

ALASKA LEGISLATURE SPECIAL COMMITTEE / SUBJECT FILES 8672

2257 SCOMM 89: HOUSE TASK FORCE ON . . . ALCOHOL ABUSE, 1993-94 827

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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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

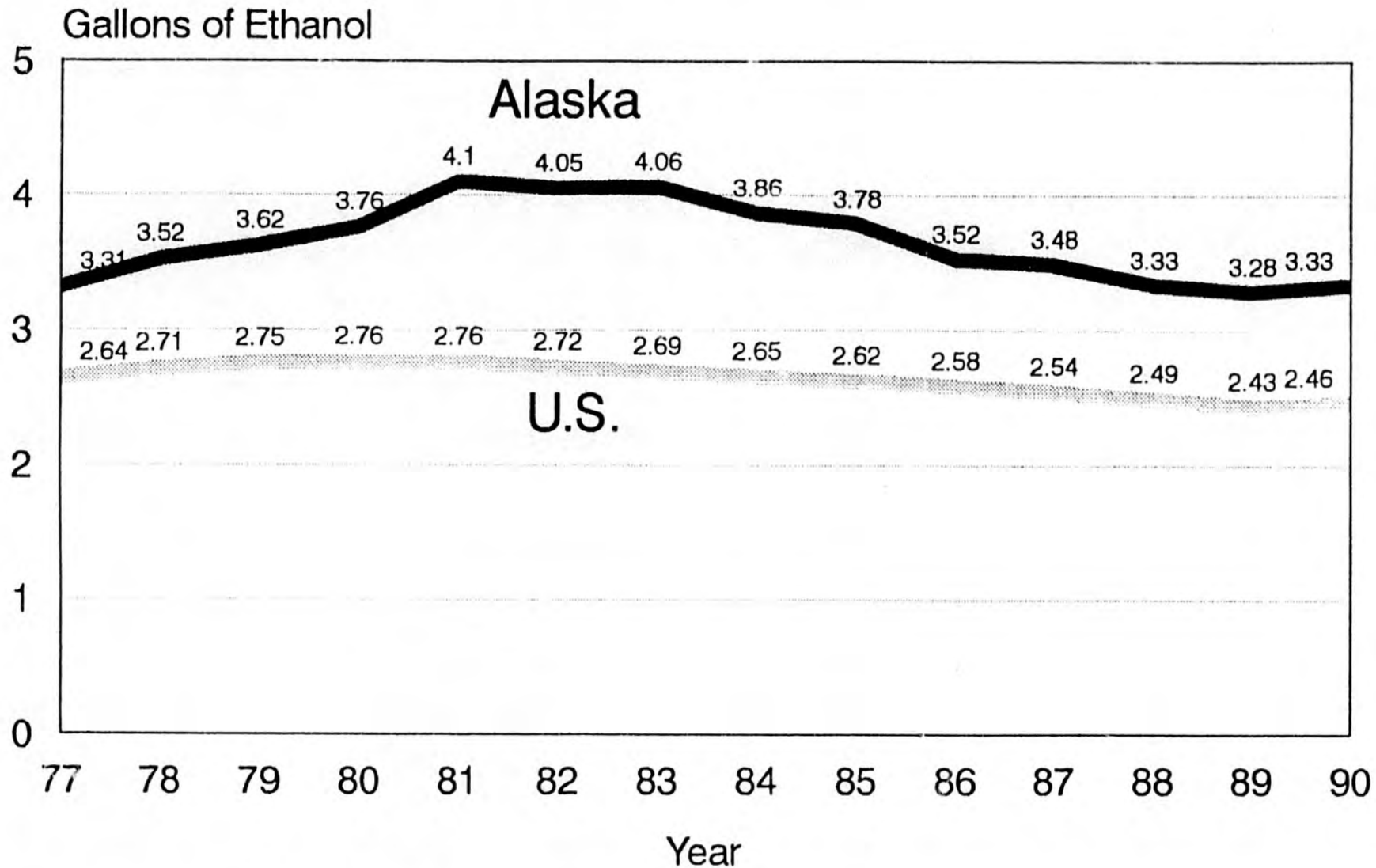
Per Capita Ethanol Consumption for States, Census Regions, and the United States, 1977-1990
 [Gallons of ethanol, based on population age 14 and older.]

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

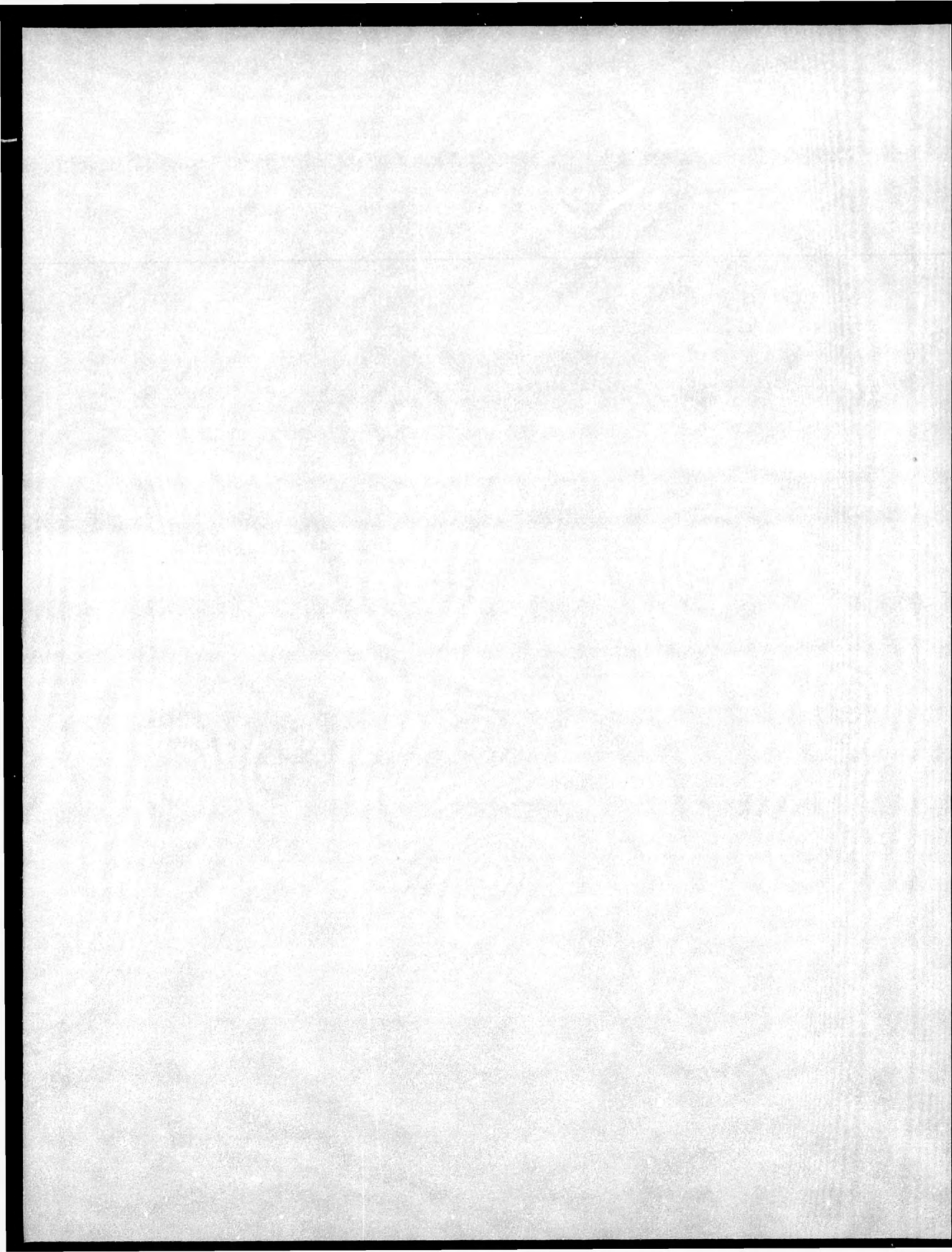
State	Gallons	Per Person Total Population	Per Person All Age 14+	Per Person Drinkers Age 14+
Alabama	4,830,000	1.20	1.50	4.16
Alaska	1,234,000	2.24	3.02	5.31
Arizona	5,860,000	1.60	2.03	3.51
Arkansas	2,774,000	1.18	1.48	2.97
California	49,880,000	1.68	2.12	3.36
Colorado	4,738,000	1.44	1.82	2.04
Connecticut	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,

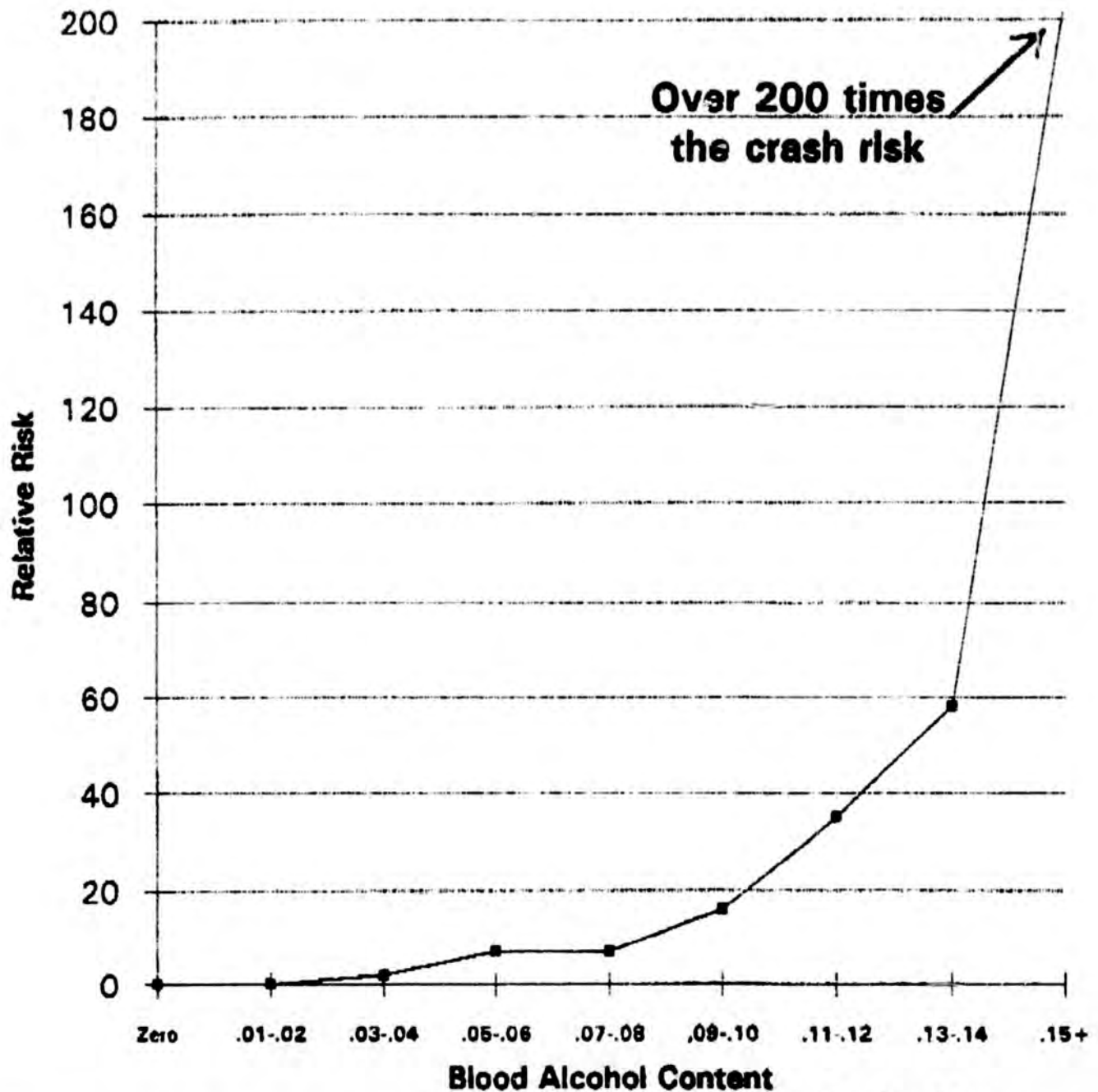


Sunny Jones
Western Government Affairs Manager

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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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

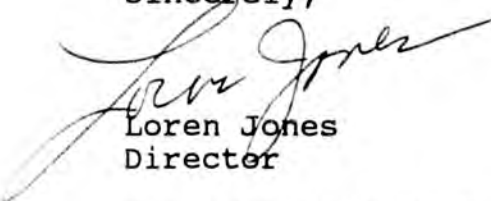
I would like to again thank the Task Force and its Chairman for the manner in which this Task Force completed its duties.

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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 Executive Director Lynda Adams

Alaskans For Drug-Free Youth

Statewide Headquarters

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 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.

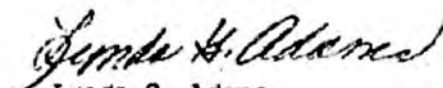
There have been some unsuccessful attempts being made on the federal level to separate alcohol from other drugs. When researching the source of these efforts and the rationale for them, it has shown that these are attempts by the strong liquor lobby. They do not want the term "alcohol" used with other 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.

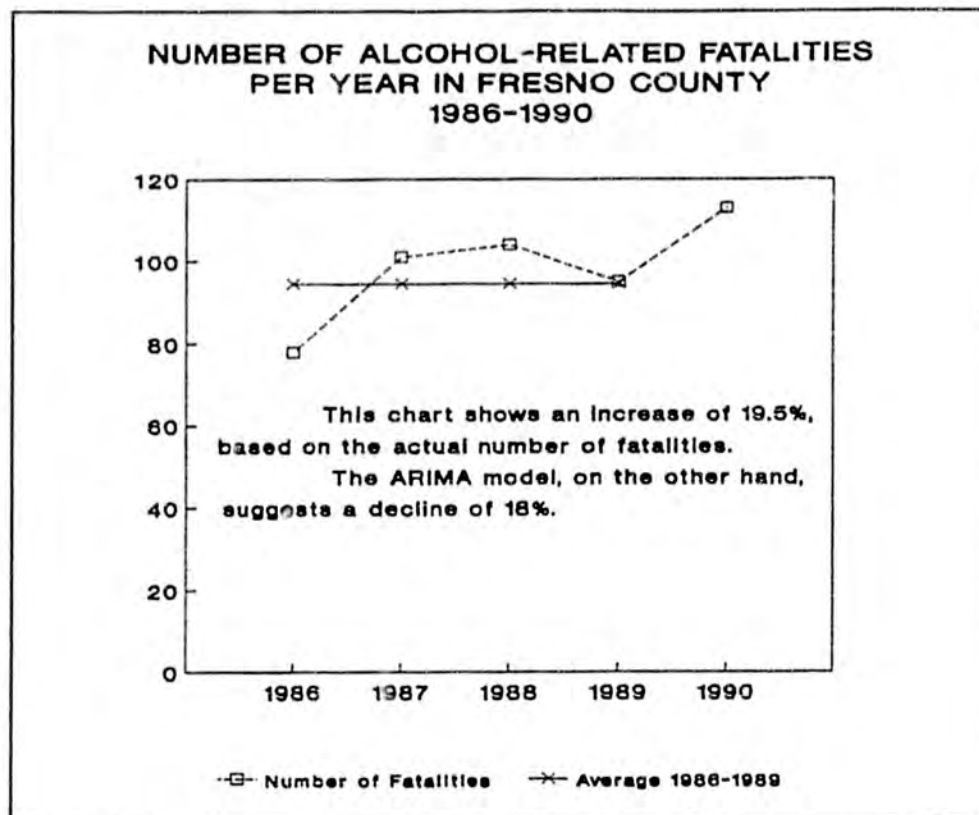


FIGURE 1

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].

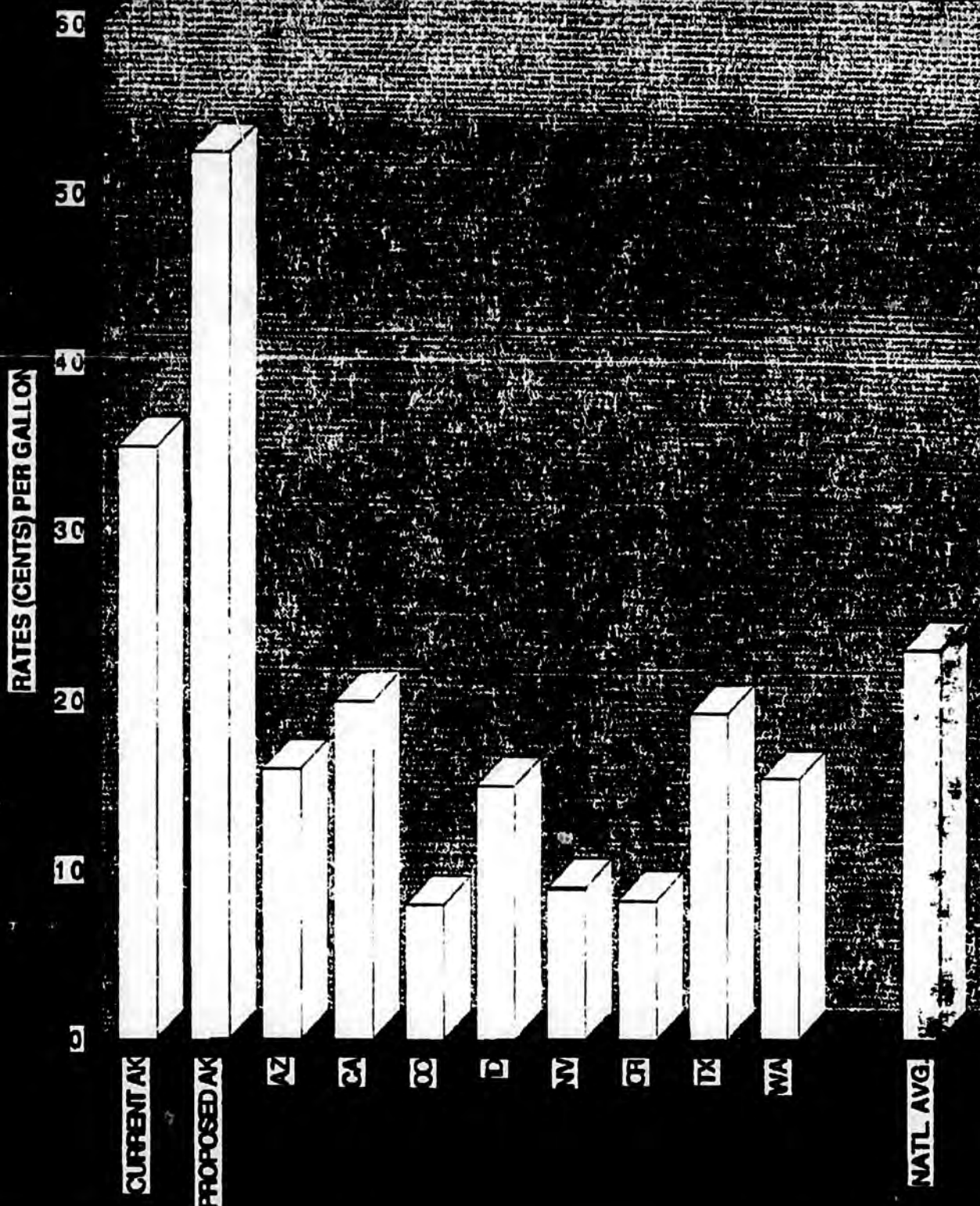
Thus, the "history" for California and the United States shows that they experienced a similar decline in *alcohol-related* fatalities in 1990 over the previous four-year period. For California, the decline was 6.1%; for the United States overall, it was 6.3%.

"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¢

SCOMM

89:2

NOME

12-21-93

HOUSE TASK FORCE ON ALCOHOL
AND ALCOHOL ABUSE
Nome, Alaska
September 21, 1993
9:00 a.m.

MEMBERS PRESENT

Representative Brian Porter, Chairman
Representative Eldon Mulder
Representative Jim Nordlund
Representative Richard Foster

MEMBERS ABSENT

Representative Joe Sitton

COMMITTEE CALENDAR

Public testimony on alcohol abuse.

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ACTION NARRATIVE

TAPE ONE, SIDE A
Number 000

The meeting was called to order by Chairman Porter at 9:50 a.m.
Chairman Porter gave his opening remarks.

CHAIRMAN PORTER: First of all, thank you very much to Representative Foster for coming and getting us and providing the logistical support for the first of the task force's meetings here in Nome. This Alcohol Task Force is comprised of myself, Representative Brian Porter. And the other task force members are Representative Richard Foster here from Nome, Representative Eldon Mulder from Anchorage, Representative Joe Sitton, who is not able to be with us today from Fairbanks, and

Representative Jim Nordlund is here.

I would also like to initially call the task force members' attention to the task force book that we have prepared by the staff of my office. The staff of my office happens to be the one person sitting right behind us, Eric Musser, and I would like to thank him very much for compiling a very comprehensive book to get us a very firm foundation of examining the problem of substance abuse and alcohol abuse within the state.

I would like to, if you haven't already, call the members' attention to the Ombudsman's Investigative Report which calls to our attention the need for evaluation programs -- the Department of Corrections' substance abuse program, which during this year's session we have heard an awful lot of testimony about the requirements of the Department of Corrections and indications that apparently most of the inmates therein are there as a result of substance abuse problems. Within the framework of that, we (inaudible) information especially from the testimony that was received by the sentencing commission. The Alaska Judicial Council report is also very interesting.

That basis really was the inspiration for House Speaker Barnes to appoint this task force, to look at the overall state policy, statutes and law that are aimed at dealing with the state's alcohol abuse problems. We have, as I've discussed with most of you, we have no fixed agenda. We're not going in with any presumptions about the extent of the problem or what is really necessary to correct it, with the exception I think of two assumptions and one conclusion that are somewhat fundamental.

One of the assumptions is that Alaska has had and still has a myriad of problems caused by alcohol abuse and more problems that are exacerbated by alcohol, the abuse of alcohol and other substances. While these problems continue, as with the case with state programs, resources to address these problems are diminishing. Consequently, it would appear mandatory that this task force look for programs that will provide measurable results that can identify potential as well as existing problems and individuals and deter potential alcohol abusers and redirect those primary abusers. I guess it's also fair to observe that the problem that we are attempting to deal with is one that has plagued this state and our nation, for that matter, for decades and that there is no one quick and single answer.

Existing responses to the symptoms or the problems, whichever they turn out to be, can be found in the philosophies of the field of education, health service, public safety, social programs and many others. What we would like to do is hear from as many of these disciplines as possible and learn their perspectives of the problems and their solutions and to get perspectives from as many members of the public as possible. (Inaudible) this information we would like to see if there are any obvious directions for the state to take in terms of coordination, innovation, or for that matter, elimination of programs. At the very least, we would like to see this task force develop a list of items of apparent promise and to deal with these individually during 1994.

I would like to note our recognition of the work presently being done by the Alaska Natives Commission, the joint federal/state board looking at all issues affecting Alaska Natives and look to receive their input as it would relate to the same topics that we're addressing.

With that in mind, we will begin taking testimony. That is as I hope is appropriate, and we appreciate his presence, the Director of the State Division of Alcohol and Substance Abuse, Mr. Loren Jones. Welcome Mr. Jones and please turn yourself on and talk to us.

LOREN JONES: Okay, thank you Representative Porter. For the record, my name is Loren Jones. I am the Director of the Division of Alcoholism and Drug Abuse for the Department of Health and Social Services. We welcome this task force, uh the division, uh is always attempting to determine from local programs and from local providers and the public what kinds of services we should provide and what the local programs need and want to address those pressing issues locally. I was scheduled for an hour of testimony. I don't think I'll take that long but I would like to just sort of give you a little bit of background on the division, how we're organized, what some of our purposes are, to describe some of the efforts we have done to address some of the issues raised in the Ombudsman's report, as well as to address issues we feel are facing the field of alcohol and drug abuse and inhalant abuse, and then to take a minute to describe some of the resources available, some of the programs available in the communities, that I believe are on the teleconference or potentially on the teleconference today, so that you have an idea as you listen to the people from the various communities what kinds of services are available there and where we feel they may be lacking services and what kinds of issues are there. I also have brought with me as much information as I could sort of glom onto to hopefully answer any questions that you might have either after my testimony or during the day if the opportunity presents itself.

The division is a division within the Department of Health and Social Services. We became a division in 1990 by executive order. Prior to that we were an Office of Alcoholism and Drug Abuse. We have an advisory board that is made up of 12 citizens appointed by the Governor. There are currently 11 members on that advisory board. The statutory authority for our division is found in AS 47.37, which lays out the duties, responsibilities of the division, lays out the philosophy of the state regarding alcoholism and intoxicated persons. Within that chapter is also the involuntary commitment act for those persons who do not seek treatment on their own and for whom individuals responsible for them feel that they need to be committed, give guidance to the court as the courts reach that decision as to whether to involuntary commit.

Our board has a status under AS 44.29. That again lays out the duties of that board which are basically to advise the department and the commissioner on issues relating to alcohol abuse, drug abuse and inhalant abuse. This task force is set up as an alcohol and alcohol abuse task force. My division also has responsibilities for drug abuse issues and inhalant issues.

At the federal level we are now being required, as a result of federal block grant funding, to be somewhat responsible for tobacco, even though within our department of Health and Social Services tobacco is structurally under the Division of Public Health. Along with CDC's recommendation, the Center for Disease Control, and other federal officials, we are now being required to do some things in terms of violence prevention as well as its related to use of substance abuse in schools, weapons in schools, the advent of gangs, those kinds of things, youth violence. We're slowly being required at the federal level to deal with that as part of our overall prevention efforts. The other task forces (inaudible) in terms of alcohol and alcohol abuse.

My division's responsibilities are quite broad. We are basically organized into three sections. We have an office in Juneau that is basically the policy section, the management information section and our administrative section where we do all the grants management. We have two offices in Anchorage. One our Anchorage field office which has seven staff members that is responsible for the quality assurance program and responsible for providing the technical assistance and grant support to all the various local programs that are funded out of our division. AS 37.37 also requires us to establish standards for quality treatment programs and to apply those standards to both public and private treatment agencies. So we do an on-site to give a certificate of approval to every program that says they provide alcohol or drug abuse treatment.

CHAIRMAN PORTER: What title is that now?

LOREN JONES: AS 37.37.130 I believe. So we do review the programs at Providence, Charter, private psychologists, private programs like that as well as state grant funded programs.

Our third office in Anchorage is the Anchorage Alcohol Safety Action Program and it's located in the Court building. They have two responsibilities: one is to provide direct services to the Anchorage court system for misdemeanor offenders referred by the court system. The Alcohol Safety Action Program started out to be programs that dealt with drunk drivers. Currently the Anchorage court system in particular and many courts around the state are now sending other alcohol related misdemeanor offenders. Our Anchorage case load is about 50% drunk driving offenders and 50% other misdemeanor offenders. Step down felonies that deal with alcohol related violence, domestic violence cases, assault, burglaries, those kind of misdemeanor cases that are in fact alcohol related are referred to the ASAP office. That has made our case load there increase in the last six or seven years by almost 200% with no increase in staff. Also these (inaudible) ASAP programs around the state to various nonprofit agencies, they do the same function.

The second function of the Anchorage ASAP office is to provide technical assistance, quality assurance and oversight of the other grantee programs that do the Alcohol Safety Action Program. The task of the ASAP is to assure there is continuity and that we offer the same

services to each court system. We have a standardized assessment process, standardized protocol for handling the cases, referring them on for other treatment or education and also getting back to the court if they are noncompliant with either their treatment or their education. That is the only direct service that the division operates. All services provided in the State of Alaska for the direct prevention, intervention or treatment of alcoholism, alcohol abuse, drug abuse and inhalant abuse are done through local nonprofit grantees or municipal government.

The grant in aid authority that we operate under is AS 47.30.475-500. It lays out the conditions for granting funds to local programs. It lays out the match requirement, which is 10%, and they also lay out the requirement for local plans, local needs assessment that are required of the local programs. We're only allowed to grant to nonprofits or municipal arms of government. We may not provide any funds to profit corporations, and by federal law we cannot provide any funds to inpatient treatment. The inpatient that is available in Alaska as within the private sector and it is funded through either private health insurance or first party pay.

We recently in FY 92, toward the end the legislature, passed HB 545 which permitted Medicaid to begin paying for substance abuse treatment. To date, regulations have not received approval to implement that program and so no program has yet to receive any Medicaid funding. It is now authorized and we are trying to get the regulations through. That would provide Medicaid funding for some residential care and mostly outpatient treatment care for those individuals who are on Medicaid. However, the way in which the Medicaid program operates, under the program refinancing scheme, we will be required to pay the match to Medicaid, which means that we reduce the grants to the local program in the amount we think they will achieve when they start billing Medicaid. So that there is some gain we are basically replacing general fund dollars with 50% federal and 50% general fund instead of 100% general fund; but under that scheme of trying to refinance, we're not able to increase the amount of services available. We're basically staying flat.

Our budget, and I know it's in the book that Eric had put together, a budget summary for you from about 1984 forward, and as you'll notice we reached a relative high in FY 92 and in FY 93 we took a decrease of about \$1.2 - 1.3 million, and for FY 94 we took an additional decrease of \$500,000. Some of that was in state money and some of that was in federal funds. The legislature has also changed the nature of our funding, as has the federal government. We receive a federal block grant from the Center for Substance Abuse Treatment. The Center for Substance Abuse Treatment is within the Substance Abuse and Mental Health Services Administration in the Department of Health and Human Services within the federal government.

Prior to FY 93 the block grant was combined with mental health. In FY 93, under the reauthorization of block grant was split between mental

health on one side, as a separate block grant, and alcohol and drug abuse service as a separate block grant. When we did that, we had a reduction in funds come to us because they took a higher percentage of that money for the mental health block grant that had previously been done. At the same time, the legislature over the last three or four years has continued to increase the amount of general fund dollars that come from the mental health trust into our budget and decrease the amount of general fund. In the largest grant component in my BRU, I have about \$900,000 of general funds out of \$17 million. \$2 million is federal, the rest is from the mental health trust. What this has done is to...

One of the criticisms of the Ombudsman's report was that our mission statement didn't necessarily give us a direction to go that we could show that we had some impact and we didn't do very much of a needs based assessment and we didn't put our money where there's the best chance of having a good return come from.

One of the federal statutes and federal block grant requirements, ...we have to spend 20% of our federal block grant on prevention. We have to spend 35% of our block grant on alcohol abuse programs. We must spend 35% of our block grant on drug abuse programs, and increasing to 20% now on women's only services. If you add that up it comes to 105%. We're also allowed to take 5% for administrative costs, which we do. We can double count in the fact that people who do receive alcohol services may be getting prevention services, women may be getting drug abuse services, and those kinds of services give the ability to double count. But it does place some restrictions on how we can spend the money, irrespective of what our plan might say, irrespective of what we might desire. We might want to spend 90% of our money on alcohol, but we are precluded from doing so.

In addition, under the mental health proposed settlement and under the court ruling, the beneficiary of the mental health trust is the chronic alcoholic with psychosis. There is a definition of law. There is no clinical definition of a chronic alcoholic with... therefore, the mental health board, acting as trustee, believes the legislature has erred in assigning 86 to 90% of my budget to the mental health trust because they feel that less than 25% of the clients we serve are in fact chronic alcoholics with psychosis. Therefore, we tried desperately not to fund prevention efforts from the mental health trust dollars and try to use general fund dollars.

Specifically, drugs are not mentioned in the mental health trust settlement so we try to use general fund and federal dollars for drug abuse funds as well. That is increasingly hard to do when you have a decreasing general fund dollar and an increase in mental health trust dollars to honor the basic law from the court that says the beneficiary of the trust is a chronic alcoholic with psychosis. So we've sort of been placed in a box that makes it difficult to put the funding where individuals feel it is best needed, to make sure that the programs, as they serve the client, who doesn't care if they are a beneficiary of the mental health trust, doesn't care if they are in a box at the federal

funding level, but do care that they get the appropriate service that they want to solve their issue they have with alcohol and drug abuse or inhalants.

That is a problem that we faced that we don't know a ready solution to. The administration's position is that the legislature has established that policy that alcohol services will be funded from the trust, that by their appropriation of those funds they have expanded the beneficiary. The mental health board feels that is not the case, that the legislature needs to pass a statute that says their standing as the beneficiaries of the trust which under the court ruling they are allowed to do.

So then, trying to plan down to the level of services under some of the recommendations of the Ombudsman, we do run into some of those financial considerations that pose a problem for us. In addition to the fact that inflation eats into the treatment and prevention dollars of the local programs, the fact that we reduced their programs the last two years in a row, you can add to that whatever inflationary factor. We went back and looked at our budget from 1984 forward to 1994 and we started out in 1984 and we just added a simple 3% inflationary factor so that you get a basic... if we had gotten a 3% increase every year... what our funding level would be, we are well below that level with FY 94, so that the impact of inflation, the impact on increased health care costs, the impact on fixed costs for residential costs where you have fuel oil dollars that go up and electricity costs that go up and you have staff costs that go up and you have increasing social security costs that go up and an increasing costs of doing business and a decreasing amount of funds coming into local programs, has really put a lot of programs on the brink. Just not being able to provide the level of service they currently provide and certainly not the comprehensive level of service they think they need to adequately serve their particular areas. Under 47.37 the legislature has laid out what they feel is a comprehensive program and this comprehensive program must include an emergency care, it must include residential treatment, it must include outpatient care and it must include after care and follow-up. We attempt to provide that level of care and at least Level 3 communities and Level 4 communities. Level 1 and Level 2 communities we have a reduced level of that care. Within health planning Level 1 communities would be small villages, Level 2 communities would be health communities, I believe that Nome falls under a Level 3 community, a population over 2500 to 3000, so we do have a level of care that sort of determines what we are willing to support in a local community. Within those realms then the local communities have some ability to change services to make those services more appropriate for the local community and I'll explain a little of that in a minute.

We have many issues that face our division and face the alcohol and drug abuse and inhalant field in the next few years. The issue of the increasing realization of the dually diagnosed population, those who are mentally ill and are also substance abusers, there are liberal debate raging at various places, not as heavy in Alaska as it is in other places, over what the extent of that population is and what's the

appropriate way to address and treat that population.

There are definitely a significant number of individuals who are mentally ill that abuse alcohol and drugs. They do that as part of their mental illness, they do that as a method to medicate themselves, they do that as a method to try to solve some of the mental health problems; they may also be physically addicted to alcohol or drugs and also be diagnosed as suffering from alcoholism or drug addiction. In addition, there are significant number of persons who are alcoholic or drug addicts who are not mentally ill, who do not have a diagnosable mental illness, and they may exhibit at times the same diagnostic characteristics. But periods of absence and a quality recovery program and those symptoms tend to go away.

It's a difficult process in some communities so separate those two and that is an issue that we are constantly dealing with, both at the federal level and within Alaska. Emergency care is a problem in that we try to provide some level of detox or emergency care within most of the hub communities, but that is expensive and not always available. And there are differences of opinion as to how you should provide that.

Anchorage is a prime example, where several years ago they used a public inebriate reception center, tried to hold people there. It was relatively inexpensive. There's a lot of individuals who didn't want to go on for detox, which is more expensive level of care. They dropped that and now have expanded the size of their detox, trying to sort out how to deal with the homeless population, trying to deal with the street people.

In a community like Nome... they have a five bed detox in this community that refers people into a residential treatment program. In Bethel there is no detox program. They have... it's been a difficult process for the community of Bethel to decide whether they want one, how they would operate it, how it wouldn't be (inaudible) just a revolving door institution for people who were ill, who needed to go on to further treatment, but simply use this to be safe in the wintertime and to get a little bit of their health back and then who refuse to go on to further treatment. That is a relative expensive level of care.

There are many communities that would like to use the involuntary commitment act that is part of AS 47.37. They have asked that we as a division look at revising that portion of the statute. With all of our other priorities we have not had a lot of time to look at that. Several years ago, then Senator Uehling had a bill in that would have changed that. It ran into some significant problems with some communities over the way it was worded. It ran into some problems with confidentiality issues and what could be shared in a court hearing from clinical treatment records and what could be not and some of those issues just didn't get resolved before the Senator was no longer in office.

Some communities use it very well, other communities do not. Two or three of the major problems with it is that it does not guarantee

treatment. If you were mentally ill and you were committed under the mental health commitment statute you have a right to treatment. If you can't be treated in the local community, then you can be committed to API. That is their final back-up if they can't use the local hospital, if they can't use the hospital in Fairbanks, then their backup is API.

Under the alcohol commitment statute there is no right to treatment. If the court commits the individual and there is no treatment available in that community, then they have to try to find another bed someplace else, and if that's not possible, then the individual does not get admitted even though the court has involuntarily committed them to a treatment program. We're not funded to guarantee that there's beds available. We're not funded to pay for the transportation.

As an example, you could have an individual in Wrangell that has an outpatient program. You get the individual care committed, there's no beds in Juneau, there's no beds in Ketchikan, there is a bed in Fairbanks. How you pay for the transportation to get that individual from Wrangell to Fairbanks, that's not part of our current budget stream, it's not something that we have felt the statute gives us the responsibility for. Sometimes they'll get that donated, sometimes the person can pay part way, sometimes the program pays, sometimes the program will pay half the cost, the one way ticket. After the person's been through treatment, then the person's responsible for the return flight.

So those are a couple of the issues facing them. Also, because it's not within the same (inaudible) as the mental health, if the local program does the commitment, they have to get their own attorney. Under the mental health statute, it's the state that is committing this person to the community mental health center and the state Attorney General's Office represents the state's interest in committing this individual.

That is not the case under the involuntary commitment for alcoholics. It may be an issue that this committee may want to look at more closely or ask some questions of those who do use the commitment act.

I believe that John Dapcivich from the City and Borough of Juneau has done a look at the involuntary commitment act and looked at public inebriate services and I think he sent that report up to Representative Porter's office. If he didn't, I'd be sure to get another copy. He looked at those issues as they were done in Sitka, Petersburg, Ketchikan, Anchorage and Fairbanks. I came to Anchorage and just had a meeting and I'll get you a copy of that. I thought that he had said that he had sent that up.

In addition, I think you'll hear during the course of this testimony, even though this is on alcohol and alcohol abuse, I think you'll hear increasing requests for services to young children for inhalant abuse. It is a growing problem in recognition and I think in actuality, in rural Alaska especially, but some in the urban community, we have been attempting to deal with that existing services with existing programs and I don't think that we are being very successful.

We have the Norton Sound Health Corporation here in Nome apply to us, to the federal government for a inhalant treatment program at White Mountain. We have some indication that there might be a chance that might be funded. We should know hopefully by the end of this month, the first part of October. If that happens, it will be one of only the second inhalant abuse treatment programs that have been funded by the federal government. One is in South Dakota, a program called Our Home or Our House and so the Nome area would have the second one in the nation that was funded specifically for inhalant abuse.

We still have the recurring issues of drug abuse, ups and downs, some increasing cocaine issues facing treatment providers. That seems to be an increasing drug of choice as people come into treatment. It is still overwhelmingly alcohol, but we are seeing more of that. Even though some of the public safety issues and some of the major arrest issues and stuff are down somewhat. We are continuing to see an increase in people that are coming into treatment for cocaine use.

We have attempted in the six or eight months since the Ombudsman's report came out and since we went through legislative hearings in the budget process to answer some of the questions, and Representative Porter certainly raised it this morning in terms of finding out which programs work, what the emphasis of the programs are, how effective they are.

We have done this in three ways. First of all, the House Finance Subcommittee had originally proposed some intent in the budget that would have required all of the programs to do outcome research and to determine the efficacy of their individual programs. That intent never made into the final budget process, but we did put a special condition in all of our treatment grants that asked them if they had done follow-up studies, if they have checked on clients after treatment, if they have done any of that research, that they are to submit a report to us by the first of December so that we can compile that information and present it to the legislature in some summary form. Also, so that we can look at are they using a common definition of outcomes, are they using the same approach, is there something here that we might be able to learn from and could institute that across all of our programs? We hope that we will get a good report from that.

Secondly, we hired a college intern this summer who has been working in our Anchorage ASAP office. She has been taking a sample of cases that were referred to the ASAP office in 1989 and then using the public safety's computer system, the Alaska Justice Information System, she has been going through and seeing if any of these individuals have repeated the offense for which they were sent to ASAP; i.e., have they done another drunk driving offense, have they committed any other offenses over the years 90, 91 and 92? That data analysis should be completed by the first part of October.

We then applied to the Department of Public Safety, through the Highway Safety Planning Agency, for money for a professor at the University of Alaska to analyze that data. Just as I was leaving yesterday, I found

out that that will probably be funded, but we won't know for another week. And if that is funded, then hopefully by the time the legislature comes in we will have that report available from the University in terms of how well at least the Anchorage ASAP office is doing.

CHAIRMAN PORTER: Who's is that Professor?

LOREN JONES: Sharon O'Raji

CHAIRMAN PORTER: What University?

LOREN JONES: Sociology Department, University of Alaska Anchorage.

And third, we were able to convince both the Commissioner and the Office of Management and Budget to use a portion of capital funds that were earmarked for Mental Health Trust facilities for beneficiaries, to use some of that money to put together a more standardized follow-up project for both rural and urban out-patient and residential programs. We have set aside \$250,000, we have received authority from General Services and Supply to sole source this contract with a program called New Standards Incorporated out of Minnesota. They used to go by the name CATOR, which is a Comprehensive Alcohol Treatment Outcome Research Project. It is a firm that has gained a significant reputation in the field and among other states starting out first in the private sector and now working more in the public sector in attempting to do some standardized treatment follow-up that allows you to compare both between programs and compare programs of like in other states, in other places. They have maintained a fairly large, expansive data base of services. We are in the process of negotiating that contract now. Hopefully the data collection will start in December. The final, final results will be 2-1/2 years from that time. The reason for this is that follow-up studies are extensive, expensive and need a lot of time.

We are going to collect data for a year. That means that when a person enters the treatment programs that we select, they will be given the standard assessment that that program does, as well as a standard assessment from CATOR. If they're in a residential program, they will be given the same instrument at discharge from the residential program. If they are in an outpatient program they will pick a time certain, usually a month or two months after they begin treatment, and they will do this discharge summary. Then all that information is collected at the local program level and sent to CATOR. They put those all into their computer data base and begin the analysis of, What is the profile of the client as they come in the door? What is their employment status, their health status, their legal status, their diagnostic categories, educational level, marital and family status, use of social services agencies, all of those things that are harmed within a person's life by their substance abuse. They will then contact that person at six months and 12 months from the time of discharge to determine what their status is on all those same variables so we can see how they've improved, which clients improved the best within what kinds of treatment and also what information will be available back at the programs. Some

preliminary data will be able to come out at nine months and 12 months because we will at least have intake information and we will know what our client population looks like, different from our management information system. To do that level of follow-up to give you the scientific validity, that you did the appropriate sampling, that you got enough clients so that you're statistically correct, that if this is not an anomaly, takes a significant amount of time and effort.

We are going to try, I think, to collect the initial information on roughly 1,400 clients. CATOR is hoping that 700 to 800 will still be able to be found and followed up 12 months after their discharge from treatment. We do expect some attrition. People will refuse, they'll change their mind, they won't want to talk on the telephone, there will be all kinds of other issues that will be raised for people who drop out, but we're hoping that effort will come about. We will have that contract and the scope of the work available when the legislature... so we will be able to walk that through the budget committee and the other legislative committees if they're interested.

In addition, we have put together a group of individuals called our Strategic Planning Team that represent the providers in the field, that represent the Departments of Corrections, the Department of Education, within our department the Division of Public Health, the Division of Family and Youth Services and the Division of Mental Health into a strategic planning team that has been looking at three things: one, at our mission statement, what we're about, why we exist, where we should go from here, and to basically try to put together a strategic plan for our division that will both push and pull us into the future and not keep us mired as much in the past as I think some of our plans have been rightly criticized for being. The first draft of that plan will be presented to our advisory board in Fairbanks on Thursday. On Friday and Saturday they will be holding public hearings in Fairbanks on that plan. We are reviewing it within themselves, making comments back to us. We will then take the month of October to finalize writing it. The last two days in October, I think the 28th and 29th of October, we will bring our strategic planning team back together to take one more look at that product and then by statute that product will then go back to the commissioner's office and then to the Governor. I believe it's AS 47.37.040(10), requires us to develop a plan for the Governor, and so this plan will be presented to the Governor and hopefully he will accept that plan and then we will be on our way to basing our fees for the next budget cycle, the next grant cycle. Hopefully that will address some of the issues addressed in the Ombudsman's report.

CHAIRMAN PORTER: Let me interject here if I may and I hope (inaudible) vote that my voice is not getting all the way to Bethel. I hope it is now. I'm a little closer to the mike. If not, let me know and I'll put it in the back of my head. I recognize that obviously for final approval that that draft plan for your division would have to go the Governor's office. I would appreciate it if you could find out for us whether or not this task force could be made aware of what that plan contains prior to that with whatever restrictions the Governor's office

might want to put on it, to the extent that we could perhaps have input from the information that we're gaining to suggest inclusions for dilution's or amendments to that plan before it gets etched in stone and has to go through another lengthy process.

LOREN JONES: I have assumed that at the October 4th meeting, which was after our board had met that, 1) there may be some testimony from those who attended that meeting, at least the front section I believe I was going to try to get to the task force. What we had the most difficult time crunch on is when you get down to the nitty gritty of defining the goals and trying to put those in the appropriate outcome measures. It's harder to get agreement and that is the weakest part of the draft to date and that is the part we will work on through October and the end of October at the strategic meeting, (inaudible) and then philosophy on some of the research and the background behind that, I'm planning to provide the task force on October 4th, after our board had looked at it and made their comments and so we will provide that.

And then as soon as that plan has been approved by the strategic planning committee, if the Commissioner desires, I will make sure you have it as early in November as I can before your December 1st hearing to make sure you do have that available.

Just a couple other things and I guess I will stop for some questions and allow other people to testify. I have an opportunity through several other hearings to say other things. One of the issues that you talked about in terms of coordination and cooperation between other programs... This division, with it's divisional status, certainly does attempt to coordinate as best we can with other divisions within our own department. Sometimes that's easier and sometimes it's harder. We do have some projects jointly with the Division of Mental Health. One of those projects is the dually diagnosed projects... (end of tape)

TAPE ONE, SIDE B
Number 000

...by the Division of Alcoholism and Drug Abuse. It provides for rural human service workers in the villages, people that can provide, like a community health aide does, providing primary health care in the village and like the (inaudible) providing primary public safety that the human services worker would be able to provide substance abuse services, mental health services, referral, after care, education, prevention work within each of the villages. The Niel Corporation in Kotzebue and the Dillingham/Bristol Bay Health Corporation are two grantees under that program that may be on this teleconference and that is a joint funded program that provides for additional services in the villages. One of the lacking of some of the services as I described those will be that lack of services into the communities.

In addition, the Department of Corrections we have work with in terms of providing counselors within each of the jails. The Norton Sound Health

Corporation here has a contract, has a contract, with the Department of Corrections to provide a counselor at Anvil Mountain. Those grants used to come from us. Corrections gave us the money several years ago. The Department of Corrections opted to want to run that more in house of their department rather than our division. We have been in the process of reversing that and we were going to RSA them money. The legislature deleted that money in the FY 94 budget so the entire inmate substance abuse program within the Department of Corrections is solely funded with the Department of Corrections funds.

We have encouraged them and they have continued to use local providers rather than hiring alcohol counselors on state salaries. We feel the local programs provide ample expertise and abilities to provide those services in the jail and to (inaudible) substance abuse costs to the Department of Corrections. However, the Department of Corrections is still using us to fund community treatment beds for inmates who are getting out on furlough or getting out on parole that need a residential level of care once they have left the institution, and so we do have a relationship with them and then we grant that money out to local providers and communities that the Department of Corrections desires, and that money then flows out to the local treatment programs to provide bed space and treatment capacities for persons leaving the Department of Corrections.

Within the Department of Education, they have a federal program called the Drug Free Schools in which the federal government gives the State of Alaska a certain money. That money is then sent out to the local school districts on a per capita basis with formula basis based on their average daily census within the schools. As part of that there is a requirement that they have an advisory board that advises the Department of Education on the plan and some of their distribution. I am a member of that, as well as a member from the Governor's office.

In addition, the Governor has awarded discretionary funds under the drug free schools act, and I think some other bureau of justice system that the governor's of each state has the ability to give where they want to provide whatever services. Governor Hickel, Governor Cowper before him, opted to give that money to the Department of Education and that is put out in prevention grants to local school districts, to some local providers.

They are all prevention efforts. They subsidize DARE programs, the Drug Abuse Resistance Education programs that are operated by local police officers, and we fund some of those directly.

So we do in many cases opt to work with other divisions and other departments in order to better coordinate services for the client.

I understand in the book you were given a map that people on teleconference won't be able to see, but basically lays out our regions. Also on the map that gives you an idea what our funding percentages are based on that population.

One group of people I'm leaving out are the Indian Health Service which

does provide a considerable amount of money directly to local programs, mostly 638 contractors, although they do have some funds that they call bi-Indian money. But most of them are 638 funds as federal public law that allows for Indian self determination and the Indian Health Services funds from (inaudible) corporations for primary medical care. Substance abuse prevention, I think some FAS funds, health care community health aids, a lot of that is under the 638.

If I might, I could just sort of go down the regions that may be on the teleconference and if I can a little bit from memory give you an idea of the (inaudible) of the bill. If you start of the top, Region 6 is basically the North Slope Borough. The major grantee is the North Slope Borough Health Department. They receive funds for both outpatient and outreach efforts in Barrow and the other communities. They are funded for a six bed detox program and a 16 bed residential program in Barrow. We are probably a minor contributor in terms of funds. I believe we contribute roughly \$500,000; I think the Borough probably puts in another \$1.5 million in order to fund that program at the level at which they do fund it.

Region 5 -- as you go down the left side, is in the Manilik region. The Manilik Association receives funding through the budget request region, the Manilik BRU. They do not receive funding out of our grant budget. They provide for village outreach, a level of outpatient care. They have a detox program and a 12 bed residential program. They also do some of the prevention work in the schools. Also, as part of Region 5, is the Norton Sound Health Corporation Region that's headquartered here in Nome. The Norton Sound Health Corporation also is funded from a Budget Request Unit. It is not funded out of our budget. I believe they primarily use our money for their residential program, Northern Lights Recovery Center. Indian Health Service money pays for their prevention effort, some of their outreach effort. I know that there's one representative here in the room that has testified. She could probably better describe that program better than I can. I'm probably not doing justice to it.

Region 7 -- which is the YK Health Corporation, the Bethel Region. They are funded in two ways. They get some money from our grant, the majority of money from our grant program. They also have their rural services, they are village counselors, there are nine, are funded through the budget request unit for YK (Yukon-Kuskokwim). The City of Bethel used to operate the treatment program there and the YK Health Corporation did the rural services. About two years ago the City of Bethel opted to no longer perform those services and so YK Health Corporation has taken over. The money has just never moved into their BRU, but I suspect that this year we will be coming in with a request to do that.

Region 2 covers the Dillingham area. The Bristol Bay Area Health Corporation is the provider there. They provide mostly outpatient services. They provide alcohol safety action programs. We pay for services in the villages, village counselors. The Indian Health Service supports that, as does the rural human services project. They just

recently opened up sort of a transitional residential place for those who have been, say in Anchorage or Fairbanks for treatment. On their way back to their village they may stay in Dillingham for two or three days to sort of adjust back, to talk to the local people, make contact with the provider there, before they go back to their local community. It's also a transition for those who are leaving their local community, maybe going to treatment elsewhere, to come in from a outlying village into Dillingham, spend three or four days talking with the staff there, and then moving on. I do believe when I talked to the program director there yesterday that she was going to try to, during the day, to testify and I'm sure that Dillingham will do that.

Region 9 is mostly the interior. It's the Tanana Chiefs/Doyon Region. I don't know if you are teleconferenced to either Galena, McGrath or Aniak, but within that river system, sort of the mid-interior, we do have a project in Galena, we do have a project at McGrath to serve all those villages there and then Aniak serves the villages of the Kuskokwim Natives Association which is called the Yukon/Kuskokwim Health Corporation District, but they do have a separate program for the seven or eight villages along the Kuskokwim River out of Aniak. As you can see by the map, it describes basically the population and the percent of dollars. These are a low population area. They get a considerable number of resources.

Region 6 has one percent of the state's population and they get three percent of our grant funds and Indian Health Service money. When you combine all the money provided out there they get three percent.

Region 5 has three percent of the population, nine percent of the funding.

Region 7 has four percent of the population, seven percent of the funding.

Region 2 has three percent of the population and four percent of the funding.

We feel that this distribution is justified in many ways. It is very difficult to provide services out here. It is very costly to provide services. When you're in the Nome area and you try to serve St. Lawrence Island and you have to fly people out and fly clients in, prevention efforts out, salaries are higher, travel costs are higher. There are real significant issues with that.

I guess with that as an overview, I'll give you an idea of whom might be testifying. I can either answer questions now or as the day proceeds, whatever you desire. Thank you very much Mr. Chairman.

CHAIRMAN PORTER: Thank you Loren, very much, for that very comprehensive overview of where we are and what's going on. I would recognize over the teleconference network that we have, I believe, Kotzebue, Bethel, we have people here in Nome of course, and Dillingham. I think I'll ask the committee now if there are any specific questions