Message from the Chair

DT: January 1999

TO: Fellow Alaskans

FR: Cheryl Mann, Chair
Advisory Board on Alcoholism and Drug Abuse

RE: Partnerships for a Healthy Alaska

There is no greater foundation for the implementation of this new state plan for delivery of alcohol and drug abuse services than partnerships at the local, regional or state level. You will find the creation of partnerships and the nurturing of new coalitions to be a common thread throughout this plan.

One of the enduring values of partnership development is that frequently more intangible resources are required than funding resources. Commitment, time and sharing of leadership are some of the most vital requirements. When Alaskans give freely of these assets, from themselves and their organizations, we will be able to stretch existing resources and focus new resources on our most urgent needs in the most beneficial and cost effective ways.

The Advisory Board can take great pride in its ground-breaking work in establishing treatment outcomes and raising awareness among providers and allied health professionals. Over the next decade we will continue to firmly embrace our mission to significantly reduce the devastating consequences of substance abuse on individual Alaskans, families and communities.

We invite each of you to find ways in which you can be a partner in achieving that desired result. If we can help you to identify other individuals and organizations that share your concerns please be sure to ask for our assistance.

Advisory Board on Alcoholism and Drug Abuse
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The Advisory Board's toll free telephone number is 1-888-464-8920. Assistance may also be requested by e.mail to **Anne_Schultz@health.state.ak.us**

Advisory Board Roster

As of January 1999, the Advisory Board on Alcoholism and Drug Abuse is composed of the following members, appointed by the Governor:

Cheryl Mann, Anchorage CHAIR

Gerry Kasiak, Ketchikan CHAIR-ELECT

Delfin Lopez, Sterling RECORDER-TREASURER

Sebastian Cowboy, St. Marys

C. Joe DiMatteo, Anchorage, appointed December 1998

Donna R. Galbreath, Fairbanks

Alice Johnstone, Sitka

Loren Jones, Juneau

Anne Kinter, Juneau, appointed December 1998

Banarsi Lal, Fairbanks

Henrietta Nugen, Wasilla

Don Peter, Fort Yukon

Valerie M. Therrien, Fairbanks

Eric Tomasino, Palmer

Cristy Willer Tilden, Dillingham

The Advisory Board acknowledges the contributions made to the strategic planning process by members whose terms expired or who moved from Alaska before the plan was completed: Roseanne Turner, Anchorage; and Suzanne Drapeaux, Juneau.

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Mission and Guiding Principles

MISSION

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.

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GUIDING PRINCIPLES

The philosophy of the Advisory Board on Alcoholism and Drug Abuse is to create an environment in which individuals can explore and expand their human potential by recognizing that:

1. Alaskans have the right to seek a life free of the devastating effects of alcohol and substance abuse.
2. The fatal diseases of alcoholism and drug addiction are both preventable and treatable.
3. Sobriety is a positive lifestyle choice for Alaskans.
4. Prevention is as important a public health concern as treatment is.
5. Services must respect personal and community needs in a holistic way that acknowledges cultural and gender differences.
6. Rights and dignity of the client must be respected at all times.
7. Best practice standards must be used by those who provide treatment and prevention services.
8. Success will be measured by improvement in health and well-being and by the elimination of substance abuse and the harm it causes.
9. Partnerships between communities, public and private organizations, families and individuals are the key to success in fulfilling our mission.
10. All decisions and actions must focus on positive impacts on future generations.

Executive Summary

Results that will significantly reduce the negative consequences of alcohol use by Alaskans is the focus of **Results Within Our Reach**, the Alaska state plan for alcohol and drug abuse services. The plan covers the years 1999-2003.

A statewide work group with expertise from many disciplines joined the Advisory Board as stakeholders in this planning effort. They brought commitment and urgency to the development of this plan. The group was able to build upon the solid foundation laid in **Meeting the Challenge**, the strategic plan for the Division of Alcoholism and Drug Abuse published in 1994.

This plan reflects the Advisory Board's commitment to results-based service delivery. It incorporates the use of indicators, strategies and performance measures that will help to monitor service delivery effectiveness.

The Advisory Board framed the process by identifying its mission and guiding principles. These emphasize the necessity for public awareness of the scope of the problem, a broad range of partnerships and personal responsibility. To ascertain attitudes of key informants throughout the state, the Advisory Board asked more than1,000 stakeholders to indicate their level of agreement with statements about alcohol and drug abuse issues. More than fifty percent responded, with remarkably favorable levels of agreement. The Board is confident that this plan is well grounded and reflects community awareness of the scope of the problem it seeks to remedy.

This plan focuses on the overarching result desired for all Alaskans: that they live free from the negative consequences of alcohol and other drug use. It identifies six indicators that will be used to track progress over the coming years. Each is supported by sufficient data collection to calculate trends over time. The Advisory Board looked to staff of the Division of Alcoholism and Drug Abuse for the collaborative development of strategies and performance measures with which to implement the plan. Public testimony was solicited. Eighteen strategies emerged, each with a set of performance measures. The strategies recognize the essential role partnerships play in changing attitudes, behaviors, and community norms. The strategies identify special populations that require greater service capacity, accessibility and intensity. A specific strategy addresses the needs of chronic alcoholics with psychosis, who are beneficiaries of the Alaska Mental Health Trust.

In order to walk the walk that is talked about in the plan, continuous attention must be paid to data development. The Data Agenda section gives a comprehensive review of the benefits and constraints of data collection and spells out the additional data that will be required in the future. This ongoing data collection effort is imperative if the plan is to achieve its desired level of accountability.

The prevention and treatment strategies identified in the plan will be implemented by the Division of Alcoholism and Drug Abuse, which has responsibility for managing service delivery in Alaska. The Division's Request for Proposals (RFP) process will incorporate strategies implementation into funding allocation decisions.
Successful grantees will develop proposals that reflect the Division's guidelines and this plan.

Both the Advisory Board and the Division will work assertively to ensure wide distribution of the plan during the coming months.

The Division will monitor performance measures to assess the level, quality and effectiveness of effort. Over the next several years the Division and the Board will be able to ascertain the effectiveness of selected strategies. This monitoring will guide course corrections during the updating of the plan as the year 2003 approaches.

Each year the Advisory Board will collect the required indicator data to determine the extent to which the strategies have influenced desired results. The Board undertakes this process being mindful that it will be necessary to view data over time before definitively assessing effectiveness over the long term.

The Advisory Board will work with the Department of Health and Social Services, Alaska Mental Health Trust Authority and the Trust's other beneficiary advocacy boards to ensure an effective integration of this plan into the Comprehensive Integrated Mental Health Plan for the state.

Background

Strategic planning is an ongoing process. Each phase builds on previous work and lays the foundation for future planning efforts. In 1994, the Alaska Division of Alcoholism and Drug Abuse published a comprehensive strategic plan**, Meeting the Challenge: A Strategic Plan for the Division of Alcoholism and Drug Abuse.** This plan identified trends in the external environment as well as goals and strategies for the Division in the 1990s.

The 1994 plan focused on four major trends that would affect the Division and service delivery through the end of the decade.

- Level and extent of alcohol, other drug, and inhalant abuse in Alaska;
- Special needs and barriers for specific populations such as rural residents, pregnant women, persons with co-existing mental illness, and women with dependent children;
- Funding sources and restrictions; and
- Increased emphasis on service delivery outcomes.

A series of strategies and goals were developed to address the needs of Alaskans within the context of these trends. As predicted, these trends have played a major role in program development and service delivery in the latter part of the decade. Furthermore, these factors are predicted to play an even greater role in the future.

Of the four major trends, the emphasis on outcomes is a pivotal factor in both program development and funding allocation. In 1996, the Division of Alcoholism and Drug Abuse and the Advisory Board on Alcoholism and Drug Abuse brought together a workgroup to identify desired outcomes for both treatment and prevention efforts. In the Request For Proposals (RFP) issued in 1997, the Division mandated the use of outcome

targets along with more traditional process measures. To support this move, standardized outcome measures were developed. They are currently being incorporated into the Division's management information system (MIS).

In 1994, the Mental Health Lands Trust claims were settled after years of litigation. The Alaska Mental Health Trust Authority was formed. Its Trustees are charged by statute with managing the assets of the Trust, and providing resources for services to beneficiaries. Trust beneficiaries are defined as Alaskans who experience one or more of the following:

- a mental illness;
- mental retardation or similar disability;
- Alzheimer's disease or related dementia;
- chronic alcoholism with psychosis.

Four boards are responsible for addressing the needs of these beneficiary groups: the **Alaska Mental Health Board**, the **Governor's Council on Disabilities and Special Education**, the **Alaska Commission on Aging** and the **Advisory Board on Alcoholism and Drug Abuse.**

The Advisory Board on Alcoholism and Drug Abuse plans and advocates for the needs of chronic alcoholics with psychosis. It also plans and advocates for substance abuse service needs of all Alaskans. To fulfill these responsibilities, the Advisory Board has completed this 12-month strategic planning effort. Many Alaskans have made valuable contributions to the process.

First, the Board invited a group of 25 Alaskans with special interest and expertise in substance abuse issues to participate in the Strategic Planning Work Group. They met initially in September 1997 for orientation to the Advisory Board's guiding principles and mission, and to become acquainted with the results-based model developed by Mark Friedman. Mr. Friedman is a policy consultant to the Alaska Legislature, the Office of Management and Budget, and the Alaska Mental Health Trust Authority. The work group participants are gratefully acknowledged in Appendix A.

To test the assumptions on which to base the revised plan, the Advisory Board sent a fifteen-question survey to more than 1,000 key informants throughout the state. With a response rate of 51%, the results indicated an overwhelming sense that substance abuse, particularly alcoholism, is the most pressing health problem in the state.

The Work Group formed three teams: the Results Team, the Indicators Team, and the Strategies and Performance Measures Team. Over a seven-month period, the teams developed a set of desired results and indicators, each team building on the work of the previous group. In July 1998, the full Advisory Board, Division of Alcoholism and Drug Abuse staff, and other key stakeholders jointly developed strategies and performance measures.

In this manner, the desired results, indicators of their achievement, strategies for success and performance measures were identified. With these key elements in place, sources of reliable data were examined and baseline data collection began. The draft plan was reviewed by the original Work Group in September 1998. Public testimony and comment were received in November and December 1998. This final document reflects the Advisory Board's plan based on those thoughtful and collaborative efforts.

About this plan…

This strategic plan will serve a number of purposes over the next four years. Most importantly, it will guide the Advisory Board and the Division in planning efforts to eliminate the negative consequences of alcohol and other drug use. It is the framework for continuing assessment of service needs throughout Alaska. It will help track the extent and quality of our efforts. Finally, it offers strategies that encourage stakeholders, clients, and communities to address issues forthrightly in ways that will achieve and sustain local benefits.

This plan is organized in the following manner:

The Model. The model was developed by Mark Friedman, of the Fiscal Policy Institute, Baltimore, Maryland. One of the compelling reasons for using this model is that it is also being used by other State agencies and the Legislature as a method for developing budgets and programs based on desired results.

Results and Indicators. Desired results are in this section. The indicators will measure progress toward achieving these results. Each indicator includes a graphic representation of recent trends and the source of the data used to create the chart or graph.

Strategies and Performance Measures. The strategies that have been selected to move us toward desired results are in this section. Each strategy includes a series of performance measures that will help chart progress.

Data Agenda. Some valuable data are not available. The data agenda identifies desirable data that support existing indicators and data that would support other potentially advantageous indicators.

Implementation. This section identifies the four distinct implementation efforts that are required in order for the plan to remain a useful tool over time.

Results and Indicators[1]

The beginning point for development of the strategic plan for alcohol and drug abuse services is to identify the desired results or outcomes. Appropriate strategies and performance measures flow from those results.

Results are conditions of well being in individuals, families, and communities, according to Friedman. Desired results are abstract and not easily measurable. They are also of an enduring nature. They are not expected to change quickly. These desired results will be the focus for the planning and service delivery effort at the state level over a period of years.

Indicators are markers that give some distinct indication of progress. These are measures for which data are readily available. While there are many sources and types of

[1] Mark Friedman, Fiscal Policy Institute, Turning the Curve, 1996

available data, only those measures that score high in data power, proxy power, and communication power are used.

Data power is an indication of the accuracy, availability, and consistency of data across the diverse regions of the state. It also takes into account the regularity with which the data is collected.

Proxy power is an indication of how well the data says something of central importance about the result.

Communication power is an indication of how well the indicator is understood by the desired audience. When the indicators are published, decision-makers as well as the general public must be able to make the connection between the results that are desired and the data reported.

Desired Results

Alaskans live free from the negative consequences of alcohol and other drug use.

The Advisory Board's vision of a healthy, productive, and happy society is one that is free from the negative consequences of alcohol and other drug use. The foundation of this plan rests on the Board's commitment to significant reduction in those negative consequences. The consequences are apparent in per capita consumption, DUI convictions, alcohol or drug related convictions, alcohol-related injuries, 12-hour protective custody holds and the rate of binge or chronic drinking by adults.

Other desired results:

- ***Alaskans are physically, mentally, spiritually, and emotionally healthy and are engaged in health lifestyles to sustain well being***.
- ***Alaskans are safe in their homes and communities***.
- ***Alaskans achieve their highest possible level of self-sufficiency***.
- ***Alaskans live with dignity and respect as valued members of their families and communities***.

Indicator One

Per capita consumption of alcohol.

The rate of consumption per person, 14 years and older, based on excise taxes collected at the wholesale level.

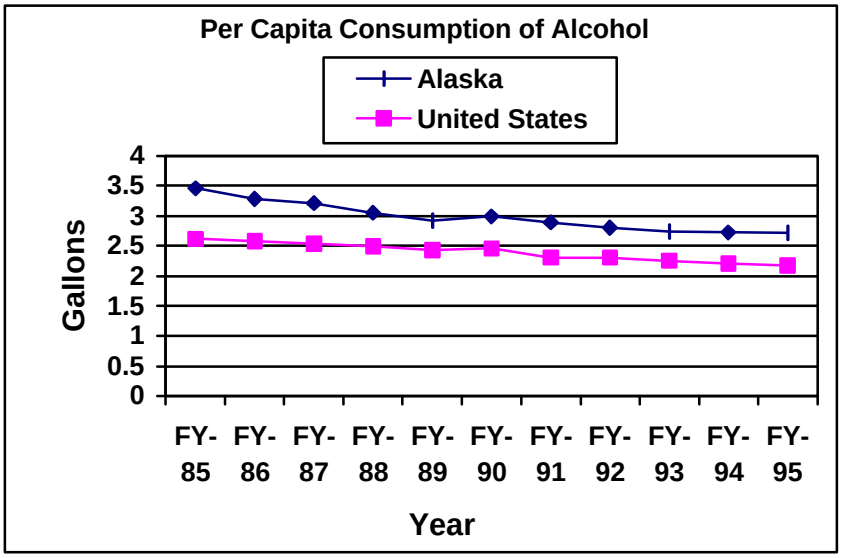


Figure 1 Source: Division of Alcoholism and Drug Abuse

The story behind the indicator headline…

The prevalence and severity of alcohol-related problems among Alaskans is directly related to the amount of alcohol consumed. The data, as collected, are based on total alcohol purchased at the wholesale level and the number of Alaskans who are 14 years of age and older. If this number were adjusted downward to remove those who completely abstain from alcohol, then per capita consumption would be greater. Although the figure for Alaska is higher than the national average, both sets of data indicate that consumption is decreasing. The population data does not acknowledge the state's significant visitor population. The consumption decrease by Alaska residents may be even greater than shown. The strategies that impact this indicator most readily are those that address public policy issues such as the number of licensed outlets and their hours of operation.

Indicator Two

Number of convictions for Driving Under the Influence of alcohol (DUI).

The number of convictions in state district and superior courts on charges of driving while under the influence of alcohol.

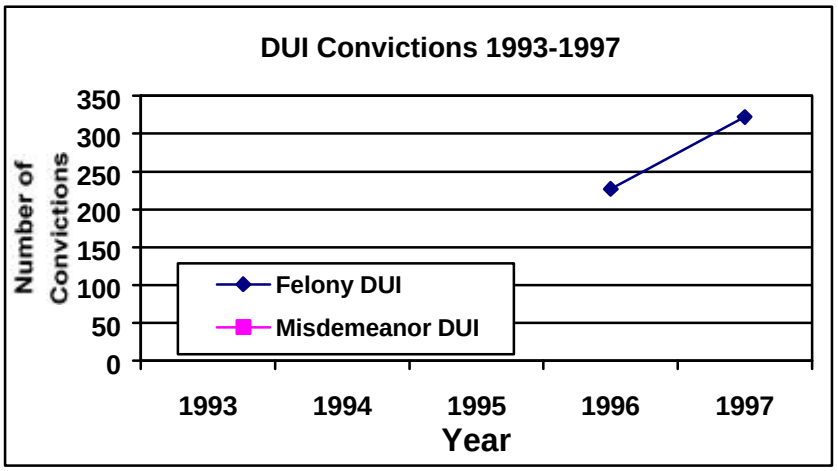


Figure 2 Source: Alaska Court System

The story behind the indicator headline…

Driving while under the influence of alcohol is one of the strongest indicators of the negative consequences associated with alcohol misuse. Data for 1997 show that 30 percent of all automobile accident fatalities had alcohol or drugs as the major contributing factor[2]. There are many variables that impact this data, including enforcement effort and prosecutor case loads. The data correlate with successful prevention efforts, particularly in terms of public awareness of the consequences of Driving Under the Influence (DUI). Driving under the influence of alcohol impacts lives, not only in accidents, injuries, and deaths, but also in family suffering, employment problems, and social functioning. Persons convicted of DUI also represent one of our most well defined target populations: individuals whose use of alcohol has directly caused negative consequences. DUI convictions are categorized by both felony and misdemeanor offenses.

Indicator Three

Number of state criminal convictions on alcohol or drug-related charges.

The number of convictions on charges which include possession or distribution of drugs, misconduct involving alcohol or other drugs, and failure to take a breath test. The indicators are based on data published by the state court system and do not include arrest data that does not result in convictions.

[2] Alaska Department of Transportation and Public Facilities, 1997 Alaska Traffic Accidents, July 1998

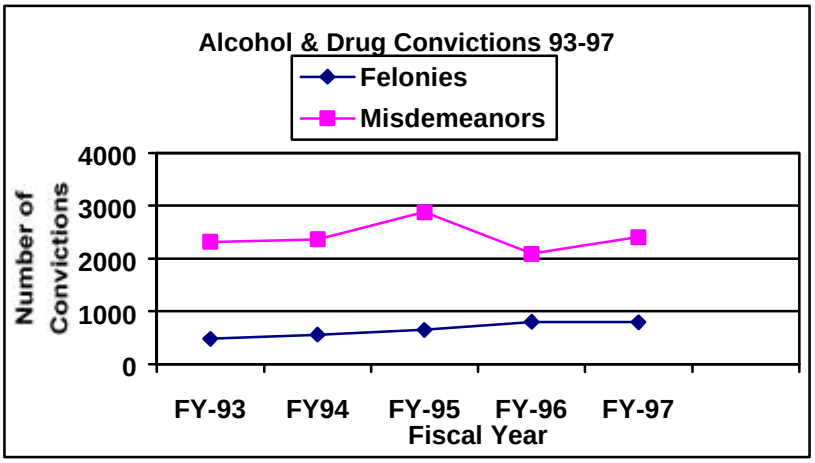


Figure 3 Source: Alaska Court System

The story behind the indicator headline…

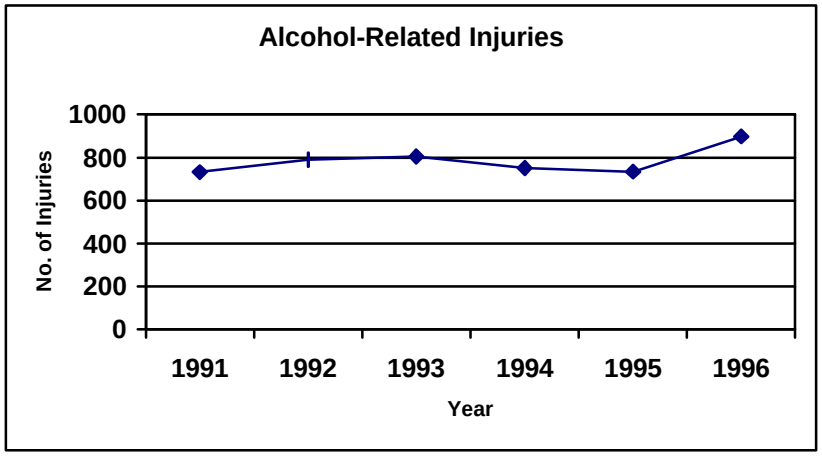
Convictions for drug and alcohol-related offenses, like DUI convictions, offer a clear picture of the negative consequences of use of alcohol and other drugs. Between fiscal years 1993 and 1997, felony convictions increased from 478 to 791. Misdemeanors have varied but show no clear increase or decrease trends. There are a number of factors that may impact this indicator including State Trooper and local police department enforcement, changes in laws, and prosecution efforts. Intervention and treatment services play a major role in decreasing the amount of alcohol and drug-related crime. Collaborative efforts have demonstrated that early intervention and appropriate, timely treatment for offenders can reduce the number of alcohol and drug-related crimes.

Indicator Four

Alcohol-related injuries requiring hospitalization.

Injuries treated in a hospital for which alcohol was determined to be a contributing factor.

Figure 4



Source: **Alaska Trauma Registry**

The story behind the indicator headline…

Injuries involving the use of alcohol represent a significant and costly negative consequence. The Alaska Trauma Registry, which collects information from every hospital in the state, tracks all injuries requiring hospitalization. It has special fields within its database to indicate the involvement of alcohol. The number of injuries seemed to peak in 1993 and start a downward trend. However, the number of injuries in 1996 showed a sharp increase. These injuries typically involve young people. They affect the injured individuals, families, and sometimes entire villages. They require the most expensive level of medical care: that provided in an emergency department or trauma center. The efforts that are most likely to impact this indicator are those which seek to restrict access to alcohol or other drugs through public policy advocacy. A recent study indicated that Alaska Natives living in "wet" villages were almost three times more likely to die from an alcohol-related injury than those living in "dry" villages[3]. Early intervention and treatment services have also been shown to have a positive impact on this indicator.

[3] Alaska Child Protection Review Team, Report to the Governor, 1997

Indicator Five

The number of 12-hour protective custody holds.

The number of alcohol-incapacitated persons held in protective custody for up to 12 hours at State correctional facilities or community jails.

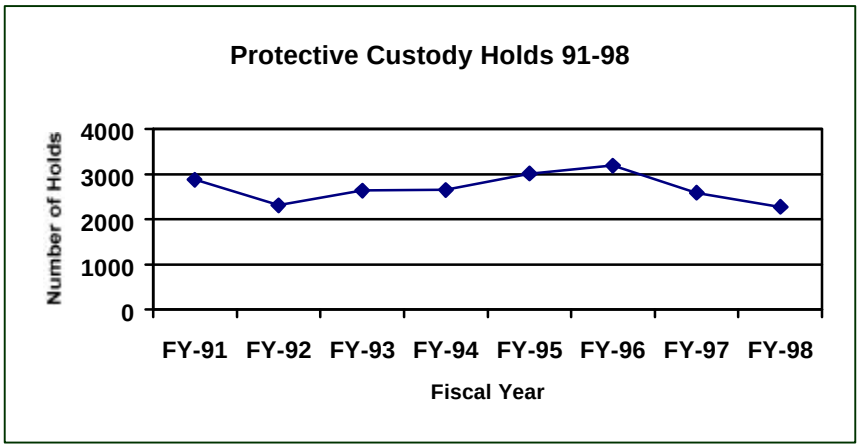


Figure 5 Source: Alaska Department of Corrections

The story behind the indicator headline…

Alaska Statute 47.37 provides that persons incapacitated by alcohol may be taken into custody in order to protect them and others from the negative consequences of their incapacitation. If suitable detoxification facilities are not available, they are taken to Department of Corrections facilities. They are held until protective custody is no longer necessary or up to twelve hours. As treatment programs work with communities to provide more appropriate services and timely interventions, the number of protective custody holds decreases. During 1995 and 1996, the Division of Alcoholism and Drug Abuse began to place more emphasis on early intervention for late stage, chronic alcoholics. This is the population most likely to require protective custody. Additional resources for detoxification have expanded community response. As a result, the number of protective custody holds has begun to decrease. During this period, the Advisory Board conducted training on the use of involuntary commitment of persons whose alcoholism is life-threatening. Community partnerships, resource expansion and community training in involuntary commitment procedures are contributing to the reduction in 12-hour protective custody holds.

Indicator Six

The rate of binge or chronic drinking by adults.

The percentage of Alaskans who self report acute or binge drinking in response to the annual Behavior Risk Factor Survey.

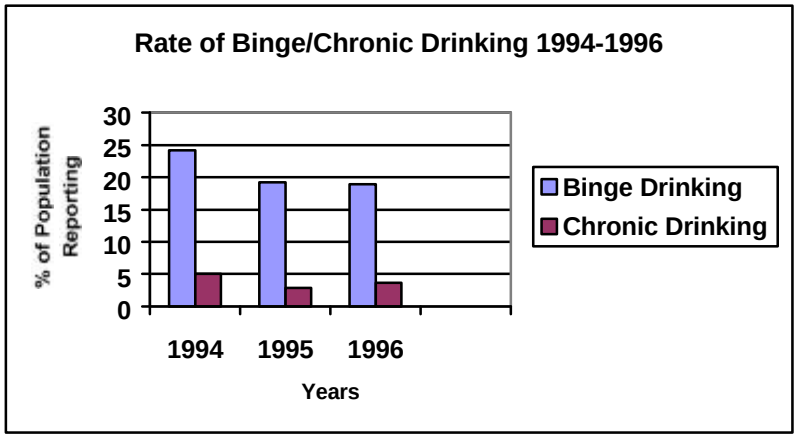


Figure 6 Source: Alaska Behavioral Risk Factor Surveillance System

The story behind the indicator headline…

Each year, the State of Alaska conducts a telephone survey to obtain information on behavioral risks prevalent among Alaskans. The interviews are conducted with a random sample of 1,535 residents, 18 years of age or older. One of the categories is the percentage of population engaged in binge or chronic drinking. **Binge drinking**, for purposes of this survey, refers to drinking five or more drinks on one occasion, at least once in the month preceding the survey. **Chronic drinking** refers to drinking an average of 60 or more alcoholic drinks in the month preceding the survey. There is a high correlation between these drinking patterns and many of the negative consequences associated with alcohol abuse -- particularly medical, family, and employment problems. The strategies that will have the most immediate impact on this indicator will be those that provide intervention and treatment services to chronic, late stage alcoholics. Early intervention services are also required to impact individuals whose disease progression has not reached the point of chronic or binge drinking.

Three sets of strategies converge to drive the plan's implementation. No single strategy is most important. The overarching focus is on partnerships, both community-based and statewide. Partnerships play a key role in the delivery of both prevention and treatment services. There is a major commitment to decreasing the negative consequences of alcohol and drug abuse by ensuring access to the appropriate range of quality treatment services for all Alaskans who need them. Additionally, we know that multiple strategies consistently targeting various populations over periods of time are more effective than strategies with a single focus.

Strategy One

Support community-based processes that build partnerships and provide more effective prevention and treatment services.

What this means…

Partnerships and collaboration are the keys to success in achieving desired results. If partnerships and collaboration are to become more than lofty goals, then communities must provide processes that nurture them. These processes include needs assessments, planning for services, integrated activities, and broad-based evaluation. Programs and activities must be relevant to the particular community. They must be conducted in a manner that respects community norms and values.

How will we measure our performance?

Performance Measure 1:	Number of agencies and groups participating.
Performance Measure 2:	Extent of participation in effort.
Performance Measure 3:	Number of new initiatives.
Performance Measure 4:	Percentage change in desired community results.

Strategy Two

Encourage activities and initiatives that will change community standards and emphasize healthy lifestyles.

What this means…

Community behaviors and activities usually reflect local standards and attitudes. These are "unwritten rules" that define what is appropriate or tolerable. Shaping these norms and values is an evolutionary process. One of the most familiar results of such a strategy is the decline in tolerance for driving under the influence of alcohol. Mothers against Drunk Drivers (MADD) started out as a small local advocacy group. Thousands of local initiatives have brought about sustained positive change because of MADD's vision and persistence. The Advisory Board will support and nurture programs that seek to influence the standards and attitudes of communities by encouraging and promoting sobriety as a healthy lifestyle choice.

How will we measure our performance?

Performance Measure 1:	Number of agencies, groups, and individuals involved in proactive partnerships.
Performance Measure 2:	Extent of participation in effort.
Performance Measure 3:	Number of new initiatives and diversity of support.
Performance Measure 4:	Percentage change in desired community results

Strategy Three

Distribute useful and effective information to targeted populations.

What this means…

The Advisory Board will encourage distribution of accurate and relevant information to help policy makers, individuals, families, and communities make wise decisions. All available research indicates that for information to be effective its message must address a specific audience. It must be relevant for particular age groups and cultures. It must be developed with a clear understanding of the desired response. Examples of this strategy are distribution of new research findings and outcome information to policy makers, promotion and advertising of available treatment services, and public information campaigns targeted to women of childbearing age.

How will we measure our performance?

Performance Measure 1:	Quantity of material developed and/or distributed.
Performance Measure 2:	Quality of material for a particular target audience.
Performance Measure 3:	Number of target group members reached.
Performance Measure 4:	Percent of target group with increased awareness.

Strategy Four

Promote the benefits of treatment, recovery, and sober lifestyle.

What this means…

Despite best efforts and positive outcomes for treatment services, members of the general public often have negative attitudes about the value and appropriateness of chemical dependency treatment. The Advisory Board will support efforts and strategies that raise public awareness of the positive benefits of chemical dependency treatment, recovery, and a life of sobriety. The Board will work to eliminate stigma and denial. Examples of these strategies include program alumni organizations, public awareness campaigns, and advocacy for recognition of the contribution the sober lifestyle makes to the welfare of all Alaskans.

How will we measure our performance?

Performance Measure 1:	Number of self-referrals.
Performance Measure 2:	Increased number of advocacy groups.
Performance Measure 3:	Cost-benefit data.
Performance Measure 4:	Positive benefits of treatment – in life domain areas of health, family, self-sufficiency, and transportation.

Strategy Five

Encourage traditional and alternative social activities that are alcohol and drug free.

What this means…

Alaskans are frequently encouraged to consume alcohol and other substances at social, athletic and other community events. In addition to providing safer and healthier alternatives for youth, alcohol and drug free activities can also help redefine community norms and values to those that support sobriety. The Advisory Board will support efforts that offer organized alcohol-free and drug-free activities involving a broad spectrum of the community.

How will we measure our performance?

Performance Measure 1:	Number of alternative activities developed and delivered.
Performance Measure 2:	Percent of target population participating.
Performance Measure 3:	Number of target group involved in planning and implementation.
Performance Measure 4:	Percent of activities initiated and/or led by target group.

Strategy Six

Advocate for positive change through legal and regulatory initiatives.

What this means…

All available research points to the conclusion that public policy decisions regarding alcohol and other substances have a major impact on the prevalence and severity of substance abuse problems in communities. Examples of such policy decisions are raising the minimum legal drinking age to 21 and lowering blood alcohol legal limits for drivers. Other legal and regulatory initiatives include limiting bar and tavern hours, restricting the number of alcoholic beverage outlets in an area, supporting enforcement of existing laws, and consistent consequences for youth who engage in use of alcohol or other drugs. A less obvious benefit of these strategies is the positive impact on community norms and values. As these initiatives impact public policy decisions, communities become more aware of the negative consequences associated with alcohol and drug abuse.

How will we measure our performance?

Performance Measure 1:	Number of initiatives introduced as legislation or local ordinances.
Performance Measure 2:	Variety of responses that indicate support, such as public opinion messages, letters, telephone calls.
Performance Measure 3:	Number of such initiatives passed.
Performance Measure 4:	Percentage change in desired community results.

Strategy Seven

Ensure the delivery of quality services by offering appropriate continuing education and training for chemical dependency treatment professionals.

What this means…

High quality service delivery depends on recruitment and retention of well-qualified treatment professionals. The Advisory Board will support funding for training programs, a statewide training coordination agency, programs which provide training components, and annual training events. The Board will support the certification process for chemical dependency professionals to ensure that persons providing services hold the highest qualifications. The Board will also support an accreditation process for programs which mandates high levels of qualification for professional staff.

How will we measure our performance?

Performance Measure 1:	Increase in the number of certified counselors in Alaska.
Performance Measure 2:	Increase in the number of certified counselors working in the field.
Performance Measure 3:	Salaries for chemical dependency professionals that are comparable to others performing comparable work.
Performance Measure 4:	Reduction in rate of staff turnover.
Performance Measure 5:	Increase in staff training opportunities.
Performance Measure 6:	Greater collaboration with post-secondary and other training systems.

Strategy Eight

Expand awareness of substance abuse issues for allied health professionals, educators and other helping agents.

What this means…

If related service or education providers are to deliver consistent, appropriate, and accurate information to target populations, they must first receive the most recent factual information. Programs to implement this strategy range from an organized regimen of in-service training to carefully designed formal course curricula for professionals. With a strong emphasis on collaboration, it is critical to consider a wide diversity of professionals including

- medical staff and other health care professionals;
- domestic violence advocates;
- educators, teachers and aides
- mental health professionals;
- senior services providers;
- disability services providers;
- public assistance caseworkers and employment specialists
- juvenile and adult corrections staff;
- family service workers.

How will we measure our performance?

Performance Measure 1:	Number of target group participating in training.
Performance Measure 2:	Percentage of target group completing training.
Performance Measure 3:	Number of target group showing increased knowledge and awareness.
Performance Measure 4:	Percent of target group positively impacted as shown by pre/post tests.

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Strategy Nine

Use education strategies to help youth improve critical life and social skills.

What this means…

Research indicates that development of life and social skills is more effective than didactic drug and alcohol education in helping young people avoid high risk behaviors. The Advisory Board will support programs that offer education and skill-building activities targeted to youth. These programs will help youth make appropriate decisions and avoid activities and behaviors with negative consequences. Multiple strategies that are age, culture, and gender specific are more effective than single, broad strategies. The education, information and messages targeted at youth must evolve with them as they mature.

How will we measure our performance?

Performance Measure 1:	Number of target group participating.
Performance Measure 2:	Number of target group completing.
Performance Measure 3:	Number of target group showing positive change or decrease in risk factors/increase in protective factors.
Performance Measure 4:	Percent of target group learning new skills, as shown by pre/post tests.

Strategy Ten

Identify people with problems as early as possible and refer them for appropriate services.

What this means…

This strategy is based on the premise that early problem identification and prompt action greatly enhances the likelihood of successful intervention. Programs that support this strategy would be located within organizations and agencies that are most likely to contact "at-risk" individuals at an early stage. Examples are schools, places of employment, and family and youth services. In these programs, individuals who are identified as "at-risk" for developing problems, or are engaging in behaviors that produce negative consequences, will be assessed and referred for appropriate services.

How will we measure our performance?

Performance Measure 1:	Number of at-risk individuals identified.
Performance Measure 2:	Percent of target group contacted.
Performance Measure 3:	Number of appropriate referrals made.

Strategy Eleven

Improve interdisciplinary coordination and collaboration at local, regional and statewide levels.

What that means…

Substance abuse professionals have a great stake in early problem identification. They recognize that they are usually not in the best position to identify these problems and intervene early. They depend on the abilities and collaboration of community members, helping agents, and other professionals to recognize the behaviors and symptoms and make prompt appropriate referrals. The Advisory Board will support efforts that foster collaboration among the various groups of professionals and programs in communities. These efforts will lead to earlier intervention and more appropriate treatment plans for clients.

How will we measure our performance?

Performance Measure 1:	Increase in number of referrals to and from providers.
Performance Measure 2:	Increase in number of referral services to and from providers.
Performance Measure 3:	Referral sources report improved outcomes.

Strategy Twelve

Support a continuum of care for chronic alcoholics with psychosis that focuses on intervention, treatment and the client's long term life domain requirements.

What that means…

Chronic alcoholics with psychosis are beneficiaries of the Alaska Mental Health Trust, established in Alaska Statute 47.30.056(b)(3). The Advisory Board on Alcoholism and Drug Abuse has a special responsibility to this group, described in AS 44.29.140. The Advisory Board must provide the Alaska Mental Health Trust Authority with specific recommendations to ensure that the service needs of chronic alcoholics with psychosis are met.

Chronic alcoholism is a problem that pervades every part of Alaskan life. It places an excessive burden on scarce medical, legal and public safety resources. Use of alcohol by chronic alcoholics with psychosis destroys their physical health and emotional and spiritual well-being. It seriously damages family and community life.
This population has traditionally been underserved by health and social service agencies. The state has both a legal and moral responsibility to provide comprehensive and coordinated services for this population. These services must be delivered with respect for clients and their families, in a manner that ensures positive, measurable results.

How will we measure our performance?

Performance Measure 1:	Increase in treatment capacity and services for chronic alcoholics with psychosis.
Performance Measure 2:	Increase in admissions to treatment for chronic alcoholics with psychosis.
Performance Measure 3:	Improved treatment retention and outcomes for chronic alcoholics with psychosis.
Performance Measure 4:	Increased availability of long term support services in life domain areas of health, housing, transportation and self-sufficiency.

Strategy Thirteen

Develop sufficient resources to meet community needs for appropriate levels of treatment for adults, youth and special populations.

What that means…

It is not possible to deliver every service component in every community. However, it is possible to have *access* to all components in a full continuum of care. Effective service delivery at the community level is determined by problem prevalence, demand, and service utilization. Examples of this strategy include establishment of detoxification facilities in hub communities, strategic placement of long term and domiciliary care facilities around the state, and development of special programs such as inhalant abuse treatment where appropriate. It is also critical that all providers understand the entire service delivery system and utilize the available resources in the best interests of clients and their families.

How will we measure our performance?

Performance Measure 1:	Increase in new services developed where needed.
Performance Measure 2:	Increase in number of communities seeking additional resources or services (financial or otherwise) using innovative approaches.

Strategy Fourteen

Identify and remove barriers that prevent clients from entering treatment.

What this means…

While some people are unwilling to seek treatment, many barriers prevent others from receiving the services that they want and need. Some of these barriers are present for all clients, such as waiting lists and financial resources. Other barriers reflect the lack of programs to address the needs of special populations. The Advisory Board will support those programs that implement strategies designed to remove barriers for those seeking treatment. Examples of these efforts include streamlined intake procedures, increased capacity based on prevalence and demand, and special programs where indicated.

How will we measure our performance?

Performance Measure 1:	Improved access, as reported in client satisfaction surveys.
Performance Measure 2:	Decreased time between first contact and admission to treatment.
Performance Measure 3:	Capacity to ensure that everyone who asks for treatment receives it.
Performance Measure 4:	Increased number of client admissions.

Strategy Fifteen

Support community efforts to establish involuntary commitment procedures and to use them when appropriate.

What this means…

For a small number of chemically dependent persons, timely and intensive services are necessary in order to prevent death. For this special population, involuntary commitment to treatment is the only remaining alternative. In order to use the involuntary commitment procedures defined by Alaska Statute 47.37, communities need to work together in collaborative partnerships. The Advisory Board will continue to support community efforts to organize and develop local plans and procedures for initiating involuntary commitments. These efforts include community training, funding for legal assistance, travel and transportation assistance, and technical assistance.

How will we measure our performance?

Performance Measure 1:	Increased number of involuntary commitments.
Performance Measure 2:	Improved treatment outcomes for those committed involuntarily.
Performance Measure 3:	Increased number of communities using involuntary commitment procedure when necessary.
Performance Measure 4:	Measurable reduction in inappropriate

emergency services for public inebriates.

Performance Measure 5: Reduction in number of 12-hour protective custody holds.

Strategy Sixteen

Provide appropriate services for underserved Alaskans.

What that means…

There are a wide variety of programs that address the chemical dependency treatment needs of Alaskans. However, a substantial number of special populations are not adequately served. These groups include:

- Alaska Natives;
- youth;
- women with children;
- seniors;
- dually-diagnosed clients;
- clients with disabilities.

Treatment success with these populations depends on program design uniquely appropriate to their needs. Examples of such programs include special services for poly-diagnosed clients, special programs for women with children, and Alaska Natives.

How will we measure our performance?

Performance Measure 1: Increased capacity for underserved Alaskans.

Performance Measure 2: Increased admissions of underserved Alaskans.

Performance Measure 3: Improved treatment outcomes for underserved Alaskans.

Strategy Seventeen

Use relevant research to identify and incorporate key variables that contribute to successful treatment outcomes.

What this means…

It is often difficult to predict how any particular individual with chronic disease will respond to treatment. For many clients, certain variables are significant indicators for success. Examples of such variables are a strong post-treatment support system, employment opportunities, and alcohol/drug free housing. Monitoring emerging research and assessing the client with regard to key variables will increase the probability of client success. This strategy will require collaborative relationships with other helping professions. Many of the variables involve services and issues not directly provided by chemical dependency treatment programs. Examples of these efforts include drug and alcohol-free transitional housing, vocational and educational referrals, and services designed to strengthen families.

How will we measure our performance?

Performance Measure 1:	Decrease in relapse rates.
Performance Measure 2:	Percentage of clients with improvement in life domains.

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Strategy Eighteen

Address the treatment needs of persons in the criminal justice system.

What this means…

All available data and research indicate that drugs and alcohol are prevailing factors in crime in Alaska. The vast majority of the incarcerated population has drug and/or alcohol problems. In order to decrease recidivism in this population, drug and alcohol treatment needs must be addressed. Drug courts and other diversion strategies identify and provide appropriate services to individuals before they are incarcerated. Depending on the nature of the offense, treatment can be ordered in lieu of incarceration. This approach leads to a more appropriate allocation of scarce corrections resources.

How will we measure our performance?

Performance Measure 1:	Increased percent of offender population with substance abuse problems accessing treatment services.
Performance Measure 2:	Decreased recidivism among alcohol and drug-related criminal offenders.
Performance Measure 3:	Increased number of inmates in treatment programs.
Performance Measure 4:	Increased number of treatment options for offender population.
Performance Measure 5:	Increased percentage of treatment completion and improvement in treatment outcomes
Performance Measure 6:	Increased number of drug courts and other diversion programs.

Data Agenda

I. **Introduction.** Consistent and reliable data are a key element in the planning process. Information about existing conditions helps to develop baselines or reference points. As this plan is implemented, reliable and consistent data will be used to measure performance and results. Careful analysis of indicator and performance measure data will help decision-makers modify strategies to achieve the best results.

II. **General Data Agenda.** There are a number of issues regarding data collection and analysis that apply to the entire planning process.

A. **Timeliness of Data**. Much of the data to be used as indicators is collected and published annually by state agencies. While this makes data collection somewhat straightforward, effectiveness is compromised by the time lag between events and data publication. Most data is typically available two years after the fact. Efforts will be made to obtain the data prior to its normal publication schedule whenever possible. Patience will be required. Data that indicate effectiveness will not be available until at least two years after the implementation of a strategy. For some strategies that seek to impact community norms and values, this time period may be even longer.

B. **Data Storage and Maintenance**. Planning is an ongoing process. Data must consistently support this process. There must be an organized, reliable system for data storage and maintenance. The data, if properly maintained, will be useful in the ongoing strategic planning process and in the annual planning processes of the Advisory Board and the Division. The greater the detail of collected data, the more diverse and useful its applications will be.

C. **Data Analyses**. The degree of effort required to collect, store, and maintain data will be driven, in large part, by the analyses desired. The use of spreadsheets, databases, or statistical programs to analyze data requires rigorous formatting. The effort is even greater if data from different sources are to be integrated for analyses. During the first year of this plan a data collection, maintenance and analysis plan will be developed to

support this effort. This plan will identify data sources and format, integration and analyses desired and appropriate computer software applications.

III. **Indicator Data Agenda.** Each of the six headline indicators is supported by data that rate high in proxy, data, and communication power. Despite this, each of the indicator data sets has variables that should be acknowledged during the analysis.

A. **Per Capita Consumption of Alcohol.** The per capita consumption of alcohol data is straightforward. There are some factors, however, which diminish its usefulness.

1. Age Applicability – The per capita consumption data are based on total population, 14 years of age and older. They do not account for drinking by youth under age 14.
2. Persons Who Abstain from Alcohol – The data do not take into account those individuals who choose to abstain from alcohol. As this population segment grows, it will lower per capital consumption. It is possible that those who drink alcoholic beverages may be drinking more while the data indicates a decrease in per capita consumption.
3. Consumption by Visitors – The per capita consumption data are based on state population. If visitors significantly impact the amount of alcohol consumed, the per capita consumption data could show an increase when, in fact, there was no increase in consumption by Alaska residents.
4. Effects of Wholesale Distribution vs. Consumption – The per capita consumption data are based on state excise tax collected at the wholesale point in the alcohol distribution chain. While this is considered a good surrogate marker for consumption, there are sales that do not result in Alaska consumption. Some residents purchase Alaska-brewed beer as gifts that are shipped out of state. Although this is probably not significant, we do not know the exact extent of this practice.

B. **DUI Convictions.** Driving Under the Influence (DUI) conviction data are collected and maintained by the State of Alaska Court System. Felony DUI data are included as a separate conviction category in regularly published reports. Misdemeanor DUI conviction data, however, are included with other misdemeanor traffic violation convictions. In order to obtain these data, a special request must be made to the Court System. An agenda item for the first year of this plan is to ask the Court System to begin separating misdemeanor DUI convictions in their published reports. Another problem with these data is that they do not include arrests that do not result in convictions. Enforcement effort, prosecution workload and strategies, and trends toward plea bargains for other charges also impact these data.

C. **Drug and Alcohol Related Convictions.** This data set has some of the same limitations present in DUI conviction data. It does not reflect arrests for which there is no conviction, or plea bargains to other charges. An additional complication is that many drug charges are prosecuted in federal court as violations of federal law. Regularly published reports show drug and alcohol convictions at the national level and overall federal convictions at the state level. Specific drug and alcohol conviction data for specific states require a special data run at the federal level. A data agenda item will be to work with the federal court system to encourage reporting of data in a useful format.

D. **Alcohol Related Injuries.** The State of Alaska Emergency Medical Services Section maintains the Alaska Trauma Registry. The registry collects data relating to injuries that are treated at hospitals throughout the state. There are fields within the registry that identify whether or not alcohol was involved. Although there is not a standard published report, the staff that maintains the registry can produce a custom report that includes desired information. Injuries that are not treated in an emergency room are not included in the registry. The data agenda item relating to this indicator is to determine exactly what information is desired from the registry each year and to work with the Emergency Medical Services staff to obtain that data.

E. **12-Hour Protective Custody Holds.** Data for 12-hour protective custody holds are collected by the State Department of Corrections. These data reflect the number of Title 47 non-criminal holds in state correctional facilities. At present, community jails, operated by municipalities and boroughs, are not contractually required to record data on 12-hour protective custody holds. The data agenda item for this indicator is to work with the Department of Corrections to develop a standard annual report that includes all Corrections facilities and community jails.

F. **Rate of Binge/Chronic Drinking.** The percentage of Alaskans reporting binge or chronic drinking is obtained from the annual Behavior Risk Factor Surveillance Survey. It is conducted using a random sample of 1,535 adult Alaskans. The survey results are published annually by the Alaska Division of Public Health. One of the contributing factors to the reliability of this data set is that the survey questions were rigorously developed at the national level. These same questions are also used in a national survey. This indicator can be tracked over time for trend analysis.

IV. **Performance Measures.** Each strategy selected by the strategic planning work group has a series of measures for evaluating performance. The data for these measures are collected and analyzed by the Division of Alcoholism and Drug Abuse and used to assess the level and quality of effort. Most of the data will be collected from grantees that are required to submit data relevant to their programs. The data from individual grantees will be consolidated to provide an assessment of statewide effort. Most data come from two sources: quarterly reports on goals and objectives and program reports to the Division's Management Information System (MIS). Despite this effort, there are some measures for which data are not now readily available. The data agenda for the Division of Alcoholism and Drug Abuse over the next two years is to examine these specific measures and explore means for obtaining supporting data.

V. **Other Data Agenda.** Beyond those indicators selected to measure progress toward results and the performance measures for strategies, there are other data and information that would be useful in assessing needs and evaluating program performance. For a variety of reasons those data are not useable at present. This provides yet another set of issues for the data agenda.

A. **Youth Behavior Risk Survey.** Every two years, the State of Alaska of conducts a survey in the education system to assess attitudes and behaviors that constitute risks to health. While this survey provides useful data, it is not administered in all areas of the state. Participation is determined by local School Boards and is voluntary. The areas not participating are significant enough that the results may not be generalized

to the entire state. The data agenda for the next two years is to advocate with the Legislature and the Department of Education to require statewide participation in this valuable survey effort.

B. Prevalence Studies. During 1997 and 1998 the Division of Alcoholism and Drug Abuse participated in a federally-funded comprehensive effort to measure prevalence of alcoholism and alcohol abuse in the general population. This massive, expensive effort involved random sample telephone surveys using rigorously developed survey instruments. The results obtained from this effort have proven extremely valuable in assessing needs and barriers to meeting those needs. Although it is not practical to undertake every year, such a survey conducted at five-year intervals would be very useful in assessing results. The data agenda item for this issue is to advocate at both state and federal levels for consistent periodic surveys of this nature.

C. Consumption of Alcohol by Pregnant Women. The Alaska Division of Public Health, Section of Maternal and Family Health, conducts an annual survey of women who give birth during the year. This survey uses an instrument developed by the U. S. Centers for Disease Control. The survey is conducted by mail using a stratified random sample methodology. The response rate for this survey has traditionally been extremely high, which makes it a valuable tool. Among the questions in the survey are a series on alcohol use during pregnancy. Given the significant negative consequences associated with drinking during pregnancy (Fetal Alcohol Syndrome and Fetal Alcohol Effect), the trends in this area would be most useful in assessing prevention efforts. Although routine reports are not published, the staff responsible for this effort is able to produce custom reports. The data agenda item for this issue is to work with the Section of Epidemiology to identify key information from the survey that can be provided annually.

D. Alcohol-Related Deaths. Consistent data on alcohol-related deaths is not readily available. This is primarily because of the many ways in which alcohol and other drugs can cause death. The cause of death usually associated with alcohol consumption is cirrhosis of the liver. However, there are other fatal medical conditions related to alcohol consumption such as heart disease and esophageal cancer. Many accidents and homicides are also associated with alcohol abuse. This is compounded by the fact that these causes of death are associated with other factors as well as alcohol consumption. The same difficulties are present with consumption of other drugs. The State of Alaska Bureau of Vital Statistics reports on causes of death annually. In 1996, for example, the Bureau of Vital Statistics reported a total of 110 deaths due to alcohol use or abuse[4]. The Bureau also reports separately for deaths due to cirrhosis and other diseases. The data agenda item for this issue is to work with the Bureau of Vital Statistics over the next five years to develop a useable method of identifying death due to alcohol or other drug consumption.

E. Department of Health and Social Services Data Warehouse. The Alaska Department of Health and Social Services is currently working on a project to provide easier access to data across Divisions. The Advisory Board on Alcoholism and Drug Abuse will monitor these efforts and assist as appropriate in developing a system that will meet the data needs of the State and providers as well as protecting the privacy and confidentiality of consumers.

[4] Alaska Bureau of Vital Statistics, 1996 Annual Report, 1998

Implementation

This strategic plan will succeed to the extent that it is consistently implemented and updated. Four distinct implementation efforts are required in order for the plan to remain a useful tool over time.

1. **Implementation of Strategies.** The prevention and treatment strategies identified in this plan will be implemented by the Division of Alcoholism and Drug Abuse, which has responsibility for managing service delivery in Alaska. The Advisory Board on Alcoholism and Drug Abuse and the Division will share responsibility for implementation of strategies that address public policy, advocacy and legal/legislative initiatives. The implementation of service delivery strategies will be accomplished primarily through the Request for Proposals (RFP) process. This process leads to funding allocation to support specific strategies. Successful grantees will develop proposals that reflect the Division's guidelines and this plan. Future Requests For Proposals (RFPs) from the Division will incorporate experience and knowledge gained by monitoring indicators and performance measures as well as emerging research. Both the Division and the Advisory Board will share responsibility for wide distribution of the plan. Each will work assertively to educate providers, stakeholders, and the public about the plan's contents and significance in reducing negative consequences of alcoholism and drug abuse for all Alaskans.

2. **Monitoring of Performance.** As strategies are implemented, the Division will monitor performance measures to assess the level, quality, and effectiveness of effort. The data required for monitoring performance will be reported by programs and collected independently by the Division. By monitoring performance in a timely manner, the Division and the Advisory Board will be able to gauge whether the selected strategies are the right ones and whether the level of effort is sufficient to impact the indicators as desired.

3. **Monitoring of Indicators.** Each year, the Advisory Board will collect the required indicator data to determine the extent to which the strategies have influenced the desired results. There are several confounding factors in this task. First, indicator data are impacted by variables beyond the control of the Division or the Advisory Board. Care must be exercised when deciding how much the data have been impacted by the strategies and how many intervening variables have impacted them. Second, the data reflected in the indicators are often one to two years old before publication. There could be a lag of three or four years after the implementation of a strategy before indicator data are available from which to draw conclusions. Once the data are available, it will be necessary to view several years of data before assessing effectiveness.

4. **Ongoing Planning.** Only one desired result was examined during this planning phase. The planning work group identified four other desired results for all Alaskans. The ongoing planning effort will follow two parallel tracks. The first track focuses on review of the performance measure and indicator data and refinement of the strategies as necessary. The second track focuses on developing indicator data, strategies and performance measures for the other results. It is recommended that the planning work group convene every third year to update the plan, building on the ongoing efforts indicated above.

5. **Integration into the Comprehensive Integrated Mental Health Plan.** The Advisory Board will work with the Department of Health and Social Services, the Mental Health Trust Authority, and the three other beneficiary boards to ensure a smooth integration of this plan into the Comprehensive Integrated Mental Health Plan.

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Glossary

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.

Accountability: Responsibility for performance and results; holding political leaders and agency managers accountable for results according to agreed upon performance standards.

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.

Alaska Mental Health Trust Authority (AMHTA): The Alaska Mental Health Trust Authority administers the Mental Health Trust established in perpetuity. It has a fiduciary responsibility to its beneficiaries to enhance and protect the Trust and to provide leadership in advocacy, planning, implementing, and funding of a comprehensive integrated mental health program to improve the lives and circumstances of its beneficiaries.

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 amnesiac 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-existing mental illness and alcohol or drug 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 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.

Fetal Alcohol Effect (FAE): FAE is similar to FAS but lacks the physical symptoms of FAS. FAE neurological abnormalities, development delays, intellectual impairments and learning/behavior disabilities are similar to, and sometimes more severe than, those of FAS.

Guiding Principles: These define what the organization stands for and are used as the foundation on which to develop a strategic plan of action.

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 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.

Indicator or Benchmark: A measure, for which data is available, that helps to quantify the achievement of a desired result or outcome.

Mission Statement: This states the purposes served by an organization's mission. By defining its mission, an organization can decide upon appropriate outcomes and performance measures.

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.

Performance Measure: A measure of effectiveness of agency or program service delivery.

Results-oriented Government: A government that values results and qualitative outcomes over expenditures and inputs. It is concerned with accountability and performance measurement.

Result or Outcome: A condition of well-being for children, families or communities.

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

Strategic Planning: A process of defining the vision, mission, goals and objectives of an organization. Through the planning process the organization identifies the results it seeks to achieve through its programs and the specific means by which it intends to achieve these results.

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

Treatment Capacity: The amount of substance abuse services that are readily accessible.

Vision: The ideal mission of a governmental jurisdiction and/or agency, and the ideal way it must operate to accomplish its mission and best serve its clients.

Resources

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

Advisory Board on Alcoholism and Drug Abuse. Annual reports of the Advisory Board's activities, and selected reports on programs and projects, as well as additional copies of this plan. (907) 465-8920 or 1-888-464-8920.

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.

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. In the coming months, the final reports of federally-funded research projects relating to prevalence in Alaska will become available. (907) 465-2071 or 1-800-478-2072.

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