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 2000

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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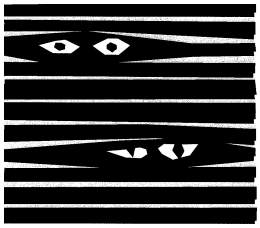


ALASKA'S ALCOHOL INDEX

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.

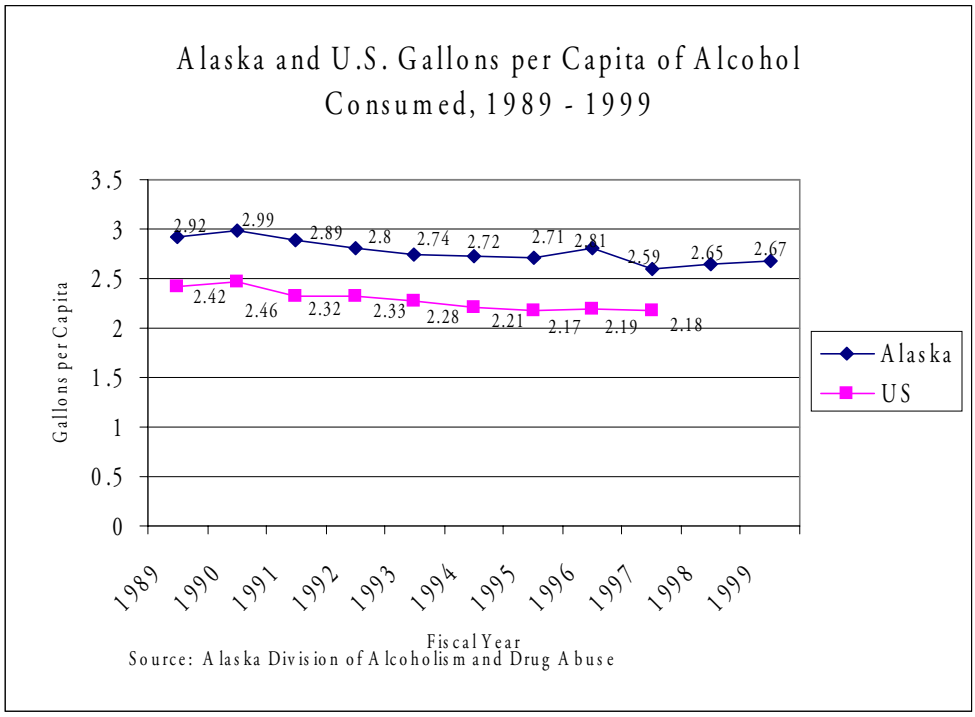
Nearly 60,000 Alaskans misuse, abuse or are addicted to alcohol. About 14,000 seek alcohol prevention or treatment services in programs that receive state funds.
State of Alaska, Division of Alcoholism and Drug Abuse

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:	ll.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 homegrown, 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
(**E**ye 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 Rosenzwieg, 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	Wine	Spirits	All
	Revenue	Revenue	Revenue	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.)

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.

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.

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