

**October 4, 2000**

**Testimony to the Senate Committee on Indian Affairs  
Hearing on Alcohol and Law Enforcement in Alaska  
By Ernie Turner, Director, Alaska Division of Alcoholism and Drug Abuse**

Mr. Chairman:

Good morning, it is an honor to provide testimony before this distinguished body of the United States Government. My name is Ernie Turner, I have worked in the field of Substance Abuse for nearly thirty years in many capacities - as a practitioner, clinical director, agency director, consultant, teacher and now as the director of the Division of Alcoholism and Drug Abuse under the Department of Health and Social Services for the State of Alaska.

I am an Alaska Native, born in Shageluk Alaska, a remote village in the heart of rural Alaska and am also a recovering alcoholic who has experienced the worst of the disease called alcoholism, which is truly a disease, and have experienced the best of recovery. The disease took me to the depths of despair, a homeless street alcoholic, suffering all of the consequences the disease had to offer. Without intervention and treatment I would have died years ago.

Thirty years ago alcoholism and drug dependency caught the ear of only a few. Today we recognize alcoholism and substance abuse as an epidemic of the Alaska Native population, invading our lives in ways we never imagined-- testing our limited resources, probing our private values, and sapping our strength. Substance abuse and dependency no longer attracts our attention--it commands it. I am often asked why I consider alcoholism to be so important in comparison to other diseases. Let me explain why and why the problem must command our attention and action. The issue is not whether alcoholism is more or less important than any other single disease. The fact is that from a public health standpoint, alcoholism is an epidemic in Alaska. Alcoholism and alcohol abuse is a leading killer of Alaska Native men, women and children in rural Alaska. The disease continues to devastate Alaska, despite the fact that it is both preventable and treatable. We need to attack the problem with the same vigor we would if a disease like tuberculosis were still killing Alaskans at an equivalent rate.

Children and adolescents are a special concern. During the 1990s, we have seen our rural children confronted by issues of alcohol and drugs as never before. Adolescents are still experimenting with alcohol and drugs and access has become easier. As parents and citizens, we cannot stand idly by while the disease threatens our children's future.

Yes, it is painful to think about the temptations and the dangers they face every day and of the way alcoholism and drug abuse among their parents and other adults influences and affects them. But alcohol and drugs are facts of life in rural Alaska; we can no more ignore them than we can death itself. We must prepare our children to face the reality of the dangers in their lives. To face the challenges ahead, our children must have scientific, dependable information about alcohol and drug use. And equally important, they must have the loving care of sober parents and the understanding and support of sober communities.

I continue to hear that "Drinking isn't my problem. . . it's theirs."

The truth is that it's everyone's problem. Because so many people are suffering from the disease and its effects especially in rural Alaska, all of us who share our fragile rural humanity are also affected--if not by the disease itself, then by those devastating companions of the disease--fear, loss, sorrow, denial, and prejudice.

We must face our fears squarely and shed our false beliefs. We need to know how deeply alcohol and drug use affect our communities. We must care for those suffering from the disease as well as those affected by the consequences of it. And we must prevent further dependence and abuse.

We believe good health is intertwined with hope and optimism. We know that a positive self-image is a critical part of the healing process. As the Division director, I do not say this lightly, because I am in the business of prevention and recovery.

So many people might be prone to say, "What's the use?" Let me answer that plea in just one word: SURVIVAL and survival with dignity. As a society, we must care not only to promote good health, but equally to promote quality of life. Having Chemical Dependency does not signal an end to life or to the spirit. Rather, the experience of this disease can also inspire. Until there is a complete cure, we must learn to live with it the only way we know how: by devoting ourselves to prevention and recovery.

I'm not here to offer unrealistic shortcuts or make false promises about easy solutions. Only to describe what we know and what we can do now: educate ourselves and our children about alcohol and drug dependency and act on what we learn; intervene early when we see someone is on the wrong path; make sure those of us in need can get assessments and effective treatment. Remember that coming to grips with the facts of life is, in itself, crucial to our well being.

The Federal government recognizes 227 Native communities in Alaska. The vast majority of these are villages, small villages ranging in size from less than 50 to over 1,000, averaging around 300 people. These villages dot the riverbanks and coastline of rural Alaska. Most are not connected by road and the distances between a village and its closest neighbor can be 20 or more miles. Travel is primarily by boat, snowmachine, ATV, or small plane. To fly over southwest Alaska, the Yukon-Kuskokwim Delta, at night, in winter, to see the small widely scattered clusters of light that dot the vast empty landscape is to be awed by the sense of space, stillness, isolation, and the tenacity of human life.

Alaska Natives and Alaska Native communities have experienced huge changes over the past 200 years. But there are also some things that have remained relatively unchanged: the importance of Native culture; the traditional values of sharing, respect for Elders, love of children; the relationship with the natural environment and the reliance on its resources. The challenge for Alaska Native communities is to preserve these constants while living well in the 21<sup>st</sup> century.

Substance abuse is a major threat both to preserving the past and to living well in the

present and future. In the words of Julie Kitka, President of the Alaska Federation of Natives, "... the impact of alcohol abuse is the most critical problem facing our villages today." In the words of the Alaska Native Commission on Rural Governance and Empowerment "Alcoholism continues as an endemic condition that ravages individuals, families and communities in rural, particularly Native, Alaska." What does ravage really mean? It means a family in which both parents were regularly drunk, beat on each other, neglected their children. By the time he was ten the oldest boy was routinely looking after his younger sibling. When that boy was about 18 his mother froze to death having fallen or been thrown from a pick-up truck during the winter. The father was driving. Within a year the boy, now drinking heavily himself, shot himself in the head and died. Within the next year his younger sister also killed herself.

Data tell us that nine out of ten Native people who choose to use alcohol become alcohol abusers. Of that nine, four become dependent/addicted. Are many people choosing to use alcohol? We don't have Native specific data, but a study of all Alaskan high school students except those in Anchorage tells us that over half had at least one drink in the preceding month and just over a third had five or more drinks in a row in the preceding month. This means that if a village has 40 high school students the data suggest that 18 will become alcohol abusers and 8 will become addicted to alcohol. Alcohol addiction is a chronic, progressive, fatal disease.

Various statistics reflect the consequences of such high rates of abuse and addiction. Alaska Natives make up about 17% of the population of Alaska, but 38% of those who die by suicide and 31% of those who die by homicide. Those deaths are linked to alcohol. Studies show that two-thirds to three-quarters of Alaska Native males who die by suicide were drinking at the time of their death. Alaska Natives make up 17% of the general population, but about 37% of the prison population. Studies show that more than 97% of the crimes committed by Alaska Natives are committed under the influence of alcohol or drugs and that in rural Alaska the amount of violence and crime appears directly proportional to the amount of alcohol consumed. One study showed that alcohol or drug abuse or addiction was present in up to 80% of Alaskan families in which repeated child abuse or neglect occurred.

Looked at another way, during the year that followed Barrow's vote to go dry, felony assaults declined by 86% and drunk driving stops by 79%. Suicide attempts declined by 34% and domestic dispute calls by 27%. Harm to children fell 32% and school attendance rates dramatically increased.

As the Barrow example shows, Alaska's local option law allowing villages to vote to go "dry" or otherwise restrict sale of alcohol in the community can be an effective tool. But controlling access, while important, is not a panacea. We have to understand that those who are dependent on alcohol will go to any length to maintain a supply. They will break the law, move to hub or urban areas where alcohol is available. Some of them end up "homeless and on the street." Others use whatever is available out of desperation. In some dry villages where alcohol is more difficult to get we have seen increases in the use of home brew, inhalants, and other drugs. Controlling access is one tool but it isn't the only tool or even the best tool to combat alcohol and drugs.

One of the most devastating consequences of alcohol abuse is Fetal Alcohol Syndrome

(FAS), harm that can be done to the fetus when a pregnant woman drinks alcohol. FAS children suffer from severe physical and mental disabilities. They are difficult to raise and difficult to educate. Alaska has the highest rate of FAS in the nation: 1 – 1.4 per 1000 births. 90% of the children diagnosed with FAS are Alaska Native. 65% of the children with FAS are not being raised by their birth parents.

Obviously there are financial costs to alcohol and drug abuse and addiction. It costs about 1.4 million dollars to raise a child with Fetal Alcohol Syndrome. About 80% of FAS affected individuals will never be able to live and work independently.

The Alaska Criminal Justice Assessment Commission estimates the state spent \$245,823,125 in 1999 on costs associated with substance abuse. This figure includes costs incurred by the criminal justice system, social services agencies, substance abuse treatment programs, medical care, and increased assistance payments. Alaska is committed to providing services to all of its people. We recognize the seriousness of the problem in rural Alaska and we probably do more than other states in the union to provide substance abuse services to the Native population. However we recognize that we fall far short of meeting the needs. Alaska Natives make up about 17% of the population of Alaska, but about 46% of those enrolled in substance abuse treatment programs statewide. And still too many Alaska Natives have to travel away from their region to receive services, and too many sit too long on waiting lists.

The economic cost of substance abuse is huge. The human cost is devastating. An example,

“A young man with a wife and three children leaves his village to go to Nome to buy supplies for the whaling season. His mother has given him money for an outboard engine that will drive the family omiak, skin boat, during the hunt. Also in his packsack are several ivory carvings that he hopes to sell for money to buy food and other supplies for his family. When he wakes up in the hospital he doesn't remember much of the first night in town or the three days that followed. He does recall that after the ivory shop did not buy his carvings he went to a bar to look for potential buyers. Now he has none of his mother's money. His carvings and the rest of his possessions including his return ticket home are missing. Physically and emotionally he feels terrible.

His family will make do on supplies donated by relatives. His physical injuries will heal in time. His family will accept him back. He can carve more ivory. His mother will still acknowledge him as the lead male elder in the extended family.

But he returned to the village ashamed and desolate. His emotional pain became an excuse for drinking more alcohol. While drunk he got angry and beat his wife. Eventually she left him, leading to more guilt, more pain and more alcohol. He got drunk one more time and fatally shot himself with a high caliber rifle. Then it was his children who felt pain, guilt, and anger. Then it was his children who began to drink.”

These tragedies are repeated over and over. But the picture is not entirely bleak. We have learned a great deal about what works to prevent alcohol abuse and addiction and what works in

treatment. We have growing numbers of people who have recovered from alcoholism, and people who have successfully avoided alcohol and drugs. We have an increasing number of village people graduating from training and working as counselors in their own villages. In fact, even the most devastating story can demonstrate hope. The oldest son of the ivory carver who shot himself is an example. He stopped drinking, went to training, and is working as a counselor. As you can imagine, he is a very good one.

A major element in the success of treatment programs for rural Alaska is attention to the culture and life realities of village people. When cultural differences are addressed and the people themselves are asked what works, unique and successful programs have developed. For example in one village with a population of just under 200 people, 98% of persons over age 5 were abusing or dependent on alcohol. Intoxicated children sprawled on the school steps. State authorities talked about removing all children from the village. The regional substance abuse counselor knew that villagers were concerned, wanted to change, but did not know how.

A counselor from a neighboring community worked with the village to develop a treatment camp. The village donated land and use of an abandoned building shell. The counselor found some funds in his budget. He and his wife moved onto the site for three months and, working with the village, developed a thirty day program that involved the entire family attending the program together. At any given time there were 5-6 families and 1 – 5 individuals participating. Participants prepared meals and shared chores. Mornings featured a group meeting to discuss recovery issues. Afternoons were spent in subsistence activities: fishing; hunting; gathering wood etc. AA meetings were held in the evenings. Individual and family counseling sessions were held throughout the day.

The entire village was invited to the camp for various weekend activities and for the evening AA meetings. Other villages in the region began to send families to the camp and help with supplies and transportation. The village held its first AA Christmas party. More than 3/4 of the village attended and celebrated the 84 village residents who had been sober for 30 days or more. Graduates of the program have gone on to assume responsible roles in the village, region, and state. The recovery camp proved to be very successful but had to close because of a lack of funds.

In another region, villagers rejected a proposal by state and regional agencies for a specialized treatment program that would take women and children out of the village. Elders especially felt that removal would stigmatize the family by singling them out. Instead they proposed an approach that involved the entire village. They worked with the agencies to develop a 3-5 day community gathering that combines traditional discussion methods with workshops, small group meetings, and educational and planning sessions. The entire community discusses problems related to substance abuse and develops community solutions. Agency presenters share the podium with village Elders. A Community Wellness Team comprised of village health aids, public safety officers, village alcohol counselors, Elders and other village education and spiritual providers is formed to provide follow-up and support activities after the gathering ends. Reports from the region say that cases of children in need of aid due to parental substance abuse are way down in communities that have had these gatherings, and that the families originally identified as the most in need have stabilized.

A final example is the Family Recovery Camp located in Old Minto. The camp is operated by Tanana Chiefs Conference (TCC) in a remote area accessible only by small planes and boats. It involves a 35-day program for 15 people and their families. Traditional values and practices are used to help families regain spiritual, emotional, mental and physical balance. Traditional daily activities linked to the land go hand in hand with discussions, meetings and exercises. Aftercare and follow-up support services continue for families after they have completed the camp. The program has been operating for a number of years and is widely recognized for its effectiveness in helping people recover from alcohol abuse and addiction.

In general, culturally relevant treatment as close to home as possible seems critical. Alaska's Regional Native Health Corporations play an important role in offering that treatment. The 227 Native communities in Alaska are divided by culture and geography into 12 regions. Each region has a hub community that serves as the commercial, service and transportation center. The Regional Health Corporations, supported by State and Federal funds, are operating residential treatment programs in many of the hub communities. They also employ village-based counselors who offer early intervention and aftercare programs in the villages. Such programs are critical in getting people into treatment and supporting their recovery after they leave formal treatment programs.

Successful treatment approaches in bush Alaska have several characteristics in common.

- 1) They are generated from within the culture and/or village.
- 2) They reflect a community's readiness to address the problem.
- 3) They are local in design and function.
- 4) They recognize the capabilities of the individual and enhance self-esteem in culturally understandable ways.
- 5) They understand that the alcoholism/drug abuse has nothing to do with individual weakness, but rather that it is a disease in which people are made more vulnerable by rapid cultural change and inter-generational post traumatic stress syndrome.
- 6) They seek to empower rather than "fix" people by helping individuals, families and communities to rebuild their vision of who they are and who they can become and their capacity to take control of their own lives.
- 7) They confront everyday problems fostering the individual's ability to construct positive pathways toward a productive future.
- 8) The point of intervention is seen as that place where one can best connect with and leverage the strengths, resources, networks, attention and trust of the community and/or the individual.

Rural Alaska's programs have physical needs as well. In recent travels to some of the villages, we found many of the publicly funded treatment facilities to be in dire need of resources to build or refurbish or expand. In one case when a village counselor was asked if she needed improvements in her office, she said "a sink would be nice." After further asking her if she wanted the sink in the bathroom or another area, she replied, "Oh we don't have a bathroom we have to go down the road to use their facilities". We need resources to upgrade and expand our rural buildings so that they more accurately reflect the importance of the problem, the caring and professionalism of the counselors, and the dignity of the clients.

There are intense life threatening needs and gaps in the treatment of alcoholism in rural Alaska especially for persons in the late chronic stages of the disease. Village clinics and even regional health facilities are often ill equipped to safely detoxify severely intoxicated people. Flying them to urban centers, which may or may not have available beds or be willing or able to admit them, presents additional risks and costs. And if admitted, rural people too often end up on the streets of Anchorage after discharge because the lack of adequate treatment infrastructure in rural areas makes coordination of aftercare and treatment with an urban provider difficult or impossible.

The inpatient treatment programs are constantly operating at capacity. Data shows that many of the clients have to wait up to ninety days for a treatment bed, especially for the women. A recent check on the wait list showed there were fifty-eight women on the wait list for forty-five beds. This is totally unacceptable if we truly accept alcoholism as a chronic progressive disease. There is no other chronic progressive disease in which a person has to be put on a waiting list for that amount of time. It would be akin to asking a person with cancer to come back in three months for treatment.

While we have made progress in understanding what works, there remains a vast gap between our understanding and our ability to put that understanding effectively into practice. We continue to have critical needs for treatment resources. In order to meet these needs we have to have trained, competent, culturally informed chemical dependency counselors. There is a strong consensus around core competencies that a chemical dependency practitioner must demonstrate in order to be effective whether in rural or urban Alaska. These competencies can only be achieved through education, training and supervised field experience. Alaska has developed a process to ensure that those standards of competency are met. The specific individual skill sets and areas of knowledge required to effectively treat alcoholism and drug addiction are broadly accepted and applicable to all treatment settings and philosophies. Demonstrated competency in those skill sets and subject areas form the basis for alcohol and other drug counselor certification within Alaska and for the reciprocity of professional certification between States. The recognized core competencies are:

- Patient Screening
- Patient Assessment
- Treatment Planning
- Referral
- Consultation
- Continuing Assessment
- Individual Counseling
- Group Counseling
- Counseling Families, Couples, and Significant Others
- Client, Family and Community Education
- Documentation
- Professional and Ethical Responsibilities

While the core competencies are built upon the acquisition of specific information and

supervised experience, there are several elements lacking in rural Alaska. The proposed requirement to give equal weight to educational achievements in other subject areas presents very real difficulties. The rural population has multiple needs that need to be provided within a specific cultural setting. The presence of trained competent culturally sensitive staff is particularly important today when many clients needing treatment have a variety of complicating conditions including both alcohol and drug addiction, mental health and other serious health and social concerns.

The Division of Alcoholism and Drug Abuse, in partnership with the University of Alaska and some of the Regional Native Health Corporations has developed a very successful program to address the unique manpower needs of rural Alaska. The Rural Human Services System Project (RHS) began training village Alaskans to work as counselors in their own communities in 1992. The foundation of the 30 credit curriculum is Native culture and values and the classes, Rural Counseling, Addictions, Case Management, Community Change to name just a few, combine traditional Native healing practices with Western treatment modalities. University faculty and Native Elders teach side by side. Eight years later, in 2000, 136 RHS trained graduates and students were employed in 82 rural villages and six hub or urban communities. Their employers report that in villages with resident RHS trained counselors, behavioral emergencies requiring transport out of the village have decreased and requests for substance abuse treatment have increased.

But there are more than 82 villages in Alaska and Alaska needs a counselor every village. Larger villages need more than one counselor. With more than 200 villages in need, we have to have resources to train and employ an additional 150 village counselors. On the face of it, it might seem expensive, around 10 million dollars per year. But when we look deeper, it's not so expensive. Ten million dollars is about what it costs to raise 7 FAS children.

Let me give you a picture of what the Alaska Division of Alcoholism and Drug Abuse looks like today and what we're doing. Under State law the Division has responsibility for planning, developing, and coordinating statewide programs for the prevention and treatment of alcoholism, drug abuse, and the misuse of hazardous volatile substances by inhalant abusers. This includes planning and coordinating prevention, intervention, treatment and rehabilitation services, developing and disseminating information in support of these services; developing and conducting training, and evaluating services. The Division also establishes standards that a treatment program must meet in order to receive state approval and state funding.

Currently the Division funds seventy-three prevention programs and two training programs. These do a variety of things including counselor and rural counselor training, peer helper programs in high schools, suicide prevention programs in villages, camps, conferences, and mentoring. In addition the Division is administering a State Incentive Grant from the Federal Government. While we are very grateful we received a SIG grant, funding for these programs is limited to 3 years. It is difficult for a prevention program, especially a new prevention program to have a measurable effect in 3 years. If we are serious about prevention, we have to commit ourselves and our resources to the long haul. By way of example, our community-based suicide prevention program is over ten years old and its evaluation has indicated that villages which operate projects continuously for three or more years are reducing their rates of suicide. Projects

of shorter duration are not as effective. It's also true that youth grow up. A project that targets middle school age children has a new target population every year. This seems obvious, yet time-limited prevention programs do not seem to get it.

The Division of Alcoholism and Drug Abuse provides grants to a number of different kinds of treatment programs. There are general residential programs and specialized residential programs for women, women with children, pregnant women, pregnant and parenting teens, and youth, 28 residential programs in all. Three additional programs for women are funded through Federal grants. Here too, time limited funding is a problem.

The Division also funds 28 outpatient programs. Where residential programs are located in urban areas and larger hub communities, many of the outpatient programs are located in mid-size and smaller communities. The Division also provides funds to one narcotic drug treatment program and eight alcohol safety action programs. Finally Federal funds administered by the Division support a multi-faceted fetal alcohol syndrome prevention and treatment project.

Alaska's treatment programs care for about 2,500 residential and 5,500 outpatients a year. Approximately 48% of the individuals entering treatment each year are Native Alaskans. The majority of these admissions are male, between 20 and 40 years of age, low income, and from rural communities. Are these programs having an effect? We believe so and various studies support our belief. They show that:

- Of Alaskan outpatients surveyed, 56 percent abstained from alcohol for one year after treatment.
- Of Alaskans in residential programs surveyed, 42 percent abstained from alcohol for one year after treatment.
- 36 percent of Alaskan residential clients surveyed were hospitalized before treatment and 15 percent after treatment.
- 28 percent of Alaskan outpatient clients surveyed were hospitalized before treatment and 7 percent after treatment.
- 66 percent of the misdemeanor offenders referred to the ASAP did not re-offend during a subsequent 3-year period.

We look forward to the day when we can talk about a statewide, culturally competent comprehensive system of substance abuse prevention, intervention, treatment and aftercare. What would such a system look like? Every city, town and village in the state, consistent with its size and cultural composition, would have some kind of substance abuse prevention and treatment program or point of entry. A small village might have one local person trained in prevention, early intervention, aftercare and referrals. This person would conduct substance abuse education classes, work with people to get them into treatment, and provide on-going support on the person's return from treatment. The person might be employed by the Regional Health

Corporation in the hub community. The regional corporation would operate the residential program or programs and provide training and support to the village workers.

Urban areas would have a full range of services located in number of different programs.

The goal is for people to be able to receive the most appropriate service as close to home as possible and to receive it when they need it not just when their name comes up on a waiting list. How far are we from this goal and what do we need to reach it?

With the help of substance abuse professionals and Alaska Native communities and individuals, we have learned a great deal about how to defeat substance abuse in rural Alaska. We need to:

- Promote public awareness that substance abuse is a public health problem and, as such, is a treatable and preventable disease. Use information technology to make facts about substance abuse treatment and prevention widely and appropriately available to the rural community health care providers and residents.
- Expand awareness of and enhance access to resources for substance abuse treatment and prevention programs in communities.
- Develop and implement strategies to reduce the stigma associated with substance abuse and with seeking help for such problems.
- Extend collaboration with and between public and private sectors to complete a Strategy for treatment and prevention in rural Alaska.
- Improve ability of primary care providers to recognize and treat substance abuse, and problems associated with substance abuse. Increase the referral to specialty care when appropriate.
- Eliminate barriers in public and private insurance programs for the provision of quality treatment and create incentives to treat patients with coexisting mental disorders.
- Institute training for all health, mental health, and human service professionals (such as clergy, teachers, correctional workers, and social workers) concerning substance abuse risk assessment and recognition, intervention, treatment, and aftercare.
- Develop and implement effective training programs for family members of those at risk and for natural community helpers on how to recognize, respond to, and refer people showing signs of substance abuse. Natural community helpers are people such as peers, elders, educators, coaches, and faith leaders, among others.
- Develop and implement safe and effective programs in educational settings for youth that address substance abuse tendencies, crisis intervention and incorporate peer support for seeking help.
- Enhance community care resources by increasing the use of schools and village workplaces as access points for substance abuse and physical health services and providing comprehensive support programs for persons who receive treatment, including the family.
- Promote a public/private collaboration with the media to assure that entertainment and news coverage represent balanced and informed portrayals of substance abuse

and its treatment and prevention.

- Enhance research to understand risk and protective factors, their interaction, and their effects on substance abuse. Additionally, increase research on culture-specific interventions, effective treatment and prevention programs.
- Develop additional scientific strategies for evaluating prevention interventions and ensure that evaluation components are included in all prevention programs.
- Establish mechanisms for regional, and state interagency public health collaboration toward improving monitoring systems for substance abuse and develop and promote standard terminology in these systems.
- Encourage the development and evaluation of new treatment and prevention technologies.

Mr. Chairman, You have asked us for our views concerning the AFN's proposal to transfer certain aspects of liquor control from the State and Municipal governments to federally recognized Tribes.

In short, we applaud the efforts of the Alaska Federation of Natives in bringing these significant issues to national attention. But much important work needs to be done to formulate innovative and workable solutions to this most difficult problem. This must happen through a broad, public process.

Certainly there is more to be learned and more that we can do, but one thing we know for sure, fully fought, the battle against substance abuse will be expensive, but not nearly so expensive as the costs of fighting it half way or the wrong way and losing.

Your interest, involvement and partnership in this battle can only help it succeed. I, my staff, and the treatment and Native communities of Alaska look forward to working with you and assisting you in any way possible.