADA's mission. This would occur if the goals were poorly conceived.⁶ ADA may find itself winning battles and losing the war.

At a minimum, program evaluation must be rigorous enough for the state to determine which programs contribute to its mission and which ones are most effective in doing so. To discern this, ADA needs some sort of outcome evaluation. Such evaluation must be done not only for the benefit of the program administrators, but as the necessary "feedback loop" to ADA as the funding source. ADA must also evaluate the effectiveness of the goals it sets through another form of outcome evaluation involving statewide statistics on the incidence of substance abuse or its effects.

ADA's funding process

To determine whether ADA's funding process reasonably relates to ADA's mission the investigation looked at how criteria are applied as well as their content.

⁶ Assume, for purposes of argument only, that public inebriates do not pose a high social cost and/or that they are not amenable to treatment. If you also assume a mission to reduce the social cost of substance abuse, then programs which successfully meet necessarily modest goals to rehabilitate a percentage of public inebriates receiving treatment may not effectively further the mission.

Is the proposal review process clear?

Based on Suzanne Perry's information, both the criteria used in judging proposals and the process used for implementing those criteria are in developmental stages.

The application process described at 7 AAC 28.030 is ambiguous. It begins:

Applications shall be processed by the department and those correctly submitted shall be referred to the Advisory Board for review. Applications which are incorrect in form or content shall be returned to the originator by the department, citing the reasons for return.

Interpretation of this regulation has not been consistent. For example, it is not clear whether the staff or the board or both review proposals using the Grant Review Criteria form. Or, if the staff may reject a proposal on the basis of "incorrect content," what is the purpose of the Advisory Board? Appendix A of the RFP, explaining the review process, states that the staff may conduct a preliminary review. It is not clear that they will, in all cases, or why they would in some cases and not in others.

The FY93 Grant Review Criteria form reflects improvements in this process over previous years. The new form attempts to standardize and quantify each reviewer's assessment for each consideration by assigning points to each section of criteria. However, it is not clear from this form how many points criteria within each section may receive. It also is not clear that reviewers have sufficient instructions, or that proposal applicants have sufficient information, to understand this tool properly. The fact that, during the FY93 funding cycle, this form was used only as a "guideline" suggests that its use may not resolve questions regarding the objectivity of this part of the decision-making process.

Do the criteria reflect the division's mission?

Since the different program areas funded by ADA have different funding criteria, analysis focuses on one, the Community Alcoholism and Drug Abuse Treatment and Prevention program, which receives the bulk of state funds. The stated purpose of these grants is to "prevent, reduce or eliminate the abuse of alcohol and other drugs," a statement which could serve as a comprehensive mission statement for the division.⁷

In determining whether ADA's funding criteria reflect the division's mission the ombudsman looked at two factors, whether the criteria:

measure the relative contribution of proposals to accomplishing ADA's mission, if proposed goals are achieved; and

measure the proposer's relative ability to achieve its stated goals.

The first of these factors measures whether the proposed program might take ADA in the right direction and how far. The second measures just how likely it is a program will get where it says it is going. These factors were selected because proposals with goals which are only marginally relevant to ADA's mission should be screened out. Likewise, proposals with relevant goals but with little likelihood or poor track records of success should be screened out.

⁷ That is not to say that the ombudsman views this as the most appropriate formulation of ADA's mission. This broad statement provides less guidance than, for example, one couched in terms of reducing societal costs related to substance abuse.

The division's proposal writing instructions and the Grant Review Criteria form, both of which are included in the annual RFP, are sources for funding criteria used by ADA.

Measuring mission compatibility

There are two strategies⁸ the division could employ to make sure that proposals match up well with its mission. One is for ADA itself to formulate and announce the outcome goals which flow from its mission, define specific needs in terms of location, type, and/or delivery setting (along the lines of California's planning effort), and solicit programs to accomplish those specific goals. ADA does not use this coordinated approach. The second strategy, and the one which ADA employs, is to require proposers to both define the needs and formulate the goals.⁹

Since defining needs is an integral part of formulating outcome goals, further references to goals will include defining needs and outcome goals. While it might work to allow proposers to determine goals, there seem to be inherent problems in this approach. To properly evaluate proposals, ADA must, at least implicitly, determine what goals will best use limited resources in accomplishing ADA's mission. If ADA must in effect set goals anyway, it would seem to be inefficient to force proposers to develop their own goals without explicit guidance from ADA as to what those goals should be.

This approach also leaves ADA in the position of choosing programs from what is offered rather than from among programs whose goals already fit into a statewide plan for accomplishing ADA's mission.¹⁰ Coordination of a statewide strategy after programs have already been proposed is much more difficult than building in coordination at the outset. ADA's program-driven approach also increases the likelihood that proposers will propose services that they are already equipped to provide rather than services which might be most needed.¹¹

For example, the RFP for the community grant states two priorities, one for "essential services"¹² and another based on the size and remoteness of the community. Apart from these very general instructions and encouraging outpatient as opposed to inpatient services, the RFP provides no other guidance regarding goals or methods. Interestingly, the RFP does not even state ADA's emphasis on treating the most severely affected, though that emphasis is stated in ADA's Plan.

While Mr. Jones indicates that the state lacks funds for formal epidemiology studies which could guide goal development, ADA must assess local needs in the funding process if that process is to have any validity. Accountability, along with accuracy, may

⁸ The division could also move away from "categorical services" and toward a system that provides vouchers for more individualized treatment services, as the Developmental Disabilities section is doing.

⁹ The division does list what it refers to as goals and objectives in its plan. However, these are general guidelines rather than goals, and they provide minimal guidance for the funding process. Part of the division's rationale for this approach is that federal grants require that programs be community driven.

¹⁰ The division does use a "levels of care" concept in determining what services may be funded in a given community, generally based on size and access to larger communities with greater services. While this provides a gross level of coordination in that it centralizes high cost services, it does not provide a coherent strategy for achieving the division's mission.

¹¹ An example of an alternative exists in California's approach. That state defines the types of services it will solicit by first reviewing needs and services already available.

¹² Essential services include prevention/education, outreach, emergency care; residential care (which includes inpatient, intermediate, long term, and transitional care); outpatient care; and relapse prevention.

well increase if this process is made explicit, even if it remains an informal process consisting of public hearings or provider input. On the other hand, as with program evaluation, there may be less costly methods of needs assessment, such as statistics on persons taken into protective custody, DWIs, domestic violence and other arrests related to alcohol, etc., some of which are already available to ADA. In any event, any related costs may result in greater efficiency.

This is not to say that local communities and providers should not have input into goal development or control their own programs.¹³ Quite the contrary. ADA prudently recognizes that local providers have important information regarding specific local needs and the best ways to address them. But the proposal review process is not the place for this to occur. This information should be considered at the statewide planning stage, in the context of research indicating whether a particular goal best meets those needs and whether meeting those needs best accomplishes the overall mission. Needs are unlimited, funds are not. ADA becomes a largely ministerial agency if it does not take a more active role in directing and coordinating the overall effort against substance abuse.

Apart from the structural problems in ADA's approach, the way that approach is implemented is also flawed. Since ADA does not set treatment outcome goals itself, it is particularly important that proposals be carefully reviewed to ensure an adequate match between proposals and ADA's mission. Of 39 criteria listed on ADA's Grant Criteria Review Form in the FY93 RFP, only one, the first criterion in the "goals and objectives" section, clearly questions the proposal's relationship to the mission of the grant program. It states:

The goals proposed are consistent with the overall goals of the grant program. . . .

Taken at face value it is hard to imagine a proposal written by a professional that would fail to meet this criterion. This sole criterion may imply additional sub-criteria, but if so, they should be explicit both to ensure fairness to proposers and to provide guidance to evaluators.

In assessing potential contributions to the stated mission, ADA could consider criteria such as whether the proposal: targets populations particularly susceptible to abuse and capable of benefiting from the intervention proposed; uses methods demonstrated to work with those populations; targets populations without access to service from other sources and those posing the highest societal cost; provides research to demonstrate the likely success of its approach; and formulates goals in terms which would unambiguously show that substance abuse has been prevented or reduced for the population receiving service. The criteria actually used would depend in part on the mission statement adopted by ADA.

Since goals and objectives are not provided by ADA, proposals must be structured in a way that allows ADA to accurately determine what the proposed goals and objectives are. Instructions for the FY93 RFP seem to increase the emphasis on writing program goals as "outcomes" and "end results" which projects are designed to achieve, rather than emphasizing program activities, as was the case with earlier RFPs. In addition, FY92 and

¹³ What this report proposes is that ADA, with community input, determine the need for a specific service in a specific location, formulate outcome goals for that service and require evaluation to ensure achievement of those goals. For example, ADA with community input, may determine that decreasing teenage substance abuse through education in a specific location is a goal that will help achieve its mission. ADA would announce that outcome goal, advise potential applicants that they will have to demonstrate decreased substance abuse in the target population, and solicit proposals in the applicable locations.

FY93 RFPs both required that applicants "indicate how the proposed services will impact the stated problem . . ." and "include a plan for evaluating the impact . . . of the proposed project . . ." which should demonstrate "the success of the project in achieving effective program outcomes. (program goals)" [sic]

Theoretically, this should assist ADA in weighing a proposal's potential contribution to the division's overall mission. Unfortunately, though the instructions use the right words, ADA still has not actually required proposers to write goals as outcomes or results, e.g. decreased substance abuse in the population served. This becomes evident in comparing actual practice, RFP instructions and the Grant Review Criteria Form. For example, the third criterion in the goals and objectives section of the review form states that

Project goals identify outcomes/results to be achieved by the project . . . which will change the condition of the target population.

Read carefully, this formulation does not require that the outcomes or results be changes in the target population, but merely that the "outcome" will, hopefully, create change. For example, Goal A of the City and Borough of Juneau's (CBJ) Inpatient Treatment Program is to

Provide a structured, recovery-oriented rehabilitation program consisting of medical, psychosocial, nutrition, and recreation services, and an introduction to 12-step programs, which encourage a commitment to lifelong sobriety.

Notably, the stated goal is not "sobriety" but activities "encouraging sobriety." No goal or objective which specifies a change in the clients treated is stated in any of the CBJ proposals. Review of five other proposal packets selected by ADA, each of which contain multiple proposals, as well as other programs in the CBJ proposal packet, indicate that no program goals were in fact stated in terms of the changes or treatment outcomes they would create. Only three proposers stated any objectives in those terms. This reduces goals to activities rather than results.

"Activity" outcomes would not pose a problem if ADA itself formulated specific mission-related goals to be achieved through those activities and evaluated to see if the target population had been changed as a result of the activity. But ADA does not do so. This continued focus on activities rather than results, both for purposes of initial funding and later evaluation, makes it less likely that funded programs will relate well to ADA's overall mission. It also makes it difficult to determine whether funded programs actually do create the desired changes in substance abusers.¹⁴

A bright spot should be noted. While ADA is not enforcing or clearly interpreting its requirements to write goals as outcomes, the Salvation Army Clitheroe Center's (SACC) proposal did state treatment outcome objectives for almost all of the programs it proposed. These objectives measure actual, relatively long term change in the treated population. For example, the fifth objective of Goal 1 of SACC's Intermediate Care proposal states:

¹⁴ The fact that this is not just a concern about imprecise wording is further borne out by the fact that, while RFP instructions and grant review criteria now require proposals to include plans for "outcome evaluation," ADA has not enforced those requirements. While some of the proposals reviewed by this office stated that evaluation would be done, only those few stating treatment outcome goals or objectives could actually do outcome evaluation. Two proposers planned follow up of some kind, but no proposers gave detailed plans for evaluation as is required by the RFP.

To have sixty percent (60%) of clients successfully completing the 28 day treatment maintain the gains made [sic] in treatment at a 6 month follow-up.

This shall be measured by:

- a. No current problem with alcohol or other drug abuse as determined by self and collateral reports; and
- b. spending more than 20 hours a week in productive activity; and
- c. no arrests for offenses committed during the follow-up period not including minor non-alcohol/drug related traffic offenses.

While this objective should likely be written as a goal for this program, it is a good example of how goals should be written. It allows a ready match between SACC's goals and ADA's mission and allows objective evaluation of the effectiveness of SACC's program in furthering ADA's mission.¹⁵

Measuring potential performance

Apart from determining the extent to which a proposal will contribute to ADA's mission, the division must also determine whether the proposer can "deliver." The criteria on the FY93 review form which deal with the ability of a proposer, at least on paper, to do what he or she says they will do is somewhat better developed than those regarding mission compatibility.

However, the division's failure to insist that goals be written as outcomes and end results and to require treatment outcome evaluation makes consideration of a program's past performance a weak spot. One criterion does ask whether previous program "goals and objectives" were met. Until ADA insists that programs write goals or objectives as treatment outcomes and perform outcome evaluation this will not measure the effectiveness of the program. A program's past, documented success in reducing substance abuse in the clients it serves should, without question, be one of the most important determinants of whether a program should be funded again.

To the extent that the FY93 review criteria are more balanced among all requirements for a program, they more closely reflect the funding criteria in regulations at 7 AAC 78.100. The disproportionate attention to budget in the old review form suggested that budget detail was more important than the treatment services proposed or the measure of their effectiveness.

Another improvement is that more criteria specifically reference the mission of changing the condition of target populations. Only two of the older review criteria mention this mission, albeit obliquely. At least five criteria in the new form reference outcomes and measuring them. While this language remains ambiguous and should be clarified to require measurement of change in the target population, changing the focus of the review criteria is a positive step.

¹⁵ SACC's proposal does not provide detailed information regarding how evaluation will be conducted as required by the RFP. However, Ray Dexter, the program director, told Ms. Crosby that counselors receive lists of their former clients at regular intervals. Counselors obtain information to evaluate treatment outcome by contacting clients or collateral sources such as family or neighbors. Mr. Dexter indicated that the data is included in SACC's monthly report to the state though it is not required. Though Mr. Dexter was not sure whether the state used the data he indicated that SACC uses the data to monitor treatment quality and improvement.

Despite recent improvements in the review form, it needs clarification and further improvement. In some cases pertinent information that would be reviewed through use of the form is made meaningless by ADA's failure to enforce requirements for measurable outcome goals and follow-up evaluation. In any event, the review form was used only as a "guideline" during the last funding cycle.

A program's ability to deliver what it promises is hypothetical until it is implemented and evaluated. While it is not possible to obtain evaluation data for proposals which have not been previously funded, proposers could be asked to provide existing studies supporting the performance record of treatment alternatives they propose. At present, ADA's funding criteria evaluate a proposer's administrative proposal and self-presentation skills rather than demonstrated effective treatment delivery.

FINDING

ADA acts as a funding conduit rather than as the lead agency in developing and implementing a statewide strategy to effectively and efficiently combat substance abuse. This is evident in virtually all aspects of the funding process.

ADA does not have a clearly articulated strategy (i.e. system of mission, goals and objectives) for reducing substance abuse. Nor does it determine local needs or state outcome goals prior to issuing RFPs. As a result, ADA passes up an opportunity to provide clear guidance and direction to proposers, impose performance standards on them through evaluation and more effectively coordinate services. By using this opportunity, ADA could continuously refine its goals and improve services.

Even if ADA argues that advantages of this provider-driven approach outweigh drawbacks, the agency must still be able to ensure that the programs it selects for funding will work. Unfortunately, ADA has only recently begun to state requirements that providers formulate outcome goals and outcome evaluation plans and has not insisted on compliance. As a result, there is no objective standard of effectiveness for state-funded programs nor can ADA demonstrate that funded programs actually work.

Given the lack of analytical framework it is perhaps not surprising that ADA's funding criteria and process are poorly developed. The process, though recently improved, remains less objective than it could be. Criteria themselves do not ensure that newly funded programs will effectively reduce substance abuse, nor do they effectively check to see if previously funded programs have been effective in doing so.

ADA has not clearly and appropriately formulated and implemented its mission, it does not adequately evaluate funded programs and its proposal review process does not reasonably ensure progress toward achieving its mission. As a result, I propose to find justified the allegation that ADA fails to ensure that the programs it funds are effective.

It is important to note that this is not a finding that the programs funded by ADA are necessarily ineffective. More than anything else it is a finding that ADA simply does not know whether funded programs are effective or whether there might be more effective ways to combat substance abuse.

Without planning which develops comprehensive delivery of services, adequate evaluation and a thorough and objective review process, the state is in the position of spending millions of dollars on urgent needs based primarily on faith that the funded programs work.

It is not true that the division cannot and need not demand outcome accountability from the providers from which it purchases services. On the contrary it appears to be very timely that Alaska move with the trend toward outcome evaluation and continuous quality

improvement if we hope to remain competitive for federal funds. Apart from the economic realities, without such evaluation, treatment programs remain a "black box" not only regarding how they work but whether they work.

AGENCY RESPONSE

In its response to the preliminary report, ADA disagreed that its funding decisions are unreasonable. At the same time, the agency acknowledged room for improvement and agreed with many of the recommendations.

ADA's primary argument was that fair evaluation of ADA's performance must recognize two contexts: its history as a developing agency and its orientation within the continuing debate among substance abuse professionals. The response stated:

While acknowledging the limitations in ADA's past approaches we do not feel that the allegation, as it has ultimately been defined, is fully justified. ADA faces the prospect of being judged "unreasonable" in its administrative actions for having failed to meet a standard that is acknowledged as the exception rather than the rule and which has only recently become the nationally accepted goal. We believe that acknowledged imperfections warrant only a finding of "partially justified." Much remains to be done and significant actions can and will be taken to increase ADA's leadership and effectiveness. But the agency's past actions should be judged in the proper context.

For example, ADA explained that its mission has evolved over a period of years and has continued to reflect not only state but federal agency positions in the substance abuse field. The response stated:

The initial thrust of these agencies was focused on developing a service system and ensuring the availability and accessibility of services meeting accepted standards of quality. Given the limited services available this was an appropriate mission during the early years of ADA's existence. It was also legislatively defined and developed in a social and political climate which placed a premium on local control. This emphasis was felt particularly in the desire to allow communities maximum autonomy in identifying local substance abuse problems and needs and in developing responses to those problems and needs.

We agree that ADA's mission could have been defined differently, focusing more on client outcomes and less on development of a system of services. This is true for other states and disciplines as well. We also agree that much could have been done over the history of the agency to improve the definition of the mission statement and the management of grant funding. However, ADA's mission statement, while not meeting the standard toward which we are currently striving, has not been so unclear, inappropriate or outside the mainstream of the national substance abuse field to warrant a finding that ADA's funding decisions have been unreasonable.

ADA's point that their mission has not been "unclear or inappropriately defined within the context in which it was developed" is well taken, in that, as this report discusses in Appendix A, the mission of alcohol abuse programs has, to a certain extent, been widely taken for granted by treatment professionals for years. ADA is correct in that they are not alone. However, it is just such professional assumptions about treatment purpose and success that make the ADA decisions questionable. Indeed, ADAMHA's rising concern for accountability reflects a national need for outcome evaluation.

ADA's response makes a similar point regarding the report's conclusion that program evaluation is inadequate. The JCAH standards which Alaska adopted in 1976 have been the national norm in program evaluation. The response states, "The efforts of ADA's limited staff were directed toward ensuring that programs met widely accepted and nationally defined standards." It continues:

As the agency and service system have stabilized and matured the focus has shifted more toward empirically based decision-making. The focus on achieving defined outcomes at the individual, program, and system levels is increasing, as it should be. The shift is evidenced, as [the ombudsman's preliminary report] notes, by changes in ADA's FY93 Request for Proposals. ADA's movement in this direction again parallels that of other states and Federal substance abuse funding agencies. The movement is increasingly toward development of comprehensive strategies on a centralized basis. While ADA has not been at the forefront of this movement neither has it been outside the mainstream.

Finally, ADA's response argues that, although not perfect, its funding decisions have been reasonable. It states:

Similarly, we do not believe that recent funding decisions have been without sufficient supporting rationale, or that the processes employed in making these funding decisions have been so flawed as to support a conclusion that they were unreasonable.

The process of awarding grants can and will be strengthened. However, regardless of the weaknesses of the processes the decisions in the last two years have been good and fair. The citizen reviewers and staff involved have transcended weaknesses in the process and have developed sound and fair recommendations. . . .

This statement, no longer regarding ADA's general orientation within the dialogue among treatment professionals but addressing how ADA "transcended" that debate to make sound programming selections, is the weakest in the response. It is unclear how ADA managed to do this with as little use of outcome evaluation as there was.

However, it should be emphasized that the point of the ombudsman's finding was not that the division's funding choices have been wrong, or bad. As has been stated several times in this report, the finding here is not that ADA's programs are ineffective. Rather, it is a finding that ADA has not ensured that the programs it funds are effective nor has it aggressively pursued the possibility of more effective ways to combat substance abuse.¹⁶

ADA's overall response is that:

We simply do not believe that the "reasonableness" of ADA's past funding decisions should be evaluated on the basis of standards of management

¹⁶ ADA's response brought to light the fact that a justified finding for the allegation as it was formulated in the preliminary report was open to interpretation regarding what was actually wrong. The allegation then read "ADA's administrative funding decisions are unreasonable in that the selection process does not ensure that the programs it funds effectively further the division's mission." While the emphasis was on ensuring effective programs, the allegation and finding were susceptible to being misinterpreted as criticism of the division's specific program choices or of actual program effectiveness rather than as a review of whether current procedures ensured effectiveness. As a result the allegation was clarified in the final report.

practice, however desirable, that have only recently been adopted as the goal for programs nationally. As information in [the ombudsman's] report indicates, few, if any, states would be judged "reasonable" in award of substance abuse funds using this standard. Admittedly ADA has not been at the cutting edge of the substance abuse field nationally in moving toward program management driven by empirical assessments of needs and outcomes. And, we would have preferred that progress had been more rapid to achieve our goals during this Administration. However, ADA's practices have not represented so significant a departure from the norm in the field of substance abuse that its practices should be viewed as unreasonable.

The sense in which this report finds ADA's practices to be unreasonable has already been discussed. But ADA's overall argument that its performance is well within the national norm for such agencies and, in contrast to this norm, is being held by the ombudsman to too high a standard, must be assessed.

The ombudsman concurs that ADA's performance has conformed to some conventional wisdom within the profession. But another standard applies, one which is not necessarily "higher" as much as more independent. That standard is the obligation for a public agency to be able to support its underlying orientation and demonstrate the effectiveness of decisions following from that orientation, independently from appeal to how it is done elsewhere.¹⁷

In this case, ADA is obliged to be able to demonstrate what gain the state receives from its programs, regardless of how programs are conducted elsewhere. The standard is that decisions and procedures stand up under scrutiny, a standard which is, preferably, most regularly applied by the agency itself. It is failure to meet this standard which makes a change in the finding to "partially justified" inappropriate.

The fact that the agency has, for the most part, accepted recommendations made in the preliminary report is a hopeful sign that the limited progress to date on these problems is only the beginning of continuing self-scrutiny and improvement in the division.

RECOMMENDATIONS

Mr. Jones stated that the next division plan, now in process, would be used to give firm direction to ADA regarding where the agency should be in the next three to five years. ADA is in the fortunate situation therefore to remedy problems identified in this report as part of their regular planning process.

In its response to the preliminary report, ADA accepted "the general direction represented by [the report's] recommendations" and stated:

ADA must and will provide stronger leadership in identifying desired outcomes at the individual client, program and statewide levels; in developing strategies to achieve those outcomes; and in working with grantees to integrate these into a consolidated system of goals, objectives, and actions that can be accurately and reasonably measured.

¹⁷ It may be noted that this standard might relate to portions of this report where more progressive states' programs were highlighted. The point of this comparison was not to place Alaska on a continuum of philosophical orientation or program development relative to other states. Instead, the point was that some states question their own effectiveness and have begun to find ways to evaluate it and, thereby, improve it.

In fact, indicating that they fit well with the department's new planning procedure which requires specified outcomes and the approaches to be employed to achieve those outcomes, ADA accepted all of the ombudsman's recommendations with only a few qualifications. The few comments on ADA's response to the recommendations which are necessary are incorporated below following the relevant recommendation. A lack of additional comments following a recommendation indicates ADA's acceptance of that recommendation.

ADA should develop a comprehensive strategy

Recommendation One - ADA should use the next planning cycle to:

- (a) restate the division's mission in terms of actually reducing substance abuse or the social effects of substance abuse;¹⁸
- (b) do a needs assessment which is formal, explicit and separate from the funding process, which includes input from both local communities and providers as well as statistical sources such as DWI and other criminal justice data, and takes into consideration services already available from other sources;
- (c) formally assess and rank the social costs posed by various types of abusers as well as any differential ability to benefit from treatment;
- (d) develop and prioritize goals and objectives which follow both from the information developed in the process described above and research revealing the most effective way to meet the needs;
- (e) ensure that ADA's goals are stated in terms of outcomes, not activities; and
- (f) develop outcome evaluation strategies by working with ADAMHA and other sources of information and experience.

ADA qualified their acceptance of subparts (b) and (c) of recommendation one. The agency agreed to review direct and indirect indicators of need for substance abuse prevention and to develop goals, objectives and strategies derived from a revised mission and from an assessment of need. Their response stated:

ADA staff have already begun compiling and analyzing data from a variety of sources which will provide information on the nature and prevalence of substance abuse in Alaska and the effects of the problem. To the extent possible, this will include a review of data by sub-state planning area. However, a community by community review is beyond the ability of ADA's single planner to accomplish in a reasonable time. This level of needs assessment is best left to proposers. . . .

We do not propose to formally assess and rank the social costs posed by various types of abusers or their differential ability to benefit from treatment, at least in the sense that we perceive the meaning of [the report's] use of the term "formal." ADA lacks the staff and fiscal resources to undertake such a review at this time.

¹⁸ Since the state has less interest in reducing substance abuse which has little social cost, and since reducing social cost provides more direction and clearer standards, the ombudsman urges ADA to adopt the latter formulation.

However, in its response ADA stated that the division had considered asking the University of Alaska's Institute for Social and Economic Research in FY94 for a study of the social and economic costs of substance abuse in Alaska. When asked in a follow-up conversation why this study is an appropriate fiscal commitment when the apparent need is to reorient the division's mission, Mr. Jones pointed out that the preliminary report suggested that the relative economic and social impacts of various substance abusing groups is one standard by which ADA might organize the division's mission and goals.

Mr. Jones elaborated that such a study was an attractive starting point for several reasons. First, unlike the more traditional starting point of a formal needs assessment, this study was probably within the division's fiscal means at this time. Second, this study would not simply evaluate social and economic costs on a gross level but could be designed to identify costs of substance abuse to specific areas of the state or to other state agencies. For example, some alcohol abuse results in costs to the medical community, other abuse costs the state Division of Family and Youth Services, while still other abuse patterns result in costs to the Department of Public Safety or the Department of Corrections. Third, the study might enable ADA to begin to get a handle on the information it needs while it prepares for a more full-blown response to the studies and plans which will evidently be required by the federal government in coming years, assuming this does not change with the new administration.

Mr. Jones said that the division's previous consideration of such a study evidenced its earlier intent to proceed with more empirical bases for their actions. Continuing with this smaller first step would preclude, he said, jumping in the wrong direction before ADA really understands what information is needed and how to get it.

In line with this, Ms. Crosby asked whether an alternative starting point for comprehensive change might be a major commitment to statewide training for providers who must also recognize and accept the refocusing which ADA has agreed is necessary. Mr. Jones' response prompted discussion pertinent to recommendation three, which is considered below.

Mr. Jones' thinking on the question of needs assessment -- about what research ADA might do to obtain whatever information is necessary to clarify its mission and makes its programs more effectively consistent with that mission -- indicated that he had taken to heart the seriousness of the revision needed by the division.

ADA should change the way it obtains services for substance abusers

Recommendation Two - ADA should consider taking a pro-active approach to obtaining services for substance abusers by:

- (a) issuing directed RFPs based on the prioritized goals and objectives which will result from the process described in Recommendation One. Such RFPs would clearly state the goals a proposer would be expected to achieve; and
- (b) implementing more individualized methods of making services available to substance abusers. Instead of funding programs, ADA might fund individualized treatment for substance abusers similar to Medicaid and Developmental Disabilities programs.

Recommendation Three - If ADA continues to allow providers to identify needs and develop outcome goals, ADA should change its RFPs to:

- (a) impose and enforce requirements that goals be written as outcomes that actually entail measurable change in the substance abuse behavior, or the social effects of that behavior, of the population served;

(b) require that proposers objectively document:

(i) that the services proposed fit into a statewide plan and meet local, high priority, needs;

(ii) that the target population does not have access to other sources of care;

(iii) the relative ability of the target population to benefit from the intervention proposed; and

(iv) that continued abuse by that population poses a relatively higher social cost than other populations;

(c) impose and enforce requirements for outcome evaluation plans which measure the substance abuse behavior, or the social effects of that behavior, of program clients prior to services, at completion or termination of services and, at a minimum, six months after completion or termination.

ADA accepted recommendation three but pointed out that such a significant change does not occur overnight or even within the framework of one year's proposal process. First of all, individual providers cannot make all of the changes which apply to them until ADA incorporates the suggestions for more centralized changes.

Specifically, the response stated:

... our experience has been that most grantees have found it difficult to make the transition from stating goals and objectives as process measure to stating them as outcome measures. We cannot expect complete success in the next RFP and it is likely that grants will be awarded to proposers whose goal statements are not entirely satisfactory.

Second, given the likelihood that not all those awarded grants will have satisfactory goal statements, ADA staff may have to spend significant time providing technical assistance to those grantees in order to define mutually acceptable outcome goals and objectives.

Third, ADA staff must monitor the performance of grantees in achieving the proposed goals and objectives. This will likely entail increased emphasis on performance monitoring as part of the on-site reviews performed by Health Facility Surveyors.

Given this, ADA was understandably unwilling to accept the language of "imposing and enforcing" outcome evaluation while, at the same time, the agency agreed that "outcome evaluation is essential and ... that this issue will be addressed during ADA's planning process and in the award of grants" and that "mandating evaluation requirements is essential in the longer term."

It was the need for bringing the providers along with the necessary changes in mission and programs that prompted Ms. Crosby to ask Mr. Jones if initiatives in statewide training might be a productive starting point for the changes the division must undertake. Mr. Jones responded with the experience of a New York state division director who tried to make comparable changes all at once and only succeeded in provoking mutiny among the state's treatment community. The innovator was forced to regroup and begin with smaller, reproducible pilot projects.

Furthermore, Mr. Jones revealed his appreciation for the extent of the recommendations when he added that some agency staff may require extensive training as

well. He again acknowledged the importance of understanding themselves what they wanted before they could require it from the treatment community. Such an understanding, if it requires reorienting years of professional training and experience, does not come and cannot be acted on overnight.

ADA should change the way it reviews proposals

Recommendation Four - ADA should clarify and standardize the proposal review process by:

- (a) ensuring compliance with regulations which indicate that staff will review proposals only for form or by changing these regulations to provide for the process used;
- (b) specifying how the Grant Review Criteria form will be used by the advisory board, and providing this information to proposers in the RFP;
- (c) further revising the Grant Review Criteria form to state the number of possible points any individual criterion may be worth;
- (d) assigning additional weight to criteria measuring a program's past performance in meeting goals; and
- (e) using the review form as the basis for funding decisions rather than as a guideline.

Recommendation Five - ADA should revise and expand the criteria in the Grant Review Criteria form to ensure that the criteria measure a program's relative ability to meet the requirements of and accomplish the mission and goals stated in the associated RFP. To some extent the nature of the revisions will depend on any changes ADA makes in the way it obtains services. The following changes in criteria apply primarily to the current approach used by ADA and focus on mission compatibility and potential performance.

ADA should adopt additional criteria to determine:

- (a) whether proposers have met each of the RFP requirements cited in Recommendation Three; and
- (b) based on ADA's evaluation of statewide and local needs, whether the proposal directs services to a relatively higher priority group than other proposals.

The division needs better information for accountability and improvement

Recommendation Six - ADA should develop plans to evaluate its own performance in reducing substance abuse, or the effects of such abuse, on a statewide level and feed this information back into its own planning process

CONCLUSION

The ombudsman is aware that this report recommends a major overhaul of the division's mission and its implementation. The ombudsman realizes that such comprehensive change does not happen rapidly even when fiscal constraints are not an issue. Those qualifications which ADA made to its acceptance of the report's recommendations are not interpreted by the ombudsman as reluctance or "foot dragging" but instead, as indication that the division appreciates how far-reaching this report is in its recommendations. For example, Mr. Jones's sensitivity to the difficulty of initiating such change indicates his understanding that these changes cannot just be on paper.

One response from ADA which qualified their acceptance of a specific recommendation was that service providers would not be expected to provide outcome evaluation right away; nor, even, could their proposals be expected to reflect emphasis on treatment outcomes right away. Mr. Jones' explanation that reorientation is required within the division before it can effectively train private providers regarding such treatment goals is reasonable. However, the ombudsman understands that efforts to implement this recommendation, as with the others, will begin as soon as possible in whatever ways are appropriate first steps.

Another recommendation which was accepted with qualification specified a statewide needs assessment independent from the funding process. ADA's response, that local needs assessment "is best left to proposers" because agency staff is insufficient for community by community review, overlooks the fact that different suggestions might come from a community if more than the providers were polled or if community ideas need not funnel through the providers. A community's needs and the providers' description of those needs might not always coincide and only external, collateral contacts will reveal this. As ADA develops its next plan, this distinction needs to be taken into account.

The ombudsman's recommendation that ADA consider distributing funds as does the Division of Mental Health and Developmental Disabilities in its programs for the developmentally disabled was rejected because ADA is statutorily constrained to fund programs, not individuals.

This is a reasonable response but it also raises the possibility that statutory changes may be required as ADA changes its mission, goals and programs to reflect more measurable outcomes.

The division may also require funds for implementing of these changes if federal funds are not available for needs assessment or provider training, for example. Given the extent of the development needed at ADA, now is not the time to reduce its funds. Rather, with the changes ADA is committed to making, the promise is there that funds dedicated to substance abuse programs will prove more rewarding to the state than they have been in the past.

Based on what appears to be ADA's commitment to comprehensive change in accord with the recommendations in this report is clear. Therefore, the final finding of record for this report is justified and rectified.

AEC:pjc
Attachment

APPENDIX A

Summary of current debate regarding how to understand and treat alcohol-related problems

To understand the heated controversy that underlies the ongoing debate about treating alcohol problems, Broadening the Base¹ explains "it is helpful to view these differing treatment philosophies as professional ideologies that guide . . . program development and movements within the field. [I]deology not only includes beliefs and theories about etiology but also provides prescriptive norms for . . . clinical practice, teaching and research." (BB p. 54.)

In the United States, from colonial times through the appeal of Prohibition in 1933, people with alcohol use problems were viewed as morally delinquent. E.M. Jellinek founded the scientific study of alcohol abuse with the first major review of treatment in 1941. In 1960, Jellinek's The Disease Concept of Alcoholism, based largely on research with Alcoholics Anonymous (AA), proposed that alcoholism was a medical rather than moral problem. He identified five "species" of alcoholics, two of which, "gamma" and "delta," fit his disease model.

For various reasons, including powerful testimony from growing numbers of sober alcoholics regarding their successful AA treatment, these former alcohol abusers and the components of AA-like programs remain a primary focus of U.S. treatment programs. A 1988 study showed most treatment professionals agreeing on a disease model definition of alcoholism: "a chronic, progressive, and potentially fatal biogenetic and psychosocial disease characterized by tolerance and physical dependence manifested by a loss of control, as well as diverse personality changes and social consequences." (BB p. 26 ff.)

In broad strokes, the disease model accepts that the primary disorder is involuntary and pathological dependence on alcohol. Appropriate treatment tenets include: (1) initial detoxification; (2) education regarding detrimental physical effects of alcohol; (3) confrontation regarding the person's readiness to connect alcohol use with its negative consequences; (4) agreement that abstinence from the cause will cure the problem; (5) commitment to a recovery plan of life-long abstinence; (6) a therapeutic environment managed primarily by other recovering alcoholics; and (7) aftercare to prevent relapse to chronic symptoms. Underlying the treatment model is the belief that if the disease is not treated, the person will die.

The 7th Special Report concurs that for the alcohol-dependent person, attempting to merely modify drinking is unreasonable and abstinence is the appropriate treatment goal. In this model, persons whose drinking problems do not fit this definition and

¹ Major references for this summary are the Seventh Special Report to the U.S. Congress on Alcohol and Health, from the Secretary of Health and Human Services, January 1990; and Broadening the Base of Treatment for Alcohol Problems, the report of a study by the Institute of Medicine (National Academy of Sciences) in response to a 1986 request from Congress. This study was also published in 1990. Although they disagreed on the interpretation of these reports, Dr. Gold and Mr. Jones both accepted them as the standard in professional literature.

treatment model -- those who successfully moderate their drinking without stopping altogether, for example -- are not really alcoholic.

Critics of the disease model point to the lack of data from controlled studies regarding the efficacy of AA-type treatment (BB p. 526 ff.) and to the fact that Jellinek himself warned that restricting "alcoholism" to characteristics "created by Alcoholics Anonymous in their own image" would overlook many other alcohol-related problems. As early as the 1983 Fifth Special Report to Congress, treatments recognizing multiple patterns of abuse with a variety of presenting symptoms "challenged the traditional concept of alcoholism as a unitary disease." (5th Report p. 116.)

The 7th Special Report disputes the idea of a progressive disease with studies revealing "no unvarying or inevitable sequence of behaviors and symptoms leading from one drinking classification to another." (7th Report p. 2.) Broadening the Base rejects the idea that people with less severe alcohol problems should be considered "at the early stages of alcoholism . . . the extension of the definition of alcoholism in such instances is not realistic." (BB p. 27.)

Broadening the Base states that "efforts to treat alcohol problems in this country have in the recent past been too narrowly focused on those persons with the most severe problems." (BB p. 46.) For one thing, there is evidence that this group is minimally susceptible to help and improvement, partly because only one in five of them receive treatment. Reasons for this range from the stigma associated with intensive treatment for those with families and jobs intact, and, for those without family, employment and community commitments, there is little motivation to change because there is little left to lose. The report states, "From planning, policy and treatment perspectives, the potential hazard is that individuals failing to be classified as alcohol-dependent might readily come to be assigned a lower priority. . . ." (BB p. 30.)

In contrast to the unitary disease model and its treatment implications, Broadening the Base proposes a broad spectrum of alcohol-related problems as the appropriate treatment target. Since 1970, epidemiological studies have revealed large populations with less than maximally severe drinking problems, people who present symptoms such as "nerves" and "bad stomach" to their doctor, "family problems" to a minister or social worker, or "trouble concentrating" to a teacher. The number of people suffering from these problems far outnumber severely impaired alcoholics. "The logical implication of this distribution of alcohol problems for intervention² . . . [is that i]f the alcohol problems experienced by the [general] population are to be reduced significantly . . . a principal focus of intervention should be on persons with mild or moderate problems." (BB p. 215.)

That this focus is counterintuitive is suggested by "the preventive paradox" -- the fact that most professional effort to reduce alcohol problems has targeted heavy drinkers who, experiencing the most difficulties, are seen as the source of the social burden of alcohol problems. It is "difficult and puzzling to be asked to shift one's gaze away from this more troubled population, and to concentrate on a less apparent . . . group." That this is recommended, however, is clear from the analysis in Broadening the Base. It states, "Indeed . . . a total orientation in our thinking . . . is required -- a shift away from the conception that all alcohol problems involve a chronic progression that can only be deterred through a single treatment approach." (BB p. 488.)

² In the disease model, "intervention" implies an early therapeutic response to alcohol problems, as opposed to "treatment" for more serious impairment. However, in keeping with its emphasis on the variety of alcohol-related problems and the appropriate responses, Broadening the Base collapses this distinction. It states "the most direct and simple definition of intervention and treatment . . . is any activity that is directed toward changing a person's drinking behavior and reducing their alcohol consumption." (BB. p.46).

To refocus research and treatment efforts, Broadening the Base defines the major problem to encompass all efforts to reduce alcohol consumption by people experiencing problems with such consumption. In contrast to the narrower focus on abstinence for alcoholics, this model allows for a variety of people "treat[ing] their use of beverage alcohol . . . for [its] optimum management." (BB p. 27.) Based on the heterogeneity of alcohol-related problems and their causes and resolutions, Broadening the Base emphasizes community-wide effort toward early, brief interventions wherever and whenever symptoms of alcohol-related problems are presented. The report states that neglecting early intervention options means "an important opportunity will be missed for reducing the total burden of alcohol problems on society." (BB p. 16.)

The Institute of Medicine study notes that even if the disease model were retained, many diseases are heterogeneous and require a variety of treatment goals and methods based on the specifics of the individual. The study states near the end of the chapter titled "What is Being Treated?" that, "There may be reasons for continuing the debate over the disease concept, but progress in treatment need not await its resolution." (BB p. 33.)

Arenas for progress, even in the face of this continuing debate, include improved "matching" of client needs with intervention methods and more instructive treatment evaluation. The first of these is beyond the scope of this report but the orientation toward evaluation from Broadening the Base is represented in the body of this report. The Broadening the Base chapter titled "Determining Outcome" opens with a quotation which begins, "We can no longer afford to provide health care without knowing more about its successes and failures. The Era of Assessment and Accountability is dawning at last. . . ." (BB p. 313.)

HB 413

Increase tobacco and alcohol taxes

February 3, 1994

Page 2 of 2

This bill would increase excise tax rates effective July 1, 1994 as follows.

	Current Tax Rate	HB 413 Tax Rate	% Increase
Cigarettes	14.5 mills* (29¢/pack)	21.75 mills* (43.5¢/pack)	50%
Tobacco	25% Wholesale Price	50% Wholesale Price	100%
Liquor	\$5.60/gallon	\$8.40/gallon	50%
Wine	\$.85/gallon	\$1.275/gallon	50%
Beer	\$.35/gallon	\$.52.5/gallon	50%

* Includes 2.5 mills assessed under AS 43.50.090.

In determining the amount of additional revenue generated from this bill, Department of Revenue used consumption data available from FY 93. Amounts below do not reflect impacts on consumption, if any, due to increased tax rates and other factors. Additional revenue generated from this bill is estimated to be \$14,998,800 calculated as follows.

	FY93 Consumption	FY 93 Revenue	HB 413 Revenue	Additional Revenue
Cigarettes	1,079,500,000	\$15,652,800	\$23,479,200	\$7,826,400
Tobacco	\$4,896,000 Sales	1,224,000	2,448,000	1,224,000
Liquor	1,100,000 gallons	6,160,000	9,240,000	3,080,000
Wine	1,288,000 gallons	1,094,800	1,642,200	547,400
Beer	13,263,000 gallons	4,642,000	6,963,000	2,321,000
Total		\$28,773,600	\$43,772,400	\$14,998,800

This bill will not affect the Department's operating costs because amendments made under this bill increase tax rates only.

**U.S. Department of Justice
Office of Justice Programs**

An Invitation to Project DARE: Drug Abuse Resistance Education

**Information You Need to Decide Whether Your
Community is Prepared to Commit the Time, Energy
and Resources Required to Implement this Program**

Program Brief

**Bureau of
Justice
Assistance**

June 1988

Preface

In response to the mounting national concern about the use of drugs by American youth, the Bureau of Justice Assistance has funded the development of this publication to inform law enforcement officers, educators, government officials, and other concerned citizens about Project DARE, an exciting approach to preventing substance use among school children.

Project DARE (Drug Abuse Resistance Education) is a substance use prevention education program designed to equip elementary school children with skills for resisting peer pressure to experiment with tobacco, drugs, and alcohol. This unique program, which was developed in 1983 as a cooperative effort by the Los Angeles Police Department and the Los Angeles Unified School District, uses uniformed law enforcement officers to teach a formal curriculum to students in a classroom setting. Project DARE gives special attention to fifth- and sixth-grades to prepare students for entry into junior high and high school, where they are most likely to encounter pressures to use drugs.

DARE lessons focus on four major areas:

- Providing accurate information about tobacco, alcohol, and drugs
- teaching students decision-making skills
- showing students how to resist peer pressure
- giving students ideas for alternatives to drug use

This innovative program has several noteworthy features:

- *DARE targets elementary school children.* Junior high and high school drug education programs have come too late to prevent drug use among youth in the past. Therefore, substantial numbers of young people have reported initiating use of alcohol, tobacco, and marijuana by junior high school.*
- *DARE offers a highly structured, intensive curriculum developed by health education specialists.* A basic precept of the DARE program is that elementary school children lack sufficient social skills to resist peer pressure and say no to drugs. DARE instructors do not use the scare tactics of traditional approaches

that focus on the dangers of drug use. Instead, the instructors work with children to raise their self-esteem, to teach them how to make decisions on their own, and to help them identify positive alternatives to tobacco, alcohol, and drug use. The curriculum addresses learning objectives in keeping with those of state departments of education and conforms with health education standards.

- *DARE uses uniformed law enforcement officers to conduct the class.* Uniformed officers as DARE instructors not only serve as role models for children at an impressionable age, but also have high credibility on the subject of drug use. Moreover, by relating to students in a role other than that of law enforcement, officers develop a rapport that promotes positive attitudes toward the police and greater respect for the law.
- *DARE represents a long-term solution to a problem that has developed over many years.* Many people believe that, over time, a change in public attitudes will reduce the demand for drugs. DARE seeks to promote that change. Equally important, DARE instructors help children develop mature decision-making capabilities that they can apply to a variety of situations as they grow up.

For those interested in learning how to bring this novel program to their community, the Bureau of Justice Assistance has also published *Implementing Project DARE: Drug Abuse Resistance Education*, an implementation manual which provides a step-by-step description of how to implement Project DARE as well as model forms and other materials.

The manual is available from:

Dorothy L. Everett
Bureau of Justice Assistance
633 Indiana Avenue, N.W.
Washington, D.C. 20531
(202) 272-4604

*L.D. Johnston, P.M. O'Malley, and J.G. Bachman, *Drug Use Among American High School Students, College Students, and Other Young Adults: National Trends Through 1985* (Rockville, Md.: National Institute on Drug Abuse, 1986).

An Invitation to Project Dare: Drug Abuse Resistance Education

America has a drug problem.

It is a problem that exacts an enormous toll in human suffering, in the expenditure of public monies, and, more importantly, in the enormous waste of human potential.

It is a festering problem whose solution has so far eluded us.

Despite urgent warnings from parents, educators, and the mass media, many of our nation's young people experiment with and use a variety of harmful substances, including tobacco, drugs, and alcohol.¹ An annual survey of high school seniors conducted for the National Institute on Drug Abuse found that, in 1985, only 8 percent of students had never used alcohol, and only 31 percent had never smoked cigarettes. Over two thirds of those seniors reported use of at least one illicit substance, with over one half (54%) having used marijuana.² Children as young as age 9 report that marijuana is "easy to get."³

Until recently, law enforcement strategies have focused on the supply side of the drug problem, with millions of dollars spent each year to control the distribution and sale of illicit drugs. Despite the confiscation of tons of narcotics, and despite thousands of arrests, the drug trade continues to flourish.

Law enforcement experts now recognize that the problem of substance use must be addressed by stemming demand, especially among young people who might become tomorrow's drug users. A recent report issued by the Commission on Organized Crime concludes that the only way to significantly reduce the drug problem in the United States is through eliminating the demand for drugs.⁴

School children must be educated to recognize the dangers of drug use and to resist both the subtle and the direct pressures on them to experiment with and use drugs.

Arresting Demand: The Development of Project DARE

In 1983, Chief Daryl Gates of the Los Angeles Police Department (LAPD) recognized that, to prevent substance use among children, he would need the cooperation of the Los Angeles Unified School District (LAUSD).

Under Chief Gates's direction, the LAPD collaborated with Dr. Harry Handler, Superintendent of LAUSD, to launch a drug use prevention education program that employs law enforcement officers in elementary classrooms as regular instructors.

A review of existing substance use curricula by Dr. Ruth Rich, a health education specialist from LAUSD, showed that lessons concentrating on techniques for resisting peer pressure, on self-management skills (decision making, values clarification, and problem solving), and on alternatives to drug use appeared to have the greatest degree of success.⁵ These methods were incorporated into the DARE curriculum, challenging students to consider the consequences of their actions and involving them in classroom exercises that gave them the opportunity to practice what they had learned.⁶

During Project DARE's first year, 1983-84, ten officers taught the new curriculum to more than 8,000 students in 50 Los Angeles elementary schools. Subsequently, the DARE program, which originally targeted senior-level elementary students (fifth- or sixth-grades), was expanded to include a junior high curriculum and lessons for grades K-4. By 1986, the program had grown to reach all 345 elementary and 58 junior high schools in the city.

Based on this success, Chief Gates invited other jurisdictions to send officers to Los Angeles for 80 hours of intensive DARE training. Officers from 33 states representing 398 agencies have now learned how to bring the DARE curriculum to the children in their communities. Because the growing demand for DARE training exceeds the LAPD's capacity, the Bureau of Justice Assistance plans to fund the establishment of up to three DARE regional training centers in 1988.

The excitement about Project DARE continues to grow. In October 1986, the Bureau of Justice Assistance awarded grants to seven jurisdictions for planning and organizing DARE implementation. The Department of Defense plans to establish DARE in all of its schools for military dependents. New Zealand plans to implement DARE in association with its law-related education program. Other countries, including England and Australia, are investigating the introduction of Project DARE in their schools as well.

There are now a Spanish version and a Braille translation of the student workbook used in the classroom. Efforts are under way to develop strategies for teaching DARE to hearing-impaired and other special needs students.

Program Goals and Objectives

Goal:

To prevent substance use among school children.⁷

The DARE program targets children before they are likely to have been led by their peers to experiment with tobacco, drugs, and alcohol. By reaching children at an age when they are most receptive to drug prevention education, Project DARE seeks to prevent adolescent drug use and to reduce drug trafficking by eliminating the demand for drugs.

Objectives:

- To equip elementary and junior high students with the skills for recognizing and resisting social pressures to experiment with alcohol, tobacco, and drugs
- To help students develop self-esteem
- To teach positive alternatives to substance use
- To develop students' skills in risk assessment and decision making
- To build students' interpersonal and communications skills

Project DARE achieves these objectives by training carefully selected veteran law enforcement officers to teach a structured, sequential curriculum in the schools.

An important by-product of Project DARE is the positive impact of uniformed law enforcement officers, working in classrooms in a nonthreatening, preventive role, upon the image of law enforcement in the community.

A Program That Works: Evaluation Results

Evaluations of Project DARE in Los Angeles reveal great enthusiasm for the program among school principals and teachers who say that DARE students are less accepting of substance use and better prepared to deal with peer pressure as a result of the DARE lessons. Moreover, these educators find that, because DARE students get to know police officers in a positive, nonpunitive role, they have a greater respect for both the law and law enforcement personnel.⁸ Beyond that, students receiving the DARE curriculum in elementary school show greater improvement, compared with non-DARE students, in grades for work habits and cooperation during their first semester in junior high.⁹

A short-term evaluation for the National Institute of Justice also demonstrates the impact of Project DARE on the knowledge, attitudes, and self-reported behavior of seventh-grade students who received DARE in the sixth grade.¹⁰ These students, compared with those who had not had DARE, indicated significantly lower substance use since graduation from the sixth grade. Moreover, DARE students, when asked to imagine friends pressuring them to use drugs or alcohol, were significantly less likely to indicate acceptance of the offer than were non-DARE students. DARE students were also more likely to use effective refusal strategies emphasized by the DARE curriculum.

In 1985, Los Angeles initiated a seven-year study of DARE and non-DARE students to assess the long-term impact of the program on students' knowledge, attitudes, and self-reported drug use.

Key Program Elements

To implement DARE effectively, specific elements are essential:¹¹

Joint Planning

DARE requires the investment and collaboration of both law enforcement and education agencies. The initiative may be taken by either agency or by a third party, such as the mayor's office or a parents' group. However, both education and law enforcement agencies must be involved early in planning for implementation. Many issues are likely to arise during the planning period:

- *Will school and police administrators have difficulty working together?* Schools and police have different administrative styles and are not commonly accustomed to working together. Communities find, however, that a structured program and a mutual commitment to preventing substance use among young people provide strong motivation for pursuing this cooperative effort.
- *Will there be resistance in the education community to a law enforcement presence in the classroom?* Police officers are usually viewed as law enforcers, not as teachers. However, DARE officers are well-trained, committed individuals who quickly prove their effectiveness as classroom teachers. When teachers and administrators observe individual officers instructing individual classrooms, resistance evaporates.
- *Are there other school-based programs currently in use or being introduced to combat adolescent drug use?* A long-standing concern about substance

use has generated many approaches to prevention education. School systems must choose among many curricula and allocate their limited resources effectively. Other educators or health specialists may be committed to another approach and may not recognize how DARE can fit into the total health education program. To meet these legitimate concerns, proponents of competing programs should be invited to participate in the planning process. In Massachusetts, for example, where a strong consensus for teacher-led instruction had emerged, DARE came to be viewed as one component of a comprehensive, multicurriculum health education strategy.

- *How can Project DARE fit into an already full classroom schedule?* Schools are concerned that the teaching of basic skills may be neglected as the demands increase to address other topics of social concern. The DARE curriculum, which was developed by health education specialists, is multifaceted, emphasizing basic skills that students must learn to make reasoned choices for good health. Moreover, DARE incorporates the application of language arts into many of its lessons. Some programs have identified ways in which the DARE curriculum meets learning objectives established by the State Department of Education.
- *Can the law enforcement department afford to reassign officers to classroom duty?* Each veteran officer on patrol is important in the fight against crime. Administrators, therefore, need to decide whether assigning an officer to Project DARE is worth the cost of a reduced presence on the street. Law enforcement administrators in nearly 400 jurisdictions, having recognized the limitations of past approaches to our nation's drug problems, have determined that it is.

One officer instructor can serve as many as ten elementary schools or up to 40 classes per year. Consequently, small law enforcement departments, which may have special concerns about the time required for DARE implementation, will find that an officer can work part-time as a DARE instructor with the balance of the officer's time being devoted to other departmental activities.

Written Agreement

Implementation of DARE requires a partnership between law enforcement and education systems. A written agreement between law enforcement and school officials demonstrates each agency's commitment to Project DARE and defines their respective roles. This agreement generally includes:

- A statement of their mutual commitment to implement DARE as a strategy to prevent substance use among children
- The law enforcement role: to assign in a non-law enforcement role qualified officers who will teach the DARE curriculum in the schools
- The school role: to provide classroom time for lessons, coordinate scheduling, and encourage teachers to support and reinforce classroom activities
- Program scope: the grade(s) to be targeted and the number of schools and students to be reached
- Specification of the agency responsible for providing such resources as student workbooks and films
- Specification of the agency responsible for program oversight
- Procedures for regular communication between the two agencies

Officer Selection

The high quality of the officer instructors is the keystone of the DARE program. Officers must volunteer for the program on the basis of a solid commitment to preventing substance use among young people and must have a clean record, a minimum of two years street experience, maturity, and good communication and organizational skills.

The officers should be from the local community, where they will be seen and recognized by students. However, when communities are small or do not have resources to assign a local officer, state police or sheriff's deputies can teach the program. As noted above, this commitment may be part-time.

The selection process generally involves posting of the position, preliminary screening, and a formal interview by a review panel that can include both police and school personnel. During these interviews, DARE candidates frequently reveal skills and experience that have lain dormant, yet qualify them for this unique challenge. School panelists have often commented on how instructive participation in officer selection has been in eliminating their misconceptions about police capabilities.

Officer Training

Training for DARE officers consists of an intensive two-week (80-hour) seminar jointly presented by law enforcement and education agencies. Several states now offer DARE officer training, using a format

developed and certified by the Los Angeles Police Department. To maintain the integrity of the DARE program, it is essential that officers be trained by certified agencies.*

The DARE training curriculum includes:

- An overview of current drug use prevention activities
- Communication and public speaking skills
- Learning methodology and classroom behavior management
- School/police relationships
- Police/parent community relationships
- Stages of adolescent chemical dependency
- Audiovisual techniques and other teaching aids
- Program administration
- Sources of supplementary funding

The most important component of the training is the modeling of each lesson by experienced DARE officers (or "mentors"). Each trainee then prepares and teaches one lesson to fellow trainees, who play the role of fifth- or sixth-graders, and who subsequently evaluate the officer's performance. Mentors advise and support trainees throughout the training, by helping them prepare for presentations and offering suggestions for improvement.

Training sites also provide orientation sessions for law enforcement and education administrators. These sessions provide an opportunity for managers to discuss organizational issues associated with DARE implementation and to review forms and systems for monitoring and record-keeping.

Core Curriculum

The DARE core curriculum targets fifth- and sixth-grade elementary school students who will be graduating into junior high at the end of the year. The curriculum consists of seventeen 45- to 60-minute lessons to be conducted by the DARE officer on a weekly basis. The lessons are structured, sequential, and cumulative. They employ a wide range of teaching strategies that emphasize student participation, including question-and-answer, group discussion, and role-play activities.

The curriculum is designed to equip students with skills for recognizing and resisting peer influences and other pressures to experiment with substances. In addition to building refusal skills, the lessons focus

on the development of self-esteem, risk assessment and decision-making skills, interpersonal and communication skills, critical thinking, and the identification of positive alternatives to substance use. A listing of the 17 DARE lessons appears at Appendix C: Page 9.

The DARE curriculum is available only to those officers who have completed certified training.

Classroom Instruction

Typically, officers are assigned to each school for a full day. Thus, one officer can serve up to five schools per week per semester, or ten schools in a two-semester school year.

Officers are to be regarded as members of the school faculty. This means that, while at the school as DARE instructors, they can be called upon to act in a law enforcement role *only* in an emergency. It is recommended that part-time DARE officers be assigned to units such as community services in order to avoid law enforcement duties that may conflict with the DARE image or result in court dates that could interfere with classroom obligations.

Informal Officer/Student Interaction

In addition to their formal classroom teaching, DARE officers spend time on the playground, in the cafeteria, and at student assemblies to interact with students informally. They may organize a soccer match, play basketball, or chat with students over lunch. In this way students have an opportunity to become acquainted with the officer as a trusted friend who is interested in their happiness and welfare. Students occasionally tell the officer about problems such as abuse, neglect, alcoholic parents, or relatives who use drugs. The officer refers these cases to the school principal or to appropriate resources in the community.

Teacher Orientation

The officer needs the support and understanding of classroom teachers to function effectively in the classroom. The DARE officer provides an in-service orientation for teachers at the beginning of the school year to familiarize them with the DARE curriculum.

*States that have developed this training capacity include Arizona, Illinois, Massachusetts, North Carolina, Virginia, and Washington. Virginia provides its officers with 120 hours of training in order to certify them as classroom instructors.

explain their respective roles, and identify ways they can cooperate in effectively communicating DARE's objectives to the students.

Classroom teachers are expected to stay in the classroom during the DARE instruction. Because they know the students well, teachers can share with the officers ways to handle classroom behavior. Frequently they assist with organizing role-play exercises, seeing that students complete their homework, or providing lessons during the week to reinforce the DARE officer's teaching. To encourage such involvement, the curriculum contains extended activities that teachers may choose to introduce.

Parent Education Evening

The cooperation and understanding of parents are essential to any substance use prevention effort. During the semester, parents are invited to an evening session at which the DARE officer explains the DARE program, describes ways to improve family communications and to recognize and respond to symptoms of substance use in their children, and provides information about available counseling resources. Some communities report that enthusiastic parents have organized follow-up informational drug prevention activities as a result of these DARE officer-led parent education evenings.

Community Presentations

Police, educators, and others committed to the success of this effort need to ensure that the program is visible and widely accepted. Meeting with groups representing all segments of the community, including parents and civic groups, community-based organizations, housing projects, and local businesses, promotes the level of community understanding and support that is essential for DARE's successful implementation.

Community support may also help to ensure program continuity if a scarcity of resources threatens to interrupt program activities. Community service organizations frequently supplement program resources by paying for student workbooks or by providing student T-shirts, bumper stickers, or other promotional materials that demonstrate the community's commitment to substance use prevention. This kind of support reinforces for students the importance of saying no to drugs.

DARE Enrichment Activities

DARE's developers have created several activities to supplement the core curriculum for grades 5 or 6.

• K-4 Visitation Lessons

Typically, an officer can teach up to four fifth- or sixth-grade classes per day. As time permits, the officer can visit each of the lower grades to introduce the students to the DARE concept. A K-4 curriculum is available for this purpose. The lessons, each 15-20 minutes long, cover such topics as personal safety, obeying of laws, and helpful and harmful uses of medicines and drugs.

• Junior High Curriculum

A ten-session junior high curriculum, which targets grade 7, has been developed to reinforce the lessons of the elementary level curriculum. To accommodate an already crowded classroom schedule, these sessions are usually taught during the health education block of instruction. In Los Angeles, DARE officers also visit grades 8 and 9. They use timely events—such as the death of Len Bias—to discuss drugs and their impact and to review critical-thinking and decision-making skills. The DARE officer assigned to the junior high school works closely with the school counseling staff on a variety of activities. These include not only formal classroom teaching, but also taking part in individual and group discussions with students considered "at risk," supervising sports or drill teams, and organizing contests and special assemblies.

• Modified Curriculum

Communities do not always have the resources to establish DARE in every elementary school. To respond to requests for a DARE education program in private and parochial schools not receiving the full curriculum, Los Angeles has developed an abbreviated program. This program includes a morning assembly for groups of students from grades 5 to 8, with follow-up visits to individual classrooms after lunch (reaching students at all these grade levels may require several days). Parent evenings are offered to these schools as well.

What Are The Costs and Who Will Pay?

Personnel

- *One full-time law enforcement officer for every ten elementary schools.* The cost of reassigning a law enforcement officer is generally borne by the law enforcement agency. In some communities, the school department pays the officer's salary or shares the cost with the law enforcement agency.
- *Program coordinator.* Unless a program is very large, the coordinator generally holds another position, such as school health education coordinator or police community relations officer.

Other Costs

- **Officer training.** While the Los Angeles Police Department has provided training to the majority of DARE officers, several states have also developed training capacities. This training is generally offered at no charge, but communities sending officers must pay travel, lodging, and meal costs, which may be paid from school or law enforcement budgets. In some communities, service clubs underwrite the cost.
- **DARE curriculum.** The curriculum supplied by the Los Angeles Unified School District is only released to communities with officers who have been trained to teach DARE. The curriculum is supplied either free or at a nominal charge.
- **DARE workbook.** A workbook, approximately 35 pages long, must be printed for each student who participates in the core fifth/sixth-grade curriculum. Depending on the quality of the cover and the number of copies produced, costs range from \$1 to \$6 per student. The cover and printing costs can be paid by the school department, the law enforcement agency, a local service organization, or a bank or other local business.
- **Films.** The film *Drugs and Your Amazing Mind* is used for the lesson introducing students to the impact of harmful substances. The film *Sons and Daughters—Drugs and Booze* is shown at the parent education evening. Total cost for both films is approximately \$900. To reduce cost, films may be shared by communities or borrowed from local film libraries.

These films may be paid for by the law enforcement agency, the school department, or a local private funding source, such as a service organization, bank, or other business.
- **Handouts.** Officers need to photocopy handouts for students, for teacher orientation, and for parent meetings. DARE officers generally use photocopying machines at the school or in their own agency.
- **Classroom supplies.** Classroom presentations are frequently more interesting to students when there are visual displays. Many DARE officers make

posters or transparencies for selected lessons. Supplies may be provided by school departments or donated by local school suppliers.

- **Promotional materials.** The distribution of brochures, T-shirts, buttons, or bumper stickers enhances support for any program. In many communities, service organizations willingly donate these kinds of items.

Money for DARE activities has come from many different sources. Because substance use prevention education for young people is a high priority in many communities, local revenues are often allocated to cover personnel and supplies. In some local jurisdictions funds from the sale of confiscated drug property have been appropriated.

Information about other possible funding sources is widely available. Notices regarding the availability of federal funding appear in the *Federal Register* and *Commerce Business Daily*, which can be obtained at regional federal offices and some libraries. To subscribe, contact the Superintendent of Documents, Government Printing Office, Washington, D.C. 20402-9731, telephone (202) 783-3238.

State funding may be available through State Departments of Health and Human Services, Public Safety, or Education, or Justice Assistance Act block programs. Many states publish funding notices similar to those available at the federal level.

Information about private foundations and corporate giving programs is available from the Foundation Center through a national network of library reference collections. To find out about the nearest collection, call (800) 424-9836 toll-free.

DARE AMERICA is a national nonprofit corporation established to create nationwide awareness of the DARE program and its effectiveness. It coordinates a national funding campaign to supply printed educational materials, notebooks, films, and other teaching aids to law enforcement agencies interested in establishing DARE. For more information, contact Sergeant Jerry Scott, (213) 485-3277.

Appendix C

DARE Lessons

The DARE curriculum is organized into seventeen classroom sessions conducted by the police officer, coupled with suggested activities taught by the regular classroom teacher. A wide range of teaching activities are used—question-and-answer, group discussion, role-play, and workbook exercises, all designed to encourage student participation and response.

The following brief summaries of each lesson capture the scope of the DARE curriculum and show the care taken in its preparation. All of these lessons were pilot tested and revised before widespread use began.

1. **Practices for Personal Safety.** The DARE officer reviews common safety practices to protect students from harm at home, on the way to and from school, and in the neighborhood.
2. **Drug Use and Misuse.** Students learn the harmful effects of drugs if they are misused as depicted in the film, *Drugs and Your Amazing Mind*.
3. **Consequences.** The focus is on the consequences of using and not using alcohol and marijuana. If students are aware of those consequences, they can make better informed decisions regarding their own behavior.
4. **Resisting Pressures to Use Drugs.** The DARE officer explains different types of pressure—ranging from friendly persuasion and teasing to threats—that friends and others can exert on students to try tobacco, alcohol, or drugs.
5. **Resistance Techniques: Ways to Say No.** Students rehearse the many ways of refusing offers to try tobacco, alcohol, or drugs—simply saying no and repeating it as often as necessary; changing the subject; walking away or ignoring the person. They learn that they can avoid situations in which they might be subjected to such pressures and can “hang around” with non-users.
6. **Building Self-Esteem.** Poor self-esteem is one of the factors associated with drug misuse. How students feel about themselves results from positive and negative feelings and experiences. In this session students learn about their own positive qualities and how to compliment other students.
7. **Assertiveness: A Response Style.** Students have certain rights—to be themselves, to say what they think, to say no to offers of drugs. The session teaches them to assert those rights confidently and without interfering with others' rights.
8. **Managing Stress Without Taking Drugs.** Students learn to recognize sources of stress in their lives and techniques for avoiding or relieving stress, including exercise, deep breathing, and talking to others. They learn that using drugs or alcohol to relieve stress causes new problems.
9. **Media Influences on Drug Use.** The DARE officer reviews strategies used in the media to encourage tobacco and alcohol use, including testimonials from celebrities and social pressure.
10. **Decision-Making and Risk-Taking.** Students learn the difference between bad risks and responsible risks, how to recognize the choices they have, and how to make a decision that promotes their self-interests.
11. **Alternatives to Drug Abuse.** Students learn that to have fun, to be accepted by peers, or to deal with feelings of anger or hurt, there are a number of alternatives to using drugs and alcohol.
12. **Role Modeling.** A high school student selected by the DARE officer visits the class, providing students with a positive role model. Students learn that drug users are in the minority.
13. **Forming a Support System.** Students learn that they need to develop positive relationships with many different people to form a support system.
14. **Ways to Deal with Pressures from Gangs.** Students discuss the kinds of pressures they may encounter from gang members and evaluate the consequences of the choices available to them.
15. **Project DARE Summary.** Students summarize and assess what they have learned.
16. **Taking a Stand.** Students compose and read aloud essays on how they can respond when they are pressured to use drugs and alcohol. The essay represents each student's “DARE pledge.”
17. **Culmination.** In a schoolwide assembly planned in concert with school administrators, all students who have participated in Project DARE receive certificates of achievement.

Sheet1

Drug-Free Schools and Communities Act - Governor's Part				
FY95 - Allocations for Set-asides				
\$11,044	State Administration			
\$176,709	Discretionary Programs			
\$187,754	High Risk Youth Programs			
\$44,178	DARE Programs			
\$22,087	Replication of Successful Drug Education Programs			
\$441,772	TOTAL			

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QUARTERLY ALCOHOL CONSUMPTION

**APPARENT PER CAPITA ALCOHOL
CONSUMPTION: NATIONAL, STATE, AND
REGIONAL TRENDS, 1977-1990**

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Margaret S. Sisson, Ph.D.
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December 1992

U.S. Department of Health and Human Services
Public Health Service
National Institutes of Health

Cygnus Corporation operates the Alcohol Epidemiologic Data System (AEDS) under Contract No. ADM 28192-6001 for the Division of Biometry and Epidemiology, National Institute on Alcohol Abuse and Alcoholism. CSF Incorporated is an AEDS subcontractor.

Table 2

Apparent Alcohol Consumption for States, Census Regions, and the United States, 1990
 [Volume and ethanol in thousands of gallons, per capita consumption in gallons, based on population age 14 and older.]

State or Other Geographic Area	Beer			Wine			Spirits			All Beverages		
	Volume	Ethanol	Per Capita	Volume	Ethanol	Per Capita	Volume	Ethanol	Per Capita	Ethanol	Per Capita	U.S. Decile
AL	80,899	3,640	1.13	4,566	589	0.18	4,830	2,000	0.62	6,229	1.94	9
AK	14,607	657	1.62	1,466	189	0.46	1,234	511	1.26	1,357	3.33	1
AZ	101,755	4,579	1.59	8,276	1,068	0.37	5,630	2,331	0.81	7,977	2.77	2
AR	46,863	2,109	1.13	1,875	242	0.13	2,774	1,148	0.62	3,499	1.87	2
CA	691,050	31,097	1.32	106,909	13,791	0.59	49,877	20,649	0.88	65,538	2.79	2
CO	77,974	3,509	1.35	5,910	762	0.29	4,738	1,961	0.75	6,233	2.40	6
CT	65,000	2,925	1.09	9,488	1,224	0.46	6,026	2,495	0.93	6,644	2.47	5
DE	17,215	775	1.45	1,552	200	0.37	1,483	614	1.15	1,589	2.98	2
DC	16,225	730	1.42	3,050	393	0.77	2,456	1,017	1.98	2,141	4.17	1
FL	365,079	16,429	1.54	32,045	4,134	0.39	26,849	11,116	1.04	31,678	2.97	2
GA	139,039	6,257	1.22	9,201	1,187	0.23	10,805	4,473	0.87	11,917	2.33	6
HI	32,470	1,461	1.65	2,753	355	0.40	1,716	710	0.80	2,527	2.86	2
ID	23,048	1,037	1.36	1,939	250	0.33	1,085	449	0.59	1,736	2.28	7
IL	290,352	13,066	1.44	25,731	3,319	0.37	18,291	7,572	0.83	23,958	2.64	3
IN	124,264	5,592	1.27	6,829	881	0.20	6,842	2,833	0.64	9,305	2.11	8
IA	66,011	2,971	1.35	3,162	408	0.18	2,893	1,198	0.54	4,576	2.07	9
KS	48,827	2,197	1.13	1,985	256	0.13	2,511	1,040	0.53	3,493	1.80	10
KY	73,696	3,316	1.13	2,570	332	0.11	4,313	1,785	0.61	5,433	1.85	9
LA	111,375	5,012	1.55	5,897	761	0.23	6,188	2,562	0.79	8,334	2.57	4
ME	26,577	1,196	1.22	2,374	306	0.31	1,974	817	0.83	2,319	2.36	6
MD	104,108	4,685	1.22	9,941	1,282	0.33	8,968	3,713	0.97	9,680	2.52	5
MA	133,706	6,017	1.22	17,298	2,231	0.45	11,623	4,812	0.97	13,060	2.64	3
MI	218,289	9,823	1.34	16,126	2,080	0.28	14,411	5,966	0.81	17,869	2.43	6
MN	101,354	4,561	1.33	7,202	929	0.27	8,032	3,325	0.97	8,815	2.57	4
MS	59,871	2,694	1.35	1,420	183	0.09	3,183	1,358	0.66	4,195	2.11	8
MO	124,578	5,606	1.38	7,080	913	0.22	6,959	2,881	0.71	9,400	2.31	7
MT	22,230	1,000	1.61	1,415	183	0.29	1,173	486	0.78	1,669	2.68	3
NE	38,905	1,751	1.42	1,888	244	0.20	1,937	802	0.65	2,796	2.26	7
NV	46,587	2,096	2.18	5,179	668	0.70	4,499	1,862	1.94	4,627	4.82	1
NH	36,470	1,641	1.85	3,356	433	0.49	4,265	1,766	1.99	3,840	4.33	1

Table 2 (continued)

Apparent Alcohol Consumption for States, Census Regions, and the United States, 1990
 [Volume and ethanol in thousands of gallons, per capita consumption in gallons, based on population age 14 and older.]

State or Other Geographic Area	Beer			Wine			Spirits			All Beverages		
	Volume	Ethanol	Per Capita	Volume	Ethanol	Per Capita	Volume	Ethanol	Per Capita	Ethanol	Per Capita	U.S. Decile
NJ	162,454	7,310	1.16	23,712	3,059	0.49	14,582	6,037	0.96	16,406	2.60	4
NM	43,377	1,952	1.69	2,506	323	0.28	1,925	797	0.69	3,072	2.65	3
NY	367,567	16,541	1.13	46,719	6,027	0.41	27,166	11,247	0.77	33,814	2.31	7
NC	138,677	6,240	1.16	11,407	1,472	0.27	8,537	3,531	0.66	11,246	2.09	8
ND	16,355	736	1.47	658	85	0.17	1,133	469	0.94	1,290	2.59	4
OH	258,980	11,654	1.35	14,476	1,867	0.22	11,130	4,608	0.53	18,129	2.10	8
OK	61,817	2,782	1.12	2,603	336	0.14	3,356	1,389	0.56	4,507	1.81	10
OR	66,615	2,998	1.32	8,200	1,058	0.47	4,010	1,660	0.73	5,716	2.52	5
PA	306,239	13,781	1.42	13,531	1,746	0.18	13,006	5,385	0.56	20,911	2.16	8
RI	24,113	1,085	1.32	2,802	362	0.44	1,579	654	0.79	2,100	2.55	4
SC	89,170	4,013	1.45	5,493	709	0.26	6,197	2,565	0.93	7,287	2.64	3
SD	16,275	732	1.37	739	95	0.18	1,046	433	0.81	1,261	2.35	6
TN	106,589	4,796	1.22	4,418	570	0.15	5,796	2,400	0.61	7,766	1.98	9
TX	479,825	21,592	1.64	26,380	3,403	0.26	18,425	7,628	0.58	32,623	2.48	5
UT	21,859	984	0.81	1,170	151	0.12	1,388	575	0.47	1,709	1.40	10
VT	14,686	661	1.47	1,687	218	0.48	936	388	0.86	1,266	2.82	2
VA	139,422	6,274	1.26	11,716	1,511	0.30	7,613	3,152	0.63	10,937	2.19	7
WA	109,067	4,908	1.28	13,734	1,772	0.46	7,114	2,945	0.77	9,625	2.50	5
WV	38,857	1,749	1.20	1,185	153	0.10	1,483	614	0.42	2,515	1.73	10
WI	149,312	6,719	1.74	9,150	1,180	0.31	9,715	4,022	1.04	11,922	3.08	1
WY	11,364	511	1.48	598	77	0.22	781	323	0.93	912	2.64	3
Regions												
Northeast	1,136,810	51,156	1.24	120,968	15,605	0.38	81,158	33,599	0.81	100,361	2.43	•
Midwest	1,453,502	65,408	1.38	95,027	12,259	0.26	84,901	35,149	0.74	112,815	2.39	•
South	2,068,727	93,093	1.37	135,318	17,456	0.26	123,255	51,028	0.75	161,576	2.37	•
West	1,262,004	56,790	1.37	160,054	20,647	0.50	85,170	35,260	0.85	112,698	2.72	•
U.S. Total	5,921,042	266,447	1.34	511,368	65,966	0.33	374,484	155,036	0.78	487,450	2.46	•

• Decile values apply only to state-level data. Numbers may not add due to rounding.

Table 3

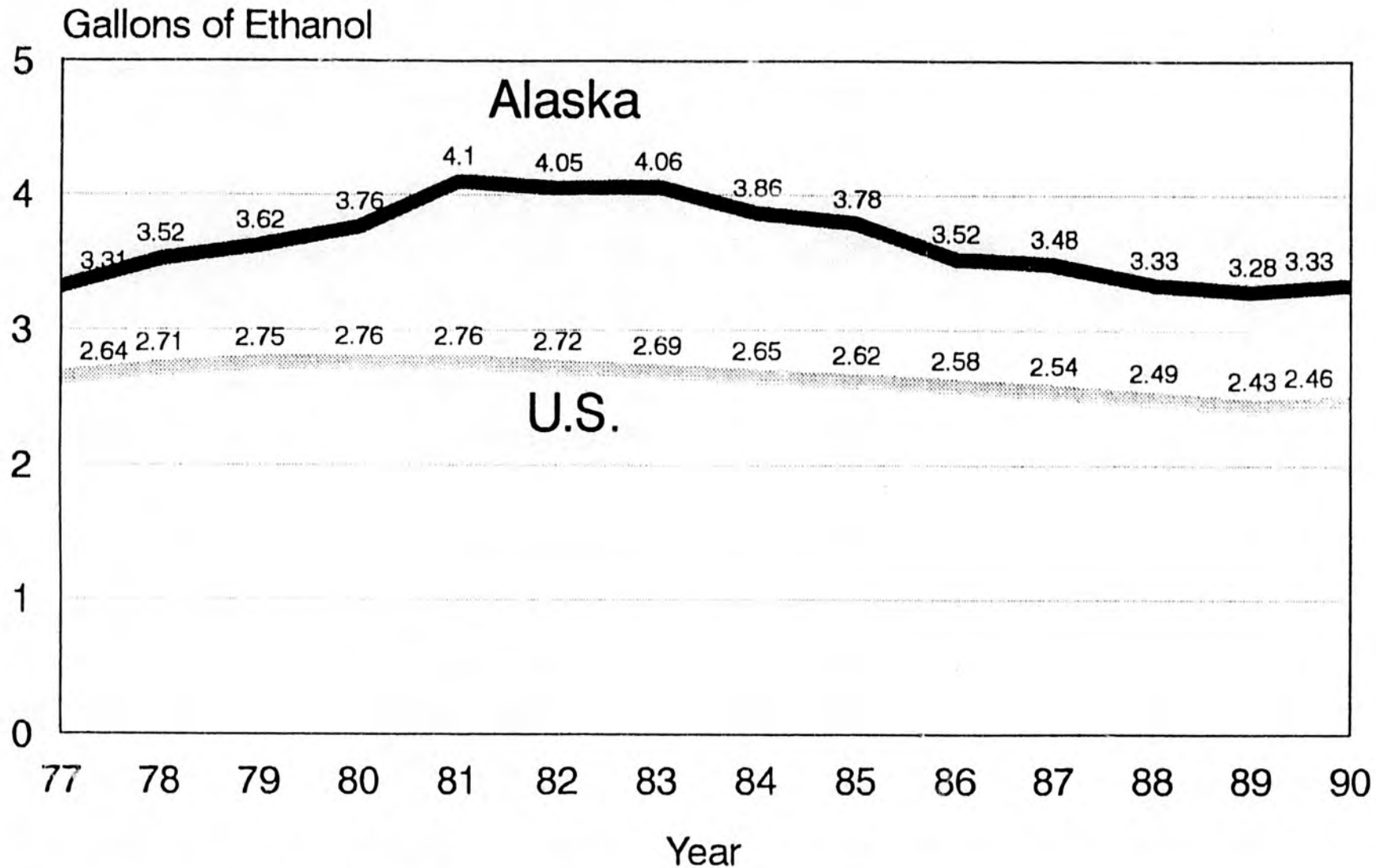
Per Capita Ethanol Consumption for States, Census Regions, and the United States, 1977-1990
 [Gallons of ethanol, based on population age 14 and older.]

State or Other Geographic Area	Per Capita Consumption				U.S. Decile for All Beverages
	Beer	Wine	Spirits	All Beverages	
Alabama					
1990	1.13	0.18	0.62	1.94	9
1989	1.10	0.18	0.60	1.87	9
1988	1.10	0.18	0.61	1.90	9
1987	1.10	0.18	0.61	1.89	9
1986	1.09	0.18	0.64	1.91	9
1985	1.06	0.17	0.67	1.90	9
1984	1.02	0.19	0.69	1.90	10
1983	1.01	0.17	0.71	1.89	10
1982	1.00	0.18	0.72	1.89	10
1981	1.00	0.19	0.73	1.92	10
1980	0.96	0.16	0.74	1.86	10
1979	0.98	0.12	0.84	1.94	10
1978	0.98	0.12	0.88	1.97	9
1977	0.99	0.13	0.84	1.96	9
Alaska					
1990	1.62	0.46	1.26	3.33	1
1989	1.57	0.46	1.24	3.28	1
1988	1.60	0.49	1.24	3.33	1
1987	1.64	0.54	1.30	3.48	1
1986	1.68	0.56	1.28	3.52	1
1985	1.68	0.58	1.53	3.78	1
1984	1.73	0.58	1.56	3.86	1
1983	1.76	0.61	1.70	4.06	1
1982	1.75	0.56	1.74	4.05	1
1981	1.71	0.57	1.82	4.10	1
1980	1.55	0.50	1.70	3.76	1
1979	1.50	0.47	1.65	3.62	1
1978	1.39	0.45	1.68	3.52	2
1977	1.19	0.42	1.70	3.31	2
Arizona					
1990	1.59	0.37	0.81	2.77	2
1989	1.68	0.36	0.86	2.89	2
1988	1.64	0.42	0.89	2.95	2
1987	1.67	0.46	0.86	2.99	2
1986	1.77	0.46	0.92	3.15	2
1985	1.67	0.46	1.00	3.12	2
1984	1.57	0.45	1.06	3.08	3
1983	1.62	0.44	1.00	3.06	3
1982	1.74	0.40	0.99	3.13	3
1981	1.78	0.42	1.01	3.22	3
1980	1.69	0.36	0.98	3.03	4
1979	1.86	0.39	1.17	3.42	2
1978	1.77	0.37	1.10	3.25	2
1977	1.70	0.34	1.05	3.10	3
Arkansas					
1990	1.13	0.13	0.62	1.87	9
1989	1.08	0.13	0.58	1.78	9
1988	1.07	0.14	0.54	1.75	10
1987	1.08	0.11	0.53	1.72	10
1986	1.06	0.09	0.48	1.64	10
1985	1.03	0.13	0.58	1.75	10
1984	1.02	0.12	0.64	1.78	10
1983	1.03	0.13	0.63	1.78	10
1982	1.03	0.12	0.63	1.78	10
1981	1.06	0.12	0.68	1.87	10
1980	1.00	0.12	0.69	1.81	10
1979	0.93	0.10	0.57	1.60	10
1978	0.97	0.11	0.73	1.82	10
1977	0.92	0.10	0.63	1.65	10

Decile values apply only to state-level data. Numbers may not sum due to rounding.

Apparent Per Capita Alcohol Consumption

Gallons of Ethanol Consumed Per Person 14 Years of Age and Older



Source: National Institute on Alcohol Abuse and Alcoholism, Surveillance Report # 23, December 1992

In our judgment, only the third category provides a realistic picture of alcohol consumption in the world of the 90s.

The current phenomenon of moderation in American drinking patterns is often represented as a phenomenon of drinkers consuming less alcohol. That is only a part of the explanation of what has been going on in recent years.

Drinkers have generally been consuming less, but also there are more people who do not drink at all. In 1985, the Gallup survey indicated

PREVALENCE OF CURRENT DRINKING

State	Percent Who Drink	State	Percent Who Drink
Utah	30%	Maryland	55%
West Virginia	32%	Georgia	56%
Tennessee	34%	Florida	57%
South Carolina	34%	Arizona	58%
Alabama	36%	Illinois	59%
Kentucky	37%	South Dakota	59%
District of Columbia	39%	Michigan	61%
North Carolina	40%	Alaska	62%*
Oklahoma	42%	Colorado	62%*
Idaho	48%	Nevada	62%*
Missouri	49%	Oregon	62%*
Arkansas	50%*	Wyoming	62%*
Louisiana	50%*	North Dakota	62%
Mississippi	50%*	California	63%
Rhode Island	50%	Montana	63%
Nebraska	51%	Washington	63%
Ohio	51%	Delaware	64%*
Indiana	52%	New Jersey	64%*
New Mexico	52%	Vermont	64%*
Texas	52%	Virginia	64%*
Kansas	54%*	Massachusetts	64%
Pennsylvania	54%*	Minnesota	65%
Iowa	54%	New Hampshire	68%
New York	54%	Connecticut	69%
Hawaii	54%	Wisconsin	71%
Maine	55%		

* Percentages derived from Gallup Survey data.

Other percentages are from Behavioral Risk Factor Survey.

The Bottom Line 12 (Alcohol Research
vol 12 Number 4 Information Service)

UNITED STATES POPULATION 1990

State	Total	Age 14+	Percent Who Drink	Drinkers
United States	246,709,873	196,385,109	57%	111,939,512
Alabama	4,040,587	3,221,847	36%	1,159,864
Alaska	550,043	408,055	62%	252,994
Arizona	3,665,228	2,880,951	58%	1,670,951
Arkansas	2,350,726	1,868,897	50%	934,448
California	29,760,021	23,532,735	63%	14,825,623
Colorado	3,294,394	2,603,661	62%	1,614,269
Connecticut	3,287,116	2,692,699	69%	1,857,962
Delaware	666,168	535,471	64%	342,701
Dist. Columbia	606,900	512,656	39%	199,935
Florida	12,937,926	10,668,411	57%	6,080,994
Georgia	6,478,216	5,119,367	56%	2,866,845
Hawaii	1,108,229	884,088	54%	477,407
Idaho	1,006,749	763,115	48%	366,295
Illinois	11,430,602	9,099,878	59%	5,368,928
Indiana	5,544,159	4,405,995	52%	2,291,117
Iowa	2,776,755	2,207,500	54%	1,192,050
Kansas	2,477,574	1,947,214	54%	1,051,495
Kentucky	3,685,296	2,946,276	37%	1,090,122
Louisiana	4,219,973	3,248,416	50%	1,624,208
Maine	1,227,928	975,799	55%	536,689
Maryland	4,781,468	3,849,946	55%	2,117,470
Massachusetts	6,016,425	4,744,643	64%	3,036,571
Michigan	9,295,297	7,360,620	61%	4,489,978
Minnesota	4,375,099	3,236,858	65%	2,103,957
Mississippi	2,573,216	2,073,379	50%	1,036,689
Missouri	5,117,073	4,075,938	49%	1,997,209
Montana	799,065	623,369	63%	392,722
Nebraska	1,578,385	1,237,138	51%	630,940
Nevada	1,201,833	962,100	62%	596,502
New Hampshire	1,109,252	885,530	68%	602,160
New Jersey	7,730,188	6,316,227	64%	4,042,385
New Mexico	1,515,069	1,159,401	52%	602,888
New York	17,990,455	14,636,757	54%	7,903,848
North Carolina	6,628,637	5,376,981	40%	2,150,792
North Dakota	638,800	499,226	62%	309,520
Ohio	10,847,115	8,643,714	51%	4,408,294
Oklahoma	3,145,585	2,487,315	42%	1,044,672
Oregon	2,842,321	2,267,718	62%	1,405,985
Pennsylvania	11,881,643	9,685,855	54%	5,230,361
Rhode Island	1,003,464	824,553	50%	412,276
South Carolina	3,486,703	2,768,358	34%	941,241
South Dakota	696,004	537,646	59%	317,211
Tennessee	4,877,185	3,731,712	34%	1,268,782
Texas	16,986,510	13,153,449	52%	6,839,793
Utah	1,722,250	1,218,597	30%	365,576
Vermont	562,758	448,879	64%	287,282
Virginia	6,187,358	4,996,795	64%	3,197,948
Washington	4,866,692	3,853,059	63%	2,427,427
West Virginia	1,793,477	1,458,345	32%	466,670
Wisconsin	4,891,769	3,667,532	71%	2,603,947
Wyoming	453,588	346,491	62%	214,824

1990 DISTILLED SPIRITS APPARENT CONSUMPTION

State	Gallons	Per Person Total Population	Per Person All Age 14+	Per Person Drinkers Age 14+
Alabama	4,830,000	1.20	1.50	4.16
Alaska	1,234,000	2.24	3.02	5.31
Arizona	5,860,000	1.60	2.03	3.51
Arkansas	2,774,000	1.18	1.48	2.97
California	49,880,000	1.68	2.12	3.36
Colorado	4,738,000	1.44	1.82	2.04
Connecticut	6,318,000	1.92	2.35	3.40
Delaware	1,505,000	2.26	2.81	4.39
Dist. Columbia	2,456,000	4.05	4.79	12.28
Florida	26,849,000	2.08	2.52	4.42
Georgia	11,077,000	1.71	2.16	3.86
Hawaii	1,716,000	1.55	1.94	3.59
Idaho	1,085,000	1.08	1.42	2.96
Illinois	18,876,000	1.65	2.07	3.52
Indiana	6,842,000	1.23	1.55	2.99
Iowa	2,682,000	.97	1.21	2.25
Kansas	2,546,000	1.03	1.31	2.42
Kentucky	4,194,000	1.14	1.42	3.85
Louisiana	6,188,000	1.47	1.90	3.81
Maine	1,999,000	1.63	2.05	3.72
Maryland	8,968,000	1.88	2.33	4.24
Massachusetts	11,623,000	1.93	2.45	3.83
Michigan	14,411,000	1.55	1.96	3.21
Minnesota	8,032,000	1.84	2.48	3.82
Mississippi	3,183,000	1.24	1.54	3.07
Missouri	6,219,000	1.22	1.53	3.11
Montana	1,173,000	1.47	1.88	2.99
Nebraska	1,937,000	1.23	1.57	3.07
Nevada	4,530,000	3.77	4.71	7.59
New Hampshire	4,265,000	3.85	4.82	7.08
New Jersey	14,582,000	1.89	2.31	3.61
New Mexico	1,917,000	1.27	1.65	3.18
New York	27,134,000	1.51	1.85	3.43
North Carolina	8,537,000	1.29	1.59	3.97
North Dakota	1,089,000	1.71	2.18	3.52
Ohio	11,130,000	1.03	1.29	2.52
Oklahoma	3,356,000	1.07	1.35	3.21
Oregon	4,010,000	1.41	1.77	2.85
Pennsylvania	13,055,000	1.10	1.35	2.50
Rhode Island	1,649,000	1.64	2.00	4.00
South Carolina	6,177,000	1.77	2.23	6.56
South Dakota	1,048,000	1.51	1.95	3.30
Tennessee	5,796,000	1.19	1.55	4.57
Texas	18,675,000	1.10	1.42	2.73
Utah	1,388,000	.81	1.14	3.80
Vermont	936,000	1.66	2.09	3.26
Virginia	7,612,000	1.23	1.52	2.38
Washington	7,114,000	1.46	1.85	2.93
West Virginia	1,483,000	.83	1.02	3.18
Wisconsin	8,949,000	1.83	2.44	3.44
Wyoming	728,000	1.72	2.10	3.39
United States	374,409,000	1.51	1.91	3.34

1990 BEER APPARENT CONSUMPTION

State	Gallons	Per Person Total Population	Per Person All Age 14+	Per Person Drinkers Age 14+
Alabama	81,022,000	20.10	25.15	69.85
Alaska	14,607,000	26.60	35.80	57.74
Arizona	104,899,000	28.60	36.41	62.78
Arkansas	46,863,000	19.90	25.08	50.15
California	709,701,000	23.80	30.16	47.87
Colorado	79,728,000	24.20	30.62	49.39
Connecticut	65,238,000	19.80	24.23	35.11
Delaware	17,215,000	25.80	32.15	50.23
Dist. Columbia	16,225,000	26.70	31.65	81.15
Florida	381,507,000	29.50	35.76	62.74
Georgia	144,718,000	22.30	28.27	50.48
Hawaii	32,470,000	29.30	36.73	48.28
Idaho	23,048,000	22.90	30.20	62.92
Illinois	294,096,000	25.70	32.32	54.78
Indiana	124,264,000	22.40	28.20	54.24
Iowa	65,535,000	23.60	29.69	54.98
Kansas	48,827,000	19.70	25.08	46.44
Kentucky	74,030,000	20.10	25.13	67.91
Louisiana	111,175,000	26.40	34.29	68.57
Maine	27,123,000	22.10	27.80	50.54
Maryland	104,108,000	21.80	27.04	49.17
Massachusetts	138,445,000	23.00	29.18	45.59
Michigan	218,292,000	23.50	29.66	48.62
Minnesota	101,354,000	23.20	31.32	48.17
Mississippi	59,871,000	23.30	28.88	57.75
Missouri	124,252,000	24.30	30.48	62.21
Montana	22,230,000	27.80	35.66	56.60
Nebraska	39,670,000	25.10	32.07	62.87
Nevada	48,292,000	40.20	50.19	80.96
New Hampshire	36,470,000	32.90	41.18	60.57
New Jersey	162,454,000	21.00	25.72	40.19
New Mexico	41,250,000	27.20	35.58	68.42
New York	367,567,000	20.40	25.11	46.50
North Carolina	138,677,000	20.90	25.79	64.48
North Dakota	17,021,000	26.60	34.09	54.99
Ohio	258,980,000	23.90	29.96	58.75
Oklahoma	61,817,000	19.70	24.85	59.17
Oregon	66,615,000	23.40	29.38	47.38
Pennsylvania	306,239,000	25.80	31.62	58.55
Rhode Island	24,113,000	24.00	29.24	58.49
South Carolina	89,170,000	25.60	32.21	94.74
South Dakota	16,275,000	23.40	30.27	51.31
Tennessee	106,589,000	21.90	28.56	34.01
Texas	483,477,000	29.00	36.76	70.69
Utah	21,859,000	12.70	17.94	59.79
Vermont	14,686,000	26.10	32.72	51.12
Virginia	148,351,000	24.00	29.69	46.39
Washington	100,067,000	22.40	25.97	41.22
West Virginia	38,857,000	21.70	26.64	83.26
Wisconsin	149,312,000	30.50	40.71	57.34
Wyoming	11,364,000	25.10	32.80	52.90
United States	5,989,213,000	24.10	30.50	53.50

1990 WINE APPARENT CONSUMPTION

State	Gallons	Per Person Total Population	Per Person All Age 14+	Per Person Drinkers Age 14+
Alabama	4,566,000	1.13	1.42	3.93
Alaska	1,466,000	2.67	3.59	5.79
Arizona	8,668,000	2.37	3.01	5.19
Arkansas	1,875,000	.80	1.00	2.01
California	105,397,000	3.54	4.49	7.11
Colorado	6,263,000	1.90	2.41	3.88
Connecticut	9,197,000	2.80	3.42	4.95
Delaware	1,552,000	2.33	2.90	4.53
Dist. Columbia	3,050,000	5.02	5.95	15.25
Florida	32,135,000	2.48	3.01	5.29
Georgia	11,618,000	1.79	2.27	4.05
Hawaii	2,753,000	2.48	3.11	5.77
Idaho	1,939,000	1.93	2.54	5.29
Illinois	25,954,000	2.27	2.85	4.83
Indiana	6,829,000	1.23	1.55	2.98
Iowa	3,107,000	1.12	1.41	2.61
Kansas	2,003,000	.81	1.03	1.90
Kentucky	2,676,000	.73	.91	2.45
Louisiana	5,897,000	1.40	1.82	3.63
Maine	2,586,000	2.11	2.65	4.82
Maryland	10,079,000	2.11	2.62	4.76
Massachusetts	17,298,000	2.88	3.65	5.70
Michigan	16,128,000	1.74	2.19	3.59
Minnesota	7,202,000	1.65	2.22	3.42
Mississippi	1,420,000	.55	.68	1.37
Missouri	7,080,000	1.38	1.74	3.54
Montana	1,415,000	1.77	2.27	3.60
Nebraska	1,927,000	1.22	1.56	3.05
Nevada	5,179,000	4.31	5.38	8.68
New Hampshire	3,356,000	3.03	3.79	5.57
New Jersey	23,712,000	3.07	3.75	5.87
New Mexico	2,506,000	1.65	2.16	4.16
New York	46,719,000	2.60	3.19	5.91
North Carolina	11,407,000	1.72	2.12	5.30
North Dakota	658,000	1.03	1.32	2.13
Ohio	14,476,000	1.33	1.67	3.28
Oklahoma	2,603,000	.83	1.05	2.49
Oregon	8,200,000	2.89	3.62	5.83
Pennsylvania	14,085,000	1.19	1.45	2.69
Rhode Island	2,802,000	2.79	3.40	6.80
South Carolina	5,493,000	1.58	1.98	5.84
South Dakota	739,000	1.06	1.37	2.33
Tennessee	4,418,000	.91	1.18	3.48
Texas	27,045,000	1.59	2.06	3.95
Utah	1,170,000	.68	.96	3.20
Vermont	1,687,000	3.00	3.76	5.87
Virginia	11,716,000	1.89	2.34	3.66
Washington	15,124,000	3.11	3.93	6.23
West Virginia	1,185,000	.66	.81	2.54
Wisconsin	9,148,000	1.87	2.49	3.51
Wyoming	598,000	1.32	1.73	2.78
United States	516,115,000	2.08	2.63	4.61

DEPARTMENT OF PUBLIC SAFETY

OFFICE OF THE COMMISSIONER

Richard L. Burton

Commissioner

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March 7, 1994

Representative Brian Porter
Chairman
House Task Force on Alcohol and Alcohol Abuse
Room 118
State Capitol
Juneau, Alaska 99801-1182

Dear Representative Porter:

In 1992, 89 traffic crashes on Alaska roadways resulted in the deaths of 108 people. Included in this total are 13 pedestrians, 7 motorcyclists, 8 ATV/snowmachine riders and 80 vehicle drivers.

The major contributors to fatal traffic crashes were alcohol, speeding, and driver inattention, in that order. Sixty-three of these people died in 51 alcohol or drug-related crashes. The number of pedestrian fatalities was 13, with the rate of alcohol involvement being 84.6 percent compared to 52.6 percent in all other types of fatalities. A far higher average of alcohol involvement then found in the rest of the Nation.

In reviewing the recently released House Task Force Report on Alcohol and Alcohol Abuse, we at the Highway Safety Planning Agency would like to thank the Task Force for their many hours of work in compiling the information to make that report possible. It is our consensus that this report clearly identified the magnitude of the alcohol problem in Alaska and also went on to identify how State dollars can best be expended to meet the challenge of reducing injury and fatalities of our States most valuable resource, it's people.

On behalf of Commissioner Burton and the Department of Public Safety, we applaud the Task Force on their work and look forward to working with them in a concerted effort to make their recommendations a reality.

Again, "Thank You" to you and all the members for a job well done.

Sincerely,



Lorn M. Campbell

Administrator

Highway Safety Planning Agency

cc: Richard Burton, Commissioner



MILLER BREWING COMPANY

March 9, 1994

The Honorable Brian S. Porter
Chairman, House Alcohol Task Force
Alaska State Legislature
State Capitol
Juneau, AK 99801-1182

Dear Representative Porter:

I have reviewed the draft report from the House Task Force on Alcohol Abuse and want to thank you for the opportunity to make comments.

First, I was very impressed with the thoroughness and balanced approach with which you and the other members and staff addressed this serious issue. I believe you have presented a thoughtful analysis as well as several productive solutions to alcohol abuse in Alaska.

Miller has been in the forefront of promoting the responsible use of its products. We provide strong support for programs such as safe driving, safe boating, responsible event planning, designated drivers, safe ride home cab rides, and have recently added a safe snowmobiling project to our other efforts. We believe education and effective treatment is the best way to bring about real change.

I was disappointed, however, to read your recommendation that the legislature reduce the presumption of intoxication from .10 to .08 BAC. Your report quotes the California experience with its .08 law in reducing traffic fatalities. This conclusion was refuted by testimony at a recent Washington House Judiciary Committee hearing on a .08 bill. After checking with their California counterparts, Washington state troopers testified very convincingly that the .08 law was not responsible for the reduction in California. In addition, a number of Washington judges opposed .08 because they would not be able to

handle the increased workload. The staff of the Washington State House Judiciary Committee can supply the exact testimony (SB 6047, heard on 2/22/94).

As you can see from the attached chart, the relative risk of a fatal crash as a function of BAC risks steeply after .10. Drivers who pose the real danger to themselves and others are those with high BAC's. Reducing the BAC to .08 will not stop heavy drinkers and repeat offenders -- they must be taken off the roads by laws which require increased penalties for each additional offense.

I am also attaching an editorial from the Richmond Times-Dispatch which expresses their view on enacting a .08.

The Task Force report also recommends passage of legislation establishing zero tolerance for minors. Miller strongly agrees that underage drinking has no place in our society. We run ads saying "if you're not 21, it's not Miller time." Nonetheless, .00 BAC may not be biologically possible. Through the natural process of digesting food, everyone has a trace of alcohol in their bloodstream. Further, products such as bread, orange juice, apple juice, etc. also contain traces of alcohol caused by natural fermentation. I recommend that you consider a .01 or .02 for minors.

Again, I commend you on your thorough report.

Sincerely,

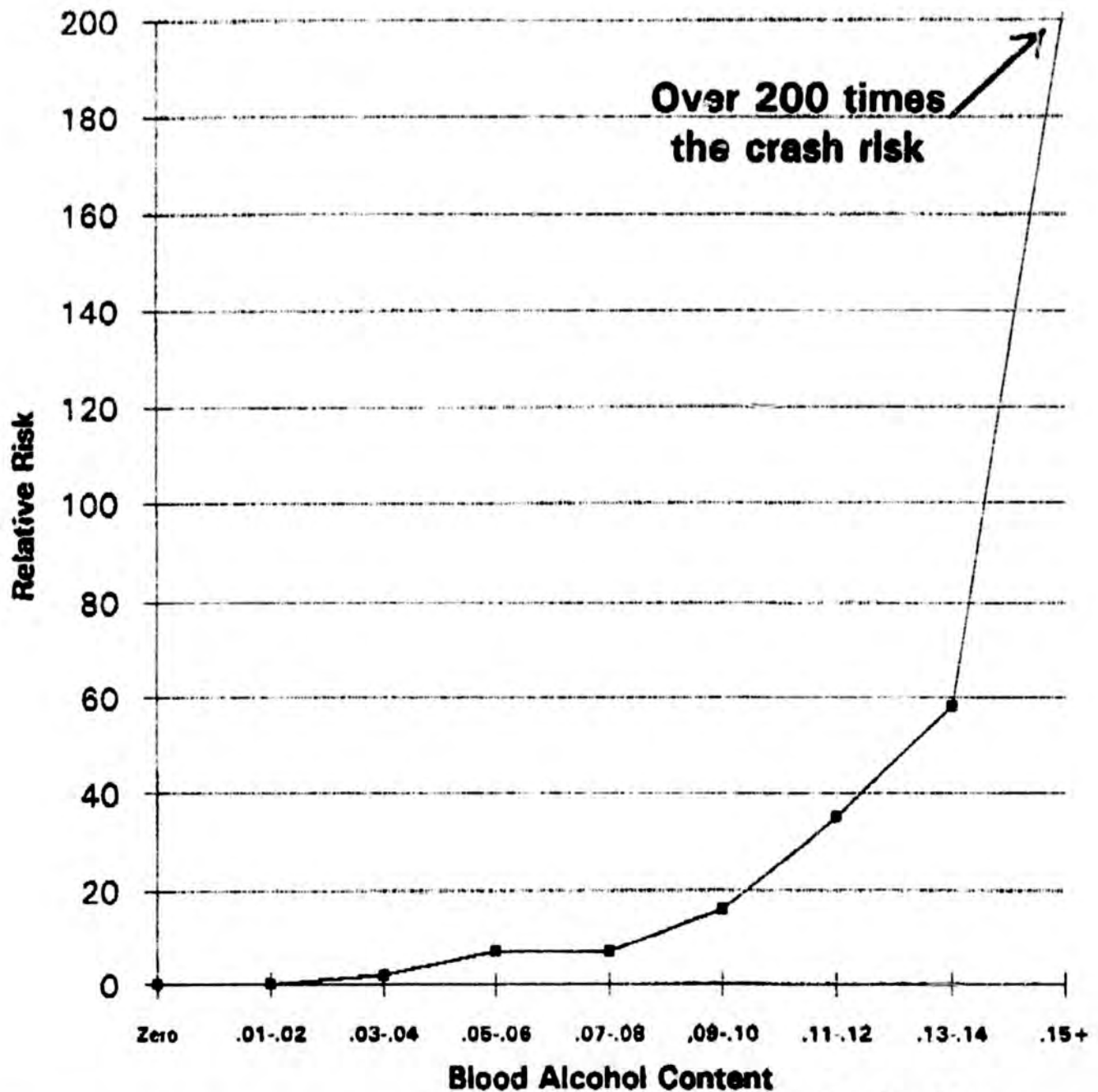


Sunny Jones
Western Government Affairs Manager

Encl.

CC: Speaker Ramona Barnes (w/encl)
Representative Eldon Mulder (w/encl)
Representative Jim Nordlund (w/encl)
Representative Richard Foster (w/encl)
Representative Joe Sitton (w/encl)
Eric Musser (w/encl)

Relative Risk of Fatal Crash As a Function of BAC



Source: "The Hard Core Drinking Driver"
Traffic Injury Research Foundation

Reprinted by:
Washington Traffic
Safety Commission

EDI**AS TUESDAY, FEBRUARY 15, 1994 . . .****Richmond Times-Dispatch**

VIRGINIA'S NEWS LEADER

Legislative Terrorism

So far the General Assembly's most conspicuous contribution to law and order has been the advancement of legislation designed to terrorize decent citizens who enjoy a couple of cocktails with dinner. It has shown no willingness even to debate a bill that would ban the sale or possession of certain assault weapons that have transformed some urban neighborhoods into war zones, but it is ripping reason and the Constitution to shreds in its eagerness to prove that it is ardently opposed to drunken driving.

The House of Delegates has approved, and the Senate is considering, a measure that would declare any motorist with a blood alcohol reading of 0.08 to be guilty of drunken driving. Under the House bill, that motorist's driver's license would be suspended immediately, without a court hearing, for seven days. Current law considers a reading of 0.10 proof of intoxication but does not allow administrative revocation of driver's licenses.

Sponsors of these draconian changes in the state's drunken driving laws — among them Democratic Delegate Richard Cranwell of Roanoke County and Republican Senator Thomas Norment of Williamsburg — profess to be motivated by a desire to make Virginia's streets and highways safer. Yet expert after expert has testified that lowering the blood alcohol reading will do nothing to deter the heavy drinkers who constitute the real menace. This is essentially "feel-good" legislation that allows the General Assembly to convey the impression that it is addressing a problem when it is not.

One member who can speak with special knowledge on this subject is Democratic Senator Richard Saslaw of Fairfax County, a legislative expert in the field. For years, he advocated a lower blood alcohol level. But drunken driving data persuaded him to change his mind. Statistics show, he says, that most people arrested for drunken driving have a blood alcohol reading of 0.15 or higher. People who are willing to violate the existing standard of 0.10 certainly will not hesitate to violate a lower standard.

The most likely effect of lowering the level, Saslaw correctly warns, would be to victimize many decent citizens who drink in moderation and pose no significant threat to their fellow travelers. In the process of arresting them, giving them a police record, and depriving them of the right to drive for at least a week, the state would not have made highway users one whit more secure against the real killers.

Lowering the reading would be unnecessarily extreme, but authorizing administrative revocation of licenses would be constitutionally abominable. A thug caught with a concealed weapon in his possession at the scene of a murder would be accorded more rights and respect than a motorist caught with 0.08 of alcohol in his blood. The thug would be considered innocent until he had been found guilty in and

would be considered guilty even before he had seen the inside of a courtroom.

Yes, this procedure exists in several other states. Yes, as Democratic Delegate Roscoe Reynolds of Martinsville has fatuously observed, "Administrative license revocation saves lives." But as the birthplace of the Bill of Rights, Virginia might have too much respect for the rights of individuals to opt for this shortcut to justice. And if the object of legislating is simply to save lives, then forget about all those constitutional protections for people who are accused of crimes — the ban against unauthorized searches and seizures, trial by jury, prohibitions against self-incrimination, provisions for reasonable bail, and so forth — and simply do whatever is necessary to maintain law and order. Expedience, not constitutionality, should be the General Assembly's watchword.

Obviously legislators should combat drunken driving. But they should do it by being more vigilant against, and less tolerant of, those who pose the real threats. They do not solve the problem by creating more drunken drivers through redefinition.



*Alaska Cabaret, Hotel,
Restaurant & Retailers Association*

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March 10, 1994

House Task Force on Alcohol and Alcohol Abuse
Representative Brian Porter, Chairman
Representative Eldon Mulder, Member
Representative Jim Nordlund, Member
Representative Richard Foster, Member
Representative Joe Sitton, Member

REG

3 11 94

Rep. Brian

To the Honorable Members of the Task Force:

CHARR appreciates the opportunity to offer public comment on the draft version of the Task Force Report on behalf of our members, the licensed beverage industry of Alaska. While there is much to be praised in the report, our organization remains deeply opposed to any legislation lowering the BAC level to 0.08% for presumption of intoxication. The justification cited in the report for this recommendation relies on a NHTSA report issued after the state of California passed such legislation.

The NHTSA report cited is fatally flawed by scientific standards, as shown in the accompanying study by David W. Moore, Professor of Political Science and Director of The Survey Center at the University of New Hampshire. Has the Emperor No Clothes?: The NHTSA Report on Lowering the BAC limit in California contains a thorough discussion of the statistical flaws of the cited NHTSA Report and concludes with the following sentence: "There is nothing, therefore, that suggests that California's new anti-DUI legislation had any special impact on California drivers beyond the general nationwide pattern of somewhat increased concern by the drivers about drunk driving."

Common sense should tell us that the NHTSA report is flawed from the point of view that it fails to take into account other legislation adopted in the same time period dealing with seat belts and air bags that may also factor in the equation. Causality cannot be proven by statistical methods.

The majority of adults who choose to drink alcohol do so in a responsible manner, a fact acknowledged in this report. CHARR's position remains unchanged that it makes little sense to adopt legislation that will impact the responsible consumer to a far greater degree than it will an alcohol abuser. 1990 NHTSA statistics show that of drivers arrested for drunken driving, 49% had a BAC of 0.20%, 30% had a BAC of between 0.15 and 0.19%, and 21% had a BAC between 0.10% and 0.14%. Since any BAC standard is arbitrary by definition, what BAC standard will most effectively reduce the rate of alcohol-related fatalities on our roadways? CHARR contends that with scarce resources (which the Task Force report amply demonstrates we have) it is essential to

direct efforts where results will be realized - namely, enforcement aimed at the problem drinker. While proponents of the 0.08% BAC level cite the impairment level of some people at that level as being 3 to 4 times more likely to be involved in a crash, at BAC levels of 0.15% and higher, the risk of a crash is 300 to 600 times higher than at zero BAC.

Some time ago, CHARR adopted a position opposing 0.08% BAC and calling for the following measures:

1. attention to the underage drinking problem through legislation
2. enhanced enforcement of existing traffic laws by appropriate funding levels for law enforcement agencies
3. increased penalties for repeat DWI offenders

Our position remains unchanged, and we are gratified to see that some of the measures we call for are incorporated in the Task Force report. In particular, measures aimed at curbing underage drinking have taken a great deal of time and effort by members of our organization in recent years and we are pleased that the Task Force recognizes the seriousness of the problem.

The recognition by the Task Force of the importance of a strong and effective ABC Board is another area of great agreement. CHARR has actively sought additional funding for this vital agency in the last few budget cycles and welcomes the Task Force report as additional support. The Legislative audits conducted on this agency as part of the "sunset review" process have always called for additional resources and it is clear that this agency generates program receipts to cover the necessary funding level.

CHARR represents the responsible members of the licensed beverage industry in Alaska and applauds the efforts of the Task Force in producing the report. We, too, want to halt alcohol abuse in our state. We appreciate the long hours spent in public hearings and poring over documents. While we are relentless in our opposition to 0.08% BAC legislation, we thank you for your work serving on the Task Force.

**DEPARTMENT OF HEALTH AND
SOCIAL SERVICES**

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JUNEAU, ALASKA 99811-0607
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[illegible]

Representative Brian Porter
March 7, 1994
Page 2

The Task Force report identifies, on Page 12, that \$29,875,100 was appropriated by the Legislature for FY 94 funding for all programs not just this Division. The State budget is \$2.4 billion. Funding to both react to and to reduce the impact of alcohol abuse and alcoholism in Alaska is only 1.2 percent of the total State budget. If alcohol is Alaska's number one health problem then the amount spent to reduce its affect should be comparable.

Treatment

We concur with your recommendation on Page 21 regarding outcome evaluations.

On February 28, 1994 our statewide treatment evaluation project began collecting data from 13 programs statewide. The final report will be issued in two and half years.

Clients will be followed for six and twelve months after treatment to measure the changes since treatment. As you are aware this type of research takes some time to complete.

Attached is the RFP issued by this Division for FY 95-96 grants. For each program description we ask for specific target populations and needs assessment. This will allow programs to better define who they are serving and what conditions they hope to improve.

On pages 44-50 you will see that we again emphasis the needs assessment, OUTCOME goals and objectives and an evaluation plan. This is also reflected in the Review Criteria on pages 72-75.

By the end of March, 1994, we are expecting a final evaluation report from the UAA on the Alcohol Safety Action Program in Anchorage. This report, funded in part by the Department of Public Safety, Highway Safety Planning Agency, studied a sample of ASAP referrals for calendar year 1989 and then checked if they had any repeat criminal offenses in the years 1990-1993.

We are committed to maintaining this emphasis on outcome based funding and evaluation.

I was impressed with your statement on Page 23, number 2. This is the first time I have seen a Legislative group define a set of outcomes for this Division. It is critical that we understand what yard stick the Legislature will use to measure our efforts.

Representative Brian Porter
March 7, 1994
Page 3

I have offered some changes to make this statement clearer and to focus the outcomes to reflect those in the Healthy People 2000 initiative.

"The outcomes and success of prevention and treatment services in Alaska should be measured by the elimination or significant reduction of the universally recognized adverse results of alcohol abuse and alcoholism. At a minimum this would include those objectives found in the Healthy People 2000 initiative of the Federal government as adopted by the Department of Health and Social Services."

I have attached a draft copy (one for each Task Force member) of the Division's strategic plan. In particular see page 29, Issue 2 of the strategic plan. This is a specific strategy to deal with the need for outcome research and funding in order to provide the best possible care for Alaskans.

On pages 23-26 of the plan are listed the Healthy People 2000 objectives related to alcohol and drug abuse. These are a good start and can then be expanded on for Alaska. The plan does this and you will see how as you read page 27-36.

Funding

The Division supports the statement on Page 24 regarding the use of increased license reinstatement fees for programs to accomplish the recommendations of the task force. We see this as a source of funds for CAASA grants as noted below.

Community Action Against Substance Abuse Grants

The Division supports the recommendation contained on Page 17 that the funding for the Community Action Against Substance Abuse Grants (CAASA) "should be substantially increased." The priorities identified for these funds are acceptable and are the current priorities established in the RFP for FY 95-96 grants. I refer you to page 40 of the RFP.

In the second paragraph of Page 17 of the Task Force report, the four programs noted there are funded by CAASA. They are not the full extent of youth alcohol education programs funded by the Division. I would ask that this be noted so as to avoid the assumption that these are the only programs funded.

We have other youth projects funded from our other grant funds in Ketchikan, Sitka, Petersburg, Anchorage, Juneau, Kodiak, Minto, and Fairbanks. These programs are not targeted in the same manner as CAASA. This does not diminish the need for additional funding for CAASA and especially for DARE and alcohol awareness initiatives.

General Policy Recommendations

I would like to suggest some changes in the wording of these Recommendations.

1. "All Alaskans should be encouraged to make positive choices regarding all issues that affect their health. Alcohol prevention and education efforts should stress that individuals must make positive and informed choices about alcohol consumption. Information provided should clearly state the negative impact of alcohol abuse on the health of the individual. The outcome of this education and information would be the reduction in consumption of alcohol by Alaskans."

2. See Above.

3. I have no alternative to the recommendations as presented. I would suggest if the messages regarding alcohol meet the recommendation under number one above, this recommendation could be dropped.

During the March 3, 1994 Task Force meeting, Representative Porter stressed the legal and illegal aspects of alcohol versus other drugs.

For youth under 21 alcohol and drugs are illegal. For youth and adults all illicit (meaning no legal use) drugs are illegal. For youth and adults mis-use or illegal possession of legal prescription drugs is illegal.

For youth and adults Driving While Intoxicated is illegal. For youths and adults operating a watercraft while intoxicated is illegal. For youths and adults using a firearm while intoxicated is illegal.

This Task Force is recommending support of "zero tolerance" legislation so as to "send a clear and convincing message that consumption of alcoholic beverages by minors is unacceptable, especially as it relates to driving."

The mixed message to youth is the same message as to adults. Not all drugs are treated equally under the law and some drugs inequality is directly related to age. Society also has ascribed differing penalties for alcohol and drugs in regards to their possession, use, and abuse.

4. I have no alternative suggestion to this recommendation. There are perhaps better words to be used but I feel the current statement conveys the message in clear and plain English.

Editing comments

All references to the Division should read: Division of Alcoholism and Drug Abuse. This is the correct name by statute.

On page 7 the last comment may not be exactly what the public comments were. There were comments that use of telephones and conference calling is used to provide aftercare to persons in villages with and without AA meetings. I did not hear any testimony supporting the holding of AA meetings this way.

In addition, AA is a completely voluntary self help organization whose only requirement for membership is a desire to quit drinking. AA is not financially supported by any organization and AA tradition states that AA neither endorses or supports any organization or treatment outside AA.

On page 8, the third bullet is not correct. The Board established by AS 44.29.100 already exists. The testimony was related to the changes in that statute by Chapter 66 SLA 1991. Those changes do not take place until the Mental Health Lands Trust is settled.

The Advisory Board has passed a resolution that request the Governor and/or the Legislature to make those section of Chapter 66 effective immediately.. These changes would expand the Board, give the Board planning powers and allow the Board to advice the Legislature, the Governor and state agencies not just the Commissioner of DHSS. A copy of this resolution has already been given to the Task Force.

On page 9, third paragraph, second sentence I would substitute the word existing for the word establishment. An Advisory Board does already exists.

On page 14, Item 3, I would recommend inclusion of the Alaska Court System on the proposed Traffic Safety Commission.

Representative Brian Porter
March 7, 1994
Page 6

Summary

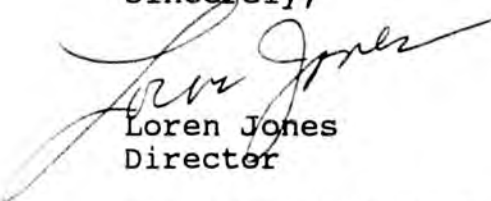
I would like to again thank the Task Force and its Chairman for the manner in which this Task Force completed its duties.

The recommendations contained in this report will be useful, used and followed by Division of Alcoholism and Drug Abuse. The strategic plan, the ASAP evaluation and the Treatment Outcome Study will guide our implementation of the changes required to make a high quality prevention and treatment system even better.

On final plea for support for the Governors budget and HB 413. Without adequate and stable resources, many of these recommendations will be only partially achieved. The Task Force recognizes this as well in several of its recommendations.

The Task Force report identifies, on Page 12, that \$29,875,100 was appropriated by the Legislature for FY 94 funding for all programs not just this Division. The State budget is \$2.4 billion. Funding to react to and to reduce the impact of alcohol abuse and alcoholism in Alaska is only 1.2 percent of the total State budget. If alcohol is Alaska's number one health problem then the amount spent to reduce its affect should be comparable.

Sincerely,



Loren Jones
Director

cc: Margaret R. Lowe, M.Ed., Ed.S.
Commissioner

**STATEWIDE ADYF OFFICE**

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Alaskans For Drug-Free Youth

Statewide Headquarters

2417 Tongass, Suite 114, Ketchikan, Alaska 99901
 March 7, 1994 Phone: 907-247-2273

Representative Brian Porter
 Alaska State Legislature
 State Capitol, Room 118C
 Juneau, AK 99801-1182

Dear Representative Porter:

I am taking this opportunity to give some reaction to your recently released draft of the House Alcohol Task Force Report. I appreciated the chance to give input when you were in the information gathering stage around the state.

There seems to be a broad cross-section of legislative participation in the solutions for the alcohol and other drug problems within our state. You and your committee have compiled a very usable document for legislative support and direction.

There is, however, one area that I believe is a distraction to the document that has been compiled. That appears as #3 on page 23 under General Policy Recommendations. I do not understand the rationale for separating alcohol terminology from that of illicit drug use when delivering prevention messages. This is in total opposition to the mandates coming from the Federal Government. The recommended terminology is "alcohol and other drugs". Funding rests upon this educational language also.

This accepted terminology was a development of years of request by the parents of this nation to educate citizens that alcohol was indeed a drug, even though a legal one for adults. It remains an illegal drug for youth under 21 just as other illegal drug use is for all ages. This terminology has been a very effective prevention tool in educating our youth to understand the health effects of illegal alcohol use by them.

On page 6 acknowledgement has been made of alcohol being a drug in the sentence, "Alcohol has historically been and continues to be the most widely available and most frequently used drug in Alaska." At the bottom of that page terminology is also appropriately used in, "...suffer the effects of alcohol and other drugs...". The proper and accepted prevention terminology has been acknowledged throughout this report. Therefore, the General Policy Recommendation #3 seems very inappropriate in this otherwise strong and credible document.

An Affiliate of the National Federation of Parents for Drug-Free Youth

Not only is "alcohol and other drugs" the accepted language in the prevention/education fields, but it is also indicative of the treatment field where poly-drug use is most often the problem. Poly-drug refers to the combination of two or more drugs being the predominant problem. Alcohol is nearly always one of these "poly drug" components of abuse.

Again this terminology is accepted prevention language when dealing with youth as alcohol is as unlawful for them to use as is other illegal drug use.

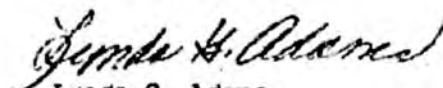
There have been some unsuccessful attempts being made on the federal level to separate alcohol from other drugs. When researching the source of these efforts and the rationale for them, it has shown that these are attempts by the strong liquor lobby. They do not want the term "alcohol" used with other illicit drugs. Apparently, they feel this is a negative reflection on their industry. These federal attempts have failed in the past. I would surely hope that this same effort is not surfacing within our state arena as we continue to find effective ways of solving Alaska's alcohol and other drug problems.

I would offer one other suggestion. On page 8, the third bullet should have further explanation. The Advisory Board on Alcoholism and Drug Abuse is already established. Implementing the portion of the stated statute would establish the ADA Board as a "policy making" board. At present the board is only advisory.

Please let me know if you are able to delete recommendation #3 on page 23. Our organization would like to be very supportive of this otherwise valuable document.

Representative Porter, thank you for any consideration you can give to our suggested recommendations for change.

Sincerely,


Lynda G. Adams
Executive Director

**Has the Emperor No Clothes?:
The NHTSA Report on Lowering the BAC limit in California**

Prepared by:

**David W. Moore
Professor of Political Science
Director, The Survey Center
University of New Hampshire
Durham, NH 03824**

April 13, 1992

EXECUTIVE SUMMARY

REPRESENTATIVENESS OF THE DRIVER OPINION SURVEY

1. Despite the REPORT's implication that the sample is generally representative of California drivers overall, it is highly unlikely that the sampling method used in the project could possibly result in a representative sample.
2. The sample is clearly unrepresentative of drivers overall, at least geographically, and probably also with respect to education, income and race/ethnicity -- all factors that are no doubt highly correlated with the responses.
3. The wording of the questions, and the context within which they were administered, are quite likely to have exaggerated the optimistic results noted in the REPORT: that drivers are very aware of the lowered BAC limit, and that drivers have improved their driving behavior since the lowered BAC limit went into effect. Even the REPORT itself says that results based on the drinking and driving questions "need to be interpreted with a large grain of salt."
4. The REPORT itself shows *no* correlation between knowledge of the two new anti-DUI laws and reported reduction in drunk driving, thus undermining any conclusions that the laws acted as a deterrent.
5. The REPORT itself also shows that the drivers who said they had reduced their drunk driving in recent years did not credit the new laws as reasons for their improved behavior. Less than five percent of the drivers mentioned either piece of legislation as a reason for reducing their drunk driving behavior, and even then did not necessarily mention that it was the *reduced* BAC limit or the *new* Administrative Per Se Law that concerned them.

DECLINE IN FATALITIES: 1990 COMPARED WITH 1986-1989

1. The REPORT makes all of its statistical estimates using ARIMA models, but there are some severe limitations to ARIMA that undermine its utility for this analysis. Perhaps the most serious limitation is the small number of data points after the new anti-DUI legislation went into effect, a point partially acknowledged even by the authors of the REPORT.
2. Another important limitation of ARIMA for this project is that it cannot use the *yearly* data on fatalities, a point made explicitly by the authors of the REPORT. Instead, the authors had to use *monthly* data, although a strong argument can be made that the yearly data provide a more reliable measure of the trends. (Even with monthly data, there are not enough data points for reliable ARIMA estimates.)

3. The ARIMA models are also inherently subjective. There is no one "true" ARIMA model, and researchers could find more than one acceptable model. A different model could lead to different estimates of the effect of a lowered BAC limit and Administrative Per Se Law.
4. Based on ARIMA models, the REPORT estimates that in 1990, California experienced an overall decline of alcohol-related fatalities of 12%. Based on *actual yearly* data, however, there was a decline of just 6.1%, only half of what the REPORT states.
5. Based on ARIMA models, the REPORT also estimates that in 1990, Fresno County experienced an overall *decline* of alcohol-related fatalities of 18%. Based on *actual yearly* data, however, there was an *increase* of 19.5%.
6. While the ARIMA model estimates a 12% decline in alcohol-related fatalities for California, it also estimates *no change* for the United States. Yet, the *actual yearly* data show that for both California and the country overall there was a decline in alcohol-related fatalities in 1990 over the previous four-year period. For California, the decline was 6.1%; for the United States overall, it was 6.3%.
7. California also experienced a similar decline with the country overall in the number of non-alcohol-related fatalities. For California, it was 1.4%; for the United States overall, it was 1.7%.
8. The similarities in the figures for both the state of California and for the United States suggest that California's legislation had *no* discernible effect on either alcohol-related or non-alcohol-related fatalities.

**HAS THE EMPEROR NO CLOTHES?:
The NHTSA Report on Lowering the BAC Limit in California**

INTRODUCTION

For years, the National Highway Traffic Safety Administration has urged legislators in the states to adopt several strategies to reduce the number of alcohol-related traffic fatalities in the country. Such programs included mandatory seatbelts, education, administrative license removal, a BAC (blood alcohol concentration) limit of 0.02 for under-age drinkers, programs and stiffer penalties for repeat offenders, and sobriety checkpoints. Never had the agency pushed lowering the BAC limit for adults to 0.08 (from the current level of 0.10). The reasons for not stressing this approach, no doubt, were related to the fact that the vast majority of alcohol-related accidents involve drivers with significantly higher BAC levels, and any sustained efforts to go after drivers with BAC limits lower than 0.10 might be counterproductive -- detracting from resources needed to deal with the major problem of repeat offenders. Further, in the four other states where the BAC limit has been reduced from 0.10 to 0.08, there has been no pattern of improvement in the number of alcohol-related fatalities or crashes.

Then, in August, 1991, a report commissioned by NHTSA¹ (hereafter referred to as the "REPORT") made some startling conclusions. In fact, the conclusions in the REPORT are heavily couched in tentative language, but their tenor and the way they are now being used by NHTSA, suggest that finally, there is incontrovertible evidence that lowering the BAC limit from

¹ "The Effects Following the Implementation of an 0.08 BAC Limit and an Administrative Per Se Law in California," DOT HS 807 777, Final Report, National Highway Traffic Safety Administration, U.S. Department of Transportation, August, 1991.

0.10 to 0.08 can have a significant impact in reducing alcohol-related fatalities. The truth is, however, that the data presented in the REPORT do *not* justify such a conclusion.

BACKGROUND TO THE STUDY

In 1990, California adopted two laws to deal with drunk driving. On January 1, a new BAC limit of 0.08 went into effect, reduced from the previous limit of 0.10. Now, drivers who tested with a blood alcohol concentration of 0.08 would be considered legally drunk. On July 1, a second law went into effect, the "Administrative Per Se Law," (also known as a Administrative License Revocation Law). This law allows police and driver licensing authorities to suspend the driver's license of any driver who either fails an alcohol test, or refuses to take one.

Both of these laws received a great deal of attention while they were being passed, and the authors of the REPORT acknowledge that as a consequence, they were unable to determine whether any reduction in alcohol-related fatalities were more related to the lowered BAC limit or to the Administrative Per Se Law. (The authors do suggest that *both* of these factors contributed somewhat to the reduction in alcohol-related fatalities, but they have no evidence to justify such an assertion. Further, as will be shown later, there is serious doubt whether *any* reduction in fatalities can be attributed to either the lowered BAC limit or the Administrative Per Se Law.)

THE OPINION SURVEY

The REPORT divided its major conclusions about the effect of these two new anti-DUI

laws into three sections: effects on drivers, effects on arrests and crashes, and effects on police and courts. The latter section is not in dispute here, but conclusions in the first two sections do raise some serious questions.

A. Effects on Drivers

Based on a survey of drivers in the offices of the Department of Motor Vehicles (DMV), the REPORT concludes that drivers were very knowledgeable about a reduction in the BAC limits, and that "the incidence of self-reported driving after drinking had decreased substantially since the BAC law went into effect" (p. xiv).

This would suggest a significant effect of the new BAC law, but the REPORT then notes that the *reasons* why people reported this drop in DUI behavior could *not* be related to either the BAC law or the Administrative Per Se Law. Most drivers who said their DUI behavior had declined mentioned in general the laws and penalties against drunk driving, but they rarely specified either of the two new laws. Indeed, less than 5% of the drivers even mentioned a concern about losing their license, and even this group did not necessarily mention the *change* brought about by the new Administrative Per Se Law. Similarly, less than 4% mentioned any concern about the BAC limit, and they did not necessarily mention the *lowered* BAC limit. As the REPORT notes, "Unfortunately, it was impossible to tell from the responses whether respondents were referring to one of the two new laws, to both in combination, or to other factors altogether, such as sentences handed down by judges" (p. xiv).

Further, as the REPORT later notes, knowledge of the new BAC limit was *not* correlated with a self-reported reduction in DUI behavior. As the REPORT states, "The relationship

between people's knowledge of the DUI laws and their drinking and driving behavior is of special relevance to this study." The authors then analyzed whether drivers who knew about the Administrative Per Se Law, and drivers who knew the correct BAC limit, were *more* likely to reduce their DUI behavior than drivers who did not know about the two laws. The REPORT concludes, "In neither case was a connection found" (p. 63).

In short, *the survey data analyzed in this REPORT cannot be used to show that drivers in California reduced their DUI behavior as a consequence of the two new laws.* But despite this information, the NHTSA "Fact Sheet" at the beginning of the REPORT emphasizes the self-reported reduction in DUI behavior after the introduction of the new BAC limit.

B. Critique of the Driver Opinion Survey

In addition to the points noted above, there is serious question about the representativeness of the opinion survey. Indeed, the survey's sampling procedures and question wording are so biased that the results cannot be assumed to represent the actual opinion and behavior of California drivers in general.

1. Sampling

Because of cost constraints, the REPORT notes that a probability sample of California drivers was not possible. Instead, the directors of the project selected four county areas and had the Department of Motor Vehicles (DMV) select a site within the county areas and distribute the questionnaires to drivers who were visiting the DMV offices during the week of May 20-24, 1991. The REPORT says that the respondents in the survey "may slightly underrepresent women (53% of the licensed drivers in the DMV sample, as compared to 58% of individuals in the

present survey, were men) and may slightly overrepresent young people (32% of the DMV sample were under 30, as opposed to 36% of present survey respondents)."²

Despite the REPORT's implication that the sample is generally representative of California drivers overall, it is highly unlikely that such a sampling method could possibly result in a representative sample. Geographically, it is clearly not representative. Only four sites in the whole of California could not possibly encompass the diversity that is contained in the state overall. Some evidence of the lack of representativeness of the four sites is found in the very statistics that the REPORT analyzes. For three of the sites, the rates of alcohol-related fatalities *increased* in 1990 compared to the previous four years, while in the state overall, the same rate *declined*. The drivers who were being questioned came from areas that were distinctly *unrepresentative* of the state with respect to the very problem the project was trying to study.

The REPORT says that the drivers in the survey were only somewhat unrepresentative of drivers overall in terms of age and sex, but the REPORT does not compare race/ethnicity, education, and income of the respondents with drivers overall, although these are factors that must strongly correlate with the kind of questions included in the survey. Further, these are factors that are very likely to be poorly represented, given the sampling method of distributing questionnaires only to drivers who happened to show up at the DMV offices during that one week in May of 1991.

2. Question Wording and Administration

The REPORT concludes that "a large majority (81%) of respondents knew that the BAC

² Pp. 49.

limit had become stricter since 1989."³ This conclusion, however, is likely to be exaggerated because of the wording of the question and the fact the questionnaire was distributed in the DMV offices. The question asked: "Has the blood alcohol concentration (BAC) limit in California changed since 1989?" The answers offered were:

1. It is stricter now
2. It is less strict now
3. It has stayed the same
4. Don't know

Not surprisingly, the overwhelming majority of drivers (81%) picked answer #1. There are several reasons why that response might have been picked, even if the respondent did not know it was the correct answer. The answer is listed first, and in written surveys, there is often a "primacy" effect on factual questions (people tend to pick the first answer when they don't know which is "right"). Further, the question mentioned specifically the year 1989, which suggested a precise point. Thus, the respondent could almost certainly rule out answer #3. Thus, the real choice was between #1 and #2, and since the question was being administered by the DMV, #2 probably would not be true.

In short, the question and the context within which it was being asked almost shouted for the respondent to answer #1.

Similarly, the REPORT notes that "the incidence of self-reported driving after drinking had decreased substantially since the BAC law went into effect. Half of all respondents who drank alcohol reported that they were less likely to drive within two hours of drinking now, while almost as large a fraction indicated their probability of driving after drinking too much had

³ Pp. xiii.

decreased."⁴

Once again, these optimistic results are likely exaggerated due to the wording and administration of the questions. The two questions involved were presented as follows:

- a. "Has your likelihood of driving within two hours of drinking alcohol changed since the end of 1989?"
- b. "Has your likelihood of driving after drinking too much alcohol changed since the end of 1989?"

The respondents were promised anonymity, but in the actual offices of the DMV, many could have been intimidated to answer that their behavior had improved, rather than gotten worse. Further, the year 1989 was once again specified in both questions. Clearly, the DMV felt that something had happened in 1989, thus cuing the respondent to what may have been the "desirable" response.

Oddly enough, the REPORT makes the very same point. "The results of the responses to the drinking and driving questions ... need to be interpreted with a large grain of salt," the authors write. "It is important to remember that they emerge from self-reported behavior. Respondents may have down-played the extent to which they drive after drinking in favor of answers deemed more socially acceptable. *The fact that the survey was administered in the DMV office may have heightened this tendency.*⁵ In spite of the questionnaires' anonymity, some people may have felt that 'bad' answers could have negative repercussions for their driving licenses" (p. 63).

In short, even the REPORT itself acknowledges that much of the data provided by the

⁴ Pp. xiv.

⁵ Emphasis added.

survey is too contaminated to be taken seriously.

3. Conclusion

In sum, the survey of drivers at the four DMV offices is likely to have obtained responses that are very unrepresentative of California drivers overall. The sample itself is clearly unrepresentative of drivers overall, at least geographically, and probably also with respect to education, income and race/ethnicity -- all factors that are no doubt highly correlated with the responses. Further, the wording of the questions, and the context within which they were administered, are quite likely to have contaminated the responses, making them unreliable for estimating the opinion and self-reported behavior of California drivers in general.

REDUCTION IN ALCOHOL-RELATED FATALITIES

At the heart of NHTSA's current efforts to reduce the BAC limits is the finding of the REPORT that alcohol-related fatalities have declined *at least partially as a consequence of the lowered BAC limit*. This, at least, is NHTSA's interpretation of the REPORT, although a closer inspection will show that even the REPORT itself does not make this conclusion. The REPORT does strongly *imply* that either or both of the new anti-DUI laws in California have contributed to a decline in alcohol-related fatalities, but the data analyses and the time-series models that are included raise serious questions about the REPORT's conclusions.

Indeed, a simpler and more realistic method of analyzing the data presents results that reach the opposite conclusions of the REPORT: The evidence suggests that *neither* of the two anti-DUI laws influenced the rate of alcohol-related fatalities.

A. The Decline in Alcohol-Related Fatalities

The REPORT argues states that "results from the analysis of statewide, alcohol-related fatalities indicate a 12% decline in the number of alcohol-related fatalities following the implementation of the 0.08% law (see Table 35). Prior to the reduction in the legal BAC, the state averaged 225 alcohol-related fatalities per month. Beginning in January 1990, this figure declined by 27.25, indicating that 27 lives were saved each month."⁶

According to the authors of the REPORT, the analytic technique they used to arrive at these conclusions was a class of time-series models known as ARIMA.⁷ Such models are widely used in forecasting, but they have serious limitations, not the least of which are problems in the validity of the findings. These problems will be discussed later, but for the time being it is useful to compare the findings of the ARIMA models with a straightforward comparison of the yearly fatality rates.

The yearly rates for California are presented in Table 34 of the REPORT. That table is reproduced below (as TABLE 1), with the percent change added in the last column - as calculated both from the *actual yearly* data, and as calculated from the ARIMA models.

⁶ Pp. 85-86.

⁷ Pp. 81.

TABLE 1
NUMBER OF ALCOHOL RELATED FATALITIES PER YEAR⁸

State/County	1986	1987	1988	1989	1990	% Change (1990 vs. 1986-1989) Yearly Data ARIMA Models
California	2620	2851	2654	2706	2543	-6.1% -12.0%
Los Angeles	520	601	558	546	590	+6.1% None
Alameda	62	58	66	76	61	-6.9% -12%
Fresno	78	101	104	95	113	+19.6% -18%
Shasta/Tehama	35	32	27	45	40	+15.1% None

In that table, the total number of alcohol-related fatalities for the four years prior to the adoption of the 0.08% limit (1986-1989) is 10,831. Over a four-year period (48 months), that means the average number of alcohol-related fatalities per month was 225.6, *exactly what the REPORT concluded*. However, according to Table 34, the number of alcohol-related fatalities in 1990 was 2,543, for an average of 211.9, a decline of 13.7 fatalities per month, *exactly one-half of the 27.25 decline noted in the REPORT*. In percentage terms, that decline was 6.1%, again just half the percentage decline noted by the REPORT.

A more anomalous conclusion was presented on page 93, where the REPORT concludes that "Data for Fresno County suggested a 18% reduction [in alcohol-related fatalities]." The actual yearly figure for Fresno County for 1990 was 113 fatalities, *the highest rate of fatalities for the whole five year period* (see Table 1 above). The average yearly fatalities for 1986-1989 was 94.5, compared to 113 for 1990, an *increase* of 18.5 fatalities per year. This represents an

⁸ The ARIMA models showed no *statistically* significant change for all four county sites, but in a footnote, and in the text, the authors stress that the ARIMA models "suggest" a reduction in fatalities of 12% in Alameda County and 18% in Fresno County. These "suggested" figures are considerably different from the figures obtained by analyzing the *actual yearly* data.

increase of 19.5% over the average of the previous four years, *not a decrease* of 18% as the REPORT states. These results, shown below in **FIGURE 1**, illustrate very clearly the problems in interpretation that the ARIMA model entails.

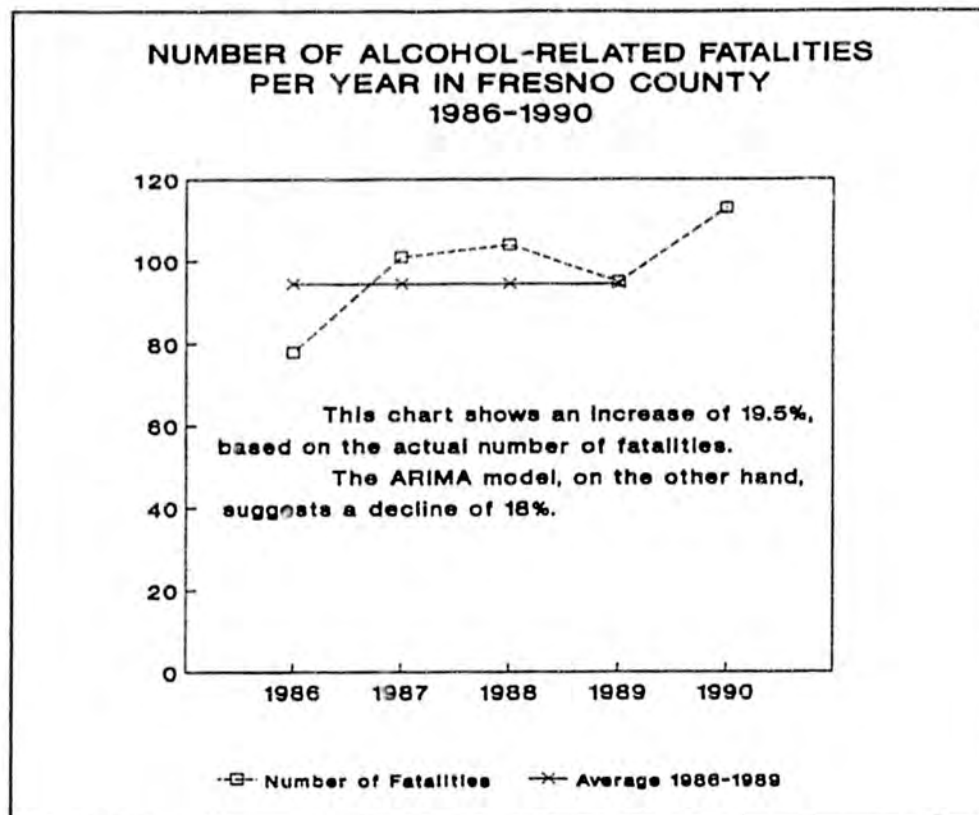


FIGURE 1

The REPORT also notes a 12% decrease in fatalities for Alameda County. Again, the authors note no *statistically significant* change, but stress that the ARIMA model "suggests" such a large decline. The average number of alcohol-related fatalities for the four-year period 1986-1989 was 65.5, compared to 61.0 in 1990. Thus, the decline in fatalities for 1990, compared to the four-year period from 1986-1989 was 6.9%, not the 12% mentioned in the REPORT. Like the results for California overall, the ARIMA model suggests a decline that is twice as large as would be obtained by analyzing the *actual yearly* data.

The REPORT says there was *no* change in alcohol-related fatalities for Los Angeles County. Yet, the yearly data show an average of 556.3 alcohol-related fatalities for 1986-1989, and 590 for 1990. The 1990 figure was the second highest figure for the whole five year period, and 33.7 fatalities *higher* than the yearly average of 1986-1989, an increase of 6.1%.

Similarly, for Shasta/Tehama Counties, the 1990 figure was 40 fatalities, an *increase* of 5.2 fatalities over the 1986-1989 average of 34.75, for a 15.1% increase.

In short, in 1990, according to actual yearly reports of fatalities, the state experienced an overall decline of alcohol-related fatalities of 6.1%, just half of what the REPORT estimates. Further, contrary to the REPORT's conclusions, Fresno County saw an increase of 19.6% fatalities, not a decrease of 18%. Further, Alameda County experienced a decline in fatalities of 6.9%, not 12% as mentioned in the REPORT. Also, contrary to the REPORT's conclusion of *no change* in fatalities in Los Angeles and Shasta/Tehama Counties, there were *increases* in fatalities of 6.1% and 15.1% respectively.

B. The Peculiar Properties of the ARIMA Models

When faced with such discrepancies between a sophisticated modeling technique such as ARIMA and the less complicated, but more straightforward analysis of actual yearly data, what should the policy-maker believe? This is not a question of a *faulty* analysis using the ARIMA models,⁹ but rather whether the ARIMA models should be used at all.

⁹ Without the monthly trend data used by the authors of the REPORT, it would be impossible to determine whether they have obtained the best possible ARIMA models to reflect the data. For the purposes of this critique, we assume they have selected reasonably good models. As the critique makes clear later on, however, the very subjectivity of the judgment allowed in selecting the models is one of the major problems with ARIMA in the first place.

1. Assumptions of the ARIMA Models

Like any statistical model, ARIMA is based on certain assumptions that must be met in order for the results to be considered valid. Further, ARIMA requires that certain conditions be met in order for the results to be considered useful in describing the data. One of the first assumptions of ARIMA is that the time series "is regarded as a *sample* realization from an *infinite population* of such time series."¹⁰ In other words, the yearly data from California are treated *not* as the actual, complete set of data for those years, but as though they were a *sample* of data for those years. The assumption is fundamentally incorrect, but it is often made so that sophisticated statistical models can be applied to the data. When statistical models help enlighten the researcher about visible trends, then the assumption may prove useful. But when the statistical models say that black is white, or vice versa, then the assumptions have to be carefully re-examined.

Another limitation of ARIMA models specifically is the number of data points that can be analyzed. ARIMA requires generally about 50 points of data (Cook and Campbell, 1979:228). Thus, *ARIMA cannot be used to analyze the yearly fatality figures that were described in the REPORT*. As the REPORT also acknowledges, (p. 96), "Yearly data does [sic] not permit statistical analysis using the ARIMA models."

In order to get around this limitation, the authors instead analyzed the *monthly* fatality reports. But even here, the number of data points after the adoption of the lowered BAC limit is rather small. Although there are more than 50 points overall, there are only 12 points (months) after the introduction of the lowered BAC limit, and only 6 points after the

¹⁰ George E.P. Box and Gwilym M. Jenkins, *Time Series Analysis: Forecasting and Control* (San Francisco: Holden-Day, 1970), p. 7.

Administrative Per Se Law went into effect. The authors acknowledge the problem, at least in the latter case, when they write that "only six months of data were available, making it difficult to assess any change" (p. 93). But this comment is applicable to the whole analysis, where only twelve months of data (after the new BAC limit went into effect) are available.

A strong argument can be made that monthly data are *not* the appropriate numbers to analyze in any case. According to the monthly trends in the REPORT, fatalities are considerably higher every year in the summer than in the winter, a periodic variation that is controlled when yearly averages are used. ARIMA models are designed to deal with such periodic variations, but there is no evidence that they deal with them any more effectively than what can be done with yearly as opposed to monthly data.

What, then, is the rationale for using monthly data rather than yearly data? The major reason is that monthly data allow the researchers to use the ARIMA models! And the reason why they might want such models is that the models allow "unbiased significance tests," to determine whether any decline in fatalities is "statistically significant." But the use of ARIMA models is not at all mandated in this case. First, there is no reason for "unbiased significance tests," since there is no reason to generalize to some hypothetical larger population. The question is whether for California, in the years 1986-1990, there was or was not a decline in alcohol-related fatalities, and a straightforward comparison of yearly data can answer that question. Further, two other points argue against using ARIMA in this project: 1) there are real doubts whether the number of data points is sufficient to provide reliable results using ARIMA, and 2) the ARIMA models obtain *estimates* that greatly contradict what anyone can see when examining the raw data.

2. Subjectivity of the ARIMA Models

Deriving the appropriate ARIMA models for each set of time-series data is an elaborate process requiring a great deal of subjective judgment by the researchers. The first step of the process is to identify some tentative ARIMA models to describe the time-series data, a process that "is necessarily inexact. It is inexact because the question of what types of models occur in practice and in what circumstances, is a property of the behavior of the physical world *and cannot, therefore be decided by purely mathematical argument.*"¹¹ The next step is an estimation of the parameters, and the last step is a diagnosis to determine if the model is "adequate."¹²

It often happens that the initial model is *not* "adequate," and the whole process is repeated. The selection of the original model is a very subjective process, and even when the model does turn out to be acceptable, *it is not necessarily the only model that would be acceptable.* McCain and McCleary¹³ note that if researchers follow the steps outlined in their article, a model will be generated that "will be the most parsimonious, adequate model for the time series, although not necessarily the 'true' model." Indeed, no model can be determined to be the one "true" model.

¹¹ Box and Jenkins (1970: 173).

¹² When the residuals of the model are uncorrelated.

¹³ Leslie J. McCain and Richard McCleary, "The Statistical Analysis of the Simple Interrupted Time-Series Quasi-Experiment," in Thomas D. Cook and Donald T. Campbell, *Quasi-Experimentation: Design & Analysis Issues for Field Settings* (Chicago: Rand McNally, 1979), p. 241.

3. Inconsistent ARIMA Models for California and Four County Sites

The four county areas analyzed by the authors were chosen, they argued, to provide a representative subset of the whole state. One test of the reliability of a sophisticated mathematical model is to compare its structure in the overall population (the state of California) with those in geographical subunits (in this case, the four county areas). A reliable modeling process should be able to identify at least some common factors underlying the trends, even if the trends happen to be going in different directions. But in this case, there was nothing similar among any of the ARIMA models. The four county models differ quite significantly from each other, and from the model that is used to describe the trends in the state overall. Not only are the models themselves different (some have autoregressive terms, some not; some have moving average terms, some not; one model even has no ARIMA terms), but the number of predictors is not the same. Further, the predictors are all based on different time lags: some based on one month, two months, four months, six months and one year. In short, the ARIMA models suggest that it is not just that the trends are different in each area, but the factors that influence those trends are different also.

The importance of this great inconsistency in the models is that it raises the question about whether ARIMA is measuring anything but "noise," or random fluctuations in the data. In any case, the lack of any consistent model greatly undermines one's confidence that ARIMA is an appropriate tool for analyzing this set of trend data.

4. Conclusion

In this project, using ARIMA models poses some severe problems. The number of data points is probably too small, a point partially acknowledged by the REPORT itself. The use of monthly data more likely *distorts* the trend than clarifies it. The results greatly contradict the

actual raw data. And because of the inherent subjectivity of the analytic process, more than one model could possibly be as acceptable as each one selected in the REPORT. A different model would quite probably lead to different estimates of the effect of the lowered BAC limit and Administrative Per Se Law. Finally, the very inconsistency of the ARIMA models, when comparing the model used for the statewide data with those used for the county-wide data, undermine our confidence that the ARIMA modeling process is appropriate for this project.

C. Causes of the Statewide Decline

It is important to keep in mind that *no statistical model can prove that change in time-series data are caused by any specific event*. If changes do occur, and they happen to occur at the same time as a particular intervention was instituted, then it might be reasonable to conclude that the intervention caused the change. But as McCain and McCleary (1979:279) caution us, "The reader should not forget that, while the role of magnitude estimates and significance tests is far from trivial, they do not provide sufficient evidence of a causal relationship." They then add, "Statistical analysis per se contributes little to ruling out threats to internal, external, and construct validities."

One of the major threats to the validity of any time-series is what statisticians refer to as "history." This refers to the possibility that any reduction in California's alcohol-related fatalities could be due *not* to the intervention (the new anti-DUI laws), but to a general reduction that is occurring in other states as well. The REPORT does in fact compare the trend in California with the trend in the United States overall in the same period of time, and it concludes that "no change was observed in the number of alcohol-related fatalities nationwide nor in the number of fatalities in California which were not alcohol-related (see Table 36). The lack of change in

these two series provide further evidence that the BAC legislation was involved in the decline in the number of alcohol-related fatalities" (p. 93).

These conclusions are based, of course, on the monthly data analyzed in the ARIMA models. An examination of the yearly figures, however, reveals a different trend. In Table 33 (p. 84), the REPORT shows that the United States experienced 85,821 *alcohol-related* fatalities from 1986-1989, for a yearly average of 21,455. In 1990, the number of such fatalities was 20,098, a decline of 1,357. This represents a decline of 6.3%, *virtually identical to the 6.1% decline in California* [see TABLE 2].

TABLE 2
TRAFFIC FATALITIES FOR THE U.S. AND CALIFORNIA

	Yearly Average 1986-1989	Total for 1990	% Change (1990 vs. 1986-1989)
Alcohol Related			
United States	21,455	20,098	-6.3%
California	2,708	2,543	-6.1%
Non-alcohol Related			
United States	24,860	24,431	-1.7%
California	2,683	2,641	-1.4%

The REPORT also states that "no change" was observed in the number of *non-alcohol*-related fatalities in California during 1990. In fact, the yearly data show there *was* a decline in the number of non-alcohol fatalities in California, although quite small. According to Table 33 of the REPORT, there were 10,730 such fatalities in 1986-1989, for a yearly average of 2,682.5. In 1990, there were 2,646 such fatalities, for a yearly decline of 36.5 fatalities, which represents a decline of 1.4%. Further, there was an almost identical decline nationwide. From 1986-1989, the total number of national fatalities that were not alcohol-related was 99,440, for a yearly

average of 24,860. In 1990, the comparable figure was 24,431, a decline of 429 fatalities. This represents a decrease of 1.7%, essentially the same as the California figure of 1.4% [see TABLE 2].

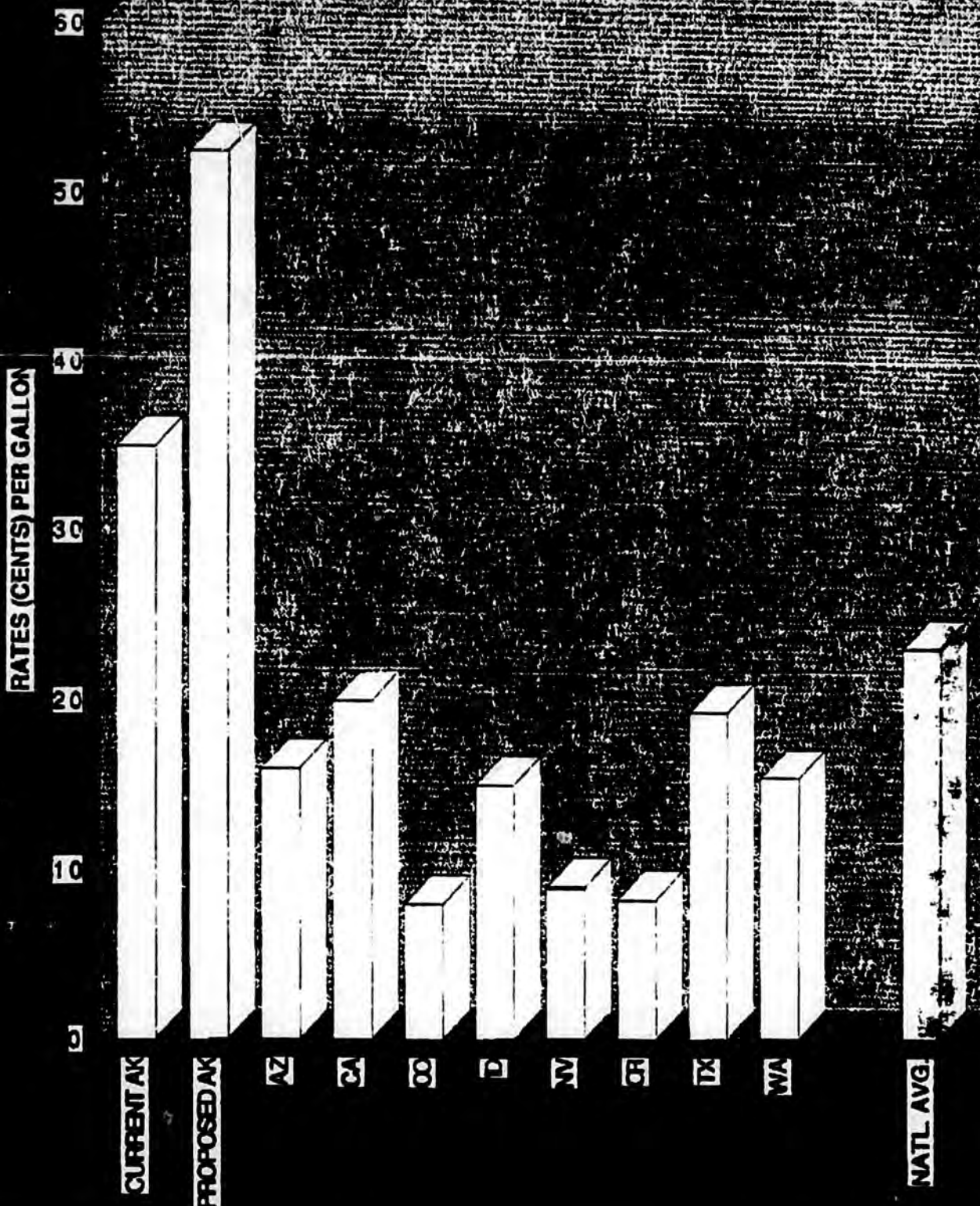
Thus, the "history" for California and the United States shows that they experienced a similar decline in *alcohol-related* fatalities in 1990 over the previous four-year period. For California, the decline was 6.1%; for the United States overall, it was 6.3%.

"History" also shows that California and the United States experienced a similar decline in the number of *non-alcohol-related* fatalities. For California, it was 1.4%; for the United States overall, it was 1.7%.

The similarities in the figures for both the state of California and for the United States suggest causes other than California's adoption of new drunk driving legislation. Indeed, given the very close parallels in the U.S. and California figures, for both the alcohol-related and non-alcohol-related fatalities, the conclusion to be drawn is that the legislation had *no* discernible effect on either kind of fatalities. In the country overall, as well as in California, there was a slight reduction in alcohol-related fatalities -- perhaps due to increased awareness and enforcement -- which was experienced nationwide, not just in California. There is nothing, therefore, that suggests that California's new anti-DUI legislation had any special impact on California drivers beyond the general nationwide pattern of somewhat increased concern by the drivers about drunk driving.

ALASKA'S BEER EXCISE TAX

PACKAGED BEER: State Excise Tax Rate Comparison



35¢ 52.5¢

20.4¢