

# The Alcoholism Report

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THE AUTHORITATIVE NEWSLETTER FOR PROFESSIONALS IN THE FIELD OF ALCOHOLISM

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Vol I, No. 5

December 22, 1972

Published Bi-Weekly

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Alcohol and drug programs are expected to suffer least from budgetary axe-wielding by Caspar W. Weinberger, President Nixon's nominee for HEW Secretary, replacing Elliot Richardson. The 56-year-old Californian has been Director of the Office of Management and Budget and thus, in the eyes of the Democratic Congress, its prime antagonist in the battle over HEW-Labor appropriations. Weinberger can be expected to carry on the economy campaign as head of HEW, trimming fat from programs considered wasteful.

He is known as a dedicated pragmatist. He came to Washington after the 1968 election from the California administration of Gov. Ronald Reagan, where he gained a reputation for putting that state's unwieldy welfare budget in order. Where he stands on alcohol and other health matters is largely a questionmark. However, as a pragmatist he is expected to accommodate himself to the realities of the drug and alcohol scenes. Both these programs have strong constituencies in Congress and in the public at large, and NIAAA is not expected to be dealt with unkindly so long as Weinberger can be persuaded that Federal monies are being expended wisely and effectively

Although Caspar Weinberger is no milquetoast (if we may be allowed a convoluted pun), his first loyalty will be to the White House, and HEW's various agencies will have to play second fiddle to overall White House domestic strategies. This is generally true of all new appointments by President Nixon, who is determined to have all departments under firm White House control, despite statements to the contrary.

In the new Congress convening January 4th, look for a two and possibly four-year renewal of the Hughes Act, with higher project grant authorizations, consolidation of grant authorities, specified personnel levels ala the Narcotics Act, and extra formula funds for states that pass the Uniform Act.

Senator Hughes will push hard for consolidation. NIAAA grant authorities, as many of you know, are now divided between three separate pieces of legislation. Formula grants are authorized by the Hughes Act, project grants by the Community Mental Health Centers Act, and training grants by the Public Health Service Act. The result of strategies and concessions involved in winning passage of the original 1970 bill, it weakens Hughes' control over management of future legislation in the field and involves alcoholism in irrelevant legislative hassles. It also creates some management problems on the community centers level.

Hughes' own bill in the last Congress called for consolidation, as well as personnel authorizations (to make it easier for NIAAA to attract top quality people) and authority for the HEW Secretary to transfer NIAAA out of NIMH to give it more flexibility and strengthen both its categorical

identity and grants management control, a move NIMH Director Bert Brown opposed. The bill also carried considerably higher project money authorizations than contained in Senator Kennedy's omnibus health bill renewal that combined CMHC's, the Hill-Burton Act and six or seven other programs. The Kennedy bill, which died, provided \$60 million for FY 74 and \$60 million for FY 75.

Extra formula funds for states passing the Model Act is considered necessary both as a legislative incentive and because some small states are limited by population from getting any more than the basic \$200,000 grant, despite proven need. Qualifying states will get an additional \$100,000 plus 10 percent of their formula grant allowance. Some new authorities for such states are also being talked about.

Hughes plans early detailed renewal and oversight hearing before his Alcoholism and Narcotics Subcommittee. Expect some searching questions and scolding of NIAAA officials regarding certain grants, but nothing so scathing as to blacken the Institute or its programs, unless some unhealthy surfaces are unwittingly scratched. Hearings will be held early to ensure passage before current authorizations expire June 30th, thus precluding any appropriations gap in NIAAA funding. Prospects for passage of an intact bill are good. The Congress has become increasingly aware that alcoholism is a major national problem, is sympathetic to Hughes' aims, and looks to him for legislative leadership in the field.

Best indication of how favorably Congress looks on alcoholism programs is the amount appropriated in the twice-vetoed HEW appropriations bill of the last session. Although mental health is regarded as a soft area in any budget cutting coming up at OMB, regardless of how the disputed appropriations are resolved in the new Congress, the odds are NIAAA will get--and be allowed to spend--most of what was allotted in last year's bill. Herewith the complete figures for your perspective:

	1972	1973			
	Base	Nixon Budget	House Allowance	Senate Allowance	Conference Action
Research Grants.....	7,543	8,043	11,043	13,043	11,043
Training Grants & Fellow..	4,089	4,089	8,089	8,089	8,089
State & Community Programs					
Project Grants.....	40,193	50,193	70,193	85,193	82,693
Grants to States.....	30,000	30,000	60,000	75,000	60,000
Public Information.....	750	750	1,000	2,000	1,000
Program Support.....	4,056	4,458	6,208	9,208	9,208
Total	86,631	97,533	156,533	192,533	172,033

The influential Christian Science Monitor published a five-part in-depth series on the liquor industry, keyed to the question of whether it's "meeting its obligation to lesson alcohol's disruptive impact." Here are some of the "findings" of the Monitor series, which ran Dec. 5-9: a "disproportionately large" amount of liquor is sold to America's nine million

alcoholics; the liquor industry's advertising equates drinking with Christmas cheer, thereby boosting sales to the highest point of the year during the holiday season; the cost of alcohol abuse to society runs \$15 billion a year while the industry pays only \$5.1 billion yearly in federal taxes and another \$3.1 billion to states and localities.

The Monitor posed this question: "Does the huge liquor industry (\$24 billion a year, all told, and 516,000 companies employing 1.9 million people) bear a special responsibility to do more to alleviate such suffering--more than it is already doing? More and more critics--specialists in treating alcoholism, road safety experts, private businessmen, and federal and state government politicians and officials--insist that the answer is yes."

"A lot of the people going into the alcoholism field are being sold short by dead-end training programs being offered in some parts of the country." That's the verdict of Dr. Wallace Mandell, program director for alcoholism training at Johns Hopkins' prestigious School of Hygiene and Public Health. Consequently, he insists that all courses in the several programs at Hopkins be college-accredited so alcoholism professionals can qualify for more advanced academic training.

The credentials behind that practice are impressive. The Johns Hopkins program for training alcoholism counselors is probably the best known in the country. Started five years ago, it has graduated 125 to date, of whom 119 are still active, furnishing the core cadre of counselors in the East. The six-month program pioneered the practice of allowing non-professionals into direct contact with the sick alcoholic. Counseling hopefuls are accepted from all parts of the country. The only requirement is literacy and, in the case of recovered alcoholics, at least two years' sobriety.

Mandell says one of his main educational tasks is to impress on recovered alcoholics that AA is not the only treatment modality. "We must expand their horizons as to what's possible in treating the alcoholic," he explains. He pictures the alcoholism counselor as essentially an advocate representing the alcoholic in contacts with service agencies that can help him. ✓

For those interested in becoming program directors, Hopkins offers a one-year Master of Health Sciences which provides training in how to organize and administer services to alcoholics. There is also a three-year program in planning and evaluation leading to a Doctor of Science.

Because states, in many instances, have hastily set up programs with largely untrained personnel in order to qualify for federal funds, Johns Hopkins has inaugurated an intensive ten-week "Continuing Education Program" for professionals already managing programs. The last two weeks concentrate on specialized problems relative to trainees' particular employers, such as poverty, public inebriate or highway safety programs. Periodic on-site training and advice follow for 14 more weeks, ending with a one-week summing-up back at JH. There is no charge to students. Understandably, the first course starting last September was oversubscribed, but applications are still being accepted for future sessions. The first two years of the

program will be spent training counselors, the last year in evaluation. Questions to be answered then are: Is this program workable? Will it meet the right needs? Can it be decentralized?

All three programs receive NIAAA funds. Counselor-training gets \$124,000 this year, continuing education \$335,000, with a non-competing continuation of \$318,000 next year (pending NIAAA evaluation) and \$45,000 in FY 75. The advanced degree programs get \$154,000 this year, \$182,000 next, and \$191,000 in FY 75 (also non-competing continuations).

Alcoholism is costing the Australian state of Victoria at least \$102,000,000 a year according to Dr. Louise Deakin, of the St. Vincent's Hospital Alcoholism Unit, Melbourne, reporting to a seminar on drug and alcohol dependence there. Work at the unit has established that the known population of alcoholics in Victoria is 100,000 people, or about 3 percent of Victoria's population. The \$102,000,000 was made up of hospital costs, sickness and unemployment benefits, unrealized earnings, work absenteeism, and the loss to industry because of decreased efficiency.

What do you do with a drunken soldier? In the Nov. 24 issue of AR, we carried a paragraph on alcoholism treatment from a 1923 medical textbook. Going back a little further in time, the 1894 Report of the U.S. Army Surgeon General offers this technique for treating the alcoholic:

"A mistaken pity for a man suffering from the effects of a debauch is liable very often to lead a too indulgent post surgeon to excuse him from duty when the guardhouse and not the hospital is the proper place for him. I am confident that this mistaken kindness has done a great deal in the past to encourage drunkenness. Each man who reported at the hospital in any stage of simple alcoholism is treated as a case of alcoholic poisoning, taken immediately to the operating room, his stomach emptied by the use of the stomach pump, and thoroughly washed out with warm two percent soda solution. After this, he is given a bowl of hot beef extract with cayenne pepper, allowed a hour's rest, after which he is generally perfectly able, however unwilling, to do his duty...

"Occasionally some resistance is met with, but two, or at most three, able-bodied hospital corps men and a perforated wooden gag, such as comes with the stomach pump will, with patience and determination, overcome almost any ordinary opposition...The deterrent effect of this treatment is excellent. It is, of course, not agreeable, though no one can deny that it is perfectly rational and merciful."

The Army program combining alcohol and drug abuse is working smoothly, claims Col. Leslie R. Forney, Jr., chief of its Alcohol and Drug Policy Division. He says that the Army, the only branch with a merged program, feels there is not enough difference between the young drug abuser and the young alcoholic to warrant separate programs. And 77 percent of the Army's active duty personnel falls in the 18-29 age bracket.

Actually, on some installations, dual programs exist because the Army stresses decentralization on both administrative and treatment levels,

allowing post commanders the option of separating drug abuse and alcoholism. While encouraging combined programs, Forney admits there is sometimes difficulty between alcoholics and addicts at treatment facilities. "Old juicers often don't like to be thrown in with young junkies," he explains. And if an alcoholism program is being operated successfully by a hard-nosed recovered alcoholic with no feel for the drug abuser, it will be allowed to continue. "There is no point," says Forney, "in trying to force a competent alcoholism therapist into a mold he can't handle."

Under Forney's division there are some 1,400 civilian and 500 military counselors. The Army, the only branch to use civilian alcoholism workers, is trying to put most of its programs under civilian direction. Counselor training is at the Medical Field Services School, Fort Sam Houston, Texas, where instruction is given in both drug and alcohol problems. In line with its decentralization policy, the Army has no large rehabilitation centers like the Navy. An official circular states that rehabilitation efforts "must center in the unit, rather than in the hospital or stockade, to enable the soldier to cope with the realities of the military environment." Forney explains that budgetary considerations also dictate against central rehabilitation facilities, pointing out that they would have to cope with an alcoholic and addict population of considerable dimensions. The Army has 850,000 on active duty, one million dependents, and 450,000 civilian workers. Every base of significant size has an Alcohol and Drug Control Officer (ADCO) charged with developing and operating the program. He reports to the base commandant rather than the medical officer because, in the Army's view, "although alcohol and other drug abuse has medical and psychological elements, it is primarily a social problem."

Forney is proud of what the Army calls its "involuntary referral" system for alcoholics. Based on the concept that rarely does the alcoholic, in the early stages of the disease, seek help on his own, the system requires the mandatory referral to a counselor of every GI whose drinking gets him into disciplinary trouble. A large number of budding alcoholics are being identified this way, according to Forney. At one post, over 50 percent of soldiers handled under the referral system admitted for the first time they were alcoholics and are staying sober in treatment.

AA is generally encouraged and heavily relied on in many post programs. Gen. Ralph Haines of the Continental Army Command recently issued a directive to all post commanders to provide facilities for AA meetings. However, Forney says ADCO's must see to it that other treatment methods are available, including group and family therapy, Antabuse, religious counseling and, on some bases, even transcendental meditation (TM), a yoga-like technique for turning on without chemicals.

Copies of the circular spelling out the Army's program can be obtained by writing to Commanding Officer, U.S. Army Publications Agency, Room 424, NASSIF Bldg., Falls Church, Va. 22041, and asking for DA CIR 600-85.

"Doctors unwilling to treat alcoholics should at least be willing-- and able--to make a diagnosis of alcoholism." There's an edge of frustration in her voice as Dr. Zelda Bowie-Elder of Howard University's Medical

School describes her years-long struggle to convince physicians in the nation's capital that alcoholism is a treatable disease. Dr. Elder heads up Howard's Alcoholism Studies Program, initiated five years ago as a broad-gauged effort to enlighten the medical fraternity, service agencies and the community at large about alcoholism.

Dr. Elder says she can detect some recent changes in attitude, but she feels that bias against the alcoholic is so deeply ingrained that a more basic and concentrated effort is needed. She cites a questionnaire sent all attending physicians at the University's teaching hospital, sounding out their attitudes toward treating alcoholics. About one percent saw fit to respond. Again, an alcoholism workshop for Washington area physicians was virtually ignored.

Dr. Elder hopes to install a didactic curriculum in alcoholism for freshman and sophomores at the medical school next year because she feels these classes have a more open attitude on alcoholism. When they reach the third and fourth years of study, cynicism and bias creep in, a rub-off, she says, from their increasing association with practicing M.D.'s. If first and second year classroom fare can be beefed up with alcoholism subjects, she thinks a bulwark can be erected against biases picked up in later medical training.

The current program, operating under a \$71,714 NIAAA grant for FY 72, includes: seminars, field instruction, family and case studies, field placements and special projects. Program evaluation is based on examinations of the students and attitude questionnaires on alcoholism before, immediately after, and approximately two years after training. In addition, trainees will be sent questionnaires regarding their actual performance in the field two years after training. Agencies will be surveyed each year for three to five years regarding services to alcoholics.

Dr. Chafetz states that the Institute will be taking a new look at the positive implications of the moral issue in the area of prevention. He feels that its potential as a preventive measure should be reexamined now that its negative aspects "have been hacked to death."

We promised you a listing of comprehensive community treatment centers and their staffing grants. Here it is, but there are some discrepancies we haven't quite been able to resolve. A listing current to the end of FY 72 contains 46 centers, with one, Appalachian Regional Hospitals of Lexington, Ky., crossed off. In conversations with a high NIAAA official, 44 centers were cited as being operational. That is also the figure implied in the draft of the Institute's annual report to Congress. We assume 44 is the correct current figure. If so, going by the following list, one of our centers is missing. Note that only 14 of those listed were new staffing grants approved in FY 72; the rest are either continuations or FY 71 funds. (We had hoped to carry a breakdown of grants approved at the last National Advisory Council meeting November 20, but NIAAA would not release the data because all grantees had not yet been notified. Again, we hope to have it next issue.)

COMMUNITY ASSISTANCE STAFFING GRANTS

<u>STATE</u>	<u>GRANTEE</u>	<u>DIRECTOR</u>	<u>FY 72 FUNDS</u> <u>(*From FY 71 Funds)</u>
Me.	The Counseling Center	R. Lamping	443,136
N.H.	Dartmouth Medical School	H. Payson	*123,126
N.J.	Raritan Bay Community Mental Health Center	R. Hoyt	*228,055
N.Y.	Kings County Hospital Center	B. Kissen	555,734
N.Y.	Community Mental Health Board of Franklin Co.		72,810
Md.	Johns Hopkins Hospital	T. Brown	230,647
Pa.	Western Pa. CMH Consortium	E. Fine	*200,904
Va.	Fairfax County Health Service		10,000
W. Va.	Appalachian Regional Hospital	D. Schmauss	316,210
W. Va.	Appalachian CMH Center	A. Portz	116,788
Fla.	Mid-Florida Center for Alcoholics	B. McLeod	283,279
Fla.	CMH Center of Eacambia Co., Inc.	M. Eaddy	460,393
Ky.	North Central Regional MHR Board, Inc.	W. Perry	57,025
Ky.	S.E. Ky. Regional MH-MR Board	R. Cribbs	124,623
Ky.	20th Regional MH-MR Board, Inc.	Z. Archer	83,976
Ky.	Western Ky. Regional MH-MR Board	K. Helpon	108,368
N.C.	Forsyth County Dept. of MH	R. Spencer	*274,062
N.C.	Sandhills MH Center, Inc.	M. Elmore	*140,467
N.C.	Orange-Person-Chatham MH Center	P. Watton	174,501
Wis.	MH Center of Sauk, Juneau & Richland Cos.	T. Fix	200,842
Wis.	Lakeland Counseling Center	W. Gleason	*142,632
Ark.	Ark. Dept. of Social and Rehabil. Svs.	E. Baxter	216,795
Ark.	S.E. Ark. MH Center	C. Perkins	*204,688
Ark.	S. Ark. MH Center	J. Cartwright	302,117
La.	Com. on Alcoholism & Drug Abuse for Greater New Orleans	A. Brisolaro	583,246
N.M.	S.W. MH Center	J. Alexander	186,439
Okla.	Western State Hospital	W. Blyth	286,528
Okla.	Central State Griffin Memorial Hospital	T. Points	503,258
Tex.	Tarrant Co. MH-MR Center	D. Lamb	*569,713
Tex.	MH-MR Center	J. Tonetti	286,245
Tex.	Bexar Co. Board of Trustees for MH-MR	G. Martin	501,851
Tex.	The St. Joseph Hospital	B. Marie	755,290
Iowa	S.W. Iowa Alcoholism Commission	R. Gerhards	150,665
Iowa	N. Central Alcoholism Research Found.	L. Laws	168,161
Iowa	N.W. Iowa Alcoholism Services	J. Voskans	77,752
Neb.	Immanuel Medical Center	C. Bonniwell	155,953
Mont.	Alcoholism & Drug Assoc. of Helena, Inc.	J. McMahon	124,938
Ariz.	Gila River Indian Community	D. Davis	132,534
Ariz.	St. Luke's Hospital Medical Center	J. Prekeep	392,121
Cal.	Santa Clara Co. Health Dept.	E. Turner	1,518,074
Cal.	Golden State Community MH Center	M. Kline	340,133
Ha.	Kalihi-Panama MH Center	D. Nixon	398,552
Alk.	The City and Borough of Juneau	M. Ballard	195,148
Alk.	City of Ketchikan Through Gateway Community Health Center	J. Edde	47,152
Idaho	E. Idaho Community MH Center, Inc.	M. Madsen	174,574
Wash.	Community Alcoholism Agency of Seattle-King County		1,002,178
TOTAL			13,581,683

\*\* The relative clumping of centers in some states is not due to any Institute design to facilitate monitoring or evaluation of centers. The applications simply came in that way, and were approved when qualified.

A major NIAAA evaluation thrust is underway with close but kindly on-site looks at all funded and operating treatment centers next year. A task force of nine five-man teams will spend three days at each center. Teams will consist of one representative from the Institute, Community Assistance Branch, one from NIMH grants management, one from the respective regional office, one from the state, and one consulting expert. Two main purposes of the visits are (1) to monitor compliance both with the law and what centers said they were going to do, and (2) to help develop better services. The intent is non-judgmental, the primary focus is on consultation. A Stanford Research Institute rating system is the main tool used by NIAAA to evaluate centers, but the task force hopes to probe areas beyond that system's scope. Each task force member, for instance, will fill out a subjective rating form on each center, answering such questions as: "Would you go there? Would you want your family to seek treatment there?" The task force will talk to administrators, treatment staff, patients and community representatives at large to get a rounded picture of the center's performance, primarily from the latter two groups. The grants management man will examine the books. Each visit will also include a community forum, and NIAAA's public affairs office will alert each community to the visits. Before leaving, the team will hold a debriefing session for program people and the center's board of directors or other higher authorities.

The main question the task force seeks to answer is: How efficiently is the center meeting the needs of its community? NIAAA is conscious of the threat of overcontrol from Washington, and the possibility of intimidation of local personnel by bureaucrats away from home parading as experts. It insists it is relying on the community for direction and is not trying to dictate to people in the field. But as Dr. Chafetz has said: "We are strongly committed to being as open and honest as we can." He is prepared to say "This grant was a mistake, this grant was a rip-off." He believes the country is "prepared and willing" for open administration of government programs.

One problem in these evaluation efforts was pin-pointed by National Advisory Council member G. Carlton Edmonds. He wondered if "quality programs" now may not be "quality programs" a few years from now. "We may be setting up a delivery system for a poor product," he said. The dilemma is that until long-term recovery follow-up can be achieved, there is no realistic criterion for evaluating programs. Long-term recovery is the pay-off. One Institute official uses the analogy of a torpedo, which has no controls once fired, comparing it to a missile, from which feedback is received after launching to direct it to the target. He feels NIAAA programs have the feedback advantages of the missile, but he admits that the target, at this stage, is a shadowy and elusive one.

Reminder. AR is published on the second and fourth Fridays of each month. Therefore there are two times a year when there is a three-week lapse between issues. The next issue, No. 6, will be in your hands three weeks from now, Jan. 12.