ALASKA LEGISLATURE COMMITTEE FILES 2001-2002 8672

10250 HOUSE JUDICIARY

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692 P.2d 961 BASS V. MUNICIPALITY OF ANCHORAGE (Ct. App. 1984)

MICHAEL BASS, Appellant,

vs.

MUNICIPALITY OF ANCHORAGE, Appellee.

File No. A-273, No. 429
COURT OF APPEALS OF ALASKA
692 P.2d 961
December 14, 1984
Appeal from the District Court of the State of Alaska, Third Judicial District, Anchorage, John D. Mason, Judge.

COUNSEL

John T. Maltas, Assistant Public Defender, Kenai, Sen K. Tan, Assistant Public Defender, Anchorage, and Dana Fabe, Public Defender, Anchorage, for Appellant. Shelley K. Owens and James A. Crary, Assistant Municipal Prosecutors, Allen M. Bailey, Municipal Prosecutor, and Jerry Wertzbaugher, Municipal Attorney, Anchorage, for Appellee.

JUDGES

Before: Bryner, Chief Judge, Coats and Singleton, Judges.
AUTHOR: COATS

OPINION

COATS, Judge. Opinion

Anchorage Police Officer Baker was dispatched to a single-car, injury accident in the area of Spenard Road at 3:00 a.m. on September 3, 1983. Baker saw Michael Bass being escorted back to the scene of the accident by an airport security officer. Bass's vehicle was overturned. Baker was told by a security officer that Bass had been in an accident, had fled the scene on foot, and had been pursued by the officer.

Baker asked Bass what happened and was told that Bass's vehicle went out of control and rolled when Bass swerved to avoid hitting another car. Baker observed the strong odor of alcohol, slurred speech and unsteadiness as Bass stood in the area. According to Baker, Bass was also extremely belligerent and noncooperative with paramedic rescue personnel at the scene of the accident.

Baker observed that Bass needed immediate medical attention. He noted that Bass had a hand injury which would require stitching and had hit his chest hard against the steering wheel. Bass was taken to Providence Hospital for treatment.

Baker arrived at the hospital emergency room at about 3:45 a.m. Upon arrival, he spoke to hospital personnel and learned that Bass had a lacerated hand which would require stitching and a severely bruised chest, with possibly some broken ribs. Baker was told that the hospital personnel did not anticipate knowing whether Bass would actually be admitted for at least two

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hours.

Baker then apparently called the municipal prosecutor, Allen Bailey, and explained that (1) because of the severity of Bass's injuries, Baker did not know when Bass's treatment would be completed; (2) even if Bass was not admitted, it would be several hours before a breathalyzer test could be done, and (3) based on what Baker was told about Bass's chest injuries, Baker was unsure whether Bass could blow into a breathalyzer sufficiently to give an accurate reading. Bailey advised Baker to obtain a blood sample.

When Baker informed Bass that blood would be drawn, Bass objected. He said that he was not going to have his blood drawn and started to walk out of the hospital. Baker then placed Bass under arrest, handcuffed him, and placed him back on the gurney. Officer Honnen assisted Baker in restraining Bass, putting Bass in a wristlock to assist Baker in handcuffing Bass. Honnen and Baker then restrained Bass, holding him onto the gurney while the laboratory technician drew blood from him. Baker admitted that there was some bleeding from Bass's lacerations at this time and that Baker was aware that Bass might have had cracked ribs, but that they restrained him as gently as they could.

Bass, on the other hand, indicated that the officers forced him down on the floor, dragged him over to the gurney, and inflicted so much pain that he could not move. He said he protested throughout the procedure. After the blood was drawn, Bass was issued a citation and the officers left him at the hospital. Bass's blood alcohol level was 0.243.

Both parties agree that Bass was conscious and alert at the time of the extraction of his blood. He actually walked into the hospital himself. He understood what was going on around him and verbalized his refusal to consent to the extraction.

On January 1, 1984, Bass moved to suppress the results of the blood-alcohol test. He based his motion upon the ground that he was not unconscious or otherwise in a condition rendering him incapable of refusing which would permit the nonconsensual extraction of his blood under AS 28.35.035(b).

District Court Judge John D. Mason denied Bass's motion, making extensive factual findings. Judge Mason interpreted AS 28.35.035(b), which allows nonconsensual blood testing where a person is in a condition rendering him incapable of refusal, to include "a person being hospitalized as a result of incidents that have occurred" who "cannot fairly be offered a breathalyzer test." Judge Mason refused to suppress the results of the blood test. After a jury trial in which the results of his test were admitted into evidence, Bass was convicted of driving while intoxicated in violation of AMC 9.28.020. Bass now appeals to this court and argues that Judge Mason erred in not suppressing the results of the blood test. We reverse.

This case requires us to analyze the state statutes which authorize the poli .o initiate blood alcohol tests following an arrest for driving while intoxicated.[1] Under the state statutes, a person who drives a motor vehicle in the state implicitly consents to submit to a breath test to determine the amount of alcohol in his blood if he is lawfully arrested for driving while intoxicated. AS 28.35.031(a)[2] If one arrested for driving while intoxicated refuses to take a blood test, after being

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informed of the consequences of such refusal, "a chemical test shall not be given, except as provided by AS 28.35.035." AS 28.35.032.[3] AS 28.35.035 provides in part:

Administration of chemical tests without consent.

(a) If a person is under arrest for an offense arising out of acts alleged to have been committed while the person was driving a motor vehicle while intoxicated, and that arrest results from an accident that causes death or physical injury to another person, a chemical test may be administered without the consent of the person arrested to determine the amount of alcohol in that person's breath or blood.

(b) A person who is unconscious or otherwise in a condition rendering that person incapable of refusal is considered not to have withdrawn the consent provided under AS 28.35.031(a) and a chemical test may be administered to determine the amount of alcohol in that person's breath or blood. A person who is unconscious or otherwise incapable of refusal need not be placed under arrest before a chemical test may be administered.

In **Pena v. State,** 684 P.2d 864 (Alaska 1984), the supreme court held that "the Implied Consent Statute provides the exclusive authority for the administration of police-initiated chemical sobriety tests to a driver arrested for acts allegedly committed while operating a motor vehicle."[4] **Id.** at 867 (footnote omitted). It therefore seems clear that the municipality can justify forcibly taking the blood sample from Bass only if the taking falls under AS 28.35.035(b).

It seems clear to us that AS 28.35.035(b) does not apply to this case. In the implied consent statutes, the legislature has gone to great lengths to avoid authorizing the police to forcibly take blood alcohol tests from defendants charged with driving while intoxicated. The legislature has, instead, provided extremely strong incentives to a defendant to take a breath test for blood alcohol by providing criminal penalties. The legislature has provided for giving breath tests without the cooperation of the defendant only in two situations. In AS 28.35.035(a), the statute provides that if a person is under arrest for driving while intoxicated and the arrest results from an accident which caused death or physical injury to another person, a chemical test of the defendant's blood alcohol may be administered without consent. The policy behind this provision seems clear. If the driving while intoxicated offense is of the most serious type, involving death or physical injury, the legislature will allow taking a blood-alcohol test without consent.

The other situation in which the legislature has authorized taking a blood-alcohol test under AS 28.35.035 is where a person . . . is unconscious or otherwise in a condition rendering that person incapable of refusal." The trial judge read this statute broadly. He found that Bass needed to be at the hospital for treatment and that the police could not give a breath test at the hospital. He also found that there was a possibility that, even if offered a breath test, the defendant would not physically be able to take it because of his injuries. He concluded that Bass was "in a condition rendering [him] incapable of refusal."

We believe that, in light of the fact that the legislature has gone to great lengths to not

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authorize the police to forcibly take blood tests, AS 28.35.035 should not be read broadly. Certainly it would have been easy for the legislature to say that the police could forcibly take a blood alcohol test if there were exigent circumstances which prevented the police from administering a breath test. The narrow language which the legislature chose precludes this interpretation. Therefore, the fact that it was not practical to offer Bass a breathalyzer test does not bring this case within AS 28.35.035(b). What does seem to fall within AS 28.35.035(b) is a narrow class of cases where the defendant is unconscious or otherwise incapable of manifesting his intent to refuse. In these cases the police would be able to take a blood test without the person's contemporaneous consent, but without having to use any violent means to obtain the blood-alcohol test. We note that the legislature did not say in AS 28.35.035(b) that the police could take a blood alcohol test **without consent** as it did in AS 28.35.035(a). Rather, the legislature said that "a person who is unconscious or **otherwise in a condition incapable of refusal** is considered **not to have withdrawn the consent provided under AS 28.35.031(a).** " (Emphasis supplied.) The legislature's choice of language seems to us to be consistent with the theory that AS 28-35-035(b) was intended to apply only to situations where a blood-alcohol test could be conducted without any violence such as where an arrestee is unconscious. A person who is unconscious is considered not to have withdrawn his implied consent and a blood-alcohol test can thus be administered under AS 28.35.035(b). This language does not seem to apply to a person in Bass's position, who definitely refused to consent to the blood test and resisted the test. Under these circumstances, we conclude that AS 28.35.035(b) did not authorize the police to initiate a blood-alcohol test, even if Bass was physically incapable of taking a breath test. We hold that Bass was not "a person who [was] unconscious or otherwise in a condition incapable of refusal" for purposes of AS 28.35.035(b). Therefore, the police should not have forced Bass to have the blood sample drawn and Judge Mason should have suppressed the evidence.

The municipality argues that the evidence against Bass at trial was strong, and that admission of the blood test result was, if error, harmless. We disagree. The blood alcohol test result of 0.243 was admitted at trial and could certainly have been critical evidence for this charge of driving while intoxicated.

The conviction is REVERSED.

OPINION FOOTNOTES

1 Municipality of Anchorage ordinances also address this situation. They are virtually identical to the state statutes. Implied consent statute AS 28.35.031(a) is equivalent to AMC 9.28.021(A), which provides:

A person who operates, drives or is in actual physical control of a motor vehicle within the municipality or who operates an aircraft as defined by AMC 9.28.020E.1 or who operates a watercraft as defined by AMC 9.28.020E.2 shall be considered to have given consent to a chemical test or tests of his or her breath for the purpose of determining the alcoholic content of his or her blood or breath if lawfully arrested for an offense arising out of acts alleged to have been committed while the person was operating, driving or in actual physical control of a motor vehicle or operating an aircraft or a watercraft while intoxicated. The test or tests shall be administered at the direction of a law enforcement officer who has reasonable ground to believe that the person was operating, driving, or in actual physical control of a motor vehicle or operating an aircraft or a watercraft in the municipality while intoxicated.

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AS 28.35.032(a), "Refusal to submit to chemical test," is equivalent to AMC 9.28.022(A), which provides:

If a person under arrest refuses the request of a law enforcement officer to submit to a chemical test under AMC 9.28.021A, after being advised by the officer that the refusal will, if that person was arrested while operating or driving a motor vehicle for which a driver's license is required, result in the denial or revocation of the license or nonresident privilege to drive, that the refusal may be used against the person in a civil or criminal action or proceeding arising out of an act alleged to have been committed by the person while operating or driving a motor vehicle or operating an aircraft or a watercraft while intoxicated, and that the refusal is a misdemeanor, a chemical test shall not be given, except as provided by AMC 9.28.025.

AS 28.35.035(a) and (b) have municipal code counterparts in AMC 9.28.025(A) and (B), which provide:

A. If a person is under arrest for an offense arising out of acts alleged to have been committed while the person was driving a motor vehicle, and that arrest results from an accident that causes death or physical injury to another person, a chemical test may be administered without the consent of the person arrested to determine the amount of alcohol in that person's breath or blood.

B. A person who is unconscious or otherwise in a condition rendering that person incapable of refusal is considered not to have withdrawn the consent provided under AMC 9.28.021Aand AS 28.35.031 (a), and a chemical test may be administered to determine the amount of alcohol in that person's breath or blood. A person who is unconscious or otherwise incapable of refusal need not be placed under arrest before a chemical test may be administered.

The motion and the arguments of both parties below, as well as the court's findings and ruling, referred to the state statutes. We thus refer to those statutes in this opinion. No party has suggested that the municipal ordinances would differ in application from the state statutes.

2 AS 28.35.031(a) provides:

Implied Consent. (a) A person who operates or drives a motor vehicle in this state . . . shall be considered to have given consent to a chemical test or tests of the person's breath for the purpose of determining the alcoholic content of the person's blood or breath if lawfully arrested for an offense arising out of acts alleged to have been committed while the person was operating or driving a motor vehicle . . . while intoxicated. The test or tests shall be administered at the direction of a law enforcement officer who has reasonable grounds to believe that the person was operating or driving a motor vehicle . . . in this state while intoxicated.

3 AS 28.35.032(a) provides:

Refusal to submit to chemical test. (a) If a person under arrest refuses the request of a law enforcement officer to submit to a chemical test under AS 28.35.031 (a), after being advised by the officer that the refusal will, if that person was arrested while operating or driving a motor vehicle for which a driver's license is required, result in the denial or revocation of the license or nonresident privilege to drive, that the refusal may be used against the person in a civil or criminal action or proceeding arising out of an act alleged to have been committed by the person while operating or driving a motor vehicle or operating an aircraft or a watercraft while intoxicated, and that the refusal is a misdemeanor, a chemical test shall not be given, except as provided by AS 28.35.035.

4 The only exception to this principle would be consent to the blood-alcohol test. Consent is not an issue in this case.

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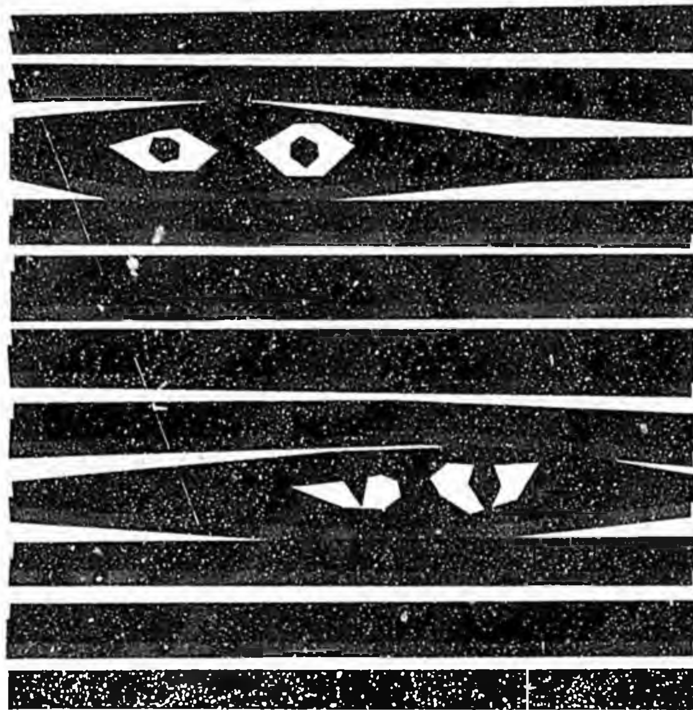

ALASKA'S GREATEST HIDDEN TAX:

The Negative Consequences of Alcohol & Other Drug Abuse and Dependence

State of Alaska
Advisory Board on Alcoholism and Drug Abuse
ANNUAL REPORT - February 2001

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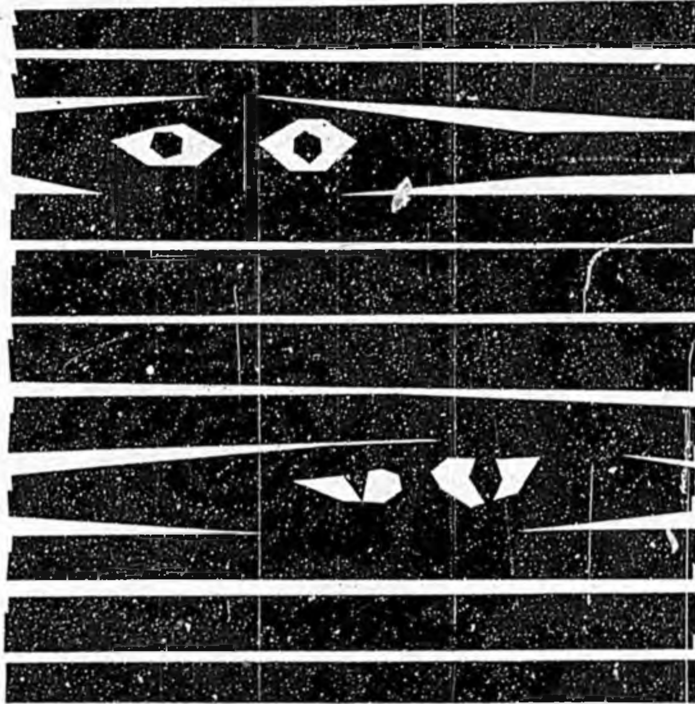

ALASKA'S GREATEST HIDDEN TAX:

The Negative Consequences of Alcohol & Other Drug Abuse and Dependence

State of Alaska
Advisory Board on Alcoholism and Drug Abuse
ANNUAL REPORT - February 2001

Who are we?

The Advisory Board on Alcoholism and Drug Abuse has 15 members. There are 14 public members appointed by the Governor to four-year terms. The Director of the Division of Alcoholism and Drug Abuse serves ex officio as the 15th member. State law requires that one member be licensed to practice medicine in the state; one member be admitted to practice law in the state, four members who are chronic alcoholics in recovery; three members who are substance abuse treatment professionals who represent public or private providers of prevention or treatment services; and five members who have a special interest in the personal and community problems associated with alcohol and other drug abuse and dependency.

What do we do?

The Advisory Board is required by law to act in an advisory capacity to the Legislature, the Governor and state agencies in matters regarding special problems affecting mental health that alcohol and other drug abuse and dependency many present. The Board follows educational research and offers public information that raises public awareness of the social problems and legal processes affecting the rehabilitation of alcoholics and drug abusers. It advocates for the development of prevention, treatment and rehabilitation programs. The Board reviews and advises the Commissioner of Health and Social Services on grant proposals and provides funding recommendations to the Mental Health Trust Authority concerning the integrated comprehensive mental health program for chronic alcoholics suffering from psychosis in accordance with state law:
AS 47.30.056(b)(3).

How may we help you?

- Call us at (907) 465-8920, or toll free at 888-464-8920
- Visit us at 240 Main Street, Suite 101, Juneau, AK 99801
- Write to us at PO Box 110608, Juneau AK 99811-0608
- E-Mail us through our Executive Director:
  Pam_Watts @ health.state.ak.us
- Visit our website at http://www.abada.com

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You may not realize it, but everbody pays for the negative consequences of alcohol and other drug abuse and dependence.

A conservative estimate is $399 in public sector expenses for every Alaskan. That was $250 million for FY98. This is a hidden "tax" on individuals and communities. It needs to be viewed in the clear light of day.

Much of that expense is incurred because there are not enough consistent efforts to prevent, intervene or support recovery in thousands of Alaskans of all ages.

An increase in the excise tax on alcohol would help to reduce consumption and to generate revenue to offset these expenses. Public awareness of the scope of the problem and commitment to healthy lifestyles are other necessary aspects of positive change.

The 2000 Annual Report of the Advisory Board focuses on research, strategies and legislative, regulatory and policy changes that will make Alaska a healthier and safer place to live. Implementation of these changes over time will also significantly reduce public sector expenses. That's good for individuals, families, communities and pocketbooks. ■

STRATEGIES TO REDUCE THE NEGATIVE CONSEQUENCES OF ALCOHOL AND OTHER DRUG ABUSE

1. Support community-based processes that build partnerships and provide more effective prevention and treatment services.
2. Encourage activities and initiatives that will change community standards and emphasize healthy lifestyles.
3. Distribute useful and effective information to targeted populations.
4. Promote the benefits of treatment, recovery and sober lifestyle.
5. Encourage traditional and alternative social activities that are alcohol and other drug free.
6. Advocate for positive change through legal and regulatory initiatives.
7. Ensure the delivery of quality services by offering appropriate continuing education and training for chemical dependency treatment professionals.
8. Expand awareness of substance abuse issues for allied health professionals, educators and other helping agents.
9. Use education strategies to help youth improve critical life and social skills.
10. Identify people with problems as early as possible and refer them for appropriate treatment.
11. Improve interdisciplinary coordination and collaboration at local, regional and statewide levels.
12. Support a continuum of care for chronic alcoholics with psychosis that focuses on intervention, treatment and the client's long-term life domain requirements.
13. Develop sufficient resources to meet community needs for appropriate levels of treatment for adults, youth and special populations.
14. Identify and remove barriers that prevent clients from entering treatment.
15. Support community efforts to establish involuntary commitment procedures and to use them when appropriate.
16. Provide appropriate services for underserved Alaskans.
17. Use relevant research to identify and incorporate key variables that contribute to successful treatment outcomes.
18. Address the treatment needs of persons in the criminal justice system.

-Results Within Our Reach, State of Alaska Plan for Alcohol and Drug Abuse Services, 1999-2003

MISSION STATEMENT

In partnership with the public, the Advisory Board on Alcoholism and Drug Abuse plans and advocates for policies, programs and services that help Alaskans achieve healthy and productive lives, free from the devastating effects of the abuse of alcohol and other substances. ■

Today I also ask for your help and partnership in addressing the often irreversible harm caused by alcohol abuse.

Alaska leads the nation in alcohol abuse. Statistics show that eighty percent of all crimes are committed by individuals under the influence of alcohol or drugs. The cost to the state runs in the millions of dollars.

--The Honorable Ted Stevens
United State Senator

Joint Session of the Second Session of the Twenty-First Alaska State Legislature
March 16, 2000
Juneau, Alaska

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ALASKA'S ALCOHOL INDEX

Year 2000

Enough alcohol was sold in Alaska in FY99 to add up to 516 drinks for every man, woman and child. That's based on an Alaska population of 627,000 and 323,689,076 drinks of beer, wine or spirits.
State of Alaska, Departments of Labor and Revenue.

Approximately 30% of Alaskan adults don't drink.

The negative consequences of alcohol abuse generate costs to the U.S. taxpayer at about 77 cents a drink. In Alaska, that meant at least $249 million in FY99.
NIAAA - "The Economic Cost of Alcohol and Drug Abuse in the U.S."
A national study just released by the Center for Addictions and Substance Abuse at Columbia University ups the number substantially. In a state by state analysis, it calculated Alaska's cost of substance abuse at $374 million in FY98. This included the negative consequences of tobacco as well as alcohol and other drugs.

The current Alaska excise tax on alcohol has not been changed 1983, even for inflation. Alaskans who drink pay a little over three cents tax on a beer or a glass of wine, and a little over four cents on a shot of hard liquor. This raised about $12 million in state revenue in FY99.
State of Alaska, Department of Revenue

You can do the math: $249 million - $12 million = a gap of $$237 million.

Alaska ranks first among all states in alcohol mortality.
How Does Alaska Stack Up?

Alaska's arrest rate for driving under the influence (DUI) and Alaska's rate of alcohol-related vehicle fatalities are among the highest in the nation.
How Does Alaska Stack Up?

Substance Abuse among elders is a much bigger problem than most people realize. Up to 17% of the older population abuse alcohol, prescription and non-prescription drugs. Fifteen to 25 percent of people over 65 have significant symptoms of mental illness. Depression is often part of the problem. Alcohol is a depressant that makes matters worse.
NCOA/SAMHSA

As many as *half* of people with serious mental illnesses develop alcohol or other drug problems at some point in their lives.
Mental Health: A Report of the Surgeon General

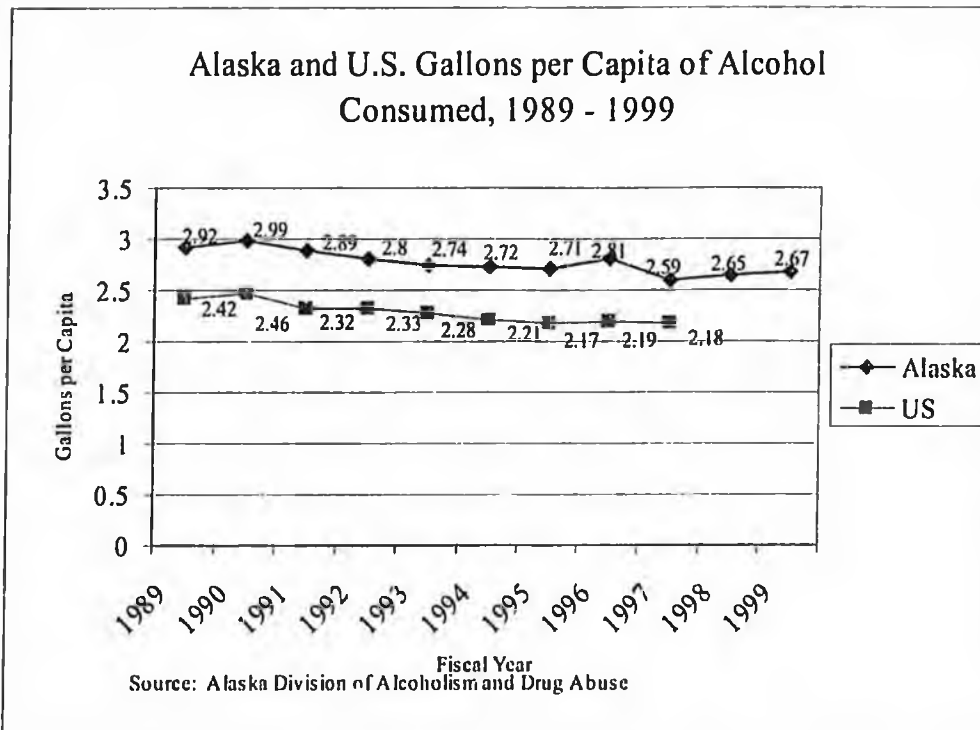
In many Alaskan communities beer is cheaper than milk, fruit juice or brand name soft drinks.

Nearly 60,000 Alaskans misuse, abuse or are addicted to alcohol. About 14,000 seek alcohol prevention or treatment services in programs that receive state funds.
State of Alaska, Division of Alcoholism and Drug Abuse

The prevalence of alcohol dependence and alcohol abuse in Alaska is just about twice the national average. About 7% nationally, and nearly 14% for Alaska.
Gallup Corporation Telephone Survey for the State of Alaska Division of Alcoholism and Drug Abuse

Alaska has the highest incidence of Fetal Alcohol Syndrome (FAS) in the world. FAS is totally preventable. Lifetime costs for an FAS birth are at least $1.4 million.
State of Alaska, Department of Health and Social Services

Where It All Begins: Per Capita Consumption



What We Know About Alaskan Drinking Patterns

Alaskan drinking patterns have some regional differences that were identified in the Alaska Adult Household Telephone Survey conducted by the Gallup Organization for the State Division of Alcoholism and Drug Abuse in 1999. When alcohol dependence is examined, the survey revealed that 9.7% of Alaskans age 18 and over meet that criteria. This is more than double the national number, 4.38%.

If you divide Alaska into four regions the percentage of persons who are alcohol dependent looks like this:

Southeast:	10.5%
Bush:	11.9%
Gulf Coast:	8.5%
Urban	9.5%

From this survey, we also know that 4.1% of Alaskans statewide abuse alcohol, and are at risk for dependence.

The study shows that more than 58,000 Alaskans are either courting or experiencing the negative consequences that inevitably accompany alcohol abuse and dependence. ■

What About Alaska's Visitors?

There is no current definitive analysis of how much of Alaska's alcohol consumption is related to the 1.4 million visitors to the state in 1999. It is reasonable to estimate that the visitors reflect U.S. adult drinking patterns. A preliminary analysis indicates that perhaps 10% of Alaska's alcohol consumption is related to the visitor industry. At the core of this analysis is an average visit length of 11.5 days. The Advisory Board will continue to seek additional information, but we know that the great majority of the negative consequences are home-grown, not visitor-related. ■

Frequently Asked Questions about Alcohol and Its Impact

To solve complex problems we need a common language and a common frame of reference. We repeat this popular "FAQ" with minor changes based on current research.

What do we mean by alcoholism?

Alcoholism, also known as "alcohol dependence," is a disease that includes alcohol craving and continued drinking despite repeated alcohol-related problems, such as losing a job or getting into trouble with the law. It includes three or more of the following:

Tolerance - a need for either significantly increased amounts of alcohol to feel its effects, or markedly reduced effect with the continued use of the same amount of alcohol.

Withdrawal - either symptoms of withdrawal such as nausea, sweating, shakiness, and anxiety when alcohol use is stopped, or use of alcohol to avoid withdrawal symptoms such as drinking in the morning to avoid symptoms.

Drinking more than intended - in larger amounts or over a longer time than intended.

Unsuccessful efforts to cut down or quit - or continuing desire to control drinking.

Much time spent drinking or recovering from the effects of drinking.

Reduction in other activities such as important social, occupational, or recreational activities because of drinking.

Continued drinking even when health is impacted - evidenced by knowledge that one's physical or emotional health as been damaged by drinking, yet continuing to use alcohol.

For clinical and research purposes, formal diagnostic criteria for alcoholism have been developed. They are included in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition,* published by the American Psychiatric Association, as well as in the *International Classification of Diseases*, published by the World Health Organization.

Is alcoholism a disease?

Yes. Alcoholism is a chronic, often progressive disease with symptoms that include a strong need to drink despite negative consequences, such as serious job or health problems. Like many other diseases, it has a generally predictable course, has recognized symptoms, and is influenced by both genetic and environmental factors that are being increasingly well defined.

Is alcoholism inherited?

Alcoholism tends to run in families, and genetic factors explain this pattern. Currently, researchers are on the way to finding the genes that influence vulnerability to alcoholism. A person's environment, such as the influence of friends, stress levels, and the ease of obtaining alcohol, also may influence drinking and the development of alcoholism. Still other factors, such as social support, may help to protect even high-risk people from alcohol problems.

Risk, however, is not destiny. A child of an alcoholic parent will not automatically develop alcoholism. A person with no family history of alcoholism can become alcohol dependent.

Can alcoholism be cured?

Not yet. Alcoholism is a treatable disease, and medication has also become available to help prevent relapse, but a cure has not yet been found. This means that even if an alcoholic has been sober for a long time and has regained health, he or she may relapse and must continue to avoid all alcoholic beverages.

Are there any medications for alcoholism?

Yes. Two different types of medications are commonly used to treat alcoholism. The first is tranquilizers, called benzodiazepenes, e.g., Valium, Librium, which are used only during the first few days of treatment to help patients safely withdraw from alcohol.

A second type of medication is used to help people remain sober. Medicine for this purpose is naltrexone. When used together with counseling, this medication lessens the craving for alcohol in many people and helps prevent a return to heavy drinking. Another older medication is disulfram (Antabuse), which discourages drinking by causing nausea, vomiting, and other unpleasant physical reactions when alcohol is used. The SAMHSA website has background information on newer medications. See p. 24.

Does alcoholism treatment work?

Alcoholism treatment is effective in many cases. Studies show that many alcoholics remain sober one year after treatment, while others have periods of sobriety alternating with relapses. Still others are unable to stop drinking for any length of time. A recent study on Alaska treatment outcomes shows 56% of outpatients and 42.% of inpatients abstained from alcohol for a year after treatment.

Many clients who are unable to avoid relapse are now being treated successfully with a combination of naltrexone and treatment. Persons with co-occurring mental illness and substance abuse or dependency may also benefit from this regimen. Treatment outcomes for alcoholism compare favorably with outcomes for many other chronic medical conditions such as diabetes. The longer one abstains from alcohol, the more likely one is to remain sober.

It is important to remember that many people relapse once or several times before achieving long-term sobriety. Relapses are common and do not mean that a person has failed or cannot eventually recover from alcoholism. If a relapse occurs, it is important to try to stop drinking again and to get whatever help is needed to abstain from alcohol. Ongoing support from family members and others can be important in recovery. Completion of aftercare/continuing care is another critical element for successful recovery.

Does a person have to be an alcoholic to experience problems from alcohol?

No. Even if you are not alcoholic, abusing alcohol can have negative results, such as failure to meet major work, school or family responsibilities because of drinking; alcohol-related legal trouble; automobile crashes due to drinking; and a variety of alcohol-related medical problems. Under some circumstances, problems can result even from moderate drinking - for example, when driving, during pregnancy, or when taking certain medications.

Are certain groups of people more likely to develop alcohol problems than other groups are?

Yes. Nearly 14 million people in the United State—1 in every 13 adults—abuse alcohol or are alcoholic. However, more men than women are alcohol dependent or experience alcohol-related problems. In addition, rates of alcohol problems are highest among young adults ages 18-29 and lowest among adults 65 years and older. Among major U.S. ethnic groups rates of alcoholism and alcohol-related problems vary. Alaska has the second highest rate of alcohol consumption in the nation, behind Wisconsin. One study ranks Alaska 5th in alcohol-related problems, and first in alcohol-related mortality.

How can you tell whether you or someone close to you has an alcohol problem?

A good first step is to answer the brief questionnaire below, developed by Dr. John Ewing. (To help remember these questions, note that the first letter of a key word in each questions spells "CAGE.")

Have you ever felt you could
Cut down on your drinking?
Have people
Annoyed you by criticizing your drinking?
Have you ever felt bad or
Guilty about your drinking?
Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover
(Eye opener)?

One "yes" answer suggests a possible alcohol problem. More than one "yes" answer means it is highly likely that a problem exists. If you think that you or someone you know might have an alcohol problem, it is important to see a qualified chemical dependency provider, or healthcare provider right away. He or she can help determine whether a drinking problem exists and, if so, suggest the best course of action. Resource telephone numbers are listed on page 24 of this report.

If I have trouble with drinking, can't I simply reduce my alcohol use without stopping altogether?

That depends. If you are diagnosed as an alcoholic, the answer is "no." Studies show that nearly all alcoholics who try to merely *cut down* on drinking are unable to do so indefinitely. Instead, *cutting out* alcohol (that is, abstaining) is nearly always necessary for successful recovery. However, if you are not alcoholic but have had alcohol-related problems, you may be able to limit the amount you drink. If you cannot always stay within your limit, you will need to stop drinking altogether.

If an alcoholic is unwilling to seek help, is there any way to get him or her into treatment?

This can be a challenging situation. An alcoholic cannot be forced to get help except under certain circumstances, such as when a violent incident or other criminal action results in police being called or following a medical emergency, a formal or informal intervention with the alcoholic, or through the Title 47 Involuntary Commitment Statute. This doesn't mean, however, that you have to wait for a crisis to make an impact. Based on clinical experience, many alcoholism treatment specialists recommend the following steps to help an alcoholic accept treatment:

Stop all "rescue missions." Family members often try to protect an alcoholic from the results of his or her behavior by making excuses to others about his or her drinking and by getting him or her out of alcohol-related jams. It is important to stop all such rescue attempts immediately, so that the alcoholic will fully experience the harmful effects of his or her drinking—and thereby become more motivated to stop.

Time your intervention. Plan to talk with the drinker shortly after an alcohol-related problem has occurred—for example, a serious family argument in which drinking played a part or an alcohol-related accident. Also choose a time when he or she is sober, when both of you are in a calm frame of mind, and when you can speak privately. If you choose not to use this informal route, seek professional help from a qualified chemical dependency provider experienced in conducting interventions. Remember that your safety is a primary consideration.

Be specific. Tell the family member that you are concerned about his or her drinking and want to be supportive in getting help. Backup your concern with examples of the ways in which his or her drinking has caused problems for both of you, including the most recent incident.

State the consequences. Tell the family member that until he or she gets help, you will carry out consequences—not to punish the drinker, but to protect yourself from the harmful effects of the drinking. These may range from refusing to go with the person to any alcohol-related social activities to moving out of the house. Do not make any threats you are not prepared to carry out.

Be ready to help. Gather information in advance about local and regional treatment options. If the person is willing to seek help, call immediately for an appointment with a treatment program counselor. Offer to go with the family member on the first visit to a treatment program and/or AA meeting.

Call on a friend. If the family member still refuses to get help, ask a friend to talk with him or her, using the steps described above. A friend who is a recovering alcoholic may be particularly persuasive, but any caring, nonjudgmental friend may be able to make a difference. The intervention of more than one person, more than one time, is often necessary to persuade an alcoholic person to seek help.

Find strength in numbers. With the help of a qualified chemical dependency counselor or healthcare provider, some families join with other relatives and friends to confront an alcoholic as a group. While this approach may be effective, it should only be attempted under the guidance of a provider who is experienced in this kind of group intervention.

Get support. Whether or not the alcoholic family member seeks help, you may benefit from the encouragement and support of other people in your situation. Support groups offered in some communities include Al-Anon, which holds regular meetings for spouses and other significant adults in an alcoholic's life, and Alateen, for children of alcoholics. These groups help family members understand that they are not responsible for an alcoholic's drinking and that they need to take steps to take care of themselves, regardless of whether the alcoholic family member chooses to get help.

What is a safe level of drinking?

Most adults can drink moderate amounts of alcohol—up to two drinks per day for men and one drink per day for women and older people—and avoid alcohol-related problems. (One drink equals one 12-ounce bottle of bear, one 5-ounce glass or wine, or 1 ounce of spirits.)

However, certain people should not drink at all. They include women who are pregnant

or trying to become pregnant; people who plan to drive or engage in other activities requiring alertness and skill; people taking certain medications, including certain over-the-counter medicines; people with medical conditions that can be worsened by drinking; recovering alcoholics; and people under the age of 21.

Is it safe to drink during pregnancy?

No. Drinking during pregnancy can have a number of harmful effects on the newborn, ranging from mental retardation, physical and cognitive abnormalities, and hyperactivity to learning and behavioral problems. Most of these disorders last into adulthood. Fetal Alcohol Syndrome (FAS) is the only 100% preventable birth defect. Alaska has the highest rate of FAS in the nation and by some standards, the world. While we don't yet know exactly how much alcohol is required to cause these problems, we do know that they are 100-percent preventable if a woman does not drink at all during pregnancy. Therefore, for women who are pregnant or are trying to become pregnant the safest course is to abstain from alcohol.

As you get older, does alcohol affect your body differently?

Yes. As a person ages, certain mental and physical functions tend to decline, including vision, hearing and reaction time. Moreover, other physical changes associated with aging can make older people feel "high" and cause impairment after drinking fairly small amounts of alcohol. Many older persons take a variety of prescribed and over-the-counter medications which can have harmful effects if combined with alcohol. These combined factors make older people more likely to have alcohol-related falls, automobile crashes, and other kinds of accidents.

Does alcohol affect a woman's body differently from a man's body?

Yes. Women become more intoxicated than men after drinking the same amount of alcohol, even when differences in body weight are taken into account. This is because women's bodies have proportionately less water than men's bodies. Because alcohol mixes with body water, a given amount of alcohol becomes more highly concentrated in a woman's body than in a man's. Men metabolize alcohol more quickly than women for that same reason. That's why the recommended drinking limit for women is lower than for men.

I have heard that alcohol is good for your heart. Is this true?

Several studies have reported that moderate drinkers—those who have one or two drinks per day—are less likely to develop heart disease than people who do not drink any alcohol or who drink larger amounts. Small amounts of alcohol may help protect against coronary heart disease by raising levels of "good" HDL cholesterol and by reducing the risk of blood clots in the coronary arteries. Recent studies indicate that grape juice may have the same protective factors as wine. The American Heart Association is recommending "calisthenics rather than cabernet" because of alcohol's other health risks.

If you are a nondrinker, you should not start drinking only to benefit your heart. Protection against coronary heart disease may be obtained through regular physical activity and a low-fat diet. And if you are pregnant, planning to become pregnant, have been diagnosed as alcoholic, or have any medical condition that could make alcohol use harmful, you should not drink.

Even for those who can drink safely and choose to do so, moderation is the key. Heavy drinking can actually increase the risk of heart failure, stroke and high blood pressure, as well as cause may other medical problems, such as liver cirrhosis.

If I am taking over-the-counter or prescription medication, do I have to stop drinking?

Possibly. More than 100 medications interact with alcohol, leading to increased risk of illness, injury and, in some cases, death. The effects of alcohol are increased by medications that slow down the central nervous system, such as sleeping pills, antihistamines, antidepressants, anti-anxiety drugs, and some painkillers. In addition, medicines for certain disorders, including diabetes and heart disease, can be dangerous if used with alcohol. If you are taking any over-the-counter or prescription medications, ask your doctor or pharmacist whether you can safely drink alcohol.

January 1998 - http://www@niaaa.nih.gov
with minor revisions by the Advisory Board on Alcoholism and Drug Abuse.

What's the Price Tag for Investing in Treatment?

Fiscal Year	State Treatment Grants	Medicaid Payments	Client Admissions	Average Cost Treatment Episode	Consumer Price Index
1992	$ 22,755,000	$ -	5,415	$ 4,202	128.2
1993	$ 21,331,000	$ -	9,144	$ 2,333	132.2
1994	$ 21,531,000	$ -	9,735	$ 2,212	135.0
1995	$ 20,411,000	$ 948,000	9,044	$ 2,362	138.9
1996	$ 19,812,000	$ 1,752,000	10,186	$ 2,117	142.7
1997	$ 20,219,000	$ 2,674,000	11,117	$ 2,059	144.8
1998	$ 21,188,000	$ 2,500,000	10,245	$ 2,093	146.9
1999	$ 19,953,000	$ 2,880,000	9,619	$ 2,374	148.4

Source: Alaska Division of Alcoholism and Drug Abuse, Department of Labor

This table shows the evidence of decreased or "flat" funding that has eroded treatment capacity throughout the state. Some specialized programs for women with children, incarcerated women, and adolescents have increased service capacity, usually driven by federal funding. However, the public treatment capacity for the typical client needing treatment continues to lag behind demonstrated need. Frequently these are clients who are engaging in behaviors and drinking patterns that have significant negative consequences.

What are the Savings from Investment in Treatment?

National Cost Savings from Substance Abuse Treatment Nears $1.7 Billion

	Before Treatment (in Millions)	After Treatment (in Millions)	Benefits to Society (in Millions)
Health Care Costs	$ 672.2	$ 653.2	$ 24.90
Earnings	$ 1,166.4	$ 1,550.0	$ 383.60
Crime-Related Costs	$ 3,215.8	$ 922.2	$ 2,293.50
Total Benefits	$ -		$ 2,702.10
Treatment Costs	$ -		$ 1,004.40

Source: U.S. DHSS, Substance Abuse and Mental Health Services Administration

This table shows the highlights of a recently released national study that examined the benefits of substance abuse treatment. Determining what these numbers are for Alaska continues to be a high priority for the Advisory Board. Of particular interest to policy makers is the remarkable reduction in crime-related costs after treatment. Early assessment and treatment whenever appropriate will continue to be a high priority for the Board. This is one of the most effective strategies that policymakers can use to reduce negative consequences.

What's the Price Tag for Alcohol's Negative Consequences?

We can be a little more precise than the late Senator Dirksen's famous quip, but the Advisory Board and many policy makers share a common frustration when it comes to putting a price tag on alcohol's negative consequences to Alaskans and their communities. The Advisory Board has learned that a comprehensive study to determine the full extent of costs is far outside the Board's budget. A small grant from the Alaska Mental Health Trust Authority will help frame the updating of two previous Alaska studies. One was completed in 1975 and the most recent one, "The Impact of Alcohol and Other Drug Abuse in Alaska," was completed in 1989.

> **"A few hundred million here, a few hundred million there. Pretty soon it starts to sound like real money."**
>
> *attributed to*
> *Senator Everet M. Dirksen, (R) IL*
> *1896-1969*

It is the Board's hope that policy makers across departments and divisions will collaborate to provide the data necessary to give all Alaskans a clear and comprehensive picture of what alcohol's negative consequences cost families, communities and the state.

Without our own Alaskan data collection and rigorous analysis, we are left estimating Alaska's costs based on national studies. The national costs of substance abuse are reviewed in studies released as recently as last month. The picture is not pretty, and we can conclude that Alaska's economic impacts are higher than the national average because Alaska's alcohol consumption is significantly higher than the national average. Because we don't have current data, we have opted for a conservative estimate based on national data: $250 million a year in public sector costs. In the meantime, the National Institutes of Health continue to develop a research agenda that encourages work on the effects of beverage prices, alcohol taxation and local regulation. Their last comprehensive study, 'The Economic Costs of Alcohol and Drug Abuse in the United States - 1992," estimated an economic cost to the country of $246 billion.

Here are some things all policymakers should know:

How does the cost of treatment for a woman of childbearing age compare with the lifetime expense of a Fetal Alcohol Syndrome birth (estimated at $1.4 million).

How does the cost of a public inebriate's frequent need for protective custody (estimated at $1,000 an incident) compare with long term care?

How does the cost of active prevention programs to discourage underage drinking compare with a year of confinement and treatment at a youth detention center? It costs at least $60,000/year to operate one detention center bed, and average length of stay can exceed one year.

How does the cost of recidivism for alcohol related crimes compare with intensive outpatient and continuing care costs to sustain good treatment outcomes?

If you think such an effort would help all Alaskans make good decisions about local and state policies and funding, we'd like to hear from you. An array of ways of contact us appear on the inside cover.

What Can We Learn From Recent Research?

10th Special Report to the U.S. Congress on Alcohol and Health

This 450-page comprehensive study of the relationship between alcohol and health was presented to the U.S. Congress at the end of last year. It offers current research findings on everything from measuring the health risks and benefits of alcohol to the role alcohol plays in violence, both for offenders and victims. Capitalizing on the growing body of research on how the brain functions, it includes the neurobiological and neurobehavioral mechanisms of chronic alcohol drinking, including the lasting changes that may occur to the brain.

There are new findings on genetic linkages and the psychosocial factors relating to a family history of alcoholism. Medical consequences are reviewed, including unique risks to women, alcohol-related breast cancer, and the dangers of prenatal exposure to alcohol.

Also of special interest to the Advisory Board are the chapters with economic perspectives. They include the effects of changes in alcohol prices and taxes, cost research on alcoholism treatment and economic costs of alcohol abuse. The growing body of research on the effects of alcohol advertising is also reviewed.

Treatment research findings emphasize the value of early screening and brief interventions. The report recognizes the systemic nature of the alcohol abuse problem in the nation. Its findings will be helpful in guiding the Advisory Board's planning efforts. ■

Barriers to Alcoholism and Other Drug Abuse Treatment for Women: Comparing Alaska Native and Non-Native Women

Advisory Board past chair Cheryl Mann, Ph.D., shared the content of her recent dissertation with the Board and Alaska Mental Health Trust during their funding deliberations last fall. She is currently a professor at the University of Alaska/Anchorage. She reviewed her findings from a survey of more than 200 women who were mothers and who required treatment for alcoholism or both alcohol and other drug dependency. Of the sample, half were Alaska Native and half were not. About half had been court ordered into treatment.

She found that Alaska Native women were more likely to be single, older, unemployed, have high school or less educational level, live in a village, be addicted to alcohol, have previously been to treatment, to and be court ordered into treatment more frequently than their non-Native counterparts. This unique look at Alaskan treatment needs provides the Board significant data for its planning responsibilities. It was agreed that policy makers and service providers should consider how to make more services available to women, both residential and outpatient.

Many heads nodded as Dr. Mann spoke of the need for more low cost services which were geographically accessible, and would address the unique needs of this high risk population. ■

Shoveling Up: The Impact of Substance Abuse on State Budgets

This is a three-year, state-by-state study released January 29, 2001 by the National Center of Addiction and Substance Abuse at Columbia University.

All together, states spent $81.3 billion, or about 13% of their budgets, dealing with the effects of drug, alcohol and tobacco abuse. This is about as much as states spend on higher education, the study found. The center's president, Joseph A. Califano Jr., lamented that only about 4% of the amount spent, or $3 billion, was for prevention and treatment programs.

Total spending by the states in 1998 was $620 billion, with 13.1 percent related to substance abuse.

Responding to the report the White House Office of National Drug Control Policy said it demonstrates the need for a "balanced strategy." "We cannot simply arrest our way out of the problem," acting director Edward H. Jurith commented in a statement about the report.

About Alaska: The study concluded that Alaska spends $532/person on government programs related to substance abuse, including tobacco, a total budget bite of $324 million. The study included expenditures in adult corrections, juvenile justice, education, health, child and family assistance, mental health, and developmental disabilities that are directly related to substance abuse. This was 9.8% of the state budget in FY98. Of these expenditures, only one-half of one percent (.5%) was dedicated to prevention and treatment services. ■

Handbook on Health Economics, Volume I, (in publication)

The Advisory Board is indebted to one of the country's most respected researchers on the relationship between alcohol consumption and taxation. Philip J. Cook, a professor at the Sanford Institute for Public Policy at Duke University. He shared an advance copy of Chapter 30 in the Handbook of Health Economics which examines trends and patterns in alcohol consumption, demand for alcoholic beverages in different populations, the consequences of alcohol consumption and taxation, the effect of drinking on productivity and an evaluation of alcohol taxation and other alcohol-control measures.

Professor Cook includes this portrayal of overall U.S. consumption by his research colleague D. Gerstein:

"If you put 10 drinking-age adults in a room, their annual consumption of absolute ethanol (pure beverage alcohol) would look roughly like this:

- There would be 3 nondrinkers.
- There would be 3 people drinking one gallon between themselves.
- There would be 1 person drinking 1.5 gallons.
- There would be 1 person drinking 3 gallons.
- There would be 1 person drinking 6 gallons.
- There would be 1 person drinking 15 gallons."

Cook pointed out that if the person drinking 15 gallons could be encouraged to cut his/her drinking to 6 gallons, then overall U.S. alcohol consumption would fall by one third. ■

What Can Be Done to Make Things Better?

Advisory Board on Alcoholism and Drug Abuse (ABADA)
LEGISLATIVE ADVOCACY PLATFORM FOR 2001

1. POLICY MAKING GOALS

ABADA advocates for public policies and legislation that recognize the diseases of alcoholism and other drug dependency as preventable and treatable, and view effective service delivery as a critical component of a healthy future for all Alaskans and their communities.

- **ABADA supports a statutory change to Title 47.37 Involuntary Commitment Statute to enable Physicians Assistants and Advanced Nurse Practitioners in rural communities to complete the required certificates of necessity where licensed physicians are not available.**
- **ABADA supports legislation to include inhalants in the Title 47.37 Involuntary Commitment Statute.**

2. REGULATORY AND ACCESS ISSUES

ABADA advocates for public policies and regulations that reduce overall consumption of alcohol, tobacco and other drugs, thereby helping to eliminate the negative consequences of substance abuse in Alaskan communities.

- **ABADA supports legislation to reduce the legal limit for the presence of alcohol while operating a motor vehicle from .10 to .08 BAC.**

3. REVENUE AND FUNDING ISSUES

ABADA advocates for revenue development and allocation that ensures adequate substance abuse service delivery to support healthy families and communities.

- **ABADA supports an increased excise tax on alcohol to match the cost of negative consequences of alcohol to the state and its residents.**

4. PREVENTION ISSUES

ABADA fosters community norms and standards that promote healthy lifestyles for Alaskans of all ages.

- **ABADA supports an Underage Drinking Initiative aimed at establishing a Juvenile Alcohol Safety Action Program to screen, assess and monitor minors cited for consuming or possessing alcohol, and**
- **Modifying state statutes to enhance opportunities for education and treatment in lieu or as part of sanctions for underage drinking or possession.**
- **ABADA supports development of additional alcohol and other drug treatment capacity for youth.**

5. TREATMENT ISSUES

ABADA supports access to a continuum of substance abuse services appropriate to the needs of Alaskans of all ages and in all regions.

- **ABADA supports the development of adequate resources to provide substance abuse/dependency treatment services to all Alaskans in need.**

6. CRIMINAL JUSTICE ISSUES

ABADA advocates for substance abuse intervention and treatment for offenders to reduce recidivism and to support positive transition back to communities.

- **ABADA supports implementation of the strategies outlined in the "Final Report of the Alaska Criminal Justice Assessment Commission, (ACJAC) Alcohol Policy Committee."**

7. QUALITY AND PERFORMANCE MEASURE ACCOUNTABILITY

ABADA advocates for accountability in service delivery, including a reliance on positive outcomes as a measurement of success.

- **ABADA supports adequate funding for management information system improvement necessary to measure service delivery effectiveness.**

8. PARTNERSHIP DEVELOPMENT

ABADA advocates for and participates in partnerships that leverage resources, maximize service delivery, minimize duplication, and enhance the health of all Alaskans.

Some Key Facts About .08 BAC Legislation

Why .08? We look to the National Highway Traffic Safety Administration for an overview of the issue. The following is excerpted from their January 2000 "State Legislative Fact Sheet."

When Congress passed a $58 billion Transportation Appropriations bill last fall it virtually made .08 BAC the law of the land. Twenty states already have adopted the .08 Blood Alcohol Content (BAC) limit. Other states have four years to do so before highway funding is reduced.

Virtually all drivers are substantially impaired at .08 BAC. Laboratory and test-track research shows that the vast majority of drivers, even experienced drinkers, are impaired at .08 with regard to critical driving skills. Braking, steering, lane changing, judgment and divided attention, among other measures, are all affected significantly at .08. Performance diminishes at a rate as high as 60 to 70% at .08 BAC according to these studies.

Opposition to .08 legislation generally includes the following claims:

The legislation will not affect high BAC problem-drinker drivers. A recent national study showed that .08 laws reduce fatal crash involvements of drivers with both low BACs and high BACs by 8%. The legislation lowers the bar for the amount of alcohol that is illegal in driving and sends that message to all potential drinking drivers, even those who typically reach very high BACs.

The .08 law will overburden the criminal justice system and jails. When California lowered its BAC limit to .08, no increases were reported in the proportion of DWI defendants pleading guilty, requesting jury trials, or appealing convictions. There was little impact on court administrators or judges. The main impact was on prosecutors' decisions concerning whether cases should be filed. Previously, DWI arrests with BACs below 0.12 typically were allowed to plead to reduced charges. Since the limit was changed, this plea-bargain "cut off" has dropped to about 0.10 BAC.

People who have a glass or two of wine with dinner will be at risk for a DWI conviction. An average male weighing 170 pounds must consume more than four beers within one hour on an empty stomach to reach a .08 BAC level. The average 135 pound female would have to drink three beers in one hour on an empty stomach to reach a .08 BAC.

Note: Each dot = 1 drink. One drink is: one 12 ounce beer, 1 ounce spirits or one 5 ounce glass of wine.

Alcohol Beverage Consumption in One Hour on Empty Stomach required to Reach .08 BAC

	90-109 lbs.	110-129 lbs.	130-149 lbs.	150-169 lbs.	170-189 lbs.	190-209 lbs.	210-229 lbs.	230 lbs up
1 hour	●●	●●	●●●	●●●	●●●●	●●●●	●●●●●	●●●●●
2 hours	●●	●●●	●●●	●●●●	●●●●	●●●●●	●●●●●	●●●●●●
3 hours	●●●	●●●	●●●●	●●●●●	●●●●●	●●●●●●	●●●●●●	●●●●●●●
4 hours	●●●	●●●●	●●●●	●●●●●	●●●●●●	●●●●●●●	●●●●●●●	●●●●●●●●

Source: U.S. Department of Transportation

A Gallery of Advocates for Successful Substance Abuse Treatment

Testimony to substance abuse treatment success came from fourteen Alaskans pictured here in the gallery of the House of Representatives last March. In an advocacy project sponsored by the Substance Abuse Directors Association (SADA) and funded with a small projects grant from the Alaska Mental Health Trust Authority, legislators and and other policy makers heard first hand about the difficult but ultimately empowering road to recovery taken by these individuals. The highly successful effort, called "Meeting the Challenge," was coordinated by SADA executive director Mary Rosenzweig, fourth from left, front row.

Nobody Tells the Story Better Than Someone Who's Been There

The March 2000 visit to Juneau by 14 recovering Alaskans was met with respect and gratitude by elected officials and other policy makers. Success breeds success, and the Substance Abuse Director's Association (SADA) is again sponsoring a March visit to Juneau so that a few of Alaska's thousands of recovering persons can speak for the importance and benefit of substance abuse treatment.

> "Looking back over a family filled with addiction....My family has been affected by at least two generations of alcoholism, perhaps more. Even though I am not an alcoholic you might say my roots are in the bottle."

This voice of advocacy is relatively new. Participants made a decision to tell others the story of their journey to recovery. Most recovering addicts are proud of their success but not everyone is ready to share that story with perfect strangers. The Advisory Board is grateful to participants in "Meeting the Challenge."

This effort is coordinated by SADA executive director Mary Rosenzweig, with a small projects grant from the Alaska Mental Health Trust Authority.

For the second year, participating substance abuse programs around Alaska are working with interested persons recovering from addictions, or their family members, to help them make their individual voices count. The project includes a self-advocacy skill building workshop to stress the importance of being involved in policy-making decisions.

> "I excelled in high school athletics and was co-captain of the varsity basketball team (the Mighty Nanooks), which was a dream I pursued since my childhood. By the time I was a junior I was able to purchase liquor at the local liquor store."

Once participants are in Juneau they are welcomed by a team of local advocates and senior policymakers. But their real value is in the one to one conversations with legislators and staff whose votes affect funding for service delivery.

While substance abuse is a systemic problem, the system has been affected one substance abuser at a time. The Advisory Board's guiding principles are well served as these courageous Alaskans speak out. --Contact SADA at 1-907 770-2927

Who Is At Greatest Risk?

ABADA Planning Efforts Focused on High Risk Alaskans

Along with legislative advocacy, the Advisory Board's major efforts are dedicated to making funding recommendations for service delivery that match the needs of Alaskans. These recommendations are made to the Alaska Mental Health Trust Authority (AMHTA), to the Governor, and to the Department of Health and Social Services. Recommendations that were high priorities for this year fell into these categories:

Beneficiaries of the Trust

These are Alaska's most impaired late-stage alcoholics. Damage can be irreversible. Both organ function and brain function have been diminished. Long term treatment capacity expansion is needed for this high risk group. About 1,500 received services in public programs in FY99. The Advisory Board views any Alaskan who is alcohol dependent as a Trust beneficiary. Research shows that more than 9% of Alaskans age 18 and over are alcohol dependent.

Underage Drinkers

Alaska's pervasive alcohol culture in many communities puts young people at serious risk. Research shows that if a young person doesn't drink before the legal age of 21 the chances of becoming an alcoholic are greatly reduced.

Alcohol-free social activities and other prevention activities are vital to the health of any community.

Treatment for Women with Children

The Board has continued to advocate for treatment expansion for women with children, especially in hub communities. Some expansion has occurred but more is needed. Rural women in particular often went without treatment because they feared losing custody of their children.

Needs of Frail Elders

About 17% of older Americans have problems with alcohol. Pilot projects in Fairbanks and Southeast, in collaboration with the Alaska Commission on Aging and the Trust, will help us to learn how best to deliver services to them.■

50 cents a brew - 2001

A brief look at some retail beer prices in Anchorage over the last 20 years:

June 1981
Major brands unit cost: 33 to 46 cents
Other brands unit cost: 32 cents

June 1983
Major brands unit cost: 37 to 56 cents
Other brands unit cost: 37 cents

June 1985
Major brands unit cost: 38 to 58 cents
Other brands unit cost: 35 cents

Fast forward to 2001
Major brands unit cost: 54 to 73 cents
Other brands unit cost: 36 to 40 cents

Source: Anchorage Times and Anchorage Daily News retail advertisers

Closing the Gap Between Tax Revenue and the Costs of Negative Consequences

VARIOUS TAX INCREASE SCENARIOS

Basis for calculations	Beer	Wine	Spirits	All
Gallons sold in Alaska in FY99	13,979,490	1,380,535	1,087,720	
Alaska tax per gallon since 1983	$ 0.35	$ 0.85	$ 5.60	
Standard drink amount	12 ounces	5 ounces	1 ounce	
Drinks per gallon	10.667	25.6	128	
Current Alaska tax per drink	$ 0.0328	$ 0.0332	$ 0.0438	
FY99 drinks in this category	149,119,220	35,341,696	139,228,160	323,689,076
Actual FY99 Revenue	$ 4,892,770	$ 1,173,088	$ 6,091,190	$ 12,157,048
Calculations of various increases	Beer Revenue	Wine Revenue	Spirits Revenue	All Revenue
Revenue @ 5 cent increase	$ 12,347,071	$ 2,940,429	$ 13,059,601	$ 28,347,101
Revenue @ 10 cent increase	$ 19,803,032	$ 4,707,514	$ 20,021,009	$ 44,531,555
Revenue @ 15 cent increase	$ 27,258,993	$ 6,474,599	$ 26,982,417	$ 60,716,009
Revenue @ 20 cent increase	$ 34,714,954	$ 8,241,684	$ 33,943,825	$ 76,900,463

Data source: Alaska Department of Revenue
Data calculations: Advisory Board on Alcoholism and Drug Abuse

Note: Revenue projections do not reflect the probable decrease in consumption based on price sensitivity.

A History of Alcohol Tax in Alaska

	Liquor per gallon	Wine per gallon	Beer per gallon
1933		$0.05	$0.05
1937	$0.50	$0.15	$0.05
1941	$1.00	$0.15	$0.05
1945	$1.60	$0.15	$0.05
1946	$2.00	$0.15	$0.05
1947	$3.00	$0.25	$0.10
1957	$3.50	$0.50	$0.25
1961	$4.00	$0.60	$0.25
1983	$5.60	$0.85	$0.35
2001	?	?	?

Source: Alaska Department of Revenue

What's the Effect of Inflation?

In 1983, a dollar was a dollar when you filled your marketbasket in Anchorage. Today, you're paying $1.48 for the same marketbasket in Anchorage. But when people purchase alcoholic beverages, they're getting a bargain. The tax is still at the 1983 level.

A sound tax increase strategy could occur in 3 steps: 1) correct for inflation, 2) set the increase at a level that will make a significant reduction in the gap between current revenue and the cost of negative consequences to the taxpayer. 3) Index the increase to the Anchorage CPI.

The table on page 19 shows in detail where a potential $40 million increase in revenues to the general fund was lost because the alcohol excise tax was not indexed to the Consumer Price Index.

Alcoholic Beverages Tax Revenue with and without CPI Adjustment

FY		Revenue	CPI	Revenue with CPI		Difference
1984	$	14,042,369		$ 14,042,369	$	-
1985	$	13,808,198	2.40%	$ 14,139,594	$	331,396
1986	$	13,161,742	1.90%	$ 13,733,699	$	571,957
1987	$	12,623,044	0.40%	$ 13,224,278	$	601,234
1988	$	11,862,337	0.40%	$ 12,477,047	$	614,710
1989	$	11,609,067	2.90%	$ 12,564,761	$	955,694
1990	$	12,439,104	6.20%	$ 14,297,845	$	1,858,741
1991	$	12,133,800	4.60%	$ 14,588,478	$	2,454,678
1992	$	12,088,139	3.40%	$ 15,027,721	$	2,939,582
1993	$	11,897,280	3.10%	$ 15,248,953	$	3,351,673
1994	$	11,995,612	2.10%	$ 15,645,517	$	3,649,905
1995	$	11,967,193	2.90%	$ 16,114,831	$	4,147,638
1996	$	11,986,770	2.70%	$ 16,577,006	$	4,590,236
1997	$	11,551,755	1.50%	$ 16,215,036	$	4,663,281
1998	$	11,749,709	1.50%	$ 16,740,295	$	4,990,586
1999	$	12,157,508	1.00%	$ 17,494,516	$	5,337,008
	$	197,033,627		$ 238,131,946	$	41,098,319

Note: The current tax rate went into effect on July 8, 1983 (FY84). Data for FY90-FY99 is from Department of Revenue annual reports. Prior data is from computer files. CPI data is from the Bureau of Labor Statistics, Anchorage, Alaska CPI-U. Annual revenue amounts might differ from those calculated from gallons because of penalties, interest adjustments or timing issues. The table assumes that the tax rates on alcoholic beverages increased with the CPI index after the change in tax rates in FY84. No adjustment was made for change in consumption as a result of higher prices. No adjustment was made for timing differences between fiscal data in gallons and CPI calendar years.

A Common Sense Approach to Maintaining Service Levels

A case may be made for "lost revenue" because the alcohol excise tax was not tied to the Consumer Price Index when it went into effect in 1983. If the purpose of the tax was to pay for government services, then the buying power of that tax has gradually "melted down" over the past 17 years. While an increase in tax revenue cannot be specifically dedicated to addressing the negative consequences of substance abuse, policymakers must be mindful of the current high cost of doing nothing, and the opportunity a tax increase represents to address unmet needs.

Encouraging Communities To Work for Healthy Change

There's a reason for the opening phrase in the Advisory Board mission statement: "In partnership with the public..." Surveys, community testimony, focus groups, and a lot of listening have verified to the Board that alcohol is everybody's problem, and everyone must be involved in creating the solution.

Last year included a number of benchmark activities that support positive change: the work of the Alaska Criminal Justice Assessment Commission (ACJAC), the work of the DUI Prevention Task Force of the Municipality of Anchorage, and the Mayor's Blue Ribbon Task Force in Barrow are only a few. There is strong alignment between the findings of these groups and the strategies for positive change that appear in "Results Within Our Reach," the state plan for substance abuse service delivery developed by the Advisory Board in partnership with stakeholder representation from all over Alaska. (See p. 2.)

In partnership with the public, the Advisory Board on Alcoholism and Drug Abuse plans and advocates for policies, programs and services that help Alaskans achieve healthy and productive, lives, free from the devastating effects of the abuse of alcohol and other substances.

Advisory Board members and staff were warmly welcomed by stakeholders in both Nome and Barrow as part of a rural outreach program made possible in part by a grant from the Alaska Mental Health Trust Authority. These intensive day and a half meetings in each community proved that local leaders and policymakers are keenly interested in addressing community problems relating to alcohol. The Advisory Board teams of five members learned firsthand from more than 120 residents in Nome and Barrow. They visited treatment programs, senior programs, and heard from 30 village Rural Human Services workers. Judges, physicians, public safety, and elected officials joined in.

In assessing planning priorities based on this information, the Board has responded to the community support for coalition building to more effectively address the problems of public inebriates. Testimony and discussion with physicians, judges, tribal leaders, and a broad range of service providers reinforced the lack of consistent community efforts to deal with this problem.

The Advisory Board has asked the Alaska Mental Health Trust Authority for support for community coalition building that includes building local expertise about the use of Alaska's Involuntary Commitment statute. The "community readiness" for such coalitions was demonstrated frequently in both Nome and Barrow. Board members and staff added additional chairs to informal discussion sessions that included a number of local stakeholders who had never met one another.

There is no more effective way for the Advisory Board to fulfill its statuatory responsibility than to advocate at every level for programs and support that empower communities, champion a culture than is not heavily influenced by alcohol, and create a more productive and healthy Alaska. ■

Glossary of Terms

Abuse of alcohol, other drugs, or inhalants: A persistent pattern of use of alcohol, other drugs or inhalants with which health consequences and/or impairment in social functioning are associated. This is different from dependence, which has such manifestations as craving, tolerance and physical dependence. Abuse is any use of a legal or illegal drug or substance that causes physical, mental, emotional or social harm, whether mild or severe.

Addict: A person who is physically dependent on one or more psychoactive substances, whose chronic use has produced tolerance, who cannot control his or her intake, and who would have withdrawal symptoms if drug use were discontinued.

Alcohol: The active ingredient in beer, wine and distilled spirits; ethyl alcohol or ethanol.

Alcohol Dependence: A psychic and usually physical state resulting from taking alcohol. It is characterized by behavioral and other responses that always include compulsion to take alcohol on a continuous or periodic basis in order to experience its psychic effects, and sometimes to avoid the discomfort of its absence. The person may or may not have developed a tolerance for alcohol. A person may be dependent on alcohol and other drugs. "Alcohol dependence" is often used interchangeably with the term "alcoholism."

Alcoholism: A primary, chronic disease with genetic, psychosocial and environmental factors influencing its development and manifestations. The disease is often progressive and fatal. It is characterized by continuous or periodic impaired control over drinking, preoccupation with the drug alcohol, use of alcohol despite adverse consequences, and distortions in thinking, most notably denial. Each of these symptoms may be continuous or periodic.

- Primary refers to the nature of alcoholism as a disease entity, in addition to, and separate from other pathophysiologic states which may be associated with it. It suggests that alcoholism, as an addiction, is not a symptom of an underlying disease state.

- Disease means an involuntary disability. It represents the sum of the abnormal phenomena displayed by a group of individuals. These phenomena are associated with a specific common set of characteristics by which these individuals differ from the norm, and which places them at a disadvantage. Use of the term involuntary in defining disease is descriptive of this state as a discrete entity that is not deliberately pursued. It does not suggest passivity in the recovery process nor does use of the term imply the abrogation of responsibility in the legal sense.

- Often progressive and fatal means that the disease persists over time with physical, emotional, and social changes that are often cumulative and may progress as drinking continues. Alcoholism causes premature death through overdose, organic complications involving the brain, liver, heart and many other organs, and by contributing to suicide, homicide, motor vehicle crashes and other traumatic events.

- Impaired control means the inability to limit alcohol use or to consistently limit, on drinking occasions, the duration of the drinking episode, the quantity of alcohol consumed, and/or the behavioral consequences.

- Preoccupation used in association with alcohol use indicates excessive, focused attention given to the drug alcohol, its effects, and/or its use. The relative value thus assigned by the individual often leads to a diversion of energies away from important life concerns.

• Adverse consequences are alcohol-related problems or impairments in such areas as physical health (e.g., alcohol withdrawal syndromes, liver disease, gastritis, anemia, and neurological disorders,) psychologic functioning (e.g., impairments in cognition, changes in mood and behavior,) interpersonal functioning (e.g., marital problems, child abuse, troubled social relationships.) occupational functioning (e.g., scholastic or job problems,) and legal, financial or spiritual problems.

• Denial is used here not in the psychoanalytic sense of a single psychological defense mechanism disavowing the significance of events, but more broadly to include a range of psychological maneuvers that decrease awareness of the fact that alcohol use is the cause of a person's problems rather than a solution to those problems. Denial becomes an integral part of the disease and is nearly always a major obstacle to recovery.

ASAM: The American Society of Addiction Medicine, a national medical specialty society of physicians dedicated to improving the treatment of alcoholism and other drug dependencies.

ASAM Placement Criteria: American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders, a clinical guide for matching patients diagnosed as having a substance use disorder to appropriate levels of care based on an assessment of:

1. acute intoxication and/or withdrawal potential;
2. biomedical conditions and complications;
3. emotional/behavioral conditions and complications;
4. treatment acceptance/resistance;
5. relapse potential;
6. recovery environment.

Beneficiary (AMHTA): The beneficiaries of the Alaska Mental Health Trust Authority are Alaskans who experience mental illness; mental retardation or similar disabilities; chronic alcoholism with psychosis and/or Alzheimer's disease or related dementia.

Binge Drinking: Having five or more drinks on an occasion one or more times in the past month.

Chemical Dependency: Physiological or physical dependence on a psychoactive substance.

Chronic Alcoholic with Psychosis: As defined in AS 47.30.056(b)(3), this group includes persons with the following disorders:

1. alcohol withdrawal delirium (delirium tremens);
2. alcohol hallucinosis;
3. alcohol amnestic disorder;
4. dementia associated with alcoholism;
5. alcohol-induced organic mental disorder;
6. alcoholic depressive disorder;
7. other severe and persistent disorders associated with a history of prolonged or excessive drinking or episodes of drinking out of control and manifested by behavioral changes and symptoms similar to those manifested by persons with disorders listed in this subsection.

Chronic Drinking: An average of 60 or more drinks a month.

Culturally Sensitive: Awareness of unique aspects and nuances of one's own culture and of other cultures.

Detoxification: Treatment to restore physiologic function after it has been seriously disturbed by the overuse of alcohol or other drugs.

Drug Dependence: A psychic and sometimes physical state resulting from taking a drug. It is characterized by behavioral and other responses. These always include a compulsion to take a drug on a continuous or periodic basis in order to experience its psychic effects, and sometimes to avoid the discomfort of its absence. The person may or may not have developed a tolerance for the drug. A person may be dependent on more than one drug.

Dually-Diagnosed: Persons suffering from co-occurring mental illness and alcohol or other drug abuse or dependence.

Early Intervention: Services designed to identify individuals who are at high risk for developing alcohol or other drug-related problems. These services are also directed toward persons who are experiencing adverse effects of alcohol or other drug use but are not dependent. Services seek to modify alcohol or drug use behaviors and attitudes.

Fetal Alcohol Syndrome (FAS): Fetal Alcohol Syndrome and other alcohol-related birth defects (ARBD) refer to a group of physical and mental birth defects resulting from a woman's alcohol consumption during pregnancy. FAS is the leading known cause of mental retardation and is 100 percent preventable. ARBD is similar to FAS but lacks the physical symptoms of FAS. ARND may include neurological abnormalities, development delays, intellectual impairments and learning/behavior disabilities are similar to, and sometimes more severe than, those of FAS.

Inhalants: Any volatile substance that can produce an intoxicating state when inhaled. A volatile substance becomes a gas at normal room temperature. Examples include common household products such as fast-drying glues and cements; paints, lacquers and varnishes; thinner and removers; lighter and dry cleaning fluids; kerosene, gasoline, lantern and stove fuel; fingernail, shoe and furniture polish; typewriter correction fluids; felt-tip pens; aerosol products; refrigerants such as freon.

Involuntary Commitment: A legal process defined in Alaska law (AS 47.37.190) whereby a person addicted to alcohol or other drug abuser may be committed to a treatment facility without the person's permission if the person lacks self control in using alcohol and presents a danger to others or is incapacitated by alcohol.

Misuse of alcohol, drugs or inhalants: Use of alcohol, other drugs, or inhalants in a way that is illegal or deviates from medically accepted use.

Sobriety: A positive, healthy and productive way of life, free from the negative effects of alcohol or other drug misuse or abuse.

Tolerance: Physiologic adaptation to the effect of a drug, diminishing the effect of constant dosages.

Treatment Capacity: Amount of substance abuse services that are readily accessible. ■

Sources and Resources

The following are only a few of the very broad range of references and resources available to those with an interest in eliminating the negative consequences of alcohol and drug abuse.

Toll Free Numbers

National Council on Alcoholism and Drug Dependence - 1-888-654-4673

State Division of Alcoholism and Drug Abuse - 1-888-654-4673

State Advisory Board on Alcoholism and Drug Abuse - 1-888-464-8920

Websites

Alaska State Library bibliography on Alcohol and Drug Abuse Treatment. Call 907 465-2916 to request a free copy. Also available from http://www.educ.state.ak.us/lam/library.html.

Alaska Prevention Partnership. http://www.alaskaprevention.com

Alcoholics Anonymous. http://www.alcoholics-anonymous.org/

Center for Science in the Public Interest "Booze News" http://www.cspinet.org

Center for Substance Abuse Prevention maintains a Clearinghouse on Alcohol and Drug Information at 1-800-729-6686. Its website may be reached at http://www.health.org.

Division on Alcoholism and Drug Abuse. The final reports of federally-funded research projects relating to prevalence in Alaska are available. (907) 465-2071 or 1-800-478-2072. http://www.hss.state.ak.us/dada/

Dual Diagnosis Website, focuses on mental illness, drug addiction and alcoholism. http://www.erols.com/ksciacca/

Higher Education Center for Alcohol and other Drug Prevention, sponsored by the U. S. Department of Education. http://www.edc.org/hec/

Join Together Online Organizations working together to combat substance abuse and violence. http://www.jointogether.org/

National Institute on Alcohol Abuse and Alcoholism. Offers a wealth of information, publications and databases on both treatment and prevention. http://silk.nih.gov/niaaa1/

The National Library of Medicine, PubMed. A very large range of medical topics, including Clinical Alerts of the National Institutes of Health, a journal database browser and links to many other sources. http://www.ncbi.nlm.nih.gov/pubmed/

National Council on Alcoholism and Drug Dependence. http://www.ncadd.org

National Organization for Fetal Alcohol Syndrome. http://www.nofas.org/

Substance Abuse and Mental Health Services Administration. http://www.samhsa.gov

Printed at Juneau, Alaska
at a cost of $1.43 per copy.

Additional copies are available upon request.
Call (907) 465-8920 or 1-888-464-8920.

DOC Inmate Substance Abuse Treatment Program
A Continuum of Care

Overview

Research indicates that drugs or alcohol, and sometimes both, play a role in the crimes of 80% of the country's 1.7 million inmates. In Alaska it estimated that at least 85% of the inmate population has a problem with substance abuse. Inmates who are alcohol and drug abusers are more likely to be reincarcerated again and again, as substance use is tightly associated with recidivism. Prisoners can be rehabilitated with appropriate treatment for substance abuse and addiction, and continuing aftercare once they leave prison.

It is DOC's belief, supported by the Alaska Legislature, that it has a responsibility to provide a continuum of care to inmates who are in its custody, so that public safety will be enhanced upon their release to the community. There is an Inmate Substance Abuse Treatment (ISAT) Program in each of DOC's thirteen institutions, as well as at the Pt. MacKenzie work farm. DOC contracts with state approved community treatment providers for the delivery of all of its substance abuse programs.

Programs vary due to the different functions and location of the correctional facilities. For example, a pre-trial facility with a rapid turnover, such as the Ketchikan Correctional Center, has an ISAT education program staffed by a part-time ISAT Counselor. In contrast, Spring Creek Correctional Center, a sentenced long-term facility with a relatively slow population turnover, provides institutional outpatient treatment through two full-time ISAT Counselors. The ISAT continuum of care consists of the following components:

I. Orientation

Orientation services are provided at the Sixth Avenue Correctional Center and the Mat-Su Pre-trial Correctional Center. Both of these programs up until recently were twenty hour a week substance abuse education programs. Due to a lack of resources the programs were cut substantially. Orientation at the Sixth Avenue Correctional Center consists of a men's group and a women's group once a week. The inmates are given information on community resources for substance abuse treatment and support services. They are also given information on how to access substance abuse treatment in sentenced facilities. Orientation at the Mat-Su Pre-trial consists of equipping correctional staff with resource manuals and substance abuse treatment referral information to provide to the inmates.

Sixth Avenue	Clitheroe Center	5 hours (taken from CIPT)
Mat-Su Pretrial	Akeela Treatment Services	3 hours (taken from PCC)

II. Education

The ISAT education programs are designed for the short-term high turnover inmate population. They provide inmates with information on chemical dependency as well as prepare them for treatment in a sentenced facility or in the community. The education level of care is offered at the following institutions by the following providers:

Ketchikan	City of Ketchikan Gateway	1 half-time ISAT Counselor
Palmer	Akeela Treatment Services	2 full-time ISAT Counselors
Yukon-Kuskokwim	Akeela Treatment Services	1 full-time ISAT Counselor

III. Education with an Introduction to Treatment

Education with an introduction to treatment is the level of care that offers more than substance abuse education, but does not include complete outpatient treatment. It is provided at the following institution by the following treatment agencies:

Cook Inlet Pre-Trial	Clitheroe Center	1 full-time ISAT Counselor
Fairbanks	RCAOA (FNA)	2 full-time ISAT Counselors

IV. Outpatient Substance abuse Treatment (in institution)

Inmates who are clinically assessed by ISAT Counselors as needing an outpatient level of care are eligible to receive treatment. It consists of education, primary care, and aftercare. Outpatient care is provided at the following institutions by the following treatment agencies:

Lemon Creek	Gastineau Human Services	1 full-time ISAT Counselor
Meadow Creek	Clitheroe Center	1 full-time ISAT Counselor
Spring Creek	Akeela Treatment Services	2 full-time ISAT Counselors*
Wildwood	Akeela Treatment Services	2 full-time ISAT Counselors
Point MacKenzie	Akeela Treatment Services	2 full-time ISAT Counselors

* One ISAT Counselor works with the adult inmate population, and the other ISAT Counselor works in the Youthful Offender Program.

V. Intensive Outpatient Treatment (in institution)

The intensive outpatient treatment program at Anvil Mountain is a culturally relevant pilot program designed specifically for the Alaska Natives in the Nome region. Ten inmates start and finish the program together. This is the only outpatient model where the inmates live in a dorm together.

Anvil Mountain	Intermountain Services	1 full-time ISAT Counselor

VI. Residential Substance Abuse Treatment Services

DOC opened its forty-eight bed Residential Substance Abuse Treatment Program for female offenders at the Hiland Mountain Correctional Center in November of 1998. It is an intensive six to twelve month program set apart from the general population. Three couselor positions and a Social Worker III position are funded through federal RSAT dollars with a twenty-six percent match from the state. The program was developed by adding on to the existing two and a half ISAT Counselor positions at the facility.

DOC opened it's forty-two bed Residential Substance Abuse Treatment Program for male offenders at the Wildwood Correctional Center on October 16, 20001. It is also an intensive six to twelve month program set apart from the general population. All of the treatment staff are funded through federal RSAT dollars with a twenty-six percent match from the state.

Hiland Mountain	Clitheroe Center	2.5 ISAT Counselors (3.0 RSAT Counselors)
Wildwood	Akeela Treatment Services	(6.0 RSAT Counselors)

<u>Continuum of Care Summary Information</u>

Total number of ISAT positions	17 full-time, 2 half-time
Total number of RSAT positions	9.0 full-time
Total number of ISAT treatment providers	6

For further information please call Sarah Williams, Program Coordinator, at 269-7417.

HMCC Women's RSAT Program
Two Year Outcome Report

The Hiland Mountain Correctional Center (HMCC) Women's Residential Substance Abuse Treatment (RSAT) Program began November 1, 1998. It is an intensive six to twelve month therapeutic community for women with serious substance abuse problems and related criminal histories. Special features of the program include an RSAT Social Worker, a Transition Counselor, and a component called Living in New Knowledge Successfully (LINKS) for women with children. The Salvation Army Clitheroe Center is the contract treatment provider for the program. The program consists of Inmate Substance Abuse Treatment (ISAT) positions that are state funded and RSAT positions that are federally funded with a twenty-six percent state match.

This outcome report indicates the re-incarceration rates for twenty RSAT Program graduates compared to twenty women who needed the program but did not receive it for various reasons, the most common being not enough time left to serve. The graduates and the comparison group were tracked from the day they left Hiland Mountain Correctional Center for six months into the community. The results clearly indicate that participation in the RSAT Program slowed down the re-incarceration rate.

Number of women who were re-incarcerated in the first six months following release.
Non participants 9
RSAT graduates 6

Total number of re-incarcerations in the first six months following release.
Non participants 17 (4 individuals had more than once re-incarceration.)
RSAT graduates 6

Number of women who were re-incarcerated with new misdemeanor charges.
Non participants 6
RSAT graduates 1

Total number of new misdemeanor charges.
Non participants 11 (3 individuals had more than 1)
RSAT graduates 1

Number of women who were re-incarcerated with new felony charges.
Non participants 4
RSAT graduates 1

Total number of new felony charges.
Non participants 5 (1 individual had 2 new felony charges.)
RSAT graduates 1

The new felony charges for the non participants all involved the possession or selling of controlled substances with the exception of 1 assault. The new felony charge for the RSAT graduate was for assault. For both groups, re-incarcerations not involving new felony or misdemeanor charges were for probation/parole/furlough/electronic monitoring/bail bond violations and non-criminal holds.

Hiland Mountain Correctional Center (HMCC)
Women's Residential Substance Abuse Treatment (RSAT) Program

Two Year Outcome Report

Date treatment program began--- November 1, 1998
Date of study---November 1, 2000
Number of RSAT graduates studied-------------------------------------twenty
Number of women in the comparison group----------------------------twenty

Thirty-five women completed the program between November 1, 1998 and November 1,2000. Of these women, twenty completed the program and then spent six months in the community. The re-incarceration rate of the graduates was studied after they had been in the community for six months. The other fifteen women were either still in the institution or had been in the community for less than six months so were not included in the study.

The comparison group consisted of twenty women who needed the program and did not get it due to lack of time. Their incidents of re-incarceration were also studied for the six-month period after they had been released from HMCC.

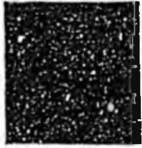
The results of the study clearly indicate that participation in the RSAT Program reduced the re-incarceration rate.

Results

RSAT graduates:
During the six months in the community six women were re-incarcerated. The six women committed a total of one new felony offense and one a new misdemeanor offense. **The six women had a total of six re-incarcerations.** (None of the six were re-incarcerated more than once.) The other re-incarcerations that did not involve new crimes were due to violations of community supervision.

Comparison group:
During the six months in the community nine women were re-incarcerated. The nine women committed a total of four new felony offenses and eleven new misdemeanor offenses. **The nine women had a total of seventeen re-incarcerations.** (Some of the women were re-incarcerated more than once.) The other re-incarcerations that did not involve new crimes were due to violations of community supervision.

For further information please call Sarah Williams, Program Coordinator, at 269-7417.



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Shoveling Up:

The Impact of Substance Abuse on State Budgets

January 2001

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Foreword and Accompanying Statement by Joseph A. Califano, Jr. Chairman and President

Substance abuse and addiction is the elephant in the living room of American society. Too many of our citizens deny or ignore its presence. Abuse and addiction involving illegal drugs, alcohol and cigarettes are implicated in virtually every domestic problem our nation faces: crime; cripplers and killers like cancer, heart disease, AIDS and cirrhosis; child abuse and neglect; domestic violence; teen pregnancy; chronic welfare; the rise in learning disabled and conduct disordered children; and poor schools and disrupted classrooms. Every sector of society spends hefty sums of money shoveling up the wreckage of substance abuse and addiction. Nowhere is this more evident than in the public spending of the states.

The heaviest burden of substance abuse and addiction on public spending falls on the states and programs of localities that states support. Of the two million prisoners in the United States, more than 1.8 million are in state and local institutions. States run the Medicaid programs where smoking and alcohol abuse impose heavy burdens in cancer, heart disease and chronic and debilitating respiratory ailments and where drug use is the largest cause of new AIDS cases. States fund and operate child welfare systems--social services, family courts, foster care and adoption agencies--where at least 70 percent of the cases of abuse and neglect stem from alcohol- and drug-abusing parents. The states are responsible for welfare systems that are overburdened with drug- and alcohol-abusing mothers and their children. State courts handle the lion's share of drunk driving and drug sale and possession cases. States pour billions of dollars into elementary and secondary public school systems that are more expensive to operate because of drug- and alcohol-abusing parents and teenagers.

Governors and state legislatures have the largest financial, social and political interest in preventing and treating all substance abuse and addiction, whether it involves alcohol, tobacco or illegal drugs, and especially among children and teens. While the federal government has heavy responsibilities to fund biomedical research, classify and regulate chemical substances and interdict illegal drugs, the brunt of failure to prevent and treat substance abuse and the cost of coping with the wreckage of this problem falls most heavily on the backs of governors and state legislatures across America.

For three years, The National Center on Addiction and Substance Abuse at Columbia University has been scouring the fine print of 1998 budgets of the states in an unprecedented effort to measure the impact of substance abuse and addiction on their health, social service, criminal justice, education, mental health, developmentally disabled and other programs in 16 budget categories. Forty-five of the states, the District of Columbia and Puerto Rico responded to our survey--the most extensive and sophisticated ever conducted in this field--and answered the endless questions of our staff. Based on an exhaustive analysis of the data collected, we also estimated the total costs of substance abuse to the budgets of the five states (Indiana, Maine, New Hampshire, North Carolina and Texas) that did not respond to our inquiries.

The results are stunning, especially given that in every case we made the most conservative assumptions about the burden that substance abuse imposes on state budgets. Four findings are particularly striking. In 1998:

- Of the $620 billion total the states spent, $81.3 billion--a whopping 13.1 percent--was used to deal with substance abuse and addiction.

- Of every such dollar states spent, 96 cents went to shoveling up the wreckage of substance abuse and addiction and only four cents was used to prevent and treat it.

- The states spend 113 times as much to clean up the devastation substance abuse and addiction visit on children as they do to prevent and treat it.

- Each American paid $277 per year in state taxes to deal with the burden of substance abuse and addiction in their social programs and only $10 a year for prevention and treatment.

- Of the $453.5 billion states spent in the 16 budget categories of public programs we examined, $81.3 billion--17.9 percent--was linked to substance abuse and addiction.

This report is a clarion call for a revolution in the way governors and state legislators think about and confront substance abuse and addiction. States that want to reduce crime, slow the rise in Medicaid spending, move more mothers and children from welfare to work and responsible and nurturing family life must shift from shoveling up the wreckage to preventing children and teens from abusing drugs, alcohol and nicotine and treating individuals who get hooked.

The next great opportunity to reduce crime is to provide treatment and training to drug and alcohol abusing prisoners who will return to a life of criminal activity unless they leave prison substance free and, upon release, enter treatment and continuing aftercare. The remaining welfare rolls are crowded with individuals suffering from substance abuse and addiction. The biggest opportunity to cut Medicaid costs is by preventing and treating substance abuse and addiction. Governors who want to curb child abuse, teen pregnancy and domestic violence in their states must face up to this reality: unless they prevent and treat alcohol and drug abuse and addiction, their other well intentioned efforts are doomed.

The choice for governors and state legislators is this: either continue to tax their constituents for funds to shovel up the wreckage of alcohol, drug and nicotine abuse and addiction or recast their

priorities to focus on preventing and treating such abuse and addiction.

State spending on children is the cruelest misallocation of taxpayer funds. We know that a child who gets through age 21 without smoking, abusing alcohol or using illegal drugs is virtually certain never to do so. It is a slap in the face of this knowledge for states to spend 113 times more to shovel up the wreckage of children savaged by substance abuse and addiction in social, criminal justice and education programs than they spend to encourage children to stay away from these substances and treat those who ignore that advice.

This unprecedented report looks behind the traditional budget labels--education, criminal justice, transportation, health care, child welfare, welfare, mental health--to detect just how many of their taxpayer dollars the states spend to deal with the financial burden that unprevented and untreated substance abuse and addiction impose on public programs. It is our hope that exposing these heretofore hidden costs will encourage governors and state legislatures to make sensible investments in comprehensive efforts to reduce the use of tobacco, alcohol and illegal drugs, particularly by children.

States spend some $25 billion a year shoveling up after the savage impact of substance abuse on our children. The largest share is spent on the burden of substance abuse to the education system--$16.5 billion; another $5.3 billion is spent for children who are victims of child abuse and neglect; nearly $3 billion is spent for substance-involved youth in the state juvenile justice systems. By comparison, pennies are spent to prevent these problems. This is perhaps the worst example of current investment policies because of the enormous payoff that could be realized by preventing addiction in the first place.

Children are key to the lasting success of any effort to curb the costs of substance abuse. Prevention and treatment efforts, especially those directed to children, must cover all substances. First, sale of any of these substances to children is illegal, and for good reason. Second, tobacco, alcohol and illegal drugs all affect the dopamine systems in the brain and, with repeated use, can change the structure of the brain itself resulting in cravings and addiction. Finally, most individuals who fall prey to abuse and addiction are involved with more than one substance.

What this report reveals for the first time is that the biggest bang for the buck in terms of taming the costs of social programs will come to those states that curb substance abuse and addiction. The return is not simply in reduced state spending. It also comes in reduced crime--and most importantly in reduced human suffering not only for the addict and abuser, but for parents and children, classmates, friends and neighbors. And, it can be counted in positive economic benefits to states from productive, law-abiding, taxpaying citizens.

Addiction is a disease--a chronic, relapsing one--that, untreated, has nasty and costly social consequences: illness, disability, death, learning disabilities, poor school performance, child abuse and neglect, domestic violence, crime--to name a few. Our fear of these consequences often leads us to respond with tough sanctions. It is of course important to hold individuals accountable for their conduct. But the first line of defense is prevention and we can do a much better job at it. Treatment is no sure bet, but success rates of good programs exceed those of many long shot cancer therapies on which we spend millions of dollars. And if we fail to treat the disease, there is little hope of stemming these consequences.

America is not the Garden of Eden and the challenge to state executives and legislators is to balance the importance of holding individuals accountable for their actions with the need to provide treatment for this disease that causes and aggravates so many social problems. It is our hope that this report will help these public officials find that balance.

Governors and state legislators (as well as mayors, city councils and county officials) hold critical keys to the future of our nation. It is the

states, in concert with local governments, which face day-to-day the tasks of moving individuals from welfare to work, reshaping our prison and criminal justice systems, dealing with child abuse and neglect, responding to highway accidents, assuring public safety, administering mental health programs, and helping with the process of educating our children. Successfully accomplishing these tasks will require many different programs and strategies. What this report makes clear is that these programs and strategies will be of limited value if they fail to deal with substance abuse and addiction. Energetic, effective and comprehensive efforts to prevent substance abuse and addiction and treat those who fall prey to these problems hold the promise of freeing up billions of dollars of state funds for other pressing needs and reducing the burden on taxpayers.

This undertaking has been CASA's most ambitious public policy analysis. To accomplish it we convened an extraordinary advisory panel of distinguished public officials, researchers and representatives of the National Governors' Association, the National Conference of State Legislatures, the National Association of State Budget Officers and the National Association of State Alcohol and Drug Abuse Directors. We assembled a team of experts in economics, epidemiology and state government budgeting and finance. We reviewed some 400 articles, books and other publications on substance abuse and public spending. We extensively interviewed state budget officers, devised a survey instrument and tested it in California, Florida and New York in order to refine it before sending it to all the states. The survey captured 1998 spending in 16 budget categories for the 47 responding jurisdictions.

Some caveats are appropriate. The complexity of this unprecedented effort means that this report should be regarded as a work in progress that will be refined in the future; that complexity has led us in every case to use the most conservative assumptions.

In several areas, such as public housing, higher education and state employee healthcare, because of lack of data, we were unable to assess the impact of substance abuse and addiction, and this report contains no costs in these areas.

As a result, this report significantly underestimates the impact of substance abuse on state budgets.

This report covers only state costs. It does not cover federal matching funds that states spend (e.g., on Medicaid and welfare); federal government costs; the spending of local governments (which bear most of the law enforcement burden), the costs to parochial and private schools and other private sector costs (such as employee health care, lost productivity and facility security) which are the subject of ongoing CASA analyses.

Finally, the human suffering of addicts, abusers and their families and friends are incalculable.

This report continues CASA's ongoing Analysis of the Impact of Substance Abuse and Addiction on America's Systems and Populations. We expect that it will form the basis of a forthcoming conference on substance abuse and state budgets as part of our series of *CASACONFERENCES*.

The report contains a list of the seasoned experts who served on our advisory board and worked as our consultants, who made an invaluable contribution. We are greatly indebted to each of them. Let me single out particularly Dall W. Forsythe, Ph.D., at the Rockefeller Institute, former budget director of New York State and director of public finance with Lehman Brothers who helped to structure the project and the report; Brian Roherty, former executive director of the National Association of State Budget Officers and former budget director in Minnesota who opened the doors of many state budget offices; and Donald Boyd, director, and Deborah Elwood, former senior researcher, at the Fiscal Studies Program, Rockefeller Institute of Government, who helped to design and administer the state survey and analyze the data it elicited. With regret we note that one of our advisors, Gloria Timmer, former executive director of the National Association of State

Budget Officers, whose expert advise and good spirit enriched our work, died last year.

Susan E. Foster, M.S.W., CASA's Vice President and Director of Policy Research and Analysis, is the principal investigator and staff director for this effort. She was ably assisted by CASA Research Associate Darshna P. Modi, M.P.H. and data analyst, Liz Peters. David Man, Ph.D., CASA's librarian, and library assistants Barbara Kurzweil and Ivy Truong were a big help. Jane Carlson, as usual, tackled the administrative chores with efficiency and good spirit.

For the financial support that made this undertaking possible, the Board of Directors of CASA and our staff of professionals extend our appreciation to The Starr Foundation, The Robert Wood Johnson Foundation, the Carnegie Corporation of New York, Primerica Financial Services, the National Institute on Drug Abuse, the National Institute on Alcohol Abuse and Alcoholism and The Abercrombie Foundation.

While many people contributed to this effort, the findings and opinions expressed herein are the responsibility CASA.

Joseph A. Califano, Jr.

Chapter I
Introduction and Executive Summary

In 1998, states* spent $620 billion of their own funds to operate state government and provide public services such as education, Medicaid, child welfare, mental health and highway safety. A stunning 13.1 percent of that amount--$81.3 billion--went to shoveling up the wreckage of substance abuse and addiction, a problem that too many of us prefer to deny or ignore.

Substance abuse and addiction is the elephant in the living room of state government, overwhelming social service systems, impeding education, causing illness, injury, death and crime, savaging our children--and slapping a heavy tax on citizens of every state.

This $81.3 billion is only part of the cost tobacco, alcohol, illicit and prescription drug abuse and addiction visits on America. It does not include the financial toll such abuse extracts from federal or local spending or the hefty private costs such as lost productivity or premature death. These costs far exceed the burden on state budgets. And, there is no way to measure the cost of human suffering--destroyed lives, broken families, addicted children.

This report is the result of an intensive three year analysis of the impact of substance abuse on state budgets. As part of this unprecedented study, CASA convened an advisory panel of distinguished public officials, researchers and representatives of the National Governors' Association, the National Conference of State Legislatures, the National Association of State Budget Officers and the National Association of State Alcohol and Drug Abuse Directors. To provide additional guidance, CASA formed a team of consultants with vast experience in economics, epidemiology and state government finance and budgeting.

CASA conducted an extensive review of some 400 articles and publications linking substance

* Including the District of Columbia and Puerto Rico.

abuse to public spending. We examined state programs designed to prevent and treat substance abuse or deal with its consequences and consulted with state budget and program officials to understand how these programs are financed. Four other CASA studies documenting the costs of substance abuse to entitlement programs, aid to families and children, prisons and jails and child welfare informed our work, and we built on our detailed assessment of the cost of substance abuse to New York City.[1]

To develop and refine our methodology for this study, CASA selected five states that would provide a cross section in terms of demographics, budgeting practices and data availability--California, Florida, Minnesota, New Jersey and Vermont. CASA conducted detailed site visits in these states between March and August of 1998, and consulted with scores of state officials.

Based on this extensive research, CASA, working with the Fiscal Studies Program of the Rockefeller Institute of Government, developed a survey of substance abuse-related spending for all 50 states, the District of Columbia and Puerto Rico. We pretested it in California, Florida and New York. The survey was administered in September of 1998, and captured spending in 16 budget categories for 47 responding jurisdictions.*

This report reveals for the first time the pervasive impact of substance abuse on state budgets: how little each state spends on prevention and treatment and how much each devotes to shoulder the burden of failure to prevent substance abuse and treat those who are substance abusers and addicts. Among the findings of this report are these:

- State governments spent $81.3 billion in 1998 to deal with substance abuse. This amounts to more than 13 cents of every state budget dollar. Substance abuse is among the largest costs in state budgets, although its impact is hidden in departments and activities that do not wear the substance abuse label.

- Each American paid $277 per year in state taxes to deal with the burden of substance abuse and addiction in their social programs and only $10 a year for prevention and treatment.

- Of every dollar states spend on substance abuse:

  - 95.8 cents goes to pay for the burden of this problem on public programs. Untreated substance abuse increases, for example, the cost of every state's criminal justice system; elementary and secondary schools; Medicaid; child welfare, juvenile justice and mental health systems; highways; and state payrolls. These costs totaled $77.9 billion in 1998.

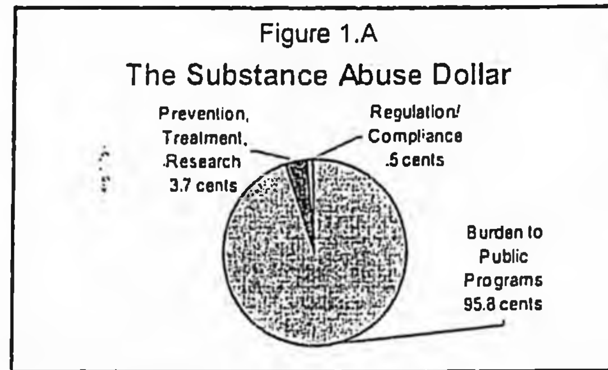
  - Only 3.7 cents goes to fund prevention, treatment and research programs aimed at reducing the incidence and consequences of substance abuse. State spending for prevention, treatment and research amounted to $3 billion in 1998.

  - One-half of one cent covers costs of collecting alcohol and tobacco taxes and regulating alcohol and tobacco products. Regulation and taxation is an untapped resource to help control spending on the consequences of alcohol and tobacco abuse and addiction. State spending on regulation and compliance was $433 million in 1998.

- States spent $24.9 billion in 1998 on the costs of substance abuse to children--an amount comparable to the entire state budget of Pennsylvania. For every $113 states spend on the consequences of substance abuse just for our children, they only spend one dollar on prevention or treatment.

* Indiana, Maine, New Hampshire, North Carolina and Texas did not participate in the survey.

- States spent $30.7 billion in 1998 on the burden of substance abuse on the justice system--for incarceration, probation and parole, juvenile justice and criminal and family court costs of substance-involved offenders. These costs total 4.9 percent of state budgets, more than 10 times the amount that states spent in total for substance abuse treatment and prevention.



- Other areas of significant state spending for failing to prevent or treat substance abuse include:

  - $16.5 billion in education (2.7 percent of state spending),

  - $15.2 billion in health (2.4 percent of state spending),

  - $7.7 billion in child and family assistance (1.2 percent of state spending), and

  - $5.9 billion in mental health and developmental disabilities (0.9 percent of state spending).

- States spend more on the problem of substance abuse than they do on Medicaid ($70.3 billion or 11.3 percent of state budgets) or on transportation ($51.4 billion or 8.3 percent of state budgets). They spend as much on substance abuse as on higher education ($81.3 billion or 13.1 percent of state budgets).

- The drug linked to the largest percentage of state substance abuse costs is alcohol. At least $9.2 billion is spent on alcohol alone, $7.4 billion on tobacco alone and $1.1 billion on illicit drug use only. The remaining spending, $63.6 billion, could not be differentiated by drug, but most of this amount is linked to both alcohol and illegal drug abuse.

- States collected $4.0 billion in alcohol and $7.4 billion in tobacco taxes in 1998 for a total of $11.4 billion. For each dollar in alcohol and tobacco taxes that hit state coffers, states spent $7.13 on the problem of alcoholism and drug addiction--$6.83 to cope with the burden, $0.26 for prevention and treatment and $0.04 to collect taxes and run licensing boards. Few states dedicate revenues to the burden of untreated substance abuse or use alcohol and tobacco tax increases as a way to reduce use by teens.

- On average, of every $100.00 states spend on substance abuse they spend $95.80 on the burden of substance abuse to public programs compared to $3.70 for prevention, treatment and research ($0.50 is spent on regulation and compliance), but state spending varies widely. The proportion spent on shoveling up the wreckage compared to prevention and treatment ranges from to $89.71 vs. $10.22 in North Dakota to $99.94 vs. $0.06 in Colorado. (Table 1.1)

Next Steps

By providing a map of state substance abuse spending, this study establishes a base against which policymakers can judge how to get the biggest bang for their buck. Many studies have demonstrated that carefully designed treatment and prevention initiatives are cost-effective tools in reducing substance abuse and related state costs. For example, Oregon estimated their return on every dollar spent on treatment services to be a $5.62 savings in state costs,

Table 1.1
For Every $100.00 States Spend on Substance Abuse:[a]
[ranked by spending on prevention, treatment and research]

State	Amount Spent on Burden to Public Program	Amount Spent on Prevention, Treatment and Research
North Dakota	$89.71	$10.22
Oregon	91.21	8.61
Delaware	93.72	6.27
Arizona	93.60	6.02
New York	93.96	5.81
Alaska	95.02	4.98
Oklahoma	94.61	4.87
California	95.30	4.32
District of Columbia	95.70	4.30
Washington	91.91	3.79
Massachusetts	96.41	3.59
Illinois	96.45	3.42
Connecticut	96.88	3.12
Nebraska	90.92	3.07
Missouri	96.63	3.04
Idaho	96.71	2.93
South Dakota	97.08	2.92
Pennsylvania	97.03	2.91
Puerto Rico	97.12	2.88
Minnesota	97.13	2.82
Montana	96.75	2.82
Maryland	97.13	2.71
Alabama	93.40	2.67
Mississippi	97.45	2.55
Florida	96.80	2.46
New Jersey	97.06	2.45
Wyoming	96.58	2.42
New Mexico	97.52	2.35
West Virginia	95.80	2.30
Vermont	96.67	2.24
Utah	97.97	2.02
Hawaii	97.99	1.99
Virginia	97.78	1.57
Iowa	98.23	1.56
Kansas	98.38	1.43
Ohio	98.40	1.42
Kentucky	98.62	1.38
Louisiana	98.29	1.36
Nevada	98.68	1.28
Tennessee	98.63	0.96
Arkansas	98.87	0.88
Wisconsin	99.43	0.55
South Carolina	99.69	0.26
Rhode Island	99.60	0.24
Michigan	99.71	0.07
Colorado	99.94	0.06
Georgia[b]	NA	NA
Average[c]	$95.76	$3.70

[a] The difference between the sum of the columns is the amount spent on regulation/compliance.
[b] Spending on prevention and treatment was not included in survey response.
[c] Throughout this report,"Total" or "Average" refers to the 50 states, Puerto Rico and the District of Columbia.

primarily in the areas of corrections, health and welfare. Since investments in prevention and treatment take time to mature, they will not immediately reduce spending on substance abuse. State policymakers will be challenged to consider the value of returns to the state beyond the two to four year election window; however, over the long run the payoff for taxpayers can be enormous.

To reduce the burden imposed on public programs, CASA recommends a revolution in the way governors and state legislators think about and confront substance abuse and addiction:

- **Investment in prevention and treatment.** The most significant opportunity to reduce the burden of substance abuse on public programs is through targeted and effective prevention programs. If we can keep children from smoking cigarettes, using illicit drugs and abusing alcohol until they are 21, they are virtually certain never to do so. Treatment is also a cost-effective intervention as it both reduces the costs to state programs in the short term and avoids future costs. States should make targeted interventions on selected populations that hold promise for high return:

➢ Prisoners whose substance abuse problems make them more likely to return to the criminal justice systems after parole or release.

➢ Clients in the mental health system whose substance abuse problems increase the probability that they will cycle back into mental hospitals or emergency rooms.

➢ Parents of children in the foster care system whose abuse of alcohol or drugs interferes with their ability to care for their children at home.

- Welfare recipients whose substance abuse interferes with their ability to be self-supportive.

- Youth in the juvenile justice system who are substance-involved.

- Children of substance-abusing individuals in the criminal justice system who have an increased likelihood of both abusing substances and committing crimes.

- Children of substance-abusing parents who have a higher likelihood of both abusing substances and neglecting and abusing their own children.

- Children of substance-abusing welfare recipients who have a greater likelihood of both abusing substances and being on welfare.

- Substance-abusing pregnant women and their partners.

- Alcohol- and drug-involved drivers.

• **Expansion of use of state powers of legislation, regulation and taxation to reduce the impact of substance abuse.** States have available a range of legislative, regulatory and tax powers to reduce the impact of substance abuse on state budgets. For example, states can:

- Eliminate mandatory sentences for drug and alcohol abusers and addicts. When prisoners are required to serve their entire sentence without the option of parole or early release, the state loses the carrot of early release that can help persuade them to enter treatment and the stick of parole that can motivate them upon release to continue treatment and aftercare.

- Require treatment for substance-abusing individuals in state-funded programs: prisons, probation, parole, welfare, juvenile justice, education, mental health, child welfare. Also require treatment for substance-abusing state employees and for those convicted of alcohol- and drug-related traffic violations. Coerced treatment is as effective as voluntary treatment and threat of incarceration or loss of benefits can provide the needed incentive to move toward recovery.[2] 1999 NIDA

- Increase taxes on alcohol and tobacco. Increases in price for alcohol and tobacco lead to decreases in the amount people, especially youth consume.[3] California has combined a $.75 tax increase per pack of cigarettes with a public health campaign to achieve a 14 percent decrease in lung cancer over the past 10 years,[4] and Maine's doubling of tobacco taxes and anti-smoking campaign have yielded a 27 percent decline in smoking among high school students.[5] As early as 1981, a study showed that a 10 percent increase in the real price of cigarettes leads to a 12 percent decrease in consumption among 12- to 17-year olds.[6] Other studies have shown that a one percent increase in the price of beer results in a one percent decrease in traffic fatalities,[7] and that doubling of the federal beer tax would reduce total robberies by 4.7 percent and murders and rapes by three percent.[8]

- Step up regulation and enforcement of the prohibition of alcohol and tobacco sales to minors. Point of sale inspections, tougher sanctions against offending retailers, and establishing a licensing system for tobacco sale, can reduce regular cigarette use among 12- to 13-year olds by 44 to 69 percent.[9] By rigorous enforcement, Louisiana reduced the number of stores selling tobacco products to minors from 75 percent in 1996 to seven percent in 1999.[10]

- Include questions about substance abuse on licensing examinations for teachers,

social workers, health care professionals, corrections and juvenile justice staff and court personnel.

- Dedicate taxes from tobacco and alcohol sales to prevention, treatment and coping with the burden of substance abuse and addiction.

• Management for better results. States should set targets for reducing the impact of substance abuse on their budgets and install management practices to achieve them.

- Train teachers, health care workers, social service, criminal and juvenile justice staff and court personnel to implement comprehensive screening for substance abuse in programs that bear a significant burden in coping with its consequences. For example, CASA's research shows that even though at least 70 percent of child welfare cases are caused or exacerbated by alcohol and drug abuse, case workers are not properly trained to assess and screen parents for such abuse.

- Assure that individuals who screen positive are given full assessments and receive timely, appropriate and effective treatment, including relapse management.

- Establish systems to measure the cost-effectiveness of prevention and treatment programs, including regulatory and tax policies aimed at curbing use, in order to concentrate resources on interventions that will provide the highest return on investment for the states and the greatest benefits for individuals.

- Require state agencies to report on the short and long term results of substance abuse-related investment strategies in the budget process. The state budget process is the only context in state government where the impact of a problem can be viewed across budget categories. If investments are to succeed, budget officers and policymakers will track the returns across budget categories and examine projected versus actual returns on investments in current budget and out years.

- Place responsibility for managing state substance abuse-related investments in a designated state agency.

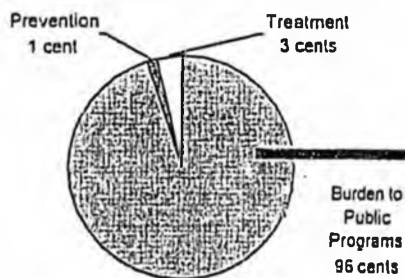
- Invest in research and evaluation of cost-effective substance abuse prevention and treatment policies and programs.

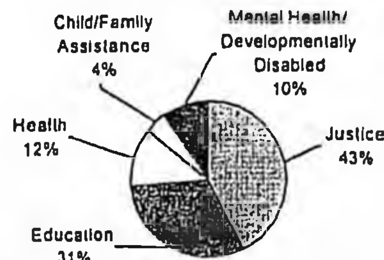
> *I will exert presidential leadership to send the clear and consistent message that drug abuse is dangerous and wrong. And I will help marshal resources at every level starting with parents, schools and communities closest to the needs of young Americans--to turn back the tide of drug abuse.*[11]
>
> --Governor George W. Bush
> Texas

Alaska

Summary of State Spending on Substance Abuse (1998)*

	State Spending by Category ($000)	Spending Related to Substance Abuse Amount ($000)	Percent	As Percent of State Budget	Per Capita
Affected Programs:	*$1,250,424.0*	*$307,734.3*		*9.4*	*$504.44*
Justice	156,363.0	131,470.0		4.0	215.93
Adult Corrections	155,000.0	130,501.1	84.2		
Juvenile Justice	1,363.0	968.9	71.1		
Judiciary	NA	NA	NA		
Education (Elementary/Secondary)	773,000.0	94,235.2	12.2	2.9	154.78
Health	150,000.0	38,307.3	25.5	1.2	62.92
Child/Family Assistance	98,353.0	13,580.2		0.4	22.30
Child Welfare	NA	NA	NA		
Income Assistance	98,353.0	13,580.2	13.8		
Mental Health/Developmentally Disabled	72,708.0	30,141.6		0.9	49.51
Mental Health	49,796.0	28,150.3	56.5		
Developmentally Disabled	22,912.0	1,991.4	8.7		
Public Safety	NA	NA	NA	NA	NA
State Workforce	NA	NA	NA	NA	NA
Regulation/Compliance:	*NA*	*NA*	*NA*	*NA*	*NA*
Licensing and Control	NA	NA			
Collection of Taxes	NA	NA			
Prevention, Treatment and Research:	*16,140.0*	*16,140.0*	*100.0*	*0.5*	*26.51*
Prevention	4,847.0	4,847.0			
Treatment	11,293.0	11,293.0			
Research	0	0			
Total		*$323,874.3*		*9.8*	*$531.95*





Total State Budget	$3,291 M
♦ Substance Abuse	$ 324 M
♦ Medicaid	$ 150 M
♦ Transportation	$ 411 M
♦ Higher Education	$ 392 M
Population	.609 M

* Numbers may not add due to rounding. Tobacco and alcohol tax revenue total $45,026,000; $73.95 per capita.

Chapter I

Notes

[1] The National Center on Addiction and Substance Abuse (CASA) at Columbia University. (1996)
[2] National Institute on Drug Abuse. (1999)
[3] Abel, E. L. (1998); Grossman, M., Chaloupka, F.J., & Sirtalan, I. (1998)
[4] Associated Press. (December 1, 2000)
[5] Nacelewicz, T. (September 30, 2000)
[6] Lewit, E. M., Coate, D., & Grossman, M. (1981)
[7] Ruhm, C. J. (1996)
[8] Grossman, M., Sindelar, J. L., Mullahy, J., & Anderson, R. (1993).
[9] Abel, E. L. (1998); Grossman, M., Chaloupka, F.J., & Sirtalan, I. (1998)
[10] Ritea, S. (November 10, 1999)
[11] Bush-Cheney 2000. (2000)

Inmate Substance Abuse Treatment (ISAT) Increment

There are several serious problems associated with failing to provide any budget increments since 1993 to the ISAT Programs:

Experienced ISAT Counselors are knowledgeable regarding security concerns and working with criminal personalities. It would not benefit DOC, the inmate population or the treatment providers to replace senior counselors with new and inexperienced ones in order to save money.

Funding for the ISAT contracts has not kept current with the cost of living, yet DOC is asking providers to produce the same product.

Salaries of treatment personnel in the institutions have not kept up with those of their colleagues in non-institutional based programs.

Providers have placed less and less of the available contract dollars in administrative and training costs in order to attempt to adequately compensate for direct service costs. Their ability and willingness to do this is stretched to the breaking point.

The Association of Substance Abuse Directors, representing the fifty-eight state funded substance abuse programs in Alaska, has increasing concerns about the potential for diminishing ISAT program efficacy unless changes are made.

The judicial system, the DOC, and treatment providers recognize that substance abuse plays a major role in crime and recidivism rates. If DOC has no other option but to decrease substance abuse treatment in institutions, increased law enforcement, judicial, and correctional costs will result.

DOC is losing experienced contractors for many of the reasons listed above. The Seward Life Action Council, the Mat-Su Recovery Center, theYukon-Kuskokwim Health Corporation, and the Norton Sound Health Corporation have provided the ISAT Programs for many years and have recently opted out of their contracts because they can no longer subsidize DOC programs. When agencies must use their own funds to be able to provide ISAT services, the non-DOC community services they provide are then short-changed.

DOC believes competition amongst vendors is healthy. But when an agency has to decide whether or not it can afford to do business with DOC, competition is diminished.

DOC appreciates the services of local providers in areas where it has institutions. Some providers can no longer deliver the services to the institutions in their communities due to budget concerns.

For further information please call Sarah Williams, Program Coordinator, at 269-7414.

Dept of Corrections

Subject: **HB 4 (Version CSHB 4) - Omnibus Drunk Driving Amendments**
Date: Sat, 10 Mar 2001 22:43:35 -0900
From: "Michele Czajkowski" <michelec@gci.net>
To: <Representative_Albert_Kookesh@legis.state.ak.us>, <Representative_Ethan_Berkowitz@legis.state.ak.us>, <Representative_Kevin_Meyer@legis.state.ak.us>, <Representative_John_Coghill@legis.state.ak.us>, <Representative_Jeannette_James@legis.state.ak.us>, <Representative_Scott_Ogan@legis.state.ak.us>, <Representative_Norman_Rokeberg@legis.state.ak.us>

MAR 12 2001

Dear Representative Rokeberg and Members of the House Judiciary Committee:

I am contacting you regarding House Bill 4 (version CSHB 4), the Omnibus Drunk Driving Amendments Bill/

HB 4 will be a useful tool in the fight against drunk driving as it will help prevent inebriates who choose to drink and drive from harming (or worse, killing) responsible drivers who inadvertently get in their way.

Representative Rokeberg has done an excellent job, crafting this very comprehensive piece of legislation. It comes at a time when the Anchorage community, and the greater community of Alaska, is looking towards the Legislature for some answers regarding this horrific problem. And it is a horrific problem - just look at the death toll this past summer. All of those deaths could have been prevented if it weren't for the careless and irresponsible actions of those few who choose to drink and drive.

By supporting HB 4, you will be giving communities the tools to stop the death and destruction caused by drunk drivers and drivers under the influence. Please help!

Respectfully,
Michele Czajkowski

ADN 5 July 2000

Pickup hits, kills bicyclist

Police say man drunk had 6 previous DWIs

By LISA DEMER
Daily News reporter

An Anchorage man with six prev[illegible] drunken driving convictions wa[illegible] [illegible]ving drunk when he struck and killed a college student riding her bicycle on the sidewalk along Minnesota Drive late Monday, Anchorage police said.

Jessie Withrow died Tuesday in Anchorage.

Russell D. Carlson, 39, who had a 2-year-old child in the truck with him, was charged with manslaughter, child abuse, driving while intoxicated and driving while his license was revoked, according to police.

The bicyclist was Jessie Withrow, who grew up in Anchorage and

See Back Page. BICYCLIST

BICYCLIST: Student enjoyed friends, family, music

Continued from Page A-1

was a dean's list student at Bates College in Lewiston, Maine. She was pronounced dead at Providence Alaska Medical Center on Tuesday afternoon.

Police Lt. Bob Griffiths said Carlson had six DWI convictions in Alaska. Details about those cases were not available Tuesday because of the July Fourth holiday.

The crash happened about 11:30 p.m. Carlson was driving a white full-size pickup, police spokesman Ron McGee said.

Witnesses told police that Carlson was weaving and driving fast while heading south on Minnesota. He ran into a Ford Explorer that had stopped for a red light on Northern Lights Boulevard, then went on the sidewalk and struck Withrow on her bike, according to police. His truck then went into the parking lot of the Aurora Village Shopping Center and crashed into three parked cars, police said.

The 2-year-old child and another man in the truck were not hurt, police said. The relationship between Carlson and the child wasn't clear.

Family friends of the young woman who died described her as exceptionally bright and creative.

"Jessie was a very unusual child. It was like she was way grown up beyond her years. She was destined to do great things. The world is going to be a cheated place for the fact she was not able to achieve her potential," said Susan Peck, who has a daughter close to Withrow and who is a friend of Withrow's mother, Wendy.

Withrow wrote for Perfect World, the teen-oriented pages in the Anchorage Daily News. She sang with her mother at the Renaissance Festival and the Anchorage Folk Festival. She served on the Anchorage Youth Court, helping kids who had gotten in trouble. In 1998, she graduated with honors from Steller Secondary School and won a scholarship to Bates College, a liberal arts school. She was home for summer break and would have been a junior, studying English.

"Her friends, her family and her music were the things she enjoyed the most," said another family friend, Ray Booker.

Carlson is being held at Cook Inlet Pre-Trial Facility on $100,000 bail.

☐ Reporter Lisa Demer can be reached at ldemer@adn.com and 257-4390.

HB

4

(File 2)

HNR: FYI Heather

Subject: Re: Federal .08 penalties
Date: Thu, 08 Feb 2001 09:45:37 -0900
From: Dennis Poshard <Dennis_Poshard@dot.state.ak.us>
To: Heather Nobrega <Heather_Nobrega@legis.state.ak.us>

Yes. This is a true statement.

Heather Nobrega wrote:

> Someone has told Rep. Rokeberg that if a state implements a .08 legal limit by Federal Fiscal Year 2007, the state will receive all of the federal highway funds withheld from FFY 2004-2007. Is this a true statement? Thanks.
>
> Heather Nobrega

Poshard, Dennis <dennis_poshard@dot.state.ak.us>
Special Assistant
Department of Transportation and Public Facilities

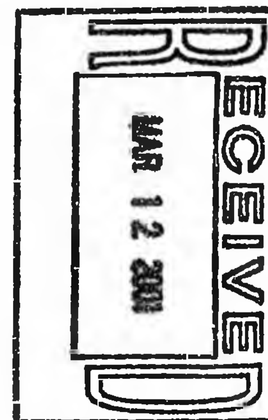
Subject: HB 4 Information
Date: Mon, 12 Mar 2001 11:27:24 -0900
From: "Hargis, Sue" <SHargis@CGAlaska.USCG.mil>
To: "'Representative_Norman_Rokeberg@legis.state.ak.us'" <Representative_Norman_Rokeberg@le
"'Representative_John_Coghill@legis.state.ak.us'" <Representative_John_Coghill@legis.state.ak
CC: "'Jeff Johnson'" <jeffj@dnr.state.ak.us>

Representatives Rokeberg and Coghill,

Below is some follow-up information for you on alcohol involvement in boating fatalities. Please check the statistics below, as my figures were incorrect during the hearing.

1. Non-Commercial Fatality Statistics:

Year	*Alcohol Involved	Unknown Involvement	No Alcohol	Total Fatalities
1991	14	13	2	29
1992	0	12	7	19
1993	8	6	0	14
1994	9	5	1	15
1995	2	17	0	19
1996	4	6	4	14
1997	7	1	15	23
1998	9	16	13	38
1999	3	3	20	26
2000	4	0	15	19
Total	60	79	77	216



Fatalities: Overall 28% confirmed alcohol involvement, 36% unknown involvement, and 36% alcohol not involved. This means that 28-64% of boating fatalities in the past ten years involved alcohol.

*Note this includes only alcohol involvement that was CONFIRMED in boating fatalities. Another 36% of fatalities during this period had unknown alcohol involvement, due to loss of the body or lack of full accident investigation.

Statistics include all non-commercial (also termed recreational) boating fatalities in Alaska.

****

2. Commercial Operator Alcohol Issues:
First time application for license: Cannot have DUI/BWI within 1 year. Must wait until
1 year is up before applying for license.
Current holders of merchant marine licenses: Depends on if infraction was during
operation of vessel, also on consequences (was someone killed,

etc.). Penalties range
from 6 months suspension to permanent revocation of license.
Mariners can appeal
permanent revocation with a request for administrative clemency five years after permanent
revocation. Clemency is then determined based on rehabilitation of individual and
assessment of future risk.

Please let me know if you need any further information for this proposed legislation.

Regards,
Sue Hargis
17th District Boating Safety Coordinator
shargis@cgalaska.uscg.mil
(907)463-2297
(907)463-2256 fax

Subject: Re: [Fwd: .08 BAC]
Date: Fri, 09 Mar 2001 11:27:42 -0900
From: Kurt Parkan <Kurt_Parkan@dot.state.ak.us>
To: Heather Nobrega <Heather_Nobrega@legis.state.ak.us>
CC: Mary Moran <mary_moran@dot.state.ak.us>, Dennis Poshard <dennis_poshard@dot.state.ak.us>

Heather-
I forwarded your email to Mary Moran. I am including her response. Does Rep. Rokeberg want an official fiscal note or is this response sufficient? Please let me know if you have any further questions. Thanks.
- Kurt Parkan

1. Yes, a state will receive the withheld federal highway funds if it passes and enforces .08 BAC legislation prior to ffy 2007.

2. If .08 was passed during thi legislative session and being enforced prior to July 15, we (DOT) would be eligible to receive approximately $348,000 in incentive grant funds for fy2001. We would continue to be eligible to receive an annual incentive grant of approximately $800,000 for the duration of TEA-21 (fy2003) or until the program is modified by congress. The annual amount will depend upon the number of states that qualify for the incentive award.

Section 163 funds can be used for any project eligible for assistance under Title 23, USC. However, since funding is based on a state's .08 BAC, it is strongly encouraged by the U.S. DOT that these funds be used for highway safety related purposes. In regard to HB4, the funds could be used for drunk driving enforcement and other alcohol-related education programs, but not for treatment programs. The funds will be jointly administered by the state department of transportation and the state highway safety office.

4. In addition to passage and enforcement of .08 BAC, there are six elements that must be met in order to satisfy the federal requirement. The elements are described below:

1. Any Person. A state must enact and enforce a law that establishes a BAC limit of 0.08 or greater that applies to all persons. The law can provide for no exceptions.

2. Blood Alcohol Concentration (BAC) of 0.08 Percent. A State must set a level of no more than 0.08 percent as the legal limit for blood alcohol concentration, thereby making it an offense for any person to have a BAC of 0.08 or greater while operating a motor vehicle. (Some states have multiple BAC levels).

3. Per Se Law. A State must consider persons who have a BAC of 0.08 percent or greater while operating a motor vehicle in the State to have committed a per se offense of driving while intoxicated. In other words, States must establish a 0.08 "per se" law, that makes driving with a BAC of 0.08 percent or above, in and of itself, an offense.

4. Primary Enforcement. A State must enact and enforce a 0.08 BAC law that provides for primary enforcement.

5. Both Criminal and ALR Laws. A State must establish a 0.08 BAC per se level under its criminal code. In addition, if the State has an administrative license
revocation or suspension (ALR) law, the State must establish an illegal 0.08 BAC per se level under its ALR law, as well.

6. Standard Driving While Intoxicated Offense. The State's 0.08 BAC per se law must be deemed to be or equivalent to the State's standard driving while
intoxicated offense.

It is my understanding via Royce, etc, that Alaska is in compliance with all six criteria.

Heather Nobrega wrote:

> Since Dennis Poshard is out of the office, I am forwarding this e-mail to you. Thank you.
>
> Heather Nobrega
>
> ---
>
> **Subject:** .08 BAC
> **Date:** Thu, 08 Mar 2001 10:51:35 -0900
> **From:** Heather Nobrega <Heather_Nobrega@legis.state.ak.us>
> **Organization:** Representative Norman Rokeberg, Alaska State House
> **To:** Dennis Poshard <Dennis_Poshard@dot.state.ak.us>
>
> Dennis,
>
> I am still waiting for a memo from the DOT regarding the fact that a state can receive federal highways funds withheld from FFY 2004-2007 if they implement a .08 BAC by Federal Fiscal Year 2007.
>
> Also, Rep. Rokeberg would like a fiscal note for HB 4 reflecting the fact that implementation of .08 BAC before 2004 will entitle the state to incentive funds, roughly $800,000.
>
> In regards to the HB 4 hearing tomorrow on the .08 BAC provisions, Rep. Rokeberg would like further clarification on what exactly those incentive funds can be used for, specifically in regards to HB 4.
>
> Rep. Rokeberg would also like the DOT to be prepared to discuss if there are further changes that need to be made to the statutes in order to comply with the Federal government's .08 BAC requirements.
>
> Thanks.
>
> Heather Nobrega

US DEPARTMENT OF TRANSPORTATION
FEDERAL HIGHWAY ADMINISTRATION
ANNUAL CORE APPORTIONMENTS AND POTENTIAL PENALTIES UNDER SEC. 163(a)
FOR FY 2004 AND THEREAFTER*
(Assuming Various Rates of Penalty)

Federal Oct. 1, 2003

State	IM / STP / NHS Total	.08 BAC adopted as Legal Standard	2% Penalty	4% Penalty	6% Penalty	8% Penalty
Alaska	**179,048,339**	-	**3,580,967**	**7,161,934**	**10,742,900**	**14,323,867**
Washington	297,631,829	X	0	0	0	0
Oregon	221,819,579	X	0	0	0	0
Idaho	140,668,319	X	0	0	0	0
Wyoming	156,383,521	-	3,127,670	6,255,341	9,383,011	12,510,682

- Based on estimated FY 2003 apportionments, after distribution of Minimum Guarantee funds

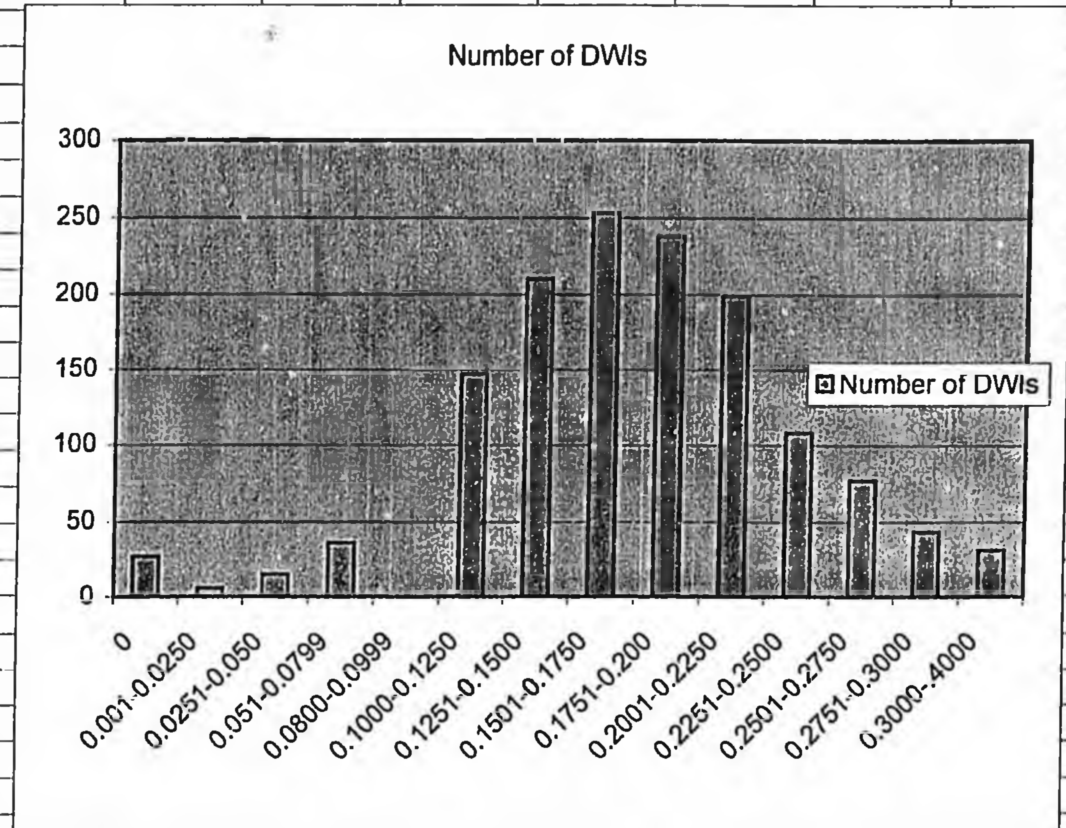
Alaska Highway Safety Office, ADOT&PF 01/01

APD	REVISED 03/08/2001
DWIs by BAC	
01/01-00 - 12/31/00	

BAC	Number of DWIs
0	27
0.001-0.0250	6
0.0251-0.050	15
0.051-0.0799	36
0.0800-0.0999	61**
0.1000-0.1250	147
0.1251-0.1500	210
0.1501-0.1750	253
0.1751-0.200	238
0.2001-0.2250	199
0.2251-0.2500	108
0.2501-0.2750	77
0.2751-0.3000	43
0.3000-.4000	31

Total = 1,451

**Net change of -3



Note: 1) A few tests may not have been counted due to loss of data in uploading process

2) The highest BAC recorded during this period was 1 test @ 0.3996

*Note: Between 01/01/98 - 12/31/99, 168 breath tests were run at APD with BACs between .0800 and .1000

(2yr. prd) approx. 84/yr

Bethel REVISED 03/08/2001

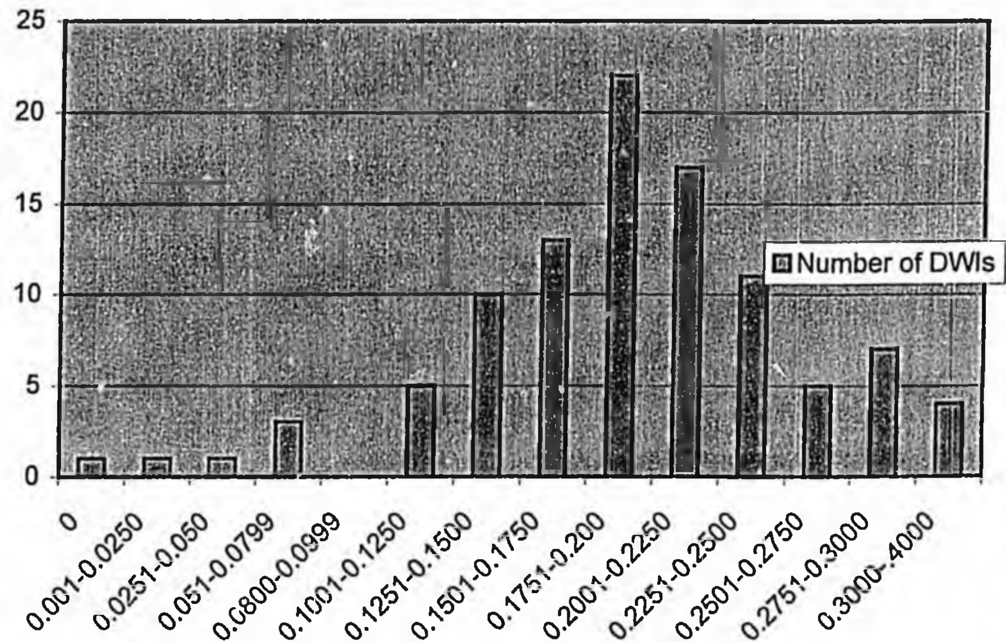
DWIs by BAC

01/01-00 - 12/31/00

BAC	Number of DWIs
0	1
0.001-0.0250	1
0.0251-0.050	1
0.051-0.0799	3
0.0800-0.0999	2**
0.1001-0.1250	5
0.1251-0.1500	10
0.1501-0.1750	13
0.1751-0.200	22
0.2001-0.2250	17
0.2251-0.2500	11
0.2501-0.2750	5
0.2751-0.3000	7
0.3000-.4000	4

Total = 102

**Net change of 0



Note: 1) A few tests may not have been counted due to loss of data in uploading process

2) The highest BAC recorded during this period was 1 test @ 0.3327

*Note: Between 01/01/98 - 12/31/99, 5 breath tests were run in Bethel with BACs between .0800 and .1000

FPD, AST/Fairbanks, Fairbanks Airport Police, North Pole PD, UAF Police Dept. REVISED 03/08/2001

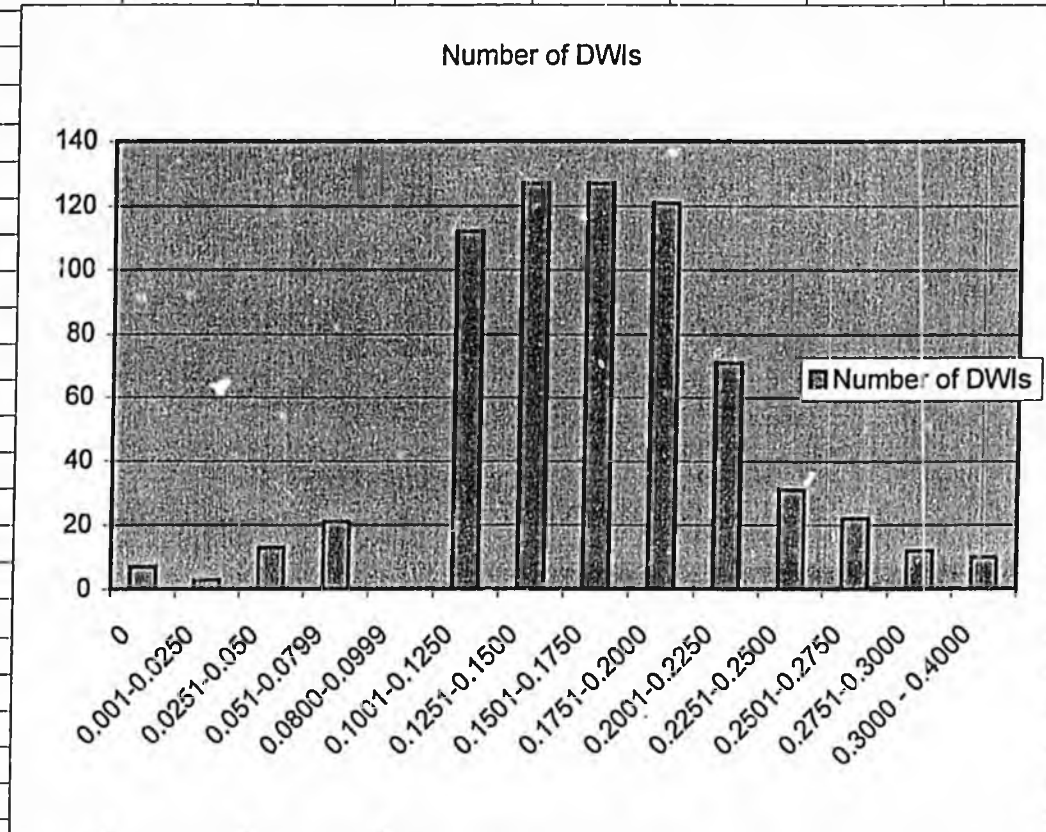
DWIs by BAC

01/01-00 - 12/31/00

BAC	Number of DWIs
0	7
0.001-0.0250	3
0.0251-0.050	13
0.051-0.0799	21
0.0800-0.0999	41**
0.1001-0.1250	112
0.1251-0.1500	127
0.1501-0.1750	127
0.1751-0.2000	121
0.2001-0.2250	71
0.2251-0.2500	31
0.2501-0.2750	22
0.2751-0.3000	12
0.3000 - 0.4000	10

Total = 718

**Net change of -2



Note: 1) A few tests may not have been counted due to loss of data in uploading process

2) The highest BAC recorded during this period was 1 test @ 0.354

*Note: Between 01/01/98 - 12/31/99, 59 breath tests were run in Fairbanks with BACs between .0800 and .1000

**Note: No data from military bases included here

JPD, AST/Juneau REVISED 03/08/2001

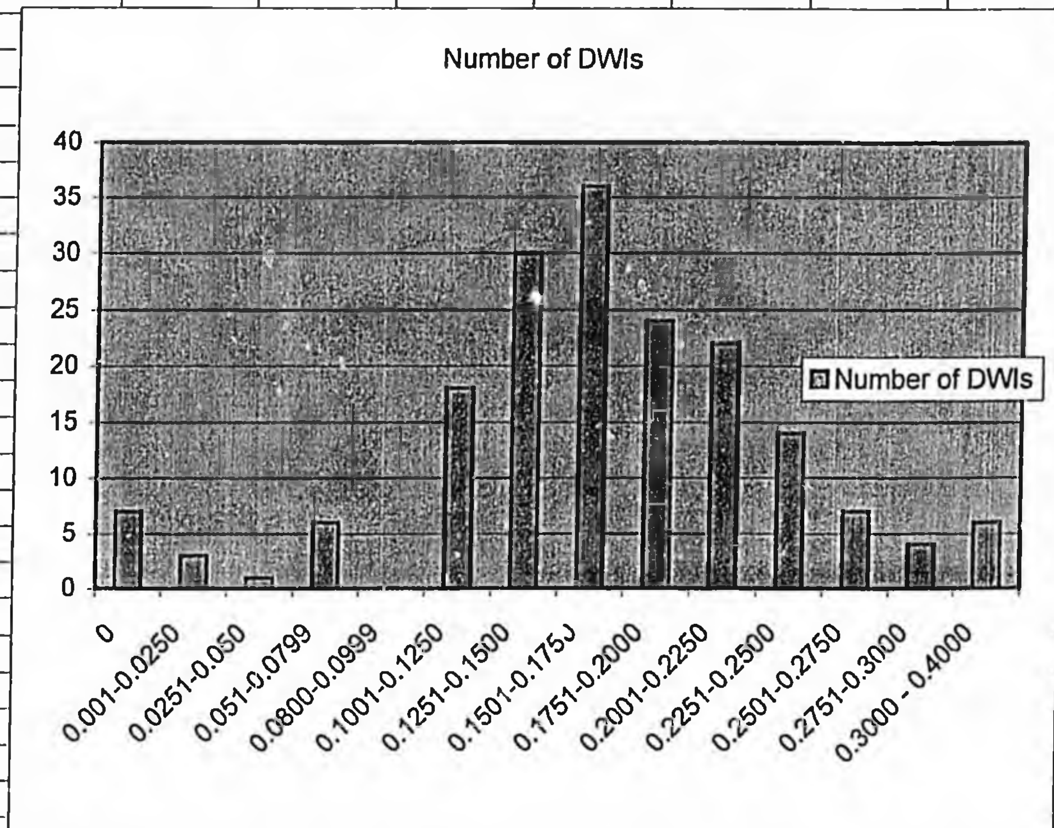
DWIs by BAC

01/01-00 - 12/31/00

BAC	Number of DWIs
0	7
0.001-0.0250	3
0.0251-0.050	1
0.051-0.0799	6
0.0800-0.0999	8**
0.1001-0.1250	18
0.1251-0.1500	30
0.1501-0.1750	36
0.1751-0.2000	24
0.2001-0.2250	22
0.2251-0.2500	14
0.2501-0.2750	7
0.2751-0.3000	4
0.3000 - 0.4000	6

Total = 186

**Net change of 0



Note: 1) A few tests may not have been counted due to loss of data in uploading process

2) The highest BAC recorded during this period was 1 test @ 0.345

*Note: Between 01/01/98 - 12/31/99, 21 breath tests were run in Juneau with BACs between .0800 and .1000

Soldotna PD, AST/Soldotna, Kenai PD, Homer PD, Seward PD REVISED 03/08/2001

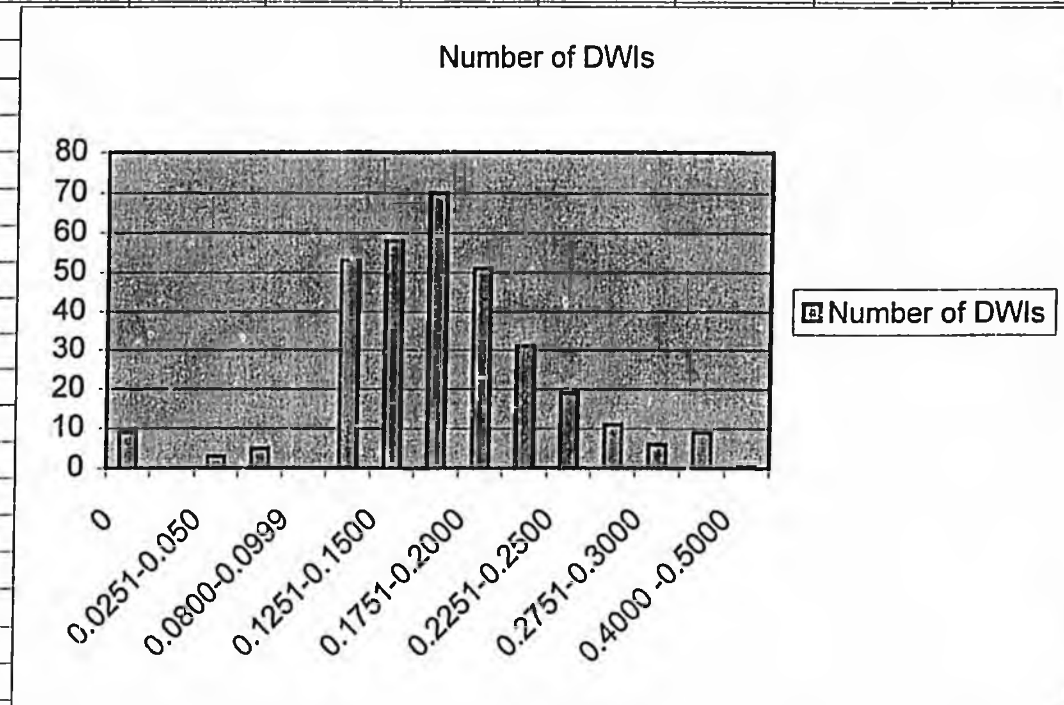
DWIs by BAC

01/01-00 - 12/31/00

BAC	Number of DWIs
0	9
0.001-0.0250	0
0.0251-0.050	3
0.051-0.0799	5
0.0800-0.0999	23**
0.1001-0.1250	53
0.1251-0.1500	58
0.1501-0.1750	70
0.1751-0.2000	51
0.2001-0.2250	31
0.2251-0.2500	19
0.2501-0.2750	11
0.2751-0.3000	6
0.3000 -0.4000	9
0.4000 -0.5000	1

Total = 349

**Net change of +1



Note: 1) Some tests may have been lost due to loss of data in uploading process

2) The highest BAC recorded during this period was 1 test @ 0.407 from Homer

*Note: Between 01/01/98 - 12/31/99, 40 breath tests were run on the Kenai Penisula with BACs between .0800 and .1000

Wasilla PD, AST/Palmer, Palmer PD REVISED 03/08/2001

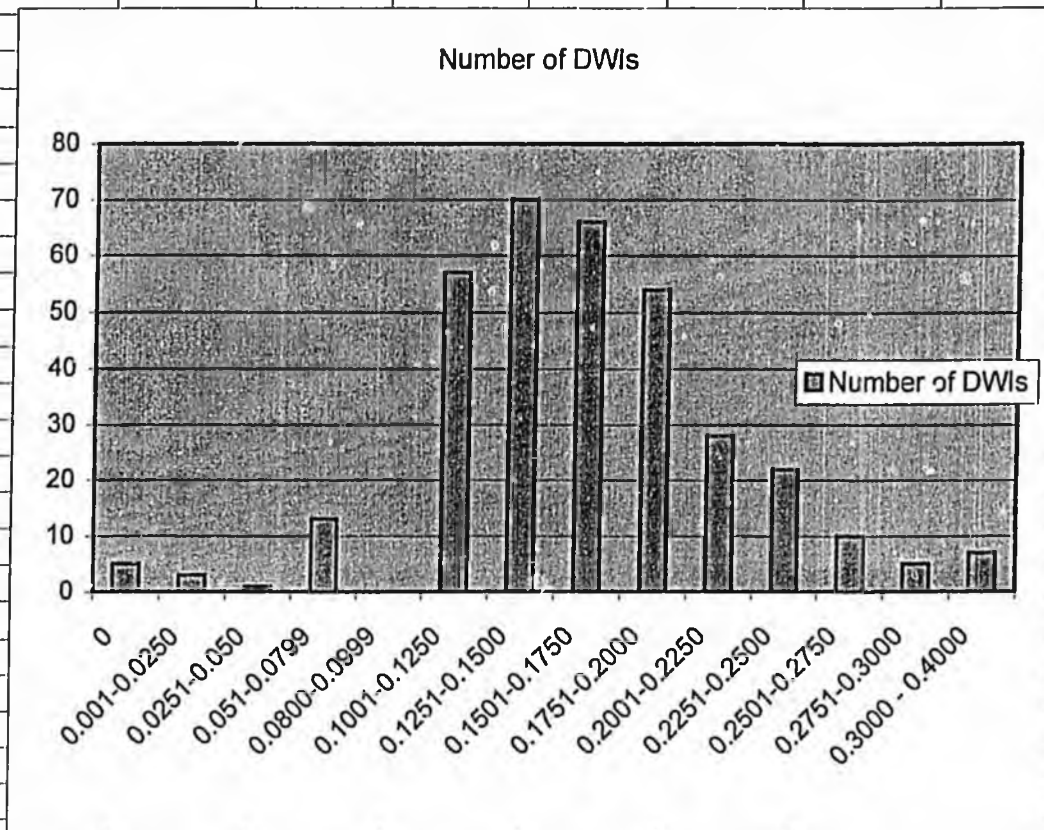
DWIs by BAC

01/01-00 - 12/31/00

BAC	Number of DWIs
0	5
0.001-0.0250	3
0.0251-0.050	1
0.051-0.0799	13
0.0800-0.0999	17**
0.1001-0.1250	57
0.1251-0.1500	70
0.1501-0.1750	66
0.1751-0.2000	54
0.2001-0.2250	28
0.2251-0.2500	22
0.2501-0.2750	10
0.2751-0.3000	5
0.3000 - 0.4000	7

Total = 358

**Net change of 0



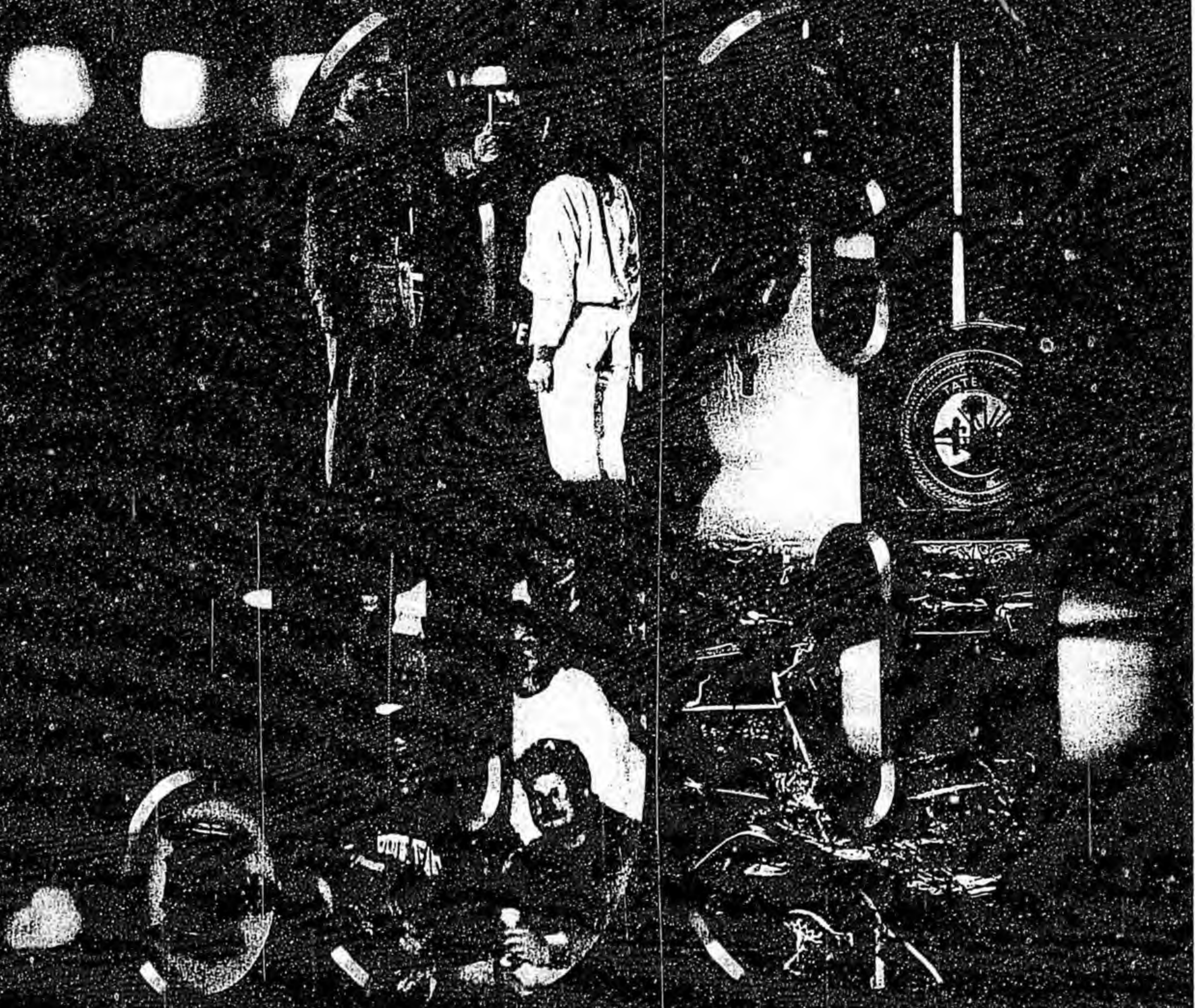
Note: 1) Several tests from AST/Palmer between 02/00 - 04/00 were lost due to loss of data in uploading process

2) The highest BAC recorded during this period was 1 test @ 0.362

*Note: Between 01/01/98 - 12/31/99, 73 breath tests were run in the Mat-Su area with BACs between .0800 and .1000

PRESIDENTIAL INITIATIVE FOR MAKING .08 BAC THE NATIONAL LEGAL LIMIT

RECOMMENDATIONS FROM THE SECRETARY OF TRANSPORTATION



What is .08 BAC?

Measuring Impairment

The amount of alcohol in a person's body is measured by the weight of the alcohol in a certain volume of blood. This is called the blood alcohol concentration or BAC. BAC measurements provide an objective way to identify levels of impairment, because alcohol concentration in the body is directly related to impairment.

The BAC measurement is expressed as grams per deciliter (g/dl) of blood, and in most states a person is considered legally intoxicated if his or her BAC is .10 g/dl or greater. Breath testing is the primary method used by law enforcement agencies for measuring BACs. At the time of the first face-to-face contact with a suspected impaired driver, techniques for detecting whether alcohol is present or absent can be performed easily by law enforcement officers during roadside stops using hand-held passive alcohol sensors. Use of these devices is non-invasive and can even be performed while the person is still in his or her vehicle.

NHTSA tests evidential breath testing equipment for precision and accuracy. Devices on NHTSA's Conforming Products List meet the agency's model specifications and are accurate within plus or minus .005 BAC of the true value.

NUMBER OF DRINKS AND BAC IN ONE HOUR OF DRINKING

.10
.09
.08
.07
.06
.05
.04
.03
.02
.01
BAC

Male 170 lbs. | **Female 137 lbs.**

NUMBER OF DRINKS AND BAC IN TWO HOURS OF DRINKING

.10
.09
.08
.07
.06
.05
.04
.03
.02
.01
BAC

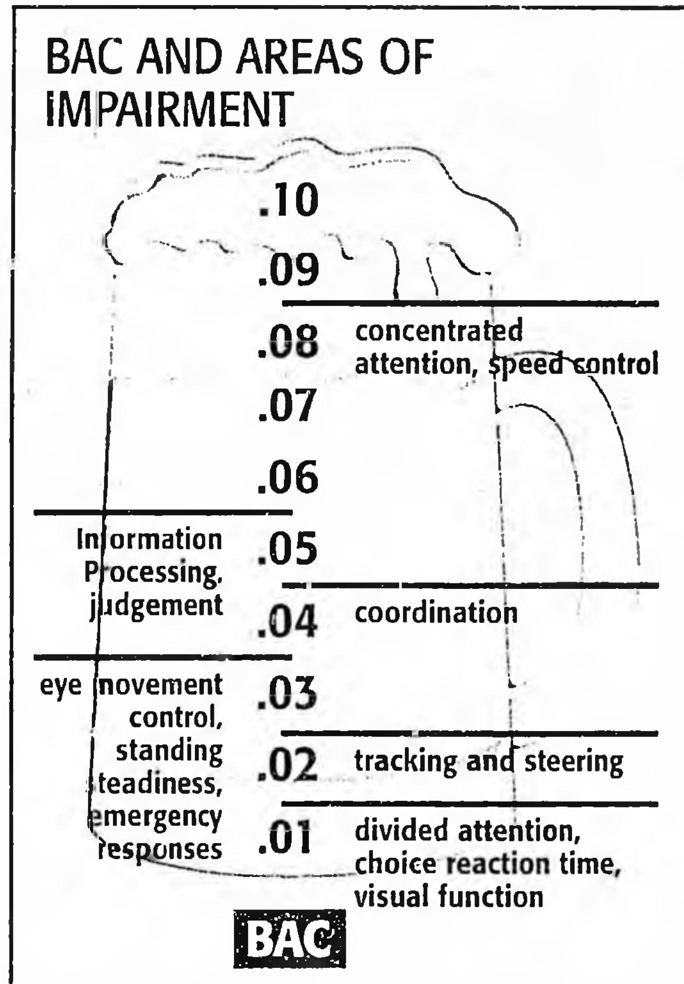
Male 170 lbs. | **Female 137 lbs.**

What is .08 BAC?

The Effect of Alcohol on Ability

With each drink consumed, a person's blood alcohol concentration increases. Although outward appearances vary, virtually all drivers are substantially impaired at .08 BAC. Laboratory and on-road research shows that the vast majority of drivers, even experienced drivers, are significantly impaired at .08 with regard to critical driving tasks such as braking, steering, lane changing, judgment and divided attention. Decrements in performance for drivers at .08 BAC are on the order of 40-60% worse than when they are at .00 BAC. Research findings suggest that the most crucial aspect of impairment is the reduction in the ability to handle several tasks at once. This skill is precisely what driving a motor vehicle requires.

The risk of being in a motor vehicle crash also increases as the BAC level rises. The risk of being in a crash rises gradually with each BAC level, but then rises very rapidly after a driver reaches or exceeds .08 BAC compared to drivers with no alcohol in their system. Research by the Insurance Institute for Highway Safety indicates that the relative risk of being killed in a single vehicle crash for drivers at BACs between .05 and .09 is 11 times that of drivers with no alcohol in their system.



HOUSE JUDICIARY COMMITTEE

March 9, 2001

.08 INFORMATION

(IN ADDITION TO ORIGINAL PACKET)

Final Report
of the
DUI Prevention Task Force

Municipality of Anchorage

October 30, 2000

Summary of Task Force Recommendations

The Task Force addressed the broad spectrum of legislative modifications, enforcement issues, potential government programs, and other types of public and private organizations within the scope of the charter statement and reached consensus on the following recommendations:

State and Municipal Legislative Recommendations

- Change the legal designation from DWI (Driving While Intoxicated) to DUI (Driving Under the Influence)
- Update present statutes to reflect subsequent court decisions
- Make third and subsequent DUIs felonies by eliminating "look back" provisions
- Identify enhancements for charging and sentencing considerations
- Graduate Blood Alcohol Concentration (BAC) levels and penalties from.08, and consider modifying AS 28.35.032, Refusal To Submit To A Chemical Test, to reflect the graduated penalty implications
- Require a valid driver's license and proof of insurance to register a vehicle
- Adopt a mandatory impoundment and forfeiture procedure at the state level
- Explore the feasibility of a centralized clearinghouse for licenses and investigate the expanded options provided by technological advances for tracking licenses whose holders have convictions for certain alcohol related offenses
- Require mandatory alcohol awareness training and a victim's panel as a prerequisite for a obtaining a valid resident driver's license
- Provide parameters for monitored, certifiable residential treatment in sentencing when enhancement factors are present
- Offer screening, mandatory alcohol education, and mandatory alcohol assessment during incarceration for DUI
- Provide for monitored alcohol treatment and ensure certifiable minimum standards in all DUI treatment programs
- Adopt Alaska Criminal Justice Assessment Commission recommendation #15 that the state should encourage the expansion of the Department of Health and Social Services Alcohol Safety Action Program (ASAP) through legislation and funding
- Recognize that halfway houses are not appropriate for repeat offenders and analyze halfway house administration
- Adopt Alaska Criminal Justice Assessment Commission recommendation #8 which relates to underage drinkers
- Make AS 04.16.050, Possession, Control, or Consumption by Persons Under 21 a misdemeanor and provide for alcohol treatment or counseling, peer options such as Youth Court, and parental/guardian notification
- Repeal AMC 10.50.015(H), Solicit the Purchase, Attempt to Purchase, or Possess Intoxicating Liquor, and require these offenses be charged under a revised AS 04.16.050

- Establish and fund a DUI Court
- Make As 28.05.095, Use of Seat Belts and Child Safety Devices Required, a primary law

Enforcement Recommendations

- Encourage focused enforcement of youthful offenders
- Encourage the state to enforce and prosecute AS 28.35.280, Minor Operating a Vehicle After Consuming
- Establish a Report Every Drunk Driver Immediately (REDDI) program in Anchorage
- Expand "Drunk Busters" program, and initiate year round saturation patrols
- Streamline drunken driver arrest processing procedures
- Initiate safety checkpoints when deemed appropriate by law enforcement
- Implement ignition interlock devices as a condition of probation for DUI offenders after their driving privileges have been reinstated

Other Government Programs

- Increase alcohol server mandatory training from every three years to every two years
- Establish media awareness campaigns that target the "uncaught offender"
- Establish mandatory alcohol education and awareness programs in schools
- Study alternative forms of transportation between Girdwood and Anchorage
- Establish an umbrella group to facilitate continued coordination, compilation and exchange of data, and exchange of materials between interested groups and organizations

Public/Private Organizations

- Establish a Responsible Hospitality Institute Chapter in Anchorage

the philosophy that the seriousness of impaired driving offenses are aggravated by such factors.

Action Needed: Change State law

Responsible Entity: State Legislature

5. **Graduated Blood Alcohol Content (BAC) levels and penalties:**
   - **.08 to .15 - existing penalties**
   - **Above .15 to below .20 - increase penalties with enhancement factors**
   - **.20 and above - felony**

Goal: Bring the state into conformance with federal guidelines, and to provide statutory recognition that higher BAC levels are directly tied to the seriousness of the offense and the likelihood to re-offend

Discussion: The Task Force recognized that .08 BAC brings the state into conformance with new federal guidelines for a legal intoxicated driving threshold. Charges and penalties should be based on the level of intoxication and consideration of previously discussed enhancement factors. According to a recent study by the Preusser Research Group for the AAA Foundation for Traffic Safety, 24% of all drunk driver fatality accidents involve drinking drivers with a BAC between .15 and .19, inclusive. The figures jump to 42% for drivers with a BAC of .20 and greater. Finally, it should be recognized that higher BAC levels are directly tied to the seriousness of the offense and the likelihood to re-offend. Local statistics provided by the Municipal Prosecutor show that the average BAC of a first offender who re-offends is .189. There is, however, a potential loophole in the Task Force recommendation for making .20 and above a felony. As long as AS 28.35.032, Refusal to Submit to a Chemical Test remains a misdemeanor, there is a potential for highly intoxicated individuals to refuse to provide a breath sample and circumventing the potential to be charged with a felony. A possible consideration is to change AS 28.35.032 to a felony.

Action Needed: Change State law

Responsible Entity: State Legislature

6. **Require a valid driver's license and proof of insurance to register a vehicle.**

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM February 8, 2001

SUBJECT: HB 4 - driving while intoxicated.

TO: Representative Norman Rokeberg
Attn: Janet

FROM: Michael F. Ford
Legislative Counsel

You have asked if HB 4 satisfies the requirements imposed by federal law that States must adopt a 0.08 blood alcohol level for purposes of D.W.I. offenses in order to avoid losing federal highway funds. As explained in this memo, I believe that with one exception, the bill meets federal requirements.

Congress included a provision in a transportation appropriations bill providing that two percent of federal highway funding will be withheld beginning in FY 2004, in a State that has not adopted the 0.08 standard. The federal provision requires enactment and enforcement of a provision described in 23 U.S.C. 163(a). Under 23 U.S.C. 163(a), States are required to enact and enforce a "law that provides that any person with a blood alcohol concentration (BAC) of 0.08 percent or greater while operating a motor vehicle in the State shall be deemed to have committed a per se offense of driving while intoxicated." There are federal regulations that implement this provision of law. The U.S. Department of Transportation has promulgated 23 C.F.R. 1225 which spells out the requirements of a 0.08 BAC law. Under 23 C.F.R. 1225.5, a 0.08 law must

(1) apply to all persons;
(2) set the blood alcohol legal limit not higher than 0.08;
(3) make operating a motor vehicle in violation of the 0.08 level a per se offense;
(4) provide for primary enforcement;
(5) make the 0.08 standard a criminal offense and apply the same standard in administrative license revocation proceedings; and
(6) be deemed to be or be equivalent to the standard driving while intoxicated offense in the state.

I believe HB 4 satisfies each requirement imposed under 23 C.F.R. 1225.5, with the exception of the definition of "operate a motor vehicle" contained in Sec. 31. Under this definition, a person would have to be in control of a moving motor vehicle, in order to commit the offense. Under 23 C.F.R. 1225.3, operating a motor vehicle means driving or