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COMPREHENSIVE ALCOHOL AND DRUG ABUSE AMENDMENTS OF 1981

DEPOSITORY

HEARINGS

BEFORE THE

SUBCOMMITTEE ON
ALCOHOLISM AND DRUG ABUSE

OF THE

COMMITTEE ON
LABOR AND HUMAN RESOURCES
UNITED STATES SENATE

NINETY-SEVENTH CONGRESS

FIRST SESSION

ON

S. 755

A BILL TO REVISE THE COMPREHENSIVE ALCOHOL ABUSE AND ALCOHOLISM PREVENTION, TREATMENT, AND REHABILITATION ACT OF 1970 AND THE DRUG ABUSE PREVENTION, TREATMENT, AND REHABILITATION ACT

MARCH 25 AND 30, 1981

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COMPREHENSIVE ALCOHOL AND DRUG ABUSE AMENDMENTS OF 1981

WEDNESDAY, MARCH 25, 1981

U.S. SENATE,
SUBCOMMITTEE ON ALCOHOLISM AND DRUG ABUSE,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, D.C.

The subcommittee met, pursuant to notice, in room 2228, Dirksen Senate Office Building, commencing at 9:35 a.m., Senator Gordon J. Humphrey (chairman of the subcommittee) presiding.

Present: Senators Humphrey, Riegle, and Williams.

Senator HUMPHREY. Good morning. Will the witnesses come to the table, please.

Good morning, this is the first hearing of the Subcommittee on Alcoholism and Drug Abuse in the 97th Congress. Our topic this morning is the reauthorization of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act.

I would like to extend a special word of welcome to our distinguished panel of witnesses who have made personal sacrifices I am sure to be able to be here with us.

There should be no doubt that alcohol abuse and alcoholism are serious national problems. The "Fourth Special Report to the U.S. Congress on Alcohol and Health," released only a few months ago, notes that the economic costs of alcohol misuse and alcoholism in the United States have been estimated at $43 billion annually. These costs reflect estimates of lost production due to absence from work, health care expenditures, motor vehicle accidents and violent crimes while under the influence of alcohol, and spending for prevention, treatment, and rehabilitation programs.

Furthermore, as has been noted before, the family discord, divorces, child neglect, and domestic violence associated with alcoholism and alcohol abuse could not be given a price tag under any system.

Thus, from my perspective, this morning's hearing is not for the purpose of convincing each other that alcohol abuse is a serious problem. Instead, our focus should be on what is the appropriate Federal role in this troubling area.

As most of you know, I have introduced S. 755, which I believe to be a vehicle for discussing the Federal Government's role in alcohol and drug abuse prevention, treatment, and rehabilitation. At this time, I only wish to say a few words about this proposal.

First, this bill provides for only a 1-year reauthorization. This approach is predicated on the fact that I intend to hold extensive oversight hearings in the months ahead. Furthermore, with the

change in administration and in Senate leadership, I believe that we all need more time to get our bearings, take a fresh look at important issues, and chart a more comprehensive and long-term course.

Second, the bill assumes a block grant framework for the distribution of Federal alcohol abuse health care dollars to the States. These treatment funds are slated for inclusion in the health services block grant. Block grants are seen as a means of giving States the greatest possible authority and flexibility, and of significantly reducing Federal regulations, paperwork, and what many have seen as unnecessary Federal interference. I support this concept while aware of the fact that many details regarding the block grant approach remain to be determined, and I look forward to contributing to this process.

Finally, my bill calls for a continued Federal role in the areas of research, prevention, demonstration programs, technical assistance, information collection and dissemination, and other related activities I believe that, at least for the time being, these are activities which the Federal Government should not relinquish to the States or to the private sector.

Unfortunately, representatives of the administration are unable to join us this morning. In part, this is due to the fact that the Department of Health and Human Services has only a few confirmed officials in place at this time. Furthermore, in view of the many reauthorizations pending before the Committee on Labor and Human Resources, of which this is a subcommittee—all having the same May 15 legislative deadline—I felt it was important to hold this hearing as early as possible.

Secretary Schweiker himself is scheduled to appear before the full committee on April 2. At that time, the issue of block grants will be extensively discussed, and questions regarding the impact of block grants on alcohol abuse treatment programs can be discussed. Nevertheless, I want all this morning's witnesses to know that comments regarding the proposed block grant framework are welcome, and I am sure I won't have to encourage you too much to comment on that aspect.

The other difficulty confronting the subcommittee this morning is that the average American citizen, John and Jane Q. Public, or Mr. and Mrs. Taxpayer, if you will, are only imperfectly represented.

The interest in reducing Federal spending and in taming the Federal bureaucracy emanates from the mandate which the Reagan administration received from the American people in November of last year. Furthermore, there is a renewed belief that the private sector has been too long ignored, in one sense, and too long abused in another.

In the field of alcoholism, Alcoholics Anonymous, certain educational campaigns, and various occupational programs are only a few examples of what the private sector can do. Most of the time, the private sector can do a better job, more efficiently and at less cost, than any Government entity. I hope we will hear more about the efforts of the private sector this morning.

Before we proceed, I would like to remind the witnesses that the subcommittee would prefer to keep as much time as possible avail-

able for questions. Therefore, every effort should be made to summarize your prepared statements, especially in the case of those which are rather lengthy.

In any case, of course, your entire statements will be entered in the record in full.

While we are holding this hearing on alcohol abuse and alcoholism programs, and another hearing next week on drug abuse programs. This division is somewhat artificial; therefore, the witnesses are free to address issues which relate to the problem of drug abuse as well. Nevertheless, our primary focus this morning will be on alcohol misuse and on related prevention, treatment, and rehabilitation programs.

At this point I will include in the record the full text of S. 755, and the remarks which accompanied its introduction.

[The following was received for the record:]

[From the Congressional Record--Senate--March 23, 1981]

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. HUMPHREY:

S. 755. A bill to revise the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 and the Drug Abuse Prevention, Treatment, and Rehabilitation Act; to the Committee on Labor and Human Resources.

COMPREHENSIVE ALCOHOL AND DRUG ABUSE AMENDMENTS OF 1981

● Mr. HUMPHREY. Mr. President, today, I am introducing legislation to reauthorize both the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act, and the Drug Abuse Prevention, Treatment and Rehabilitation Act. This proposal calls for a continued Federal presence in the areas of alcohol abuse, alcoholism and drug abuse. A strong Federal presence is appropriate in view of the serious consequences of alcohol and drug abuse, and the negative impact of such abuse on education, work and interpersonal relationships.

Under this proposal, the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the National Institute on Drug Abuse (NIDA) would be maintained as separate entities, and they would focus their resources on research, training, national prevention and education activities, information collection and dissemination, the provision of technical assistance to the States, and the encouragement of demonstration programs.

The Reagan administration has recommended that Federal funding for alcohol and drug abuse health care services be included in the proposed block grant framework, out of the belief that maximum authority and flexibility should be given to the States. Furthermore, block grants promise to reduce significantly Federal regulations, paperwork, and what many have seen as unnecessary Federal interference. Obviously, many details regarding the block grant approach remain to be determined, and I look forward to contributing to this process. The bill introduced today does not, therefore, address the issue of block grants directly. The bill simply assumes a block grant framework for the bulk of the alcohol and drug abuse treatment programs.

The bill focuses current project grants and contracts on model and demonstration programs, and other activities appropriate for the Federal Government. Under this new approach, funds could no longer be accessed by State governments—their funding would come via the block grants—individual grantees could receive awards for a maximum of 5 years, and no award could cover more than 75 percent of the costs of a given project in any year. Furthermore, at least 25 percent of project funds would be channeled to prevention activities.

Finally, the proposal would allow funds received from NIAAA to be used for projects aimed at drug abuse as well as alcohol abuse and alcoholism. Similar flexibility is authorized for NIDA grants. In a society where substance abuse frequently means concurrent abuse of alcohol and other drugs, it seems appropriate that the Federal response be flexible. Nevertheless, alcohol abuse and drug abuse have many unique features, and this fact must not be overlooked.

In the case of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act, the bill maintains separate language authorizing grants to States to encourage passage and implementation of the Uniform Alcoholism and Intoxication Act which decriminalizes public intoxication and commits individual States to providing a continuum of care for those afflicted by the disease of alcoholism. As under current law, a State could receive grants under this program for a maximum of 6 years. The amount of individual grants would be determined by the Secretary of Health and Human Services.

For research aimed at alcohol abuse and alcoholism, a single authorization for the national research centers and all other research activities is provided. In the case of NIDA research, the bill would authorize projects aimed at developing less addictive pain and medications, long-lasting blocking agents for treatment of heroin addiction, and new detoxification agents to ease the physical effects of withdrawal, as well as investigations related to other drug prevention, treatment, and rehabilitation activities.

Mr. President, the Subcommittee on Alcoholism and Drug Abuse has scheduled hearing on Federal drug and alcohol abuse programs. On March 25 at 9:30 a.m. in room 2228 Dirksen Senate Office Building, the subcommittee will consider those programs dealing with alcohol abuse and alcoholism. On March 30 at 9:30 a.m. in room 4232 Dirksen Senate Office Building, the subcommittee will focus on comparable drug abuse programs. At these hearings, comments regarding the proposed block grant framework for the distribution of Federal funds for alcohol and drug abuse health care services will be most welcome. Furthermore, we will be interested in views regarding what is the appropriate Federal role in the area of alcohol and drug abuse, and how NIAAA and NIDA have been performing.

The legislation would reauthorize Federal alcohol and drug abuse programs only through fiscal year 1982. My intent is to hold extensive oversight hearings in the months ahead in order to be in a better position to chart the future course for these Federal programs. A 1-year reauthorization will force us to take a fresh look at Federal alcohol and drug abuse programs next year, and I think this is the best approach to take in view of the tremendous changes brought about by the November elections.

Mr. President, I ask unanimous consent that the text of my bill be inserted in the RECORD following these remarks.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 755

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Comprehensive Alcohol and Drug Abuse Amendments of 1981".

TITLE I—ALCOHOL ABUSE AND ALCOHOLISM PREVENTION, TREATMENT AND REHABILITATION

REFERENCE

SEC. 101. Except as otherwise specifically provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or a repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970.

FINDINGS AND PURPOSE

SEC. 102. Section 2 is amended to read as follows:

"FINDINGS AND PURPOSE

"SEC. 2. (a) The Congress finds that—

"(1) alcohol abuse and alcoholism are serious national problems requiring a Federal response;

"(2) alcohol abuse and alcoholism impair the physical and psychological well-being of individuals, and thereby lead to an unfortunate waste of human talent and energy; and

"(3) alcohol abuse and alcoholism interfere with education, work, and interpersonal relationships, causing great harm to families, communities, and the Nation.

"(b) It is the policy of the United States and the purpose of this Act to provide a Federal response to alcohol abuse and alcoholism which—

"(1) is constructive, cost-effective and well coordinated;

"(2) reserves to the States as much authority and flexibility as practicable;

"(3) encourages the greatest participation by the private sector, both financially and otherwise; and

"(4) concentrates on carrying out functions which are truly national in scope.".

ALCOHOL ABUSE AND ALCOHOLISM AMONG GOVERNMENT AND OTHER EMPLOYEES

SEC. 103. Section 201(b)(2)(B) is amended by striking out "single State agencies designated pursuant to section 303 of this Act" and inserting in lieu thereof "the State agencies responsible for the administration of alcohol abuse prevention, treatment, and rehabilitation activities".

TECHNICAL ASSISTANCE

SEC. 104. (a) Section 301 is amended to read as follows:

"TECHNICAL ASSISTANCE

"SEC. 301. (a) On the request of any State, the Secretary, acting through the Institute, shall, to the extent feasible, make available technical assistance—

"(1) developing and improving systems for data collection;

"(2) program management, accountability, and evaluation;

"(3) certification, accreditation, or licensure of treatment facilities and personnel;

"(4) monitoring compliance by hospitals and other facilities with the requirements of section 321; and

"(5) eliminating exclusions in health insurance coverage offered in the State which are based on alcoholism or alcohol abuse.

"(b) Insofar as practicable, technical assistance provided under this section shall be provided in a manner which will improve coordination between activities supported under this Act and under the Drug Abuse Prevention, Treatment, and Rehabilitation Act.".

(b) Sections 302 and 303 are repealed.

SPECIAL GRANTS

SEC. 105. (a) Section 310(a) is amended by striking out "September 30, 1981" and inserting in lieu thereof "September 30, 1982".

(b) The first sentence of section 310(c) is amended to read as follows: "The amount of any grant under this section to any State for any fiscal year shall be determined by the Secretary.".

GRANTS AND CONTRACTS

SEC. 106. (a) The section heading for section 311 is amended to read as follows:

"GRANTS AND CONTRACTS FOR THE DEMONSTRATION OF NEW AND MORE EFFECTIVE ALCOHOL ABUSE AND ALCOHOLISM PREVENTION, TREATMENT, AND REHABILITATION PROGRAMS".

(b) Section 311(a) is amended—

(1) by adding at the end of clause (1) "and with particular emphasis on identifying new and more effective alcohol abuse and alcoholism prevention, treatment, and rehabilitation programs,";

(2) by inserting "and" after the comma the last place it appears in clause (2);

(3) by striking out clauses (3) and (5) and by redesignating clause (4) as clause (3); and

(4) by striking out the comma and "and" at the end of clause (3) (as redesignated by clause (2) of this subsection) and inserting in lieu thereof a period.

(c)(1) Section 311(c)(2)(A) is amended—

(A) by striking out "designated under section 303 of this Act, if such designation has been made" in the first sentence and inserting in lieu thereof "responsible for the administration of alcohol abuse and alcoholism prevention, treatment, and rehabilitation activities";

(B) by striking out "the" before "State comprehensive plan" in the third sentence and inserting in lieu thereof "any"; and

(C) by striking out "under section 303" in the third sentence.

(2) Section 311(c)(3) is amended—

(A) by inserting "and" after the semicolon in clause (B);

(B) by striking out the semicolon and "and" at the end of clause (C) and inserting in lieu thereof a period; and

(C) by striking out clause (D).

(3) Section 311(c)(4) is amended to read as follows:

"(4) The Secretary shall encourage the submission of and give special consideration to applications under this section for programs and projects aimed at underserved populations such as racial and ethnic minorities, native Americans, youth, the elderly, women, handicapped individuals, and families of alcoholics.".

(4) Section 311(c) is further amended—

(A) by redesignating paragraph (5) as paragraph (6);

(B) by inserting after paragraph (4) the following new paragraph:

"(5)(A) No grant may be made under this section to a State or to any entity within the government of a State.

"(B) No grant or contract may be made under this section for a period in excess of 5 years.

"(C) The amount of any grant or contract made under this section may not exceed 75 percent of the cost of carrying out such grant or contract."; and

(C) by adding at the end thereof the following new paragraph:

"(7) Nothing shall prevent the use of funds provided under this section for programs and projects aimed at the prevention,

treatment, or rehabilitation of drug abuse as well as alcohol abuse and alcoholism.".

AUTHORIZATION OF APPROPRIATIONS—PROJECT GRANTS AND CONTRACTS

SEC. 107. (a) The first sentence of section 312(a) is amended by striking out "and" after "1980," and by inserting before the period a comma and "and $20,000,000 for the fiscal year ending September 30, 1982".

(b) The second sentence of such section is amended by striking out "and" after the semicolon the first place it appears and by inserting before the period a semicolon and "and of the funds appropriated under this section for the fiscal year ending September 30, 1982, at least 25 percent of the funds shall be obligated for such grants".

AUTHORIZATION OF APPROPRIATIONS—RESEARCH

SEC. 108. Section 503 is amended by adding at the end thereof the following new sentence: "There are authorized to be appropriated for carrying out the purposes of sections 501, 502, and 504 $25,000,000 for the fiscal year ending September 30, 1982.".

TECHNICAL AMENDMENTS

SEC. 109. (a) Section 101(a) is amended by striking out "Health, Education, and Welfare" and inserting in lieu thereof "Health and Human Services".

(b) Section 103(b)(1) is amended by striking out "Health, Education, and Welfare" and inserting in lieu thereof "Health and Human Services".

(c) Section 201(s) is amended by striking out "Health, Education, and Welfare" and inserting in lieu thereof "Health and Human Services".

(d) Section 334 is amended by striking out "Health, Education, and Welfare" each place it appears and inserting in lieu thereof "Health and Human Services".

TITLE II—DRUG ABUSE PREVENTION, TREATMENT, AND REHABILITATION

REFERENCE

SEC. 201. Except as otherwise specifically provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or a repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Drug Abuse Prevention, Treatment, and Rehabilitation Act.

CONGRESSIONAL FINDINGS

SEC. 202. Section 101 is amended to read as follows:

"§ 101. Congressional findings.

"The Congress finds that—

"(1) drug abuse is a serious national problem requiring a Federal response;

"(2) drug abuse impairs the physical and psychological well-being of individuals, and thereby leads to an unfortunate waste of human talent and energy; and

"(3) drug abuse interferes with education, work, and interpersonal relationships, causing great harm to families, communities, and the Nation.".

DECLARATION OF POLICY

SEC. 203. Section 102 is amended to read as follows:

"§ 102. Declaration of national policy.

"It is the policy of the United States and the purpose of this Act to provide a Federal response to drug abuse which—

"(1) is constructive, cost effective, and well coordinated;

"(2) reserves to the States as much authority and flexibility as practicable;

"(3) encourages the greatest participation by the private sector, both financially and otherwise; and

"(4) concentrates on carrying out functions which are truly national in scope.".

ADDITIONAL DRUG ABUSE PREVENTION FUNCTIONS

SEC. 204. (a) Section 406(a) is amended—

(1) by inserting "and" after the semicolon in clause (2);

(2) by striking out the semicolon and "and" at the end of clause (3) and inserting in lieu thereof a period; and

(3) by striking out clause (4).

(b) The section heading for section 406 is amended by striking out "Health, Education, and Welfare" and inserting in lieu thereof "Health and Human Services".

(c) The item relating to section 406 in the table of sections for title IV is amended by striking out "Health, Education, and Welfare" and inserting in lieu thereof "Health and Human Services".

FORMULA GRANTS

SEC. 205. (a) Section 409 is repealed.

(b) The table of sections for title IV is amended by striking out the item relating to section 409.

GRANTS AND CONTRACTS

SEC. 206. (a)(1) The section heading for section 410 is amended to read as follows:

"§ 410. Grants and contracts for the demonstration of new and more effective prevention, treatment, and rehabilitation programs.".

(2) The item relating to section 410 in the table of sections for title IV is amended to read as follows:

"§ 410. Grants and contracts for the demonstration of new and more effective prevention, treatment, and rehabilitation programs.".

(b)(1) The first sentence of section 410 (a) is amended to read as follows: "The Secretary acting through the National Institute on Drug Abuse, may make grants to and enter into contracts with individuals and public and private nonprofit entities—

"(1) to provide training seminars, educational programs, and technical assistance for the development, demonstration, and evaluation of drug abuse prevention, treatment, and rehabilitation programs;

"(2) to conduct demonstration and evaluation projects, with a high priority on prevention and early intervention projects, and with particular emphasis on identifying new and more effective drug abuse prevention, treatment, and rehabilitation programs, including improved drug maintenance and detoxification techniques; and

"(3) to determine the cause of drug abuse in a particular geographic area and prescribe methods for dealing with drug abuse in such area.".

(2) Section 410(a) is further amended by adding at the end thereof the following new sentence: "Furthermore, nothing shall prevent the use of funds provided under this section for programs and projects aimed at the prevention, treatment, and rehabilitation of alcohol abuse and alcoholism as well as drug abuse.".

(c) Section 410(b) is amended by adding at the end thereof the following new sentences: "For carrying out the purposes of this section, there are authorized to be appropriated $20,000,000 for the fiscal year ending September 30, 1982. Of the funds appropriated under the preceding sentence, at least 25 percent of the funds shall be obligated for grants and contracts for primary prevention and intervention programs designed to discourage individuals, particularly individuals in high risk populations, from abusing drugs.".

(d)(1) Section 410(c)(1) is amended by striking out ", or to State agencies over local agencies".

(2)(A) The first sentence of section 410 (c)(2) is amended by striking out "designated or established under section 409" and inserting in lieu thereof "responsible for the administration of drug abuse prevention activities".

(B) The third sentence of such section is amended—

(i) by striking out "the" before "State comprehensive plan" and inserting in lieu thereof "any"; and

(ii) by striking out "under section 409".

(3) Section 410(c)(3) is amended—

(A) by inserting "and" after the semicolon in clause (B);

(B) by striking out the semicolon and "and" at the end of clause (C) and inserting in lieu thereof a period; and

(C) by striking out clause (D).

(e) Section 412(d) is amended to read as follows:

"(d) The Secretary shall encourage the submission of and give special consideration to applications under this section to programs and projects aimed at underserved populations such as racial and ethnic minorities, native Americans, youth, the elderly, women, handicapped individuals, and families of drug abusers.".

(f) Section 410 is further amended by adding at the end thereof the following new subsection:

"(g)(1) No grant may be made under this section to a State or to any entity within the government of a State.

"(2) No grant or contract may be made under this section for a period in excess of five years.

"(3) The amount of any grant or contract made under this section may not exceed 75 percent of the cost of carrying out such grant or contract project.".

RECORDS AND AUDIT

SEC. 207. Section 411(a) is amended by striking out "409 or".

ENCOURAGEMENT OF RESEARCH DEVELOPMENT

SEC. 208. (a) Section 503(a) is amended—

(1) by striking out "and" after the semicolon in clause (3);

(2) by striking out the period at the end of clause (4) and inserting in lieu thereof a semicolon and "and"; and

(3) by inserting after clause (4) the following new clause:

"(5) drug prevention, treatment, and rehabilitation.".

(b) Section 503(b) is amended by striking out "and" after "1978," and by inserting after the period a comma and "and $50,000,000 for the fiscal year ending September 30, 1982".

TECHNICAL AMENDMENTS

SEC. 209. (a) Section 205 is amended by striklinf out "Health, Education, and Welfare" and inserting in lieu thereof "Health and Human Services".

(b) Section 302 is amended by striking out "Health, Education, and Welfare" and inserting in lieu thereof "Health and Human Services".

(c)(1) Section 405 is amended by striking out "Health, Education, and Welfare" each place it appears and inserting in lieu thereof "Health and Human Services".

(2) The section heading for section 405 is amended by striking out "Health, Education, and Welfare" and inserting in lieu thereof "Health and Human Services".

(3) The item relating to section 405 in the table of sections for title IV is amended by striking out "Health, Education, and Welfare" and inserting in lieu thereof "Health and Human Services".

(d) Section 408(g) is amended by striking out "Health, Education, and Welfare" and inserting in lieu thereof "Health and Human Services".

(e) Section 501 is amended by striking out "Health, Education, and Welfare" and inserting in lieu thereof "Health and Human Services".

Senator HUMPHREY. We have three panels of distinguished witnesses who will be helping us this morning. I shall try to conclude the hearing this morning around 12 o'clock, if possible. We will have to play it by ear, but I would hope that the witnesses will bear that in mind so that those who will follow them will get a fair opportunity to air their thoughts.

Our first panel is comprised of John R. Doyle, chairman of the board of directors of the National Council on Alcoholism; Dr. R. Keith Simpson, president of the National Council on Alcoholism; Dr. Sheila Blume, president of the American Medical Society on Alcoholism; and Judith Johnson, executive director of the National Coalition for Jail Reform, Washington, D.C.

STATEMENT OF JOHN R. DOYLE, CHAIRMAN, BOARD OF DIRECTORS, NATIONAL COUNCIL ON ALCOHOLISM; DR. R. KEITH SIMPSON, PRESIDENT, NATIONAL COUNCIL ON ALCOHOLISM; DR. SHEILA BLUME, PRESIDENT, AMERICAN MEDICAL SOCIETY ON ALCOHOLISM; AND JUDITH JOHNSON, EXECUTIVE DIRECTOR, NATIONAL COALITION FOR JAIL REFORM, A PANEL.

Mr. DOYLE. Mr. Chairman, on behalf of the National Council on Alcoholism, if it please the Chair, I would like to have Dr. Keith Simpson lead off. We are going to present ourselves in such a way we hope not to be repetitious and within the spirit of the remarks you have just made.

Senator HUMPHREY. Fine. Have you all discussed that order of precedence and it's agreeable to everyone?

Mr. DOYLE. Yes.

Dr. SIMPSON. Good morning, Mr. Chairman, the National Council on Alcoholism is pleased to appear before this subcommittee concerning the bill to reauthorize the National Institute on Alcohol Abuse and Alcoholism.

The National Council on Alcoholism is a private voluntary organization representing thousands of citizens throughout the country who volunteer time and resources to help the person and the family with alcoholism and prevent the harm that this disease causes in their communities.

NCA is comprised of about 230 local affiliates with a national board of directors, of which I am president.

The national voluntary movement is critical to the existence of the program being considered by this subcommittee, having played a key role in the establishment of NIAAA 10 years ago and in its continuation of programs since.

There are a number of concepts embraced in the proposed legislation to reauthorize NIAAA which NCA strongly supports. First is the continuation of NIAAA as a separate Institute. This is fundamental and critical to the field. Any diffusion of focus or resources at the national level through combination of the program with drug abuse or mental health will set back the progress that has been made in the community and in the scientific world in their acceptance and understanding of alcoholism as a specific disease entity.

We also appreciate the extension of NIAAA research activities, continuation of the uniform act grants and authorization of a demonstration grant program to be administered by NIAAA.

In light of the pressures and priorities on this subcommittee to embrace the President's block grant proposal, authorization for a separate demonstration block grant program is not only a courageous move but one that recognizes that there are essential activities which are national in scope which will allow the testing of new ideas that must be conducted by the National Institute. This is a concept that NCA strongly supports and one which has, we believe, already proven its effectiveness in the short history of the Institute.

We would like to urge you, Mr. Chairman, to reconsider your decision to seek only 1 year's reauthorization of this Institute.

We appreciate your desire to conduct oversight hearings and we look forward to the opportunity to bring the field up to date on the accomplishments of the Institute. But I submit that the logistics alone of having to conduct these oversight activities and having to reauthorize the program at the same time next year will impede rather than enhance your and your staff's ability to accomplish that goal.

But more importantly, States, communities, and our volunteers look to you for strong commitment to alcoholism through continuation of this Institute as a viable national program. A 1-year extension does not send that message to our communities, to medicine, and to science.

We strongly urge that you reconsider that provision in this legislation. Please do not run the risk of losing the collective gains we have made in the community by sending a message of ambivalence about alcoholism.

Now, concerning the block grant proposal, NCA strongly supports the concept of returning financial and management responsibilities for federally assisted projects to the States, but we believe that there are some grave implications for alcoholism services in the consolidated block grant proposal as we now understand it.

First, there is no means of assuring that allocations of dollars will be used to provide alcoholism services. The grant also takes the services component out of NIAAA, driving a wedge between knowledge development activities at the Federal level and services in the community.

How can assessments be made of services and grants identified, or effectiveness of service approaches tested if there is no traceable link from the services in the community to the National Institute?

We feel that both services and knowledge development activities will suffer as a result. As an alternative to the block grant program as proposed, we suggest the designated grant to States be administered by NIAAA, but with minimal administrative or costly reporting requirements.

We also suggest these grants be matched dollar for dollar at the State level so that the goal of the Federal dollar is to serve as an incentive and not a subsidy. Recognizing this is a very difficult time to make a decision about the Federal role in human services, we are not calling for more Federal dollars to support these activi-

ties; business and industry can finance them through insurance coverage or appropriation of State funds.

We do call for retention of those national knowledge development activities which cannot yet be done in a cost-effective manner by the States. In this regard, we applaud the continuation of the demonstration authority of NIAAA and the continuation of categorical research activities. NCA supports the recommendations of the National Academy of Science's Institute on Medicine, which calls for an even higher priority for research in alcoholism. A copy of that report is submitted for your consideration along with a more detailed statement from NCA.

[NOTE.—The report referred to may be found in the files of the subcommittee.]

In closing, I would like to remind this subcommittee of the success of this important national program on alcoholism by citing a few examples of programs which have literally exploded in the private sector in the last 10 years. A great deal of the incentive for these activities came from our national program, NIAAA, and all are evidence of the fact that treatment of alcoholism produces results.

The latter statement, the treatment produces results, is one now which we can bring hard data to you to demonstrate.

When we would make an appearance of this nature 10 or 15 years ago, the program had a lot of blue skies to fill. We had our convictions and we were trying to sell our product on credibility. But in the past years we have had a lot of treatment programs assisted through insurance companies and business and industry. The remarkable thing is there is a very good chance that medicine—and I use the word in the broadest sense because the body of knowledge on alcoholism does not reside in physicians, it rests in alcoholism counselors, but the field of alcoholism now can do a better job in the treatment of alcoholism than probably medicine can do with any other chronic disease.

As far back as the 1950's Carl Menninger stated that persons involved in a recovery program came out the other end a lot more intact, more functional and a more integrated person; in other words, it's the only disease of which I know that one comes out of the other end better put together than before you got the disease.

So in recovery statistics, regardless of where you get them, you would find between 70 and 80 percent of the people can expect to get better. Airline pilots have the highest statistic at 85 percent. I happen to have two 747 pilots and a DC-10 pilot, and six 737 pilots as patients back in my out-patient clinic in Newport Beach, Calif.

The enlightened attitude of the major airline companies is quite significant. We have a fellow who presented himself as a first officer; he went into treatment with the company's full knowledge and support and filed for his exemption, and during that period of time he was promoted to captain.

The incentive of the pilot to get well and stay well is immense. I have heard figures of up to 85 percent, if you use a conservative figure or if you use a figure that physicians, who see the majority of these pilots applying for exemption, it is 85 percent.

So recovery is not an issue as much any more. We have other problems. The cost effectiveness is no longer debatable. In other

words, we have organizations such as General Motors in major retrenchment and selling a lot of their assets. Even with people laid off, they have not laid a glove on their alcoholism programs because they can prove these programs save them money.

There are programs in the public sector such as the Postal Service, and the U.S. Navy and again we have data available which shows a $2 to $3 savings for every dollar spent. In the private sector you will hear figures quoted for every dollar spent in occupational alcoholism programing they get $8 back.

In one instance with a multinational company, they are coming out with a paper this year saying they get $20 back for every $1 they put in The cost effectiveness is there, plus an increase in productivity.

Interestingly enough, the ALPA program began with a NIAAA seed grant.

There is a role for the Federal Government, as I have explained. In addition to that there are people at the State, city, and county level, who simply don't have access to health care systems for a variety of reasons. I visited a program, at St. Vincent DePaul in Portland, Oreg. last year, which takes care of people on skid row, basically, and their program costs around $14 a day. They have a $137,000 NIAAA grant. People at this level, in this kind of programing are not going to be able to at the commencement of next fiscal year make the type of effort to enable them to compete at the level they should to grab the moneys that are coming down, and there is some $80 million to be put in the block grant and to compete for.

As you might guess, they are quite busy doing what they are doing with reduced staff, and they are going to lose. I witnessed this in Des Moines where I used to live, and we got a fair amount of money appropriated by the legislature on "may," not "shall" wording in the bill, for alcoholism and a great number of the communities around Des Moines dedicated most of that money to alcoholism. We had a good political base and we were able to compete successfully for it. In Boone, Iowa, they chose to buy a fire truck. Well, that is all right because Boone could send their patients to Des Moines and get treated at no charge.

The type of infrastructure at the grassroots level needed to compete successfully for most money, if they are included in a block grant, is not in place yet. I have seen nothing in my 19 years of experience in this field to indicate that there would be any assurance that the money dedicated to alcoholism originally provided by the program would be spent for alcoholics and services. We need some time there, honestly. We don't have all the answers and some of the answers we do have need to be tested and replicated and refined, but this is one role that the Federal Government can play in the area of demonstration and applied research in addition to the vital need for continued biomedical research and clinical training to which Dr. Blume will speak later.

I thank you very much for this opportunity to address you.

[The prepared statement of the National Council on Alcoholism as presented by Dr. Simpson, follows:]

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Statement of the

National Council on Alcoholism

concerning

"A bill to revise the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 and the Drug Abuse Prevention, Treatment and Rehabilitation Act."

before the

Subcommittee on Alcoholism and Drug Abuse

Gordon J. Humphrey, Chairman

March 25, 1981

80-616 O—81——2

The National Council on Alcoholism is grateful for the opportunity to testify before the Subcommittee on Alcoholism and Drug Abuse concerning revisions to the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970.

NCA is a private voluntary organization representing thousands of citizens throughout the country who volunteer time and resources to help alcoholics and their families, and to prevent the harm that alcohol abuse and alcoholism create in their communities. NCA is comprised of 230 local councils on alcoholism, and a national board of directors which includes individuals of prominence in business, industry, government, medicine and science. The national voluntary movement is critical to the existence of the program now being considered by this Subcommittee, having played a key role in the establishment of the National Institute on Alcohol Abuse and Alcoholism ten years ago, and in the continuation of its programs since.

The Federal program on alcoholism and the National Institute on Alcohol Abuse and Alcoholism must be continued. Since its creation, NIAAA, through its research, training and treatment services programs, has contributed dramatically to the growth of public and private resources for alcoholism. Throughout this country, breakthroughs in research have saved lives, and have prevented unnecessary death and injury. Training programs for physicians and health professionals have advanced the field years ahead of where it once was, and enabled earlier identification and more effective treatment of this disease. Education programs have helped men, women and young people to make healthier choices about drinking.

Technical assistance and demonstration projects have shown private industry ways to save billions of dollars through employee assistance programming. Assistance to States has contributed to the birth of comprehensive State service systems with services ranging from prevention to community-based treatment. Incentive grants have been useful in efforts by States to provide comprehensive services following decriminalization of public drunkenness. Through their affiliation with self help groups, NIAAA treatment grants have contributed to the growth of self help for alcoholics and their families throughout the world. The unique treatment needs of minorities and other underserved groups have been explored, and programs established to meet their needs. High quality technical information on insurance coverage has assisted many States in removing financial barriers to needed treatment services through insurance coverage. National clearinghouse, information and data systems have been a cost effective means of obtaining necessary information on alcoholism problems, and sharing it among States and communities.

Many of these activities are new, and the successes recent. It is absolutely critical that we continue to learn more and to do more about the disease of alcoholism, and that leadership at the national level continue with authority in the even more critical years ahead. These successes must continue to unfold.

There are aspects of the draft legislation before this Subcommittee which will contribute in a limited way to the growth in national awareness and capacity to respond to the problems of alcohol abuse and alcoholism. There are many more aspects of the draft legislation which are a threat to this capability.

NIAAA

Continuation of the National Institute on Alcohol Abuse and Alcoholism as a separate entity within the Department of Health and Human Services is a necessary part of our national response to alcoholism, and an important feature of the draft legislation. Any diffusion of focus or resources at the national level, through combination of the program with drug abuse or mental health, will set back progress that has been made in the community, in the scientific world and in education to increase awareness and acceptance of alcoholism and alcohol-related problems.

However, one year is too short an extension on the life of this important program. NCA appreciates the desire of the Chairman to conduct oversight hearings on NIAAA in the coming year, but this need not limit its reauthorization to one year. Reauthorization of NIAAA should be for four years, through fiscal year 1985. The alcoholism field, in both the public and private sectors, will benefit from a strong commitment from the Congress on the continuation of NIAAA. Any weakening of the national leadership at this critical juncture in human services will hurt progress at the State and local level in combatting this problem.

Research

Continuation of the research activities of NIAAA is an important feature of the draft bill, but one year is an insufficient period of reauthorization. Research activities must be recognized as a continuous process, not one that can be adapted to rapidly shifting economic or political conditions and be expected to remain productive.

One of the Institute's most important achievements is the organization and funding of research programs. The research effort, though samll in relation to the job to be done, has improved the outlook for those impaired by the medical consequences of drinking. The effects of alcohol in the liver have been well described and are now beginning to be understood. Rational treatment for the life-threatening liver damage is in sight. Research on alcohol and endocrine systems, particularly testosterone, has uncovered severe disorders of reproductive function, previously unrecognized, which are part of the misery of alcoholism.

The etiology is being unravelled; procedures for therapy and prevention may be expected to follow. Investigations on the brain are still in the descriptive stage, but research proceeds in the National Alcohol Research Centers and the many extramural laboratories funded by NIAAA. Surely much more medically and socially useful information will emerge, as it has in so many other fields of research.

Within limited Federal resources, NCA believes that there must be a higher priority for the development and sharing of urgently needed knowledge about alcoholism and alcohol-related problems. In spite of the growth of the treatment system, and advances in knowledge, we are still lacking in knowledge about the causes of alcoholism; its effects on physiology; what kinds of treatment are most effective; prevention strategies that are effective for various age and population groups; what are reasonable costs of treatment; and what are reasonable outcomes of treatment. Knowledge is needed to successfully make the case for needed changes in reimbursement policies in programs such as Medicare and Medicaid, as well as private insurance programs.

Alcoholism is a leading cause of death and illness in this country, behind only cancer and heart disease. Yet this country spends only one one-hundreth on alcoholism research what is is spent on cancer relative to the social and economic impact of the disease.

A recent report of the Institute of Medicine of the National Academy of Sciences produced an extensive review of alcoholism programs by prominent scientiests. This report concluded that support of alcoholism research is "disproportionately low relative to the estimated economic impact", and called for a greater portion of the resources within NIAAA to be allocated to research. Specifically, the study stated that appropriations should be increased by fifty percent in each of the next three years. NCA stongly concurs in this recommendation, and urges that authorizations be increased accordingly. The report of the National Academy of Sciences on alcoholism research is included for the Subcommittee's hearing record.

While States do have the capability to raise money for treatment services, either through appropriations, mandated insurance or special taxes, with few exceptions they do not have the capability to conduct research, to test new ideas, or collect data on the cost and effectiveness of treatment programs. This is especially true in prevention, which is such a needed initiative in this nation.

Leadership at the national level will be much more effective if instead of committing a major portion of its resources to subsidizing primary care, it can provide the base of knowledge which volunteers and others need to make the case for alcoholism programs in the minds of decision-makers in government, business, medicine, science and the community.

A new policy of the Reagan Administration to limit research activities to biomedical studies alone deserves this Subcommittee's attention. Termination of research on the social and psycholical aspects of alcoholism and alcohol abuse will place impossible limits on the ability of the Federal research program to achieve its stated purpose. Studies of tissues and cells are far from sufficient to develop the knowledge needed to effectively treat and prevent this disease. Therefore, NCA urges the Subcommittee to strengthen the authorities for psycho-social research contained in the existing law, and consider the establishment of a mandatory research program on psycho-social issues.

One of the areas of the least knowledge in alcoholism research is on the effects of alcohol and aging. Because of the rapidly growing segment of the population which is reaching old age, NCA strongly supports a high priority for research in this area. A strong, coordinated research program is needed to study the physiological aspects of alcoholism and aging, histories of late on-set drinking among older people, effective treatment modalities, and the effects of life-course events on drinking by older people. This program should be conducted by a high quality core of scientists, working in conjunction with both NIAAA and the National Institute on Aging.

Assistance to States

The draft legislation proposes repeal of existing State formula grant and State planning authorities, on the assumption that all services will be supported by means of a consolidated health services block grant to States as proposed by the Reagan Administration. The National Council on Alcoholism believes that the Federal government should commit a portion of its resources to assisting States and communities to develop needed alcoholism services, but opposes the consolidated block grant as the means for doing so. Although the lessening of direct Federal control over community projects and a shifting of financial and management responsibility to the States is one which NCA strongly supports, a consolidated block grant will be disasterous to the alcoholism service system as it has grown in the past 10 years.

Among the grave implications of this block grant, repeal of the State plan authorities removes the Federal mandate for States to provide any alcoholism services with the Federal dollars that they receive for this purpose. Some assurance and accountability must be maintained.

Also, the method of allocation of the proposed grant is one which is not equitable among States. It favors those who have historically been successful in tapping Federal grant programs, and does not reflect recent shifts in population. The block grant would end NIAAA's capability to conduct national projects which cannot be done in a cost-effective manner by individual States. Activities such as national studies and evaluation, information systems and national prevention campaigns could not be performed.

The timing of the proposal is also not good. The beginning of fiscal year 1981 is only six months away. Yet many State legislatures have already adjourned, and by the time Congressional action could be complete on authorizations and appropriations for the block grant many more will have adjourned. Those which have not adjourned will be far beyond the point of being able to reallocate dollars under the block grant. The inability of most States to make up funds for this program immediately, coupled with the promised reduction in Federal dollars, will create disruption of services throughout the community. Elimination of the formula grant program funding alone will result in the immediate displacement of 1,200 public service programs, which are serving nearly 1.5 million people.

One of the most critical faults of the block grant proposal is the removal of any link between the services component of the Federal alcoholism programs and the research and knowledge development components of NIAAA. Without communication among these activities, the quality of both services and research will suffer as a result. And, removal of the services component from NIAAA would in all likelihood remove it from the jurisdiction of this Subcommittee, thereby depriving a needed means of oversight and opportunities to improve the program.

The Federal government should commit a portion of its resources to assisting States to develop comprehensive alcoholism services programs, because this incentive has been and will continue to be critical to the development of service systems. NCA hopes this will be accomplished in a manner which will at the same time assure accountability and provide the greatest flexibility for States to make decisions about the use of the funds, with a minimum of red tape.

NCA recommends that the Subcommittee retain the authority for a targetted categorical grant to States under Section 301. Grants should be administered by NIAAA, but given directly to States on the basis of population, and upon receipt of a simple proposal every three years outlining the intended use of the monies. Federal requirements for the grant need be limited to targetting of the funds for alcoholism services, and State match of the funds received.

In order to provide an incentive to State and local financing of services, as well as their management responsibilities, NCA believes that there should be a requirement for States to match the Federal grants to States dollar for dollar. The purpose of the Federal dollar is as an incentive to State and local program development. It is not the Federal government's responsibility alone to carry the burden of maintaining and financing a system of public services. By requiring matching of the Federal grant, the Federal investment is worth more.

Demonstrations

NCA strongly supports the retention of a demonstration grant program at NIAAA as is proposed under Section 311 of the draft bill, and urges that this be authorized through fiscal year 1985. Because new and innovative projects are those least likely to find immediate community support, demonstration projects should be entitled to receive the total cost of the project in the first year, but Federal assistance should decline in every year for the duration of the grant rather than be maintained at a 75 percent level as proposed in this bill. A funding policy on services and demonstrations which requires State and local involvement as a condition of receiving Federal dollars is long overdue. Experience has shown that programs supported by the community and State and local government are those most likely to survive; programs built only with Federal dollars are houses built of straw. By the final year of funding, a demonstration project should be receiving no more then 30 percent of its funds from the Federal government.

NCA supports the requirement that 25 percent of demonstration projects be for prevention, through outreach, intervention and education. As a result of growing incidents of addition to alcohol and other drugs, projects now funded by NIAAA are often serving clients suffering from both addictions. NCA does not object to the provision which would allow NIAAA demonstration projects to serve drug abusers as well, however, in recognition of the differences in clinical needs, client populations, and the need to maintain the integrity of alcoholism services, any project funded under this authority should have as its primary focus alcoholics and their families.

In order to make the demonstration program most valuable, a strong emphasis must be maintained on evaluation, especially in the area of prevention, and on the efficient transfer of knowledge gained in these projects so that new and innovative ideas may be put to use in other communities.

Uniform Act

Extension of the Uniform Act grants is an important feature of this bill, and one which should be continued for four years. NCA points out to the Subcommittee that there is a need for a national assessment of the impact of the Uniform Act grants, and the extent to which States and the Federal government have met the needs of the public inebriate.

In addition to the points mentioned above concerning the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970, NCA asks that the Subcommittee consider the authorization of the White House Office on Alcoholism Policy, with responsibility for coordination of alcoholism prevention, treatment, and research programs and policies.

The Federal role in the development of occupational alcoholism programs in the private sector must be limited to technical assistance and consultation. There have been several incidents in which Federally subsidized occupational programs have supplanted opportunities for private programs in business and industry.

NCA supports an increase in authorized spending for the National Commission on Alcoholism and Alcohol-Related Problems, and suggests that two issues be added to the Commission's mandate: 1) an assessment of the effectiveness of Federal and State efforts to meet the needs of the public inebriate; and 2) an exploration of the unmet service and research needs of elderly alcoholics and their families.

The National Council on Alcoholism is grateful for the opportunity to present this statement concerning reauthorization of the National Institute on Alcohol Abuse and Alcoholism.

Senator HUMPHREY. Thank you, Dr. Simpson. I will certainly want to ask you some questions.

I think probably the best thing is just to go forward and ask everyone for their statement and then go into questions.

I should have mentioned at the outset, Senator Don Riegle, who I am sure is well known to all of you, intends to be here. We are expecting him shortly. He is the ranking member of the subcommittee.

Dr. Blume.

Dr. BLUME. Good morning and thanks for having me here.

I, like Keith, have spent the 19 years of my psychiatric career devoted to the study and treatment of alcoholism. I am currently director of New York State's Division of Alcoholism and Alcohol Abuse, and a member of the National Commission on Alcoholism and Other Alcohol-Related Problems.

But I am testifying today as president of the American Medical Society on Alcoholism. AMSA is an organization of over 800 physicians nationwide with a special interest in the prevention and treatment of alcoholism. We are the medical arm of the National Council on Alcoholism.

We meet today at a time when the role of government, particularly the Federal Government, in the affairs of our citizens is undergoing a critical reevaluation. It is within that context that AMSA would like to make the following points:

First, I agree, Senator, we don't need to debate the importance of alcoholism as a public health issue. I simply remind all of us that the White House Conference on Families placed alcohol abuse, with a 92.7 percent vote, right at the top of its list of critical problems for the American family, to which all of us look for the leadership of tomorrow's generations.

The second point I would like to make, as both you and Keith said in your introduction, is that in the past decade we have made absolutely enormous progress, thanks very much to the leadership of NIAAA, for example, in determining models of treatment and prevention.

In other areas such as manpower development NIAAA has also led. In New York, for example, we have issued nearly 800 counselor credentials and we have additional people in the application process. That initiative was directly due to NIAAA's leadership in developing alcoholism counselor criteria.

Advances in data dissemination and collection, research, studying funding mechanism, health insurance coverage, and perhaps most important, in humane treatment of suffering people, for example, decriminalization, have been directly due to NIAAA leadership.

The third and most important point is that we must recognize that the current alcoholism service system is not strong enough, not well enough developed or established, particularly in its funding sources, but also in knowledge and in accessibility, to survive without federal participation and Federal leadership. In the area of basic and applied research, the Federal Government is the only possible support for nationwide efforts concerning this problem. Let me give a few examples in areas of special concern to AMSA.

Adequate and appropriate medical care for alcoholics and their families is perhaps our first interest as a medical group. The physician is in an ideal position to be the person who recognizes, alcoholism, diagnoses and initiates treatment. For example, in the latest Alcohol and Health report, in passing, it is mentioned that in one study 70 percent of the alcoholics who entered treatment had been to visit their private physicians in the previous year. Yet we are all aware today that physicians in practice, even those who will be graduating next month from medical school, are not prepared to recognize these cases, make an early diagnosis and initiate treatment.

We also must realize that the only long-range solution to this problem is adequate and appropriate medical education about alcoholism. Now NIAAA has been active in this area both in the career teacher program which it shares with NIDA and in a new initiative to bring alcoholism teaching into family practice residency programs. We understand that there is an administration proposal to phase out these programs by the end of 1983. I think that would be a tragic mistake. Rather than be phased out, I think such programs should be extended so that every specialist, especially in primary care, is prepared to diagnose and initiate treatment for alcoholism.

We know today that alcohol-related birth defects, particularly the fetal alcohol syndrome is the third most common cause of mental retardation due to birth defect, and the only one of the top three which is preventable. Yet we won't prevent this tragedy until physicians are prepared to diagnose alcoholism in women of childbearing age, something they are not prepared to do today.

I don't think we can afford to relax our efforts in medical education. The price in health care and human waste is too high. We need a Federal leadership in that area.

The next subject I would like to consider is in efficacy of alcoholism treatment. In my written testimony there are many examples of how valuable and effective treatment programs are at every level. I would like particularly to call to your attention a study in a health maintenance organization setting which demonstrated that while a group of alcoholics and their families showed a reduced health care utilization in the 2 years following treatment, a similar group of untreated alcoholics and their families showed a 56-percent increase in health care cost. Now we need a strong Federal initiative to continue making such studies and bringing this to the attention of the Nation, because we have not yet arrived at a stable system.

In New York State, for example, we don't have the required health insurance coverage for alcoholism. A person who may be working, supporting family and paying for health insurance for years, finds himself medically indigent as soon as he goes into alcoholism treatment. We have not yet arrived at the point where alcoholism is treated like other diseases.

Another area of interest for AMSA is research. In recent years we have all seen a tremendous payoff from research in heart disease. We have seen changes in American diet and exercise patterns and they have been very helpful.

Alcoholism research, although it has been chronically underfunded, as the Institute of Medicine study demonstrates in tables and charts, is now reaching a point when we can expect payoffs, particularly in the area of genetics and of the effect of alcohol on the body. Research on risk factors may within the next few years enable us to identify beforehand those people who have a predisposition to alcoholism. That would be tremendously helpful.

In studies of the male hormone testosterone, the effects of alcohol on the male reproductive system and on the human sperm, we are reaching a point where we may have a payoff within the next few years. That research must continue.

For research to continue, however, it needs the backup of systematic literature collection, and dissemination which NIAAA has supported and must continue to support or the research will not continue.

I would like to point out an excellent example of NIAAA leadership in connection with the volunteer sector (NCA) in research: Studying the harmful effects of alcohol on the fetus. The discovery of these effects was made only 8 years ago, a very short time ago. The follow up of that discovery was directly due to NIAAA leadership with a push from the National Council. That area has developed very strongly, and, resulting knowledge has now been disseminated. Public policy, based on research findings, has informed people about alcohol and pregnancy. That would not have happened had research and public policy been administered by different agencies and coordination of priorities had not been possible.

AMSA would like to see the authority and responsibility for alcoholism research remain in NIAAA so that kind of coordination and leadership will survive.

I finally have a few remarks on the relationship between organized treatment and Alcoholics Anonymous, answering the question, "If A.A. is out there, why do we need alcoholism treatment?" This is all in the written testimony. If you like, I can comment on it.

Senator HUMPHREY. Yes, if you will.

Dr. BLUME. The relationship between A.A. and the treatment community has been one of hand-in-hand working together. Bill W., the founder of A.A., derived many of his ideas and concepts from to physicians who worked with him and supported his ideas. Later in his own career, after years of sobriety, Bill W. went into psychotherapy and profited from it. What Bill W. and A.A. members have told us is that medical treatment alone often doesn't lead to recovery from alcoholism, not that medical treatment is unnecessary. The A.A. literature points out many functions that A.A. cannot and will not do, for example, detoxification, medication, diagnosis, and treatment of physical and mental illness, marital counseling, and others.

Today, most if not all alcoholism programs work cooperatively with A.A. A.A. members will hold meetings for patients at the program site and welcome them into local meetings. A.A. members are often the primary stimulus for program development. For example, I led a program on Long Island for 15 years. That program, which goes back to 1962, owes its existence to a group of A.A. members in the community who saw the need for an in-patient

program and worked with State authorities to get it going. Most of the patients I saw in those years had already been to A.A., but for some reason had not been able to work with the program, and sought treatment.

Finally, many treatment staff members are themselves recovered alcoholics who know A.A. through personal experience. This group includes physicians and nurses as well as alcoholism counselors, who Keith said have been the backbone of alcoholism treatment.

Therefore, A.A. and alcoholism treatment are not an either/or but work hand in hand for the recovery of the individual and the family.

There are many other areas with which AMSA is concerned but let me just finish by saying that some leaders have said, in the economy of 1981 that our Nation cannot afford to treat alcoholism. On behalf of AMSA and myself, I would like to say that we cannot afford not to.

[Dr. Blume's prepared statement follows:]

Testimony for the United States Senate
Subcommittee on Alcoholism and Drug Abuse

by Sheila B. Blume, M.D.
President, American Medical
Society on Alcoholism
March 25, 1981
Washington, DC

Good morning. I am grateful for your invitation to speak here today. As a physician and psychiatrist involved in the study and treatment of alcoholism for the past 19 years, I am director of New York State's Division of Alcoholism and Alcohol Abuse and a member of the National Commission on Alcoholism and Other Alcohol-Related Problems. I am testifying today in my role as president of the American Medical Society on Alcoholism, medical arm of the National Council on Alcoholism, and a nationwide organization of more than 800 physicians with a special interest in the prevention and treatment of alcoholism.

We meet today at a time when the role of government, particularly the federal government, in the affairs of our citizens is undergoing a critical re-evaluation. At such a time, AMSA would like to make the following comments on the federal role in combatting the vast array of serious alcohol problems faced by our nation.

First, I believe we will all agree that alcoholism is one of the primary public health problems in America today. The statistics are overwhelming and undisputed; but translating from numbers on a page to the extraordinary suffering of men, women and children caught up in the dreadful disease of alcoholism, and in its physical and social damage: cirrhosis of the liver, cancer, heart disease, injury and death on the highway, mental illness, suicides, family violence and the like, we can not, sitting here today, begin

to imagine the breadth and depth of human pain that my medical colleagues and I see every day. I would also point out, for example, that the White House Conference on Families placed alcohol abuse with a 92.7% vote at the very top of its list of priority problems for the American family, the institution to which we all look for the strength of our future generations.*

The second point to consider is that enormous progress has been made in the past decade directly attributable to federal leadership: in the development and evaluation of models of prevention and treatment, in collection, evaluation and dissemination of critical data, in research, in manpower development and training, in initiatives aimed at developing stable funding mechanisms such as health insurance coverage, and in stimulating advances in humane alcoholism care at the state and local level such as the decriminalization of public intoxication.

Thirdly and perhaps most important, we must recognize that the current alcoholism service system, although far ahead of where it was in 1970, is not yet well enough established and developed; not in basic knowledge, not in treatment methods, not in accessibility to all in need of care, and not in achieving stable financing; to survive on its own if the federal leadership role were withdrawn or substantially crippled. In both basic and applied research the federal government is the <u>only</u> possible source of significant support.

Allow me to cite a few examples in areas of special concern to AMSA:

* Listening to America's Families, a summary, White House Conference on Families, 1980, page 16

Adequate and appropriate medical care for alcoholics and their families is one of our chief goals. The physician is an ideal position to recognize and diagnose the alcoholic patient and to begin treatment. Over 70% of alcoholic men and women were reported to have made one or more visits to their private physician in the year before beginning alcoholism treatment.* Yet we are well aware that most physicians in practice today are unprepared and unequipped to make this diagnosis early, and that millions of Americans are still treated annually for the complications of alcoholism without effective attention to the underlying disease. The only long term solution to this problem is adequate and effective alcoholism education in the medical schools: at the undergraduate, post graduate and continuing education levels. Although we are far today from having achieved this goal, the National Institute on Alcohol Abuse and Alcoholism's (NIAAA's) leadership through its medical school career teacher program has contributed immensely to curriculum development and has established a small but growing number of dedicated experienced teachers. NIAAA's recent initiative in grants to family practice residency training programs to develop alcoholism teaching is another very positive step. AMSA understands that there is a proposal now under consideration to eliminate all such training grants by 1983. This would be a tragic error. Rather than eliminating these stimuli to medical education, the family practice incentives should be extended to cover the training of <u>all</u> specialists, particularly internists, pediatricians, and others in primary care. The fetal alcohol syndrome is now considered the third most common cause of mental retardation associated with birth defect in the United States; and the only one of these

* DHHS: Alcohol and Health: Fourth Special Report to the US Congress, January, 1981, page 199

three that is preventable. We cannot reduce the cost to society of alcohol-related birth defects unless obstitricians and other health professionals diagnose alcoholism in women of childbearing age and intervene effectively, something they are not today able to do. Ladies and gentlemen, we cannot afford to relax our efforts in medical education. The cost in unnecessary health care and in human waste is too high.

An article on this subject in the latest issue of the Harvard Medical Alumni Bulletin is attached for your information.

Alcoholism is a treatable disease, and alcoholism programs are effective. As in any other chronic illness, the earlier treatment is instituted the better the outcome. Programs serving primarily socially stable middle-class alcoholic men and women report combined abstinence and improvement rates as high as 92%* in patients followed for 1 1/2 years after inpatient care (75% of nearly 800 patients were successfully followed). Even public alcoholism programs serving less socially stable patients produce remarkably positive results. As an example, I have attached to this testimony a 6 month follow up study of 1340 alcoholic men and women, treated in 13 New York State operated alcoholism treatment centers co-located on the grounds of state hospitals, and 3 others operated on contract by non-profit community agencies. At 6 months after inpatient discharge 60% of the patients followed had been abstinent during the previous month. The group showed much improvement on a wide variety of measures, including economic cost to society. The average patient

* Patton, M., Validity and Reliability of Hazelden Treatment Follow Up Data, Hazelden, Center City, Minnesota, 1979

cost society roughly $200 less per month. An excellent review of 11 research studies that demonstrate the impressive savings in health care costs accomplished by alcoholism treatment programs was published in December of 1979.* These studies show, for example, that alcoholism services in a health maintenance organization (HMO) setting can produce a decline in the total health care bills of both patient and family over a 2 year period while the costs for a comparison group of untreated alcoholics and their families rose by 56% over the same 2 years. AMSA has passed the appended resolution encouraging the federal government to extend the requirement for alcoholism services in HMOs beyond the present very limited care to a full range of treatment services.

A strong federal initiative through NIAAA is needed to stimulate further studies of this sort, without which alcoholism services will not become integrated into the greater health care delivery and reimbursement system. Program models still need development and testing, especially to meet the needs of special target populations. AMSA supports the language to that effect in your discussion paper but underlines the need for a greater financial commitment to this critical area.

A few words on research. We have seen in recent years a tremendous payoff from the investment in epidemiological research in the area of coronary artery disease. The dissemination of these findings has led to very positive changes in the diet and exercise patterns of Americans. Research in the

* Jones, K., and Vischi, MA, Impact of Utilization, Supplement to Medical Care Vol. 17, #12, December, 1979

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alcoholism field, in spite of the fact that it has been drastically underfunded in comparison to research in other illnesses, as documented in the 1980 report of the Institute of Medicine of the National Academy of Sciences, is reaching a point where similar payoffs may occur. Research in genetics, in basic mechanisms of alcohol's effect on the body and in the epidemiology of alcohol problems may soon allow us to identify persons predisposed to the disease and exposed to other important risk factors. Very recent research on the effects of alcohol on the production of the male sex hormone testosterone, the male reproductive system and the human sperm will soon yield practical results. The role of federal research dollars and NIAAA direction which focus specifically on critical alcoholism issues is of utmost importance. AMSA strongly recommends that NIAAA retain responsibility and authority for the federal research effort. An excellent example of NIAAA leadership is the research on alcohol's effect on the fetus which was first described in this country only 8 years ago. It is a direct result of NIAAA's efforts that an immense amount has been learned in the very brief time since that initial report, and that the knowledge gained has been brought to professional and public attention.

Basic to conducting research is the support provided by timely and efficient collection and dissemination of the alcoholism literature. We cannot afford to lose this vital NIAAA function. AMSA recommends that this function continue and that funding for research itself be increased in the amount recommended by the Institute of Medicine, as an investment in future saving.

I would finally like to make some comments on why we need organized alcoholism treatment when Alcoholics Anonymous already exists in a community. A.A. and the treatment community have always worked hand in hand. Bill W., the founder of A.A., owed both his physical survival and many of his concepts to a physician who was very supportive of his efforts. Later in life, Bill W. also underwent a successful psychotherapy. What Bill W. and A.A. members pointed out was that medical treatment alone does not often lead to recovery from alcoholism, not that such treatment is unnecessary. A.A. literature points out many functions that the organization cannot and will not do, for example: detoxification, medication, diagnosis and treatment of physical and mental illness, marital counseling and others.

Today most, if not all alcoholism programs work cooperatively with A.A. A.A. members often lead meetings for patients at the program site and also welcome them at local community meetings. A.A. is one of the primary sources of referral to many alcoholism treatment programs, and often the stimulus to program development. For example, the treatment program I directed for 15 years, the Charles K. Post Rehabilitation Unit on Long Island, owed its establishment in 1962 to a group of A.A. members who saw a need for an in-patient rehabilitation program and worked with state authorities to get it going. Nearly all of the patients who entered the Post Unit had been to A.A. previously but had not yet found lasting sobriety.

Finally, many treatment staff members in alcoholism programs are, themselves, recovered alcoholics knowledgable about A.A. from personal experience. These recovered staff members include physicians, nurses,

psychologists and social workers as well as alcoholism counselors. Thus, treatment and A.A. are not "either - or", but cooperative components in the recovery of many victims of alcoholism. Attached is an AMSA position on this subject.

There are many other areas of AMSA concern. Allow me to conclude by remarking that some leaders have said that in the economy of 1981 our nation cannot afford to treat alcoholism. I say we can't afford not to.

Thank you.

HARVARD MEDICAL ALUMNI BULLETIN - December 1980

THE ALCOHOLISM IN OUR PATIENTS

So your patient is an alcoholic. Now what are you going to do about it?

by Sheila B. Blume

Sheila B. Blume '58 is director of the New York State Division of Alcoholism and Alcohol Abuse. She recently received the "Dr. Milton Helpern Distinguished Physician's Award for Outstanding Contribution to the Field of Alcoholism."

The patient was a seaman in his 40s with tattoos of flowers and anchors on his arms. He was referred to the neurology clinic because of a recent history of convulsions. I, as a third year Harvard medical student nearly twenty-five years ago, completed my first workup, examination, and diagnosis: alcohol withdrawal seizures, also known as "rum fits." I recall the praise from my instructor and the pride I felt as we discussed the findings with the patient. Rum fits. That was all. Neither I nor my mentor felt any responsibility for the treatment of the man's alcoholism. That, somehow, was *his* business.

Much of our medicine at HMS in those days was learned from alcoholics, of which Boston was said to have an abundant supply. Medical workups often began, "This 53 year old alcoholic . . ." (or sometimes "ethanolic," to be cute). We looked upon the alcoholism as a given attribute of the individual — like age, sex, or nationality. It was quite different from the term "diabetic," which implied medical responsibility for diagnosis, assessment, regulation, and management.

I occasionally think about that seaman I met so many years ago. He had cleaned up and dressed up for the appointment. He was frightened, as most of our patients are, and consequently more amenable at that moment to sympathetic intervention into the progress of his alcoholism than perhaps at any other time in his life. I missed that golden opportunity as I missed countless others in the men and women I treated when I was a student. When I think of him and the others it is with the hope that they somehow were able to find the help they so desperately needed — the help that I and my colleagues had failed to provide.

Today, almost twenty-five years later in spite of the greater availability and effectiveness of alcoholism treatment, there is evidence that the medical profession continues to miss these

opportunities for intervention.[1] I believe there are a number of factors that interact to sustain the status quo.

The disease concept: an uneasy acceptance

Although the idea that alcoholism is a disease (or illness, or syndrome) has been with us since Benjamin Rush in the late eighteenth century, and is subscribed to by most physicians, alcoholism is thought of differently than other diseases. Other illnesses "happen to people." Alcoholism is considered self-inflicted, a product of "lifestyle," and thereby it retains its societal moral stigma, even in the consulting room. This makes the physician uncomfortable in suspecting an alcohol problem in his middle or upper class functioning and paying patients, and even more uncomfortable in confronting the patient in whom the problem is obvious.

I find the "self-inflicted" argument quite curious. If a youngster slips and fractures his ankle on the basketball court, we do our utmost to provide the best possible care. We would hardly think of dismissing that problem as self-inflicted, even though nobody forced him to play basketball. Participation in sports is a socially approved activity and involves a known risk. We treat its casualties with care and compassion, and include them in health insurance coverage. Drinking alcohol is also a socially approved and strongly promoted activity in our culture, in spite of the fact that roughly one out of ten American drinkers experiences serious alcohol-related problems.[2] Alcoholism is one of the casualties of this particular approved behavior, and should be treated accordingly.

Although definitions of "alcoholism" have varied — so that both the World Health Organization's *International Classification of Diseases 9* and the American Psychiatric Association's *Diagnostic and Statistical Manual III* have chosen to use the term "alcohol dependence syndrome" — criteria for its diagnosis are widely available.[3] Recent research has compiled considerable evidence for a strong genetic predisposition to alcoholism, at least in men.[4,5] Other studies have cast doubt on early psychopathology as a necessary causal factor. Vaillant, for

example, in following a male cohort of physically and mentally healthy students of an ivy league college in the years 1940-1942, found that fourteen percent of the sample had developed a drinking problem by the age of fifty. Although unhappy childhood, personality instability in college, and adult evidence of personality disorder correlated with so-called "oral-dependent" traits in adulthood, they showed no correlation with alcohol problems. The many psychological difficulties in these problem drinkers were found to be a *consequence* rather than a *cause* of their alcoholism.[6] The incidence of alcohol problems did correlate with a positive family history of the disease.

What we now think of as alcoholism will probably turn out to be a group of "alcoholisms," related syndromes with different causes and natural histories. This fact should in no way deter the acceptance of the disease concept as applied for those who have lost voluntary control of their intake of alcohol and can be restored to health through treatment and rehabilitation.

Lack of emphasis in medical education

Joe Pursch, one of my colleagues who specializes in the treatment of alcoholism, regularly addresses medical audiences as "fellow members of the four-two-one club, who spent four years in medical school and received an average of two hours of instruction on the nation's number one health problem." It remains true, in most undergraduate programs, that a great deal of time is spent teaching the complications of alcoholism, and very little devoted to the recognition and treatment of the disease itself. Most students graduate without learning how to take a good alcohol history and without learning how to present the diagnosis effectively, to motivate, and to treat or refer an alcoholic patient. Psychiatrists still complete residency training without having engaged in therapy with an alcoholic patient, their experience having been limited to diagnosing alcoholics only for the purpose of screening them out. Internists, family physicians, and others in primary care face equally limited train

ing experiences. Is it surprising, then, that many practicing physicians prefer not to treat alcoholics and that even those who are willing to deal with the disease fail to recognize alcoholism when they see it?

Many groups have been working to remedy this deplorable situation. Summer schools around the country, such as the Rutgers Summer School of Alcohol Studies, offer special courses for physicians. Training combined with direct patient care experience is provided to U.S. Navy physicians at the Long Beach, California Naval Hospital, and to civilian physicians by Roosevelt-St. Luke's Hospital in New York City, among others. The American Medical Society on Alcoholism, medical arm of the National Council on Alcoholism, sponsors and accredits continuing medical education courses in the field. Self-study materials are also available.[7]

At the undergraduate level, Operation Cork, an experimental program for alcohol-related teaching, was begun in 1977 at Dartmouth Medical School. The program has a strong evaluative component. Similar Cork programs are now being developed at the University of Colorado, Morehouse, Rush, University of Washington and Case Western Reserve medical schools.

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the National Institute on Drug Abuse (NIDA) have jointly sponsored a grant program to support career teachers in alcohol and substance abuse since 1972. There are presently more than sixty such teachers in U.S. medical schools taking part in the program. Another current NIAAA initiative is the development of alcoholism components to be incorporated into thirty-nine family medicine teaching programs.

These efforts, while commendable and useful, are fighting an uphill battle against the negative attitudes passed on from generation to generation of medical students by their role models, the attendings and the house staff. A definitive solution to this problem of attitude continues to elude us.

Alcoholism in women: a special opportunity

From what little is known about alcoholism in women, we suspect that such women differ in many ways from their male counterparts.[8] They start drinking and begin their pattern of alcohol abuse later in life than men, yet appear for treatment at about the same age, presenting a more rapid or "telescoped" development of the disease. They are more likely to develop secondary dependence on sedatives, minor tranquilizers, or amphetamines (usually iatrogenic), and are more likely to have past or present depression and a history of suicide attempts. They drink considerably less than male alcoholics on the average — for example, 4.5 ounces of absolute alcohol per day for women entering treatment versus 8.2 ounces of absolute alcohol per day for men, in one study[9] — but get just as sick, and may even have a higher rate of cirrhosis.

One very important difference is the motivations cited for entering treatment. For men the most commonly mentioned are problems on the job or with the law. In women the most frequent are problems with health and family. The medical profession is thus in an ideal position for casefinding. Nearly all alcoholic women visit physicians frequently during their illness, but the presenting complaints seldom directly mention drinking.

The recent delineation of the fetal alcohol syndrome (FAS) and other alcohol-related birth defects has added increased urgency to the need to identify problem drinkers among women.[10] FAS is thought to be the third leading cause of mental retardation due to birth defects, exceeded only by Down's syndrome and spina bifida. Of these, FAS alone is preventable. Adequate prevention must involve the diagnosis and treatment of alcoholism in women of childbearing age, in addition to effective public information campaigns. Interruption of heavy drinking during the course of pregnancy leads to lower fetal risk. We have here another golden opportunity to prevent and relieve human suffering. Will we miss it?

This brings me back to the seaman and the medical student, and the role and responsibility of the physician vis-a-vis the alcoholism in our patients. Are we doing them justice? Can we do better? I find myself communicating one more call for self-examination of our attitudes, prejudices, and educational deficiencies. One more call for action. One more job to do. Well, nobody ever told us that being a physician would be easy. □

References

1. Westermeyer J, et al., "An Assessment of Hospital Care of the Alcoholic Patient," *Alcoholism: Clinical and Experimental Research, 2:* 53-57, 1978.
2. "NIAAA Alcohol and Health First Special Report to the U.S. Congress," DHEW Publication 73-9031, 1971.
3. National Council on Alcoholism Criteria Committee, "Criteria for the Diagnosis of Alcoholism," *Annals of Internal Medicine 77:* 127-135, 1972.
4. Goodwin D, et al., "Alcohol problems in adoptees raised apart from alcoholic biological parents," *Arch. Gen. Psychiatry 28:* 238-243, 1973b.
5. Goodwin D, et al., "Drinking problems in adopted and nonadopted sons of alcoholics," *Arch. Gen. Psychiatry 31:* 164-169, 1974.
6. Vaillant G, "Natural History of Male Psychological Health: IV Antecedents of Alcoholism and 'Orality,'" *Amer. Journal of Psychiatry 137:* 181-186, 1980.
7. Mullin C S, "Office Treatment of the Alcoholic Patient — A Guide for the Physician," Division of Alcoholism, Mass. Dept. of Public Health, Boston, 69 pp., 1978.
8. NIAAA Research Monograph #1, "Alcohol and Women," DHEW publication ADM 80-835, 1980.
9. Armor D J, et al., "Alcoholism and Treatment," R-1739-NIAAA, Rand Corporation, Santa Monica, Calif., 1976.
10. Streissguth A P, Landesman-Dwyer S, Martin J C, and Smith D W, "Teratogenic effects of alcohol in humans and laboratory animals," *Science 209:* 353 (July), 1980.

Senator HUMPHREY. Thank you, Dr. Blume.

Who is the next volunteer?

Mr. DOYLE. Mr. Chairman, I am John Doyle, chairman of the board of the National Council on Alcoholism, a voluntary, nonprofit agency.

We don't, as I am sure the Chair knows, receive any Government money. We are all volunteers and it is an organization with some 230 affiliates throughout the country.

I happen to live right in the middle of the country and I would like to focus on a couple of things that the Chair has indicated you would like to receive information on. Before starting that, I would like to point out that, as a couple of the speakers have said—particularly Dr. Keith Simpson—we have arrived at the point in the education, prevention, and treatment of alcoholism to where, with this tremendous explosion that has occurred with the help of Government agencies such as NIAAA, we pretty well have the treatment facilities in place throughout the country. They are ready to receive them. In fact, some people are saying that they don't have the beds all filled.

This is what we refer to as the tertiary portion of the total approach and that is when somebody is so bad, they have degenerated physically, mentally, and spiritually to the point where they have to go into the hospital; we think we have that system in place.

We feel that the emphasis is shifting to what we would call a secondary prevention and, hopefully, even to primary, but let's talk about secondary prevention for a minute where we can intervene and get help to this person before we have to go into this tertiary position.

We have seen that with the help of NIAAA—of course, I think it's frightfully important that we preserve the institute. We have seen too much good work.

You know, out where I live, when the Federal Government says something with the credibility of an institute, the people listen. They look up to this, they receive it and it is very helpful as quoting for a precedent to establish a program such as I am going to tell you about that exists in my hometown.

I live in a town, the capital of the State of Nebraska. It has 170,000 people; lived there all my life.

We have an affiliate of the National Council on Alcoholism located in our community, and I like to think it is one of our very good active affiliates. I think I can say that truthfully. And with the help of NIAAA, which we are asking to be continued and reauthorized, we started a rather unique program and that was in the field of employee assistance. Since we don't have any large plants, huge manufacturing concerns, we made the approach to the small businesses and we have about 40 or 50, somewhere between 40 and 50 businesses in our community that have joined in this consortium of employee assistance programs.

We sat down with a local banker, we sat down with some local professional people, some leaders in the community, and we decided now, what are we going to charge these people? And we had to arrive at a rate that would be charged per employee for the bank,

the insurance company, the small manufacturing plant, and so forth.

We also have the Lincoln school system involved in this thing. They are one of our biggest clients in this program.

So we charge per head of employees that will receive the help. This thing has progressed to the place now, with the help of NIAAA over the past 4 years, to where I guess you could call it a diminishing partnership because their help financially has gone down while our help has come up to where now we are 67 percent sufficient.

I left a meeting just week ago where we sat down with the president of our Lincoln council; we run this program and have the counseling there, and do the referral. Once in a while, they have to go into this tertiary thing; they have to go to the hospital.

So we sat down and figured out how we are going to do this. We think we can do it. First of all, we have a bill going in the State legislature and we are shifting this onto a State basis, but I must confess that I don't think that all of the States are in a position to do that. Some of the State legislatures have gone home, some of them have progressed so far that at this time any bill introduced is going to get caught in a logjam and won't go.

We approached it from two angles. We have this one bill which is going to give us some relief strategically from the State legislature and it's been marked a priority bill. We know that it has a very good chance of passing, plus the fact that we are going to businesses and foundations in the community and we feel from the commitment we had at this meeting, we will be able to pick that thing up and make it work.

What's happened? The partnership has diminished to where the Federal Government is almost out of it. But we could never have gotten the thing started without the help of the government; Without the help of the tremendous prestige and status of NIAAA. That is just one example of what has been going on. I guess we would call that applied research. This is something that has happened in the community.

Now, primarily, we have not yet arrived although we have a program in the public schools. There again, NIAAA I think can be frightfully important with their expertise and research capabilities, and so forth, to come up with something that is very subtle and works well.

I want to refer to one more thing. I left Washington (I was back here testifying on the House bill just a couple weeks ago) and I returned home to find what is going on in most every State in the Union, the boys' State basketball tournament, who are on the front page, and I regret to tell you this is on the front page of our hometown newspaper, this is a private school, Pius X High School. (I hate to tell you I incorporated this school 25 years ago.) They have our kids there at the tournament in the coliseum at the University of Nebraska. Here's this sign that says, "Party if we win, party if we don't win, with a beer keg there." These kids are all underage, they can't even drink beer in Nebraska. The age is 20 years of age in Nebraska—varies in some States.

But my point is that this kind of a mind set has subtly come about. When I was in high school this was unheard of. We wouldn't

be doing that. I am not that old either, Senator, I want you to know. But we feel that without the capabilities of NIAAA that can get the kind of—they can bring to bear on this thing as we move away from the tertiary into secondary and primary prevention—they have the stuff to do it and they have the people with the knowhow that can come out into the communities; then we get these community based programs going.

Then we can enter into—I think the field is limitless—the kind of diminishing partnerships we can enter into—And we can become self-sufficient.

Our State's pretty far along on the alcoholism portion, but I have also seen one thing that I think has been said here before, we would like to go on record on the block grants: We would like to refine that in such a way that there is some designation as to how it will be used—designated for alcoholism.

I have seen this at home. When we got our first appropriation to really get our department of alcoholism off the ground 4 or 5 years ago, LB304 or 302 was referred to in the alcoholism community as the "Oh, yeah" bill. Why was it called the "Oh, yeah" bill? Because the money was coming and it was coming in the form of a bloc grant, so to speak, in the State itself. Although alcoholism was in there, the medical professionals were taking it and saying we will spend it this way or that way, but we had to say that alcoholism is in there too, and then they would say, "Oh, yeah."

You know, it is forgotten and we think that because of problems that come up on that level that this stuff should be designated. The funds should be designated.

We are urgently urging you to keep NIAAA in place and we'll take our cut with everybody else. If you are going to cut the funds we understand that. I think consistently with the administration's program on saving money, give it a good cut. You can cut hard. But don't take away the institute.

One layer of bureaucracy you could cut out is ADAMHA and you would save 15 million.

Senator HUMPHREY. Cut what?

Mr. DOYLE. ADAMHA, and you could save 37 percent of the paperwork that NIAAA has to do just reporting to them.

So we are all for it. We understand what is going on in the country and I agree with the administration's program that we have to have these cuts. But let's not throw out something that is really working and we see it right in the middle of the country. I should repeat, Senator, in the other parts of the country.

Thank you.

Senator HUMPHREY. Thank you.

Ms. JOHNSON. Thank you. Mr. Chairman, I am pleased to be here today on behalf of the National Coalition for Jail Reform.

The National Coalition for Jail Reform is made up of 32 national organizations, including the National Sheriffs' Association, National Association of Counties, National League of Cities, American Public Health Association, National Center for State Courts, and the American Bar Association, who are concerned about the conditions in jails and people who should not be there. All 32 organizations agree that public inebriates should never be held in jail.

A public inebriate is a person who is repeatedly drunk in public, has frequent contact with the police, often resulting in incarceration, and has limited financial or other resources.

I would like to show you and the staff some pictures from the Gallup, N. Mex. drunk tank in the jail. They have 26,000 people coming through their drunk tank each year.

Driver Dewitt an alcoholic, was arrested over 200 times for public intoxication and spent two-thirds of his adult life in jail on charges of public intoxication.

Robert Sundance and two other men were arrested a total of 645 times in 10 years and during the decade from 1964 to 1974 the three men spent 16 years in jail for public intoxication.

In Los Angeles at that time, which was 1975, they had 55,000 arrests a year for public intoxication. And about 1,000 people accounted for most of those arrests.

There are a great many public inebriates in the country. We don't have good data on the exact numbers but the 1979 uniform crime reports of the FBI said that there are 1 million arrests for public drunkenness. A third of all the arrests in the country were for public intoxication. In Kentucky, 33 percent of all arrests are for public drunkenness. In Utah, according to the State Alcoholism Agency, in 1979, 25 to 35 percent of the jail population was held due to public intoxication. This is an enormous and very expensive problem for the country.

Jails are very, very expensive nowadays and many jails are under suit because of the problems of overcrowding in the jail. A lot of this overcrowding is due to the public inebriate. It costs $25,000 to $60,000 to build each cell and $7,000 to $26,000 a year to maintain each person in jail. Jails don't have services for the public inebriate. Half of the jails have no medical facilities, only a quarter of the jails have rehabilitation programs. Public inebriates are victims of alcoholism. Alcoholism is a disease. We do not put people with cancer in jail, we should not be putting the public inebriate in jail.

Public inebriates in jail commit suicide a lot when they are going through withdrawal and there are no services in the jail. There is a high rate of suicide in jail.

Page Hudson, chief medical examiner of North Carolina, reported in a study he did of deaths in North Carolina jails from 1972 to 1976, that one-third of the deaths were suicides. More than half of these suicides took place during the first 12 hours in jail and 85 percent of the people who committed suicide were intoxicated.

In North Carolina he estimates that intoxicated people make up over half of those in jail. Cities and counties are now liable for these people who commit suicide in jail and it is a great liability for jurisdictions. Under section 1983 of the Civil Rights Act of 1871, jurisdictions now can be sued and are being sued across the country for this problem.

There are programs in the country that do help rehabilitate the public inebriate and are cheaper than jails, but most of the States don't know about these programs. The average daily cost of jail is $40 to $50 and social model detoxification programs can be much cheaper.

The Salvation Army program in Indianapolis, Ind., provides detoxification services for $27 a day. The Lawton, Okla. public inebriate programs costs $26.50 a day. The Greater Southwest Conference of Norwalk, Calif., spends $17 a day and the 7th Street Center in Charlotte, N.C., costs $29 a day. Jails are much more expensive than that.

It is very important to have the Uniform Act, but beyond that we have to have services in communities for the public inebriate and we really need Federal leadership in this area. It just doesn't make sense to have 50 States each searching for good programs, each trying to find the answers that exist, when you can have these kinds of questions answered at the Federal level. There are not that many good programs for public inebriates in the country, and most people don't know about them. We are just on the edge of finding out which are the good programs and trying to get this information out.

And it can much more effectively be done at the Federal level than to have each of the States trying to do the same kind of things. We need Federal help in getting programs started and locating information and in giving assistance to the States and answering questions.

Our office, because nobody else is doing this, gets an enormous number of questions that I don't have the answers for. We need to help communities know where there is a good transportation program, and what are the advantages of a social model detoxification versus a medical model. We need a capacity at the national level to answer these questions. We need an evaluation of the Uniform Act to see what the implementation money has been used for and which programs work best and what the problems have been.

We need a research and technical assistance capability at the Federal level to answer the questions that the States have and to help them establish workable programs. We need descriptions for the States of different kinds of programs that are working. We need Federal help in all of these areas.

Public inebriates are truly an underserved and neglected group of people who need our help and who cost society a great deal of money. And with some Federal leadership in this area, we could save money and save lives and help all 50 States avoid repeating what the other States are doing.

Thank you.

[The prepared statement of Ms. Johnson follows:]

National Coalition for Jail Reform

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Members of the Coalition

American Association for Ex-Offenders in Criminal Justice, Inc

American Civil Liberties Union National Prison Project

American Correctional Association

American Correctional Health Services Association

American Friends Service Committee

American Public Health Association

Benedict Center for Criminal Justice

Committee for Public Justice

Correctional Services Federation U.S.A.

Institute for Economic and Policy Studies, Inc

John Howard Association

National Association of Blacks in Criminal Justice

National Association of Counties

National Association of Criminal Justice Planners

National Center for State Courts

National Council on Crime and Delinquency

National Criminal Justice Association

National Institute of Corrections

National Interreligious Task Force on Criminal Justice

National Jail Association, Inc

National Jail Managers Association

National League of Cities

National Legal Aid and Defender Association

National Moratorium on Prison Construction

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Facilitator
American Arbitration Association

STATEMENT FOR THE RECORD

BY

THE NATIONAL COALITION FOR JAIL REFORM

CONCERNING

THE FEDERAL ROLE IN

ALCOHOLISM SERVICES AND RESEARCH

BEFORE THE

SENATE SUBCOMMITTEE ON ALCOHOLISM AND DRUG ABUSE

GORDON J. HUMPHREY, CHAIRMAN

MARCH 25, 1981

Mr. Chairman and members of the subcommittee, I am pleased to testify today on behalf of the National Coalition for Jail Reform.

The National Coalition for Jail Reform is made up of 32 national organizations including the National Sheriffs' Association, National Association of Counties, National League of Cities, American Public Health Association, National Center for State Courts, and the American Bar Association who are concerned about the conditions in jails and people who should not be there. All the members of the Coalition agree that public inebriates should never be held in jail and are working to develop alternatives to jail for these people.

Congress can help ensure that this neglected group of people is cared for by providing for federal leadership in the alcohol field. The public inebriate is a difficult group to provide services for and most cities and counties are at a loss for information on what works, how to establish programs, and what the most cost effective methods of care are. A federal research and technical assistance capability would save money for states and local governments.

It doesn't make sense for 50 states to each be collecting the same information, each trying to locate good programs, each producing materials for local programs and answering the same questions 49 other states are asking. This research (on who the public inebriate is, the advantages of social vs. medical detoxification, which programs have the lowest repeat rate, what transportation mechanisms there are), technical assistance on setting up programs, evaluation of programs, and dissemination of information should be done just once--by the federal government. Most states do not now know what works best and how to establish such programs. The federal government can provide assistance to the states and local communities on how to most effectively use their money.

A public inebriate is someone who is repeatedly drunk in public, has frequent contact with the police, often resulting in incarceration, and has limited financial or other resources.

A third of all the arrests in the country, more than a million a year, according to the 1977 FBI Uniform crime report are for public intoxication. In some jails, as many as 40 or more percent of the people are there simply for being drunk in public. There are many suicides by intoxicated people in jail. Communities face liability for these deaths and for not providing detoxification and appropriate follow-up services.

Servicing the public inebriate in the criminal justice system is very expensive. We spend over $400 million a year in criminal justice system costs on the public inebriate. Many have been jailed hundreds of times for public intoxication. Few jails provide services for the public inebriate to break the cycle. Jails are very expensive: They cost an average of $60,000 per bed. Our jails are desperately overcrowded and using expensive secure jail space for public drunks is a waste of public resources. We need to save jail space for serious offenders who need to be there. In addition is the waste of police and court time processing the same people through again and again.

The public inebriate was a major reason for the establishment of NIAAA and the development of the model Uniform Act in 1971 which decriminalizes public intoxication. Today, ten years later, the Uniform Act has been adopted by 32 states. But still public inebriates remain in jail, due to a lack of alternative programing for them. When the police have nowhere else to take them, they take them to jail in "protective custody" or charged with trespassing or vagrancy, or disorderly conduct. If there were detoxification programs tied to continuums of care, as the Act calls for, then these people would not end up in jail.

In addition to the 400 million dollars we're spending in the criminal justice system on the public inebriate, we're also now spending a great deal of wasted money in the health care field on the public inebriate. Many public drunks are taken to hospitals, when the jail refuses to take them. By going to the hospital again and again each year, the public inebriate uses up a lot of resources. Utilization of expensive hospital bed space for the public inebriate who can be treated with less expensive services is a waste of scarce resources. A social model detoxification program costs $6,000 a bed per year compared to $30,000 per year for a jail bed and over $100,000 a year for a hospital bed. We need to assess the true social cost of the public inebriate and help states to develop more cost effective means of caring for these people.

It is important for the states to pass the Uniform Act, but it is not enough. States need to include the public inebriate in their state plans. We have little idea of how the states have spent the Uniform Act implementation money. There has never been an evaluation of whether or not the implementation money resulted in the public inebriate no longer going to jail and effective services for the public inebriate being developed. We don't know which programs that were funded worked well and which didn't divert anyone from jail.

If we continue to treat the most chronic and advanced alcoholics as criminals, how can we ever convince the public that less advanced cases are deserving? Continued neglect of the public inebriate issue will only weaken treatment efforts on behalf of all alcoholics. The federal government must take a leadership role in this area.

Under section 1983 of the Civil Rights Act of 1871 cities and counties may be held liable if they do not protect the human rights of those confined. The serious medical problems of the public inebriate make adequate medical care in the jail impossible. This is a major liability problem for local jurisdictions. They will have to deal with establishing alternatives to jail for public inebriates. But they need help. They need federal guidance rather than floundering, state by state, for information on what works best.

There are many specific things that need to be done at the federal level:

1. States and local governments need federal money to implement the Uniform Act. But we need more specific guidelines to the states on what the incentive funds can be used for. The money, in the original act, was to provide services for the public inebriate or training for the police in how to divert the public inebriate from jail, or establish a transportation network or emergency service patrol. We need to ensure that the money is used for these purposes.

2. We need an evaluation of how the money has been spent, what local programs work best, how many public inebriates they have treated, what the response of the Criminal Justice system has been, what the problems have been, how many public inebriates are still in jail and why, what the savings in the criminal justice system have been, and what the increased costs to the alcohol field are.

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3. There needs to be a research and technical assistance capability at the federal level to answer questions the states will have and help them establish workable programs. A manual for local communities is needed which offers a rationale for change (costs, liability etc.) and gives advice on how to make the change. A publication on what a continuum of care encompasses (from wet hotels and detoxification centers to true rehabilitation programs.) We need examples of things that work--"Best Strategies" (ie: a good transportation system in Denver, a cheaper social model program in New York, a program in Florida supported by fees from recovered inebriates who have contracted to repay the center for their care etc.) NIAAA nees a full time staff who has the capability to help communities set up programs, to provide assistance to new programs, to answer the hundreds of questions that are asked by states.

4. States need to include in their state alcohol health plans how they will handle the public inebriate, what programs they will establish for them, and how they will include public inebriates in existing alcohol programs. States could be directed to spend a certain percentage of their alcohol budget on the public inebriate--to ensure that this much neglected population begins to receive services.

The public inebriate is truly an underserved population but federal leadership can begin to change this. Ten years after public intoxication was decriminalized, with 32 states having enacted the Uniform law, we still are spending hundreds of millions of dollars to keep public intoxicants in jail. Congress can change this by ensuring that states plan for the public inebriate and by providing help to the states as they do this planning.

THE LEGAL HISTORY

Dewitt Driver was a homeless, derelict alcoholic who had been arrested over 200 times for public intoxication and had spent at least two thirds of his adult life in jail for nothing more than public intoxication. In 1966 the U.S. Court of Appeals for the Fourth Circuit precluded convicting a homeless alcoholic for public intoxication, under the eighth amendment prohibition against cruel and unusual punishment. Other courts ruled similarly on the basis that the inebriate's actions were involuntary.

In 1965 the President's Commission on Law Enforcement and Administration of Justice recommended elimination of public intoxication as a criminal offense throughout the country and substitution of public health, welfare, and rehabilitation measures to handle the problem.

In 1968 Congress enacted the Alcoholic Rehabilitation Act (P.L. 90-574, 82 Stat. 1005, 1006, (1968))and in this statute Congress made the following declaration of purpose:

> The handling of chronic alcoholics within the system of criminal justice perpetuates and aggravates the broad problem of alcoholism whereas treating it as a health problem permits early detection and prevention of alcoholism and effective treatment and rehabilitation, relieves police and other law enforcement agencies of an inappropriate burden that impedes their important work, and better serves the interests of the public.

This was followed by the Comprehensive Alcohol Abuse and Alcoholism Prevention Act of 1970 (P.L. 91-616, 84 Stat. 1848 (1970))which created the National Institute on Alcohol Abuse and Alcoholism. President Nixon in a February 1971 message to Congress on National Health Strategy stated that NIAAA would expend the money in certain priority areas which include rehabilitating the public inebriate.

In 1971 the National Conference of Commissioners on Uniform State Laws developed model legislation - The Uniform Alcoholism and Intoxication Treatment Act which decriminalizes the act of being drunk in public and establishes a continuum of care in the alcohol treatment field for the public inebriate. Thirty-two states have now enacted this model legislation.

Senator HUMPHREY. Thank you, Mrs. Johnson.

The distinguished ranking member of the subcommittee, Senator Riegle, has joined us.

Good morning.

Senator RIEGLE. Thank you, Mr. Chairman.

Senator HUMPHREY. Do you have a statement?

Senator RIEGLE. Thank you, yes, I do.

OPENING STATEMENT OF SENATOR RIEGLE

Senator RIEGLE. Let me welcome the witnesses. We have four subcommittees meeting today; in addition, I had a longstanding commitment to meet with a large organization across town. So I apologize for arriving late, I want to welcome many old friends who I see around the room today. Many of you have been involved in this work for many years. Your concern about some of the changes that have been proposed are my concerns as well, and we'll work together on those as we go down the track and, hopefully, we'll be able to find some solutions and approaches that make good sense.

I want to take this opportunity to congratulate my colleague, Senator Humphrey, on his newly assumed chairmanship of this subcommittee and to thank him for holding this hearing on the reauthorization of the Federal alcoholism effort.

I also want to again welcome the witnesses and other interested citizens who have come here today to express their concerns and to offer their suggestions to us regarding alcoholism, which is one of the Nation's most serious health problems.

Alcohol abuse and alcoholism currently cost this Nation an estimated $53 billion annually in lost production, health and medical costs, and industrial and traffic accidents and injury. Alcoholism is the third leading cause of death in the United States, following cancer and heart disease, and is one of the leading causes of mental retardation and birth defects.

Some 10 million Americans are alcoholics, or problem drinkers and an additional 3.3 million young people have alcohol problems.

The Federal alcohol services programs currently support treatment for some 351,000 citizens across the country. Their personal incomes, on average are less than half that of the public at large, so those services are directed at people in very severe economic circumstances.

I think if we view these statistics in the context of a 10-year old-Federal alcoholism effort, it's clear that we have only begun to understand and to address the nature and effects of this illness which pervades all social and economic aspects of American life.

Scientists have yet to conclusively establish the cause of alcoholism, although researchers have made great strides in the last decade. We now know more about the heredity component in transmission of this disease as well as the relative vulnerability of certain ethnic groups to alcohol abuse and alcoholism.

A clear relationship between alcohol intake during pregnancy and birth defects has been established.

Public information campaigns are progressing to make pregnant women aware of this serious health hazard. We are just beginning to serve targeted populations whose needs have been historically neglected, such as women, minorities and elderly persons.

This decade has seen increased cooperation between labor and management in efforts to establish employee assistance programs with strong substance abuse components, often with technical assistance provided by NIAAA.

Much of the work has been funded by Federal dollars and there is a great deal of work yet to be done. I must say that I regret that the administration has not yet come forward to explain the radical changes it proposes for Federal alcoholism policy.

I, too, am committed in the broad sense to reduction, significant reductions, in Federal spending. However, I am concerned about the deep budget cuts proposed by the administration for the Federal alcoholism efforts, cuts that will likely act as roadblocks to obstruct this Nation's 10-year ongoing effort to combat this dangerous and very expensive, both in human and money terms, but nevertheless, treatable and curable, disease.

I am further concerned that the administration's proposal to block grant remaining moneys to the State will result in alcoholism services taking a backseat to other social service programs also experiencing fiscal reductions.

Most importantly, I am concerned about those individuals who may fall through large gaps in the service system during a potentially chaotic transition to increase State control with decreased numbers of treatment slots and fewer social services available. So I look forward to hearing the testimony of the witnesses and it is my very deep hope that we can work together to create policy which will further this Nation's efforts to stop the human and economic toll of alcoholism and alcohol abuse.

I'd just finally say that it's the nature of the work in the Senate that every Member has the responsibility for a large number of areas. In my own case, I serve on four major committees, nine subcommittees, four of which are meeting at this exact hour, and so there is intense competition for time and attention as a fact of life here.

Having said that, when we chose subcommittee assignments on this committee. My seniority is now such that I had an option to select from a variety of subcommittees. I chose consciously to retain the ranking position on this subcommittee, having been its chairman in the previous 2 years. I did so because I have a very strong feeling about this problem and about our need to deal with it effectively. We must have a national effort and commitment and understanding to deal with this problem.

It is of enormous size and consequence. It is one of the areas of the budgeting where we can be most costeffective, in terms of doing things that make sense in people's lives and in hard cold dollar terms, by acting responsibly to help people, by acting in a preventive way wherever we can to try to get the facts across and help people find paths for themselves that take them away from alcohol abuse and alcoholism.

We have made progress, largely with the help of many people in this room who have given leadership in a number of ways and continue to do so. These are hard days, these are hard days in terms of the change the Government direction and transitions that are upon us, but I am determined, speaking for myself, to work

with you constructively to figure out how we continue to maintain this momentum and this progress.

I think we can. It's not going to be easy, but that is my commitment. That is why I chose to retain my seat on this subcommittee and the fact I was late in arriving this morning ought not to in anyway mislead anybody on that point, because that is how I feel, that's how my staff feels, and we are determined to move forward on this and we will do it together.

So, Mr. Chairman, that is my comment and I appreciate your patience.

Senator HUMPHREY. Thank you, Senator Riegle.

Let me begin by addressing my questions to the members on the panel who are from the National Council on Alcoholism or affiliated with it.

I suppose the first thing that comes to mind is the debate about whether it's wise to in effect trust the States with the responsibility of setting their own priorities, each one, versus the idea of continuing as we have to set priorities here in Washington.

I have to tell you that I have only been here 2 years, of course—a little over 2 years—but during the last 2 months I have been contacted in one way or another by more, I'll use the word "special interest groups," I don't mean that in a pejorative sense but for lack of a better word, and all of them feel as you have expressed this morning that their own program is so particularly unique and important and productive and money saving that we should not subject this program to the will or the discretion of the States.

So what you have said, while I don't doubt your sincerity, and you probably have a very good case, is what everyone is telling us, frankly.

Why shouldn't we allow the States to set their priorities? If there is such a compelling case for alcoholism programs—obviously, there is—why do you think that the States will ignore the compelling case and zero out or drastically reduce programs for alcoholism?

Dr. SIMPSON. Mr. Chairman, I think that State inaction led to the strategy of developing NIAAA as a national leadership focus.

When you look at alcoholism as far as the number of its victims and look at its level of funding, the comparison speaks for itself. In other words, we are the third from the bottom. This is our reality. Because of this reality we are begging you to take it into consideration.

We'll work like the dickens at the local level to make sure we educate and provide State legislators with the proper rationale to adequate fund local programing. But the state of the art and political network necessary to give alcoholism programs at the city, county, and State level a fair shake just isn't quite there yet.

I know you are scared to death of having them in the position saying let Uncle Sam do it all, but what we are looking for is transition rather than abruptness. The Institutes leadership has helped immensely in certain States where there has not been that constituency to build leadership to protect that population and achieve cost effectiveness enjoyed by the private sector.

Senator HUMPHREY. We propose to continue the Institute in its leadership role but in effect what we propose to take away from it and give to the States is the authority to distribute these grants.

Dr. SIMPSON. That is what I was referring to. I focused too much on the Institute, maybe, but it is preserving that $90 million that will go into that massive bloc grant. That is what we are asking you to reconsider, if you could do it as a transition so we could get our ducks in a row at the local level.

Senator HUMPHREY. Isn't the argument for your case that you don't trust the States to give proper recognition to the problem of alcohol abuse?

Dr. SIMPSON. I am not sure, res ipsa loquitur, it speaks for itself. People didn't run to Molokai to help out Father Damien with the lepers because they simply did not see what good it would do—it wasn't that popular an issue.

We are bringing alcoholism out of the closet so it gets a fair shake, Betty Ford, Bobby Welsh, Buzz Aldrin, people of stature talk openly of their recovery.

That is the strategy, all we are looking for is a chance to earn our place so we can compete successfully at the State level. For a whole variety of reasons we are simply saying—we are just not there yet. I realize a dozen other people are telling you the same thing. We invite close scrutiny

Dr. BLUME. I would like to comment on Dr. Simpson's remarks and ask why we are so underfunded, why in that Institute of Medicine's report does it show how poorly alcoholism has done. It has to do with why we are all sitting here today. It has to do with the stigma that has been attached to alcoholism since it began.

Now the disease concept is not a new concept. Benjamin Rush, father of American psychiatry and signer of the Declaration of Independence, wrote about the disease concept in the 18th century.

Nevertheless in the document appended to my statement from the Harvard Medical Alumni Bulletin, I go into the fact that even the medical profession has yet to fully accept the disease concept.

Now that is why there is an institute, and that is why funding has been earmarked and should continue to be earmarked; because society has yet to turn around the old moral ideas that alcoholism is a free choice rather than an illness. That does not apply to all areas.

Dr. SIMPSON. The field carefully choose the strategy of setting up a national model to teach States. The institute was established as a separate entity on that same principle, that job isn't just quite done yet; that is all.

Mr. DOYLE. If the Senator please.

Senator HUMPHREY. Yes, certainly.

Mr. DOYLE. Of course, you know in the heart area and cancer, they are recognized diseases with a tremendous—I guess for lack of a better word—endowment, practically $1 billion on cancer and over a half billion dollars on heart. We have, through the volunteer efforts, struggled and done an awful lot to cause the adoption of the legislation to create NIAAA.

We think now we have this national focus that can be very helpful in getting things started on the State level. I think we are talking about an investment in the future. We have a limited

population, but after World War II when the GI bill came in, which was probably the greatest thing that ever happened to this country, and yet it affected a limited population of veterans. We think we have a population out there of people that are suffering from alcoholism, and we make this initial investment and then we can get the States and the private sector involved, but this is not the time to cut it off.

I think we can work together on this thing.

Senator HUMPHREY. I am going to alternate periods of questions with Senator Riegle and I want to come back to this because it seems to me we are talking about two different things. You keep talking about the relatively inadequate level of funding for alcoholism programs versus other major diseases and you have a logical argument there, but what I am trying to get to is why you distrust the States.

I am not talking about relative allocations—that is a different subject—but the heart of the changes that are being proposed is to give States the responsibility for ordering priorities which the Federal Government now pretty much reserves to itself. I will come back to that.

Senator Riegle.

Senator RIEGLE. Thank you, Mr. Chairman.

I think one of the problems here—and I hear the witnesses speaking to it—is that any time you combine a number of programs together, in this case 15 other different programs will be combined in a block grant with alcoholism programs, and the amount of money is reduced from what all of them separately were getting, you create a very intense problem at the State level.

I think the likelihood is that alcoholism treatment programs are likely not to do very well, simply because of the pressures on dollars in this intense competition in these fiscal circumstances. Those are hard facts of life, and we may not be able to change those directly. I am talking about the fiscal realities in the various States. But there is another issue you have to couple with that one and that is that there are some expenditures that are cost savers and there are some that create additional cost.

I think if there is one area where treatment services are cost effective, it is here in alcoholism treatment activity. We are in a sense losing something on the order of $53 billion a year out of the economy and society in dollar terms, not to mention the heartache and the incredible human suffering that goes with it, from violence within families to accidents on highways. I had a young man the other day in Michigan, a very close acquaintance who had been out drinking, was despondent, and, had lost a job and so forth, drove into a telephone pole and was killed on the spot. There are any number of cases like this. This happens to be a recent one that I am familiar with.

I think that we have to view this in terms of what constitutes a prudent expenditure to reduce a horrendous cost that this society is now bearing.

When I look at these photographs, for example, of these persons who are in what I guess what you might call a drunk tank or something of that sort, and I see these human beings in there and no service is being provided to try to get at this problem and to try

to get these folks squared away and back into some kind of a productive life pattern, this is not an answer.

This is a nonanswer and it is an expensive nonanswer in human and dollar terms.

So I think the argument we need to advance here is one of a prudent investment that reduces costs, that creates benefits, creates a flow of positive results in human terms and economic terms that the Government comes out ahead, the society comes out ahead.

I think we are way behind. Alcoholism does carry stigma, science has not pressed forward as quickly here as we need.

One of the problems is a lot of people in the medical profession have alcohol problems of their own. This is also well known. I don't mean to say that all do or that even most do, but some do and that also is a complicating factor here in terms of the degree of attention that it's gotten.

So I guess my thought would be that we ought to view this as a prudent investment that helps our country and where we are going to get dollar returns far greater than the modest amount of money that we spend to deal with this problem.

I think you could justify that almost on the basis of the fetal alcohol syndrome alone if you want to just take a very vivid single illustration of what medical science tells us about the effects of excessive drinking. But if we did case history, going up and down every block in this country, New Hampshire or Michigan or other places in terms of what is actually happening out there, money that we spend alerting people and helping people to combat this disease and move away from being victims of it, I think is money very well spent.

Obviously, that doesn't mean that every single program is managed in a perfect way. That is not the nature of things, but in terms of the fundamental justification here, I think it is enormous. In fact, it is almost so big that it's easy to miss and I am afraid that may be what is happening.

I do have some questions. I have spent most of my 5 minutes——.

Senator HUMPHREY. I was going to say, by the way, that was a good question. [Laughter.].

Senator RIEGLE. I probably ought to yield back and on the next go-round I will get to my questions.

Senator HUMPHREY. Let's go back to the crux of the situation as I see it and I want to pursue that. I don't want to be obnoxious in this. But some of you earlier said that perhaps if things have to go this way, there might be some guidelines, some instructions to the States to use certain portions of these block grants for specific alcoholism programs.

Does anyone care to comment further on the question of leaving it to the States to decide whether they want to have alcoholism programs and to what extent they do?

Dr. BLUME. Let me say that my comments on the disease concept were not about NIAAA. They were meant to explain why, when the hard choices have to be made at the State and local level, the legislators are not besieged with phone calls and letters saying alcoholism is a problem. It is thought by the public to be a moral

problem, "Let the churches take care of it," "Let AA take care of it."

The awareness is not there. That is why the block grant is frightening to AMSA.

Senator HUMPHREY. What is the basis of your statement that it is not there? You are suggesting that the people in the States, the legislators, and so on, responsible public officials are not enlightened somehow as enlightened as we at the national level. I am not sure that is true though.

Dr. SIMPSON. By virtue of having the Institute in place with its leadership role having Federal funds available, dedicated to alcoholism, we have set up a model for the States. Now we come from the grassroots level to present to you our lifes experiences so you can make the best decision.

As Senator Riegle mentioned, there will be a marked increase in pressure because of decreased dollars. That is factor 1.

Second, alcoholism isn't all that popular a disease entity yet, although we have made immense gains. So that puts it in a bad position.

Third, the structure needed at the local level to educate the legislatures and compete is not yet well developed. It is en route but it is not there.

All I can do is tell you that from the seat of my pants of 19 years experience this is what I fully expect to happen; I have been a consultant and working in other States in the last years where it's combined with mental health or with drug abuse. It works very adversely for alcoholism and the people who have it. There is a variety of reasons.

I am telling you what is and I am telling you in all honesty I think our expectation is correct. It is not a matter of—I don't like to use the word "trust," of State legislatures, but we don't have our job done out there yet. We are not going to let up 1 minute, but if that is cut loose and put in that large block grant this next fiscal year, we'll suffer immensely.

The people in the field will suffer immensely because we just won't be able to compete that sharply and we are just not ready for that yet. We are not asking it never be in such a grant, we are asking if you can transition into it so we can get our skills up to par. I just know it is going to happen.

Senator HUMPHREY. Yes.

Mr. DOYLE. Senator, I guess my answer would have to be past experience. I think we are leary.

The alcohol program was created here because of the failure of primary health care and mental health care in the States to address this issue. We feel that with the immense prestige of the Institute putting the finger on how this stuff should go, that then we are not going to run into the competition for funds at the State levels.

I guess we just have to flat out say experience. I think dedicated volunteers that have lived with this for years, we kind of think this is the best way to do it.

Senator HUMPHREY. Well, what are your suggestions in regards to some minimal constraints on these block grants, if that is the way we go?

Dr. SIMPSON. Basically, it would be designating an amount of money, of the amount that it comes to and shall be used, and let the States decide the programing, that is their right and privilege. We are asking you to protect that conduit a little bit.

Senator HUMPHREY. What about a ratio of funds to be spent on alcoholism programs within the block grant—let's see, a means somehow to peg it so that the ratio is the same as it is today? In other words, if——.

Dr. SIMPSON. I got you, yes.

Senator HUMPHREY. Am I expressing it well?

Dr. SIMPSON. Well, you are doing a lot better than I am, but that concept expressed in percentages is also valid if that is more effective wording.

Senator HUMPHREY. What do you think of the contention that in effect we'll be spending essentially the same amount of money on these programs, 75 percent pretty much of present appropriations if you factor out Federal administrative costs?

Dr. SIMPSON. I think I followed you.

Senator HUMPHREY. Do you buy that? The rationale for the 75 percent block grants is that we are going to save about 25 percent on Federal administration. So if we spent 75 percent next year as we spend today, that is a proposal, do you have a comment on that?

Dr. SIMPSON. Just at the first go that looks all right. In other words, we realize that 25 percent will not be there. We realize with the change in reporting mechanisms there will be essential savings. As Mr. Doyle said, we understand there will be cuts but whatever we end up with going to the State level, we just would like to have that saved either in percentages or whatever else.

That is as much as I can tell you. I am not that swift in keeping up with the percentages and the numbers, and so on and so forth.

Senator HUMPHREY. Senator Riegle.

Senator RIEGLE. Thank you, Mr. Chairman.

The numbers we tend to work with show the administrative costs on the State level would probably be no higher than 4 or 5 percent on the average; in Michigan it's about 2 percent. So I don't know how to squeeze 25 percent out of the 2 percent.

I just don't think there is 25 percent in there to squeeze out. I think that's—well, I don't think that is a practical target, if you will. That's got to eat into the program, eat into the services, the outreach, you're extending to people—I think substantially so.

Let me raise some questions if I may. I want to say, we have Lane Kirkland testifying upstairs on the subminimum wage, and I want to go up and ask a couple of questions shortly.

What do you see the impact of the Reagan block grant proposal to be?

Second, if the block grant is enacted, what provisions, if any, would you suggest to insure an adequate level of support is provided by States to alcohol treatment and prevention services?

In other words, if the States are going to run the show, is there some way to make sure that we don't see alcoholism services just squeezed out of the act by financial pressures or whatever.

I wonder if you could comment briefly on the administration's proposal to restrict social research and what your thoughts and reactions would be to that?

Dr. BLUME. Yes, I would be glad to make a few comments. It depends on how you define "social research," of course, but part of the effort in the past few years, both at the Federal and State level, but with the Federal's coming first, has been to focus on special populations: Black people, American Indians, Hispanics, public intoxicants, rural poor, women, youth—the only way that we can learn what are the needs of these populations, how they react to treatment, how they react to prevention, what is the incidence of alcoholism in these communities, and what the risk factors are, because these populations differ. If you study these populations, it can't be only through studying the constituents of their blood and liver, it will have to include seeing them in the settings and under the social pressures in which they live. We will not know how to approach these special problems unless that research is done. If this is what is meant by social research, it would be a terrible loss to lose that.

My special area of interest has always been in women's problems. Studies of women have showed us, only as recently as last year, that the employed married woman is the highest risk for alcoholism of all women. We wouldn't have guessed that from what we thought clinically. But knowing that, we have to redouble our efforts to focus industrial programs on women.

If social research were cut out we wouldn't know that, and we wouldn't know where to look and where to invest our scarce dollars.

Senator RIEGLE. Anybody else want to comment?

Dr. SIMPSON. Just to say that I think under the broad category of applied research, I think some of the social type research studies would be conducted, but we must carefully choose the words.

Senator RIEGLE. What did you say?

Dr. SIMPSON. Find a careful choice of words. What we are doing is finding a word here and there that has fallen into disrespect.

Senator RIEGLE. Can you pull the mike closer?

Dr. SIMPSON. So what we have to do is a disrespect and strategy and not use it and not simply to game play and say applied research, but use the words "applied research" in the true sense that we are looking at biomedical and the demographic and epidemiological type studies which are definitely needed, and I guess I wouldn't know how to define social research per se.

But the types of studies Dr. Blume talked about are necessary and if it is unwise to call them that, then let's call them applied research.

Senator RIEGLE. That is a quick fix, I know, too, with respect to elderly persons, aged people.

Dr. SIMPSON. We just finished a whole study on alcoholism in aging and we will be presenting a report to the White House Conference on Aging, and it was a very enlightening event, also very inexpensive.

Senator RIEGLE. You were going to comment, Mr. Doyle.

Mr. DOYLE. Senator, in this area, I think it is vital by way of comment, I came here to Washington and I find a clipping in the Washington Post under date of March 7, 1981.

This is an article that leads off with the head, "Study Finds a Little Alcohol may Lead to safer Driving."

I am not going to read the article to you but it starts off that,"If you take just one drink, one glass of wine or one bottle of beer, you may be a slightly safer driver afterward."

Now this was a study done several years ago and somehow or other was dug up and comes out in the Post about the time of these hearings.

And I am saying that with an outfit with the prestige of NIAAA the research that can be done to combat and shoot holes through this stuff is worth in primary and secondary prevention—is worth millions of dollars. It is incalculable.

This is the role I see, one of the many things that is a good example of social research. Maybe that is not the best words "applied research," I don't know. But in that area that you are talking about—this is rubbish and NIAAA can shoot holes through it with the expertise that they have on a national focus. This stuff's going out on the wires.

I read this in Lincoln, Nebr., and the Omaha World Herald. They pick it up on the AP wire. But if an alcoholic reads this, he might take a drink but it might be his last drink.

Senator HUMPHREY. He might decide to have another drink.

Mr. DOYLE. Yes, and it could be his last.

Senator HUMPHREY. I take it the reporter in this case did not call NIAAA to get another view on that.

Mr. DOYLE. I am sure he didn't.

Senator RIEGLE. If I have time now, I would like to have you discuss with us the impact of alcoholism on the family. I think this is a critical area of concern and again something about which not enough is known, partly because the family difficulties and problems are often hidden because families want to keep difficulties private. So there isn't necessarily the degree of awareness on what alcoholism within the family circle can do to damage family life. I know I am about at the end of my 5 minutes for questions. But I think it is very important that we get your expertise today on the impact of alcoholism on families.

The chairman has suggested that you respond to that now and that would be helpful if you could do that.

Dr. SIMPSON. Just to start off.

Ten years ago, we focused on trying to take care of the person with alcoholism, getting him in an appropriate recovery program, then getting him back out.

Missing the point completely, the milieu you move the person into was also sick milieu, that the spouse and youngsters in the family where there is a person that has alcoholism marked dislocations in their normal activity and are suffering serious damage to their mental health.

The modern programing attacks the patient with alcoholism, the spouse and the youngsters each with their own program and treatment recovery track. That is proven to yield longer periods of

sobriety for the person, plus it also gets the spouse and the youngsters back in the picture again as part of a partnership.

There are statistics, and I don't have them in my head, about the impact of having a person with alcoholism in the family and the work costs or the loss of production costs on the spouse. There is data on that.

There is also good data I believe on the effect of having a person with alcoholism in the family and the youngsters' participation or achievements in school. I would like to pass it on to Dr. Blume if she wants to add anything to it.

Just suffice it to say that that's an area we are just getting data on and it's surprising data. We didn't realize the impact was that severe.

Dr. BLUME. I mentioned earlier the almost unanimous vote of the White House Conference on Families that put alcohol and drug abuse at the top of their priority list.

I think the easiest way to understand it is that if you see an alcoholic person as somebody wrapped around the bottle, you must understand the family is wrapped around the alcoholic wrapped around the bottle.

We have found during the past few years that even if for some reason we can't reach the alcoholic, there is a lot to be done to help the family unwrap from that situation and lead an easier life, which then often leads to the alcoholic accepting treatment.

We talked earlier about the genetic influence of alcoholism. That is coming clearer through research, but there is also an environmental influence of the parent, the inconsistent, and lack of, security in the home that shows up in poor school performance, hyperactivity, and juvenile delinquency.

I don't think we have mentioned maybe the most serious of all which is the family violence and child abuse.

Senator RIEGLE. I think we need to talk about that. These are important things; pull the mike closer.

Dr. BLUME. It has become clearer over the past few years in other areas of social research that child and spouse abuse, and child neglect are very closely linked to alcohol abuse in the family. We do not yet have all the answers to approaching that problem and helping the entire family readjust. It is something we are working with in models now that needs funding and leadership.

Senator RIEGLE. Do either of the other two of you want to say anything on this violence in the family situation? I don't want to squeeze something out you are not prepared to say.

Dr. SIMPSON. There is good emergency room data that ties the use of alcohol to violence and having worked some years in the emergency room, I can back that up with personal experience.

So we have a data base that we can point to the need for directing efforts to dealing with just the family if you can't catch the patient.

Senator RIEGLE. Would you try to get that data and put it in the record?

Dr. SIMPSON. Certainly.

Mr. DOYLE. Senator, one thing from personal experience, as a practicing courtroom lawyer, I have handled a lot of divorce cases and although I don't keep statistics, invariably there has to be over

50 percent of these divorce cases that I handle that alcohol is directly involved.

Senator RIEGLE. Over 50 percent.

Mr. DOYLE. Over 50 percent.

Senator RIEGLE. Let me give you one question for the record, if I may, and not take the time now. I would like each of you to give us your thoughts on the impact of and discuss the problems of the fetal alcohol syndrome. I just think it's important we have a perspective on that from each of you. How you see that problem; its urgency; how it relates to the possible program shifts and what recommendations you would have for us.

If you would provide that for the record that would be very helpful.

Dr. BLUME. New York State now has a public information professional information program going of which I am chairman, and for our task force report, we calculated using national and international data, how many infants a year are born in the State of New York with these birth defects. We calculate about 380 with the full syndrome, and about 1,500 with other alcohol-related birth defects. The lifetime additional cost for caring for those born in 1 year, 1978, was $155 million for the children born in 1 year. And the pain of this is that it is preventable.

Senator RIEGLE. And it is not correctable?

Dr. BLUME. Right.

Senator HUMPHREY. As usual, we are going to have to pay a little closer attention to time. We get into these interesting topics and there just never is the time to do what we like. But in any case, before we go to the next panel, I would like to address a few questions to Ms. Johnson.

How many States have adopted the uniform code so far and what is the problem with the balance?

Ms. JOHNSON. Thirty-one States have adopted the Uniform Act and it varies in different States as to what the problems are.

One of the big problems is that just implementing the act is not enough—until you implement it by getting the services.

Senator HUMPHREY. What is happening in the 31 States; has anything changed?

Ms. JOHNSON. One of the problems is we really don't know how much has changed because we don't have an evaluation of what the effect of implementing the Uniform Act has been. We really desperately need that kind of an evaluation to see. What I have is very spotty since we don't have a national survey.

In States where they have set up alternative services, it has worked very well and people are not going to jail. In places where it doesn't, people go to jail under different charges. They no longer are being charged with public intoxication but they are charged with trespassing or vagrancy or loitering or sometimes disorderly conduct, or in New Mexico, those pictures you saw, all of those are in there under "protective custody."

They have passed the Uniform Act there but they are still going to jail because there aren't the services for them.

Senator HUMPHREY. The difference is they are not being charged.

Ms. JOHNSON. That's right.

Senator HUMPHREY. I am not sure that you would have the answer to this, but probably you do, certainly it isn't your responsibility; that is not what I am trying to imply. Why have we been so slow in evaluating the effect of the act?

Ms. JOHNSON. I don't know. I wish I had the answer. We have not done it and we should have.

Senator HUMPHREY. What is the NIAAA doing today in the area of the public inebriate? What else are they doing, anything at all?

Ms. JOHNSON. They have not done very much. They have not recently seen it as a mandate from Congress as they did before and that is one of the things that I hope that Congress will specifically give them that mandate again.

In the beginning that was one of the reasons for the founding of NIAAA and we have gotten away from that and I am hoping we can come back to it.

They are having a meeting next week on what the institute should do about the public inebriate. So they are just beginning to get involved in this.

Senator HUMPHREY. We have quite a number of questions we would like to submit to each of you in writing, if we may. I wish we had the time here to do it.

Thank you very much for coming.

Mr. DOYLE. Thank you very much.

Dr. BLUME. I have with me a document of a New York State look at public intoxication and I would be glad to give it to you also.

Senator HUMPHREY. Thank you.

[Responses to questions submitted in writing and other material referred to follow:]

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April 16, 1981

Dear Mr. Powell:

Thanks for the short extension on AMSA's reply to the five enclosed questions. As I mentioned in our telephone conversation the executive committee of the American Medical Society on Alcoholism met on April 12th and discussed the questions in detail. There was further membership input at the annual business meeting on April 14th. Based on the above, I enclose AMSA's replies.

In addition to the enclosed replies, AMSA passed the following resolution:

The American Medical Society on Alcoholism supports both the reauthorization of NIAAA for four years as a separate institute, and the budget recommendation of the Institute of Medicine report that recommends an increase in the NIAAA research budget of 50% in each of the next three years.

Please feel free to call on me or AMSA for any further assistance we might provide.

Very truly yours,

Sheila Blume

Sheila B. Blume, M.D.

Senate Committee on Labor
and Human Resources
4230 Dirksen Building
Washington, DC 20510

cc: Henry R. Desmarais, M.D.

Enclosure

SB/db

AMSA replies to questions following the March 25, 1981 hearing on the Reauthorization of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act, based on AMSA executive committee meeting 4/12/81 and membership meeting 4/14/81.

1. Do you agree that NIAAA initiatives with regard to third-party payments are important, and why or why not?

AMSA is convinced of the necessity for adequate third-party payment for alcoholism treatment, a condition which has not yet been achieved nationwide. Until alcoholism treatment is adequately and appropriately integrated into the mainstream of health services and health funding, alcoholism programs will remain heavily dependent on categorical funding, and consequently will remain unnecessarily vulnerable to shifts in economic policy. There is a national need for sound research data in this area. For this reason AMSA recommends the continuation of the NIAAA initiatives. We further recommend that, in order to make the data developed as useful as possible, an advisory group of recognized research scientists and health economists expert in appropriate methodology be formed. The task of this group would be to advise NIAAA, offering their technical assistance to assure the soundness of methodology of any grant awarded under this program.

2. Would you discuss your view of the importance of the National Commission on Alcoholism and other alcohol-related problems?

AMSA is fully in support of the National Commission on Alcoholism and Other Alcohol-Related Problems. At this historic point in the development of the federal alcoholism effort, we feel that an independent evaluation of that effort and a set of recommendations for future direction would be both timely and important.

3. Do you feel the Commission can operate effectively under its current financial restraints? What changes would you recommend?

AMSA recommends that the Commission, either in its present or a similar form, be given sufficient time and resources to do a truly comprehensive evaluation of the federal program. A superficial report will have little real effect. To accomplish this job in a credible and useful way, AMSA believes that a minimum of two to two and one half million dollars will be required. AMSA strongly recommends that this sum not be derived from the already meager pool of funds appropriated to the NIAAA to fund research and demonstration projects.

4. Do you feel the state plans and state advisory councils mandated by the Comprehensive Act in its current form are effective? Please discuss briefly reasons for their effectiveness or how they could be improved to be more effective. S.755 repeals these requirements. Is this a good idea? Please comment.

The AMSA executive committee discussed the question of advisory councils at length, since members from different states had a variety of experiences with the effectiveness of such councils. The general consensus was in support of advisory councils as an independent voice to advocate for adequate and effective programs. AMSA does recommend, however, that increased participation of physicians active in the alcoholism field be required for these councils. Comments on state plans are included in the next reply.

5. New Hampshire's combined state plan prepared to qualify for alcohol and drug formula grants runs about a 175 pages. Everyone knows the importance of planning, but this type of plan seems more like something aimed at meeting bureaucratic demands that serve no useful purpose. The New Hampshire State Director has told us that he could come up with a reasonable plan in 30 pages or less. Shouldn't he be given that freedom rather than forced to comply with Washington's rules?

AMSA recognizes the value of planning for alcoholism services at the state level, and the particular importance of having the state alcoholism plan become an integral part of state planning, both in the area of health and in other areas of state responsibility that have an impact on alcohol-related problems, such as urban planning and highway safety. AMSA does feel however, that far more discretion should be left to the states to develop their own plans in a format which best integrates into their own particular organizational structure.

Resolution Concerning Alcoholism Services to be Provided by Health Maintenance Organizations

Adopted by AMSA
February 6, 1981

Recognizing the unique role of the Health Maintenance Organization in the provision of medical care, including health maintenance and prevention of disease,

And, recognizing that alcoholism is a treatable disease, which, if not treated early, produces a wide range of physical and mental complications,

So that men and women with alcoholism are treated under other diagnoses without addressing the underlying illness,

The American Medical Society on Alcoholism recommends that the Health Maintenance Organization requirement for provision of alcoholism treatment be enlarged from the present requirement for detoxification and referral, to include a full range of treatment, on the same basis as other diseases.

AMERICAN MEDICAL SOCIETY
ON ALCOHOLISM

RESOLUTION

On Self-Help Groups

10/19/79

WHEREAS, Alcoholism is a complex disease affecting the body, mind, family, occupational and social life of the person afflicted;

WHEREAS, the treatment of the disease Alcoholism requires a cooperative effort involving many disciplines in addition to physicians;

WHEREAS, self-help groups, particularly Alcoholics Anonymous, have been a tremendous help in recovery to many thousands of alcoholics, their friends and families;

THEREFORE, be it resolved that the American Medical Society on Alcoholism encourages all physicians and the alcoholism treatment agencies with which they work to develop relationships of maximum cooperation with the self-help groups, such as Alcoholics Anonymous.

Decriminalization in New York: Health Needs of the Public Intoxicant

by: Sheila B. Blume, M.D.
Director, NYS Division of
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Albany, New York 12229

For presentation at: the conference on "Alcohol Abuse and the Criminal Justice System: The Public Inebriate in Our Communities and Our Jails", to be held July 14-16, 1980 at Wingspread, Racine, Wisconsin.

January 1, 1976 was "D" day for us in New York -- "D" for decriminalization. I well remember how we looked forward to that day with fear and trembling. The emergency service network that we had planned was far from adequate and far from in place. As January 1st neared we tried to persuade the legislature to allow us to put off the date for six months, fearing that public inebriates might freeze in the cold winter weather. On December 31st, the famous "New Year's Eve Mailgram" was sent to police and local governments by the then Commissioner of Mental Hygiene. In this message, he designated all state mental hospitals, detoxification units, emergency rooms, and sobering up stations as facilities approved to accept admissions under the new law. New Year's Day came and went, and luckily none of our worst fears came to pass. Looking back now, four and one-half years later, it is appropriate to ask, where are we now?

Decriminalization in New York

We had made certain predictions about the needs of the public intoxicant to be addressed. Based on studies in the late 50's such as Pittman and Gordon's famous "The Revolving Door", we expected that our urban population would consist of older males, with a higher proportion of minority members than in the population of the city at large, who were largely unskilled, uneducated and unemployed. We expected that our black clients would be younger than our whites. This in fact has been our experience, particularly in New York City, where programs for homeless men have reported a progressive increase in the proportion of minority members, a decrease in median age, and a general tendency for both black and Hispanic persons to be younger than whites.

We also had expectations of what our suburban and small town populations would be like. A 1974 study of 29 such communities in New York, accounting

for over 4,000 public intoxication arrests, yielded the data in Figures 1, 2 and 3. Notice the differences in the age distribution (more people under 25) in the larger suburbs and small towns. Also note the low percentage of homeless persons, the high proportions of local residents and of those regularly employed full time, in the suburbs and small towns. This population has also appeared in our emergency care system.

In preparing for the change in law, New York State assembled a task force which reviewed current literature. Based on studies done in Toronto in the late 1960s and in San Francisco in the mid-70s which demonstrated that less than two percent of public inebriates required acute hospitalization, and that perhaps 5 percent required an emergency room visit, New York decided to put in place a system of sobering up stations. These have developed into three slightly different models. Twenty-one of the 31 facilities presently operating in New York State are freestanding sobering up stations, with arrangements for medical backup with a nearby hospital and emergency room. Six are components of comprehensive alcoholism services, usually associated with intermediate care, daycare or outpatient services, which often gives them access to a physician in addition to the regular staff. Both models are used in urban settings and as regional emergency care centers in populated suburan/exurban areas. The third model is hospital-based, and has been useful in rural areas. This model employs 1 or 2 holding beds in the emergency service of a local general hospital, with referrals made from the emergency room. Staff in addition to the program director are called in on an "as needed" basis. There are currently 4 such services in the state. The network as it stands today is quite incomplete. Combined problems of shortage of funds and community resistance have hampered our efforts to make these services uniformly available throughout New York.

Where then do we stand in terms of getting the public inebriate into our system? Table I demonstrates changes in arrest patterns between 1974 and 1978 in the state as a whole, in New York City, and in that part of New York State outside of the city. The latter division is necessary because both arrest patterns and admission patterns to sobering up services are quite different in New York City. Looking at the agregate data (first row), one might guess that persons arrested for public intoxication before 1976 might have been arrested for vagrancy or loitering after the law changed. However when the data is broken down between New York City and the rest of the state, it becomes clear that nearly all of the loitering arrests were in New York City, where there had been virtually no public intoxication arrests prior to decriminalization. The data does show a large drop in disorderly conduct arrests in New York City however, in contrast to the rest of the state. It appears that the increase in loitering arrests may relate to this change. These data, on their face, thus do not seem to show that decriminalization was met by a simple change in type of arrest. The figures for sobering up service admissions (bottom row) seem to indicate that many public inebriates find their way into the system.

An interesting study was conducted by Diane Casbeer of the New York State Research Institute on Alcoholism in Buffalo. She surveyed 460 police departments throughout the state at three months, and at one year after decriminalization. Figure 4 shows the impressions of the police chiefs as to the effect on their communities of the new law. Very few stated that arrests were being made on other charges, but few also indicated that police were transporting these persons to sobering up stations. In fact, sobering up services and transportation were commonly mentioned as outstanding needs in their local communities to provide appropriate aid to the public inebriate.

Data collected for the seven facilities in New York City in 1979 shed further light on the role of law enforcement. Referrals into the sobering up system were made by police in only three percent of the cases. Next to self referrals (38%), the most common sources of referral were other alcoholism programs (19%), and emergency rooms (10%). The fact that the clients were not brought in by police should not be interpreted as evidence that they are not in fact public intoxicants. These clients are often experienced users of the system, who know it well and find their way to the facility by themselves or with the help of friends.

In "upstate New York" outside of New York City, about 17% of sobering-up admissions were referred by police, while on Long Island 28% were so referred. In these parts of the state as well, self referral was common (26%), and health and social service agencies (26%) were important sources of clients. This would seem to indicate some integration of these facilities into the human service system.

In summary, there is some evidence that a large proportion of public inebriates are finding their way into the alcoholism service system in New York, rather than simply being arrested on other charges, and that the police may not be the major referral mechanism in areas of concentrated population, but are important in suburban, exurban and rural areas.

Health Needs of the Public Intoxicant

The older literature on the public intoxicant stressed poor nutrition and poor hygiene leading to high rates of tuberculosis, liver disease, and anemia, as well as unusual syndromes such as cutaneous diphtheria. A study by Eichner et al (1) compared 65 ambulatory skid row alcoholics with 47 middle and upper class ambulatory alcoholics. They found no significant difference in the

extent of liver disease or anemia between the two groups, but the anemia in the skid row group was an iron deficiency type, presumably due to frequent blood donations, while folate deficiency was the most common cause of anemia in the upper and middle class group. Studies in the late 60s from Toronto highlighted both the general health and mental health status of the public inebriate seen in that city. Olen in 1966 (3) reported on the health needs of 227 chronic drunkeness offenders in the Toronto jail. Fifteen percent of these had tuberculosis, 13% had peripheral nervous system lesions, and 18% had liver disease. Many other health problems were found. Forty-two percent of 456 admissions to a Toronto detoxification unit in 1968-69 were found to be suffering from an acute or chronic condition requiring medical supervision that in a normal population could have been adequately carried out on an ambulatory basis (2).

Similar surveys were conducted during the 70s. Figure 5 is from a study of O'Brient et al at a social setting detox in San Francisco, California, on a sample of 99 persons admitted to the program, examined at various intervals after admission. This sample did not include the five percent of cases which were referred to medical facilities. Table II is a similar survey made by the Manhattan Bowery Project in New York City. This table reflects mental health conditions as well as physical conditions. Both studies highlight that the health needs of this group are great.

One of the many factors that makes provision of care to this population quite difficult is their lack of health insurance coverage. An unpublished study performed by Stuart and Evans in 1978 surveyed 3,000 clients admitted to a sobering up station in the Bronx, New York. The medical coverage available to this group is shown in Table III. More than half of the clients treated in this urban setting had no health insurance coverage in spite of the fact that

most were indigent. How well are we meeting the health needs of this group? The data available to us indicate that between one-half and 65% of clients leaving our sobering-up system accept referrals for further care. The number who actually follow through on these referrals is unknown but may be presumed to be less than ideal. The following section will address some of the probable reasons for this situation.

Trends in Public Inebriate Populations; Effect of Deinstitutionalization

Both a series of personal interviews conducted with staff of programs serving the homeless inebriate in New York City's Bowery area and a review of recent surveys point to a change in the characteristics of public inebriates requiring service in some areas of the state. In a 1976 survey of a random sample of 327 men assisted at the New York City Men's Shelter on the Bowery, 48% were found to have pronounced pyschiatric problems. Many of these men were also public inebriates. The Manhattan Bowery Project (see Table II) during the same period found that 34% of the clients detoxified had psychiatric illnesses. Programs in this area of New York are seeing a concentration of former residents of large psychiatric institutions, eking out a marginal existence largely outside of the psychiatric and social rehabilitation systems. Many of them have developed alcohol problems which at times become the presenting emergency. This multiply disabled population has placed a definite strain on agencies traditionally geared to the needs of the long term chronic alcoholic who was otherwise free of mental illness. The following is a quotation from a speech by the Reverend David G. Henritzy, director of the Bowery Mission in New York City, in April 1980: "As I see it, because of deinstitutionalization, those of us who are trying to operate social services agencies, whether in the public or in the private sector, are

being forced into the position of having to provide services for which we are not geared. We are no longer able to serve our target populations. The Bowery Mission for example has, as of last year, 100 years of experience in dealing with alcoholics. That has given us a vast storehouse of expertise in this area. We are not set up, we are not designed and we do not know how - in the sense of practical expertise - to deal with persons who are lethally anti-social. We are being forced into that position and we are trying to cope. But these new pressures are forcing us to provide services for which we are unprepared. The result is that the things that we know how to do and the things that we do well are suffering. The purposes of our programs are being destroyed and watered down by virtue of the necessity to deal with external forces over which we have little if any control."

The 1980s may well be the decade of the multiply-disabled public intoxicant. Figure 6 shows the results of a 1980 survey of 87 "street people" on the upper west side of New York City, one of the so-called "impacted areas" in which formerly hospitalized chronically mentally ill persons reside. The people surveyed were offered service on the street. Notice the overlap in disability areas.

This multiple disability is not limited to urban areas. Table IV is an unpublished census of 120 residents of proprietary homes for adults in a suburban seaside resort area in Nassau County, New York. The multiple disability shown by this group is striking.

Service Models for the Multiply Disabled Public Intoxicant Group

It seems clear to us, in New York, that programming for this most difficult multiply-disabled group can best be accomplished as a joint venture between the alcoholism and mental health service system. The difficulties in

establishing such services in our state are enormous. For example, one of the "impacted" communities requested assistance from the Division of Alcoholism more than two years ago. A joint program with the Office of Mental Health, consisting of an outreach van and a day hospital staffed by both alcoholism and mental health professionals was designed. This program has yet to be implemented. Members of the community expressed fears that the establishment of new services for alcoholic people would attract more alcoholics to their area. The program plan has been continually reshaped to meet community objections and suggestions. At the moment it calls for the centrally coordinated addition of a number of alcoholism counselors and other health professionals to presently established mental health programs. We hope this program will be initiated and will provide experience and direction for future programming. We are also anxious to explore other models, and feel that in spite of the difficulties we must persevere in our efforts to discover ways to serve this difficult and needy population.

Directions for future study which would be most helpful to us in this task would include detailed studies of the drinking patterns of the multiply disabled, including the drinking patterns of female public intoxicants, a group often overlooked, and comparative studies of various models of intervention with this group. Both the health needs and mental health needs of the public intoxicant of the 1980s present a continuing challenge to the health care system and to our society as a whole. If we, as a society, truly care about our least attractive and most difficult to serve clients, then we will show it here, on the Boweries and the skid rows and the "impacted" areas of our nation.

REFERENCES

1. Eichner, E.R., Buchanan, B., Smith, J.W. and Hillman, R.S. Variations in the hematologic and medical status of alcoholics, Amer. J. med. Sci. 263: 35-42, 1972

2. Robinson, L., "Report on Detoxication Program", 24 Harbord Street, Toronto, Ontario, April, 1970

3. Olin, J.S. "Skid Row" syndrome: a medical profile of the chronic drunkenness offender, Canad. med. Ass. J. 95: 205-214, 1966

SOURCE OF FIGURES AND TABLES

Figures 1 - 3: "Survey on Public Intoxication in Suburban and Rural Communities in NYS", Diane L. Casbeer, Research Institute on Alcoholism, Buffalo, NY 1975

Figure 4: "The Impact of Decriminalization of Public Intoxication in New York State", Diane L. Casbeer, Research Institute on Alcoholism, Buffalo, NY 1977

Figure 5: O'Briant, Robert, et al, "How Safe is Social Setting Detoxification?", Alcohol Health and Research World, Winter 1976/77, pp. 22-27

Figure 6: Mesnikoff, A.M., et al, "Process and Progress in Community Support Systems", presentation made as part of a panel on Community Support Systems at the Office of Mental Health Directors Conference, Spring Valley, New York, April 30, 1980

Table II: Ten Year Report of the Manhattan Bowery Corporation, 1967-1977

TABLE I

New York State Arrests and Sobering-Up Admissions
(in thousands)

All Arrests*	1974	1975	1976	1977	1978	1979
pub. intox	34.3	26.8	0.4	----	----	
dis. cond	88.6	73.0	56.8	52.6	49.1	
vagrancy		2.0	11.7	----	----	
loitering	----	----	----	23.2	14.1	
state total	122.9 &	101.8	68.9	75.8	63.2	
NYC Only						
pub. intox		0.5	----	----	----	
dis. cond.		50.3	28.7	22.8	19.7	
vag/loiter		1.1	10.6	21.7	12.9	
NYC total		51.9	39.3	44.5	32.6	
Non- NYC						
pub. intox.		26.3	.4	----	----	
dis. cond.		22.7	28.1	29.8	29.4	
vag/loiter		0.9	1.1	1.5	1.2	
non NYC total		49.9	29.6	31.3	30.6	
Sobering-Up**						
admissions: statewide			21.2			40.0
NYC			.1			13.2
non-NYC			21.1			26.8
individuals:statewide			5.0			15.0
client days:statewide			----			100.0
average stay: statewide			----			2.5 days

* source NYS Division of Criminal Justice Services
**source NYS Division of Alcoholism and Alcohol Abuse
(26 facilities operating 1979, (31 are operating in 1980)

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TABLE II

Medical and Psychiatric problems occuring in the 3,145 admissions from July 1, 1976 to June 30, 1977

Problem	%	Problem	%
Heart Conditions	3	Hypertension	20
Wounds, Cuts, Burns	50	Diabetes	6
Severe Eye Infections	3	Severe Liver Disease	6
Fractures	20	Seizures	4
Severe G.I. Bleeding	5	Hx of Seizure Disorder	25
COPD	15	Hallucinations	20
Pneumonia	6	Severe Depression	5
Active Tuberculosis	4	Severe Psychosis	9
Inactive TB	15	Severe Brain Damage	20
Venereal Disease	3	History of Drug Abuse	5

Source: Ten Year Report of the Manhattan Bowery Corporation, 1967-1977

TABLE III

INSURANCE	NUMBER	PERCENTAGE Male	Female
Medicaid	1125	34.0	41.1
Blue Cross	51	1.5	1.8
Other	30	1.0	0.9
None	1590	57.0	49.1
Unknown	204	6.5	7.1

**Table developed by R. A. Evans while completing a research project at South Oaks School of Alcoholism Studies 1977 - 1978.

TABLE IV

1979-1980

Survey of the Residents of an "Impacted Area":
Long Beach, New York (Nassau County)

The following data is based on the survey conducted by Southeast Nassau Guidance Center, Inc., Seaford, New York. Six hundred (600) residents of Private Proprietary Homes for Adults (PPH) located in Long Beach, NY were surveyed. Long Beach is an area in which many former hotels and boarding houses became houses for the so called "deinstitutionalized" former mental patient discharged from large institutions in response to the community mental health movement.

Total Number of PPH Residents Surveyed = 600

Number with Significant Alcohol-Related Problems = 120 (20% of the cases)

The definition of alcohol impairment included impairment of daily functioning, health, social interaction and/or work activities by alcohol. Characteristics of the 120 PPH residents with identified alcohol problems were found as follows:

Sex:	Male	77%
	Female	23%
Age:	Under 50	22%
	50-65	44%
	Over 65	34%
Ethnicity:	White	80%
	Black	13%
	Puerto Rican	7%

Marital Status:	Single	52%
	Married	6%
	Div/Separated	18%
	Widowed	14%
	Unknown	10%
Religion:	Jewish	7%
	Catholic	42%
	Protestant	23%
	Unknown	28%

Medical Problems: total: 41 (34%)

Cardiovascular: 12 cases
(6 hypertension; 1 infarction; 3 athrosclerotic Disease; 2 stroke)

Respiratory: 6 cases
(TBC 1; emphysema and Obstructive Pulmonary isease 5)

Neurological: 9 cases
(seizures 8; tardive dyskinesia 1)

Endocrine: 3 cases
(diabetic)

Phlebitis: 1 case

Musculo-Skeletal: 5 cases

Blind: 2 cases

Genito Urinary: 1 case

Anemia: 1 case

Cancer: 1 case

Psychiatric Problems: total: 57 (48%)

Schizophrenia: 33 cases

Affective Illness: 8 cases
(Manic Depressive 3; depression 5)

Organic Illness: 6 cases
(1 senile and 1 pre-senile dementia, 1 mental retardation, 3 chronic brain syndrome)

Substance Abuse: 4 cases

Neurosis: 3 cases
(2 anxiety; 1 anorexia)

Personal Disorders: 3 cases
(2 sociopathic; 1 passive dependent)

Length of Residence in Long Beach Area

Under 1 year	15%
1 - 4 years	50%
Over 4 years	35%

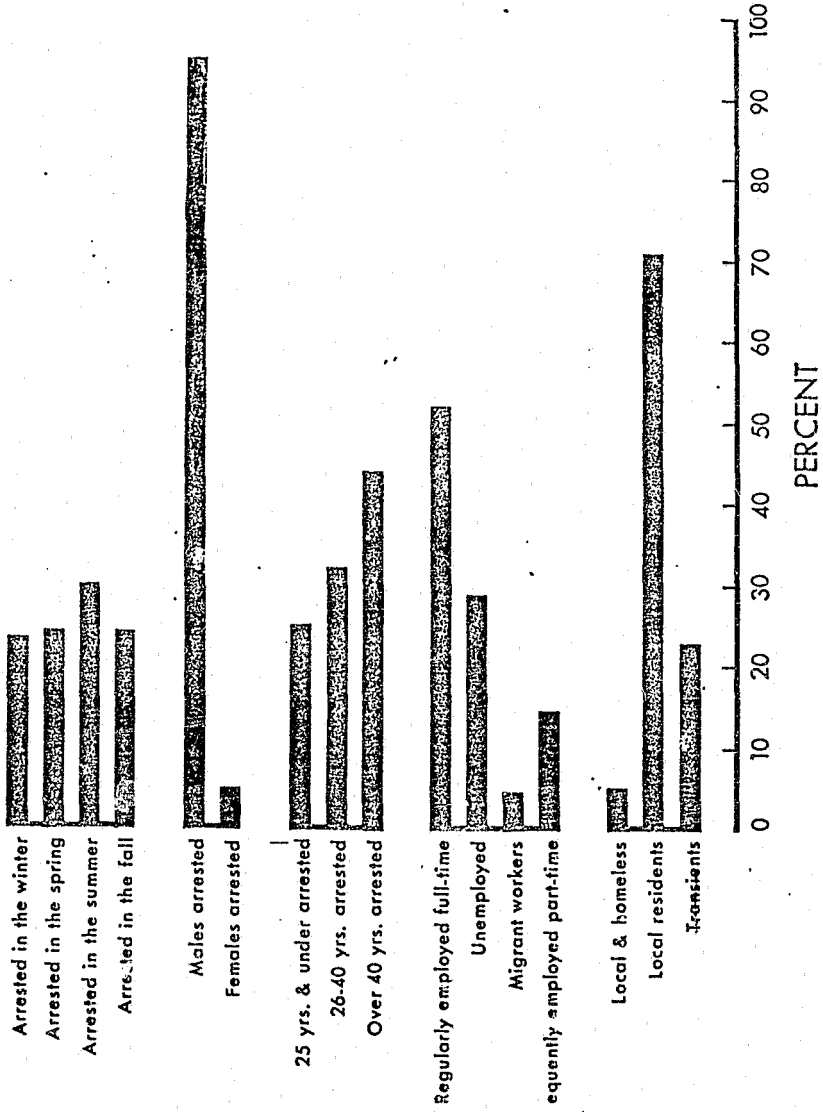

Figure 1. A profile of public intoxication arrests in small towns. (Population under 25,000) N=19, 2,077 arrests; from: "Survey on Public Intoxication in Suburban and Rural Communities in NYS", Diane L. Casbeer, Research Institute on Alcoholism, Buffalo, NY 1975

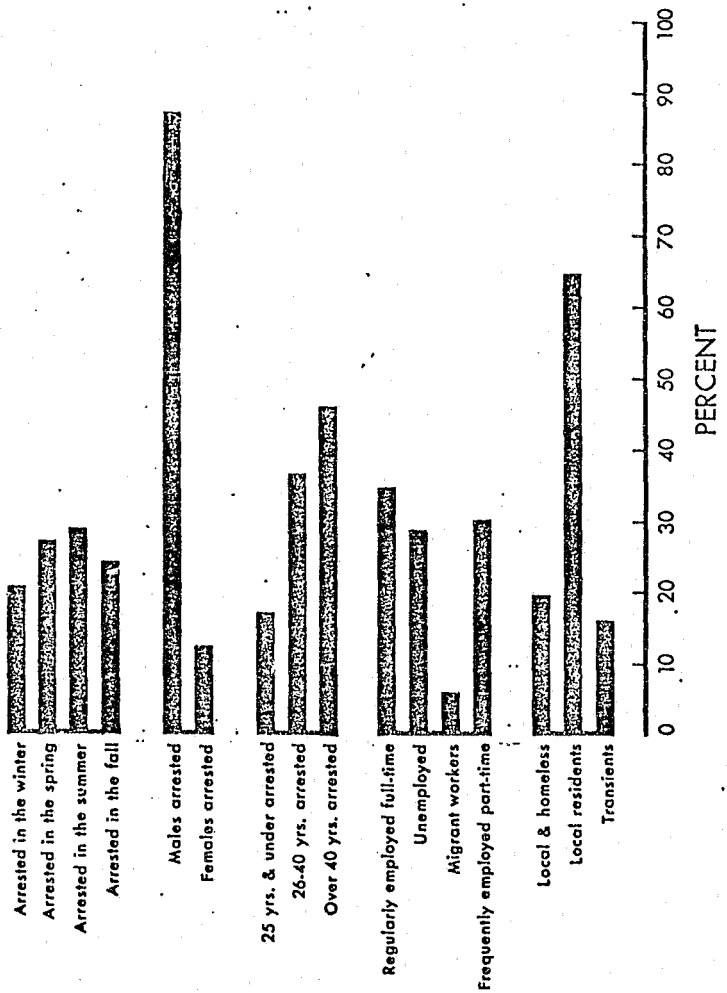

Figure 2. A profile of public intoxication arrests in small cities/medium suburbs. 1974; N=6; 1,036 arrests;(population 25,000 - 50,000,) from: "Survey on Public Intoxication in Suburban and Rural Communities in NYS", Diane L. Casbeer, Research Institute on Alcoholism, Buffalo, NY 1975

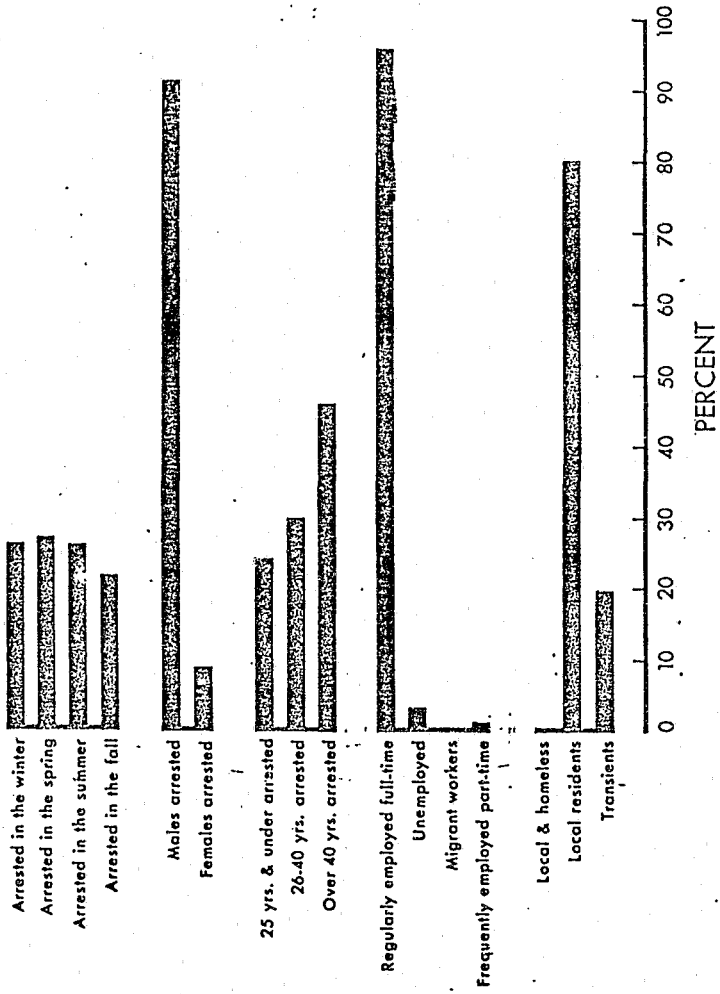

Figure 3. A profile of public intoxication arrests in large suburbs. 1974; N=4; 1,053 arrests, (population over 50,000;) from: "Survey on Public Intoxication in Suburban and Rural Communities in NYS", Diane L. Casbeer, Research Institute on Alcoholism, Buffalo, NY 1975

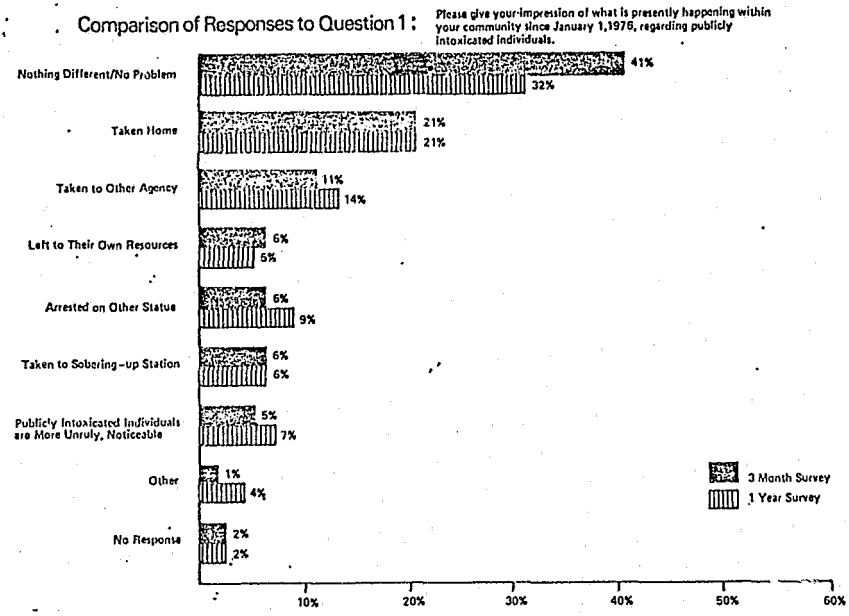

Figure 4. Source: "The Impact of Decriminalization of Public Intoxication in New York State", Diane L. Casbeer, Research Institute on Alcoholism, Buffalo, NY 1977

Pathology	Total Frequency *	24-Hour	48-Hour	72-Hour
Liver enlargement	51	18	17	16
Hypertension	31	13	12	6
Skin/rashes, etc.	24	8	10	6
Teeth/gums	20	3	6	11
Cardiac condition	19	6	8	5
Lung anomaly	17	3	9	5
Motor (myopathy)	14	4	6	4
Insomnia	12	3	5	4
GI tract	11	3	2	6
GU tract	10	6	2	2
Rectal/prostate	10	2	6	2
Infections	9	3	4	2
Pancreatitis/diabetes	8	3	1	4
Lacerations/contusions	7	4	1	2
Sensory (neuropathy)	6	2	2	2
Cerebellar degeneration	6	4	—	2
Neuritis	5	1	2	2
Reflexes	4	1	—	3
Nystagmus	3	2	—	1
Genitalia	2	—	2	—
Pelvic anomaly	1	—	—	1
Glaucoma	1	—	—	1

Figure 5.

*"Frequency" is the reported presence of an abnormal condition. based on 99 cases (80 men, 19 women), Source: O'Briant, Robert, et al, "How Safe is Social Setting Detoxification?", Alcohol Health and Research World, Winter 1976/77, pp.22-27

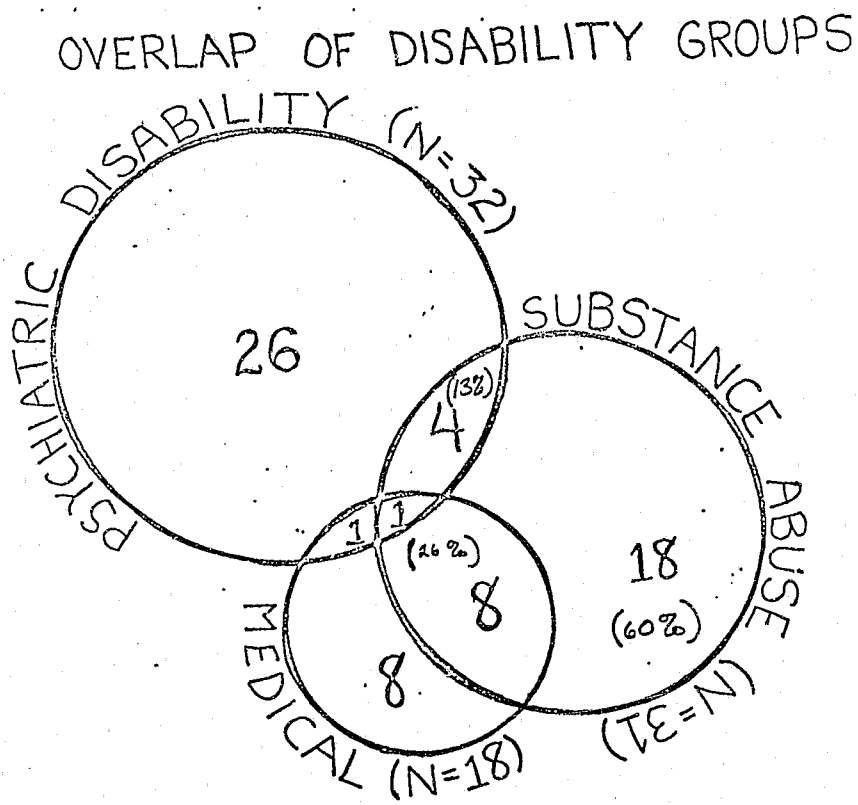

Figure 6. Survey of 87 "Street People": median age: mid-40's; 63% male, 37% female; 25% homeless.
Note: "Substance abuse" consists largely of alcohol abusers
Source: Mesnikoff, A.M., et al, "Process and Progress in Community Support Systems", presentation made as part of a panel on Community Support Systems at the Office of Mental Health Directors Conference, Spring Valley, New York, April 30, 1980.

(Note: In the interest of economy, certain other material submitted by Dr. Blume was retained in the files of the subcommittee because of its voluminous content.)

National Coalition for Jail Reform

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JUDITH JOHNSON
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American Arbitration Association

April 14, 1981

TO: Henry R. Desmarais, M.D.
Majority Staff Director
Subcommittee on Alcoholism and Drug Abuse

FROM: Judith Johnson
Executive Director
National Coalition for Jail Reform

SUBJECT: Answers to the questions submitted for the record by the subcommittee at the Alcohol Hearing of March 25, 1981. Reauthorization of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act.

Question 1. Legislative changes needed to meet the needs of the Public Inebriate.

Answer a. The public inebriate has been neglected within the alcohol field. Whether the alcohol funds stay at the federal level or are incorporated into block grants, the public inebriate needs to be a priority population within alcohol funding.

b. Jurisdictions could be required to outline proposed comprehensive service for the public inebriate in their state/local health plans.

c. Due to the great social and economic costs the public inebriate presents to society, this should be a priority for NIAAA. Congress should require the agency to include the public inebriate as a priority in research and technical assistance efforts of the agency.

d. A capacity at the federal level needs to be maintained to help states deal with this problem. If states are to fund programs, they need to know what works, what the alternatives, problems, and costs are. They need to know what other states have done and avoid making the same mistakes. There is a need for social research to see which programs are most effective and what techniques work best for this difficult group. This research, publication and technical assistance role can be most effectively done at the federal level and will help states save money as they set up programs. There needs to be a clearinghouse for information collection and dissemination which should be done by NIAAA.

Question 2. The cost of treatment facilities for the public inebriate.

Answer There is a wide range of costs and no study has been done evaluating programs or assessing what the costs cover. Some of these programs use a medical model for detoxification, which is obviously more expensive than a social model program.

From program information that I have:

-Los Angeles Volunteers of America - Detoxification $30 a day per person, Residential care $13.00, Recovery home $16.00.

-Witchita, Kansas Public Inebriate Program averages $32 a day.

-Chicago Northwestern Memorial Hospital Institute of Psychiatry is $42 a day.

-Indianapolis, Indiana Salvation Army Program--Detoxification $27, Work Therapy $22, Residential Work Therapy is self supporting.

-Grand Junction, Colorado Bridge House, Detoxification $60, Intensive Residential Treatment $38, Halfway House $28, Outpatient $10.

-Louisville, Kentucky Seven Counties Services--
Detoxification $100, Residential Treatment $60,
Transitional Living Services $35, Regular
Treatment $25, Day Clinic $20.

-West Palm Beach Florida, Comprehensive Alcoholism
Rehabilitation Program. Funded with $200,000
in client repayment fees a year.

Question 3. Impact of the Reagan Budget regarding NIAAA on Uniform Act grants.

Answer Under the proposed budget, the incentive funds for states to implement the Uniform Act would be ended. The Uniform Act funds have been the only incentive for states to deal with this problem. They have been significant in giving states the impetus to set up programs for the public inebriate as alternatives to jail. When states have seen that they save money for the state, they are picked up with state or local funds. But the incentive monies have been crucial in starting programs. If the incentive for states to establish such programs is eliminated, there will be no reason for them to decriminalize public intoxication. And without such incentives, implementation of the Uniform Act in states that have decriminalized, will be difficult.

Question 4. The success rate of programs which NIAAA has funded.

Answer There has been no national study of how the incentive funds have been spent, how the implementation of the Uniform Act is working, or how successful any programs have been.

From my reading and discussions with various programs, there are many successful programs that NIAAA has funded.

The Manhattan Bowery Program is an inexpensive program for public inebriates which has relieved the police of an enormous job. They handle 3,000 public inebriates a year, thus saving the police, courts and jail a great deal of money. They have shown that people will voluntarily choose to get help when offered it.

The Comprehensive Alcohol and Rehabilitation Program in Florida has experimented with a new model of funding which has been very successful. A public inebriate contracts with the program for his care and pays his costs back when he is recovered.

D R A F T

PUBLIC INEBRIATE PROCEEDINGS

TREATMENT ALTERNATIVES FOR PUBLIC INEBRIATES

What are adequate treatment services for public inebriates? How is a continuum of care defined? What are the essential components of such a continnum? What if the inebriated person refuses the service? These and similar issues were the focus of discussion throughout the conference. An attempt was made to develop concensus on exactly what the appropriate treatment alternatives for public inebriates.

The issue was raised that the primary concern of a program has to be the provision of services that sustain life through fulfilling basic human needs. Thus, fuud, shelter, clothing, and a safe environment are the basic services that must be provided in each community. Yet these fundamental services are not enough, for it is also necessary to offer additional treatment alternatives to the inebriate to assist in breaking the cycle of alcoholism. Yet caution was raised that some treatment programs and detoxification centers were too concerned with pushing clients into a continnum of care and thus, deemphasize the responsibility of meeting the basic human needs of these clients in a clean and safe environment as many times as necessary.

Another issue was raised regarding the right of treatment staff or others to insist that the public inebriate change their chosen lifestyle of living and drinking on the streets. It was aruged that the true inebriate is not making a choice, for because of the disease of alcoholism judgment and rational decision-making abilities are impaired. Dr. Irv Shandler pointed out that it is alright to consider that occasionally the inebriate is not in need of our intervention, but we must not retreat behind this into dangerous indifference for there is a real suffering on skid row.

> "The sober culture has a responsibility to interrupt irrationality."
>
> Irv Shandler, Pennsylvania

> "It is not, as some might believe, the last vestige of the American frontier. If we allow ourselves to view the inebriate as a bold non conformist in need of simple tolerance, we may be reluctant to intercede on his (or her) behalf."

In Portland, the Public Inebriate Program (PIP) operates within a law enforcement setting. Holding facilities, with nursing stations that monitor for vital signs, serve the repeater populatio , some with as many as 500 admissions. Although this is apparently a successful program, there was general concern among those participating in the discussion that close identification with the jail system is injurious. It invites old definitions of public inebriety that were in use when it was widely viewed as a crime, rather than an affliction. Jail may be a convenient setting, but it is, for this and other reasons, also a dangerous one.

Consensus was developed on the fact that the alternatives available to the public inebriate must be safe, clean, and readily available. A drop off center where public inebriates lie out on the floor and receive little or no care is not an acceptable alternative. In this case, the treatment alternative is nothing more than a jail in disguise.

> "Have we forgot what drunk tanks were before decriminalization? It's just several steps down to mats on the floor again."
>
> Charles Kester, Washington

Consensus was also developed on the fact that using the medical model for treating public inebriates is not always appropriate or economical especially for those programs just providing shelter and food. In these situations, staff trained in the disease of alcoholism and basic first aid skills can be effective in serving this client population.

Jim Cooks of Wisconsin questioned some basic assumptions people hold about the public inebriate.

- We should not assume that each public inebriate is like the other; that what works for one will work for all. Cooks himself drank for 22 years; six of those years spent on skid row. During his drinking, he was admitted to hospitals seven times and it was at the seventh where he began to get well, that he finally felt treated as a person; as an individual.
- We should not assume that education matters more than experience and empathy? Cooks has seen alcoholism counselors with no special credentials, who could barely fill out complicated report forms, help doctors, nurses and social workers rescue an alcoholic.

- We should not assume that by drying out the alcoholic we have done our job? Recovery involves more than treatment; it means ongoing support systems. When we fail, it is usually because we have not followed up.

"Recovery involves more than treatment."
Jim Cooks, Wisconsin

Conference participants confirmed that the needs of public inebriates are different and more complex than the average alcoholic, thus, traditional alcohol services based on middle class values are not going to be effective with this population. Rather, one must look at developing services that will actually meet the needs of the public inebriate. These services must address the more complex social, socialization, and environmental needs. This system must also be flexible in order to accept the fact that a large percentage of this group will be recitivists and thus, enter services continuously. It is necessary if one is going to be effective with this population to treat the client each time as a new client - a new chance to work with the individual in order to service their needs. In working with public inebriates, it is important to temper one's expectations of success. Providing basic care and supporting the dignity of the individual must become a self-fulfilling goal. Then if the individual does choose to enter a continuum of care, a real victory can be claimed.

All treatment and support services for public inebriates must be readily available and accessible. A shelter that is located miles from skid row will not be utilized by inebriates. Experience has shown that services that are available will in fact be utilized. If they are not readily available, the inebriate will find another means to meet their needs.

Discussion centered on defining exactly what constitutes a continuum of care for the public inebriate. The Uniform Alcoholism and Treatment Act states "alcoholics and intoxicated persons may not be subjected to criminal persecution because of their consumption of alcoholic beverages but rather should be afforded a continuum of treatment in order that they may lead normal lives as productive members of society." The Act goes on to suggest that this continuum should include: emergency treatment provided by a facility affiliated with a hospital; inpatient treatment; intermediate treatment; and outpatient and followup treatment. General consensus was reached that these services, with some additions,

make up the ideal continuum of care for public inebriates. A true continuum must provide everything needed to bring a person to full recovery and with the public inebriate this means more than just traditional treatment services. An ideal continuum would include:

- o Shelters - reception centers (basic human needs)
- o Transportation services
- o Detoxification services
- o Inpatient care
- o Residential treatment
- o Halfway houses
- o Domiciliary care
- o Outpatient and follow up treatment

Shelters

As previously mentioned, the basic service to be made available to public inebriates is safe, clean, and comfortable shelter. In some communities these are known as sleep offs, sobering up stations, reception centers, and other similar names. This type of shelter provides supervised care as well as shelter, food, and clothing. Usually, they are located close to skid row areas and are open 24 hours a day or at least all evening (6:00pm - 6:00am). Staffing for this type of facility usually includes several workers with at least one trained in emergency medical care in order to make an initial diagnosis of those needing medical care. Often the staff will include nurses or medical interns. The key to the success to this type facility is that it be made available to all who seek admission. A criteria may be established that requires the person be drunk but most often these type facilities are available to anyone in the community who is in need of a shelter. Due to this facility being utilized by more than public inebriates (such as other homeless individuals on the streets), funding and staffing can often be obtained from the local general social service/welfare budgets.

One example of the effectiveness of shelter type programs is found in Denver. At the emergency service program, Denver CARES, 35% of those who enter the program only utilize shelter care and return frequently. However, 65% choose to ge through detoxification amd many go on to halfway houses and eventually break the revolving door pattern.

Beau's Cafe, funded by the city of Anchorage, serves as a day shelter in that community. It is a small cafe within two blocks of the skid row area. The function of this cafe is to provide meals to the homeless and street people of Anchorage. The facility opens at 5:00 am and closes around 6:00 pm and provides three meals at a nominal charge. An approach to providing shelter in a rural area is found in Vermont where volunteer families take in emergency cases for short periods until long range treatment options can be developed. The director of the Alcoholism and Drug Abuse Division reports that the program has been very successful.

A variation on the shelter idea was created in San Francisco. A park was developed for those individuals who live on the streets around the "Tenderloin District." A block was developed which included park benches, cement tubes for sleeping and protection from the weather and rest rooms. The idea behind the park is to offer public inebriates a place where they could sleep and congregate, yet be in a concentrated area away from the downtown businesses. To assure that the park served the needs of this population, several street people were consulted for their expertise prior to the actual development of the park.

Transportation

A good transportation system is an essential element of a continuum of care. Unless a means is available to transport clients to the necessary facilities, the beds and services will not be utilized. Also with decriminalization, police are often less hesitant to transport the inebriate co the shelter or detoxification centers.

Community service patrols have been initiated in many communities. Most often these are vans that patrol the skid row area to pick up public inebriates. Staff for these vans are trained in emergency medical treatment. These vans are available to handle all cases involving drunkendness that the police would usually handle. In Anchorage the police time spent dealing with drunkendness requests was reduced from 12.4% of all police time to 3.18% over the two and a ahlf year period after the vans were established. In Seattle, the emergency services unit of the county health department has replaced the police in picking up 12,000 public inebriate each year. Other communities contract with ambulance services or use county medical teams to pick up public inebriates. Don McConnell of Connecticut pointed out that a taxi token system has been used in his state. A contract is established with a taxi firm to provide transportation for those drunk in public. Each trip where a taxi transports a public inebriate is billed to the state/county. Other systems used volunteers for transportation. A list

of volunteers is contacted. In some situations the activity is totally volunteer, in others a stipend, expenses or use of a state/county care is provided. In the rural areas around Portland this system is used to transport inebriates from a holding area in each rural jurisdiction to the detoxification center in downtown Portland. This type of volunteer transportation system works especially well in rural areas.

Another option being used in many locations is to use the police for transportation to the detoxification or shelter facility. However, use of police can have significant implications to the effectiveness of the total service package. For example:

- Although there is a great diversity among jurisdictions, it is not uncommon for police to resent their role as a transportation service for inebriates. This is especially true in rural areas where transportation to a treatment facility may be more inconvenient and time consuming than transportation to the local jail.[2]

- Apprehension and transport to a treatment facility does not normally count toward arrest totals or quotas, giving police officers little incentive to carry out this task. As a result, it appears that the police in many jurisdictions where decriminalization has been adopted tend to ignore public inebriates as much as possible, thus perhaps depriving them of necessary care.

- Police can circumvent decriminalization legislation by arresting public inebriates for other offenses such as disorderly conduct and vagrancy.

Although response to this problem has generally been limited, there are a number of approaches which communities may take. For example, the incentives for police pickup of public inebriates may be increased by simplifying the paperwork required for picking up intoxicated persons and delivering them to treatment facilities. In addition, jurisdictions could provide credit toward officers' arrest quotas/totals for pickup and transport to treatment programs. Police officer cooperation may also be enhanced through improved training. Training manuals on human relations and contact with public inebriates, such as those developed by the International Association of Chiefs of Police, may be useful in this effort.[5] Departments may establish information programs to apprise officers of the range and location of treatment facilities available. Finally, the officer will be more responsive to the program if he/she is made to feel like they are providing an invaluable service. One program makes coffee and a quiet office available to the police so they can take a break and/or complete this report.

Several other examples of successful transportation options include:

- In New York City, the Manhattan Bowery Project--a model program--employs rescue teams composed of plainsclothes police and recovering alcoholics. The director asserts that these rescue teams provide adequate and timely coverage.

- In Sacramento, California, civilian vans picked up 2,900 public inebriates from the downtown area in the first half of 1979.[9] In other California jurisdictions, however, a project evaluator reports that van pickup provides inadequate coverage.

- In Vermont, according to the Director of the state's Alcoholism and Drug Abuse Division, a very successful volunteer pickup service has been established. Rural areas often have serious difficulties with such programs, however, because of the long distances to treatment facilities.

- In Wisconsin, the director of the Bureau of Alcoholism and other Drug Abuse reports plans to contract out pickup and transportation to civilian drivers.

An issue raised around transportation is the liability of these providing the transportation. Usually the state/county or program is insured to cover those working on transportation. Another issue raised is the authority of the transportation staff in dealing with the inebriate. Generally the staff work with the inebriate to try and convince the person to consent to being transported. However, if the inebriate refuses to cooperate then the staff does not use force in attempting to transport the inebriate.

Detoxification

Community based detoxification services must be made available in each community either operating under purely medical or social setting model or a combination of both. Most social setting programs do utilize some medical staff, usually a nurse. Detoxification programs are most often set up as 3-5 day programs with the option for extended care, if necessary. These facilities often have a dramatic effect on public intoxification arrests. In Madison, public inebriate arrests were reduced by 30% after a detoxification program was established.

New York State utilizes a three progned approach to detoxification. In some communities there exist free standing detoxification programs. In other communities detoxification is one aspect of comprehensive treatment program. In the third instance, detoxification is linked up with a hospital. The drunken individual is given a quick check over by the hospital emergency room staff and is then assigned to a room for detox adjacent to the emergency room. Once the detox process is complete, the individual is released from the facility.

Other communities have beds reserved in nursing homes or other care facilities for detoxification. Often in rural areas the detox center is located in one community and surrounding communities transport appropriate clients to the center. In these cases, transportation becomes an essential element of the process.

Extended Care

Once a client has completed detoxification, the next step is to move them into extended care where the individual can complete his stabilization and begin an integration back into the community (inpatient care). Usually this phase of a program averages four to six weeks. The purpose is to keep the client in a protective environment where they can begin to explore alternatives to drinking and continue the process of stabilizing their emotional and physical processes. Long range treatment planning will often take place at this time.

Another component of the continuum is extended residential treatment for those clients who are so socially and physically debilitated that this type of long term care is essential. This phase may be several months in length. The focus of treatment is on realization of one's problem and development of strageties for long term sobriety. Halfway and three-quarter way houses are utilized in helping clients integrate back into the community. In most situations the client will live in the house yet hold a job in the community. Attendance at Alcohol Anonymous meetings and other counseling is also provided. The prupose is to offer the alcoholic a protected environment in which they can live while attempting to integrate into the community alcohol free.

Long term care is an extremely expensive phase of treatment. Some interesting and relatively successful long term programs have been established. Yet most, however, are still very small scale efforts because of inadeuqate funding. Some examples of long term practices are:

- In Wisconsin, structured case management provides public inebriates with advocates to help them obtain government benefits. The state has also established a number of chronic care model programs in both rural and urban settings.

- In New York City, the Manhattan Bowery Project has established an outpatient clinit, residential treatment, and a multiphased reintegration program involving counseling and supervised work. The director reports that the project is developing employment opportunities in public works, general construction, and housing renovation.

- In Florida and Oregon, long term care facilities have been established which include counseling, recreational therapy, and ultimately regular employment.

Domiciliary care is one option often needed for chronic public inebriates. Many of these individuals will never be able to return to society as "productive" citizens. Domiciliary care provides long term residences for this group of public inebriates. Minnesota has set up a series of homes known as Board and Lodgings. These are houses that have been converted into residences for debilitated alcoholics usually housing six to ten individuals. They include a common living area and kitchen facilities. An attempt is made to create a family atmosphere in the home. The staff consist of house parents who have knowledge of support programs available in the community for alcoholics. Each resident is required to pay for room and board, this money usually coming from welfare, VA, social security, or other benefits.

It is necessary to work with the citizens of the community where a domiciliary facility is to be located to insure community support for the home. In several situations, after extensive community organizing, the residents of such facilities have been "adopted" by citizens in their respective neighborhoods. These type facilities work particularly well in rural areas and neighborhood communities within larger cities.

In downtown urban areas effort have been made to convert older hotels into domiciles for public inebriates. In many instances older hotels will be renovated and set up as a service center for public inebriates. Rooms, at minimum charge, are rented to public inebriates. This provides for a shelter off the streets. Staff at this type facility can all be social service workers or at least trained in the alcohol treatment resources available within the community. Thus, when a resident is ready for treatment an appropriate referral can be made. In some instances, known as wet hotels, individuals are allowed to drink in their rooms. The philosophy behind this is the belief that if a person is going to drink, it is better to drink in the safe confines of one's residence.

The proposed "El Rey" project in Los Angeles is going to convert an old hotel into a comprehensive treatment center for public inebriates. The facility will handle 500 public inebriates a day on a shelter drop-in basis, 200 on an emergency only basis, and 100 on a detoxification program with an aftercare component. In Portland, Burnside Consortium, the agency that deals with public inebirate program operation and funding, is working to assist older hotels in finding funds to renovate in order to meet health and safety codes. They realize that each hotel that closes will result in an increase of homeless individuals on the streets of Portland.

The final component of a continuum of care is an aftercare component. This component works to assure integration of the recovered alcoholic into the community and serves as a support mechanism for the individual. One component of Seattle's aftercare program is a vocational resource center that follows the client for up to two years. These aftercare components often are the agencies to which the alcoholic can turn to for support after a relapse.

All of the components outlined above as part of a continuum of care are not available in all communities. Each community needs to analyze which components of the continuum are needed and then develop a plan for obtaining the resources to create the program. It is also essential that these be coordinated among components of the continuum. If this does not exist then clients will inevitably slip through the cracks.

Following are two examples of a continuum of care found in two diverse cities.

Division of Alcoholism, King County, Washington--The Seattle, King County Department of Public Health, parent organization for the area alcoholism authority, serves unincorporated King County, the City of Seattle, and the 28 incorporated smaller cities within the county's boundaries. The 1980 Census set the county's population at just under 1,300,000. It is estimated that persons needing alcoholism treatment services in King County number 83,544. In 1968, the last year prior to decriminalization, there were approximately 12,000 arrests for being drunk in public. It is the county's policy that alcoholism is a primary disease; that the disease is treatable; and that recovery is possible through a treatment program which includes total abstinence and finally, recommends participation in Alcoholic Anonymous as the most effective support program for the long term recovery process. The continuum of care for public inebriates includes:

- Emergency Services Patrol - vans patrol 24 hours a day. The vans are staffed by _____. Last year 13,079 individuals were picked up from the streets by the patrol.

- Alcohol Screening Unit - conducts medical examinations, recommends treatment, and initiates referrals.
- Detoxification - a 96-bed facility based on a modified-medical model. The facility is _____ miles from the skid row area.
- Extended Care -
- Vocational Resource Center -
- Outpatients Clincis - five community alcohol centers (CA), one located in each health district of the county. They provide the following services: outreach, diagnostic, and outpatient counseling, court services, and work with the family.

Comprehensive Alcoholism Rehabilitation Program (CARP), West Palm, Florida--CARP is the comprehensive alcohol treatment program in Palm Beach County which has a population of _____. Most of the services are concentrated in the cities of West Palm Beach. Lake Worth, however, one facet of the program concentrates on the rural migrant populations found in the western part of the county. The program advocates treating each admission as if they were a first time client, for that contact may be the one that leads to recovery. Emphasis is also placed on working extensively with the community to insure acceptance and support for the alcohol program. The continuum of care for public inebriates includes:

- o Receiving Center - primary focus is stabilizing physical needs and sleep off. Length of stay is usually under eight (8) hours.
- o Primary Care - detoxification services averaging 3-6 days utilizing a modified medical model with a nurse always on duty. Emphasis is on keeping client quiet and anxiety free as stabilization is sought.
- o Treatment Planning and Motivation - hub of the continuum; provides in-depth data gathering and referral to continued care.
- o Extended Care - this facility, Palm Beach Retreat, provides 4-8 weeks of residential treatment with emphasis on social stabilization, helping the client accept their alcoholism, and providing motivation to recovery.
- o Halfway Houses - two facilities, both focusing on integrating the client back into the community. In both, clients must work, establish a bank account and attend AA.
- o Domiciliary - long term care facility for the chronic inebriate who cannot remain sober without extended care.
- o Outpatient Services - follow up and community integration counseling and support.
- o _____ Area Alcoholism Program - evaluation and treatment services to a population primarily rural migrant.

The issue of how to fund public inebriate programs was raised throughout the conference. One example is Georgia where the lack of resources has hindered the full implementation of decriminalization legislation. Consensus was developed on the fact that public inebriate programming is not a glamorous issue and thus receives little attention while at the same time, due to reoccurrence of individuals within treatment centers, programming for this population is expensive.

An example of a community that has saved money be removing the public intoxicant from the criminal justice system is Suffolk County, New York (?state). The police estimated that it cost them $188.21 a day to pick up an intoxicated person. (This does not include court costs.) The comparative cost for the public inebriate being handled through the Division of Alcoholism and Alcohol Abuse's system of Emergency Care Services was $40.18 in 1979. The Emergency Care Program provides food, shelter, counseling, emergency treatment, transportation, and referrals to ongoing treatment. Half of the people that go to the emergency shelter go on to long term treatment. Many of these become sober and obtain jobs, contributing to the tax revenue and decreasing the public assistance rolls.

A statewide study conducted in Minnesota four years after the state decriminalized public intoxication found that "the state's municipalities lost $443,310 annual in criminal fines from public intoxicants, but they found themselves spending between $7 and $8 million less annually in expenses for dealing with public intoxication."

One program, CARP, has created a client finance department which has two functions. The first is to assist clients in obtaining benefits for which the client is eligible. The staff of this unit are aggressive in working with welfare departments, medicaid _____, etc., to make sure that the clients eligibility for the service is determined. The second function is to impress upon the client their responsibility to pay for services rendered so that recovery can be provided to others. A payment plan is initiated after a client enters the program and once imployed is expected to start reimbursing the program for services rendered. The program has found that paying for treatment has increased the client's investment in the recovery process. Last year, this department was able to generate approximately @200,000 in client fees, roughly 25% of the programs total budget.

Another approach that could be used for funding is to get the local merchants concerned with public inebriate outside their establishment to approach the city and county councils to request funds for services for this population. In this instance, those with clout are being used as a means to approach governing bodies. Another suggestion raised was the question of an earmarked tax on liquor to pay for public inebriate services. Such a tax in New York State of a half a cent per bottle generates $7 million a year.

Panelists went on to offer some summary comments on public inebriate. Charles Kester of Seattle pointed out that the problem of the public inebriate cannot be ignored. In Seattle, services are provided to more public inebriates in a year than the Seattle mental health system does to mentally ill. Yet services are

expensive for the average inebriate runs up a bill of $600 each month in health, social, and police services. He provided two interesting statistics:

- o A 1979 study matched persons who had entered the detox program 10+ times since 1979, (N=276), against the 1978 jail booking records with only fourteen duplications. Since the majority of these chronic alcoholic cases had long criminal histories prior to 1979, this shows that the transition to the emergency care system was made.
- o A 1980 computer study of persons entering the detox three or more times in each of the years 1975 through 1979 showed only sixty-two persons had done so. This raises interesting questions about the reliability of the "revolving door" theory of facility misuse.

> "The recovery of Robert Sundance, a chronic public inebriate, is a remarkable example of the ability of the human spirit to rebound."
>
> Timothy Flynn, California

Harry Polle of New York, A Lt. Colonel in the Salvation Army, reminded the gathering that the Salvation Army has been servicing the needs of homeless, destitute, inebriate men and women for almost 100 years. Poole's contentions was that there will always be public inebriates; that society is unlikely to find the answers to this problem. Reducing the toll in human misery may be the best ambition. Dr. Shandler reflecting on the Sundance case summed it up by saying: We have saved one! It is too easy to dehumanize public inebriates, to stop seeing them as people instead see them as simply social problems.

> "We have saved one!"
>
> Irv Shandler, California

Perhaps what each public inebriate needs/is to redeem their life to someone to show an interest. Colonel Poole added emphasis by pointing out that systems come and systems go, but it is, in the final analysis, people that are important. The dedication of good people can save lives, even if it cannot always change them.

Mr. DOYLE. Thank you for having us here, Senator.

Senator HUMPHREY. My pleasure.

May we have the next panel, please.

Our second panel is comprised of Col. Ernest Miller, director of the Washington Affairs of the Salvation Army; Dr. Robert Pandina, associate director for Applied Research, Rutgers University Center of Alcohol Studies; Dr. John A. Carpenter, director, Rutgers University Center of Alcohol Studies, New Brunswick, N.J.; Mr. Shannon Wall, president of the National Maritime Union, labor cochairman, NMU Pension and Welfare Fund; and Martin Hickey, management cochairman, National Maritime Union Pension and Welfare Fund.

Good morning, gentlemen, thank you for coming. Thank you for your patience. Let's go right into the statements and would you keep them as abbreviated as possible.

Colonel Miller, will you lead off?

STATEMENTS OF LT. COL. ERNEST MILLER, DIRECTOR, NATIONAL PUBLIC AFFAIRS, THE SALVATION ARMY; DR. JOHN A. CARPENTER, DIRECTOR, RUTGERS UNIVERSITY CENTER OF ALCOHOL STUDIES, NEW BRUNSWICK, N.J.; DR. ROBERT PANDINA, ASSOCIATE DIRECTOR FOR APPLIED RESEARCH, RUTGERS UNIVERSITY CENTER OF ALCOHOL STUDIES; SHANNON WALL, PRESIDENT, NATIONAL MARITIME UNION AND LABOR COCHAIRMAN, NMU PENSION AND WELFARE FUND; AND MARTIN HICKEY, MANAGEMENT COCHAIRMAN, NATIONAL MARITIME UNION PENSION AND WELFARE FUND, A PANEL

Colonel MILLER. Thank you, Mr. Chairman.

First of all, I want to express appreciation for the opportunity to be here.

My name is Ernest Miller, I am the director of National Public Affairs for the Salvation Army, but I am not here today on behalf of the Salvation Army. Rather, I am here on behalf of the national coalition for adequate alcoholism programs.

Now, this coalition is made up of some 30 organizations which represents a broad spectrum of organizations active and interested in the program of alcoholism. You asked earlier for some statement about the private activity and private effort in alcoholism. I think one of the most exciting things in the field is the existence of this coalition. It includes, for instance, organizations like Rutgers University, which is involved in research; organizations like the Smithers Foundation involved in prevention, organizations like the Salvation Army and Volunteers of America, which are involved in treatment and rehabilitation programs; and organizations like the Brewers and Wine Institute and the Distilled Spirits Council, which are involved in the beverage industry.

Senator HUMPHREY. I understand you sometimes have problems agreeing on issues. I can understand why.

Colonel MILLER. The fact these things can be brought together, though, for a single purpose is itself an exciting fact. These disparate interests which have been in confrontation in the past, are now joining their efforts in a common purpose, which is to deal

with the problems of alcoholism and, in particular, to do something about the people who become the victims of alcohol abuse.

We appreciated the recognition of the situation with alcoholism contained in the chairman's opening statement and we need not make further comment on that. We do feel that an appropriate strategy towards solution must deal with a cooperative effort, which of course is the reason the coalition exists. We believe in cooperation and we believe in bringing our efforts together for a common purpose and we are trying to accomplish that. We believe in a Federal role.

There are several elements of the Federal role that we believe ought to be included and these are contained in the statement that we have presented.

We believe it ought to include research. It ought to include prevention, particularly in the provision of information to young people. We believe that it ought to include occupational alcoholism programs.

We believe that there ought also to be some provision for treatment and rehabilitation. Now the last category, treatment and rehabilitation, was not contained in the chairman's opening statement.

We believe something of treatment and rehabilitation ought to be a part of the Federal role.

We support the categorical aid, particularly for research as well as to maintain funding for all the various elements of the program.

We believe that waste and duplication ought to be eliminated and there has been some earlier comment on that in these hearings this morning.

Now, you have asked for further comment about the private effort. We believe that the private effort is a major part of the alcoholism program in America today. In fact, the capabilities, the ability of the private group to do more for less as has been said in your statement, the capabilities of the private sector are enormous; the commitment of the private sector is enormous.

Sometimes private organizations, and not only in the field of alcoholism but in many other fields as well. Sometimes private organizations are treated like stepchildren to the public or Government effort.

In the field of alcoholism I do not know what the total Federal or Government commitment might be, but in my own organization, the Salvation Army, I know for instance that my organization is spending about $100 million a year in alcohol abuse programs. We have 12,000 beds which will be 95-plus percent filled every night of the year in alcohol abuse programs.

There was mention made earlier of the cost of one of those programs in one city; the total cost for those 12,000 beds is less than $25 a day. But multiplied by all of the beds and all the days, $100 million is a pretty substantial contribution from a private organization with totally private funds.

There are other organizations who are also making very substantial contributions which are not worthy to be considered as stepchildren of the public effort. We would like to see a closer cooperation between the private and public efforts with a due recognition and encouragement of the private effort.

We believe that the public role should include support for innovation. New ideas wherever they may be found should be encouraged. New ideas do not historically come from bureaucracies, rather they are more likely to come from individual private efforts.

We believe the public role should continue support for research, particularly for information resources which private organizations cannot support adequately.

Certain types of information systems and resources need public support.

We believe that there needs to be a climate of freedom in which the private sector can succeed and this might include such ancillary things as the charitable contributions legislation which may help the private organizations successfully raise the money they need to succeed.

Questions have been raised here relative to block grants. We believe that political realities in the States are likely to legislate against the alcoholism considerations. We believe the alcoholism community in the States does not have the political clout that other programs might have. The alcoholism programs don't have the glamour or, if you like, the sex appeal of some of the other more glamourous kinds of programs.

There is still a stigma attached to alcohol abuse. There are still many people who believe that alcoholics, and the victims of alcoholism somehow deserve their fate. We believe that those persons who are more enlightened in their view and in their perspective need to help assure that the alcoholism interests will get their share of resources.

Mention was made of the impact of alcoholism on the families. There is a ripple effect which affects far more than the person in a family who may be an alcoholic. The children are not able to pursue their education as they may wish to do. There is poverty, a direct result of alcoholism. There are social problems which come to the attention of organizations like mine and some of us who have been involved for many years in dealing with those family problems can testify at great length about specifics of the ripple effect of alcoholism in the family life.

We believe that the Government needs to continue to give attention to these things and to encourage the private effort to do a successful job.

Thank you.

[The prepared statement of Colonel Miller follows:]

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Alcohol and Drug Problems Association of North America
American Bar Association
American Business Men's Research Foundation
American Federation of Labor-Congress of Industrial Organizations
American Medical Society on Alcoholism
Association of Halfway House Alcoholism Programs of North America
Association of Labor-Management Administrators and Consultants on Alcoholism
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School of Industrial and Labor Relations - Cornell University
United States Brewers Association
Volunteers of America
Wine Institute
Women for Sobriety

Statement of the

National Coalition for Adequate Alcoholism Programs

concerning

Alcoholism and the Misuse of Alcohol

before

Senate Subcommittee on Alcoholism and Drug Abuse

Gordon J. Humphrey, Chairman

March 25, 1981

STATEMENT ON ALCOHOLISM AND THE MISUSE OF ALCOHOL

(This statement was approved by the National Coalition for Adequate Alcoholism Programs on March 20, 1981 for submission as testimony to the Senate Subcommittee on Alcoholism and Drug Abuse. Although approved as a Coalition statement, it does not necessarily reflect the individual policies of the member organizations.)

A representative number of authorities from a variety of disciplines state that alcoholism is one of the top four major health problems confronting the nation. That alcoholism is a disease has been accepted widely by a large number of national and international health agencies, both governmental and voluntary.

There is, however, a disturbing residue of ignorance, doubt and indifference about this disease -- and, very often, about its devastating human, social and economic consequences. This is due, largely, to inadequate scientific research and public information and education.

The specific causes and certain cures of the disease are still unknown to the scientific community and, therefore, unavailable to the public. The current state of knowledge -- or lack of knowledge -- indicates that:

a. Abstinence is the only way out for the alcoholic, and
b. Moderation is the only way for those who can drink.

Under the circumstances, it makes sense for every section of the population -- public, private and voluntary -- to join forces in a concerted national, state and local effort to combat alcoholism.

Prevention and treatment are the two sides of the same coin -- and the worth of this coin will not diminish if it is used by all concerned with responsibility and efficiency and with unsubstantiated figures, inflated promises and inflated pseudo-scientific findings.

It is imperative, therefore, that Congress continue to support and adequately fund an agency, such as NIAAA, to devote itself to:

a. The development of scientific research in the causes and cures of alcoholism;
b. The collection and dissemination of accurate and verifiable information among the people, particularly the youth of America, about prevention and treatment;
c. The promotion of occupational alcoholism programs in which labor-management participate not only because it is the right and humane thing to do but also because it is the practical thing to do in order to achieve a healthier workforce which will improve America's competitive role in the international marketplace.

d. The encouragement of treatment and rehabilitation programs to restore victims of alcoholism to useful and productive places in society.

Much more needs to [illegible] one, of course, and it is here where the public, private and voluntary sector can play a vital role. The development of adequate and experimental treatment facilities, the training of skilled and sensitive counselors, the establishment of labor-management alcoholism programs, the dissemination of accurate information on the consequences of drunken driving, the impact of problem drinking on family life and the need for insurance coverage of the disease of alcoholism in the same manner as other diseases are covered -- all these and much more can be shared by the public, private and voluntary sector as its responsibility with the encouragement and support of the Federal govenrment through grants, matching grants, incentives, public endorsements and personal association.

Categorical aid for research on a national level is essential since research is not circumscribed by local boundaries. Both categorical and mainstreaming aid for occupational programs are necessary since the effectiveness of each program depends, to a large extent, on the type of industry, occupation, workplace and union organization included. Mainstream funding for educational and informational programs among the young through local school systems and youth-serving agencies can be effective. Funding for the encouragement of treatment and rehabilitation progrmas is essential.

All Americans recognize, of course, that inflation means not only economic erosion, but social and political erosion as well. Americans will support a determined anti-inflation program based on equality of sacrifice. But for many years the field of alcoholism has sacrificed more than its share. Although it is one of the nation's major health problems, neither our public nor our voluntary alcoholism agencies receive the kind of moral and financial support that other agencies fighting other diseases have received over the years. The stigma attached to alcoholism still affects the public response. It is necessary that government and the voluntary and private sectors, including the alcoholic beverage industries, continue to coordinate their efforts to combat this disease.

Waste and inefficiency must be eliminated, of course. But to unduly curtail the funding of NIAAA would cause great hardship to our economy, to our society and to our nation as a whole.

Among the truly needy in our society are many victims of alcoholism. The safety net to protect those truly needy must surely include alcoholics and their families, and others affected by alcohol misuse.

Senator HUMPHREY. Thank you. Very forceful.

Dr. Carpenter.

Dr. CARPENTER. I am Dr. John A. Carpenter, director of the Rutgers Center of Alcohol Studies. It is a privilege to be here. I have brought with me Dr. Pandina, because his knowledge and verbal facilities has been compared favorably to that of Hubert Humphrey. He can talk.

Dr. PANDINA. First time I have ever heard that, Senator.

Senator HUMPHREY. I hope he leaves us time for lunch. (Laughter.)

Dr. CARPENTER. The seriousness of the illness has been dealt with very well. I don't need to go into that. But I would like to talk about cost-effectiveness of research. Sheila Blume said it very well, and I will paraphrase it. The cost-effectiveness of research is the difference between or the relationship between the social cost of not doing it and the cost of the research.

I like to use polio as an example because it is a very clear and memorable disease to most of us. It took 115 years of research to knock that out but in 25 years of not having done taking care of those people, just the victims of it, would far exceed the cost of having done the research in that period. So that research is really cost effective and it will be, also, in alcohol research when we finally finish the problem.

One of the things that ought to be mentioned was that when polio was finally knocked out, the technique used was one used in existence for 80 years prior to the finishing touches put on it, established by Louis Pasteur. The point is we may be sitting on a technique and the knowledge now to prevent alcoholism, but we don't know enough about the natural history of alcoholism to identify that or use it. Therefore, the natural history of alcoholism in all its details through both social science and medical science needs to be pursued.

No one believes that polio is a good model for the prevention of alcoholism. It is not; alcoholism will not be prevented by injecting something. But polio is a good example of a research model applied to a social problem.

Search means to look, that is all it means. And the looking is a very special procedure used by science, and that is what we use to find out how to bring about the results that we want. If we don't do it we will not have the solution to the problem.

What we need is careful and patient research. Alcoholism is a multi-disciplinary problem. The knowledge that deals with it comes from a great many areas. Even medical science has its social science component, for example, epidemiology is as much social science as it is medicine.

I would like to point out that in the development of the final blow to polio, a great deal of social science went into this. Not many people know this unless they read the history of it, but the fact that the age of the victims was increasing year after year had to be explained. Remember, originally it was called infantile paralysis; later it became not infantile at all. It was the fact that the immunity to polio was clearly established in poor social classes, but the upper classes lacked immunity.

This was an important hurdle that the medical sciences had to deal with before they could go on. Again, there is no such thing as poor medical science unless you are stuck in a laboratory looking at glassware.

There are social science elements in all of these things. Alcohol is defined in terms of social consequences and behavior and that will not be dealt with by medical science; social science will have to handle that. Despite advances made in the biomedical sciences, such as in inherited isoenzymes of alcohol and aldehyde dehydrogenases, the fact these are inherited, the fact they are distributed differently in different people in different races, no connection has been established yet between them and the behavior of individuals or the social groups and social behavior of individuals or as to who becomes an alcoholic and who doesn't.

That work has to be done in the social science. Even contagious diseases have their social aspects. Syphilis is a good example. That is a bacteriological disease; it is transmitted by social means and there is no other way to get around it.

The difference between alcoholism rates in American blacks, Indians, European and African Jews are all understood in social science terms. For example, the explanation of the relationship, different rates between European and African Jews is based on the non-Jewish peoples from which they were derived, which they lived in before they came to Israel. This is social science. And this must be continued.

The last point I want to make has to do with university based information systems I would like to say, and I will read it to be sure:

The sciences progress not only from the research activities of individuals but as a collective society of researchers. Without supporting scientific information systems that encompass the widest range of disciplines and languages, research duplicates itself, slows down, and may stop.

George in England may find a solution to it, and we in America may not know it. Without communication it is not possible.

It cannot build on the progress of others if it cannot obtain information generated by others. A university based, worldwide, scientific information system is a necessary element in the progress and cost effectiveness of science. Universities are the only places that possess the libraries, languages and range of scientific expertise necessary to produce such systems. It cannot be done commercially. Such a system can only be supported by federal government sources, and you don't pay for them when they are there.

Thank you very much.

[The prepared statement of Dr. Carpenter follows:]

RESEARCH STATEMENT ON ALCOHOLISM AND ALCOHOL MISUSE

PRESENTED TO THE

SENATE SUBCOMMITTEE ON ALCOHOL AND DRUG ABUSE

GORDON J. HUMPHREY, CHAIRMAN

March 25, 1981

Although approved as a National Coalition for Adequate Alcoholism Programs statement it does not necessarily reflect the individual policies of the member organizations.

This statement was prepared by:

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MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

I am John A. Carpenter, Director of the Rutgers Center of Alcohol Studies and with me is Dr. Robert Pandina, one of the Associate Directors of the Rutgers Center. It is a privilege to appear before this subcommittee. My comments, which were prepared by Dr. Carlton Erickson of the University of Texas at Austin and me, will be directed to research.

Introduction

There is no question that alcoholism is a major illness, perhaps in epidemic proportions in the U.S. Although figures vary, it is generally ranked as the second or third disease in incidence, suffering and economic cost to the nation. Prevailing opinion places alcoholism in the disease category, yet as a disease that is not significantly treated by physicians, it is considered to be hopeless except by those who attempt to treat or prevent its symptoms through intervention and education.

Overall, recidivism of alcoholics runs about 65% to 75%, which is considered too high to significantly reduce the incidence of the disease. Indeed, prohibition, incarceration, education campaigns and other measures have not lowered the abuse of alcohol in the U.S. over the years. In contrast, other diseases which at one time were socially significant have been reduced to rarities or eradicated completely. These include tuberculosis, polio, epilepsy, measles and smallpox. In the future, Americans expect cancer, heart disease, diabetes, muscular dystrophy and other diseases to be "cured" through advances in research, as indicated by the emphasis placed on finding the causes of these diseases through present Federal and private support for research.

Cost Effectiveness of Research

Scientific research is always cost effective but, unfortunately, this can only be determined after the problem has been solved. The course of research, particularly in its early stages, is a process of eliminating many salient

ideas in order to build the knowledge that finally leads to a solution. As Edison is supposed to have said, "I know a thousand and four things that would not work", all of which he had tried before he found the one that would.

In order to evaluate the cost effectiveness of research in health, we must compare the research cost to the social cost of not doing it. While no scientist believes that alcoholism will be prevented as polio was, by injecting something, the history of polio research is a good model of the cost effectiveness of research. A reasonable estimate of the duration of polio research is 115 years. It was very expensive and progress was slow. In the last 25 years, if the polio vaccines had not been produced, there would have been enough surviving cases of paralytic polio to constitute a significant public health burden in terms of dollars. This does not consider the social costs. The costs in dollars of supporting just those victims would have exceeded the costs of all the research in the 115 years and would increase with time without end.

Incidentally, the description of the natural history of polio by research led to the use of the mechanism of immunization first described by Pasteur eighty years earlier. By analogy we may be sitting on the means to stop alcoholism now, but because we understand so little about its natural history, we can not identify the means or use it.

The Research Model as Applied to Alcoholism

As stated earlier, no one today believes that alcoholism will be prevented by a "simple" biological means as polio was; the alcoholisms are much more complicated. Nevertheless, the general model of research as a device for solving a major public health problem is as applicable to the alcoholisms as it was to polio.

The Alcoholisms: a Multidisciplinary Problem

As with physical illnesses, alcoholism prevention will occur as a result of knowledge gathered from a number of disciplines. It is not widely recognized outside of professional circles that significant contributions to the solution of the polio problem was made from the social sciences. Epidemiology is as much social science as it is medical, and sociological methodology was important in determining the fact that upper classes appeared to suffer more from polio than lower ones. The explanation is a combination of social and biological knowledge.

The alcoholisms appear to have more social science components than biological. Nevertheless, great strides in mechanisms that will doubtless be fundamentally linked to the alcoholism have been made by biological sciences in the last 10 years. I refer to the inherited isoenzymes of alcohol and aldehyde dehydrogenases; the biochemical and physical chemical mechanisms of neural and cellular function; the potential role of the placenta and diet in F.A.S.: the development of animal models based on criteria derived from accurate observation of the condition in human beings, and so on. Incidentally, birth defects (F.A.S.) from excessive alcohol use, or any cause, are a most costly burden that society must support because many victims have normal life expectancies.

The Role of the Social Sciences

Social factors play a major role in determining who, when, where and how individuals become alcoholic. We still have a problem in relating the biological knowledge illustrated above to the status of individuals and their behavior in both alcoholics and normal people. No matter how advanced our biological knowledge of inheritance, for example, mating remains a social phenomenon and the link between the biological science of genetics and human behavior is still being determined.

Differences in alcoholism among and within American Indians, American Blacks, and European and African Jews, all groups with discernably different biological characteristics, are to be understood chiefly by social science explanation. For example, the explanation offered for the differences in alcoholism roles between European and African Jews, both living in Israel, is related to the drinking habits of the non-Jewish societies from which the two groups of Jews originated. These are powerful demonstrations of the influence of social and psychological factors in the alcoholisms, and of course these factors apply to other societies in different ways and to different extents.

Drinking among youth is another phenomenon falling within the realm of the social sciences, and it must be described and understood in those terms. With understanding comes amelioration and not without.

Social science research on the alcoholism must be supported on a par with the biomedical.

University Based Scientific Information Systems

The sciences progress not only from the research activities of individuals but as a collective society of researchers. Without supporting scientific information systems that encompass the widest range of disciplines and languages, research duplicates itself, slows down, and may stop. It cannot build on the progress of others if it cannot obtain information generated by others. A university based, world-wide, scientific information system is a necessary element in the progress and cost effectiveness of science. Universities are the only places that possess the libraries, languages and range of scientific expertise necessary to produce such systems. It cannot be done commercially. Such a system can only be supported by federal government sources.

Funding

Over the years, funds for alcoholism research have run at less than 10% of the NIAAA budget, less than 3% of the funds for cancer research, less than $1.00 per victim and about 1/5000 the estimated cost of the disease to the U.S. economy. In 1980, the annual cost of alcoholism to the country in terms of lost productivity, medical care, welfare, and accidents approached the national budget deficit.

In terms of cost effectiveness, research into the causes of alcoholism appears to offer the best hope for the future elimination and more effective treatment of the disease. It is time to take advantage of the present scientific and lay support within the field by backing the prestigious Institute of Medicine report and to boldly admit that research, patiently and expertly done, in the biomedical and the psychosocial sciences will hasten the future successful treatment of alcoholism and its prevention.

Recommendations

We recommend the following funding levels for the next fiscal year:

Research	$35 million
NARC	$15 million
Scientific Information Systems	$2 million

I appreciate this opportunity to testify before the subcommittee and I wish to assure you that we are available to provide any assistance you may desire.

Senator HUMPHREY. Thank you. I understand that Rutgers has the finest library in the field of alcoholism; is that correct?

Dr. CARPENTER. That's correct.

Senator HUMPHREY. He said modestly. [Laughter.]

Dr. Pandina, please.

Dr. PANDINA. Senator, I have no formal statement to make. I prefer to save time for questions.

Senator HUMPHREY. Dr. Pandina passes. I thought you were quite a talker.

All right, Mr. Wall.

Mr. WALL. Yes, Mr. Chairman.

My name is Shannon Wall and I am the president of the National Maritime Union. We have offices throughout some 29 ports of the United States, principally on the east and west coast, but also including the lakes and rivers.

I am also here as cochairman of the NMU Pension and Welfare Plan.

Certainly it is a pleasure to be here and we thank you for the opportunity——

Senator HUMPHREY. Excuse me, will you pull the mike a little closer to you.

Mr. WALL. We thank you for the opportunity to testify and present our views on this subject. We might be inclined under your chairmanship and Senator Riegle to simply file our report and leave it at that, but we think that we address some of the problems raised by you and certainly the question of why is not the State addressed in our testimony.

The National Maritime Union was one of the first labor organizations in the country to rally to President Reagan's call to rebuild the economy; mobilize against inflation, and revitalize our merchant marine. The NMU has listened intently to the presentation of the President's program for economic recovery and has recommended that they be given a fair hearing and general support. We agree with the President that the economic straits of the country demand a radically new approach and join the call to all of America to make sacrifices and to behave with economic responsibility.

Still there is grave concern that the necessary budget cuts should make fiscal and social sense. The President's Budget Director recognized this when he indicated that his program is not carved in stone. Along these lines, we were quite delighted to hear the President speak of a social safety net in his message before the Congress last month. This, hopefully, would protect the poor from an excessive share of the burdens of scaled down assistance programs.

While this is an important area demanding careful scrutiny, my prime concern, as a labor leader, is for the working men and women and the Federal programs which have become important to their lives. Work is at the heart of life. No other activity occupies so much of our conscious time. No other activity is so critical to the productive capacity of this country.

Senator HUMPHREY. Is it your intention to read your whole statement?

Mr. WALL. It is not that long.

Senator HUMPHREY. All right, but it is closely spaced. Can you summarize, in fairness to those who will come behind you? We do have another panel.

Mr. WALL. We simply want to say we have been since 1974 involved in a program of—alcoholic program.

Senator HUMPHREY. Yes.

Mr. WALL. Under the direction of the NIAAA. We think that our programs are a sound investment and give an enormous return. We have returned a lot of workers that have been lost in the sea of alcoholism to the job market.

When you talk about the effect upon family life, we can produce for you letters from fathers and mothers thanking us and the program for restoring their son or their daughter, as the case may be; from wives, and from husbands, that have been directly affected in the family life by alcoholism and have been returned to the program.

We have approximately a 75-percent recovery rate in our program.

One of the reasons that we feel very strongly about the Federal program, that it's played quite a role in the development of our program. The maritime industry was looked at through its historical background of the seamen on the waterfronts of the world and they felt there was a program here that was national in scope.

Merchant seamen are still wards of the Admiralty. We are regulated by the U.S. Coast Guard. Our medical treatment is covered by the U.S. public health hospital. We feel that we would be completely lost if we were turned over to the State grants. The seamen that are shipping out of New York and who may live thousands of miles from his port of employment, it would be very difficult to convince the people in Arkansas, for instance, or any one of the 50 States that the problem of the seaman in New Orleans is really indeed their problem, because that is where he makes his home.

We have had experience with this in the United Seamen's Service; during the war the welfare for seamen was covered under a national program. When that disappeared, we had to go to every local community to raise welfare funds and we were lost. We were unable to convince the local area of the need of watching out for merchant seamen.

So we just do not feel that we would fit in with the bloc grants. I think what is true for the National Maritime Union would also be true for others that are national in scope.

I think, we, too, would wait for the questions to get to the more specific answers.

Thank you.

[The prepared statement of Mr. Wall and questions and answers follow:]

Testimony of Shannon Wall

The National Maritime Union was one of the first labor organizations in the country to rally to President Reagan's call to rebuild the economy, mobilize against inflation and revitalize our Merchant Marine. The NMU has listened intently to the presentation of the President's program for economic recovery and has recommended that they be given a fair hearing and general support. We agree with the President that the economic straits of the country demand a radically new approach and join the call to all of America to make sacrifices and to behave with economic responsibility.

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While this is an important area demanding careful scrutiny, my prime concern, as a labor leader, is for the working men and women and the federal programs which have become important to their lives. Work is at the heart of life. No other activity occupies so much of our conscious time. No other activity is so critical to the productive capacity of this country.

At the National Maritime Union we have been involved, since 1974, in assisting men and women who are experiencing problems in their lives which appear to be interfering in the quality of their work. Our programs have both remedial and preventative features that have saved lives, families and jobs. They have restored skilled and highly productive seamen to the work force and prevented many from slipping out of the world of work and into the ranks of the jobless, poor and those of ill health.

The NMU programs are sound investments and give an enormous return. For the most part, we have funded them entirely within our own organization, but in the case of the Alcoholism Program, we have applied for and received technical assistance and some financial support from the National Institute of Alcohol Abuse and Alcoholism. The Institute recognized the shipping industry as fertile ground for an innovative demonstration project.

The network affecting the life and work of merchant seamen is complex and diverse. It includes the United States Coast Guard, U.S. Public Health Service Hospitals, a large number of voluntary agencies, as well as Shipping Companies and Maritime Unions. The NIAAA reasoned that if a sound occupational alcoholism program could take hold in this setting, it would have a ripple effect extending throughout and beyond the maritime industry.

Within a short time, the hopes of the NIAAA were justified and then exceeded. A strong program developed with a 75% recovery rate for merchant seamen with job performance or medical problems related to alcohol. In addition, an education and prevention program was organized, which reached hundreds of seamen each year. Supervisory staff aboard ship, union officials, and union physicians were also trained in motivating and directing seamen to seek help when their job or health was alcohol impaired. When the United States Coast Guard saw how well the NMU Program worked, they developed, in conjunction with the NMU and NIAAA, a national policy statement for the entire American Merchant Marine. The Coast Guard had seen a better than 66% decrease in misconduct proceedings for seamen who had been referred to the NMU Alcoholism Program for impaired performance of duty related to excessive drinking. The ripple effect soon extended even beyond the American Merchant Marine. Soon there were inquiries from Britain, Australia and Scandanavia on how the NMU Program worked.

From our own experience we are certain that occupational alcoholism programs work.They succeed because they intervene in the problem early, while the leverage of the job is still a prime motivating factor. Organizations, like our own, need time to demonstrate to their trustees how cost-effective employee assistance programs of this nature are. Because of our Program's success the NMU Pension and Welfare Plan now contributes $2.00 for every $1.00 in NIAAA assistance. The Program's next objective is to demonstrate that the pilot project which has done so well in New York can be replicated in three additional cities and thus mature to a national program able to reach out to and assist all NMU seamen and their families. We expect the program will be totally self supporting, once it can demonstrate its effectiveness on the national level.

The federal government has played a dominant and catalytic role in the development of occupational alcoholism programs throughout the country. Applied research, scientific approaches, cost-effective analysis, evaluation and accountability measurements have all been introduced into the field largely through NIAAA leadership. The special and formidable contributions of the occupational branch of the Institute was recognized most recently when it was raised to division status. If the federal government abdicates its leadership role, it seems unlikely that individual states can fill the vacuum.NIAAA occupational initiatives cut across state lines and focus on national organizations, like our own, or on broad manifestations of alcoholism problems, which would almost of necessity escape local attention. For example, I understand that the occupational division of the NIAAA is now looking to develop models which will assist high level executives and small businesses, two areas still relatively untouched by occupational alcoholism programs.

In addition to the strong advantages of federal leadership and national focus in this area, this is a case where the federal bureaucracy is just simpler. Present bureacratic entanglements are a piece of cake compared to the potential problems for a national organization, like our own, having to apply to each state in which our organization is represented for assistance in program development. The NMU is a national organization with a national focus with 26 branches, principally on the East, West and Gulf Coasts but also including the Great Lakes and rivers. The major focus of our organization is national. We do not fit in to local organizational planning and are clearly not a local priority. The block grant mechanism would almost definitely eliminate a national organization from access to assistance. No locality is going to be interested in developing programs for a constituiency which may not even reside within its confines. A seaman could ship out of the Port of New York, but live hundreds of miles away in another state. While this situation is dramatically true in our own case, it is true to some degree for most national organizations. Clearly we do not have the political base to compete for local funds and certainly we will get lost in the shuffle.

This is amplified still further by the fact that the merchant marine has always been under federal jurisdiction. Our work is supervised by the U.S. Coast Guard and our health is administered by the

U.S. Public Health Service. We are a national priority and indispensible resource. The only proper auspice and governing body for the American Merchant Marine is the Federal Government. The unique situation of an organization like ours warrents consideration for exclusion from local block grant planning and structure.

In conclusion, I will sum up and emphasize the following. I think there must continue to be a federal leadership role on the national level for the development of occupational alcoholism programs. Without a federal presence in this field the momentum for innovative programs, occupational research and demonstration projects, and national programs will be lost. A movement which held so much promise for our nation may very well fizzle out. The Occupational Division of the NIAAA should continue to be funded at a level which will allow it to maintain its programs and carry out its charge. Presently planned cuts would amount to the virtual elimination of the Institute and a complete abdication of federal leadership and responsibility in this area. Also, consideration needs to be given for exclusions from local block grant structure for organizations which are national in focus with no local presence or base. Such organizations can only properly come under federal jurisdiction.

Finally, I return to our support for this Administration which we have great confidence in. I am convinced that occupational alcoholism programming is closely akin to its deepest concerns and priorities. These programs save lives and money. They are cost-effective and dramatically increase productivity. They very much fit into the scheme of an Administration which believes compassion and fiscal responsibility are not necessarily opposed.

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United States Senate
COMMITTEE ON LABOR AND
HUMAN RESOURCES
WASHINGTON, D.C. 20510

April 6, 1981

Shannon Wall, President
National Maritime Union

Questions - Alcohol Hearing March 25, 1981
Reauthorization of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act

1. Would the Maritime Union have established its alcoholism program without NIAAA help? What prevents the program from being self-supporting now as opposed to some time in the future?

2. If your program has proven itself in the New York demonstration, why is the Maritime Union reluctant to take full responsibility for its establishment nationwide?

3. Isn't it true that the vast number of occupational programs operated by members of the Association of Labor Management Administrators and Consultants on Alcoholism are already self-supporting or could easily be self-supporting?

Answers to questions posed by the various members of the Sub-committee on Alcoholism and Drug Abuse:

#1 The National Maritime Union Pension and Welfare Plan actually did begin its own Alcoholism Program in the Port of New York some 18 months prior to NIAAA assistance. The Union's Social Service and Safety Director and a recovering seaman with experience and training in alcoholism counseling organized our first efforts to assist seamen with drinking problems affecting health, work and family life. They did an excellent job, but saw immediately that a much more ambitious and comprehensive program was necessary. This early phase of our program was very much like first aid. While many seamen were helped, many more slipped away because a full, concentrated effort to assist them and follow up on their care could not be mounted.

We came to know from studying the rapidly developing occupational alcoholism field that a sound program touches base with strategies for prevention, education, supervisory training, evaluation, cost-effective analysis, and professional development of staff. In short, this field represents both a highly refined art and science. We wanted a solid and effective program for our organization, but we did not have the financial resources, industry wide understanding of the problem, or programatic expertise to achieve such a goal.

There are probably few in this nation today who do not know that the maritime industry is strapped with severe financial constraints. Although these fiscal problems do not exonerate shipping company operators from their responsibilities toward the welfare of their seamen, they do demand expenditure for only the soundest and most cost effective benefits. Both labor and management are committed to this principle, and it is for this reason that we turned to the NIAAA.

The Institute helped us develop a sound and comprehensive program, in tune with all the prerequisites for effectiveness. The grant and consulting expertise received from the NIAAA stimulated interest in our industry and led to increasingly greater support of the New York project. Without NIAAA assistance our program would still be in the first aid stage. We needed time and help to demonstrate that a comprehensive program gives a favorable return for each dollar spent. We need still more time to get the job completed. Although our program has developed faster than we ever envisioned, with 52 different companies spread across the nation and with hundreds of potential referral sources, two years is a short time to infiltrate such a widely extended and diverse industry.

The response to question #2 develops this point still further.

#2 The National Maritime Union has contracts with some 52 tanker and dry cargo operators dispersed throughout the East, West and Gulf Coast ports as well as the Great Lakes and inland waterways.

The shipping companies which have come to see the value of the Alcoholism Program are mainly in the New York area. The companies based on the Gulf or West Coasts have little direct experience or knowledge of the program. In addition to the shipping company operators, our program involves partnership and cooperation with local Union officials, NMU Pension and Welfare Plan medical personnel, the United States Coast Guard, the U.S. Public Health Service Hospitals and Clinics, and a number of other agencies and departments associated with the life and work of merchant seamen. Like the companies, these potential referral sources have no working knowledge of the NMU Alcoholism Program. in replicating the model which has worked so well in New York, our Alcoholism Program will attempt to integrate all of the above into its referral network.

The NIAAA has come to know our organization and to appreciate its unique problems. For example, we turned to the Institute with the problem of how we are to monitor a seaman's recovery in an organization which has 26 branches from where a seaman can join or leave a ship and still uphold high ethical standards of confidentiality and preserve anonynimity. Here the Institute helped us sort out difficulties and maintain a delicate balance, so that our program obtained the leverage it needed without being perceived as undertaking a witch-hunt for the shipping companies. When we sought a national policy statement from the U.S. Coast Guard regarding disciplinary action for merchant seamen with alcohol related problems, our close association with the Institute was essential. NIAAA financial and technical assistance convinced the Coast Guard that our program was on a strong foundation and in concert with sound, well tested principles. As we expand to a full national program, partnership with the Institute will be even more crucial. The Institute is nationally connected and will introduce us to those in new localities who have training and treatment expertise. NIAAA will help us set up accountability measurements and consult on ethical delimmas in structuring new referral and monitoring networks unique to the new localities. Some financial assistant will be necessary as seed money, until the program is underway and our own local organization sees its value and recommends self-maintenance.

Support for the program will grow in these branches and ports as the program demonstrates its effectiveness. These other regions, though, are new to our program and the NIAAA assistance will be needed to engage the same interest and support. Our organization could not set up a full and comprehensive program in these new localities without NIAAA technical and financial assistance.

#3 The vast number of occupational programs operated by the Association of Labor Management Administrators and Consultants on Alcoholism are management sponsored and based. Usually a single company, centrally administrated, controls the program. Supervisory training to detect deteriorating job performance is the principal referral vehicle. It is a relatively simple and neat package.

The NMU Program, though, is industry wide and operated under our Welfare Plan. There is no single company, but 52 companies with 237 ships. There are some 20 distinct, identifiable referral sources in each port in which the program is located allowing for countless variations in how our people come to us for help. Our training efforts must reach out to not only shipboard supervisors, but also to union officials, Welfare Plan physicians, shipmates, Coast Guard Marine Inspection Officers, and many others. Our program has a much tougher organizational job than the more orthodox management based Employee Assistance Program. If our industry were not so complex, extensive and national in character, the simpler program we first initiated might have been sufficient. However, a serious attack on this disease proved to demand so much more.

Finally, our Alcoholism Program is part of the NMU Pension and Welfare Plan, administered by a Board of Trustees consisting of six union and six employer representatives. All contributions to the Plan are made by employers in accordance with collective bargaining agreements. The assets of the Plan exist for the sole purpose of providing benefits to seamen participants. The Trustees are morally and legally obligated to safeguard the assets of the Plan and to assure cost-effectiveness of all benefits. Direct financial support from the NMU Pension and Welfare Plan has grown proportionally with the Alcoholism Program's demonstration of effectiveness. NIAA is helping us accomplish in a few short years what otherwise would have taken many. We need the Institute to finish the job.

Senator HUMPHREY. Thank you, Mr. Wall.

Mr. Hickey.

Mr. HICKEY. Thank you, Mr. Chairman.

I am Martin F. Hickey and I am with T. & M. Service Corp. in New York City. T. & M. Service Corp. is a trade association representing a substantial number of shipping and tanker companies which operate off the east and gulf coasts of the United States. The companies I represent, represent over 90 percent of the companies participating in the National Maritime Union Pension and Welfare Funds, and I am a trustee for the NMU Fund, along with Mr. Wall.

I have a supplemental statement to Mr. Wall's, but since you asked him to summarize, I presume you want me to summarize mine?

Senator HUMPHREY. Yes, if you will. Your full statement will be included in the record.

Mr. HICKEY. Thank you.

Basically, we are a highly automated technologically advanced industry and it is no place for a drunk. That is the problem. We have vessels that are the size of three football fields that are manned by a crew as few as 20, and it only takes 1 man to cause a very serious accident.

Just in the past few months, with weather and other problems, you can understand what could happen.

I think the problem as far as the seafarer is concerned is that in the minds of many alcohol and seafaring are hand in glove. I think everybody's heard the seaman's chant "The life of a drunken sailor," and it is time to change that.

Just a few statistics with the program that we have established, starting in 1977 in the NMU pension and welfare plan. This was a labor-management initiative. I must say on my behalf, it was the most difficult problem with my employers to try to convince them of the need of such a program, because of the problems they thought might result in the treatment of alcoholics, such as voided discharges, men being forced back on their payrolls. They didn't want them back. It took a lot of arm twisting before they were convinced to go ahead with the program.

A pilot study done shows we have a 75-percent sobriety maintenance reported in 6-month followups and in a group that was taken at random these men, prior to being involved in the program were hospitalized 1,155 days, and after being in the program they were hospitaled 365 days. That is a reduction of two-thirds, that is an enormous savings to this industry which needs all the savings it can get.

For another group taken at random, the shipping time for these individuals increased by 44 workdays per year, which I think is probably an increase of somewhere around 20 percent; I don't have the percentage figure.

But, really, the heart and soul of the program is the ability to reach and assist the problem drinker. That is what we are trying to do. My two oldest sons at this point in time have decided to select seafaring as a way of life, and I must tell you that I would hope they don't come up with a problem as far as drinking, but I would

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like to know there is a program available for them if that should happen.

I would also like to know that they can rely on their shipmates they are sailing with because they go around the world.

That is the problem of bloc grant concepts, I think. Organizations such as the National Maritime Union and the shipping industry are not State or local, they are international in scope and it is really inappropriate to try to allocate funds on a State or local basis.

As far as I am concerned, and the people I represent, we need the continued Federal leadership role and not just financial assistance but professional expertise available through NIAAA.

Thank you.

[The prepared statement of Mr. Hickey and questions and answers follow:]

Testimony of Martin Hickey

Alcoholism is a devastating, complex, progressive disease. It is estimated that it costs our society 53 billion dollars annually, primarily in loss of production, health care expenses, accidents and fatalities. Of course, the social injury to the individual and family is inestimable.

More specifically, the cost of problem drinking to industry is enormous. It translates to impaired performance, labor turnovers, and increased costs of operation. The Third Special Report to the U.S. Congress on Alcohol and Health estimates 10% of the adult male population and 3% of the female population are problem drinkers. Estimates of how many problem drinkers are part of the work force range conservativly from 3% to 8%.

Work impaired by alcohol is alarming to any manager, but it is intolerable in an highly automated and technologically advanced industry. In the maritime industry we presently have vessels the size of three football fields manned by crews of 20. Peak performance and highly refined skills are called for. Impaired performance can lead to damage of equipment, delays in schedule, accidents and even loss of life.

Until recently, alcohol and seafaring seemed to go hand in glove in the minds of many. It is not my purpose to dispute the impression, but only to offer a significant correction . Today, due to ambitious programming and comprehensive education, it would be more accurate to associate seamen either with those who are recovering from the disease of alcoholism or with those in our society who are most informed about the effects of excessive drinking on health, jobs and families.

A major step in the maritime industry's attempt to assist merchant seamen experiencing health and job performance problems due to alcohol was taken in early 1977 with the approval and implementation of this National Maritime Union Pension and Welfare Plan Alcoholism Program. The Program developed out of a joint labor-management initiative with the full realization that in regard to alcoholism services, fiscal and humane concerns are absolutely convergent.

As we explored the development of an Alcoholism Program, we sought technical assistance and some financial help until the Program could demonstrate its effectiveness. We found the help we needed in the National Institute of Alcohol Abuse and Alcoholism. The network of the maritime industry is enormous. It is comprised of some fifty companies, supervised by the U.S. Coast Guard. The NMU Pension and Welfare Plan, Public Health, and a large number of voluntary agencies are all involved in meeting the health, social, legal and personal needs of seamen. The union itself controls employment through a rotary system in its Hiring Hall.

Our Alcoholism Program needed time to demonstrate it could unite these disperate elements into one force, able to identify and assist the seaman with impaired job performance or health due to alcohol. With technical and financial assistance from the NIAAA, the NMU Alcoholism Program was able to do just that. Through our New York Project hundreds of seamen have found recovery, 75% have maintained sobriety in regular 6 month follow-ups. In a pilot study of a group of seamen, we found that in the two years prior to involvement in the Alcoholism Program they were hospitalized 1,155 days. In the two years after involvement they, as a group, were only hospitalized 385 days. Among another group studied in the same way for work days, shipping time increased by 44 days per year.

As the Program demonstrated cost-effectiveness in its New York Demonstration Project, so did willingness to render it internal support. The Alcoholism Program is currently underwritten at $2 for every $1 of federal assistance. We now look forward to the Program being able to demonstrate the same favorable results on the national level.

The heart and soul of an Alcoholism Program is in its ability to reach and assist the problem drinker. A strong program, though, rises from this foundation to a sound and comprehensive structure. Educational programs aimed at prevention, help for families, training for union officials and job site supervisors, program evaluation for cost effectiveness and to ascertain that the job is getting done, accountability measurements and professional development for program staff, maintaining and developing referral sources, and deepening

collaboration with treatment agencies are all essential prices in Alcoholism Programs. The NMU Pension and Welfare Plan Alcoholism Program works because it touches base with all of the above.

Without NIAAA assistance we would not have had the financial resources or the professional expertise to develop the comprehensive program NMU seamen benefit from today. The NIAAA played a crucial role in helping us obtain a national policy statement on alcoholism from the United States Coast Guard. They helped our people unite a loosely federated industry with many diverse components in a single purpose in identifying and assisting the merchant seamen whose health, job, or family is threatened by alcohol.

In conclusion, I reenforce the notion that federal leadership in the occupational alcoholism field must continue. Organizations, like ours, tie together 50 Shipping Companies and subsidiaries across the country. The merchant seamen who man those ships come from every state in the Union. No single state would see our organization as an appropriate structure for local funds. Without NIAAA assistance our program would only be a shadow of present achievements. Instead, it is on the brink of expanding to a national program with capability of serving the vast majority of NMU seamen. Without a federal mechanism to help national organizations, progress in occupational programming will certainly be slowed and many organizations may never gain the support and confidence to even begin.

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United States Senate

COMMITTEE ON LABOR AND
HUMAN RESOURCES
WASHINGTON, D.C. 20510

April 6, 1981

Martin Hickey
Management Co-Chairman
National Maritime Union
Pension & Welfare Fund

Questions - Alcohol Hearing March 25, 1981
Reauthorization of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act

1. As you state in your testimony, the cost to industry of alcoholism and alcohol-related problems is "enormous." You further cite a pilot study where involvement in the programs you have initiated resulted in significantly reduced hospitalization and significantly increased productivity. Considering the proven advantages in terms of productivity, why shouldn't we expect industry to fully finance occupational alcohol programs?

I would agree with the general principle that industry should "fully finance occupational alcohol programs." It is, in fact, a goal that our industry has persistently pursued. Internal support for our Alcoholism Program has grown from 66% to 75% during the approximately 2½ years we have received NIAAA assistance. While we aim at full support, it is not a goal we can achieve immediately in our industry.

To a large extent the occupational alcoholism movement is in its infancy. While such programs harbinger excellent results, they are still in the formation stage and not completely tested. Their application to a unique and widely dispersed industry raises further questions as to their validity where control is shared by such disparate agents. Supervision of the seaman's job performance is shared by the Union, the Shipping Company and the U.S. Coast Guard. His health and physical capacities are monitored by the NMU Pension and Welfare Plan and the U.S. Public Health Service. Add to this the possibility of joining or leaving a ship in countless locations and you have some serious questions as to whether a movement still untested in more orthodox work settings can be applied to the most complex. Because these programs intervene early in the problem and even aim at primary prevention through education and outreach, we have decided to experiment with them in our industry. We turned to the NIAAA because of their experience in working with unique populations. The maritime industry will not buy this program, until it can demonstrate that it works, does in fact save money, and gets the job done. Early studies from limited samples are positive, but far from complete. To have these services at the worksite is a new and radically different approach involving a whole change of climate.

There are some 52 Companies under contract to the National Maritime Union, some of which are faced with enormous fiscal problems. They take a long, hard look at any request for extention of benefits. More than that, though, these Companies, dispersed throughout the entire coastal areas of the nation, know little about the workings of an occupational alcoholism program. At the outset, they may even be suspicious and view the Program as detrimental to their operation. Instead of seeing the Program as cost-effective and an opportunity to retrieve recovered and highly skilled workers, they may perceive it as the Union's attempt to return problem workers to a ship under the guise of recovery.

A lot of work and education needs to be done before the Alcoholism Program's credibility establishes its own momentum. While we have had great success with the New York area Steamship Companies, there is new ground to break in other areas of the country. I cannot ask these companies to pay for a Program they are dubious about or may even view as self destructive. We are not one, centralized Company sitting down to study an issue in orderly fashion, but many organizations at vastly divergent levels of awareness.

The NIAAA is expert at just the type of education and accountability measurements which convince managers of the value of such Programs. They have helped us do the job in New York and now we look forward to their assistance in completing this task on a national level. Technical assistance and seed money for the early efforts of the Program from the Institute will allow this complex industry with unique problems to attain the goal put forward in your question.

I would like to conclude by reenforcing a notion put forward in my testimony. An organization which is national in scope can only appropriately be assisted by an agency with national capabilities. The dismantling of the NIAAA federal leadership role will be a severe blow to our Program and to the development of others like it in the future.

Senator HUMPHREY. Thank you.

Senator Harrison Williams from New Jersey has joined us.

Good morning, Pete. Do you want to make a statement or would you wait?

Senator WILLIAMS. Yes, just to say that I deeply regret the fact that we have another subcommittee hearing in progress on the subminimum wage proposal and it was necessary for me to be there. Though, I wanted to be here, but I had a report on what has been happening here.

I think we share many views and conclusions on how to approach our continuing program work in terms of alcohol and alcohol abuse.

There are some great questions on blocking the money, and I have them, and I understand those who have testified also have them. Certainly, I will read all the material and, Mr. Chairman, thank you very much.

I must return to the other meeting very shortly, but I would like to hear as much as I can within a brief time.

Senator HUMPHREY. Fine, we are glad you came. We certainly understand the problem.

Starting with Colonel Miller, you stated that the Federal Government could do more to encourage private and volunteer organizations in the area of alcoholism programs. Specifically what do you have in mind?

Colonel MILLER. I think that encouragement can occur in a number of ways. One is to assist in funding innovative programs. A number of innovative programs have been attempted, pilot programs developed in recent years with assistance from Federal

grants. In my own organization I know a number of these have occurred in various parts of the country.

One of the most recent ones was the development of programs for women. We have been traditionally programed primarily in our focus toward men alcoholics. But we have developed programs for women in a number of institutions in recent years.

Other programs deal with the relationship between private and public groups. That is with the police courts, and with the criminal justice system, in attempts to deal with the human beings affected by alcohol abuse at a more humane level than may sometimes be the case in criminal justice systems.

The innovations in these matters can often be encouraged through public support of some of the programs which are carried on.

I think there is also a sense of the climate in which private organizations work. I mentioned that private groups have sometimes been regarded as stepchildren by the governments. I am sure that there is a mindset in governments which tend to exercise hegemony over organizations affecting private groups, but I think a climate of respect and acknowledgement and recognition of what private organizations are doing and are capable of doing can provide an incentive for greater success by private organizations. They have felt sometimes they were on the outside because they have not been encouraged to report what they are doing and to participate with the broader perspective.

I think much can be done in changing the climate in which private groups work. And alcoholic groups may be more reclusive than many other groups because of the nature of the stigma associated with them.

I am sure that it would benefit all of us if the alcoholism programs and their success and objectives could be brought more into the light of media attention or whatever is necessary to make the public aware of what is happening and what needs to happen.

Senator HUMPHREY. What can be done beyond Federal grants? Frankly, I don't think you are going to see any increase, probably a considerable decrease in that area in the next some years until we restore health to the economy at least. What can we do to encourage voluntary private efforts beyond passing out money?

Colonel MILLER. Well, for one thing, I would like to see NIAAA pay closer attention to what is happening and what has been happening in private organizations.

My organization has been active in the field for more than a 100 years, throughout the world in more than 85 countries. We probably do more alcohol treatment work than any agency in the world by a wide margin. But not much is done to examine what we are doing and to learn of the methods that we are working with.

We are dealing with the people who are at the bottom of the rung. We get them when everyone else has given up on them and we have reasonably good rates of sobriety after reasonable time frames to indicate the success of our work.

We would like a little closer attention and perhaps some help in studying what we are doing. We have not written much for the literature. Our people are not oriented to that. They are oriented more to doing the work, but it might be helpful if the Government

helped to fund some studies of what we are doing or to direct their attentions toward some of these programs, not only our own, but other organizations which have and can be successful.

Senator HUMPHREY. You are suggesting then that NIAAA has not really focused on private efforts to see what lessons can be learned about effectiveness and efficiency?

Colonel MILLER. I think a case can be made for that.

Senator HUMPHREY. That is an interesting observation. Who wants to speak for the union? Mr. Wall?

How did you use the technical and financial assistance from NIAAA in setting up your program and at what point can we expect it to become self-supporting in terms of funds?

Mr. WALL. They were very helpful coming in and giving the expertise and establishing the program. We started out simply in New York and we were looking just recently to expand to three other cities down to New Orleans, Houston and San Francisco on the west coast.

It would be expected shortly after those are established that we have convinced the ship owner representatives of the necessity of carrying on the program and I believe that our figures right here indicate that the NIAAA has advanced some $82,000 to the NMU program.

The NMU pension and welfare plan itself has advanced some $247,000 in this program. So I would think within a few years, establishing it in the three ports, two in the gulf and out on the west coast, we would then become self-sufficient.

Senator HUMPHREY. Mr. Hickey, you are from management; is that correct?

Mr. HICKEY. That's correct.

Senator HUMPHREY. I didn't understand that distinction, in that case, how come you guys weren't enlightened enough to pay for this in the beginning.

Mr. HICKEY. How come we weren't?

Senator HUMPHREY. Yes.

Mr. HICKEY. We did. Mr. Wall just—we put in $3 for every $1 in grants we get from the NIAAA and we started for the pilot basis, and applied for the grant, and through the grant were able to expand the program, and also noted by Mr. Wall, our hope now is continuing with the grant to be able to expand it to the three additional cities and, hopefully, within the next few years be self-sufficient. But at this moment we feel that we can need both the financial assistance and technical expertise from NIAAA to do that.

Senator HUMPHREY. Well, in your own interests, you made the statement that the port facilities or docks or whatever are not the place for drunkenness, which obviously is true, any more than it is in the cockpit of an airplane or many other places, the operating room.

Why then—you can see now if you didn't see earlier and I guess you did see earlier that it is in your own self-interest, economically and in other ways, to have such a program.

Would you be willing to pay for the services that NIAAA provides in terms of technical assistance and so on?

Mr. HICKEY. I can't give you that. I would have to go to the people I represent. I know that it has been a successful program and I would hope that if that became necessary we might be able to do it, but I do know as I mention in my statement, we had a great deal of difficulty in getting them to establish a pilot program, and to get them to agree to extend the program which involved even more money, the people I represent would have to make that decision.

Senator HUMPHREY. Senator Williams, did you want to jump in at this point?

Senator WILLIAMS. No, but I am glad I could be here just briefly enough to know that I am going to take my homework with me and read all of your statements.

I missed something that Colonel Miller was suggesting here though, and maybe my mind drifted to an aspect that I thought was being developed. It impresses me that the public does not receive comprehensive information on the problem of alcoholism. The most dramatic things you see in the media that everybody sees are the National Council's ads and they are effective, but they only suggest a recognition of a problem.

I haven't seen any documentary, at least one that is interesting, that would get an audience, describing what is being done to reach the people who are described so dramatically with an alcohol problem in the ads.

It is 30 seconds, you see, you recognize the problem, the public generally, doesn't know how you all are so successfully dealing with this problem and very successfully I might add.

Am I way off on that?

Colonel MILLER. No, you are right on target, Senator. That I think is a very important factor. The public sees the skidrow bum while he's lying in the gutter and insists something be done about it, pick him up so I won't have to see him. But the public doesn't give its interest to the followup of that man in the process of his rehabilitation by which he is restored to a proper place in society.

One story I recall some years ago in the city of Des Moines, at a Rotary Club we brought to be the speaker Capt. Tom Crocker, who had been successful in developing our program in Chicago, with many hundreds, thousands of people who passed through the program.

Present in the audience was a man who had been rehabilitated after having been flat on his back in skidrow, West Madison Street in Chicago. In the course of his comments, Captain Crocker called for this man to stand up and recognize that he had been rehabilitated from being a skidrow bum.

And sitting at the head table one of the Rotary Club members said, "Why, he is my neighbor." Which illustrates that people can be and are restored to useful places in society after having been flat on their back in the gutter.

We do not give as much attention to that as we ought, and I agree completely that we maybe ought to place a few of those purely human stories of what can happen in the rehabilitation of alcoholics to restore them to proper places in society.

Senator WILLIAMS. That is what I felt, and you know more than I do about the needs out there because you are on the action front. I

know personally just the residential situations that are available, and the program response that is so very successful. But that is not generally known, I do believe, and we have seen within the last decade and within the last couple years really substantial increases in the treatment opportunities. That is true, my friends from New Jersey will bear me out on this. We have had the creation within this past decade the areas of response and certainly, hopes have risen as we have entered into a decade that makes available places for the effective treatment of the disease.

I would like to see more media attention to this and I don't know how we are going to get that.

Colonel MILLER. We'll certainly respond to your support, Senator, and see if we can't do anything about it.

Senator WILLIAMS. I do applaud the AD Council which does have the resources they put on the ads.

Colonel MILLER. The Salvation Army within the last year has produced a 28-minute, 16-mm film that goes to the point you precisely mentioned.

Senator WILLIAMS. We know that, and but that is exactly what we are talking about.

Colonel MILLER. This is in circulation to TV stations around the country and because I am on the film commission I know about it, but we will use your endorsement to see if we can't encourage more showing of the film.

Senator WILLIAMS. I am glad we raised it.

Thank you very much, Colonel.

We have had a transition here as you know, within the last 2 months.

Senator HUMPHREY. I wasn't going to mention it. [Laughter.]

Senator WILLIAMS. I want to just say it is not the easiest thing to go from majority to minority, but within our committee, we have had what I view as a wholesome transfer of majority authority here and this committee is well served by Senator Humphrey, and I just wanted to put that on the record, if you don't mind, Gordon; does that embarrass you?

Senator HUMPHREY. Oh, no, no.

Senator WILLIAMS. Or we can strike it.

Senator HUMPHREY. I would respond to that by saying that conferring of the chairmanship does not confer instant wisdom and I will certainly be relying upon the experience of those who served on this committee for far longer than I have, including the Senator from New Jersey.

Senator WILLIAMS. My description of the harmony of the transition was there verified.

Thank you.

Senator HUMPHREY. Mr. Hickey, I had another question for you. In all that flattery, I have forgotten what it was. [Laughter.]

We will submit it in writing along with a bunch of others, if you don't mind.

I wish we had more time to pursue this but we have a third panel.

Thank you all very much for coming.

Colonel Miller, actually it was for you. I remember the question now. You said you spend $100 million on alcoholism programs.

How do you raise that money? That isn't from all these little buckets. You must have more sources.

Colonel MILLER. The $100 million in the alcohol abuse program is raised almost entirely in thrift stores and related programs. That comes out of the clothing you donate to the Salvation Army and furniture and everything else. It is the dual rehabilitation programs which rehabilitate goods along with lives.

Senator HUMPHREY. Do you do any solicitation for corporate gifts; do you have a foundation?

Colonel MILLER. Not for alcohol abuse programs, no.

Senator HUMPHREY. I would think the industrial or the commercial community would be, business community, would be vitally interested in this area. My wish as one citizen would be that we could have more private initiative because it is a heck of a lot more efficient and apparently very effective as well.

Thank you. Thank you, gentlemen, very much.

May we have the panelists for the third panel.

The members of the panel are Williams J. Hartigan, chairperson of the Massachusetts State Advisory Council on Alcoholism; Anne D. Robertson, director of the Division of Alcohol and Drug Abuse of the Department of Mental Health from Jackson, Miss.; and Richard W. Esterly, director of the Chit-Chat Foundation, from Wernersville, Pa.

Thank you all for coming. I guess Ms. Robertson gets the award for having come the greatest distance today, all the way from Jackson, Miss. In any case, thank you very much for coming and for your patience. We will go right into the statements if possible, leading off with Mr. Hartigan.

STATEMENTS OF WILLIAMS J. HARTIGAN, CHAIRPERSON, MASSACHUSETTS STATE ADVISORY COUNCIL ON ALCOHOLISM, MOUNT AUBURN HOSPITAL, CAMBRIDGE, MASS.; RICHARD W. ESTERLY, DIRECTOR, CHIT-CHAT FOUNDATION, WERNERSVILLE, PA; AND ANNE D. ROBERTSON, DIRECTOR, DIVISION OF ALCOHOL AND DRUG ABUSE, DEPARTMENT OF MENTAL HEALTH, JACKSON, MISS.

Mr. HARTIGAN. Thank you very much, Mr. Chairman. Again I would like to thank you for inviting the Alcohol and Drug Problems Association, ADPA, to give testimony today. We represent through ADPA over 10,000 professionals in this field of alcohol and drug abuse programs.

I myself come from a perspective which is somewhat different than both my colleagues who are here. I am chairman of a State advisory council on alcoholism, a council that exists as a result of the Federal legislation in each of the 50 States as well as the territories and in most cases is appointed by the Governor or the legislature to serve in an advisory capacity in development of State plans.

Many of the remarks I had originally prepared have already been made by other individuals. I am pleased that the question of the seriousness of the problem and the need for Federal response is before us and is agreed to by all.

I think that perhaps what might be most helpful is for me to focus on the issue of the State, the Federal relationship, and the

issue that you raised, Senator, earlier in terms of the question of the distrust in terms of where States are.

It would be obviously difficult for me, in my position, to distrust where States are. I think the question before those of us on the State level is really looking to the Federal Government for leadership, for leadership in dealing with this important health problem and it is a health problem that has been before the Nation since its history began. Reference to the acohol abuse problems of the country were referred to by both Presidents Adams and Jefferson. The country in some ways is now in the 10th year of a second attempt on the Federal level to deal with the problem and the first attempt was the Volstead Act which involved a constitutional amendment and 12 years later a second constitutional amendment in many ways recognizing the ineffectiveness of the first.

For those of us in Massachusetts we are particularly impressed with the success of the recent program. I think I would like to just give you some information that we have.

We have looked at deaths in the State from cirrhosis of the liver going back to 1910 up to 1973. Every year those deaths occurred, they moved in a constant level and ended up leveling off at close to 1,200 deaths per year in 1973.

Since 1973 every year since then, those death rates have gone down and that they now are approximately at 800 deaths in Massachusetts from cirrhosis of the liver.

What I am saying is while we don't have research that shows a direct correlation between the Hughes Act and those figures. That is significant information to us. That is 400 lives a year.

In addition to that, we looked at the level of membership in AA, the programs and the effectiveness of programs for a broad range of citizens that were not impacting on lives but impacting on the quality of lives that people have.

I think that what we feel from the potential—or what we fear in terms of the block-grant concept is that in some ways it appears to us to be the Federal Government saying we have not done very well in general. We have made bad decisions.

We don't know which of those programs were good, and which of those programs were not good. We hand all that decisionmaking back over to you.

What we really feel is critical to come from the Federal Government is not a message about the failure of the Federal Government but a message that clarifies the areas in which the Federal Government has been effective and in which Federal Government action has not been effective.

We feel that to put whatever amounts of money are going to be coming from the Federal Government to the States, into defined categories that say to the States, "We recognize the effectiveness of these programs; these are the kinds of programs that the Federal Government is proud of; these are the kinds of programs that the Federal Government feels need to be replicated and continued to be developed on the State level."

So I think that that's an essential question, that is the request that we have in terms of what funding mechanism and in terms of our fears about the block-grant concept.

I also think that we recognize the need in terms of the Federal level for continuation of some kinds of services, services for prevention and education such as the National Clearinghouse. It is much more cost-effective for those terms to be developed centrally rather than duplicated throughout the country.

The need for coordination and assistance of the States so that people who are dealing with alcohol problems in Massachusetts, for example, need to know what is effective in Mississippi, they need to know what is effective in Nevada, and that level of communication is a role that exists for the Federal Government.

Special initiatives in the area of counseling, credentialing, program accreditation, training, working in the area of third-party payors and developing and continuing to develop programs in the area of occupational alcoholism.

Finally, the area of biomedical and psychosocial research in the area of alcohol abuse.

We have learned so much in the last 8 years that we need to get that information out and we need to continue to ask questions.

We need to work in that area and that is again something that we see as primarily coming from the Federal Government.

Again, I thank you for the time and I would like to give some time to Anne Robertson and Rick Esterly. Thank you.

[The prepared statement of Mr. Hartigan follows:]

Statement by the Alcohol and Drug Problems Association of North America, Inc., Washington, D.C.

Mr. Chairman and subcommittee members, I am William Hartigan, Chairperson of the Massachusetts State Advisory Council on Alcoholism, a body composed of gubernatorial appointees charged with providing oversight and guidance for our state's program for alcohol abuse and alcoholism. Under present federal regulations, all states and territories are required to have such advisory councils.

I want to begin by thanking you for inviting representatives of the Alcohol and Drug Problems Association -- ADPA -- to provide public testimony at this hearing. ADPA represents about 10,000 professional workers throughout the public and private sectors of the field of alcohol and drug abuse. Having a membership base of this size and nature, we believe that our testimony will, as a whole, be consistent with the opinions of those persons in the nation who are most familiar with the problems associated with alcohol abuse and alcoholism.

You requested in your letter inviting us to appear here today that we address several distinct issues relating to the development of sound national legislation including the reauthorization of the National Institute on Alcohol Abuse and Alcoholism. In addition, you requested commentary on the draft legislation. In the brief time allotted for my statement, I will touch upon each of these. My colleagues, Mrs. Robertson and Mr. Esterly, will address several of these issues in more detail.

Your first point, Senator Humphrey, and quite rightly so, dealt with the question of just what the federal role in the area of alcohol abuse and alcoholism should be. We have noted in the draft legislation the following statement: "Alcohol abuse and alcoholism are serious national problems requiring a federal response". Considering that a recently released government report estimates that these problems cost the economy a staggering $53 billion each year in direct, measurable costs, I hope that none here would dispute the seriousness of the problem or the need for a federal response commensurate with the problem.

ADPA believes that an appropriate federal role would focus on those aspects of alcohol abuse and alcoholism which are national in scope or which would be most economically handled at the federal level. Some of these are as follows:

1. Support for prevention and education activites such that there would continue to be a national clearinghouse for developing, gathering and disseminating information. National outreach programs are clearly more economical. The 50 states will derive great economic benefit from having materials developed and available from one single source.

2. State coordination and assistance to provide a mechanism for accountability for the expenditure of alcohol abuse and alcoholism funds at the state level. Recent history is filled with stories of the abuse of funding where centralized control was lacking.

3. Special initiatives serving the states and the field such as counselor credentialling, program accreditation, training programs, assistance in securing third party coverage and the like. Such efforts are economic, are interstate in scope and have the effect of assisting states to help each other.

4. Research in both the bio-medical and psycho-social aspects of alcohol abuse and alcoholism. Applied or practical research is of distinct value to program adminstrators and counselors.

You also requested that we comment on whether present programs have worked or not. Given that millions of lives and dollars and thousands of programs have been involved, certainly there have been failures and false starts. As a whole, though, I honestly believe that present programs while insufficient to meet the demand, do generally meet the needs of society and their clients.

In this regard, I believe I have what might be an interesting statistic for you. It involves cirrhosis of the liver, commonly recognized as resulting from the abuse of alcohol. From 1929 to 1973, deaths across the nation from this condition increased with each passing year. NIAAA became operational in the early 1970's. From 1974 to the present, cirrhosis deaths have dropped every year. It could require millions of dollars, of course, to scientifically prove a correlation. Nevertheless, the implication is obvious.

These programs are working, Senator Humphrey, in Massachusetts and New Hampshire and Mississippi and Alabama and elsewhere. Mrs. Robertson and I can provide detailed information on this in our states should subcommittee members request such information.

You indicated that you would appreciate remarks regarding private sector activity in the field. Mr. Richard Esterly, Executive Director of the Chit-Chat Foundation's program in Wernersville, PA, will address this issue in his statement.

You requested commentary on the block grant concept. As we understand it, this concept calls for funds presently administered by NIAAA to be consolidated into blocks of funding along with funds for other programs and then given directly by the Treasury to state governments. There would be no direct federal requirements on oversight regarding the spending of these funds by states. It would appear that states would not have to spend federal tax dollars on those particular functions for which funds were appropriated by Congress. If the stories we have heard are true, then ADPA is unequivocably opposed to the idea. There must be a federal response to alcohol abuse and alcoholism. Subjecting federal dollars to jeopardy in state capitals in no way represents meeting federal responsibility. We believe, in fact, that is akin to certain heavily criticized practises in the past of "throwing federal funds at a problem". There have to be safeguards at the federal level to insure that these funds are spent as intended by the Congress.

With respect to the details of the draft legislation, we have submitted a separate statement which we respectfully request be made a part of the hearing record. There is much in the draft which we believe is reasonable and sound. However, there are certain points or implications in the draft which would not be in the best interests of the country from either an economic or health perspective. The principal points for which modification is recommended are:

1. The Institute should be reauthorized for three years rather than just one year so as to promote continuity and sound planning. Year-by-year reauthorization cannot be justified on economic grounds.

2. Authorization of a total of $45 million -- or 20¢ per capita for the entire American population -- for project grants and contracts and research is woefully inadequate as a federal response to the problems of alcohol abuse and alcoholism. With these problems costing the nation $53 billion each year, the ratio of these funds to the cost is less than a thousand to one. We favor a significant increase in project grant and contract funding and, for research, conformity with the 1981 recommendations of the National Institute of Medicine.

3. The proposed repeal of formula grant authorities would result in a current NIAAA function going to the states. Other functions are proposed for termination or for sharply reduced funding. We believe that sufficient authorities must be vested in NIAAA so as to continue it as a visible, independant federal agency. The federal response to the problems of alcohol abuse and alcoholism will not be served by the disappearance of NIAAA or by its becoming an insignificant operation in a larger agency.

In closing, I again want to express to you the appreciation of the Alcohol and Drug Problems Association for inviting us to testify at this important hearing. Thank you.

Senator HUMPHREY. Thank you, Mr. Hartigan.

Ms. Robertson.

Ms. ROBERTSON. As with other of the witnesses, many of the things in my prepared statement have been said. I would summarize and highlight the ones where I think I have special information or feelings about.

In your letter inviting ADPA to testify, you indicated several issues you were interested in us discussing. One was the programs funded by NIAAA, in other words some estimate of the success of the effort of the past several years.

During the course of the hearings this morning we heard a lot about the stigma of alcoholism but I must say that that stigma is certainly not what it was in 1972. We see numerous national figures pronouncing their problem with alcoholism and their recovery from it. A lot of that has to be attributed to the public information, education, and other activities of the NIAAA. As Mr. Hartigan indicated, we would like to see those sorts of efforts continued from the Federal level.

Also, AA has been mentioned here today as a self-help group which we feel is very important for treatment. It has an integral role and part of the programs funded within NIAAA formula grants in Mississippi. It is a self-help group which maintains, and helps individuals maintain sobriety. We have seen in Mississippi a number of AA chapters grow from 44 to 172 from 1972 to the present day. Most of those people are coming out of our treatment programs and maintainig sobriety through AA contacts.

We have had followup programs in Mississippi for 3 years now trying to measure recidivism rates of people who have been through our programs. The 20 percent recidivism rate we show, although we acknowledge we cannot trace people across State lines and so on, seems to be compatible with other figures stated here this morning.

In other words, it is possible to recover from alcoholism and efforts of the past years have proven that. Also, I think a measure of success can come from the fact that the programs have been heavily overseen from Congress, the administration, from our Governors, and legislators.

We have been responsible and accountable to all those sources. I think that in one way that is seen in the fact that State government is beginning to fund alcohol treatment services.

I do not believe they would be doing that, or consider doing that if they did not think the programs were effective.

I would briefly like to touch about the concept of the block grants, and that has been touched on this morning. I would like to touch on that for a moment. I would like to enter into it by mentioning briefly the recission which will go into effect if Congress doesn't oppose the administration which will put a lot of States in the position of closing down programs and Mississippi will face it July 1, when programs will no longer be funded through the Federal formula grant.

Other States can go to the end of the Federal fiscal year. We are on a State fiscal year and the Federal Government was on that same fiscal year when the grant started so we are faced with that problem.

Many other States are in worse shape as far as these programs are concerned. But I really feel we will have difficulty if we close programs down when the block grant does become available if it is not maintenance-of-effort directed. If we are in the position of having to close programs down we are in essence asking to restart something else and I believe our negotiating and bargaining position with whoever makes those decisions at the State level will be seriously jeopardized. I believe that with that I would turn this over to my colleagues.

[The prepared statement of Ms. Robertson follows:]

(Statement Made on Behalf of ADPA by Anne Robertson)

Chairman Humphrey and subcommittee members, I am Anne Robertson, Director of the Division of Alcohol and Drug Abuse for the state of Mississippi. I am a member of the ADPA Council of State Authorities which includes as members the chief state alcohol and drug abuse officials in all 50 states.

In the brief time available, I want to address several issues you raised in your letter which invited ADPA to submit testimony today.

You requested that we comment upon whether or not the programs funded by NIAAA were successful. Like Mr. Hartigan, I, too, believe that as a whole these programs have been highly successful.

Why? To a great extent because of the many changes which have occurred in our country during the decade that the Institute has been in existence. For one thing, the stigma associated with the disease of alcoholism has been noticably reduced. NIAAA, through its prevention and public education and informational programs, has played a key role in this. Who would have thought 15 or 20 years ago, for example, that such a person as Wilbur Mills or Betty Ford would have publically admitted to having alcohol problems? NIAAA has made a significant contribution to the nation in helping us to recognize and admit that alcoholism is an illness which can be successfully treated.

NIAAA funding going to the states since July, 1972, has resulted in many unexpected benefits. For example, a substantial increase in self-help sobriety programs, most notably AA, has resulted from the work of publically funded programs in many states. Why? Because such programs work hand-in-hand with AA and similar groups in treating clients. In Mississippi, we had 44 AA chapters the year NIAAA funding started. We now have 172, a four-fold increase. Considering the nature and scope of the problem -- estimated by the government to cost society $53 billion each year -- funding for alcohol services has always been relatively limited. We have therefore had to economize right from the start. AA remains the cheapest form of treatment for those for whom this approach works.

Another measure of success involves the recidivism rate of persons who have received treatment. What is our success rate measured in these terms? Mississippi has had a follow-up program for over three years. Although we do not attempt to track people across state lines or engage in exhaustive searches, those former clients we have been able to contact under this program exhibit only a 20% rate of recidivism. While I take great pride in the programs in my state, I doubt that our rate of success is <u>that</u> much higher than the national average.

But the really critical question, I think, is just what makes these programs work right? In my opinion, they are successful because they have to be. They operate under the eyes of the Congress; of the administration; of state governors and legislatures and officials; of public boards and councils and constituency groups and the press and so on. There are many, many levels of accountability, and these programs survive because they are perceived, on the whole, to be worth their cost to the taxpayer.

A specific example of a program in my state well worth the cost involves impaired physicians. We operated a program last year for these clients at a cost of $45,000. Six physicians recovered from their abuse and addictions problems and are presently functioning as productive members of society. Others are currently in treatment. Can anyone doubt that restoring six physicians to productive status is not worth $45,000?

Let me mention just one more tangible indication of success. This is represented by decisions on the part of the Mississippi state legislature and other sub-state governmental bodies to provide funds for programs which were started with federal dollars. Until 1977, we essentially operated at 100% federal funding. Each year since then, the federal share of the cost of our operations has dropped. This year, about a third of our funding is federal. Given this trend -- and Mississippi is probably more the rule than the exception -- I believe that most states could be relatively self-sufficient in about three years.

However, we cannot become self-sufficient in the six months between now and the beginning of FY 82.

It is apparently being proposed that in six months federal funding for alcohol abuse and alcoholism would be incorporated into a consolidated block grant to states -- after being cut by 25% -- and then governors and state legislatures would be empowered to disburse funds from the consolidated block as they saw fit, regardless of any possible intent on the part of the Congress. There would be no real accountability procedures to insure that funds seemingly voted by Congress for alcohol services would be so spent at the state level.

It is my firm opinion that such an approach to funding would result in fiscal chaos in virtually every state. Just think about it for a minute. In a single year, this approach would first reduce each dollar down to 75¢. Inflation would further reduce it to perhaps 67¢. And then the 67¢ could well end up being spent for something else. Can states really help that much? Given state deficits and reduced tax revenues due to unemployment and other factors, is it realistic to assume that many states could make up much, if any, of the 33¢ on all those dollars?

I honestly believe that the threat to alcohol services in the great majority of the states is of crisis proportions. Should health and human services spending be cut by 25% in FY 82, I believe that the dollars which Congress may vote for alcohol services will frequently end up going to pay for those

services with the most pressing, immediate, visible needs as perceived by voters in states. Involved would be services to people who are hungry today; people who are sick today and without funds or insurance; people who could freeze to death tonight. Those with alcohol problems are often desparate people, but they would probably not compete well as a group with those who seemingly face immanent physical destruction. Should not choices of this nature be made by our national Congress rather than in 50 state capitals?

In closing, I want to comment briefly on a related issue involving funding for alcohol services. This is the proposed rescission of FY 81 formula grant funding to the states. Contrary to what some apparently believe, these funds were slated to be used by many states including Mississippi during this fiscal year. Ironically for some states, the rescission may be serving as a sort of warm-up fo FY 82. Iowa, for example, has already been forced to issue employment termination notices to 45% of its state staff effective April 23rd, and has notified programs across the state that 25% of their funding is to be cut almost immediately. Michigan would have started utilizing these funds back in February. Michigan is now in the process of making its third staff layoff and programmatic reductions in six months. The first two resulted from lowered levels of state fiscal support because of economic problems in the state. The third is directly attributable to the rescission. Other states throughout the country face similar problems either now or over the summer.

One consequence of the rescission will be to put many state alcohol officials in a relatively bad bargaining position should block grants become a reality by reducing their staffs and resources prior to FY 82. Another effect of what is becoming widely perceived as a general federal withdrawal from the problems of alcohol abuse and alcoholism is that state governments will follow suit. In Alabama, for example, the state alcohol and drug abuse office was recently reduced in status to become a section within the Department of Mental Illness. Again, this sort of thing will hurt should it become necessary within states to bargain over shares of a block grant. I believe that approval of the rescission cannot help but have a multiplier effect in terms of alcohol funding lost to states and in reducing states' capabilities to deal with alcohol problems prior to FY 82.

I want to thank you, Mr. Chairman and subcommittee members, for the opportunity to offer testimony here today. If I have described a rather desparate situation, it is because I know the consequences to would-be clients and communities when essential alcohol services are not to be had. Keeping NIAAA in place for an additional three years, and mandating accountability mechanisms such that funds appropriated by Congress for alcohol abuse and alcoholism are so spent at the state level will accomplish a great deal to alleviate what could otherwise become a very serious situation.

Thank you.

Senator HUMPHREY. Thank you, Ms. Robertson.

Mr. Esterly.

Mr. ESTERLY. Mr. Chairman and staff of the committee, it is an honor to testify before you on the reauthorization of NIAAA. My name is Richard Esterly and I am speaking as a person in recovery from alcoholism and drug addiction and as chief executive officer of Chit-Chat Foundation.

Chit-Chat Foundation is a 22-year-old private nonprofit corporation and has treated over 14,000 alcoholics. We have not in the past, nor do we now, received Federal or State grant funding.

As a professional working in the private sector, I would like to testify in favor of maintaining the institute and to maintain it at a high level of visibility and commitment. The treatment of alcoholism and drug addiction are specialties which have developed an eclectic approach utilizing psychology mental health, social work, and medicine.

Because of the moral stigma and misconceptions about alcoholism, countless millions of still-suffering men, women, and children alcoholics go untreated. Prior to the treatment made available through Federal funding, alcoholism progressed within the individual and most alcoholics died in their addiction.

The alcoholic entering treatment used to be 50 years old, debilitated, unemployable, and had a poor prognosis for recovery.

The Federal effort has made a most positive impact. Today it is not unusual to see patients in their 30's as the largest treatment group. They are generally healthier, employed, and have an excellent prognosis. This has impacted not only on publicly funded programs, but private programs such as our own.

The institute, in a strong partnership with other Federal agencies and State authorities, should provide:

First, research and training.

Second, coordination and funding of prevention activities.

Third, funding through the States to provide for the disadvantaged and debilitated alcoholics without resource.

Fourth, funding through the States for treatment of minorities, women, youth, and other special populations.

Fifth, a national clearinghouse for disseminating information and instructive materials.

The areas mentioned above are proper roles for the Federal Government, contribute to the overall effort, and provide for areas that no one else is responsible or equipped to deal with.

As a private, nonprofit program, Chit-Chat Foundation receives generous donations from our alumni and the business community which allows us to establish an annual fund to accept patients who do not have insurance or the means to pay. However, this provides for treatment of only 40 persons a year out of the approximate 900 that we treat.

This is insignificant compared to the number of persons who will die if they do not receive treatment and do not have the resources to pay for them.

In closing, I would like to make three relevant points. First, the cost of alcoholism can best be seen in the ravages within the family. Violence, delinquency, child abuse, and other behavioral manifestations are too common in the alcoholic home environment.

These threats to the family are felt from one generation to the next. Most alcoholics come from alcoholic families.

Second, the Federal effort has brought alcoholics into treatment earlier and resulted in less costly and more effective treatment. If that effort is lessened, treatment will return to the more expensive and less effective hospital setting. The prevention of one bout of cirrhosis or other physical or mental complication more than pays for the cost of rehabilitation.

Third, the Federal effort has been effective. The reams of evidence on cost-benefit studies and the thousands and thousands of people who have mushroomed the ranks of AA and other recovery programs, testify clearly to the effectiveness of treatment.

In summary, we have made great progress over the last 10 years and should feel very positive about that. This is an emotional issue. These are human lives suffering from a disease they did not want and are not responsible for contracting. They should not have to continue suffering the physical and mental consequences.

I do hope that the Federal Government will maintain its commitment to help those who want help.

Thank you.

[The prepared statement of Mr. Esterly follows:]

SUBCOMMITTEE TALK

March 25, 1981

Mr. Chairman and members of the subcommittee on alcoholism and drug abuse, it is an honor to testify before you on the reauthorization of NIAAA. My name is Richard Esterly and I am speaking as a person in recovery from alcoholism and drug addiction and as Chief Executive Officer of Chit Chat Foundation. Chit Chat Foundation is a 22 year old private, non-profit corporation and has treated over 14,000 alcoholics. We have not in the past, nor do we now, receive federal or state grant funding.

As a professional working in the private sector, I would like to testify in favor of maintaining the institute and to maintain it at a high level of visibility and commitment. The treatment of alcoholism and drug addiction are specialties which have developed an eclectic approach utilizing psychology, mental health, social work, and medicine. Because of the moral stigma and misconceptions about alcoholism, countless millions of still-suffering men, women, and children alcoholics go untreated. Prior to the treatment made available through federal funding, alcoholism progressed within the individual and most alcoholics died in their addiction. The alcoholic entering treatment used to be 50 years old, debilitated, unemployable, and had a poor prognosis for recovery.

The federal effort has made a most positive impact. Today, it is not unusual to see patients in their 30's as the largest treatment group. They are generally healthier, employed, and have an excellent prognosis. This has impacted not only on publicly funded programs, but private programs such as our own.

The institute, in a strong partnership with other federal agencies and state authorities, should provide:

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The areas mentioned above are proper roles for the federal government, contribute to the overall effort, and provide for areas that no one else is responsible or equipped to deal with.

As a private, non-profit program, Chit Chat Foundation received generous donations from our alumni and the business community which allows us to establish an annual fund to accept patients who do not have insurance or the means to pay. However, this provides for treatment of only 40 persons a year. This is insignificant compared to the number of persons who will die if they do not receive treatment and do not have the resources to pay.

In closing, I would like to make three relevant points:

--First, the cost of alcoholism can best be seen in the ravages within the family. Violence, delinquency, child abuse, and other behavioral manifestations are too common in the alcoholic home environment. These threats to the family are felt from one generation to the next. Most alcoholics come from alcoholic families.

--Secondly, the federal effort has brought alcoholics into treatment earlier and resulted in less costly and more effective treatment. If that effort is lessened, treatment will return to the more expensive and less effective hospital setting. The prevention of one bout of cirrhosis or other physical or mental complications more than pays for the cost of rehabilitation.

--Thirdly, the federal effort has been effective. The reams of evidence on cost/benefit studies and the thousands and thousands of people who have mushroomed the ranks of A.A. and other recovery programs, testify clearly to the effectiveness of treatment.

In summary, we have made great progress over the last ten years and should feel very positive about that. This is an emotional issue. These are human lives suffering from a disease they did not want and are not responsible for contracting. They should not have to continue suffering the physical and mental consequences. I do hope that the federal government will maintain its commitment to help those who want help.

Senator HUMPHREY. Thank you, Mr. Esterly. You have piqued my curiosity because of your statement that you had not received any Government funds. Did I get all that right?

Mr. ESTERLY. Yes.

Senator HUMPHREY. You mentioned that you raised some of your funds from alumni groups, but that was only a tiny fraction. Where does the balance of the money come from?

Mr. ESTERLY. Through insurance companies, third-party payors, and persons paying their own way.

Senator HUMPHREY. I see. But there is no other solicitation beyond that to the alumni?

Mr. ESTERLY. Well, we make an annual solicitation to our alumni and to the business and industrial community that we work with and we do raise a sizable amount of money but it can only go so far and we do have to end up with a balanced budget in order for us to survive.

So we at the present time work in very close proximity, cooperation with all the other community programs in Pennsylvania, each of us trying to do our own share.

Senator HUMPHREY. Yes.

Mr. ESTERLY. That is the kind of partnership I think that has to continue.

Senator HUMPHREY. But to give me an idea of how an organization such as yours operates, would you give me a rough breakdown in percentage terms of the amount of money as a portion of your budget that you raise through solicitation, the portion contributed by third-party payors, and who would they be beyond insurance companies?

Mr. ESTERLY. Primarily insurance companies, although in some cases there may be a State agency or a county. It is rather insignificant but there are those.

It is primarily insurance companies.

Senator HUMPHREY. What are those various percentages?

Mr. ESTERLY. About 50 percent are through insurance companies; about a little less than 50 percent, 45 percent are private pay; about 5 percent are ones that are paid through our fund that we raise each year outside.

Senator HUMPHREY. Is there a national association of private groups such as yours?

Mr. ESTERLY. There are a couple of associations we would belong to.

Senator HUMPHREY. Would it be——

Mr. ESTERLY. The council within ADPA is certainly one of those that we belong to.

Senator HUMPHREY. OK.

Mr. ESTERLY. The point I was trying to make is that we try to do our share of providing for people that do not have insurance.

Senator HUMPHREY. Yes, I see.

Mr. ESTERLY. But that if the commitment from the State and Federal Government was lessened, we would be inundated with people that wanted and needed treatment and we would not be able to handle that.

Senator HUMPHREY. I understand. You are not trying to put down your public sector compatriots. Would you care to comment

on the matter we touched on during the period when the first panel was seated; namely, suggested guidelines on block grants to insure that sufficient percentages of the allocation are directed by the States into alcoholism programs?

Perhaps Ms. Robertson.

Ms. ROBERTSON. Yes; I would.

We would certainly be interested in a maintenance-of-effort situation, the ratio concept that you had in mind. Also, I think Federal dollars that come back to the State should come back with some Federal policy or some Federal priorities to be mandated. And this particular field, such that it is, is such that there is a vast attitude range from militant abstainers to those who think drunkenness is funny and I think we need a national policy and would like to see statements that would continue the direction of the Federal Government's direction in the past surrounding utilization of funds in the block grant.

Senator HUMPHREY. Mr. Hartigan.

Mr. HARTIGAN. I would agree with what Anne has said that what would be very helpful is that there would be a mechanism of maintenance of effort, essentially a statement to the local government saying, "We feel that it is important that you address the needs of alcoholism problems in that community."

The specifics about the how, I feel, are decisions that are appropriate for that local government to make and to keep the Federal Government informed of how they are utilizing those moneys and what decisionmaking and planning goes into it.

But I think a maintenance of effort, in terms of the dollars that are being sent into the respective States by the Federal Government and to be categorically defined as that, would be our preference.

Senator HUMPHREY. Ms. Robertson, you mentioned a unique problem or a problem that is particularly severe for your State, the situation where there may be a gap between the end of your fiscal year and the beginning of the Federal fiscal year.

What you were addressing there was the proposed rescission that is pending; is that right?

Ms. ROBERTSON. Yes.

Senator HUMPHREY. We still don't have definite word on that. As you probably know, the mechanism is that if Congress doesn't act within 45 days affirmatively to accept it—that is, endorse it—it just dies. So far, time is on your side, I guess.

Ms. ROBERTSON. Yes; I think a number of programs are in the posture of cutting out the program, eliminating staff, and so on which means elimination of service to clients.

Senator HUMPHREY. Senator Denton, another member of this subcommittee, wrote me a note to express his regret that he could not come today. He has had to chair another subcommittee, as a matter of fact. Every one of us has a number of subcommittees that we chair. Some have major chairmanships of committees as well, and it is just impossible to tend to all we would like to do.

But in any case, he sends his regrets and he is going to submit a number of questions for the various witnesses to submit answers for the record.

Senator Riegle likewise has further questions for the record as do I and in any case we will leave the record open until 5 o'clock this afternoon for submission of questions that the members would like to have you answer.

The record will remain open for the submission of answers, of course, for another 15 days.

Thank you for coming this morning. We appreciate your patience. It was very interesting to listen to you and I would assure you that your testimony is not going to become just a musty pile of papers somewhere. It has some effect. I have been listening to what you have been saying and I hope we can come to some compromise that will please the administration and please the drug and alcohol abuse community, if you will, to the maximum possible extent.

Thank you very much.

Mr. HARTIGAN. Thank you, Mr. Chairman.

Senator HUMPHREY. I will include in the record a statement of Senator Denton which he would like to have in the record.

[Senator Denton's prepared statement follows:]

PREPARED STATEMENT OF HON. JEREMIAH DENTON, A U.S. SENATOR FROM THE STATE OF ALABAMA

Mr. Chairman, I appeciate having the opportunity to participate in this hearing.

Many of the issues which we must consider as members of the Senate are important, yet remote from our experience. Not all of us have known poverty, been victims of crime, or have experienced political repression, for example. But almost all of us can say that we have known someone who is an alcoholic.

The injurious effects of alcoholism on individuals and on society come quickly to mind—families are ripped apart, children and spouses are abused, productivity in the workplace is diminished, careers are ruined, crimes are committed, tragic deaths and accidents occur. A few simple statistics bring the magnitude of the problem sharply into focus. According to a Washington Post story which appeared last Sunday, one in every two drivers will be involved in an alcohol-related accident during his or her lifetime. I also read recently that half of all hopital beds in use in this country are occupied by persons with aliments linked to alcohol consumption.

Mr. Chairman, I am pleased to join you and the Reagan administration in the recognition of alcohol abuse and alcoholism as a pervasive problem deserving national attention. The direction of your legislation and of the administration's thinking is commendable, a strong Federal role in research and in testing new prevention and treatment methodologies, combined with State determination of the types of services needed, is sound policy.

I believe enhanced State responsibility for the planning and managing of Federal alcoholism prevention and treatment programs is essential for insuring the effective use of these moneys. The alcoholism and drug abuse division director in my own State has said the "direct grants have not noticeably helped Alabama. The 'initiatives' do not match our needs and when grants have been awarded, the projects they support operate without relationship to the existing system of services. They are poorly administered by a distant Washington agency." I believe the proposal we are considering today will redirect these misguided efforts.

On the other hand, the National Institute of Alcohol Abuse and Alcoholism, through its research grants, has substantilly added to our knowledge. Ten years ago, there was little information about alcohol abuse or alcoholism. Today, our knowledge about treatment and about the effects of alcohol consumption on the body has increased considerably. Furthermore, the Institute has played a leading role in corroborating the existence of fetal alcohol syndrome in infants whose mothers drank during pregnancy.

I'm sure the witnesses you have invited, Mr. Chairman, can touch on these issues in much greater depth, and I look forward to learning from their testimony.

Senator HUMPHREY. At this point I order printed all statements of those who could not attend and other pertinent material submitted, for the record.

[The material referred to follows:]

AIR LINE PILOTS ASSOCIATION
1625 MASSACHUSETTS AVENUE, N.W. □ WASHINGTON, D.C. 20036 □ (202)797-4000

March 27, 1981

The Honorable Gordon J. Humphrey
Chairman, Subcommittee on Alcoholism
and Drug Abuse
Committee on Labor and Human Resources
United States Senate
Washington, D. C. 20510

Dear Mr. Chairman:

The Air Line Pilots Association wishes to affirm support for the maintenance of a strong federal presence in the area of alcoholism programming. The Association recognizes the unique value of programs for the identification and rehabilitation of persons afflicted with the disease of alcoholism. In many instances, organizations conducting such programs, particularly on a demonstration basis, affect working groups on a national scale. Oversight of these efforts at lower than the federal level, i.e., state or local, would not provide adequate technical assistance, financial support or monitoring of the demonstration value of these programs.

In the case of working populations affected by federal regulatory agencies, the necessity for a federal presence in alcoholism programming is essential. The Air Line Pilots Association has conducted a demonstration program for professional airline pilots afflicted by alcoholism since 1974. Through this program, we have been able to demonstrate the unique value of the combination of national association, federal regulatory agency, and the National Institute on Alcohol Abuse and Alcoholism in effecting the voluntary participation of this sensitive work group in receiving treatment for alcohol problems. We feel that this effort provides additional substantive evidence for the necessity of federal presence in the area of alcoholism programming.

Sincerely,

J. J. O'Donnell, President

JJO'D:hcs

TESTIMONY SUBMITTED TO THE SENATE SUBCOMMITTEE ON
ALCOHOLISM AND DRUG ABUSE, MARCH 25, 1981

Dear Senator Humphrey and Members of the Committee:

I am Jack H. Mendelson, Professor of Psychiatry at the Harvard Medical School and Director of the Alcohol and Drug Abuse Research Center at the McLean Hospital. McLean Hospital is an affiliate of Massachusetts General Hospital, a major teaching hospital for Harvard Medical School. I have been involved in alcohol related research, service and training for over two decades and have published over 200 research reports and reviews on alcoholism and drug abuse in biomedical journals and textbooks in the United States and throughout the world. I am a Diplomate of the American Board of Neurology and Psychiatry, a member of many national and international societies including the American Society for Pharmacology and Experimental Therapeutics, the Committee on Problems of Drug Dependence (which was established over 45 years ago by the National Academy of Sciences and the National Research Council and is currently sponsored by many leading national, biological and behavioral research societies). I have served as a consultant to the President's Biomedical Research Panel and along with my wife, Dr. Nancy K. Mello, was recipient of the Jellinek Award, the highest international prize given for research achievement in alcoholism. During 1980 I had the honor to serve on the Nominating Committee for the Nobel Prize in Physiology and Medicine.

I appreciate this opportunity to share with members of the Committee some views concerning the mission and organizational structure of the NIAAA. During 1967-70 I served as Chief of the National Center for the Prevention and Control of Alcoholism, the predecessor agency to the NIAAA. The National Center for the Prevention and Control of Alcoholism was a branch of the National Institutes of

Mental Health and its mission was to conduct and support research designed to provide new knowledge about causation and perpetuation of alcoholism, alcohol abuse and alcohol related illness. Virtually all funds expended during my tenure were for investigator initiated research evaluated by peer review process and funded on the basis of priority score ratings for excellence. Few funds were expended for contracts and absolutely no funds were provided under our authorization for treatment or service activities.

During the final year of my tenure at the National Center, my staff and I were frequently consulted about the provisions in the Senate authorization which later became to be known as the "Hughes" Bill for the establishment of the NIAAA. At that time I was opposed to the new National Institute on Alcoholism and Alcohol Abuse administering project and formula grants for alcohol related services and treatments in the various states. I should hasten to point out that this opposition was not based upon my reluctance to advocate better treatment services for persons with alcohol related illness, but rather that the NIAAA was not the appropriate government agency to carry out this mission. My judgment was based upon the model which had been established at the National Institutes of Health, an agency which was responsible for research, research training and dissemination of research findings but was not involved in the direct provision of treatment services. In 1970 I believed and still believe that a research institute's mission should be limited to research and not encompass policies or practices which highlight social action or social change.

Services provided for persons with alcohol related problems through federal project or formula grants should not involve policy making activities or management at the federal level. If federal funds are provided for treatment services for persons with alcohol problems, state and community officials in consultation with knowledgeable persons in their own areas should establish their own

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priorities based upon their own needs. A research agency cannot successfully conduct both treatment management programs and research without compromising either activity. Any alleged facilitation between research and treatment in health science management rarely occurs and often there is great redundancy in basic support services required for both activities.

Again I would like to reiterate that I believe resources for treatment and services for persons with alcohol problems should be provided by the federal government but that support should be provided by a more efficient and less costly mechanism than the NIAAA. At this time, as ten years ago, I would strongly recommend treatment and services appropriations be facilitated through a block grant program and not via an Institute whose primary mission is research.

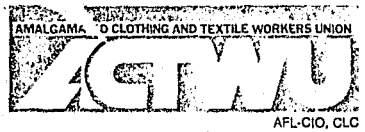
I would also like to recommend that the NIAAA research mission be supported and strengthened. Programs, policies and leadership of the NIAAA should strive to emmulate the quality of excellence in research fostered by the NIH. Currently our fund of information about the causation and perpetuation of alcoholism and alcohol abuse is meager. If we are to make any impact on the public health problems associated with alcoholism and alcohol abuse we require better knowledge in virtually all aspects of scientific endeavor including biological, behavioral and socio-cultural areas. I sincerely believe that if NIAAA focuses upon excellence in research rather than an amalgamation of research, service and information dissemination activities the quality of its research mission will improve. I would also hope that you and your colleagues would consider the potential resources for activities such as dissemination of information to the public about alcoholism which currently exist in the private sector. For example, organizations such as the National Council on Alcoholism for many years acted as an information retrieval and referral resource and continued and enhanced activities of this group within the private sector should be encourage rather than suppressed

by costly redundant programs maintained by the federal government. Similarly facilities such as the Rutgers Center for Alcohol Studies has for many years provided superb documentation services and information retrieval for both the layman and scientist.

In summary I would hope that the mission of the NIAAA be redirected toward the acquisition of new knowledge through research which is characterized by innovation and excellence in all disciplines. I would also hope that resources for treatment of those persons with alcohol related problems who require federal assistance for such treatment be provided through a mechanism which is cost effective and assures better program management and decision making at the local level.

Respectfully,

Jack H. Mendelson, M.D.



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TESTIMONY PRESENTED BY THE

AMALGAMATED CLOTHING & TEXTILE WORKERS UNION

In 1979, aided by a grant from the National Institute on Alcohol Abuse and Alcoholism, the Amalgamated Clothing & Textile Workers Union (ACTWU) established a work-based alcoholism program. ACTWU is one of the largest unions in the country, representing an estimated 450,000 workers nationally, who work in the fields of male apparel, textiles and shoe production. The program was developed specifically because of a demonstrated need for alcoholism services among women, who constitute over 70 percent of our membership.

As a result of the alcoholism program, several hundred workers have been enabled to remain at the job, productively employed rather than becoming disabled and unemployable--both likely, and costly, consequences of the disease of alcoholism. In addition, the alcoholism program has reduced costs to insurance carriers by enabling the correct diagnosis of the disease followed by appropriate treatment, rather than repeated stays in the hospital to treat problems caused by alcoholism (gastrointestinal and nervous disorders, etc.), but which cannot be alleviated unless the disease itself is recognized and treated.

Because of cost benefits it can create for industry and the insurance system, as well as human savings, I strongly urge that the NIAAA be maintained and strengthened by the current administration.

Joyce D. Miller

Joyce D. Miller, Vice President
Director, Social Services
President, Coalition of Labor Union Women

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STATEMENT BY DAVID LIVINGSTON, PRESIDENT, DISTRICT 65, U.A.W.

DISTRICT 65 U. A. W.

13 ASTOR PLACE • NEW YORK, N.Y. 10003 • (212) 673-5120

March 20, 1981

Senator Gordon Humphrey
Chairman Senate Alcoholism and Drug Abuse Subcommittee
4203 Dirksen Senate Office Bldg.
Washington, D.C. 20515

Dear Senator Humphrey:

District 65, U.A.W. is outraged by the proposed elimination of federal funds to combat one of the most dangerous, deadly, and neglected diseases from which our members and their families suffer. By rescinding NIAAA grants for alcoholism projects, the Waxman bill now before Congress would eliminate occupational programs many of our members need in order to survive, maintain their jobs and their families.

The majority of our Union shops are small businesses and institutions which cannot afford the in-house alcoholism programs provided by some major corporations. Our Union has consistently taken the position since its founding that we must do everything possible to provide the health and welfare services necessary to our members' survival. One critical threat to District 65ers has been alcoholism - a cause of severe illness, serious injuries, loss of employment and family breakdown among our ranks. Through our Security Plan we have been providing some services to members and their families with severe drinking problems - but lack the resources to identify, educate and help members before their drinking interferes with their health and safety, their jobs and their very lives.

Our efforts to treat this disease when jobs are jeopardized have been extremely expensive due to alcoholism's chronic nature, hospital bills, disability payments, supportive family services and arbitration hearings. Without federal assistance we are unable to launch the project we have submitted to NIAAA for a union-wide program in cooperation with management, based on prevention and early identification of drinking problems.

We are counting on you NOT TO VOTE FOR RECISSION OF NIAAA's 1981 BUDGET, and to CONTINUE FEDERAL SUPPORT for the OCCUPATIONAL ALCOHOLISM PROGRAMS our union and our country's working people so desperately need.

Sincerely and Respectfully,

David Livingston

David Livingston
President
District 65, U.A.W.

DL:th

IT PAYS TO BELONG TO DISTRICT 65

A Statement Submitted for the Record on
the Hearings on the Re-authorization of the
Comprehensive Alcohol Abuse and Alcoholism Prevention,
Treatment and Rehabilitation Act held by
the Senate Subcommittee on Alcoholism and
Drug Abuse on
March 25, 1981
by the

Association of Labor-Management Administrators
and Consultants on Alcoholism, Inc.
1800 North Kent Street - Suite 907
Arlington, Virginia 22209 (703) 522-6272

The Association of Labor-Management Administrators and Consultants on Alcoholism (ALMACA) is a private organization of persons employed in the development or administration of occupational alcoholism programs. ALMACA is ten years old and has 2,300 members. Many of our members work in the private sector and most of their programs are supported out of the budgets of management or unions. Only a very few of our members work in programs supported by grants from NIAAA and, in these, government support is partial and time limited.

These written comments will address the issues raised by Senator Humphrey in his letter of March 17, 1981 to ALMACA, many of which were repeatedly asked of witnesses by Senator Humphrey during the March 25th hearing. The comments are supplemental to the testimony of Mr. Shannon Wall and Mr. Richard Hickey during the hearing. Mr. Wall and Mr. Hickey are labor and management co-chairman of the National Maritime Union Alcoholism Program. The staff of that program are ALMACA members.

The issues rasied by Senator Humphrey include the future federal role in the area of alcoholism and alcohol abuse, the private sector activities in the field, the proposed block grants and research, training, prevention and education activities.

ALMACA believes that there must be a strong national government presence in the field of alcoholism. Therefore, we are pleased with the indications that the members of the committee support the re-authorization of NIAAA. The occupational programs in which our members work are mostly in the private sector, but need a strong national alcoholism program to effectively serve alcoholic workers and their families. Specifically, a strong national effort is needed in the following areas:

Treatment - Occupational programs almost always utilize community treatment resources. Since the passage of the Comprehensive Alcohol Abuse and Alcoholism Act of 1970, the system of community based treatment resources has grown all over the country. However, with increasing pressures on hospitals and other health care providers to make basic changes in the health care delivery system throughout the country, there needs to be a strong national advocate to assure that the health care community continues to treat alcoholism as a disease and devote staff, beds, education, training and research to this major public health problem. The tremendous potential of occupational programs to motivate people to sober and healthy lives cannot be fully met unless treatment resources are there. Many providers would interpret a weak NIAAA as a signal to let up in their community based treatment efforts.

Insurance - Employers and unions that develop occupational alcoholism programs are concerned that there is a means to pay for the required treatment. The costs of this treatment is borne

by the employers and/or unions through self insurance or third party coverage. In either case, ALMACA members need to be concerned about the cost for treatment. Although health insurance coverage for general hospital based alcoholism treatment has greatly improved during the last decade, there is a need to develop better health insurance coverage for non-medical and out-patient treatment. ALMACA has been pleased with the recent leadership role that NIAAA, under John DeLuca, has played in the insurance field. NIAAA must be able to continue its leadership role in the insurance field.

Management and Treatment Information Systems - The national government needs to have a strong information system role in two ways. It needs to provide technical assistance to all components of the alcoholism service system, including occupational programs, on the design of information systems to be used at the program level for effective management. Moreover, it needs to collect limited, specific information about the incidence of alcoholism and treatment outcome in order to guide future policy and to evaluate present efforts.

Program and Personnel Standards - Occupational alcoholism programs are found in a variety of settings, including; industrial medical departments, personnel offices, safety and hygiene units and loss control efforts. Often these programs have started as the result of interest of one dedicated, hard-working employee who may have been a recovering alcoholic. As the effectiveness of these programs and the extent of alcoholism in the workforce becomes recognized, other industries want to start programs. These later efforts will be much more effective if they are able to systematically build on the experiences of early programs. NIAAA has been working with ALMACA and other groups to develop program outlines and personnel guidelines which would be models for newer programs. This is a modest national effort which has the potential for providing rehabilitation for large numbers of persons and needs to be continued.

Research - ALMACA believes that a strong national research effort needs to be mounted and that this should be guided by NIAAA. We are deeply troubled by reports that the administration is considering withdrawing support for psycho-social research under a general policy of prohibiting federal involvement in "social engineering". This may be a classic case of "throwing the baby out with the bath water". The alcoholism field, and particularly the occupational field,badly needs applied and evaluative research. We need to know, for example, if newer, younger employees respond to similiar treatment as do long-time, middle age employees.

During the hearing, members of the sub-committee requested suggestions about how the private sector could be encouraged to do more in the alcoholism field. ALMACA believes that the federal government could encourage the development of occupational programs by providing tax credits for these programs and requiring federal contractors to have occupational alcoholism programs. ALMACA will comment below about the block grant concept, but if a block grant for alcoholism is adopted, the legislation should encourage continuation of state efforts to provide technical assistance to unions and employers in developing occupational efforts. The federal government needs to recognize that the development and administration of occupational programs is basically the responsibility of labor and management and that federal regulations should tread lightly on the responsibilities of those parties to administer occupational programs.

ALMACA is concerned that, if alcoholism is included in a general health block grant, that the amount of public support for alcoholism services will suffer greatly. The S.A.S.D.P. (State Alcoholism Services Demonstration Project) grants which NIAAA initiated with five states last year is an alternative model which would achieve the objective of mainstreaming federally supported alcoholism projects into state administration and funding while not endangering the gains made over the last decade. Under S.A.S.D.P. the states administer the NIAAA approved project grants and have authority to re-allocate alcoholism funds among projects. Since the states, and not the programs, apply for S.A.S.D.P. grants, this concept would provide more authority to the states but would assure the alcoholism constituency that it would not receive any more of a reduction in federal support than other health programs.

It is our understanding that the sub-committee draft bill continues NIAAA's authority to provide demonstration grants to special populations, particularly underserved populations. ALMACA believes that the alcoholism field continues to devote a disproportionate share of its resources to programs designed for the stereotype, skid-row alcoholic. Most alcoholics have jobs and are part of an intact family. We, therefore, strongly urge the committee to include employed persons in the listing of historically underserved populations so that applications to NIAAA for occupational programs will be given special consideration. This is especially needed for multi-site occupational groups that states may not be able to serve, such as in the transportation industry.

ALMACA is grateful for this opportunity to provide input to the sub-committee on the re-authorization of NIAAA. We believe that the occupational alcoholism field has a strong future and that the federal government should be an importnat partner with the private sector.

AFL-CIO
Appalachian Council

1018 Kanawha Blvd., Suite 207 Charleston, W. Va. 25301 304-345-0264

OCCUPATIONAL ALCOHOL ABUSE PROJECT

DANIEL A. O'ROURKE
DIRECTOR

RECEIVED MAR 2 3 1981

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March 16, 1981

Mr. Gordon J. Humphrey
Chairman of the Subcommittee
on Alcoholism and Drug Abuse
4230 Dirden Senate Office Building
Washington, D.C. 20510

Dear Mr. Humphrey:

Enclosed please find my written testimony concerning the reauthorization of NIAAA. I would appreciate it if you would enter this testimony in your official records indicating that the AFL-CIO Appalachian Council supports the reauthorization of NIAAA.

Sincerely yours,

Daniel O'Rourke

Daniel A. O'Rourke, Director

DOR/bj
opeiu-67, afl-cio

The AFL-CIO Appalachian Council Occupational Alcohol Abuse Project was funded in 1977 for a three-year period by a grant from the National Institute on Alcohol Abuse and Alcoholism. It was funded to demonstrate whether the joint labor/management approach could be an effective tool to deal with occupational alcoholism. The Project has a three State effort with four offices in Pennsylvania - one in Lancaster, Johnstown, Erie and Scranton; two offices in Alabama - one in Mobile and Birmingham; and one office in Charleston, West Virginia. Each office employs a secretary and staff representative on a full time basis with the Director of the Project being located in Charleston, West Virginia. The Project is supported by the Technical Assistance Unit of the Appalachian Council with offices in Washington, D.C. and Charleston, West Virginia.

The original funding period for the Project terminated on November 1, 1980; however, the AFL-CIO Appalachian Council applied for and was granted continuation of the funding for an additional three-year period. The new funding was granted under the dual review process of the federal government and was granted solely on the success and merit of the Project.

The Occupational Alcohol Abuse Project is a cost effective project operating exactly on the same amount of funds in Year 1981 as it did in 1977. The Project is reaching blue collar workers in the Appalachian Region; the same blue collar workers who are paying taxes to fund projects of this type. The Project has been a tremendous asset to management by providing an avenue of assistance

in dealing with alcoholism in the workplace. Until the implementation of the Project, in most cases, the problem was not being addressed constructively.

In the past three and one-half years, the Project has established 104 working programs between labor and management in the three State target area. The Project programs cover:

56,780	Union employees
7,943	Non-union employees
64,723	Total employees

The Project has a comprehensive training segment where staff representatives go on-site and train union and management personnel how to operate their own program. The Project has trained:

604	Union leaders
662	Management personnel
1,266	Total

The Project is currently in the process of doing updated training for plants where the Project has been operating for several years. The Project has retrained:

15	Union leaders
52	Management personnel
67	Total

As I memtioned earlier, this Project is funded by a grant from the National Institute on Alcohol Abuse and Alcoholism, and without their support, this Project would be unable to operate.

The problem of occupational alcohol abuse is a very, very serious one in this country and failure of this administration to realize it will be a tragedy for the American worker and failure to reauthorize NIAAA will be a tragedy for this country in general.

Enclosed please find a complete evaluation report from the West Virginia University on this Project.

Respectfully submitted,

Danny O'Rourke

Danny O'Rourke, Project Director
AFL-CIO Appalachian Council
Occupational Alcohol Abuse Project

DOR/bj
opeiu-67, afl-cio

MARKETING PROFILE OF THE UNION-MANAGEMENT OCCUPATIONAL ALCOHOL PROGRAM

to

AFL-CIO Appalachian Council
Research Department
Dr. John R. Spears, Director

Submitted by:

Office of Educational Research
and Field Services
West Virginia University

January 1980

NATURE OF THE PROJECT

The Occupational Alcohol Abuse Project was funded in November, 1977, by the National Institute on Alcohol Abuse and Alcoholism (NIAAA). The AFL-CIO Appalachian Council was given primary responsibility for the direction and implementation of the Project over a three-year period of funding. The purpose of the Project was to initiate, develop, and administer in two target states a labor-management program to identify, refer, treat, and rehabilitate those workers with alcohol problems. A secondary objective was the development of community awareness of the alcohol problem. The long term objective was to make the programs self-sufficient and self-perpetuating. Of greatest importance was the fostering of labor-management cooperation. This joint arrangement was intended to reduce conflict and instill a climate of cooperation for assisting the worker within the workplace.

The purpose of this report is to describe the current status of the marketing process of the project in Pennsylvania and Alabama. The report will take the form of a marketing profile highlighting the major strategies, procedures, obstacles, and other factors relevant to initiating a joint occupational alcohol abuse program. The profile is based on the status of the various programs operating as of January, 1980, in the four Pennsylvania regions: Erie, Harrisburg-Lancaster, Johnstown, and Scranton and the two Alabama regions: Birmingham and Mobile. The third-party evaluators have visited each of the regions and interviewed representative groups and individuals involved in the project. The types of people interviewed were as follows:

1. State Coordinator
2. Staff Representatives
3. Alcohol Professionals
4. Community Representatives
5. Union Officers
6. Management Officers
7. Joint Union-Management Committee
8. Contact Persons

The primary instrument of the evaluation was a structured interview that probed the role of the group or individual involved and their perceptions of central facets of the program pertaining to initial marketing and program adoption. Extant records and documents were also examined. Furthermore, the progress reports furnished by the Research Department of the AFL-CIO Appalachian Council were used to supplement basic findings. Lastly, the evaluators discussed various aspects of the project with the Project Director, the Operations Analyst, and the Project Officer of the funding agency, NIAAA.

The third-party evaluators conducted the interviews from August 1979 through January 1980, spending approximately three-five days at each of the six cities. The data obtained from these interviews were analyzed so as to document the current status of the following aspects of the marketing process: the qualities of the staff representatives, the characteristics of program adoptors, and the effect of environmental factors on promoting programs. The evaluators wish to emphasize that the marketing profile reflects the summary impressions of the interviewers concerning critical factors that are involved in establishing programs in the six regions.

Thus, the purpose of the report is not to present a quantitative evaluation or to assess the impact of the project at this point. Rather, the report is intended to identify the major factors that contribute to successful program adoption. The focus is on the project as a six-city effort and the profile is a composite analysis.

PROJECT PROGRESS

The following profile outlines the key factors contributing to successful program adoption. The profile attempts to make explicit what is in many cases implicit in the performance and accomplishments of the Staff Representatives. By a careful analysis of these factors, the evaluators will describe the general marketing process. Although this is not a product evaluation, it is clear to the evaluators that the general effects of this demonstration project are positive and warrant documentation. Based upon professional judgement, analysis of structured interviews, and certain unobtrusive measures, the evaluators present the following findings in the form of a preliminary set of indicators of procedural success.

--In a short period of time, the Staff Representatives have obtained 64 letters of agreement, which represent a formal, binding contract between union and management. Moreover, these memoranda are characteristically uniform in terms of policy and procedure.

--These letters of agreement represent a potential benefit to 28,882 workers and their families. Although the majority of these workers are union employees, the memoranda cover both management and labor. Perhaps even more importantly, immediate assistance under terms of the memoranda has been provided in the form of referrals to treatment professionals, and individual cases of rehabilitation are already present.

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--The programs adopted to date represent a diversity of client groups in a variety of settings. Small, intermediate, and large-sized employers can be found among the adoptors of this program. The program cuts across many occupational areas, from the building trades to heavy manufacturing, from semi-skilled to skilled, from clerical to top level management, and from state and municipal workers to textile workers. Moreover, participating plants encompass a wide geographic coverage, from highly industrialized urban plants to small "single product" firms in rural settings. Accordingly, numerous kinds and types of unions within the AFL-CIO are represented.

--In the program setting, a representative labor-management committee is responsible for providing assistance to the employee. These committees are a formal part of all contracts between labor and management. They are composed of union members who are selected by the local union president and management representatives, usually including the personnel manager and other supervisory personnel.

--The orientation and training sessions are viewed as an informative and vital part of the overall educational process that is provided jointly to management and union members.

--As a change process, the occupational alcoholism project has had several visible effects on community awareness and the shaping of local opinion toward the understanding of alcoholism as a treatable disease. In this sense, the program has attracted favorable publicity and has garnered the support of alcohol professionals, religious groups, civic organizations, and local media.

--To date, formal reports submitted by the Research Department of the Appalachian Council of the AFL-CIO indicate systematic progress toward attainment of general program goals. These assessments have been corroborated by numerous on-site, field visits by the staff of the third-party evaluators, who found representatives of government agencies and alcohol treatment centers concurring with the above findings.

--There exists an adaptive and innovative program which is being implemented by a strongly committed and well informed staff. Although this program is characteristically innovative and adaptive, the procedure followed can be described in a systematic fashion and the factors contributing to success observed so far can be identified.

MARKETING PROFILE

The evaluators have been able to derive a set of key factors that contribute to the successful signing of a letter of agreement. These

factors are intended to provide a preliminary anatomy of the marketing phases of this project.

Qualities and Prerequisites of the Staff Representative

The Staff Representative is a composite of many types: a change agent in the tradition of the social worker and the Peace Corps volunteer, a salesman, a skilled negotiator, an ambassador of good will, a teacher, and a union member. He represents a program that seeks to save lives, preserve jobs and families, and prevent irreparable physical and emotional harm.

The Staff Representative may emerge from the ranks of labor and union, but he soon finds his role to go well beyond partisan boundaries, for he must work as much with management as he does with labor. Attempting to introduce his program to as wide an audience as possible, he must be the advocate of many local groups and their causes and yet must maintain professional distance from community politics.

Although each Staff Representative has his or her unique personality and talents, it is possible to provide a few generalizations concerning the attributes of these change agents that contribute to their marketing success. These generalizations refer to commonalities among all six individuals and are intended to identify the basic characteristics needed for carrying out this task. Put in the vernacular of business, these are the ingredients one should be looking for in a "salesman." Or in the vocabulary of social science, these are the prerequisite skills and strategies needed for change infusion at the local level.

1. The Staff Representative must be knowledgeable about alcoholism, recognizing that it is a treatable disease, and be deeply interested in helping those who may be in its early, intermediate, or late stages of abuse. Short of being a personal crusade, bringing help to the alcoholic or alcohol abuser at the work site must be an all-consuming ideal of the Staff Representative. He must be committed to developing programs and have a minimum of competing obligations.

2. He must know the unions--where they stand on certain issues, who holds the power, how their current negotiations with management are progressing, and so forth.

3. In order to establish viable occupational programs, the Staff Representative has to be very familiar with the political, social, economic, and cultural conditions in the community. He must be able to work with diverse groups, each of which may have varying and, at times, conflicting aims. Also he should have the unequivocal support of top labor so that he can make contacts with individual locals with a modicum of difficulty.

4. An effective Staff Representative is one who works well with both management and labor. He must be able to appreciate the needs and priorities of the employer as well as those of the union and the worker.

5. Concomitantly, he must be adept in labor negotiations, the give-and-take of the bargaining process in which absolutes are inevitably compromised in the process of obtaining incremental gains and accepting momentary losses.

6. He must have access to top leaders and influential spokesmen in unions and community.

7. He must have perseverance and fortitude to keep pushing a program in the midst of delays, uncertainties, opposition, and disappointment.

8. He must be a self-starter--a person who wants to make things happen without relying too much on others.

9. He should come from one of the major local unions (large in number and/or prestige) and be experienced in community service or social activities programs.

Successful marketing depends on the Staff Representative having these basic characteristics. But the amounts of the various ingredients are as important as their types. The analogy could be made to the baking of a cake. Just knowing the ingredients does not guarantee a successful cake. Thus a staff representative must be able to analyze the local conditions and by possessing the above mentioned attributes be able to bring the appropriate forces together in mutual cooperation so that successful program adoption can occur. In short, the staff representative's ability to work within a dynamic network of community relationships will largely determine whether programs are adopted or not.

Marketing the Program to the Target Groups: Unions and Management

Based on interviews with the Staff Representatives and representatives of unions and management in the six regions, the evaluators have attempted to identify the most significant factors underlying the process of marketing a program to both union and management. The following section presents those factors generic to both groups that shape and influence marketing strategies and marketing success.

These factors are discussed below in the form of answers to specific questions about marketing the program to unions and management.

Are there certain factors that explain why some local unions are more likely than are others to adopt a program?

Those local unions that show a high interest in an Occupational Alcohol program and eventually decide to adopt it display certain common characteristics.

--These unions tend to be progressive and socially enlightened; they have historically been involved in providing social welfare benefits to their membership.

--Consequently, in their negotiations with the employer, these unions have bargained for social benefits for their membership.

--Normally, their district and state organizations also have endorsed these types of social activities.

--Furthermore, they tend to be strong organizationally, with very stable leadership.

--Also in the course of negotiations they have demonstrated a spirit of cooperation with management, with a low level of labor-management conflict.

--They are aware of and sensitive to the wants and needs of their members.

Why are some employers more likely than are others to adopt an Occupational Alcohol program?

The most likely program adoptors exhibit several common traits.

--Employers who become highly interested in the program recognize the potential social and economic benefits for the company and its employees.

--They see the program as a means of retaining highly skilled and long-tenured employees.

--They are aware of the program's potential for reducing grievances, absenteeism, and tardiness.

--These companies are socially enlightened, with high level management sharing the same concerns as the union for the welfare of the employee.

--These employers have had a cooperative relationship with the union in terms of contract negotiations and providing supplementary benefits to the employee.

--In several cases, a "dramatic event" has recently taken place at the plant, such as a suicide, a death through chronic alcoholism, etc. These incidents have influenced both management and union in adopting an Occupational Alcohol program.

Does the Staff Representative use certain channels to approach the potential buyer?

The Staff Representative uses several channels in "prospecting" for and approaching prospective adoptors. Figure 1 illustrates the marketing channels used by the Staff Representative.

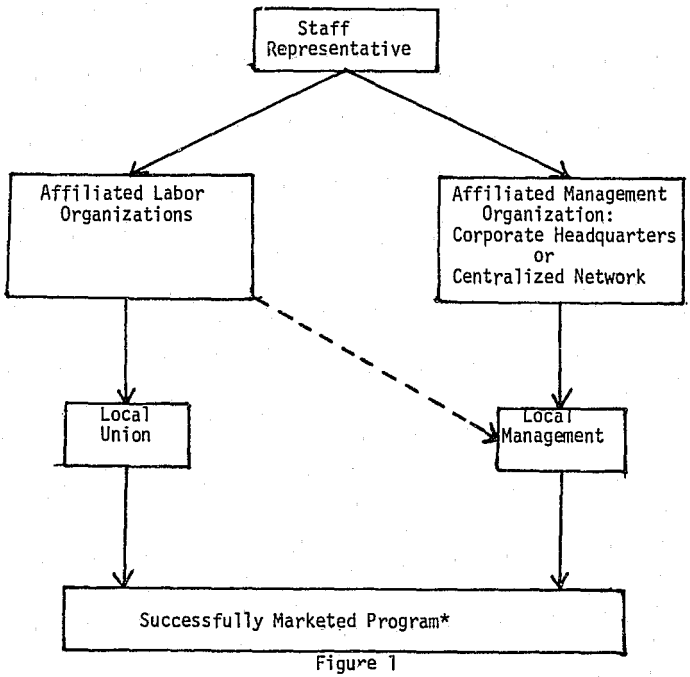

Figure 1

Union/Management Marketing Channels

*Defined functionally as one with a signed letter of agreement, has received training, and has a labor-management committee.

The Staff Representative's most successful channel is his affiliation with unions at various organizational levels within the AFL-CIO network. In Pennsylvania and Alabama, a distinct feature is the formal system of coordination whereby the Staff Representatives are directed by a State Coordinator, who, in turn, serves as liaison for the project with the state AFL-CIO. This structure provides particular advantages for marketing and developing individual programs. It offers a unified network for promoting legislation and communicating project developments to the statewide union organization. It also serves as a system whereby the State Coordinator monitors project accomplishments and communicates needs and priorities to the Project Director and the Research Director.

The built-in linkages among the Staff Representatives, the State Coordinator, the Project Director, and the Council Research Director provide a formal organizational framework for planning, coordinating, training, delivery of services, and periodic monitoring. With respect to the marketing process, the organizational structure promotes a "team approach" at all levels along the system. This ties the project into the existing AFL-CIO Community Service Committees, whose primary interests are the social welfare of all union members. In addition, the Staff Representative as union member can call on the State AFL-CIO affiliated local in the state.

At another level, one of the most instrumental channels for contacting local unions is the Central Labor Council. The Central Labor Council is composed of all local AFL-CIO affiliated unions and is governed by a hierarchy of officers. Often it is the President of the Central Labor Council or another high ranking official who directly assists the Staff Representative in making contacts and influencing various

locals to invite the Staff Representative to make a program presentation to their Executive Council. In this case, the Central Labor Council provides the link between the Staff Representative and the Executive Council. And, in most cases, the support of the Executive Council assures the adoption of a new program.

In several other cases, the Central Labor Council provides the Staff Representative with accurate and up-to-date information about the current status of labor-management relations at various companies within the region. Such information as the history of negotiations, the social attitudes of the employer and the union, the economic condition of the company, the power arrangements within the local union, and the existence (prior or current) of an alcohol abuse program can be provided by those in positions of authority within the Central Labor Council.

Also, at times, the Staff Representative works closely with management affiliates to either establish a single program or to multiply the number of programs to the same "employer." This is most often the case with marketing the program to a municipal or county government employer. For example, the Staff Representative may approach elected officials such as the mayor and city council to establish programs with several groups of workers, perhaps, firefighters, police, and hospital workers. In these situations, the Staff Representative approaches "local management" through the conduit of more centralized management channel.

In sum, those unions and employers who adopt an Occupational Alcohol program share a set of common characteristics. Successful marketing depends in large part on the Staff Representative's awareness of these characteristics and his ability to work through channels to contact the most likely adoptors of such a program.

Working with the Local Environment

It is clear to the third-party evaluators that the successful marketing of Joint Union-Management Occupational Alcohol programs is heavily dependent on the degree to which the Staff Representative can mobilize community forces and overcome local obstacles. In this regard, certain educational strategies for working with the environment have been utilized by the Staff Representatives.

They have adequately publicized the project so that the general public and key community leaders now understand the purpose of the endeavor. Alcoholism has carried with it a rather strongly pejorative and socially undesirable image, which if left unabated would prevent many in the community from supporting such a project. This educational effort has had as its major objective the presentation of the fact that alcoholism is a disease that is treatable.

Correspondingly, the Labor Representative to the United Way, Red Cross, or other similar community service agencies has been informed of the project's aims and has become directly involved in its development. This individual has been immensely helpful in opening doors and gaining the much needed support of local community leaders, many of whom, in turn, have influence over corporation and elected officials.

Equally important has been the fostering of a close working relationship with local and area alcohol treatment centers and related agencies. Thus the treatment centers and alcohol professionals have been important for both positive and negative reasons.

--They are used for training.
--They help in procuring additional companies.
--They are needed, naturally, for providing treatment.
--They are sources of credibility for the project from the standpoint of professional and technical expertise.

--In many cases, they are already conducting programs in occupational settings and they can thwart the efforts of the Staff Representative and endanger the viability of the entire project if they are not convinced of its importance or soundness.
--After initial exposure to the project, these professionals normally are eager to assist the Staff Representative because they recognize the potential of the project for expanding their services.
--They serve as valuable members of the project's Community Advisory Board.
--They are also sources for new information on such matters as insurance coverage, new legislation, innovative treatment techniques, etc.

Another important environmental variable is the political make-up of the community. Selling or marketing a new social services program may have impact on existing political arrangements, and the Staff Representative often finds himself dealing with those in positions of political power, such as the mayor, members of city council, county government representatives, members of the chamber of commerce, and so forth. Naturally, unions and their employers are affected by these groups, and it has been extremely important for the Staff Representative to work with those in positions of power so that his programs gain their support.

Environmental Groups and the Staff Representative

Marketing of programs requires the Staff Representative to work regularly with a variety of local groups, many of whom have interdependent relationships with each other. In most of the program settings, the following group configurations are typically present.

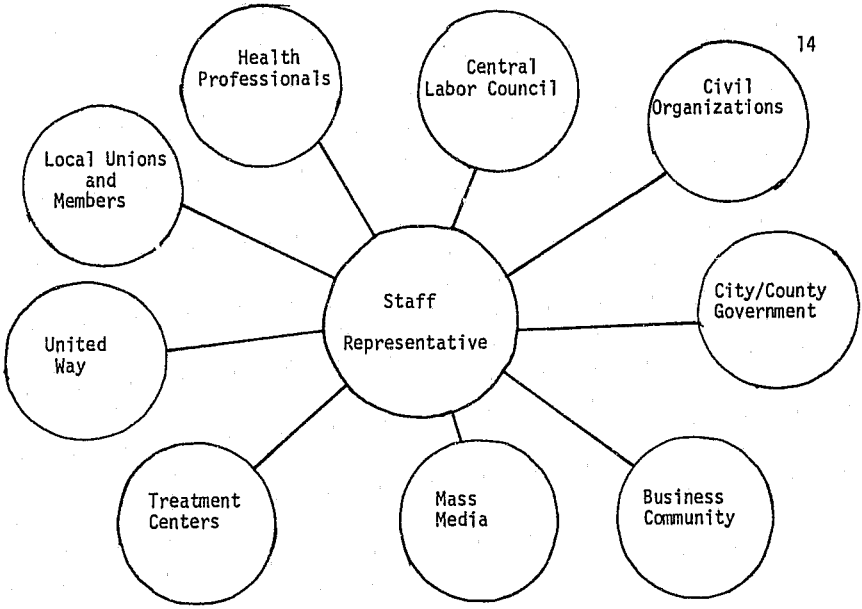

Figure 2

Local Groups and the Staff Representative

In this figure, the Occupational Alcohol program should be looked upon as a potential "integrating device" linking various groups from diverse sectors of the community in a common cause. One does not sign a program with a particular employer in a vacuum. The positive ramifications of an Occupational Alcohol program vibrate throughout the community and thus the marketing approach takes on the broadest of community bases.

In this context, the staff representative has both an educational and a promotional (or public relations) role. He must inform his many publics about the prevalence of alcohol abuse and at the same time enroll their support for the correcting of the abuse and the restoring of the

worker to full productivity. In this sense, he must deal with many "publics." In essence, the Staff representative must be experienced in community "politics" and adept in public relations. "Nothing succeeds like success" and there is a very distinct "echo" or "ripple" effect present in the project.

The relationship of these publics to the Staff Representative can be depicted in terms of a marketing flow (Figure 3).

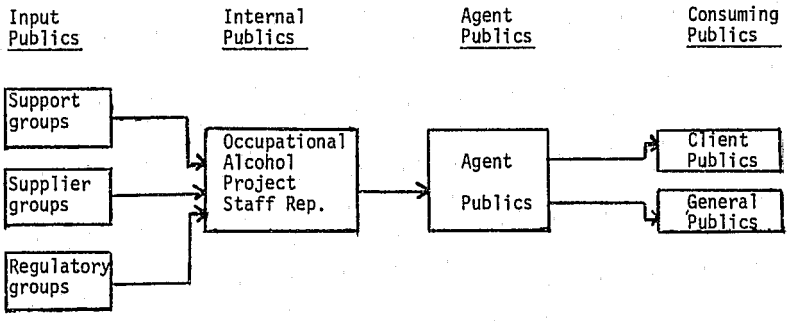

Figure 3

Main Publics and the Staff Representative

For the Occupational Alcohol project, the supporters consist of the unions, civic organizations, business and community groups, and government agencies. Suppliers include treatment centers and health professionals. Regulatory groups represent insurance carriers, legal representatives of government and corporations, and the union-management contract negotiations committees.

The inputs of these groups are filtered through the Project--the Staff Representative and the Community Advisory Board. In turn, the Project's services or "products" are distributed either indirectly through agents or directly to consuming groups. For the Occupational Alcohol project, the agents include the mass media and, depending on the situation, labor representatives in the United Way, and health professionals.

The consuming publics consist of the following major groups: the client groups are workers who are in the early, intermediate, or late stages of alcohol abuse and their employers. The indirect consumers or general publics are the families and friends of the alcoholic.*

A further classification of groups related to this project helps to explain the dynamic environmental relationships through which the Staff Representative markets the project. A successfully adopted program is one that is "negotiated" among various groups in the community. The Staff Representative typically finds himself dealing with groups that have a reciprocal relationship with the project: his (former) local union, the central labor council, and the labor representative in the United Way. But he must also establish working relationships with a sought public, that is, groups and individuals who may not be currently interested or supportive of the endeavor. Employers, business groups, and civic organizations are the most frequent examples of the sought public. Thus, the programs are marketed in terms of exchanges between the local project and other groups. In this case, the various publics see the program as

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*Obviously, a group may function in more than one of the seven publics depicted in Figure 2. A government agency, for example, may often be both a support public and a client public.

representing one type of value or another for which they are willing to exchange one or more of their resources: time, money, personnel, etc.

Group Exchanges and Successful Marketing

Each participating public, then, exchanges its resources for certain values that it attaches to the program. Employers perceive such advantages as improvements in employee productivity and morale; declines in absenteeism and tardiness; and improvements in safety. Civic groups view the programs as meeting the needs of the general public and thereby improving the health and social welfare of local citizens. They are thus willing to commit their time and efforts to endorsing the endeavor and assisting the Staff Representative in promoting it. Similarly, elected officials and political groups are sensitive to social action programs as a means of fulfilling their responsibility to their constituents. Like other groups, they are motivated by pragmatic as well as idealistic reasons.

In essence, the successful Staff Representative approaches the local environment as an arena for maximizing his contacts within a wide spectrum of community groups and leaders. He recognizes that working with one public inevitably involves making contacts with others. Also he recognizes that he is involved in making exchanges ("trades") of one type or another to obtain the commitment of resources to his program.

Support Services

In both states, the project benefits from a number of factors that were in existence before it began. The AFL-CIO contracted with the state universities and their respective labor studies departments to provide seminars on issues relevant to community service. Moreover, support for

endeavors of this type has been consistently provided by community agencies and by state and local government in these regions. For example, in one of the cities, a private hospital provides free public relations materials and 24-hour counseling services to the community and the project.

Correspondingly, most program sites are located in regions that feature an unusually large number of treatment facilities, reflecting serious and widespread support for alcohol and drug abuse programs. Thus, there is a uniquely positive social service culture surrounding the project that promotes outreach programs and is particularly conducive for the establishment of joint union-management alcohol programs.

Coda

The evaluators have presented a general profile of the major factors prompting successful marketing of Occupational Alcohol programs in the six project sites. The principal elements of the profile are the role and attributes of the Staff Representative, the characteristics of the unions and employers adopting the program, and the relationship of main publics in the community to the project. This marketing analysis might furthermore be considered as a complementary report to the Appalachian Council's Research Department's second case study, "Establishing an In-Plant Program" (November, 1979). The second case study focuses on 12 formal events or steps to be followed in setting up programs with unions and management. The marketing analysis, on the other hand, probes the informal domain of the project and focuses on those factors and activities that, in the main, precede the first of the 12 formal steps. To state the matter another way, the marketing profile centers on the prospecting phase

of the project; whereas the second case study concentrates on the phases of approaching, presenting, demonstrating, handling objections, and closing the sale. The prospecting phase of marketing, which precedes all other activities, involves locating potential buyers.and screening them to determine their level of interest for adopting a program.

The evaluators recommend that this marketing profile be used in conjunction with other project reports compiled by the AFL-CIO Appalachian Research Department and project staff in order to develop a final Phase II project report. This report should highlight replication strategies for marketing, project management techniques, delivery of services, and project outcomes.

Senator HUMPHREY. The subcommittee is now adjourned pending the call of the Chair.

[Whereupon, at 12:18 p.m., the subcommittee adjourned to the call of the Chair.]

80-616 O—81——13

COMPREHENSIVE ALCOHOL AND DRUG ABUSE AMENDMENTS OF 1981

MONDAY, MARCH 30, 1981

U.S. SENATE,
SUBCOMMITTEE ON ALCOHOLISM AND DRUG ABUSE,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, D.C.

The subcommittee met, pursuant to notice, at 9:30 a.m., in room 4232, Dirksen Senate Office Building, Senator Gordon J. Humphrey (chairman of the subcommittee) presiding.

Present: Senators Humphrey and Denton.

OPENING STATEMENT OF SENATOR HUMPHREY

Senator HUMPHREY. May we ask the first panel to come up and take your seats.

This hearing of the Subcommittee on Alcoholism and Drug Abuse will now come to order.

I would like to extend a special welcome to our three panels of witnesses, most of whom have traveled great distances and made personal sacrifices to be here. I am especially happy to welcome several individuals from my own State of New Hampshire. Our topic today is the reauthorization of the Drug Abuse Prevention, Treatment, and Rehabilitation Act.

All of you undoubtedly share my profound concern over the serious problem of drug abuse. The latest statistics released from the Institute for Social Research at the University of Michigan indicate that 65 percent of all high school seniors in the country report using some illicit drug during their lifetime, and 39 percent have used an illicit drug other than marihuana.

It is somewhat encouraging to know that the data suggests that most of the specific illicit substances are showing either a decline or a leveling in use. Still, as the authors of the University of Michigan study emphasized, the level of illicit drug use among young Americans of high school age is probably higher than that in any other industrialized nation in the world.

Drug abuse is having a terribly negative impact in this country's classrooms, as any educator can tell us. The psychological and physical consequences of such abuse are staggering. Illicit drug sales are estimated to be at least $64 billion annually, meaning a vast underground economy operating in our midst.

As you can see from my comments, it will not be necessary for us to spend much time convincing each other of the seriousness of the drug abuse problem in America. Instead, the subcommittee seeks to focus its attention on what the Federal Government should be

doing in the areas of drug abuse prevention, treatment, and rehabilitation. In my view, certain activities are appropriate for Federal involvement, while others are best left to State and local governments, or to the private sector.

S. 755, a bill I have introduced to reauthorize Federal alcohol and drug abuse programs, will provide a framework for our discussion of the Federal role in these areas. The bill calls for a continued Federal presence in the areas of research, prevention, demonstration programs, technical assistance, information collection and dissemination, and other related activities.

The bill assumes the return of treatment responsibilities to the States. This would occur under the proposed health services block-grant, an approach designed to give the States the greatest amount of authority and flexibility, and to reduce significantly Federal regulations, paperwork, and what many have seen as unnecessary Federal interference.

I support the block-grant concept while aware of the fact that many details remain to be determined. Thus, the comments and advice of this morning's three panels of witnesses will be helpful as we continue our deliberations on the block grant framework.

With respect to S. 755, I would note in passing that this is a 1-year reauthorization. This approach should not be seen as a message that the Federal role in the area of drug abuse is expected to end with the close of fiscal year 1982.

Instead, it is predicated on the fact that I intend to hold extensive oversight hearings in the months ahead. Furthermore, with the change in administration and in Senate leadership, I believe it would be prudent to allow more time for all of us to get our bearings, take a fresh look at important issues, and chart a more comprehensive, long-term course.

Finally, none of you need to be reminded of the unfortunate state of our economy. The Reagan administration's plan for economic recovery is aimed at correcting this situation. An important reordering of our national priorities is in progress. Once the economy is under better control and once the Federal Government is restored to its proper role, we should be in a better position to consider important national problems, such as drug abuse.

As was the case for the subcommittee's hearing on alcohol programs last Wednesday, representatives of the administration are unable to join us this morning. In part, this is due to the fact that the Department of Health and Human Services has only a few confirmed officials in place at this time. Furthermore, in view of the many reauthorizations pending before the Committee on Labor and Human Resources, all having the same May 15 legislative deadline, I felt it was important to hold this hearing as early as possible.

As I indicated last week, Secretary Schweiker, himself, will appear before the full committee on April 2. At that time, the issue of block grants will be extensively discussed, and questions regarding the impact of block grants on alcohol and drug abuse treatment programs can be addressed.

It is a healthy sign that many people are beginning to understand that the Federal Government does not hold a monopoly on wisdom. There is a renewed belief in the ability of the private

sector. More and more people are demanding that the Federal Government take steps to encourage private sector activities rather than trying to do every task itself. Most of the time, the private sector can do a better job, more efficiently and at less cost than any Government entity.

We are fortunate, this morning, in having with us representatives of one of the most exciting private sector movements. I am, of course, referring to groups of parents, community leaders, and even students, who are banding together in the struggle against the abuse of alcohol and other drugs. I know they have a great deal to share with us, and I hope we will hear about other efforts within the private sector as the morning progresses.

Before we proceed, I would like to remind the witnesses the subcommittee would prefer to keep as much time available as possible for questions.

Therefore, I will ask you to make every possible effort to summarize your prepared statements.

Your prepared statements, themselves, will be entered into the record, in full.

Finally, while we are holding this hearing on the drug abuse programs, and last Wednesday's hearing was focused primarily on alcohol programs, the division is somewhat arbitrary.

Therefore, the witnesses are free to address problems of alcoholism and alcohol abuse, drug abuse, and related prevention, treatment and rehabilitation programs.

Senator Riegle, who is well known to all of you and the ranking member of the subcommittee, asked me to express his regrets for not being able to be here today. He has an amendment pending on the floor of the Senate at this moment, or very shortly, which will require his presence for most of the morning.

He also asked that I give special welcome to citizens from his home State, Mr. Eaton and Mr. Smedes.

Senator Riegle asked that I assure you that he and his staff will be reading all the statements and asked that his statement be included in the record.

[Opening statement of Senator Riegle follows:]

Opening Statement of Senator Riegle

Senator Riegle. I would like to welcome the witnesses and interested citizens who have come to this hearing on the reauthorization of the National Institute on Drug Abuse. We are all here today because of a mutual concern—that concern is drug abuse, a problem that victimizes increasing numbers of our Nation's citizens as each day passes. I see many friends here today—people who have shown a long and enduring commitment to tackling this problem, including friends from my own home State of Michigan. I am also gratified to see that our first panel today is comprised of parents and students. Recent studies indicate that our young people are experimenting with drugs at earlier and earlier ages. A recognition of this trend and its potentially tragic implications on the part of parents and young people themselves is critical to any effort to stop drug abuse.

Drug abuse is estimated to cost this Nation $15 billion annually in lost production, health care costs, and injury and death from

crime and accidents. There are 380,000 known hereoin users today and millions of people, young and old alike, use or have experimented with dangerous, illicit drugs.

We are today in the grips of a major influx of heroin from Iran, Afghanistan, and other countries in Southwest Asia. Heroin addiction, which had been on a steady downward curve during most of the 1970's, has taken a sharp turn upward as a result. Heroin-related emergency room admissions and overdose deaths have increased dramatically and there are waiting lists for treatment in cities all along the northeastern corridor. A heroin habit costs between $150 to $200 a day to support and most addicts turn to crime to finance their habits. Consequently scores of people are affected in a variety of damaging ways—in addition to the pain and hopelessness felt by the heroin addict and his or her family.

The administration proposes a rescission for State formula grants this fiscal year. Federal funds support 233,000 people in treatment each year and represent 40 percent of this Nation's total drug treatment system. President Reagan's budget proposals further seek to cut drug abuse appropriations by 25 percent, and to block-grant remaining moneys with some 12 other social service programs to the States. I believe that a cut of this magnitude under current circumstances is unwise.

I was gratified to hear President Reagan, in his most recent press conference, make a strong statement on the seriousness of the drug problem. I quote: "I think this is one of the gravest problems facing us internally in the United States." I cannot help but wonder how such a statement can be reconciled with a fiscal recommendation that can only serve to undermine the efforts of this Nation to combat this grave problem. President Reagan went on to say in that press conference, that law enforcement in regard to drug smuggling would likely never be completely successful in combating drug traffic. He said, and again I quote: "* * * it's far more effective if you take the customers away than if you try to take the drugs away from those who want to be customers." I cannot help but wonder how we are to take the customers away from drugs if we also take away or severely retrench the very programs that offer these individuals alternatives to a life of drug abuse. I speak here not only of treatment and prevention services, but also of economic and social service support systems which provide the recovered addict with vehicles to reenter the mainstream of productive living—educational and job training programs for youth such as CETA, vocational rehabilitation services, title XX day care support, medicaid—all these programs have been slated for deep cuts.

Regrettably, the administration is not here to testify on behalf of its proposals or to tell us precisely what commitment it intends to make to the resolution of this enormous social problem. Clearly, that commitment will not take the form of Federal dollars.

In closing, let me say that I regret that my commitments on the Senate floor prevent me from remaining at this hearing. Let me assure you, however, that I will read your testimony with great interest. I am anxious to hear your views on the ways in which the President's proposed rescission and block-grant proposals will impact the services you now provide to drug abusers, and how they

will affect drug abuse prevention efforts in general. I thank you all again for taking the time from your busy schedules to attend this hearing. I look forward to working with you to see the prevention, treatment, and rehabilitation needs of drug abusers and potential drug abusers and their families continue to be met.

Senator HUMPHREY. Good morning again, and we will proceed in an orderly fashion, but it is informal and the purpose is to learn as much as possible and have a dialog.

Again, will you please bear in mind that we have three panels of excellent witnesses.

I have another hearing to Chair at 1 o'clock. I hope to get in a little time for lunch. So, in fairness to all involved, please try to summarize your testimony so that we can leave time for others and time for questions.

Dr. Gleaton, do you want to lead off?

STATEMENTS OF DR. THOMAS GLEATON, NATIONAL FEDERATION OF PARENTS FOR DRUG FREE YOUTH; JOANN LUNDGREN, PARENTS WHO CARE, INC.; WILLIS FINCK, SANTA CLARA DRUG ABUSE COMMISSION; HELEN JOBIN AND EDWARD MORIN, CONCERNED CITIZENS AGAINST DRUG AND ALCOHOL ABUSE; AND WALTER HAYS AND ANDREA GAC, GUNN HIGH SCHOOL, PALO ALTO, CALIF., A PANEL

Dr. GLEATON. I will be as brief as possible.

I think it is very interesting that the committee has chosen to begin its testimony with the parents, looking at the grassroots of what is happening in the country today.

Senator HUMPHREY. Excuse me, Doctor. We are having some difficulty hearing you. Can we turn up the volume of the microphone? I can barely hear you. Maybe if you can pull it in a little closer.

Dr. GLEATON. I can get a nod if I am going too long and you can break in on me at anytime for questions.

Today the testimony I would like to leave with you and the testimony of the other witnesses I hope you will agree probably will be the most valuable you will hear.

A lot of us who are professionals can speak on a professional level, but when we try to represent the feelings of the people, I think that is awfully difficult and I think we have to get out and talk to the people.

The National Federation of Parents was formed in Georgia a year ago. Prior to the formation of this, I talked to several professionals and semiprofessionals and parent groups because we felt we needed a voice so that we could be heard.

The word coalition kept coming up and coalition rang a funny kind of sound. I do not like coalition. I thought federation sounded like a nice term, joining together.

That is what the federation is, parents joining together to help each other and asking to be helped. We are not blaming anyone for the problems today, but we are asking for your help.

There are two or three things I would like to mention.

The study you mentioned from Michigan is the best study that we have but it is with high school seniors. There are two great weaknesses in that study, and I must point that out to you today.

One is that it is of seniors only, and these people are survivors. I recently saw statistics from the Chicago public schools that 50 percent of those who start drug use do not continue through to senior year, so we have to realize that those who graduate are not as high a risk group as those who do not graduate.

We have State and local studies where the figures run much higher. What we have observed over the past 10 years is an increased use of drugs by youth at younger and younger ages.

In World War II we had to be bombed as a nation before we were ready to stand up and be counted.

As parents and adults we are watching kids fall out of their chairs in school. As parents we have to do something because we have the most to lose. We also have the most to gain.

A healthy child can make a contribution to our society and not take away from it.

The indicators of concern would be the number of requests for reprinting the Reader's Digest article "Marjuana Alert" by Peggy Mann. They have had a request for over 3 million reprints. That is the largest request that they have had in their 43-year history. That should tell us something about the national concern.

On the "Good Morning, America" show we had 17,000 requests for information when the National Federation of Parents was represented.

Those are quantifiable indicators.

But I would like to remind you that there are little towns, rural areas today, that are in a hurry to do something.

In one town, Wrightsville, Ga., they just had a double teenage suicide, drug related. It is a town of 2,500. They had a town meeting and 1,000 people were at that meeting. The same is true in other small towns, not just the cities or the ghettos, but all the cities are involved.

The White House Conference on the Family indicates that the No. 1 concern of our people is alcohol and drugs in this country.

Now, the programs we have had in treatment and law enforcement have not been successful and we have not been successful in education. We have failed in this country to stop this problem. I think that the missing ingredient has been the commitment of the American people and the parents to do something about this.

I would like to bring up one point here. I think it is very important for our health agencies to be involved. In this country our health agencies primarily, at national, State, and local levels, are run by the medical profession, physicians, nurses, and others trained in the medicial field. Those people trained in medicine spent years and years of their lives learning how to rehabilitate and treat diseases.

They talk about preventive medicine. But I would like to ask, let me see your budget and where does the money go? It goes into treating the sick individual. That needs to be done. It has to be done. We have no choice.

But if we are ever to get away from that syndrome, we have to put some money into education and prevention and working from the demand side of the whole drug issue.

Relative to the specific legislation, and I will be brief, when we look at teenage drinking patterns, we are very concerned. Back in

the fifties we used to go to the beach and dance all night with a can of beer in our hand. We had to be cool. If our friends got drunk, we said, cut it out.

Today, youngsters say, let's get drunk and they mean that literally.

So that whole pattern of drinking has changed.

I would warn parents when a child comes home with beer on his breath, that they should not breathe a sigh of relief and say "it's only alcohol." He might have consumed an entire six pack on the way home. It is important to remember that patterns have changed.

We need leadership from the Federal level. I would like to speak a bit about NIDA, because we have been involved more with NIDA than any other agency in particular. They have done some good things this past year. They have stopped calling us crazy parents and they are now calling us a National Federation of Concerned People because we are not blaming NIDA or anyone else for what is happening, but we are saying, give us your help.

They provided us with the film "For Parents Only." It is in high demand. We have a long waiting list for its use. The book "Parents, Peers and Pot" is also in demand. They have distributed 300,000 copies from NIDA. The information materials coming out of NIDA has become somewhat better in the past year. They are beginning to listen to the voice of the people who are saying, we need your help in getting out literature.

I hope this can be continued and even increased. The funding would help, so that we can set up a network of parents throughout the country to work together, talk together to help their children avoid drug use.

If we look at the contracts that are being written, we must remember that we need good people.

Now business, I know, will take a look at who the contractor will be. I would encourage the National Institute in some way, on top of all the regulations they have, and they do have tons of them—if they could find a way feasible to look for quality and a proven performance record, especially for their pyramid contract.

Some would have to sublet them. Drugfair, for instance, has done an excellent job in beginning to initiate some effort on the part of the communities.

We think NIDA should be aggressive. The block grants—to the State are good and bad. When I was trying to establish the National Federation of Parents, I talked to Jack Durell of NIDA and Jack said, there is no way we can work with every individual parent group. Jack suggested that we form a coalition of parents so that one collective voice could be heard from the parent groups.

Now, I look back and I will say this. We need some focal point that we, the parents, can look to, also. We have our federation started but can we still look to NIDA or some institution in Washington for the Federal leadership so that we can have a focus.

I would like to make that a plea. I ask that the appropriations particularly for prevention be considered with favor by the Congress. I am looking forward to working with this committee and with anyone else who will help us as parents to support our children and help them to survive that which is a very devastating part of our culture today.

[The prepared statement of Dr. Gleaton follows:]

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Statement of

Dr. Thomas Gleaton

Representing

The National Federation of Parents
For Drug Free Youth

before the

Subcommittee on Alcoholism and Drug Abuse

Gordon J. Humphrey, Chairman

March 30, 1981

Mr. Chairman and Members of the Committee:

I am pleased to appear before you on behalf of the National Federation of Parents for Drug Free Youth to offer testimony as you consider the reauthorization of the National Institute of Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism.

The National Federation of Parents for Drug Free Youth was formed a year ago in Atlanta, Georgia, by over 300 parents representing groups from across the country who have organized their own communities to more effectively address the national epidemic of adolescent drug use. We now know of at least 1,000 such groups that exist in every state of our nation and involve literally tens of thousands of parents.

I think it particularly significant that you have chosen to open your hearings with testimony from parents. Parents across our country have tremendous concern about the negative impact of drug and alcohol abuse on the healthy growth and development of our children. A few examples might serve to put this in perspective. A little over a year ago when the Reader's Digest published its first article on the health impact of marijuana use, they received more requests for paid reprints of that article than <u>any other</u> in the 43 year history of the magazine. In addition, in November when "Good Morning, America" produced a week long series on the parent movement and adolescent substance abuse, we

at the National Federation received over 17,000 letters requesting further information about the problem and how parents may better respond to it. I could go on to cite additional statistics and public opinion polls but the mere fact that you have seen fit to invite us as parents to provide the lead off testimony demonstrates a keen awareness of the priority this problem has for parents.

For years government has made a significant effort to address this difficult problem. Some progress has been made, but we have come to the realization that treatment and law enforcement alone are not going to solve the problem. Even though both of these approaches are very important, we believe that the major component in the program, which heretofore has been absent, is that of involving parents in their own communities to begin to take action. This action takes the form of parents coming together, often in small groups, to learn more about the issue. They take a firm stand in their own homes against drug and alcohol use by their children, and then make certain that the clear notion of "NO" to adolescent drug and alcohol use is, in fact, supported by other institutions in the community.

Some examples of what we have done might be helpful. We have waged a battle against the proliferation of paraphernalia so that we are not on the one hand saying "no" to drug use and on the other hand permitting our children to see drug paraphernalia being sold, in effect, saying to them "It's OK to use drugs." In addition, we have joined hand in hand with our teachers and school

administrators to work together to make certain there is an adequate and appropriate discipline structure in our schools, so that our children can learn in a drug free environment. Lastly, and probably most importantly, we have joined with other parents in local communities to not only learn and act together but also to exert our rightful role in taking the primary responsibility for our children's healthy growth and development. Parent support groups meet in living rooms to share experiences, and to develop codes of conduct with which most parents in the community can agree. These codes of conduct address such things as curfew hours, the appropriate supervision for our children's activities, and a generally agreed upon standard of behavior. The sum total of these efforts is beginning to make a real difference in changing basic attitudes in communities regarding adolescent drug and alcohol use. Parents are stepping forward in a clear and firm way to say that drug and alcohol use does interfere with the healthy growth and development of our children. We are bound and determined to do all we can to assure a drug free environment for their growth and development.

Relative to the specific legislation under consideration, I will direct my remarks primarily to the National Institute on Drug Abuse, since that is the organization with which we have had more experience and contact. I do, however, want to emphasize that the National Federation of Parents is equally concerned about the abuse of alcohol among adolescents in our country and in no way wish to have our testimony misinterpreted to indicate that we are not concerned with adolescent alcoholism.

The National Institute on Drug Abuse has been supportive of the parents movement over the past year. They have, through the Pyramid Prevention Project, provided technical assistance to many parent groups across the country. This assistance is extremely valuable. We believe it must continue. In addition, NIDA's research into the health aspects of marijuana use is critical. We as parents look to the Institute to provide the necessary leadership in discovering and clearly publicizing the health hazards associated with marijuana and other drugs. In addition NIDA's recent publications are more accurately reflecting the needs of parents. Many parents have been concerned about the lack of clear public policy statements regarding the use of marijuana in the past. It has been clear to parents of marijuana using children that this drug was doing extensive damage to their children. Heretofore, this was not reflected in the publications from the scientific community.

We have found publications such as "Parents, Peers and Pot" and the movie "For Parents Only, What Kids Think About Marijuana" to be extremely useful. My understanding is that there has been an unprecedented demand for these publications and they have been circulated to tens of thousands of parents across this country.

As you know, much of the NIDA funding for prevention has gone through the single state agencies for drug abuse. We are concerned that the response on the part of single state agencies in supporting the parent groups has been uneven. An excellent

example of very fine cooperation and support exists in the state of Florida where a small amount of formula grant funding from the state has been directed to both encourage the formation of new parent groups in Florida and provide a mechanism for communication and networking of all the parent groups within the state. Unfortunately many other states have not followed this direction and in some cases we are concerned that state agencies may be continuing to give out information which is out dated or misleading to the parents. In addition, we feel quality treatment must be made available to adolescents and their families for the specific purpose of addressing drug use in its very earliest stages.

We would very much like to have NIDA be more forceful and directive in getting the states to be more responsive and sensitive to the parent movement and its objectives. We believe that increased appropriations for prevention are important. We are concerned that diminution in the NIDA role by an unidentified block grant funding proposal might lead to decreased emphasis and support for adolescent drug abuse issues at the state level.

We look forward to opportunities to continue to work in an effective way with the National Institute on Drug Abuse. As a member of NIDA's National Advisory Council I am in an ideal position to convey the feelings and needs of parents to NIDA and in turn to interpret NIDA's policy decisions and program back to the many parent groups. We look forward to additional opportunities to work constructively with members of Congress on this important issue and again thank you for the opportunity to provide this testimony.

Senator HUMPHREY. Thank you, Dr. Gleaton.

I am so glad to hear what you have to say, and to see this flowering, this blooming, of the parents' movement. I realize others are involved but I think it is chiefly the parents that are getting involved and breaking this almost unspoken cycle of silence.

I thought your comment on providing—the Federal Government providing a focus was excellent. That is the same view I have. That is the kind of Federal law that I envision, for my part.

I am only one member of the subcommittee, obviously, but I would intend to see that the Federal Government does provide that focus, even though we are fundamentally changing the structure in going to a block grant framework.

Mrs. Lundgren, would you please give us your statement next?

Mrs. LUNDGREN. I speak to you this morning as an adult and a parent, and my husband and I have four children. Three are adults and one is a senior in high school.

All four of their lives have been affected by the drug and alcohol scene, two as participants and two as nonparticipants.

This was the motivation for me to try to help change the scene.

I would like to just talk about what we have done at Gunn High School. Parents Who Care is a grassroots movement in the San Francisco Bay area. It began 16 months ago. It has moved with incredible speed and interest. It has, to me, been an unbelievable thing that this has happened, the interest of the parents.

What happened at Gunn High School has served as a kind of model in the bay area. We received our information from "Parents, Peers and Pot." That was our beginning. We started as parents simply getting together and saying, we do not have a peer group. None of us know what the other parents are thinking or doing in relationship to the drug and alcohol scene, and therefore, we need to talk to one another.

So we did that. As a result of that, I would say that we came to an agreement which I think is basic in the parent movement. We are agreed on the fact that drugs and alcohol are illegal and that we do not want our children to be involved with them. The laws were formed for a purpose—to protect our youth.

I bring this up because in our area, at least, that has not been a commonly held view. About 3 or 4 years ago, the prevailing view was that it was OK for parents to give cocktail parties for the kids. They provided the booze and sometimes the pot.

I think that has changed, I think the prevailing attitude is definitely now one of disapproval of parents who serve illegal drugs to youth.

So that is very encouraging.

After the agreements, we educated the parents. All of this took place simultaneously. Becoming knowledgeable about what the kids were involved in and what effects marihuana and alcohol and other drugs had the body was an important first step. We concentrated more on educating about the scene the students were involved in and getting parents to agree to take a common stand in relationship to this scene.

We spent all last year educating parents, both in small groups and in large presentations.

I will just give one example. When we first gave our large presentation at Gunn High School, we asked for the auditorium which seats 5,000 people, and the administration kept trying to convince us that we should be in a room, which holds 125. The administration was very cooperative.

With their help and with parents personally calling 1,800 parents in the school, we had 400 parents turn out to hear about the drug and alcohol scene. Everyone felt tremendously good about that response.

Over the last summer, we felt that what had to happen was to get to the students. Parents could talk together and they could come to a lot of agreements, but if the youth did not get on board, we were not going to have an effective change in the scene.

We feel very pepped up about what has happened. We have 13 students with us as evidence of what has happened at Gunn High School. Not that it is an overwhelming majority of the students, but we have had 50 students come to the meetings. The students varied with about 30 students coming every Monday night, just talking about how they felt about the scene itself.

We learned a lot as parents from that. I think the students learned. They will themselves talk a little bit about that. You can ask them more questions later.

We found that partying was synonomous with drugs and alcohol, and the students basically had never had a party without booze and pot. They were afraid to because of fear of rejection by their peers. There was a kind of mystic with the students themselves. They were afraid to speak up and say they did not like the scene, or they found it boring or they did not want to participate.

There is a variation of this. I am making a generalization. You realize it covers a wide range. But what has happened is that these seniors have moved out to every other senior in the high school as of just this last week. They gave dinner parties for the other seniors.

These 50 kids provided the food and they had a rap session about the scene.

I would say, basically, the overwhelming majority of the kids that came, and we reached about a fourth of the seniors—were interested in a change in the social scene. That has been encouraging.

There are over 150 students now interested in helping change the parety atmosphere. They are going to give a day in the spring that is going to be for all the students at the school. It is called a "New Games Day" which are non-competitive-type games that are just fun, outdoor activities. The kids, just by talking to one another, have broken the mystic that somehow everyone is into the "party scene".

So we feel very hopeful that the students around the country could get on the bandwagon and say, "We do not all feel this way, and we will start speaking in another manner."

So that is basically what we have done at Gunn. There are now about 5 student groups meeting in the bay area. Our hope is that this trip to Washington and Atlanta, by these 13 students and by their willingness to speak up in favor of a positive change will have an effect on other students throughout the country.

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Senator HUMPHREY. That is a very upbeat statement.

You say there are 500——

Mrs. LUNDGREN. As a result of the senior group at Gunn High School—the juniors have now started to meet. They have a group of 30 students. The sophomores have met. They have about 45. They have met and they have planned a party and the freshmen have done the same.

Seniors have moved out to the lower classmen and talked to them and said, "Look, you do not have to get into that scene." There are five other schools in the bay area that are also starting student groups as a result of what the seniors have done.

[The prepared statement of Mrs. Lundgren follows:]

Parents Who Care, Inc.

P.O. Box 50663, Palo Alto, California 94303

March 23, 1981

Senator Gordon Humphrey, Chairman
Senate Subcommittee on Alcoholism
and Drug Abuse
4230 Dirkson Building
Washington, D.C. 20510

Attn: Henry Desmarais

Background Information on Parents Who Care

Santa Clara County is an area characterized by rapid growth, due primarily to its reputation as one of the best areas in the country in which to live and work. Its population quadrupled since 1950 and San Jose, its largest city, was the fastest growing major urban center in the country last year. Due in large part to its flourishing electronics industry, it has the densest concentration of high technology in the world. It ranks fourth in the nation in terms of quality of life among large Standard Metropolitan Statistical Areas. The county is located on the southern end of San Francisco Bay and stretches from Palo Alto in the north to Gilroy in the south.

The Problem

Every area in the United States is faced with an epidemic adolescent drug/alcohol problem. In the 1979 study Monitoring the Future, compiled by the Institute for Social Research, the University of Michigan indicated that approximately 11% of high school seniors in this nation are daily users of marijuana.

In San Jose, the county seat of Santa Clara County, Project Dare decided to do a study to monitor drug/alcohol use and abuse among junior and senior high school students. The city was divided into ten planning areas and approximately 2,000 students were randomly surveyed on three separate occasions in 1977, 1979, and 1980. One of the survey questions concerned itself with regular use patterns of marijuana, alcohol, and other illicit drugs. Regular use was defined as at least once a week. On all three surveys the results indicated that more than 20% of the high school age group responding to the question on regular use considered themselves regular users. These figures correlated closely with results obtained from an independent ten-year study, 1967-1977, conducted in San Mateo County which is adjacent to Santa Clara County.

What is not shown by surveys is the mass acceptance by teenagers that use of drugs and alcohol at their social gatherings is the normal and acceptable standard of behavior. If individual students choose not to participate in this scene, they feel they are in a definite minority and are quiet and sometimes apologetic about their stance. The mystique that exists as a result of this situation is difficult to penetrate and change.

A Solution

In November of 1979, the Parent-Teacher-Student Association (PTSA) of Gunn High School in Palo Alto, the most northerly city in Santa Clara County, held a meeting of parents about their major concerns. A group of 17 parents expressed concern about drug and alcohol use among the youth, and the fact that this behavior had become the "norm". The group continued to meet and invited other parents to evening discussions in neighborhoods throughout the Gunn High District.

The group in cooperation with the PTSA decided to hold an educational evening on drug and alcohol use among students. A meeting date was established during March 1980, and with the help of about 20 parents, every parent of the 1800 students enrolled in the school was called. In addition, the principal wrote a letter urging parents to attend. About 400 adults came and were educated about the drug/alcohol environment facing their students.

In sixteen months the parent movement in Santa Clara County has grown from a small collection of seventeen parents into a powerful and dynamic force for positive change away from the adolescent drug/alcohol scene. Several thousand people now consider themselves "Parents Who Care", and more than 100 schools within the county have representatives from Parents Who Care. Parents Who Care, Inc. now includes over 125 chapters representing over 182 schools in the San Francisco Bay Area.

The attitude and philosophy of Parents Who Care has largely been responsible for its success. Parents take total responsibility for their children and blame no one for the present situation. They advocate working with schools and the community, and take the position that demand reduction is the most significant way to address the problem. The group would agree with the definition of primary prevention developed by the National Institute on Drug Abuse in 1975: "Primary drug abuse prevention is a constructive process designed to promote personal and social growth of the individual toward full human potential; and thereby inhibit or reduce physical, mental, emotional, or social imprisonment, which results in or from the abuse of chemical substances.

The non-threatening stance taken by Parents Who Care has allowed schools to admit to the extent of the drug/alcohol problem without feeling as though the community was zeroing in on them. More than 60 schools in Santa Clara County have had a drug education-information evening for parents followed up by small discussion groups in homes. In October of 1980 Parents Who Care hosted a county-wide conference attended by more than 600 people. The conference highlighted outstanding educational models and demonstrated how to form parent groups in elementary, middle, and high schools.

The most exciting and encouraging activity to date has been working with students. As a result of working with students at Gunn High School, a group of seniors have moved out to the rest of the school to share their concerns about the party scene and to express the need for drug- and alcohol-free social activities. Because of their willingness to speak out, there are parents and students at every grade level actively involved in providing fun, drug-free social activities. More and more students are risking breaking the "norm" and becoming involved in bringing about a different climate in the social scene at Gunn. There is an increasing awareness among these students that they can affect the environment in which they live.

Where Do We Go from Here?

These are difficult times for you. The economic conditions in this country make your task of attempting to balance the budget in face of monumental human services needs, a task most of us would be unwilling to face.

Historically, groups such as Parents Who Care have usually addressed meetings such as this one with requests for government funds. There is no question that money makes most tasks easier to perform, but perhaps it is time to address this problem from a new direction.

There are many things that Congressional leaders could do that would have a positive affect upon the parent movement without risk of large expenditures of government financing. Indeed, you are honoring that concept today by allowing us a few minutes to express our opinions to you. If Congresspersons would return to their individual districts and do what they could to reinforce the parent groups, they would make the job much easier and give credibility to the work that is being done.

We live in an era of epidemic adolescent drug/alcohol use and abuse. The problem cannot be resolved without massive mobilization of concerned parents and community members. We urge your support in our war against the most serious threat we face - the well-being of the future leaders of this society, our youth.

Senator HUMPHREY. We will come back to each of you for questions.

I guess it is best to proceed with the statements.

Mr. Finck.

Mr. FINCK. Everytime I hear Mrs. Lundgren talk about the parent movement in our area, I am overwhelmed and I am overwhelmed by what has occurred in the past 16 months. It has been very profound and I certainly am honored to have the opportunity to be associated with that movement.

One of the things that I repeat a number of times, but it bears repeating, is that the high school age group, probably 25 percent of them, are regular users, at least in our area, of marijuana, and/or alcohol.

Senator HUMPHREY. What do you mean by regular users?

Mr. FINCK. I am talking about at least once a week, or more. The junior high school, about 8 percent of our junior high students are regular users, again meaning once a week or more. I keep repeating that figure because, even though we hear it and the comments made from the Michigan study, somehow it seems so difficult to internalize that whole thing.

The very idea, that so many of our young people are seriously involved with drugs and alcohol is difficult to comprehend. Maybe

the problem has been difficult to surface because it was so painful and so hard for so many of us to really look at. I cannot think of a problem in this country that is more potentially destructive of our national security or of our future, if we are going to survive this century.

We have to address it and I feel we have to address it immediately.

As we prepared to come to this meeting, I said, what are some of the things that we could ask of you, or what are some of the things that I would want from you in terms of the kind of support that I feel would be helpful to us.

I put down a few things and I would like to share some of them with you.

I would like to see you support the concept of demand reduction or a significant alternative. We have been working on supply reduction since before prohibition. It is very costly and I think we really need to take a look at that.

I would like to see your personal support and encouragement to the more than 700 parent groups that are starting to roll in this country.

I think it would be very meaningful, very supportive, if you and your fellow elected representatives, and members of your families, would speak out in support of the current movement. That would be very helpful to us.

Senator HUMPHREY. I would be happy to give my support.

Mr. FINCK. Beyond that, even going on radio and television, doing public service announcements from the various States you represent would be certainly very meaningful.

I have a difficult time separating drug use and alcohol use, because we are finding in California, marijuana use and alcohol use run right together.

It is a real concern that so many of our active athletes are endorsing alcohol, tobacco, and illicit drugs on radio, television, and the public media. I think we are coming to the age of the antihero, and I think there are too few people for young folks to look up to.

I am also concerned about the deregulation of radio and television. Some of the experiences we have had in California is that some radio is almost abusive in the way they broadcast the drug message, particularly. And I am wondering what will happen after the deregulation occurs.

One of the other things that concerned me was the amount of alcohol displayed in prime time television coverage of the inaugural events here in Washington. Young people still look up to the Nation's Capital and the Nation's leader, and I am not sure that that is a message that we necessarily want to see

Then I would suggest that maybe you and your colleagues and quite a few students from your neighborhood schools sit down and have a candid discussion about the problems.

We will provide you with a few dynamic young people who will tell you first-hand their experiences so you can internalize that. It is a hard message to get inside the system.

I guess I would like to see you support us and seek new funding for primary prevention from both the public and the private sectors of the economy.

In our area, certainly, business and industry are paying a big price and they are going to continue to pay a big price for the young people that we are graduating from high schools who have these abuse patterns that are going to work in their industries.

I hope the future well being of our young people will be among your very highest priorities. Do we really want 25 percent of this generation growing into an adulthood having been weaned on drugs and alcohol?

We really must look at that.

Thank you.

Senator HUMPHREY. Thanks, Mr. Finck.

Andrea Gac, who is a student at Gunn High School in Palo Alto, Calif.

Ms. GAC. This testimony is kind of a personal experience with me. I want to share this with you because I feel like it really tells how things are a lot more than talking about figures.

In my first 2 years of high school my family and I suffered through a great deal of unnecessary pain because of the conflict of values which existed in our home. This conflict came into existence my freshman year when my parents became aware of the frequent use of drugs, such as marihuana and alcohol, which had become a part of my social life in high school.

For my parents, the fact that drugs were acceptable to me, my friends, and some of their parents, was shocking. I am sure that at the time they would have liked to shelter me from the decisions I was confronted with—about drinking or getting high—at such a young age. Indeed, that is how I feel now when I think of my own little sisters. However, along with many others, I found out the hard way, by experiencing "partying" first-hand. I feel fortunate because I found out I didn't need it before it was too late for me to change, unlike some of the other kids who have let it take over a major portion of their lives.

I have had many close friends who are very, very bright, and I feel like they have so much potential and I think it is wasted because they do not really care about anything, anymore. That really hurts me.

Upon entering my first year in high school, my friends and I felt uncomfortable and out of place. At 14 years of age, most kids are very conscious of the changes they are experiencing, both physically and mentally, and don't like to be different. So, if you see everyone getting drunk and high on the weekends, they most likely will, too—without even thinking about it. Partying gave me the security I needed in a group of girls and guys which I felt were just like me.

I had always been very honest with my parents about what I did up until I started using liquor and marihuana. I finally told them what I was doing on the weekends, because I hated to lie to them like all of the other kids I knew who lied to their parents. As I said before, my parents were shocked, and very hurt. They asked me to promise not to drink or smoke marihuana, but if I stopped I wouldn't have anything to do with my friends. This is how I chose

the security of my friends over the trust of my parents, something which caused my family a great deal of pain. From then on, when I asked to go out, my parents refused, and we fought or I would sneak out. I later found I was not the only one who experienced this.

When I started talking in these discussions that the parents had set up, one of my friends at the time when I was getting into fights with my parents, said to me, you know, my dad said to me the other day, Andrea doesn't get along very well with her parents, and my friend said, Andrea is a lot more honest with her parents than I am with you, dad. So I felt a little better about my honesty but I did not feel good.

When my sophomore year came around, the partying I did became more intense, because I was unhappy at home. As a result I did poorly in school, and had trouble forming relationships with others. The only time I was happy was on the weekends.

This is how I finally quit. One night I went out with my friends after a fight with my parents, and I got very, very drunk. I drank so much that I almost overdosed on the amount of alcohol which I had consumed. It was as if I could view myself objectively—my mind and body were detached. Frankly, what I saw made me want to cry. I couldn't believe the young sick girl was me. The following week I transferred high schools to get a clean start at a new school. I didn't party anymore. True, I didn't have as many friends as I did when I partied, but I learned to like myself, and I gained back my parents' trust. To me that is quite enough compensation.

My friends often drove when they were too intoxicated to be on the road. Since I quit partying, my friends have been in several accidents. One of them died. I don't want to lose anymore.

I hope that through working with groups like Parents Who Care other kids like me when I was a freshman, can at least think about choosing whether they want to party or not. I know my experience is no exception There are many kids who don't know their limits, and they may end up hurting themselves and their families before they find out what they've done.

I hope they won't have to.

[The prepared statement of Ms. Gac follows:]

TESTIMONY OF ANDREA GAC

PARENTS WHO CARE, INC.
P.O. Box 50663
Palo Alto, California 94303

before the

Senate Subcommittee on Alcoholism and Drug Abuse

March 30, 1981

9:30 A.M.

Room 4232

Dirkson Senate Office Building

TESTIMONY OF ANDREA GAC

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Senator HUMPHREY. Thank you for that very courageous statement.

Senator Jeremiah Denton, a member of the subcommitte, has just come in.

Good morning.

Do you want to make a statement?

Senator DENTON. I have a very brief opening statement, Mr. Chairman.

Mr. Chairman, thank you for calling this hearing to reauthorize the important research and demonstration efforts conducted by the National Institute on Drug Abuse. This subcommittee will play a crucial role in determining the response our country will make to the destructive and costly problems of drug abuse, and I am pleased to be a part of it.

I would first like to commend you, Mr. Chairman, for recognizing the benefit of including drug abuse services in the President's health services block grant proposal. NIDA has already been distributing these funds through statewide grants and contracts, and the block grant will give States even greater flexibility to target programs to specific needs.

As chairman of the Judiciary Committee subcommittee that has jurisdiction over the Drug Enforcement Administration, I realize that drug abuse and misuse presents an enormous challenge to society. It is estimated that illegal drug trafficking is a $64-billion-a-year industry in this country. It is more difficult to place a dollar estimate on legal drug misuse. We are just beginning to focus on the public health problem which the abuse of prescription psychotropic drugs presents.

The National Institute on Drug Abuse is a vital component in our Nation's strategy to wrestle with these dual problems. It has fostered research aimed at determining the effects of abuse and misuse and information campaigns targeted toward changing attitudes and behavior concerning drug use. I believe that widespread acceptance of the use of marihuana among many young people is in part a result of the belief that it is not a harmful substance. Through NIDA research, we now know that long-term marihuana use may affect the reproductive system and lead to lung damage. As a result, we are better prepared to dispel this myth. In the area of misuse of legal drugs, NIDA's initiatives have shown, for example, that in our pursuit of thinness, we may become addicted to over-the counter diet pills.

Research of this type will provide the States with the knowledge necessary to intelligently and effectively carry out their treatment and prevention programs. I believe the legislation we are considering today will allow NIDA to continue its leadership in this area.

I welcome the witnesses who have come to talk on these and other subjects and look forward to hearing their remarks.

Senator HUMPHREY. Now, if my good friends from New Hampshire would not mind, I would just like to jump over them momentarily to ask Mr. Walter Hays, a student at Gunn High School, for his testimony.

Mr. HAYS. Thank you.

I have come to talk to you today about my experience with the drug and alcohol scene in high school and how Parents Who Care has affected it for me.

I have never been personally involved in drugs, but I feel as if I know what it is like. I have a sister who was heavily involved in the party scene for 2 years. Looking back on those times, I can see how torn apart our family became on account of my sister's involvement in drugs. My parents and sister fought all of the time, and the house was rarely quiet from their yelling. My family was in turmoil and I was not very happy.

I saw what a terrible effect drugs were having on my sister. She was depressed and angry most of the time, and she lied and lost the trust and respect of my parents. I never tried drugs, mainly because I saw what they had done to my sister. I saw no reason that getting drunk or high could be worth losing my parents' trust.

Because of my decision to not take drugs, my social life suffered. I did not have many good friends, and I was always on the outskirts of the social scene. To fill this gap in my life, I became involved in many extracurricular activities such as student government, theater, and Boy Scouts. I was soon busy enough that I didn't feel as lonely, but I was never really comfortable at school. I wasn't asked to parties or to go out with people because I didn't know anyone. I didn't know many people because I didn't go to the parties. I would say that even though I was not directly involved in drugs, the scene affected me by leaving me with few close friends.

This year my involvement with Parents Who Care has changed things for me. It has let me know that there are many students who don't take drugs and alcohol, and that I am not alone. By helping me find and meet people who don't take drugs, my involvement in Parents Who Care has helped make me much more sure of myself at school. I feel I have a much stronger base now than I did last year.

One of the ideas that was brought up in our discussion groups this year was the fact that we are seniors and we are already past the point of peer pressure. We have made our own personal decisions in relation to drugs and alcohol. My hope would be that we could reach out to younger students who are being faced with drugs now and tell them that they don't have to take them to be accepted.

This year we have been able to talk with students from the eighth grade as well as the freshmen and sophomores. For the underclassmen, just seeing a senior—who everyone thinks takes drugs—saying "It's all right if you don't take drugs," really has a positive effect on them.

Through my experience with the scene and the activities that we've done in Parents Who Care, I would say that the most important thing we can do is to get students together talking about the scene. Talking with other students has made an incredible difference to me this year, and I would hope that we could start projects like this all over the country.

Senator HUMPHREY. Thank you.

I was particularly impressed by your remark—about the use of the phrase, base of support. It seems to me that is getting very close to the crux of this problem. It is awfully difficult to stand

alone. That is one of the burdens of leadership. I am sure you are aware of that. It is awful tough to realize you made a mistake. Somehow, we have to find a way to bolster these individuals to have the courage to withstand peer pressure and realize they made a mistake.

I think you probably have more ideas of this than I do because you are involved on a more immediate level.

[The prepared statement of Mr. Hays folows:]

TESTIMONY OF WALTER HAYS

PARENTS WHO CARE, INC.

P.O. Box 50663

Palo Alto, California 94303

before the

Senate Subcommittee on Alcoholism and Drug Abuse

March 30, 1981

9:30 A.M.

Room 4232

Dirkson Senate Office Building

TESTIMONY OF WALTER HAYS

I have come to talk to you today about my experience with the drug and alcohol scene in high school and how Parents Who Care has affected it for me.

I have never been personally involved in drugs, but I feel as if I know what it is like. I have a sister who was heavily involved in the party scene for two years. Looking back on those times I can see how torn apart our family became on account of my sister's involvement in drugs. My parents and my sister fought all of the time, and the house was rarely quiet from their yelling. My family was in turmoil and I was not very happy.

I saw what a terrible effect drugs were having on my sister. She was depressed and angry most of the time, and she lied and lost the trust and respect of my parents. I never tried drugs, mainly because I saw what they had done to my sister. I saw no reason that getting drunk or high could be worth losing my parents' trust.

Because of my decision to not take drugs, my social life suffered. I did not have many good friends, and I was always on the outskirts of the social scene. To fill this gap in my life I became involved in many extracurricular activities such as student government, theatre, and Boy Scouts. I was soon busy enough that I didn't feel as lonely, but I was never really comfortable at school. I wasn't asked to parties or to go out with people because I didn't know anyone. I didn't know many people because I didn't go to the parties. I would say that even though I was not directly involved in drugs, the scene affected me by leaving me with few close friends.

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80-616 O—81——15

Senator HUMPHREY. Now, I would like to ask Mr. Edward Norin, chairman of the Education Committee of Concerned Citizens Against Drug and Alchol Abuse from my home State of New Hampshire, to go next.

Mr. MORIN. Thank you.

I would like to preface my talk, if I could, by thanking NIDA for the help that they have given us which has really been fantastic. It is a super organization.

I would also like to thank the National Federation, Pride and Pyramid. These agencies are fantastic. Any parent group that would like to be started should contact them.

Another thing I want to add as a preface is that I feel the Government should grant block grants to the States to be directly given to the concerned citizens and parent groups.

Now, I say this because of what our group has done. I am sure we are paralleling many other groups in the Nation. But to date the Dover, N.H., Concerned Citizens Against Alcohol and Drug Abuse have expended $550.

I would like to tell you what we have been involved in, what we have determined, and what we plan to do, and what we expect from the Federal Government.

We became involved in this Concerned Citizens Against Alcohol and Drug Abuse when our local police chief introduced a paraphernalia ban in our city which happened at that time to be the first one in the State. Since then, there have been several others that have evolved.

We have gone to the State level at present and that is being voted on, I believe, this week.

We were appalled at the Nation's statistics. We were hearing things that we felt could not possibly apply to a small little State situated in New England, and on the seacoast region of New Hampshire. But we were wrong.

We took a poll of the high school students and found that about 85 percent of the high school students were involved in marihuana and alcohol use. Also, 62 percent were continuing on this experimental level.

Now, when you mentioned your national statistics, I, too, feel that where they are probably just involving the senior groups, it is low. We find a considerably higher group using in junior high than did the Palo Alto group.

The Concerned Citizens in our area became very, very concerned. At that time we formed our group and decided that self-education was probably the most important thing we could do because the kids knew more than we did.

Granted, a lot of the stuff they knew was not proper. It was from Do It Now. It was from NORML. It was from Stash and organizations such as this, organizations which promote marihuana use. I am very sad that on the State level in New Hampshire of all the literature available from the New Hampshire Southeastern Alcohol and Drug Abuse Council, over half is distributed by Do It Now.

When I asked why, I was told that it was free or nearly free. I feel that some of the stuff is helpful but I was extremely concerned and am in the process of reviewing it with Mr. Diament, so that the out of date and biased material can be removed.

But organizations such as Do It Now that are using publications that are not up to date, must be read very carefully and reviewed very carefully before it is distributed. We, unfortunately, distributed some of this material at our blitz meetings.

What we were interested in doing was determining where we go from here, what was the most cost effective and cheapest way of going about the problem of drug control.

It was undoubtedly through prevention. We had to divide prevention up into three categories. One was public awareness, one was education, and then the other one was early intervention. I am talking about the junior high and high school level. We started a 5-week blitz through education and public awareness programs. We had to educate other parents because we had the horrible realization that many of the groups knew very little and where being educated by their children.

We educated ourselves through films, through public speakers, through books, through literature, even Do It Now, and some of these publications that are distributed by the State. Unfortunately, we did not have a fantastic turnout in the beginning. We figured we would have thousands and thousands of people there. We had a good turnout, though. We had anywhere between 250 and 500 people at our meetings.

Our town is approximately 24,000 people. We started off with education and public awareness through a "Drug orientation program". We went to "Drugs and the Law", which was represented by the local police chief. Some juvenile officers, probation officers, judges, and a couple of lawyers were there and answered questions and gave their opinions.

We had a program "Personal stories" similar to the ones you have heard here. Fantastic. It really happened.

We had another meeting entitled, "What Is Happening In Our Schools", which was totally devoted to the school system. Parents wanted to know, what happens if my child gets caught in school with drugs? Will the child go to jail? Am I going to be written up in the paper as being a bad parent?

The last and probably the most important meeting we had was called "Parents, Peers and Pot". I know that it has been mentioned several times here. It was after the book, "Parents Peers and Pot," by Dr. Keith Manatt Schuchard. She received funds from Pyramid to come and speak to our group. So what did we accomplish? We scared everyone.

People were amazed to find out that marihuana was grown right here in our country. We do not have to go to Colombia or Mexico. We go to California and we find it is 30 times more potent than it was a couple of years ago.

Where do we go from here?

We had to have another meeting. We indoctrinated several heads of the committees and we formed a youth alternative committee, a legislative committee, a committee to earn money, a program committee and an education committee.

From these meetings through the education committee, involving schools and the parents' groups, we came up with two very important programs. One of these was reverse peer pressure. The way

reverse peer pressure would work was through youth alternatives, as was mentioned, and by public awareness or student awareness.

We feel that approximately 15 percent of our high school and junior high students would not stop smoking, would not stop shooting, would not stop using drugs under any circumstances. We feel, as well, there are 15 percent that would not use drugs or alcohol under any circumstances.

We have a 70 percent target group in the middle that we have to aim for. This is the group that is influenced by their peers, extremely so. They are extremely concerned with the way they appear. They are extremely concerned with the way they come off with their peers and being in with the group. We feel through alternatives, whether they be recreational or academic alternatives and through a student awareness program, this 15 percent that would not use drugs can become the in group and all of a sudden reverse peer pressure begins.

It is no longer cool now to use drugs. Reverse peer pressure is very important.

The second one is the introduction of what is called a SYVA emit test program from the SYVA Corp. and it is, incidentally, from Palo Alto, Calif. They came and demonstrated to the Concerned Citizens group, the police department, and to members of the Wentworth-Douglass Hospital, a urinalysis and serum testing kit for cannabinoids and other drugs. This machine can be used by a novice and can detect whether or not marihuana has been used in the previous 14 days. It was suggested by the committee on education that this SYVA machine be purchased for use in the Dover High School system. Because the teachers have received drug education through the Concerned Citizens awareness program and because teachers are working with and testing the students and are monitoring their behavior with their peers, then the teachers are best qualified to sense abnormal behavior in the students. When abnormal behavior is sensed, the teacher would indicate this to the principal of the school and the parents would be notified. The parents and the student would be asked if they would mind having the student submit to the urinalysis. If they agreed and passed the test, then physical and mental tests could be suggested. If they agreed and failed, then the student would be required to take a drug education course set up by the Concerned Citizens group, the school board, and the police department. Educational and awareness material would also be sent to the parents. If the test were refused, then the course would be mandatory. The mark received in the course would become part of that student's grade for the marking period. The student would have to continue this course until a passing mark was made.

The fact that this machine would be available would be quite a deterrent. You just think that if you were in this room today and there was a police officer here who could tell if you had gone over 55 mph within the last 2 weeks it would be a great cause for concern. You might think about it. There is definitely deterrent value there.

There is one last program I would like to see instituted at the Federal level. That is to set up guidelines in which drug use intoxication tests are similar to the ones for alcohol.

Unfortunately, it is not illegal to smoke marihuana if you can get that marihuana into your body without being nailed for the possession of the joint. Unfortunately, there are many units that can be sold through drug paraphernalia companies that can hide this. They call it sneak-a-toke, or no-smoke. You can use it in an auditorium, theater, or school. The idea is, you sneak this joint of marihuana. You get this smoke into your body very quickly and if you do not fall down or do not have any major problems, then you are home free as far as the law is concerned.

Let's get these people off the road. This became apparent to us when there was an accident in the Dover area. The individual was asked if he had been drinking. He had, said he had, and he was tested. He just missed the 0.10 percent alcohol level. He was not therefore found guilty. But his main problem for which he was not arrested was that he smoked three joints and he admitted this later.

If we had a machine such as a SYVA industry machine, where we could determine the same as we do for alcohol the exact amount of drug in the body then we could set limits where intoxication could be proven. Let's make sure all these drugs are tested equally and let's make sure that it is easy for prosecution on all drugs.

Thank you.

[The prepared statement of Mr. Morin follows:]

CONCERNED CITIZENS AGAINST DRUG AND ALCOHOL ABUSE

P. O. Box 896

Dover, New Hampshire 03820

PREFACE

The Concerned Citizens group from Dover, New Hampshire, expended thousands of hours of time in its prevention program -- through education, public awareness and early intervention. We all feel that we are working to free our children and our communities from the malignancy of drug pushers.

If the Federal government would entrust the citizens groups around this nation with funds through block grants, then the citizens of this country would fight to see that those funds were spent properly so that their children and their communities were not short-changed.

If these groups could do even half of what the Dover, New Hampshire, group has done with its $550.00, then this country would truly be run by "people helping people".

Respectfully submitted,

Helen Jobin

Helen Jobin, Chairperson

Edward L. Morin

Edward L. Morin, Chairman
Education Committee

CONCERNED CITIZENS AGAINST DRUG AND ALCOHOL ABUSE

P. O. Box 896

Dover, New Hampshire 03820

As citizens of a small city in southeastern New Hampshire, we became involved with a drug paraphernalia ban being introduced to our area by our local police chief, Charles D. Reynolds. This introduction of a drug paraphernalia ban also introduced us to many drug-related problems with staggering statistics. We felt that Dover, New Hampshire, nestled in the seacoast area of a small New England state could not possibly fall in line with the national figures being thrown at us. We were wrong! Polls taken in the local high schools confirmed that 85% of students have tried marijuana and 62% were experimenting on a regular basis with marijuana, alcohol or both.

The Concerned Citizens Against Drug and Alcohol Abuse was formed in August, 1980. We consisted of parents and citizens extremely ignorant as to the effects of drugs or even what they looked like. We had the horrible realization that the parents knowledge of drugs also represented a cross section of the nation. We had to start with self education. Through self education by films, books, publications, speakers and a variety of information sent us from Otto Moulton of the National Federation of Parents for a Drug-Free Youth, we determined that PREVENTION was the least expensive and most cost effective means of combating drug and alcohol abuse in our city. We divided our prevention program into 3 areas of approach:

(1) Education
(2) Public Awareness
(3) Early Intervention

We felt that these programs would save money by alleviating, a) a crowded court system, b) consumption of precious police resources, c) extensive taxation because of the donated time by concerned citizens helping as they learn how to protect their children.

(1) and (2) EDUCATION and PUBLIC AWARENESS

The Concerned Citizens Against Drug and Alcohol Abuse of Dover, New Hampshire, sponsored a 5-week education "BLITZ" for the citizens of southeastern New Hampshire.

The purpose of our free seminar on drug and alcohol abuse was to inform the public about the use, abuse, and effect of drugs and alcohol on the Dover community -- its citizens, children, parents, businesses and schools -- with the ultimate goal of helping one another through education and public awareness. (See attached program) We had 1500 copies of this seminar program distributed to the local churches, newspapers, and parking lots by local scout troops and concerned citizens and their children. Local radio stations aired our seminar throughout the five-week period.

Our first meeting was held January 15, 1981, at Dover High School and the theme was "DRUG ORIENTATION". We started at exactly 7:30 p.m. and ended precisely at 9:30 p.m. This first session gave an overview of the drug scene today. Guest speakers for this program were Otto Moulton, vice president of the National Federation of Parents for Drug-Free Youth and Dr. C. W. Dempsey, professor of physics at the Department of Psychiatry and Neurology, Tulane University School

of Medicine. Dr. Dempsey discussed marijuana as it affects the brain. Drugs of the day and drug paraphernalia were on display and explanations of their use was given by Captain James Rowe of the Dover Police Department. Also, a young married couple related their experiences with drug abuse since the age of twelve.

Our second meeting was entitled "DRUGS AND THE LAW" and was held exactly one week after our first meeting. Panelists for this program included Joseph Nadeau, District Court Judge of Durham, New Hampshire; Charles D. Reynolds, Chief of Police, City of Dover; and probation and juvenile officers from the greater Dover area. They answered questions like "What are the courts doing about drugs? , Police? What are the laws dealing with drug use and abuse? e.g. Dover's Drug Paraphernalia Law", and other related issues.

Meeting #3 was entitled "PERSONAL STORIES". Also involved were four service agencies regarding residential and outpatient services. Strafford Guidance Center, Southeastern New Hampshire Drug and Alcohol Abuse Services, Inc. and Alcoholics Anonymous related personal program descriptions. Odyssey House presented three teenagers who told their personal stories as to how they got involved in using drugs and how they succeeded in conquering their drug abuse.

Our fourth program was called "WHAT'S HAPPENING IN OUR SCHOOLS". It involved Dover Public Schools, St. Thomas Aquinas High School, and Dover Catholic Schools who presented their educational programs and problems regarding students and health, drug and alcohol education. A panel of educators discussed the current drug scene in their schools and their efforts in combating the presence of drugs

and alcohol. The panelists attempted to define a positive working relationship between schools and the community. We have found this relationship to be possible only when the community, the schools, and the police department work closely together helping each other in their abilities to educate each other through public awareness.

Our last program of the five-week BLITZ was entitled "Parents, Peers and Pot" after the book by Dr. Keith Manatt Schuchard. She was involved in various neighborhood action groups and has found out a lot about young people and their cultural environment and ways in which parents can have a positive influence on them. Dr. Schuchard is Associate Director of PRIDE (Parents Resources and Information on Drug Education), Georgia State University. Dr. Schuchard spoke within our program and then spoke at two assemblies of our high school, one assembly at St. Thomas Aquinas High School, and to the doctors of the Dover area at the conference room of Wentworth-Douglass Hospital. The doctors were so impressed that they asked for copies of her book to give their patients. We received the books free of charge from N.I.D.A.

Immediately following this five-week seminar, we began receiving desparate calls from parents who were afraid their children were on drugs but were afraid to involve the police. We had calls from students wanting to tell about people selling at the high school. We had offers to speak from three different Rotary Clubs in the Seacoast area. Several towns and cities around the state of New Hampshire and nearby state of Maine were interested in starting similar programs.

We had a few weeks where we went to all of our surrounding

towns and asked the mayors and police chiefs if they would introduce paraphernalia bans in their towns as Dover had. We felt that other citizens would become aware of the drug problems as we did. Several towns introduced and passed paraphernalia bans, i.e. Newington, Farmington, Lebanon and Nashua, New Hampshire. The town of Berwick, Maine voted to let the Concerned Citizens speak against paraphernalia at their town meeting and then they passed a paraphernalia ban which is the only paraphernalia ban in Maine, which has decriminalized marijuana.

The Concerned Citizens group met opposition from three or four towns because of the pro-paraphernalia advertising done by the New England Tobacco Accessories Trade Association which previously was called the Accessory Trade Association, and previous to that, was the P.T.A. or the Paraphernalia Trade Association. This group has much money and threatens lawsuits against towns that pass paraphernalia banning legislation, i.e. Nashua, New Hampshire. These towns did not dare introduce any legislation that might cost their taxpayers exorbitant legal fees. We knew at this point that we had to go for a statewide paraphernalia ban. We had many senators who wanted to sponsor such a "motherhood" bill and were fortunate enough to have it introduced to a joint session of the Senate and House. This will take place March 25th at 6:30 p.m. (See Attachment) Since learning of our fortune in having this bill introduced by sixteen Senators, the Concerned Citizens have coordinated a series of motorcades from forty different groups within the state to converge on Concord for the joint session of House and Senate on this paraphernalia ban. We have

assigned different aspects of this bill to different individuals so as to cut down on repetition at the meeting and to be sure each portion of the bill is covered properly.

(3) EARLY INTERVENTION

At the time we were working with these educational and public awareness portions of our program, we realized that an EARLY INTERVENTION aspect was starting to take shape. We were getting calls from worried parents afraid to call the police, worried students afraid to tell their parents, students worried about friends of theirs on drugs. Through our education program we are training teachers to be more aware of drugs and what to look for as far as abnormal behavior due to drug abuse is concerned. This is the first step in our reverse peer pressure approach. This approach is based on the fact that some students will take drugs regardless of the facts or situation. We feel that this group is as small as those who would not take drugs under any circumstances. We are looking at the target group in the middle that is swayed by pressure from their peers. If we can have this target group be influenced by those who do not use drugs by awareness education and extra-curricular alternatives then the non-users become the "cool" kids because they do not have to rely on drugs. This is the start of "reverse peer pressure".

We had to have another meeting to determine where to go from here. At this meeting we formed several committees that would meet separately and then meet back once a month to tell of progress and offer suggestions. These committees are:

(1) Youth Alternatives
(2) Legislation
(3) Incorporations and Money
(4) Programs
(5) Education/School Information/Neighborhood Groups

Through the Committee on Education we had a group from the SYVA Corporation of Palo Alto, California, come and demonstrate to the Concerned Citizens group, the police department, and to members of the Wentworth-Douglass Hospital, a urinalysis and serum testing kit for cannabinoids and other drugs. This machine can be used by a novice and can detect whether or not marijuana has been used in the previous fourteen days. It was suggested by the Committee on Education that this SYVA machine be purchased for use in the Dover High School system. Because the teachers have received drug education through the Concerned Citizens awareness program and because teachers are working with and testing the students and are monitoring their behavior with their peers, then the teachers are best qualified to sense abnormal behavior in the students. When abnormal behavior is sensed, the teacher would indicate this to the principal of the school and the parents would be notified. The parents and the student would be asked if they would mind having the student submit to the urinalysis. If they agreed and passed the test, then physical and mental tests could be suggested. If they agreed and failed, then the student would be required to take a drug education course set up by the Concerned Citizens group, the school board and the police department. Educational and awareness material would also be sent to the parents. If the test were refused, then the course would be mandatory. The mark received in the course would become part of

that student's grade for the marking period. The student would have to continue this course until a passing mark was obtained. This course would be run by the Concerned Citizens Committee on Education at no cost to the taxpayer.

The Concerned Citizens Against Drug and Alcohol Abuse have spent a total of $550.00 to date. Our proposed budget for the next six months should be approximately $1,400.00 with speakers and books for the local libraries and libraries at the University of New Hampshire using a large portion of this sum.

We are an open-minded group that decided that we had to take action and are continually looking for new ideas and approaches and are more than willing to share our ideas with concerned citizens in other areas of the country. THE TIME IS RIGHT!

Respectfully submitted,

Edward L Morin

Edward L. Morin, Chairman
Education Committee

Senator HUMPHREY. Thank you.

Mrs. Jobin?

Mrs. JOBIN. Thank you, Senator.

I am president of the Concerned Citizens Group in Dover, N.H. I became involved because I am the parent of five children, four boys and one girl, ages 25 to 16; and I had four of my children who had experimented with marihuana. I went the route of pain and agony four times.

Looking back on my first experience 8 years ago, I knew nothing about the dangers of marihuana, only the fact that it was illegal and frightening. But I did not know why it was so frightening. Even my husband a year ago had said they should legalize it because then it would not be as interesting to try. Anything that is legal is not as interesting.

Thank God, we did not legalize it then and I do not want it legalized now; because since my 16-year-old was involved a year ago, I began to read many articles, the first one being "How I Got My Daughter To Stop Smoking Pot," by Susan Bromwell, which really got me to send for some literature.

Many of my friends shared the same problems. I was not unique.

We would get together and share the agonies and the victories. I did have some victories.

All four of my children are now drug-free and leading good, healthy, normal lives. My daughter was just married Saturday and

it is very exciting for me to know that my family is together today because I did fight to give the information to them that I did seek and that we saved them from a drug-riddled life.

I must say that I felt something was radically wrong. Why did I have to go that route and why wasn't I told about those facts 6 years ago when the research was in. When I read a copy of the hearings before the subcommittee to investigate the administration of the Internal Security Act, there were many eminent doctors and researchers who gave all this information to the subcommittee.

At Senator Mathias' hearings in 1980, Dr. Nahas, Dr. Heath, and Dr. Carlton Turner, had testified on the dangers of marihuana, and yet I did not see anything coming before the public to inform us about these facts. We parents had to dig for it ourselves.

I am happy to say that NIDA Pride and Pyramid did have this information. I read "Parents, Peers and Pot," which was the most marvelous thing we could have read. I quote Dr. Schuchard many times because I felt so intensely what she felt. The pain was there, and I can rejoice with her at the successes we have had.

I realize also that we need the help of the legislators to rid ourselves of the drugs that are tearing our families apart and rendering our children wasted, unable to function and live a normal and fruitful life. We owe our youth clear, updated, and scientific information. We have to really dispel the myth of the harmlessness of this drug, and especially when all the children are listening to the drug messages, the rock music, the movies, the TV commercials, role models that all seem to be geared to enticing our youngsters into this scene, to make it seem so normal. In fact, when we hear on 60 Minutes that marihuana is grown in our country, that really is kind of frightening, to think that we are allowing this.

I would like to share with you just a couple of the comments that the parents have made at our seminars to show you how concerned they really were how and much we did.

No. 1:

I thought the program was excellent. I wish Dr. Dempsey had emphasized even more that the human EEG's of potheads are the same as monkeys. We need to overemphasize the danger of pot because kids are so certain that it is innocuous.

No. 2: Another one.

I am already well informed on marihuana and can always learn more, which I did. I would like to see more things like films in schools and getting the newest information the quickest. Also have new studies done on marihuana and other drugs.

No. 3.

Dr. Dempsey's talk was superb. Wanted to hear more from him. What can we do to get more junior high and high school kids and their parents to hear these things and come to more meetings?

No. 4.

I was disappointed. All those stories about the dangers are not new to me. I appreciate the efforts the good doctor made. It seemed to me that there is a conspiracy going on. The gentleman from Massachusetts was the biggest disappointment of all when his bottom line was, write your Congressman. The government is not at all interested in addressing this problem, as shown by the complacency, by allowing the growers in California to continue undisturbed in their production of the weed. I watched 60 Minutes. I feel that palms are being greased on a fairly regular basis.

Maybe this is an extremist, but I feel the fears are there and we have to hear the cry of the people. I really feel, Senator, that I could suggest—also like the gentleman suggested here, that the information must come to the parent through the media and possibly prime time television should be bought so that we can have these researchers tell the story to the parents.

It is very hard to take individual parent groups and work when we do not have the support of our Government.

Now, there has been a consensus of opinion that the parents do not need to get all this information because it has not worked before. But it is very important to note that the information we were getting was not adequate and it was scanty and outdated. We found out that millions of people were requesting reprints of Reader's Digest articles, by Peggy Mann, which showed that the parents are really concerned.

I would like to seek the elimination of High Times magazine, which greatly exceeds the first amendment privileges. It should be banned. They advocate the use of illegal drugs and promote the growth of illegal marihuana, and they contribute to the delinquency of our children. It is very frightening to read one of their publications.

I would like the public aware of the United Nations International Treaty in 1961 with 131 nations signing that treaty. There are not very many people aware of that. But the organization NORML knows about it and they must be exposed for their advocation of marihuana use and legalization. We think it is of the utmost importance that our legislators be able to know the difference between THC and marihuana. Marihuana is what is being publicized as medicine when in fact it is only THC, the one chemical out of 421, which is being considered for medical use.

The paraphernalia ban, I think, is exceptionally important as has been shown by the concern of parents from thousands of towns and cities across the Nation.

I would say that covers all the issues I could offer this morning.

Thank you.

Senator HUMPHREY. Thank you, Mrs. Jobin.

It certainly is one of the threads that has been woven through the testimony of many of you this morning, that there has been a lack of knowledge from our institutions, including Government, the media, and also academia, as well as a certain attitude of tolerance and even encouragement of the drug culture. I do not know if there have been changes as this process of education goes forward.

[The prepared statement of Mrs. Jobin follows:]

CONCERNED CITIZENS AGAINST DRUG AND ALCOHOL ABUSE
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My name is Helen Jobin. I am president of the Concerned Citizens Against Drug and Alcohol Abuse in Dover, New Hampshire. I am married and the mother of five wonderful children, four boys and one girl, ages 25 to 16. My husband, Raymond, and I were instrumental in starting the Concerned Citizens group and the response has been tremendously exciting to us.

Because of our own personal involvement with marijuana and four of my children, I felt I could share the agonies and victories with several close friends who were also experiencing these same problems. We would share anything that we could get our hands on to inform ourselves about drugs. We first read the article "How I Got My Daughter to Stop Smoking Pot", by Susan Bromwell and then sent for the added literature that they listed in the article. We sent for information from PYRAMID, PRIDE and NIDA.

The book "Parents, Peers and Pot" by Marsha Manatt was an inspiration to us and the ideas of forming parent groups took root and spurred us on to form our Concerned Citizens group and share what we had learned and distributed some material at our meetings. We found there was a hunger and thirst for knowledge and a tremendous need for sharing by so many parents. And, so we grew in number at a rapid rate -- all eager to seek solutions to this problem that effected us all in the same devastating way. But we gained strength from each other with our concerns for one another

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and the hope we felt growing each day as we listened to the various speakers we had assembled for our seminars. We were indeed fortunate in having Dr. C. W. Dempsey and Dr. Keith Manatt Schuchard with such important information.

I have available with me some of the responses of the people who attended these seminars so that you may sense their appreciation for the information they so desperately needed.

I could not help but feel that somehow something was radically wrong when so many of us were blind to the facts of what the dangers of marijuana were. Why is it that we were not told sooner about these facts when we discovered that the research had been done and reports were in since 1974.

In fact when I read a copy of the hearings before the Sub Committee to investigate the Administration of the Internal Security Act and other internal security laws of the Committee on the Judiciary, United States Senate, I was astounded by the volumes of testimony given by so many eminent doctors, scientists and drug enforcement administrators, all explaining the horrors of marijuana and attesting to the epidemic proportions of drug use.

That was six years ago, gentlemen, and none of these horrendous facts have been brought before the public. Even now it is difficult to comprehend why there has not been any concerted effort by the United States government to inform the people of this country through the media, of the dangers of marijuana. I would plead with you Senators to hear the cry of the people of this nation. We are a desperate society, so badly in need of solid direction.

We need your help to rid this country of the drugs that are tearing our families apart and rendering our children wasted and unable to function and live a normal and healthy and fruitful life.

We owe our youth clear, relevant, accurate and constantly updated scientific information on marijuana because the widespread myth of its harmlessness has been the major factor which has allowed them to be victimized by the merchandizers of drugs.

According to Dr. Keith Schuchard back in 1975, the prevailing professional opinion was that drug information was unimportant, that we had tried the informational approach and it hadn't worked. Against that professional consensus, we parents argued that the information available was scanty, outdated and irrelevant to the implications of the child, adolescent, female and longer-term adult user. That began the do-it-yourself process by which so many parents have become drug "experts", for they felt emboldened with the knowledge they had a credible health argument to use with their children. Unfortunately that argument on the uselessness of marijuana health information is still being made by many people in the drug profession who have the greatest potential for collecting and analyzing the data and getting it quickly to the public.

The absurdity of the argument, that people are not interested in scientific information on marijuana has been spotlighted by the unprecedented response to Peggy Mann's Readers Digest articles, which have evoked nearly 2,000,000 requests for reprints. But, as Peggy askes, Why should it continue to be mainly the efforts of a few mothers who have to struggle to get this information into the media and into the national counsciousness.

In most of the new publications coming out of our federal and state agencies, the most important biological fact about marijuana -- the lipid-solubility of the cannabinoids is not even mentioned! And the worst ones are those going out to children in so-called drug education courses. Quite frankly, I think it is a national disgrace that the basic facts that the cannabinoids are absorbed in cell membranes, that they have a long chemical half-life, and that they accummulate in the body and brain -- that these rock-hard biological facts are not known by every school child and citizen of this country. Young people, including the most stubborn and defiant college-age users are always surprised and disturbed, made to think by these basic biochemical facts. This information gap is what led to the proto-typical 1970s image of the fitness freak who smokes pot, of the fanatical jogger and health-food nut who smokes pot, of the anti-nuclear demonstrator who fears the accummulation of low-level radiation in his membranes and smokes membrane-accummulating marijuana while he demonstrates. It's a ludicrous image, if it were not so tragic.

To quote Dr. Schuchard: "I've wondered why the important, and in many ways, excellent (marijuana and health) reports published by HEW kept printing surveys about young peoples attitudes and opinions about marijuana as if these were equivalent to the scientific findings given later in the book. Why would the data that a certain percentage of high school seniors do or do not think marijuana is harmful be relevant to this health report, if there is not corresponding effort to find out if the seniors know anything about marijuana's biological effects? I wonder how many seniors have a clue about the research

findings that the report documents. I've also wondered why for three years with all the data-gathering expertise and powers of HEW, NIDA, and CDC, there is still no systematic effort to collect case histories, clinical observations, accounts by parents, coaches, teenagers, and users of what they see with their own eyes about the way marijuana effects the body and personality, especially the very visible effects on the body of the adolescent male. How many millions of physically wasted teenage boys will we have to produce before we systematically total up the accounts of physical burn-outs and admit that what we see all around us is true after all."

The government can regain their credibility, Senators, by taking the responsibility of educating the masses. The people will respect the government much more if they take leadership in this endeavor. The government needs respectability and owes it to our youth to make up for the lack of factual information being presented in the last seven years.

One very effective way to do this would be for the government to put on a national television program for one hour of prime time with our leading researchers and doctors, such as Dr. Carlton Turner and Dr. Gabriel Nahas and Dr. Robert Heath. Also to include in this program parent consultants such as Dr. Keith Schuchard, author of "Parents, Peers and Pot" to bring to the American people the facts they need to know.

We must also seek the elimination of such publications as High Times Magazine, which greatly exceeds their First Amendment privileges. This magazine is currently banned in Iran, Canada, USSR, England, Chile , Republic of South Africa, Spain and the U. S.

Federal Prison System. How can we allow a magazine in America that advocates the use of illegal drugs and promotes the growth of illegal marijuana by demonstrating how this drug can be camouflaged so it can be grown in your backyard undetected. There is sufficient proof that it contributes to the delinquency of minors by encouraging them to use illegal drugs and in turn these drugs put them in a frame of mind to commit crimes.

We would further hope to have the public made aware of the United Nations Single Convention on Narcotic Drugs of 1961. By this International treaty, the United States and 131 other nations define marijuana as a drug of abuse and agreed to keep marijuana illegal except for medical research and medical purposes.

The organization, NORML, knows about this treaty and since they dropped their sham campaign for decriminalization and came out more honestly for legalization, their in-house publications and supporting publications, like High Times make the United States re-negotiations or withdrawal from the treaty a high priority in their lobbying efforts. What a tragic mistake that would be.

NORML's present plan, according to its president, is to push for legalization with more organizing efforts to infiltrate college campuses! They must be exposed for their manipulation of people and facts.

And lastly, we Concerned Citizens feel that the growing of marijuana in this country cannot be allowed to continue and the government must act swiftly to reconsider the spraying of Paraquat to eradicate these crops here and abroad.

We must negotiate to gain the cooperation of the countries involved in the growing of this insidious weed.

We will succeed. So Help Us God!

Respectfully,

Helen Jobin

Helen Jobin
Chairperson

Senator HUMPHREY. Let me go back to Dr. Gleaton.

Is there any data available at this point that would demonstrate the effectiveness or ineffectiveness, presumably it is the former, of these parents groups across the country in combating drug abuse? Any kind of measurement, any kind of index?

Dr. GLEATON. There is not.

I have requested funds for 3 years from the National Institute and the State people and so forth and so forth.

What I have heard is, we do not have a good model for testing this. So whether or not we get good data is going to depend on whether or not someone is going to take a chance and begin to develop a model. That is an evaluation and research issue that is very extensive.

In Atlanta, Ga., in one school system, we have 35,000 children. We have a little over 15,000 households. We have three pieces of information, or will have by the end of this year, delivered through the peer system. In each home there will be the publication, "Parents, Peers and Pot." They will have the Reader's Digest combined three articles by Peggy Mann, "Marihuana Alert,"and a series running in our local newspaper about drugs and usage in Atlanta.

By that basic information in each home, the following year, we begin our second stage and we are working at a 5-year plan right now. It is not funded. I have begged and borrowed extensively.

We want to inform the parents and let the parents set some reasonable rules and regulations within their households, and this idea across the communities neighborhoods and the children's friendship circles.

For example all of the 10th graders had to be home by 10:30 p.m., it would be a lot easier, instead of some at 10:30 p.m., some at 11 p.m., and some at midnight. We are trying to change the rules and regulations, and even the punishment; punishment, for example, like taking a hair dryer away. That is a terrible thing for a 14-year-old.

But we need strong parents, parents who feel comfortable saying "No" in a firm and, at the same time, loving caring manner.. We are organizing these parents. We are organizing not against the children but for them. With a lot of love and care on the part of the parents, we can make progress.

But there is no good data available.

Senator HUMPHREY. How do your typical affiliated groups raise money; among the parents themselves? Or do they branch out and tap into other sources within the community?

Dr. GLEATON. They are ingenuous. They do it in various ways. Many parents use their own funds, such as grocery money, or have rummage sales. Other ways of raising money are through local businesses, foundations, health agencies, PTA's churches, and any organization which is supportive of the movement. In one particular town, Arcadia, Fla., convicted drug users are fined $300 to $800 dollars by the court system and the money is then donated to the parent group for an education program. Each parent group has its own ideas of how to raise money.

Senator HUMPHREY. Incidentally, I would be happy to lend my endorsement to fund-raising efforts to any established and reputable group to spread that word. It is a fact that sometimes it helps

in raising money to have a letter on official letterheads of a U.S. Senator.

Dr. GLEATON. It definitely does, and we will definitely make note of that.

Can I make one other point?

As we discuss block grants, I would like to say that in many States it has worked well, in others it has not. Florida is an example of where it has worked well. With a small amount of money, we have started promoting parent groups. In many other States, that is not true.

I do not know how it happened. It is sandbagged, and they use the money for some other program. When you begin to look at prevention, you say, we will use the money for primary prevention.

What is the definition of "primary prevention"? You will see that in one area such as law enforcement confiscation of cocaine is considered prevention. Someone else says in the area of treatment, we have 14 addicts over here who are being treated and they have been drug free for 16 months. That is considered prevention.

Senator, we have to have a clear definition of what primary prevention is.

Senator HUMPHREY. Good point.

Mr. Finck, as the leader of an influential group in California, do you have any observations about the proposed changes in block grants for funding at the Federal level?

Mr. FINCK. Well, no. I am really not sure on that issue, and I am still listening and trying to formulate what I personally think would be the opinion that I want to go with. Rather than commenting on it now, I would rather reserve that.

If I might, I would like to go back just a second to the question that you asked; because there are some measurements that I would like to mention, if it is possible.

Senator HUMPHREY. Certainly.

Mr. FINCK. I think there are some unobtrusive information that we are beginning to get; that is, that although we do not have a particular test to measure, we can see changes in community attitudes which are observable. We can see a change in law enforcement; for example, a willingness to get involved in the work, see a change certainly in our area in the schools.

Two years ago, it was almost impossible to get a school in our area to admit that in any way they may have—they would have had a problem on their campus. I think that has changed significantly. I think the attitude of parents and I think now the new awareness of young people—I think all of those things have made a significant observable difference that we can see.

We also have a local study in our area that I feel is very important that we continue to support so that we can see an actual test measurement if indeed the program is effective.

Senator HUMPHREY. Let me ask questions of the students of Gunn High School.

Can you, Ms. Gac—can you give us some characterizations of the attitudes of your colleagues, your peers, both before and after this program was in place?

Ms. GAC. For a lot of people who did not want to party before but partied because by using drugs and alcohol, they felt secure with

their friends, they found they could stand with another crowd. And so they found security there, and they became more sure of themselves.

The biggest change that I am really happy about is that the younger people, freshmen this year at our school, are not as pressured as I was my freshman year, and they do not feel like they have to participate. They are not going to as many parties and they are having a lot of get-togethers where they do not drink or anything. Before, they used to get together and drink.

Senator HUMPHREY. You mentioned you have been having get-togethers of young people who have not been abusive of drugs and alcohol.

What other ways have you institutionalized this? By that, I mean what other methods and practices have you implemented to afford a haven, if you will, of support for those who opt to avoid drugs?

Ms. GAC. Some of the get-togethers are dinners that we set up that we could get together and talk. We found some other forms of entertainment that helped us busy ourselves other than standing beside a keg of beer and drinking.

Senator HUMPHREY. Mrs. Lundgren, what ways can parents and other young people that are interested in this problem set up means of support, moral support for youngsters who are willing to buck the pressures?

Do you have any programs that recognize drug-free youth, for instance?

Mrs. LUNDGREN. We do not yet. I think that might be a very valuable thing to do. I think just the fact that, for example, these students have come here to testify would give them a lot of credibility. That is what we are counting on, that they will get recognition and that they are known at their school. Everybody knows they were coming and everybody knows why they were coming and that they are not partying.

Senator HUMPHREY. Giving them the recognition gives them an image. I understand there are some other students here from Gunn High School.

Mrs. LUNDGREN. I think some had to leave.

Senator HUMPHREY. I am going to recess the subcommittee for about 30 seconds so we can give them a round of applause.

Will the students stand? [Applause.]

The subcommittee is back in session.

Mrs. LUNDGREN. It is the idea of a family wellness center. It is a concept that I think has real possibilities, of forming centers in neighborhoods where there would be a cooperative effort to set up rap sessions with adults and teens, to teach communication skills to teach people to learn to listen to one another's frame of reference. A lot of things could occur in that kind of a center.

Dr. GLEATON. In Louisiana, the Louisiana State Legislature funded, to the tune of $350,000, a program for the building of teams. It is parents, youth, and teachers and other community members who are forming teams to begin to do what you are talking about, develop an alternative to the drug group so they have some place to go.

Another thing that I have to tell you is kind of a story, but it sums up to me the idea that the parent movement wants to im-

press upon parents and that is to look out for their own children, stay with them, monitor their behavior.

A mother in Oklahoma, after a session of 2 hours, she said to me, I will tell you one thing: My son may see me but he is not going to enjoy it. I am going to stay with him because I care about him.

Senator HUMPHREY. Mr. Hays, do you have any ideas on how young people like yourself can be accorded recognition so that more will join in your ranks or any other ideas on how to build some support for students such as yourself?

Mr. HAYS. Yes.

We explained what we did with the senior class. I think that has been an excellent example of what we can do. It helped me.

We started out last September with about 40 seniors and through the course of the year we invited every senior to a dinner. I think that is the type of thing that should happen. We gave everyone the opportunity to come and followed up with a letter. It has made a great difference to me this whole year knowing that all those students are not partying and to have people come to the dinners to talk.

We had a discussion for about 1½ hours over a pot luck dinner and that is an excellent way to get students involved. That is the way it has made a difference to me. When people talk about it, then they start thinking.

Senator HUMPHREY. I am not a psychologist, but what would be your feeling about some sort of club which would involve the wearing of a pin, or would that not be a good idea?

Mr. HAYS. I think if you had enough students that that would be a good idea. Unless you had enough students-they might get looked down upon as a fanatic group.

Senator HUMPHREY. I assume they still have the National Honor Society, and awards such as that, and young people still wear those kinds of pins as a form of recognition. On that basis was my suggestion. I do not know if it would work, but it is an idea.

Mrs. Jobin, I understand your organization has spent only $600.

Mrs. JOBIN. Since August, we have spent $550.

Senator HUMPHREY. You have been amazingly effective, apparently, from what I hear, not only from your testimony but from some others back home.

To what do you attribute that incredible effectiveness, given the fact that you have spent so little money?

Mrs. JOBIN. We are so fortunate that Pyramid did pay for Dr. Schuchard's visit. So we did not have to contribute but a small fraction of her fee. The fact that we had community support. We had the high school that really supported this. They seemed to really want to have the involvement with the parents. They felt this was their grand opportunity to really meet with them and share their thoughts, too. They were concerned about the youth, but they had felt that if they were going to take any action, that the parents were going to fight them on this and they could not get anywhere.

Once they shared that with the parents and heard the parents' views and they could give their help in seminars, and they were very open, then we felt that when we heard such speakers, such as Dr. Dempsey, who did give some excellent information with his

slides, people really responded to that and they realized—they said, I did not know this was happening to my kids. They really came in large numbers to hear the stories of children. They heard personal stories. We had 500 people that night.

Then the response was, we want to hear more.

When Dr. Schuchard came, that was the culmination of all of our efforts. She explained the way they did it in Georgia and they were successful because the parents did do as Dr. Gleaton said. They formed their groups, neighborhood groups so that they could all have the same basic guidelines for their children and they could keep their children really together, more or less, and doing the same things. They could all be enjoying some fun activities without the need for drugs.

It took several months to have that take place. I know that we had surrounding areas come to our meetings, people from surrounding areas who wanted to start their own groups. We have been contacted by these people saying we want to start groups; can you help me. I certainly do. I am so excited. I will meet with them any time.

They ask, can you send me some information? We certainly have been able to do that. We got more from NIDA. We could also ask them to write for their own information.

Then we had parents calling asking us what they could do. How can they further help us. They were all excited.

We have not gone as far as this Palo Alto group. They are exciting me with the fact that I can hear these youngsters saying, they are being effective with their own peers. I think that is what we would like to happen in our town. I know the feeling is there because since the seminars, I know they are just dying to get going to find a way.

Senator HUMPHREY. Certainly, the time has come. I remember campaigning with Ronald Reagan last year and it was amazing when he got up and mixed with people, just how often he was asked, not about farm policy or taxes or inflation, but about what he would do about drugs in the schools.

Thank you all very much. I wish we had more time to pursue this. We have two more panels to follow and, in fairness to them, we have to move on.

Thank you, very much.

May we have the second panel, please.

The second panel comprises Mr. Kenneth Eaton, Mr. Donald McConnell, and Mr. Joseph Diament.

I understand that you have agreed among yourselves on the order of proceeding.

So, Mr. Eaton, will you proceed?

STATEMENTS OF KENNETH L. EATON, ADMINISTRATOR, MICHIGAN OFFICE OF SUBSTANCE ABUSE SERVICES; DONALD J. McCONNELL, EXECUTIVE DIRECTOR, CONNECTICUT ALCOHOL AND DRUG ABUSE COUNCIL; AND JOSEPH DIAMENT, DIRECTOR, OFFICE OF ALCOHOL AND DRUG PREVENTION, STATE OF NEW HAMPSHIRE, A PANEL

Mr. EATON. We will attempt to be brief.

At the outset, I would commend the subcommittee for moving ahead on this very important issue, and say we are pleased to continue our acquaintance with you, Senator Humphrey. We have known of your work over the past 2 years; and please accept our congratulations for becoming the chairman at this point.

Senator HUMPHREY. Thank you, but I had nothing to do with it.

Mr. EATON. We were very interested in the comment made by the Concerned Citizens Group. I suspect our discussion might focus somewhat on how we might accomplish some things toward resolving or at least working on many of the problems that they discussed with you.

I am also happy, of course, to see on your agenda Bob Smedes, from our own State of Michigan. I know he will have important information for the subcommittee.

Please transmit my regards to Senator Riegle. He has been a person long interested in this area.

Senator, we have spent about the last 10 years with the State-Federal partnership, which I think provides a very important concept.

To be very brief about it, it looks something like this:

About 10 years ago, it started with the Federal Government assuming virtually 100 percent of the role, especially the financial role at that particular point in time. A decade later, many, many things have happened. We will highlight a few of them.

One of the significant events concerns sources of funding.

Today, in fiscal year 1980, the States provided $350 million in funds for alcoholism services and about $325 million in support for drug abuse services. They outpace the Federal contribution.

We started 10 years ago with the States doing very little; all that we had were the agencies and the Federal Government doing most of it.

I think the evidence of its workability and its success is laying at that bottom line. It shows how much participation we have elicited from the States and the local communities in that very brief period of time. The partnership has been stable. It has been maturing and I think it has had some outstanding results, some of which we would like to discuss with you this morning.

A quick summary:

In fiscal year 1979, the Federal Government provided $97 million to the States in alcohol and drug abuse formula grants. That amount was decreased in 1980 by about $4 million, down to $92.8 million. In 1981, its continuing resolution provided only $80 million and, as you know, that amount was proposed to be rescinded by the current administration. I know we are not dealing with the recession and do not pretend to. But I would like to point out that continuous reduction of the Federal share has in the past been made up by the States. The present rescission amounts are not going to be made up by all the States, I cannot think of a single occasion in which this time frame will permit State legislatures to provide these sources of funding. Many State legislatures have already adjourned or will have adjourned by the time consideration of the legislation is completed by Congress.

Many are under the impression that the rescission of those funds will have no impact on the programs.

We have some nationwide information. We would be happy to provide this to the committee. I can tell you in three sentences what effect the rescission will have in Michigan.

We have close to 50 programs. We will be cutting 200 staff; about 8,000 client services will be lost. In short, we will be taking out about $2.7 million for the statewide system because of this rescission. We have carried over $800,000 from a previous year's appropriation. I make that remark to emphasize that precipitous acts here can make a great difference, and sometimes when we look at what seems to be reasonable statistics from reports, they may either be very old or misapplied.

We can raise havoc in our communities, and with our agencies, without intending to do so.

The formula grant has been the mainstay of this partnership and I think it is a very important part of it. A second element has been in the alcoholism area, what we call the Uniform Act. This incentive program has been adding funds to States which have passed State legislation decriminalizing public drunkenness. It has not been a very costly program for the Federal Government, but it has made massive progress throughout the Nation by decriminalizing and treating alcohol as a health problem rather than as a problem in our criminal justice system.

A third element has been what we refer to as statewide service grants within the National Institute on Drug Abuse. In fact if you put the formula grants and the statewide service grant together, it appears very much like a block grant in the drug abuse area.

My State has followed the practice of providing Federal funds, matched by the State agencies, and subsequently awarding to service programs. A joint monitoring and accountability system has been created. Responsibility for this system rests with both the Federal and State Governments. It is very good; those two things together permit the achievement of objectives the utilization of more responsive and closer State management structures, a shared funding between these two levels of government and for the services to be provided at a local level. Also in many, many cases matching funds are contributed by local service providers.

Another element has been a similar concept development in the alcoholism area in which this statewide grant has been applied on an experimental basis over the past year and a half. I understand NIAAA is pleased with this effort and intend to expand and include that concept to local government.

Examining these concepts together, we have something that is very close to the proposed block grant.

The effectiveness of these programs is unquestionable. We could take a whole day talking about effectiveness.

I would like to highlight one point with respect to the economic effectiveness of alcohol and drug abuse services.

I know the subcommittee is very, very cognizant of the statistics about economic costs, and so forth. There is no need to repeat that.

The State of Michigan receives about $12 to $13 million a year in various forms of Federal grants. They are 10 or 11 different grants. In the last fiscal year, 60,000 people were treated in our system. We raised a great deal of State money and Federal money to accomplish this.

Here is the point that I want to make:

Among the clients that received these services, personal income increased by $48 million that same year. Approximately $12 million in increased Federal income taxes and social security taxes came directly to the Federal Government as a result of that increase in Federal income among the clients on a before-and-after basis. A 22-percent decrease in unemployment was also reported.

Here is the real point:

For every single dollar it raised, that dollar came back in the form of increased taxes from the clients who were successfully treated as a result. I wish I could make personal investments that were that lucrative.

I am extremely concerned and bewildered as to why the Federal Government would be so tainted by questioning the ability of that investment to continue.

I would make the investment bigger, because that benefit does not even count the benefit to our general economy or help provide to the families or numerous other benefits.

Michigan I do not think has a unique program. I think that if we looked at the facts and figures in every State, that the performance would be repeated. What we have is a circumstance in which Federal funds are not spent. They are invested. They are in fact returned almost one for one, dollar for dollar, in a direct fashion, plus achieving a national objective that our programs have attempted to achieve.

I would now like to make a specific reference to the future, with a special focus on S. 755.

First of all, we are very pleased that the subcommittee has taken the lead and begun to move ahead on this important matter. It is vital and we are pleased that you are getting a jump on this.

There are several points which I would like to make.

We have prepared a detailed statement which has been submitted for the record. We hope that the committee will look at the prospect of multiyear authorizations as opposed to a single year. I understand some of the motives and reasons for looking at a single year authorization. It has been done on several occasions in the past.

One of our hopes is that the Congress can conduct some very intensive oversight hearings.

With a single-year authorization, it has appeared in the past that by the time the legislative process is finished, it is time for the subcommittee's energy to be subsumed once again with reauthorizing the program for another coming year. The oversight function is lost because Members of Congress must spend the majority of their time making authorizations for the legislation and carrying out the related activities.

We hope that that will not happen this year and feel that a longer period of authorization will provide more stability.

With respect to the Uniform Act, we urge the subcommittee to give careful consideration to continuation of this important program. There are still massive problems around the entire Nation and I hope that we would not lose the visible leadership in dealing with that particular problem.

Match requirements for the proposed demonstration grants might be a problem for many programs. For some, it will not be a big problem. But many of the programs that are proceeding, even on a demonstration basis, are hanging by a shoestring. They have trouble keeping their doors open the way it is. They have difficulty because of the characteristics of their clientele. Third-party payments and client fees are often nonexistant for these programs. You might want to review and consider whether or not there might be some provision made for agencies that cannot meet the 25-percent-match requirement.

We would strongly urge that you not disqualify the States from applying for demonstration grants.

I think the language of the proposal we looked at perhaps excludes State universities, for example, as entities of State government. We would urge that you reconsider this issue carefully before you take subcommittee action.

The prevention provision is very good in concept. It was particularly good when we were looking at a nationwide service system to be supported by project grants, but I am not sure you will find it as workable under the concept of smaller contribution grants. I urge that you review this as well as the concept of a much more limited program, as proposed by this legislation.

Please do not believe that that is a disparaging statement about where prevention ought to be, as far as its priority in the alcohol and drug abuse field. It ought to be very, very high. But I wonder whether it is going to accomplish very much by setting aside that same percentage of a much smaller pie.

With respect to research, we urge you to look carefully at the provisions respecting social and biomedical research. It leaves out a great many issues. Many of the advancements that have been made over the past several years in research have been in areas other than biomedical research. We clearly need an understanding there.

But there are so many key social issues that you need to consider.

You have heard about the parent groups. These kinds of issues are important to their efforts. So I urge you to look at that before you make final decisions.

The formula grants I have mentioned are of a special concern to us, whether they are considered in their current form or in some other form, or whether the block grant replaces them. But whatever mechanism we develop, the principle they represent is vital to continued progress in the field of alcohol and drug abuse. It represents an ongoing dialog. It is more than the passage of money from the Federal coffers and the State coffers. It permits the establishment of national and Federal policies, utilizing modern management structures in State government.

The dialog brings in a great deal of money in addition to the formula grant money, both from State legislatures and from local sources.

The block grant proposal, quite frankly, needs a great deal of policy refinement if it is intended to fill some of the gaps which repeal of the formula grant program will create. Here I am talking about more of a difference in level of funds. I think you will find

the States willing and able to match programs with lesser amounts of money.

It does appear, both in terms of Federal revenues and State revenues, that that is going to be a political imperative. Maybe the answer is in a smaller block. I do not know. Maybe the answer is in the recommendation of specific language.

We presume that the State alcohol and drug abuse authorities will continue to make the thrust in the alcohol and drug abuse areas. I think, however, the greatest gap is in the extent to which the block grant would reduce or eliminate the visible role the Federal Government has played, as far as services are concerned, over the past decade. I think that role which has been successful in the past is not finished.

An issue of great concern is how the dollars authorized in the block grant legislation will be divided among the States. When we ask this question everyone runs away.

What kind of formula is going to be used, based on what a State received before? Actually, at this point, no one knows what each State had before. How can we achieve a transition without inadvertently making people unnecessarily suffer is really the challenge I think we must face with respect to the block grants.

My experience, as I know all of my colleagues at the State and local levels, has been that the stigma that this Nation has historically placed on the victim transcends those individuals and is also applied to the advocates, to the agencies that provide them services. It is possible that the alcohol and drug abuse programs will receive more than a 25-percent funding cut.

When we compete with child and maternal health care, that stigma plays a role in policy decisions. I am not suggesting that one is more important than the other. I am suggesting that the 40- or 50-year history of great turmoil with respect to alcohol and drug abuse programs is beginning to take its toll in the competition that will occur among the States for a much, much smaller piece of the pie.

It is possible that elimination of the present regulation and categorical planning requirements may result in a 5- to 8-percent cost savings, though this is an optimistic estimate. This cost savings is certainly not large enough to balance the 25-percent reduction in available funds, especially when adjusted for inflation.

The State of Michigan, with respect to its $12 or $13 million, interacts with the Federal Government with about 10 or 11 different groups. A certain amount of cost savings will clearly occur when these are all consolidated into one.

I would hope we might look at some other levels of consolidation as an interim measure toward the large block grants, because the rest of the proposed reduction in funds beyond that 8- to 10-percent savings is simply going to have to come out of local services. There is not any other alternative. With that reduction, the leadership staff at most State agencies is going to be right down to the bare bones; it is going to be very difficult for us to manage under that circumstance.

In closing, I would like to stress the vital importance of this subcommittee looking at an appropriate Federal role for the Government to continue to play over a long period of time; it is vital.

There are numerous components which make up this necessary Federal role.

One is to provide categorical leadership and visibility; that does not have to mean, clearly, the continuation of all the categorical grant programs. But if the Federal Government does not provide that categorical leadership and visibility, I can promise you, Mr. Chairman, that the social importance which has been applied to these fields over the past 5 years will diminish in the face of competition. We will lose much of our ability to respond to the very serious problems and, quite frankly, many of the very fine opportunities that were represented in the earlier panel of testimony.

A second element I hope will be a modern management and a cost-effective approach to the problems of alcoholism and drug abuse. Maybe the current structure needs to be refined or streamlined. I think it probably could through some consolidations, and so forth. But, clearly, I think the responsibility for that rests most effectively with the Federal Government.

Third, the Federal Government needs to assure that a comprehensive approach, even if it is reduced, is continued nationwide; comprehensiveness in the sense that it includes the components of research, training, treatment, prevention, knowledge development, and so on and so forth; comprehensive in the sense that it has the ability to bring in the resources, human and funding, of the health care system, the rehabilitation system, social services, highway safety, and on and on.

This involves many agencies of the Federal Government, like the Department of Transportation; Health and Human Services; in some cases, the Department of Defense; the Veterans' Administration. A White House role is imperative and strong leadership is necessary.

A fourth component is strong Federal and State participation. I am deeply afraid that if we quickly throw the Federal role out, we are going to lose what has been so valuable in that partnership.

Fifth, a close partnership between the public and private sectors, private, in my view, being defined as parent groups such as the one we heard this morning, the volunteers, and the private business sector.

Accountability for the use of public funds is another component no matter where they are appropriated, so that the Nation can see what progress we are making in these fields.

If those elements can be continued, I think we can continue the progress of our partnership and continue its maturation. We hope the subcommittee can assist in developing those kinds of proposals. If we can review the block grant and refine it, perhaps that is a reasonable approach, or other refinements may be necessary. I think the transition is very important so that we do not let people fall through the cracks as a result of the vicissitudes of the legislative and political procedures that we are all destined to go through both at the Federal level and, quite honestly, at the State legislative level.

Let us watch carefully so that the people do not suffer from the rapid change or the radical change that we are likely to go through.

80-616 O—81——17

I think I will stop with that, Senator, and ask my colleagues if they might make their remarks.

[The prepared statement of Mr. Eaton and responses to questions follows:]

TESTIMONY OF

KENNETH L. EATON
ADMINISTRATOR
MICHIGAN OFFICE OF SUBSTANCE ABUSE SERVICES

and

CHAIRMAN
LEGISLATIVE COMMITTEE
NATIONAL ASSOCIATION OF STATE ALCOHOL
AND DRUG ABUSE DIRECTORS

before the

COMMITTEE ON LABOR AND HUMAN RESOURCES

SUBCOMMITTEE ON ALCOHOLISM AND DRUG ABUSE

UNITED STATES SENATE

on

S. 755 TO REAUTHORIZE THE FEDERAL ALCOHOL
AND DRUG ABUSE PROGRAMS

MARCH 30, 1981

INTRODUCTION

Mr. Chairman, I am pleased to appear before the Subcommittee on Alcoholism and Drug Abuse today on behalf of the National Association of State Alcohol and Drug Abuse Directors (NASADAD). NASADAD is a non-profit organization whose membership is comprised exclusively of the officially designated State authorities for alcoholism and drug abuse treatment and prevention. With me today are Joseph Diament, Director of the Office of Alcohol and Drug Abuse Prevention, Concord, New Hampshire and Donald J. McConnell, Executive Director of the Connecticut Alcohol and Drug Abuse Council. In addition to this formal statement each of us is prepared to present a brief summary of the situation in our respective States and of concerns with the proposed reauthorization legislation. Each of us will be pleased to answer any questions that the Subcommittee wishes to pose to the State Directors at this time. Also, if you require additional data, we will be pleased to submit any such data for the record.

THE CURRENT APPROACH TO ALCOHOL AND DRUG ABUSE SERVICES

Federal-State Partnership

The State Alcoholism Authorities and the Single State Agencies for Drug Abuse Prevention were created by the States in response to Congressional action in the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 and the Drug Abuse Prevention and Treatment Act of 1972 respectively to have sole responsibility in the State to plan and administer a Statewide alcoholism and/or drug abuse service prevention and treatment network.

The Federal Government's initial efforts were to provide national leadership and to stimulate State and local government participation in the development of a well-coordinated and comprehensive alcoholism and drug abuse service delivery system. Although a Federal-State partnership has been developed and preserved over the past decade, the role each level of government plays has changed over the years. When this partnership was initiated, most State alcoholism authorities and State drug abuse agencies were generally small, had limited authority and low visibility within their State governments, and State and local financial support of community based service programs was very limited with the notable exception of a few States. Today, the State agency's role in the Federal-State partnership has evolved into one of strong advocacy for State and locally supported alcoholism and drug abuse community programs.

The States have also dramatically increased their share of the financial burden. In fiscal year 1980, the States provided more than $350 million of State-derived revenue for alcoholism services. This is more than double the total NIAAA budget for that year. In the same fiscal period, the States spent approximately $325 million of State revenue for drug abuse treatment and prevention activities. This exceeded the NIDA budget for that period by over $50 million.

While the Federal government was the major resource provider in the provision of alcoholism and drug abuse prevention and treatment services over a decade ago, the States' portion of the money provided for needed services has increased to the point where the States' contribution far exceeds that of the Federal government.

Continued maintenance of the Federal-State partnership is of particular concern to NASADAD. Although the States are assuming an ever-increasing share of the burden for the provision of alcohol and drug abuse services, an appropriate Federal contribution to the cost of maintaining this service network is necessary for its continued stabilization and growth. States should not have to bear the total burden without continued Federal support. It is necessary to maintain the partnership to maximize effectiveness.

Formula Grants and Uniform Act Grants

An important part of the Federal-State partnership in alcohol and drug abuse services is the formula grant program. In addition, for the alcohol field the Uniform Act Grant Program represents another key Federal-State effort. The formula grant program provides funding to the States based on a formula that is determined by several population and income factors as well as by estimates of the extent of the alcohol or drug abuse problem in the State. In fiscal year 1979 the formula grant program provided $97.8 million to the States to use within the categorical areas of alcohol or drug abuse as the States saw fit. For fiscal year 1980 that amount was reduced by $4 million. For the current fiscal year there is presently a rescission request before the Congress, which would rescind the $80 million provided by Congress for these programs under the current continuing resolution which provides funding for HHS. In fact, Congress provided $80 million for the FY 81 alcohol and drug abuse formula grant program after President Carter had earlier requested total elimination of the program. In addition, for those States which have passed the Uniform Act decriminalizing public inebriation (currently more than three fifths of the States) funding has been provided based on the respective State's formula grant award for a period of up to six years to assist in implementation of that Act.

The planning guidelines for alcohol/drug abuse programs have been minimal, although in each successive renewal of the two programs the Congress has added more subject areas for the States to consider. It is especially worth noting that, although there are some areas in which the planning requirements for alcohol and drugs are duplicated, many of these areas have been eliminated in recent years in response to Congressional inquiries and requests from the States since many submit combined alcohol/drug abuse plans. By far the largest amount of money provided under the formula grant programs is used to provide either direct services at the community level or to provide back up State level services, with State dollars thereby being freed for community-based services. In many States the formula grant program has enabled a State agency to seek other State funding and has provided the base for a program that has grown in strength over the past decade. Federal requirements for planning have assured that formula funds, other Federal funds and State funds have been spent in a manner which is truly responsive to community needs. Although at times some States have felt that some details of Federal requirements are unduly burdensome, overall the States' experience with the formula grant programs has been a positive one. To discontinue the program would be a mistake.

It is especially important to note that continuing the formula grant program is the only way the Federal government can assure that there is a focal point for attention to alcohol and to drug abuse in State government. The formula grant program includes the requirement that there be a designated State agency with central responsibility for assuring that there are systems of services in the States. If these agencies disappear, there is danger that the funding available for alcohol and drug abuse services may be spent in response to political pressures only and distributed in a scatter shot approach without the areas or communities in greatest need receiving attention first.

Statewide Services Grants

The National Institute on Drug Abuse today provides its treatment funding almost exclusively through Statewide services grants which are administered by the State drug abuse authority. There are a few directly funded NIDA grants still providing treatment services, but all are scheduled to be administered by the Single State Agency for drug abuse within the current year. The concept of a Statewide funding mechanism, with the SSA responsible for assuring that programs meet quality standards, is one that has been implemented by NIDA since the mid-1970's. This systematic approach has assured that States provide State funds as well as garnering community funds to meet the required 40% match. It has enabled States to move funds from one geographic or programmatic area to another in response to need and it has enabled States to deal effecively with individual service providers who are not providing adequate services or not meeting appropriate standards. Federal standards for services have always provided necessary direction, and many States have substituted their own, often higher standards, for the Federal ones.

Thus the drug abuse treatment network is one which is truly a system rather than simply a collection of unlinked, individually funded programs. Although there are some general public health service contract and grant requirements which the States have to meet, and which at times are burdensome, many of them have been reduced over time. The current need that the States now have is for greater flexibility in the use of this money so that those States which desire to allocate more of their funding for prevention and early intervention activities and can do so while in other States money needed for treatment and rehabilitation, can be so concentrated. The system could be further improved by moving toward greater recognition that State government agencies are accountable, just as Federal government agencies are, and thus do not need the kind of close grant or contract requirements and monitoring that private organizations may need. The Cooperative Agreements Act provided a mechanism for this reduction of red tape, but implementation and guidance from both the Office of Management and Budget and the Public Health Service have unfortunately been slow.

In response to requests from the States, based in part on the NIDA experience, NIAAA recently instituted a Statewide Services Demonstration effort for Federally funded alcoholism programs. The five States in which this program is presently operating receive funds directly for alcoholism service programs in their State and are building the same kind of system for alcoholism services which has been built over the past decade for drug abuse. There is presently no set minimum level for Federal contribution to total program costs, and that lack has discouraged some from participating on this program. Although this effort has only been in operation for about one year and NIAAA currently is evaluating the program, NIAAA has already been impressed enough with the success of the

program that it has gone ahead with an alcoholism services grant announcement which will encourage States, as well as appropriate local governments, to gather together service providers in their area under a large single grant, reduce administrative costs and build service systems appropriate to the need of the State or the community. NASADAD believes that NIAAA should be provided funding to continue to encourage this important system building effort.

Other Partnership Areas

In addition to these major partnerships both NIAAA and NIDA have provided funding directly to State agencies in the areas of training and prevention. State based training systems and prevention programs, have been developed by the State Agencies. NIAAA has in the past provided funding for occupational program consultants to the States to encourage these important programs through the State agencies as well. Continual support for clinical training is necessary to assure that the systems developed by the States with Federal assistance do not become lost investments.

Overall, it is clear that there are details of the current Federal-State partnership that NASADAD and individual States would like improved and even changed to recognize more fully the role and capabilities of the States, but a viable, growing and successful partnership does exist. That partnership enables funds for alcohol and drug abuse to be spent without fraud and abuse in the most effective and appropriate manner possible, and should continue to be encouraged. To combine funds within a larger block grant may destroy some of the State level partners and result in fewer services to those clients who cost our society ever increasing sums of money.

THE PROPOSALS IN S. 755

Reauthorization of NIAAA and NIDA

NASADAD is pleased at the introduction of S. 755 to provide for the continuation of both the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the National Institute on Drug Abuse (NIDA). There are several sections of the bill with which we have some concerns, however.

Need for a Three Year Re-authorization

A proposed three year re-authorization, with an additional contingency year, for both NIAAA and NIDA is needed to provide continuity and stability in both fields. The present Congressional budget process requires that authorizing action be taken by May 15th in order for the program to be included in the regular appropriations process for the next fiscal year. The early deadlines imposed by that schedule require authorization legislation to be carried out early in the Congressional session so that supplemental appropriations can be avoided and program stability assured. We are faced with this situation at the present time.

A multi-year re-authorization will enable the Institutes to conduct long range planning activities for a stable system and will not limit this subcommittee in any way from holding appropriate oversight hearings. In fact, a multi-year reauthorization will enable the Subcommittee to carry more complete oversight without pressures of reauthorization deadlines.

Uniform Act Continuation

NASADAD fully supports the continuation of the special grants for implementation of the Uniform Alcoholism and Intoxication Act. This incentive program has been successful in 32 States where the State legislatures have passed legislation decriminalizing public drunkenness and and diverting the public inebriate from the criminal justice system to the treatment system. The Federal government should collect limited information from the States on this program so that the Congress may be adequately informed of its success.

Demonstration Project Grants and Contracts

The proposed continuation for NIAAA and NIDA demonstration project grants and contracts programs is generally supported by NASADAD. These demonstration grants and contracts can be of extreme importance to the alcohol and drug abuse fields; hopefully they provide model prevention and treatment programs to serve nationally identified underserved populations, and conduct evaluations. However, because they are demonstration programs, NASADAD feels they should be fully-funded, at least initially, with a declining Federal share over a multi-year period. A declining Federal share of funding thus would require a demonstration program to obtain additional State or local community support over several years. If the program is able to demonstrate a capability to successfully meet the needs of the community, its costs will be assumed by a State or local public or private entity. Starting at the 75% funding level would not, however, make it possible for many programs to demonstrate their success.

Because State agencies have frequently been leaders in the alcohol and drug abuse fields, NASADAD feels that States should continue to be eligible to apply for demonstration funds. The Senate bill, as proposed, would not only prohibit the State alcohol and/or drug agency from applying for demonstration funds, but also would prohibit State universities and medical schools from making such applications. State operated local programs would also be so prohibited. In order to assure the broadest possible competition and therefore the best possible use of Federal demonstration dollars and matching funds, State entities should be allowed to compete for these funds. NASADAD is pleased that your proposed legislation will allow demonstration projects to cross the categorical lines which too often are drawn between alcohol and drug abuse. Since those who use them excessively or inappropriately often do not make such a distinction, Federal funding should also not draw such strict lines.

Prevention Set-Aside

NASADAD is supportive of a requirement that a certain percentage of each services grant to a State be used for alcohol and drug abuse prevention; however, the 25% setside for demonstration grants is questionable. Given the relatively limited authorization of funding for demonstration efforts (and Uniform Act grants in the case of NIAAA), there should be no limits on how such demonstration funds are used. Rather there should be a requirement that such funds be spent to enhance research findings and to respond to service needs, whether the area is prevention, treatment and rehabilitation, or some other.

Research

NASADAD supports the explicit research authorizations included in the proposed legislation for the Federal alcohol and drug abuse program. This inclusion of the authorizations in the proposed renewal legislation reflects the recognition of Congress that the research activities are an integral component of the Federal alcohol and drug abuse effort. NASADAD requests, however, that a clarification of the scope of research authority to include more than simply biomedical research be refected in the legislation. The Federal alcohol and drug abuse research activities need to conduct appropriate assessments and evaluations of treatment and prevention and to assure that mechanisms for distributing these research results are implemented so the results will be available to the service providing community. Technical assistance, training support, training manuals and Federal clearinghouses should all be part of the research effort.

In clarifying that research is more than simply biomedical research, it is appropriate especially for the alcohol and drug abuse field that applied research activities be continued. Without social research into the causes and methods of prevention for particular population groups who have alcohol and drug abuse problems, it would have been impossible for the progress which has been made to have occurred. Alcohol and drug abuse are complex health problems and social services problems and future efforts should not be limited. Any attempt which would force research activities to neglect the social aspects of alcoholism and drug abuse is inappropriate and short-sighted; just as it would be inappropriate to spend funds exclusively on social research areas and neglect the biomedical aspects of these diseases. NASADAD recognizes that there perhaps have been individual social research projects which were inappropriate, but it believes that the amount spent and the extent of these inappropriate projects has been limited. Thus NASADAD encourages this Subcommittee to state clearly its support for continuing social research. It is not only proper; it is also necessary when one is dealing with alcohol and drug abuse.

Formula Grant Programs

NASADAD notes with special concern that the proposed bill, by leaving to the block grant, funding for services and not continuing the formula grant programs in NIAAA and NIDA, it is also eliminating the requirement that States designate a focal point within the State government to deal with these important areas. The requirement that a State agency be designated for alcoholism and that one be designated for drug abuse does not limit States' organizational flexibility. Today most States have combined the two areas into a single organizational unit. In some States the director is chosen directly by the Governor, while in other States the unit is in a larger department, perhaps a health and social services agency, a department of health or a department of mental health. Other States have continued the pattern of maintaining two separate agencies with different locations for each within the State government. Thus, it is clear that there is great flexibility for State governors and legislatures within the present system. It is important, however, that a State level focus be maintained. It is therefore NASADAD's request that there be a State designated focal point for the problems of dealing with alcohol and drug abuse.

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Other Authorities Repealed

The bill before the Subcommittee, S. 755 proposes repeal of other authorities in addition to the formula grant program. Since these are not yet definitive legislative proposals for the much discussed consolidated block grants, it would be better to leave existing authorities in place. When the proposals are enacted by the Congress, there will be a need for an orderly transition period. After that transfer is completed, existing sections of the law which are not longer needed can be repealed. Meanwhile it is important not to cause unintended disruptions of alcohol and drug abuse services if unexpected delays occur.

Reauthorization Levels Proposed

NASADAD notes the amounts proposed for reauthorization in this one year proposal are somewhat limited. For NIAAA in particular only $20 million is proposed for both demonstrations and for the Uniform Act incentive program. Such a level of funding would mean that there would be either very few demonstrations or that those States eligible to receive Uniform Act funding would receive such small amounts of money per State that there would be little incentive to pass the legislation. Given that States have typically incurred much great costs of implementation of the Uniform Act than the amounts provided by Uniform Act grants, it seems that the $20 million authorization level proposed is much too small - especially if it is desired to promote effectively Uniform Act passage and to fund demonstration projects. If a multi-year reauthorization is contemplated it is even more important that this amount be increased. For NIDA the $20 million authorization level proposed for demonstrations would severely limit efforts to develop systems that can assure more effective treatment and prevention activities. Again, if a multi-year reauthorization is contemplated this amount should be much larger.

The research authorizations -- $25 million for NIAAA and $50 million for NIDA -- are also severely limited. Although they do cover the amounts proposed by the Administration for next fiscal year, they barely do so. For NIAAA the $25 million level does not take into account a recent report by the National Academy of Science's Institute of Medicine which recommends that research funding in alcoholism be significantly increased over the next several years. For both Institutes the levels proposed do little to take into account the impact which inflation has had on research activities in the two Institutes over the past years. Thus NASADAD recommends a mult-year reauthorization for both research programs with authorization levels sufficient to allow expansion of both intramural and extramural research activities, including national research centers.

FUNDING FOR SERVICES

The Administration's Proposed Block Grant

The President's proposal to combine more than a dozen health programs, including alcohol and drug abuse, into a health services block grant is of great concern to members of NASADAD. Also of concern is the 25% proposed reduction in available funds. Although specific legislation has not been released for the Administration's proposal, NASADAD expects the proposal to have a serious impact on the delivery of alcoholism and drug abuse services.

State Alcoholism Authorities and Single State Agencies for Drug Abuse Prevention will be required to compete with representatives of many other health and social service programs in the State budget process. If the State alcohol or drug abuse authority is a well developed, integral component of the State system and has a good relationship with the Governor's office, then the program may be able to obtain an amount of Federal funding equal to or slightly more than present levels. However, even if the alcohol and drug abuse constituency has a well-respected relationship with a current Governor, there may be other programs which may be at a certain time more important. For example, the Black Lung Benefit program might be currently a higher priority in some States where the coal miners have threatened to strike if the program funds are reduced. Fuel assistance may be a need in other States. Alcohol and drug abuse services could be drastically affected in such a situation. The Federal categorical programs have been the catalyst for the State programs. If the catalyst disappears there is always the danger that the State level programs, which it made initially possible, will disappear also.

Impact on States of Consolidation

Historically separate alcohol and drug programs in many of the States as well as on the Federal level were established to assure adequate attention to these areas. The disability area to which they were often assigned did not pay in some States adequate attention to the needs of alcoholics and drug abusers, inappropriate treatment was tried and then frequently only domiciliary care was provided. Therefore, separate programs were established. Due to the historical reasons, consolidation of State alcohol and drug abuse Federal funding with a multitude of other worthy service areas is not something which State directors look forward to in most States. Even in those States in which the alcohol and drug areas have strong support and can now reasonably expect to get a share of any Federal funding equal to or even increased from that which they are presently receiving, such support is unlikely to be a permanent feature of the alcohol and drug abuse fields. A consolidated health service block grant will increase the instability of funding for programs which are still developing.

Although alcoholism has become more respectable and at times has even been used, according to some, as an inappropriate excuse and justification for illegal acts, drug abuse, particularly use of heroin and other opiates, does not have such limited respectability. It is also worth noting that even the respectability of alcoholism is only comparative; those who have publicly admitted their alcoholism without losing public respect are frequently individuals for whom there is already broad public respect for other good reasons. For many, alcoholics, as well as drug abusers, especially

those who are treated in publicly funded programs, the stigma of the disease is still great. Thus the political support at the State level, faced with fierce competition with other disability areas that are more respectable, is likely to be temporal.

The disadvantage with which alcohol and drug abuse would have to begin a competition on the State level for reduced Federal funds can be readily seen by examining Federal policy. The two are not treated in either Medicare or Medicaid on the same basis as other health problems. Rather they are seen as subsets of mental health, an area which is itself discriminated against by low lifetime ceilings of payment, by requiring higher percentage co-payments than for other areas, and by ommission as a mandatory service area. Also, except in those States which have prohibited such discrimination, alcohol and drug abuse are often not covered by private health insurance plans. Broad social service programs, such as those funded by Title XX of the Social Security Act, also do not explicitly require that the victims of alcohol and drug abuse be provided assistance, although they do prohibit discrimination.

Support for some alcohol treatment services is rapidly increasing, but for other types of treatment and for other activities such as prevention services, continued public support is needed for several years. In comparison, support for non-categorical drug abuse services is limited. The issue is not one of lack of trust of State level decisions. When the alcohol and drug abuse fields can compete for public funds to provide only specialized services or assistance to limited groups on an equal footing with other health and social service areas, they will be happy to do so.

In short, the proposed health services block grant consolidation could result in eliminating the programs in a few States, badly crippling the programs in other States as well as setting the stage for a constant, continuing battle for survival with at best barely adequate funding levels, in most States. A smaller block with percentages set aside for each of the service areas included but still leaving State discretion for at least a portion of the money would be better for the alcohol and drug abuse fields.

Impact of 25 Percent Reductions

This continuing battle must be viewed along with the proposed 25% reduction in funds. The Administration's assumption that the cost-savings associated with the proposed regulations and program requirements will balance the 25% reduction in funds also does not apply in the alcoholism and drug abuse systems. NASADAD does not anticipate that most Federal requirements will be discontinued by the States. Expenses associated with these required activities will continue, with the States assuming total costs either from their own resources or by reducing funds available for services. These required activities include:

Planning - The Statewide service delivery network is one which requires extensive coordination and planning to assure wise allocation of resources. Federal funds assist States in this effort. Constant revision of the plan and identification of new, locally identified needs will and must continue.

Program Monitoring - Monitoring of programs to assure the provision of appropriate, cost-efficient and quality services will continue. This requirement is an integral part of the State system and assures citizens of quality services. States presently provide funding for these efforts, the Federal portion supplements the State effort.

Fiscal Reporting - Common sense leads us to believe the Federal government will continue to require the documentation of how Federal funds are being spent by the State. Certainly State governments will in any case.

Client Data Reporting - This is possibly one of the greatest sources of information to treatment and prevention service providers, planners and administrators. Increase in the incidence of abuse of a particular drug are first reported in this data. Increases in adolescent alcoholism and information necessary for prevention are also collected in this reporting system. If Federal funds are deleted or reduced the data reporting system may have to be dismantled. National, regional and Statewide trends of abuse will not be unveiled. For adequate planning and accountability, such reporting must be continued.

It is possible that elimination of the present regulation and categorical planning requirements may result in a 5 - 8 % cost-savings, although this is an optimistic estimate. States now spend slightly more than 8% of their own and formula grant funds for planning. Much of that would have to continue, and, although Federal requirements in other areas would produce some cost savings, the total amount would certainly not approach 25%. This small savings, when balanced against the proposed 25% reduction in available service dollars would result in a one-sixth decrease in dollars available (plus inflation) to a fragile network of alcohol and drug abuse services.

It is worth briefly noting that the proposed 25% reduction is apparently an arbitrary figure. Two years ago, under a previous Administration's proposal to combine funds for grants to States in the alcohol, drug abuse and mental health fields, the reduction proposed was only 10%. Less than two months ago, until other budgetary considerations changed, the figure was 20%. No calculations of the current costs to the States and the communities of the Federal requirements proposed for elimination have been presented. No evidence of consideration that the Federal requirements may, at least in part, be ones which States will wish to continue with only minor modifications has been offered. There has not even been a gross estimate of potential savings. There has only been a general assertion that there will be cost savings and the announcement that a 25% reduction is necessary.

Without any evidence to the contrary and given that many of the areas now Federally required will have to be continued by State programs of alcohol and drug abuse, the only conclusion is that services will suffer with a reduction in Federal dollars. Fewer persons will be treated in alcoholism and drug abuse programs and there will be fewer prevention programs. Many of these individuals will end up costing the taxpayers more money, either through ending up in more expensive health care delivery systems which could be headed off if early service had been provided, or by being involved in accidents or criminal behavior which harm themselves as well as others. Fewer services will mean more less productivity and tax losses in the short and long run.

APPROPRIATE ROLE FOR THE FEDERAL GOVERNMENT

It is necessary for accountability that those who vote to authorize and appropriate the money - you, the members of Congress - should know how that money is spent and what services it purchases. Thus a reporting and information system, planning to assure wise allocations and fiscal accountability are necessary. The Federal government should use common definitions and collect information, as well as promote such planning.

An appropriate Federal role will continue a strong partnership in providing services, in demonstrating programs to develop new treatment and prevention techniques, in providing training support, not only in research areas but also in clinical areas, and in doing basic research which then can be refined in demonstrations. The Federal government should also continue to be clearly involved in the provision of technical assistance to the State programs, making information available about clinical issues and management issues.

The major responsibility of the two Institutes should be in the areas of stabilizing service funding, research, demonstrations, training support, and technical assistance support. Services management should be largely the responsibility of the States. The Institutes cannot be crippled, for there should continue to be a national program, with national level information services available, with national priorities set in terms of types of prevention and treatment services and target groups to be served. It is NASADAD's perference that the Institutes continue to be involved in all these areas, including funding agencies for the services managed by the States. By tying together research, demonstration, training support, and technical assistance support with the funding authority for service delivery, the most appropriate, effective, and efficient services can be rendered to the clients of alcohol and drug programs.

Tying the package together in a categorical fashion assures that we will not return to the problem era when alcoholics were stigmatized and admitted to hospitals only after many years of drinking and after their physical health had gone to the point where they needed expensive care either from injuries due to accidents, gastrointestinal problems or cirrhosis.

Drug abuse should continue as a categorical program with recognition that it is a health and social service problem that needs treatment throughout the country, with Federal support. Even more, it should not be returned to the days when drug abuse was seen primarily, if not only, as a problem for law enforcement. It is imperative that the Congress assure that the White House continues to be involved in drug abuse in order to promote greater coordination of law enforcement efforts with those in prevention and treatment.

If both the Congress and the Administration provide appropriate Federal leadership, then we in the States, in a continuing partnership can assure them these problems are limited, and with adequate resources, perhaps even reduced.

Than you for the opportunity to present this statement. I will be happy to answer any questions.

National Association of State Alcohol and Drug Abuse Directors

President
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April 14, 1981

Response to Questions submitted to Kenneth Eaton, Administrator, Office of Substance Abuse Services, Regarding Hearing March 30, 1981, Reauthorization of Drug Abuse Prevention, Treatment and Rehabilitation Act.

Question 1: Testimony received by the Subcommittee expressed a fear that private treatment programs now receiving federal funds would not be funded if alcohol and drug abuse treatment funds were given to the states through a block grant mechanism. Instead, only state-run programs would be funded. This sounds like a possible conflict of interest. Could you comment on this?

Response: In my view there are two aspects to this question although neither of them constitutes what I consider a conflict of interest. Both in fact are integral parts of a block grant approach for Federal funds going to State governments. As I understand the Administration proposal, it is entirely possible that all of the funding would go to State run primary health care centers providing outpatient services or maternal and child health centers providing outpatient services. Even within a more limited alcohol, drug abuse and mental health block, it is possible that a State run mental health program providing outpatient services would be funded before private programs, including those in the alcohol and drug abuse fields, would receive any funding. Similarly, funding could go to city or county run programs before private programs. The prohibition on using funds for construction purposes or for inpatient services, except those allowed by the Secretary would effectively prevent massive amounts of funding being used for State mental institutions, however.

The second aspect of the concern relates not so much to the block mechanism as to the proposal that the total funding for the block be reduced by 25 percent from current levels. With such a cut, which clearly will be much greater than any savings, it is entirely possible that some States will choose those categories in the block where there are State run programs for funding first. Areas, such as alcohol and drug abuse, in which most of the services are now provided by private, community based programs, would be low in the State's priority for funding and as a result would receive cuts even greater than 25 percent.

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Question 2: NASADAD's prepared testimony emphasized the importance of a continued White House involvement in the area of drug abuse. Could you expand on this?

Response: It is especially important that there be a White House focal point for drug abuse activities and perhaps alcohol as well, given the proposed diminished authority for the National Institute on Alcohol Abuse and Alcoholism and the National Institute on Drug Abuse. Without a focal point for Federal leadership at an appropriately high level, it is likely that drug abuse efforts in particular could suffer. There is a need for White House level coordination to assure that both domestic and international law enforcement efforts are coordinated with one another to intercept and stop the flow of illicit drugs into this country. Likewise there is a need for Federal programs that provide social services and training for employment to be coordinated with treatment services. Such needed Cabinet level coordination can only be accomplished by the White House.

In the past it has also been important for the Congress to be able to get answers across bureaucratic jurisdictional lines from someone in the White House with coordination responsibility. Without such coordination, it is very likely that important areas will somehow fall between the cracks.

Question 3: The Subcommittee is interested in your testimony with regard to the need for continued social science research. What specific questions, in your view, still need to be answered through social research?

Response: One area in which there needs to be continued social research is that discussed in your hearing on the alcohol programs -- employee assistance programs. The cost effectiveness of these programs need to be thoroughly demonstrated to assure that private employers will carry out appropriate, well-designed programs so that the burden does not fall so heavily on the taxpayer. In addition, the area of prevention which I see as a most important area during the decade of the 80's, needs further social research. Issues such as what kind of prevention programs work best with groups such as the elderly - whom we are learning have increasing alcohol as well as drug abuse problems that are very different from our stereotypes of alcohol and drug problems - raise questions which can be answered only through appropriately designed social research efforts. Treatment improvements require social research as well as biomedical efforts. The way drug abuse and patterns of alcohol misuse change over time are also important topics for social research if both private and public programs are to be effective in dealing with these problems. I recognize that social research projects can be inappropriate, just as biomedical ones can be, however, now is not the time, to use the standard cliche, to "throw the baby out with the bath water".

Question 4: You mentioned that the States would like specially earmarked money to do demonstration projects. Why would it not be possible for States to use some of the block grant money for those kinds of projects?

Response: Although it would be possible for the States to use some of the block grant money for demonstration efforts, that money particularly, with a 25 percent reduction, is going to be already over-committed to simply continuing existing services. There is ample evidence from the past that if States are to be expected

to fund demonstration projects after Federal funding has run out, it is necessary for the States' to be involved financially from the beginning. Thus States should not be excluded by law from competing with others for demonstration funds, though certainly States should not have demonstration funds earmarked especially for them.

In addition, some demonstration programs are designed to develop models for replication throughout the country. State universities, State medical schools and other types of State entities that do both social and biomedical research should be permitted to apply for demonstration funds so better prevention, rehabilitation, and treatment programs can be developed in ways that will be beneficial to private and public sectors throughout the country.

Senator HUMPHREY. Mr. Eaton, thank you for that comprehensive statement.

May I inquire—we are getting into a real time problem here, I think—how much time do you anticipate using, Mr. McConnell, for your opening statement?

Mr. McCONNELL. Pardon me, Senator, could you repeat the question please?

Senator HUMPHREY. How much time do you need for your opening statement?

Mr. McCONNELL. For my opening statement?

Senator HUMPHREY. Yes.

Mr. McCONNELL. I hope I can keep it within 5 or 6 minutes.

Senator HUMPHREY. Mr. Diament?

Mr. DIAMENT. The same, Senator.

Senator HUMPHREY. Thank you. Will you proceed, please?

Mr. McCONNELL. Thank you, Senator, for this opportunity. It is a pleasure to be here today.

My name is Donald J. McConnell and I am the executive director of the Connecticut Alcohol and Drug Abuse Commission; it is the combined single State agency in Connecticut that deals with alcohol and drug abuse treatment, rehabilitation, prevention, and education programs. I am also a board member of NASADAD and the former first vice president of that organization.

I am presently serving as director of region 1, which includes all New England States. So, rather than taking a global look at the country and the Federal Government as Mr. Eaton has done, I would like to direct my remarks specifically to the New England States. Also, because I am located in Connecticut—and if you are in the lower half, you are a Yankee fan; if you are in the upper half, a Boston fan—I am involved with the tristate effort on drug abuse, which includes New Jersey and New York.

I would like to address three issues. Mr. Eaton has addressed them in his statement and I will specify them to the Northeast region. First, the formula grant rescission, because I cannot divorce that from the block grant and the reauthorization of the institutes. Second would be the block grants and the impact that the 25-percent cut would have on our States in the New England region and also the tristate area. Third is the reauthorization of the National Institute of Drug Abuse and the National Institute of Alcohol Abuse and Alcoholism.

The formula grant rescission for fiscal year 1980-81, in my opinion, makes no sense, considering the way the administration is moving. Formula grant funds are the states' discretionary moneys, and the only discretionary moneys the States have left. In moving

toward a block grant, the administration wants the States to have more discretion.

The fiscal year 1981 formula grant moneys have been planned for, have been programed, and have been approved and budgeted for this fiscal year, yet we have not received them. At this time in a State's fiscal year, there is no possibility of finding new moneys to replace what, in Connecticut, would be $1.5 million.

I was happy to see that you, Senator Humphrey, are sympathetic to this situation. In a letter recently sent by you to one of our State's program directors in New Britain, you called these cuts odd. I quote:

> It is evident that you consider the formula funds of tremendous importance. It appears odd to me that it is always the formula funds with the fewest strings attached that are threatened rather than those funds over which the federal government has the greatest control.

I could not agree with you more. They have been threatened by rescission three times. We have these proposals for rescission twice, and here we are back at the same table again. I realize that this may be a little bit out of your subcommittee's area right now, but it is so important to the issues you are dealing with.

In short, we need these formula grant funds, and we need them as soon as possible. Congress, I am sure, appreciates this more than OMB, and it is our Senators and our Representatives who must bring some sense to this confusion, as you have done before, and as I ask you to do again.

With that, I will close my remarks on the formula grant moneys.

Senator HUMPHREY. Thank you.

Mr. McCONNELL. But I would like to mention the block grant and then, finally, the reauthorization, if you will.

Senator HUMPHREY. Fine.

Mr. McCONNELL. On the block grant proposals, I see many dangers and pitfalls and much unnecessary infighting and competition among human service professionals perpetrated by this global concept of the block grant. Furthermore the confusion surrounding the block grant proposal now is perpetrating a lot of paranoia.

States have different problems, and hence have, and will have, different priorities. Thus, if there is to be a block grant, or four block grants, as we hear being proposed at thus time, such grants should be earmarked, lest the people we deal with, the last on the ladder in most States, be forgotten. If we do not have these block grants earmarked, we are in trouble.

For instance, Governor O'Neill called a meeting of the State agency heads last Thursday and presented to us the total impact of the Federal cuts that are expected in Connecticut on various human and social programs.

We are to lose in Connecticut $258 million in health and social funds, and that means, right off the top, that 770 State employees will be laid off. This is in a State that is now facing a deficit of over $50 million.

I suggest that in this regard, if the block grants are to become a reality, as seems likely, that the moneys within the blocks are earmarked and are not reduced by 25-percent, but allocated to the States at the present level of funding or a bit higher. Some States are in trouble with their own deficits.

I took a brief survey, and I will make this very brief, of the New England States and what the 25 percent cuts in the block grants will mean to us. In Connecticut, we will lose $2.5 million; 33 of my State staff will be laid off in a single State agency; 16 treatment programs serving 8,263 clients will probably have to close; 10 prevention programs and early intervention programs reaching over 2,500 people will definitely close. These programs depend completely on this money that will be cut; mainly the formula grant, and if that goes this year, they go out of business July 1 or October 1. I do not think that the other funds will flow quickly enough to keep them open.

In Massachusetts, I was told by the State director that these funds are used for a variety of programs, and was presented with an outline of the program in Massachusetts. In any given fiscal year, the Massachusetts director states, 15,262 people are served. With the cuts, it will mean a drastic negative effect on the system, and of the approximately 15,000 people reached, at least 10,000 of them will no longer be served. He also talked about the 2.5-percent cap in Massachusetts and what effect this is having in the State. There, of course, Massachusetts loses $1.8 million in these types of programs.

In Vermont, summarizing the comments of the State Director, residential capacity is cut in half; the prevention and education effort wiped out; and emergency crises responses are reduced or eliminated.

In Maine, according to the State Director, three staff will be laid off at the State level, which is most of the administrative personnel in Maine's single State agency; and there will also be significant reductions in five regional councils. Of seven prevention projects, four will be eliminated and three will be decreased. These projects are presently serving a total of 6,200 young people. In the statewide service area, there are 700 people served in five programs. If the 25 percent cut takes effect, these programs will be reduced by 20 or 25 percent and at least one contractor of the five will go out of business; that is, if they get any money at all for drugs and alcohol in the State of Maine on a block grant basis. This said the State director from Maine is an indication of what is happening to some of our colleagues out there.

In the State of Rhode Island, nine staff will be laid off at the State level in the single State agency, and they are not a big single State agency. There will be a cut of approximately 180 treatment slots in the drug field; and 3,290 clients currently served in treatment and prevention programs will no longer receive services.

I will leave New Hampshire to Mr. Diament's statement, having presented to you the other five New England States and the impact of a 25-percent cut that we are looking at.

Finally, my colleagues from New Jersey and New York wanted me to reiterate that at times of stress in our society, and unemployment, double-digit inflation, et cetera, admissions to our drug and alcohol programs increase. Besides these variables, we in the Northeast are facing a heroin outbreak right now that has been in existence for over a year. It is worse than what we saw in the late 1960's and early 1970's.

I have been in this work, Senator, for the last 12 years at various levels, in the Department of Corrections, in a university setting, and now as a single State agency director. This heroin crisis has been with us for a while, maybe 18 months. Our local Drug Enforcement Administration officials tell us that it will be with us for quite some time in the future and that they cannot predict how long.

This outbreak, or epidemic, as some people call it, has had a terrific impact on our treatment system and our criminal justice system. Our drug-free residential facilities in the Northeast are full. All of our methadone clinics in New York, New Jersey, and Connecticut have waiting lists of as long as 3 months, and 3 weeks to get detoxed from heroin. The people could be dead in that time, as they wait and continue to shoot up.

In the Connecticut criminal justice system—right now, we have an overcrowding in our jails that is critical. Of the inmates, 63 percent are there for drug-related crimes, and cannot be taken out on transfers and given treatment. Though there is some treatment service in the criminal justice system, neither is there much, nor is it the environment in which to give treatment most of the time.

Our families and our schools are in crisis and they are crying for help to prevent substance abuse and to cut down on the demand. We have to keep these people healthy.

So, I submit to you, in conclusion, that this is not the time to rescind or to cut moneys in the drug and alcohol field nor to dismantle a system that has taken over 10 years to build. It is also highly questionable in this time of crisis as to whether this system should be thrown into the mechanics of a nebulous block grant with very little hope that the drug and alcohol agencies will receive their fair share of the proceeds.

I thank you once again for this opportunity, and if you have any questions, of course, I will be more than happy to entertain them.

Senator HUMPHREY. Thank you.

Mr. Diament?

Mr. DIAMENT. Senator, it verges on a dream come true for me to be here this morning, especially following the distinguished and committed panel that preceded us.

In 1969, when I noted a significant group of my peers in college virtually beginning to fall by the wayside, I started a drug crisis intervention and community information program. I did that at no cost, and I got permission to do so in substitution for a course.

At that time, we experienced a situation where we begged for parental cooperation and approval. At that time, the problem simply was not known. It is, as I said, a dream come true to have the level of participation and the firm commitment that we now have in this country on the part of parents.

I would like to make my comments very brief, in deference to your time constraints and, of course, will offer myself to your staff at any time.

Senator HUMPHREY. Thank you.

Mr. DIAMENT. There are two issues that I wish to point out. One is the structural and regulatory problems that we have in State and Federal relations. We have two institutes that focus varying degrees of emphasis on research, prevention, treatment, and evalu-

ation. It is difficult for States, at times, to attune themselves to the various foci, if you will.

The planning and review process itself, at times, is quite difficult because there is a use of consultants to review State plans. Now, the idea behind that is quite meritorious. It is designed to perhaps minimize any arbitrariness on the part of Federal officials.

On the other hand, what we find at times is arbitrariness on the part of the consultants, who come from States other than the State being reviewed and really have very little understanding of the dynamics of that State. So, that creates some problems.

I wish to read one incident regarding the planning process to you, and close at that point. The example I wish to point out deals with the planning process required by the two institutes.

The State of New Hampshire, recognizing the duplication of effort inherent in having separate offices for alcohol and for drugs, combined its treatment and prevention services into one agency called the Office of Alcohol and Drug Abuse Prevention, nicknamed OADAP.

Shortly after OADAP came into existence, NIDA held a workshop to introduce the States to a new combined State plan option. A great deal of time and expense on the part of NIDA and the States transferred the knowledge of how to write such combined State plans and to deal with dozens of regulations pertaining to such a plan. These guidelines were published and promulgated by ADAMHA. These procedures required that nine copies of the combined State plan be committed to the Office of the Director of ADAMHA by July 31 of each year.

In the first week of June, we received a call from the NIAAA regional office informing us that our State plan had not been received and was overdue, since it was to be in Boston by June 1. When it was explained that this was a combined plan written according to the ADAMHA guidelines and therefore not due until July 31, we were told that we had not received approval for a combined plan review. This was a procedure not covered in either the ADAMHA guidelines nor NIDA's combined State guidelines. In fact, OADAP had received no guidelines from NIAAA concerning the combined State plan.

In order to comply with this June 1, already past deadline, we hastily completed the plan and submitted it. The copies that were sent to ADAMHA were never received by NIDA. In fact, NIDA did not even contact us concerning the fact that they had not been received until several months later. We then sent them extra copies of the plan, and a review took place in November. Shortly after that review, NIDA received the copies that had been mailed to ADAMHA 5 months after they had been received in the Parklawn Building.

This year, we wrote to NIAAA requesting permission to be reviewed as a combined State plan. Seven months later, we received a form letter from NIAAA requesting States to submit a preference as to whether or not they wished to be reviewed as a combined State plan. We once again wrote requesting a combined plan review. As of this date, the plan is completed and ready for submission, but we have not been notified as to whether it will be a combined plan review. So, in order to cover all bases, we are

sending copies of the plan to NIDA, NIAAA, the NIAAA regional office, and ADAMHA.

My point here, Senator, is not that we are opposed to planning. As a manager with graduate training in that area, I feel it is a significant part of any organization's behavior. Surely, as an executive director of an agency, however, I wish to have general guidelines and be given a mission to accomplish rather than restrictive regulations.

I thank you for your time and indulgence.

Senator HUMPHREY. Thank you, Mr. Diament. Assuming, from your standpoint, the worst and we go to the block grant—that is, that drug abuse funds are included in a health block grant, what kind of guidelines, Mr. Eaton, would you suggest? Do you have any suggestions?

Mr. EATON. There are two possible approaches, Senator. One is that it might be worthwhile giving some consideration to some slightly smaller blocks. You know, rather than just the entire health area, perhaps it would make sense to consider an alcohol, drug abuse, and mental health block as well as a health block. That would help because it would keep the services that are competing with each other more compatible.

Otherwise, I suspect one needs to look at things that will be difficult politically, such as earmarking, either proportioning amounts or sort of grandfathering in proportions for different areas based on what they have gotten in previous years.

Most of the suggestions we can come up with, I think, will run into difficulty with respect to the concept that is the thrust of the block grants. But I believe they should be tried and we would be happy to expand on those and several other possibilities.

Senator HUMPHREY. Mr. Diament, New Hampshire, like so many States, is in fiscal difficulty. What would the legislature and the Executive Department do if the drug funds come down in just a wide, broad health block grant? Would the drug programs get their due consideration? What is your guess?

Mr. DIAMENT. My guess, Senator, is that because of the current situation in New Hampshire, I think we would fare reasonably well. However, in light of the proposed budget in New Hampshire that is being discussed by the legislature at the present time, we were treated somewhat more favorably than some of the other public health programs. As a result, I believe a block grant might lead to further emphasis on supplementing those other health programs that have been neglected in the State budget with those Federal funds, so that we might lose some of our share of Federal funds.

But, overall, I think that if a block grant came into New Hampshire at the present time, my agency would get a fair shake.

Senator HUMPHREY. You feel, then, that the public awareness of the severity of drug abuse is such, at least in our State, that in the ordering of priorities, drug programs would get their fair allocation?

Mr. DIAMENT. If I remember the question, correctly, I think, that would be accurate to say of the State as a whole.

Senator HUMPHREY. Yes.

Mr. DIAMENT. I am not certain as to how it would be received in the legislature at the present time. Some occurrences over the past week in certain committees of the legislature when certain legislation on this matter came up would lead me to be concerned. However, I believe that it is that specific committee rather than the legislature as a whole.

Senator HUMPHREY. Mr. McConnell, what would happen in Connecticut under that situation?

Mr. MCCONNELL. Well, right now, we are trying to figure out, No. 1, what the State legislature will do. We are working with our Office of Policy and Management to try to get our fair share of what we had, with the 25 percent cut. I do not think we can depend on that, however, because other forces might come up.

For instance, emergency fuel funds for the elderly might take precedence. In our State, we have political constituencies that will be contacting the State legislators and the Governor. For instance, mental retardation has one of the strongest constituency movements and they always get a larger share of the funds.

I also have a little apprehension because we are separate from the department of mental health as was determined by our State legislature 3 years ago. If we had a block grant for alcohol, drugs and mental health, it might be a little cozier for us, but we will still have some infighting there.

Unfortunately, here, Senator—and we find the same thing as we go around to the Governor's Human Service Committee for hearings—we have pitted human service organizations against human service organizations, which all have valid needs. I really do not feel comfortable saying that my drug addicts and alcoholics need services more than the retarded children. This is the dilemma we are faced with here. We are not fighting the bad guys, if there are any bad guys. We are fighting all the good guys, and I feel very uncomfortable.

I feel, No. 1, that the mandated programs will receive funds first. We have very little mandated in the drug and alcohol field. In fact, we are losing out on title 18, 19 and 20; and we are getting wiped out for alcohol detoxification. So, in a sense, as far as the services we deliver, are a unique organization and there is no other place in the State where one can get treatment for drug addiction or alcohol except in our facilities.

People are going to have to see that in the state, and hopefully we will get our share of funding. But we will not be high on that ladder; we are not popular, as Mr. Eaton has said.

Senator HUMPHREY. What do you mean by "your facilities?" Are they State-operated?

Mr. MCCONNELL. No; we are a conduit. Our agency is a conduit of both federal and state funds. We have $6 million state and $5 million federal that we pour back into the communities and to the taxpayers, with very few regulations but with a good monitoring system. I would not want to see that go; however, that will go.

I do not object on a State level to the planning procedures that we have been put through. I think, sometimes, the Federal Government has to push the States to do proper planning. Unlike New Hampshire and some other States, our planning review process has

not been all that traumatic in Connecticut; we sort of fly through that year by year.

Senator HUMPHREY. So, these are grantees. Are they private organizations or are they community, county or town or city——

Mr. MCCONNELL. We have no counties in the State of Connecticut, as you know, since Governor Ribicoff. But there are community agencies, mostly private, nonprofit agencies that we fund.

Senator HUMPHREY. Well, I am disappointed to hear that you have abolished counties because I was born in Hartford County.

Mr. MCCONNELL. I did not abolish the counties. [Laughter.]

Senator HUMPHREY. I was born in Connecticut, in Hartford County

Mr. MCCONNELL. Well, we still have Tolland County; they still have sheriffs.

Senator HUMPHREY. Mr. Diament, in New Hampshire, are the groups you fund grantees; are they private organizations?

Mr. DIAMENT. Yes, sir. Part of the reorganization that was sanctioned by the 1979 legislature in New Hampshire mandated that we convert to funding local programs rather than operating State-run services. As of July 1 of this year, the only service that will remain in State operation will be a halfway house that was willed to the State and will be run that way. All other programs are community-controlled.

Senator HUMPHREY. Mr. Eaton, I thought I heard a little implication coming through, a little implied charge by some of these parent groups that States, in general, have not been particularly supportive of parent groups. Can you address that issue?

Mr. EATON. I think the States often are supportive philosophically, Senator, but do not have the means to respond financially to their requests. They have been organized in the last year to year and a half, and they have made many requests all over the country. At the same time, we are busy closing down treatment programs because of either State budget cuts or, as I mentioned before, the State formula grant funds being consistently reduced over the last several years.

I think the problem is not the lack of a common goal or any lack of desire on our part. I am sure there are some States where the relationships are rough, but I think the goal is similar and the States would like very much to be close partners with the parent groups.

Mr. MCCONNELL. May I, Senator?

Senator HUMPHREY. Yes.

Mr. MCCONNELL. We fund some of these groups and we have about 300-some thousand dollars in prevention groups with parents concerned, et cetera. We just started a new group in the Enfield area for north central Connecticut, which takes in seven towns.

Getting back to the State system, I have gone to our State legislature and asked, "Look, if we get these formula grants rescinded, what can you do to keep this going until the block grant money comes in, even at the 25 percent cut?" They said, "What do you get?" I said a million and a half. "That is what you are losing?" "Yes." "Well, pare it down to what is absolutely essential."

As I went through it, first they cut research. I have an incidence and prevalence research project going; cut that $50,000. We have a

training system of $72,000; cut it. I did not want to go any further. They said, "What is next?" I said, "Well, how do you want to prioritize this?" They said, "We will save the money for those who are suffering." Now, that is very relative.

Next, I can talk about prevention and education programs; they said to cut them. How much of this money is going into the suffering addicts and alcoholics in treatment? So, we are back to treatment and rehabilitation, and that is where we have been as State agencies for the last 10 years. Every time we try to get up front, which is where we certainly have to get and where these parents are—and God bless them for being there; we need their support. A lot of it is being done for nothing.

The one thing I said to the Enfield group was, "If I give you money, I hope I do not ruin your effort. You will hire an executive director and your personal effort is going to go." That has not happened, but that is how the States are looking at this cut and that is where prevention is going to go—out the window.

Senator HUMPHREY. I see your point.

Well, I think in the interest of time, I am going to have to conclude at this point. Thank you very much for coming; it has been very helpful.

Mr. EATON. Thank you.

Mr. MCCONNELL. Thank you.

Senator HUMPHREY. I appreciate your patience in waiting your turn.

[Introductory remarks to questions and responses and prepared statement of Mr. Diament follows:]

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State of New Hampshire

DEPARTMENT OF HEALTH AND WELFARE
OFFICE OF ALCOHOL AND DRUG ABUSE PREVENTION

HAZEN DRIVE
CONCORD NEW HAMPSHIRE 03301

April 13, 1981

Senate Committee on Labor and
Human Resources
4230 Dirksen Building
Washington, DC 20510

I have reviewed the text of my testimony and have indicated the minor corrections that are necessary. I suppose I should always remember that I speak quickly, thereby making transcription difficult.

Your letter of April 6 asked two questions. My response to the first question is really a form of clarification of my statement. In my testimony I indicated that priority-setting is an appropriate role for any government. What I meant by that statement is that if government research indicates that certain methodologies are more cost effective than others (e.g. prevention over treatment or vice-versa) government has a right to indicate that a greater priority or emphasis be given to the more cost effective modality. Thus, I was speaking of priority-setting at what may be appropriately described as the macro level. I was not suggesting the kind of specificity that would have the federal government dictating the type of therapy to be used in every outpatient program in the country. Similarly, I do not believe it to be appropriate for my agency to make similarly excessive demands on local programs.

The "modified structure of the institutes" that I referred to was essentially something akin to the New Hampshire Office of Alcohol and Drug Abuse Prevention. I suppose my bottom line would be to recommend a singular institute with functions similar to those indicated in the draft notes of your reauthorization Bill. I would, however, prefer that the funds for alcohol and drug abuse be distinctly identified and flow through this institute. The primary reason for this channel of distribution of funds is to insure dissemination of information from federal research initiatives and conversely to insure communication from the states to the institute.

Mr. James M. Powell, Editor
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In closing, I wish to thank you and Senator Humphrey for the opportunity to testify before your Subcommittee, and offer my continued assistance at your pleasure.

Sincerely,

Joseph Diament
Director

JD/bc
Enclosure

CC: Henry R. Desmarais, M.D.
Majority Staff Director
Subcommittee on Alcoholism and Drug Abuse

Testimony of Joseph Diament submitted to United States Senate's Sub-committee on Alcoholism and Drug Abuse, Senator Gordon Humphrey, Chairman.

March 30, 1981 Hearing on the Reauthorization of the National Institute on Drug Abuse.

Mr. Chairman, Honorable Senators, my name is Joseph Diament and I am Director of the New Hampshire Office of Alcohol and Drug Abuse Prevention. The latter is the Single State Agency for Drug Abuse and the State Alcohol Authority. I am deeply honored and pleased to have this opportunity to address this august body. My statement will cover the following topics:

1. A summary of the situation in New Hampshire
2. My perceptions of structural problems with the current National Institute
3. Examples of difficulties posed by federal regulations, and
4. Suggestion of a role for the federal government in this area

During its 1979 session, the New Hampshire legislature authorized the merger of two distinct agencies into the one I currently head. This enabled an efficient unified effort to combat alcohol and drug abuse. Within about one year the new agency was able to increase funding of community programs by more than 70% without an increase in total appropriation. This was done by elimination of poor management practices, combining administrative support functions, and shifting ultimate service design and delivery to community based organizations.

While recognizing that certain epidemiological distinctions remain between alcohol and drug abuse, we feel that the service technology is sufficiently similar to warrant the single agency at the state level. I respectfully submit that at least some of New Hampshire's experience may be applicable to the federal level.

Structural Problems at the Federal Level

Presently, New Hampshire must adhere to regulations promulgated by two Institutes. This is made particularly difficult by the Institutes' varying degrees of emphasis on research, prevention, treatment, education, evaluation, and other systemic components. The planning process is particularly cumbersome and confusing. In recent years, the Department of Health and Human Services has allowed the combination of alcohol, drug abuse, and/or mental health plans. Yet New Hampshire's combined alcohol and drug abuse plan is reviewed seperately, at different times and locations.

The plans and grant review process is another example of structural difficulties. Both Institutes utilize review panels under varying conditions and formats. In an effort to avoid arbitrary decision making, "outside consultants" are often used to review state documents. While meritorious in its intent, this mechanism has often yielded very poor results. That is, States may not be subject to arbitrary actions on the part of Institute staff, but are subject to such actions on the part of consultants. I hasten to add that periodic improvements in the review mechanism are made, but the basic lack of familiarity with local issues exists. A further structural flow exists in the very simple fact that separate federal mandates require New Hampshire to report on at least a quarterly basis on nearly a dozen funding documents. This occurs despite the fact that there are only two institutes and one master plan of action submitted by the State.

Difficulties with Federal Regulations

There are several examples of regulatory problems. I shall briefly describe some of them and offer one glaring example. P.L. 96-181 amending P.L. 92-255 attempted to direct the Secretary's attention to the needs of rural states. However, to my knowledge, there have been no changes in the funding formula for Section 409 which would address the nuances of rural states or sparsely settled regions of larger states.

Further, no provision is made to adequately adjust other funding mechanisms to meet the needs of this special under served group. On pages 2759-60 of the discussion of P.L. 96-181, there is considerable discussion concerning the needs of the elderly. This is further stressed in Section 410. The Federal Funding Criteria are structured so as to eliminate from eligibility for treatment, the most common forms of drug abuse among the elderly and other special population groups.

NIDA has promulgated regulations requiring a 90% utilization level for Section 410 treatment slots. While New Hampshire applauds NIDA for developing a system for measuring performance and proper use of federal funds, we are troubled by the apparent lack of sensitivity to rural programs. For a large urban program (e.g. 200 slots), a 10% cut represents about one staff person who may be layed off. For New Hampshire programs which typically range from 5-25 slots, a 10% reduction in mid-year is traumatic. Bear in mind that New Hampshire's entire slot allocation is smaller than some single urban programs.

The final example I wish to point out again deals with the planning process required by the two Institutes. The State of New Hampshire, recognizing the duplication of effort inherent in having separate office for alcohol and for drugs, combined its treatment and prevention services into one agency called the Office of Alcohol and Drug Abuse Prevention (OADAP). Shortly after OADAP came into existence, NIDA held a workshop as part of a series of regional workshops held across the country to introduce to the states a new State Plan option, the "Combined Alcohol and Drug Abuse State Plan." A great deal of time and expense on the part of NIDA and the states transferred the knowledge of how to write such a combined state plan and to deal with dozens of regulations pertaining to such a plan. These guidelines were published and promulgated by ADAMHA. These procedures required that 9 copies of the combined plan be submitted to the Office of the Director of ADAMHA by July 31 of each year.

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The first week in June we received a call from the NIAAA office in Boston, informing us that our State Plan had not been received and that it had been due in Boston June 1. When it was explained that this was a combined plan written according to the ADAMHA guidelines, therefore not due until July 31, we were told that we had not received approval for a combined plan review. This was a procedure not covered in either the ADAMHA guidelines or NIDA's combined state plan guidelines. In fact, OADAP had received no guidelines from NIAAA concerning the combined state plan.

In order to comply with this time constraint, we hastily completed the plan and submitted it. The copies that were sent to ADAMHA were never received by NIDA. In fact, NIDA did not even contact us concerning the fact that they had not received the plan until several months later. We then sent them extra copies of the plan and the review occurred at the end of November. Shortly thereafter, NIDA received the copies that had been mailed to ADAMHA, five months after they had arrived in the Parklawn Building.

This year we wrote NIAAA requesting a combined plan review. Several months later we received a form letter from NIAAA requesting states to submit a preference as to whether or not they wanted a combined or separate plan review. We, once again, wrote requesting a combined plan review. As of this date, the plan is completed, and ready for submission, but, we have not been notified as to whether it will be a combined plan review. So, in order to cover all bases, we are sending copies of the plan to NIDA, NIAAA, the NIAAA Regional Office and to ADAMHA.

Please note that New Hampshire is not suggesting the elimination of strategic planning. We recognize that planning is vital in any organization's behavior. I simply ask to be treated as an executive who is given a mission, asked to strategize accomplishing that mission, and is held accountable for his success or failure. I believe that a good executive functions best with general rather than restrictive criteria. Despite the series of difficulties detailed in this statement, New Hampshire believes that the Institutes do share a common goal with the State. For the most part, day to day problems are resolved in a reasonable manner.

The difficulty arises when the problems stem from structural or regulatory issues.

Suggestions for a Federal Role

Because substance abuse and chemical dependence are problems that transcend geographic boundaries, and affect vital components of our national fabric (industry, military, families, etc.), we feel that there is a very definite need for federal involvement. This involvement must be on both the supply control or law enforcement side and demand reduction side, which means prevention and treatment. This involvement should be governed by the view that the tasks of government, any government, are primarily priority setting, funding, quality assurance, technical assistance (technology transfer) research and evaluation.

Congress has already established alcohol and drug abuse as a priority. However, New Hampshire sees the federal role as further establsihing what relative emphasis research, prevention and education, treatment, and rehabilitation should receive. The specific design and implementation of prevention, treatment and rehabilitation programs should lie at the State level. Research, being both expensive and often times generic, should be ongoing and federally managed. States may well be the laboratory settings, but, not the managers of the experiments.

This leads into the notion of the block grants. New Hampshire strongly favors combining alcohol and drug abuse funds. We would prefer to have these funds flow through a modified structure of the Institutes. The primary reason for this is to insure that the knowledge developed at the federal level, either through research or the collection of information on demonstration projects, is systematically linked to the flow of program funds. As is clear from my testimony, we do want regulatory relief, but we do not wish to lose the positive attributes of the Institutes.

This statement was prepared with the understanding that this Committee wishes to hear from many people and time is short. I wish to thank you for affording me this opportunity. I shall make my self available to your staff at any time.

Respectfully,

Joseph Diament, Director

Senator HUMPHREY. The next panel, if they are still here, is comprised of Mr. Richard Pruss, president of Therapeutic Communities of America, which is an umbrella group of non-profit, residential, drug-free treatment agencies, including Odyssey House and Marathon House, in New Hampshire; Mr. Robert Smedes, president of Project Rehab, Grand Rapids, Mich., a treatment facility, who is appearing at the special request of Senator Riegle; and Ms. Carol Marcus, codirector of the PYRAMID project, and vice president of the Pacific Institute for Research and Evaluation. PYRAMID is a national prevention technical assistance and information sharing program funded by the National Institute on Drug Abuse.

Good afternoon, welcome, and thank you for your patience. Have you agreed on an order of testimony? Well, Mr. Pruss is going to go first.

Mr. Pruss, will you lead off?

Mr. PRUSS. Yes, thank you.

Senator HUMPHREY. If possible, summarize your statement.

STATEMENT OF RICHARD PRUSS, PRESIDENT, THERAPEUTIC COMMUNITIES OF AMERICA, AND EXECUTIVE DIRECTOR, SAMARITAN HALFWAY SOCIETY, FOREST HILLS, N.Y.; ROBERT SMEDES, PRESIDENT, PROJECT REHAB, GRAND RAPIDS, MICH.; AND CAROL MARCUS, CODIRECTOR, PYRAMID PROJECT, AND VICE PRESIDENT, PACIFIC INSTITUTE FOR RESEARCH AND EVALUATION, A PANEL

Mr. PRUSS. As I have been sitting here, I have been summarizing more and more.

Mr. Chairman, I would like to thank you for this opportunity to testify. I am Richard Pruss and I am president of Therapeutic Communities of America, which is a volunteer consortium representing not-for-profit, residential, drug-free treatment agencies from coast to coast. I am also executive director of the Samaritan Halfway Society, a multimodality drug abuse prevention and treatment agency located in Queens County, N.Y.

At his press conference on March 6, President Reagan responded to the following question. "Mr. President, in light of what appears to be growing concern about the drug abuse problem, especially among teenagers, what will your priorities be, and specifically, do you expect to have White House policy on drug abuse?"

The answer to that question was, "Yes, I do and, in fact, it can be stated as clearly as this: I think this is one of the gravest problems facing us internally in the United States. I envision whatever I can do at a national level to try and launch a campaign nationwide because I think we are running the risk of losing a great part of a whole generation if we do not."

We were heartened by both President Reagan's comments on a national campaign against drug abuse, and also by the congressional findings at the beginning of your reauthorization legislation for title II, "Drug Abuse Prevention, Treatment and Rehabilitation," which states, "The Congress finds that drug abuse is a serious national problem requiring a Federal response."

Although it was mentioned before, I think that before focusing on the concept of block grants and what that Federal response will be, it is essential that I too emphasize that since fiscal year 1979,

substance abuse has lost approximately 20 percent of its funding, if the pending rescission goes into effect.

In addition to that, when placed in the block grant with a reduction of 25 percent, we find ourselves losing as much as 45 percent of the drug funding. I am talking specifically about two categories and that is the money that affects the private, not-for-profit provider; it is both the formula money, the 409 money, and the 410 money, which is community service grants from NIDA. That amount was $201 million in fiscal year 1979.

If we enter fiscal year 1982 with a 25-percent reduction in the block grant, we will receive approximately $120 million. That is a devastating cut in the services which we will be able to provide.

We fear that the proposed placement of drug abuse into a block grant with as many as 40 health providers will have a devastating impact on the national war on drugs, which must continue as a national war.

State militias are not called to the defense of the Nation; neither can the States do more than participate in a partnership with the Federal Government in our Nation's war on drugs.

Drug abuse, Senator, is a contagious disease, and if smallpox or black plague broke out in a section of the country, I doubt very much that the Federal Government would allow the States to take action with an appropriate response. I think that the Federal Government would act in partnership with the States.

Similarly, I would question whether the work of the DEA or the FBI should be transferred to State and local police, but instead continue to work in a partnership. Drug abuse treatment and prevention requires a Federal response.

Unfortunately, there is still a commonly held misconception that drug abuse is a problem only of the inner-cities and that drug abuse relates only to heroin addicts wandering ghetto streets. It is just that; it is a misconception. The tragic fact is that heroin and polydrug abuse continue to invade rural, suburban, and urban areas.

Heroin addiction, as stated earlier, is increasing. In 1979, the U.S. Department of Justice, DEA Administrator's Office of Intelligence, published a report entitled "Middle Eastern Heroin Intelligence Assessment: Operation Cerebus." Further, in July of 1980, Senator Joseph Biden testified before the Committee on Foreign Relations and Committee on the Judiciary on the "Sicilian Connection: Southwest Asian Heroin En Route to the United States." What these reports and testimony reiterate is the following:

The heroin epidemic of the late 1960's and early 1970's, which resulted in the addiction of 700,000 U.S. citizens, was caused by the production of 80 metric tons of opium per year from Turkey. In 1979, the illicit opium production in Iran, Pakistan and Afghanistan was estimated, conservatively, at 1,600 metric tons—20 times the amount produced in Turkey.

This heroin has already reached and saturated the European market. West Germany, which had nine heroin overdose deaths in 1969, had 447 in the first 9 months of 1979. This heroin has hit the streets of the United States. I was given some statistics from New York State, and several other States have similar statistics.

From January through September 1980, heroin emergency room episodes show an increase of 141 percent. A year ago, the average purity of street heroin was between 3- and 5-percent. From August through October of 1980, the purity of heroin analyzed ranged from 6- to 7-percent. The price of heroin on the street is down 10 to 15 percent. Prison detoxification admissions rose 30 percent.

As stated previously, residential drug-free programs, methodone maintenance programs, and detox programs are at or above 100 percent of capacity and there are substantial waiting lists.

A terrifying and disruptive factor in communities across the country is the ever-increasing specter of crime—violent steet crimes which threaten all members of society is particularly paralyzing to the elderly, who are often less able to defend themselves.

In a recent study conducted by several Temple University researchers, it was found that over a period of 11 years, 243 male addicts committed more than 500,000 crimes. They have also found that when these same addicts were off drugs, their crime rate plunged 84 percent. In an interview, Dr. John Ball, one of the authors, said he was surprised by both the sheer volume of the crime for which the addicts were responsible and by the marked difference in crime rates for an addict while on and off drugs.

I think that I have to add at this point my surprise and consternation when I made this report and discussed this report with some Members of the Congress and the initial response was, "Well, then, perhaps our approach should be the legalization of heroin to avoid the crime problem."

Aside from a feeling of indignation on my part, which I managed to control, and moral outrage, I also know that the legalization of heroin would not be a successful response. Those who receive legal heroin will still seek street heroin and continue to commit crimes.

Senator Biden said that this new study strongly supports the theory that Southwestern Asian heroin now streaming into the United States contributes to the recent increase in property crime rates in east coast cities. He warned that budget cuts proposed for DEA and federally financed drug treatment programs would make the problem even worse.

The yearly cost of street crime based on 100 addicts is, conservatively, $9 million. Equally alarming to all of us, of course, is the rise in polydrug abuse. It permeates all socioeconomic strata in our society. The substances of abuse go far beyond heroin, including marihuana, cocaine, barbiturates, amphetamines, very often mixed with alcohol and a variety of prescription drugs, many of which are physically more harmful than heroin and psychologically as devastating.

One of our member agencies, Odyssey House located in New Hampshire, reported the following. Their program treats in excess of 200 adolescents per year. The average age is 15.5 years of age. The most popular drugs are marihuana, LSD, amphetamines, barbiturates, and cocaine. The devastating impact of drug abuse on our youth, families, and communities has far-reaching effects. Surveys repeatedly indicate that the American family considers drug abuse one of the major threats to the survival of family life and to the very structure of the family as we know it.

The American public is also extremely concerned with the ability of the United States to defend itself militarily. The problem of addiction within the Armed Forces is widespread and could possibly undermine our military readiness. Between 40 and 60 percent of all residents in drug treatment programs are males between the age of 18 and 24.

It is noteworthy that the sources of heroin entering the United States include Afghanistan and Pakistan. A recent Department of Defense survey indicates that marihuana and alcohol abuse are continuing to rise throughout the Armed Forces.

There is an alternative to drug abuse and the resulting crime, threat to national defense, and devastation to American family life. The Republican platform recognized that alternative with the following statement:

> Private, nonprofit drug abuse rehabilitation agencies have taken the lead in fighting drug abuse and they deserve greater cooperation and flexibility from Federal, State, and local agencies and grant programs.

Therapeutic communities are devoted to a drug-free self-help model which is geared toward fostering independence and reintegrating individuals back into the productive mainstream of society. In addition, as private providers, we pride ourselves on cost-saving and cost-conscious efforts in the field of drug abuse.

In a recent review of eight of our member agencies, the following was revealed. In 1979, approximately 355 individuals graduated from those programs.

Senator HUMPHREY. Excuse me, Mr. Pruss. How much more time are you going to need?

Mr. PRUSS. Let me conclude in approximately one minute, Senator, OK?

Senator HUMPHREY. Yes, thank you.

Mr. PRUSS. I am very sorry.

Senator HUMPHREY. That is quite all right. I know you feel very strongly about what you have to say, but you have already been speaking, for 15 minutes and if we give each of the others 15 minutes, we will be here all day.

Mr. PRUSS. My apologies. In fact, I would rather answer questions from you.

Senator HUMPHREY. OK, fine; thank you.

Mr. PRUSS. If I can just point up our concern with regard to the block grants. Drug abuse is not a popular subject. Being thrown into a block grant with 40 other health providers will, in fact, be devastating.

Another problem we face is as a private, not-for-profit provider. Many States give money to counties which also run their own drug abuse treatment programs. Generally, those programs are less effective and always more costly than those that are undertaken by the private, not-for-profit providers.

However, most of our colleagues have to apply to those counties for funding. In fact, what we have is a situation of a conflict of interest. Does the county keep its own bureaucracy going, or do they give to the private provider, even if that provider is far more cost effective and shows much better results?

We would favor categorical funding. We think that the State partnership through the single State agency and NIDA is an excel-

lent partnership. If that is not possible, we see potential in a single-item block grant going to the States, but only with some type of language indicating the utilization of the private, not-for-profit sector. If not, many of our agencies will be frozen out, and it would be a great loss because we are far more cost effective and far more efficient in what we do.

Senator HUMPHREY. Well, it is a good point because in trying to transfer responsibilities away from Washington, we are trying to eliminate some of the bureaucracy. And if all we are going to do is transfer it to another bureaucracy, we are not getting too far.

Mr. PRUSS. Fifty.

[The prepared statement of Mr. Pruss follows:]

TESTIMONY OF

RICHARD PRUSS

PRESIDENT

THERAPEUTIC COMMUNITIES OF AMERICA

AND

EXECUTIVE DIRECTOR

SAMARITAN HALFWAY SOCIETY, FOREST HILLS, N.Y.

SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES

SENATE SUBCOMMITTEE ON ALCOHOLISM AND DRUG ABUSE

REAUTHORIZATION LEGISLATION

FOR THE

NATIONAL INSTITUTE ON DRUG ABUSE

MARCH 30, 1981

Mr. Chairman, members of this prestigious body, I am grateful for this opportunity to testify.

My name is Richard Pruss, I am President of Therapeutic Communities of America, a volunteer consortium representing not-for-profit residential drug-free treatment agencies, from coast to coast, which are effectively treating people who were once abusing drugs: legal and illegal drugs, costly and cheap drugs, all of them damaging when misused and some of them brutally deadly.

I am also Executive Director of the Samaritan Halfway Society, a multi-modality drug abuse prevention and treatment agency located in Queens County, New York. I can, therefore, offer the committee special perspectives on our work both nationally and at the community level, and I appreciate your invitation to share information with you.

At his press conference on March 6, 1981, President Reagan responded to the following question:

"Q. Mr. President, in light of what appears to be a growing concern about the drug abuse problems, especially among teenagers, what will your priorities be and specifically, do you expect to have a White House policy on drug abuse?."

"A. Yes, I do, and in fact it can be stated as clearly as this: I think this is one of the gravest problems facing us internally in the United States.

"I've had people talk to me about increased efforts to head off the export into the United States of drugs from neighboring nations. With borders like ours, that as the main method of halting the drug problem in America is virtually impossible; it's like carrying water in a sieve.

"It is my belief -- firm belief -- that the answer to the drug problem comes through winning over the users to the point that we take the customers away from the drugs, not take the drugs necessarily -- try that, of course you don't let up on that. But it's far more effective if you take the customers away than if you try to take the drugs away from those who want to be customers.

"And I envision, whatever we can do at the national level, to try and launch a campaign nationwide. Because I think we're running the risk of losing a great part of a whole generation if we don't."

We are heartened both by President Reagan's commitment to a national campaign against drug abuse and also by the "Congressional Findings" at the beginning of your re-authorization legislation for Title II - Drug Abuse Prevention, Treatment and Rehabilitation which states:

"The Congress finds that --

"(1) drug abuse is a serious national problem requiring a Federal response;

"(2) drug abuse impairs the physical and psychological well-being of individuals, and thereby leads to an unfortunate waste of human talent and energy; and

"(3) drug abuse interferes with education, work, and interpersonal relationships, causing great harm to families, communities, and the Nation."

One of our fears at this time is that the proposed placement of drug abuse into a block grant with as many as 40 health providers will have a devastating impact on the national war on drugs which must continue. State militias are not called upon by Washington to provide our national defense, neither can the states do more than participate in a partnership with the Federal government in our nation's war on drugs.

Let me preface my next remarks with this: the commonly held misconception that drug abuse is a problem of the inner city and drug abusers are heroin addicts wandering ghetto streets is just that -- a misconception. The tragic fact is: drug abuse continues to invade our rural, suburban and urban areas.

Our large national constituency is often reluctant to identify itself due to the strong social stigma and shame associated with drug abuse. We have to contend, every day, with the prejudice, the suspicion and, in some cases, the hostility that drug-treatment programs face on the community, county and state level.

First, I will address the issue of heroin. In 1979 the United States Department of Justice, Drug Enforcement Administrator's Office of Intelligence published a report entitled "Middle Eastern Heroin Intelligence Assessment: Operation Cerebus". Further, in July of 1980, Senator Joseph R. Biden testified before the Committee on Foreign Relations and Committee on the Judiciary on the "Sicilian Connection: Southwest Asian heroin enroute to the United States." What these reports and testimony reiterate is the following:

The heroin epidemic of the 1960's and 1970's, which resulted in the addiction of 700,000 U.S. citizens, was caused by the production of 80 metric tons of opium per year in Turkey. In 1979, the illicit opium production in Iran, Pakistan and Afghanistan was estimated conservatively at 1600 metric tons -- 20 times the amount produced in Turkey. This heroin has already reached and saturated the European market. West Germany, which had 9 heroin overdose deaths in 1969, had 447 in the first nine months of 1979. The Los Angeles Times reported in February that: "Authorities here say that Iran has become the biggest single sources of opium trafficked in the West and in particular the U.S.". According to Interpol, "the increase in opium supplies emanating from Iran is truly alarming."

This heroin has hit the streets of United States cities, suburbs and rural areas as evidenced by the following statistics from the State of New York.

Heroin/Morphine Emergency Room Episodes

From January through September, 1980, the episodes show an increase of 141 percent over the comparable period in 1979.

Purity of "Street" Heroin

A year ago the average purity was between three and five percent. From August through October of 1980 the purity of heroin analyzed ranged from six to seven percent.

Street Price of Heroin

The average street price has declined between 10-15%.

Prison Detoxification

Admissions rose 30 percent in the first nine months of 1980 compared to the same period in 1979.

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Treatment Admissions With Heroin as Primary Drug of Abuse

Between 1978 and 1979 heroin admissions increased 26 percent (from 18,644 to 23,464). Through the first quarter of 1980 heroin admissions continued to climb until the capacity to accept additional clients was reached. Waiting lists now exist in methadone maintenance, residential drug-free and ambulatory detoxification programs. Currently the lists number more than 1000 persons. Our programs are operating at or above 100% of capacity.

Equally alarming is the rise in poly-drug abuse, permeating all socio-economic stratas of our society. The substances of abuse go far beyond heroin, including marijuana, cocaine, barbituates, amphetamines, often mixed with alcohol and a variety of prescription drugs. Many of which are physically more harmful than heroin and psychologically more devastating.

One of our member agencies, located in New Hampshire reported the following: Their program treats in excess of 200 adolescents per year, with the average age of 15½. The most popular drugs are marijuana, LSD, amphetamines, barbituates and cocaine.

The devastating impact of drug abuse on our youth, families and communities in the United States has far-reaching effects. Surveys indicate that the American family considers drug abuse one of the major threats to the survival of family life and to the very structure of the family unit as we know it.

A terrifying and disruptive factor in communities across the country is the ever-increasing specter of crime. Violent street crime, which threatens all members of society, is particularly paralyzing to the elderly who are often less able to defend themselves. In a recent study conducted by several Temple University researchers, it was found that over a period of 11 years, 243 male addicts committed more than 500,000 crimes. It also found that when these same addicts were off drugs, their crime rate plunged 84%. In an interview, Dr. John C. Ball, one of the authors, said he was surprised by both the "sheer volume of crime", for which the addicts were responsible and by the marked difference in crime rates for an addict while "on" and "off" drugs.

Senator Joseph Biden said this new study strongly supports the theory that Southwestern Asian heroin, now streaming into the United States, contribute to recent increases in property crime rates in East coast cities. He warned that budget cuts proposed for the Drug Enforcement Agency and federally financed drug treatment programs would exacerbate the problem. The yearly cost of street crime based on one hundred addicts is conservatively,$9 million.

The American public is extremely concerned with the international arms race and the ability of the United States to defend itself militarily. The problem of addiction within the armed forces is widespread, and could possibly undermine our military readiness. In fact, 40.5% of all residents in drug treatment programs are males between age 18-24. It is interesting to note that the source of the heroin entering the United States include Afghanistan, recently invaded by Russian troops and Iran, a government with a deep and abiding hatred of America. A recent Department of Defense survey indicates that marijuana and alcohol abuse are continuing to rise throughout the armed forces.

There is an alternative to drug abuse and the resulting crime, threat to national defense and devastation to the American family life. The Republican platform recognized that alternative with the following statement:

"Private, non-profit drug abuse rehabilitation agencies have taken the lead in fighting drug abuse, and they deserve greater cooperation and flexibility from federal, state and local agencies and grant programs".

Therapeutic communities are devoted to a drug-free, self-help model which is geared toward fostering independence and re-integrating individuals back into the productive mainstream of society. In addition, as private providers, we pride ourselves on our cost-saving and cost-conscious efforts in the field of drug rehabilitation. In a recent review of eight of our member programs, some startling information was revealed. In 1979 approximately 355 individuals graduated. Utilizing HHS' figures, in combination

with data provided by DEA relative to property crime and other criminal activities attributed to the untreated addict, these former addicts account for approximately $30 million annually while engaged in addiction activities. The total government contribution toward the treatment of these young men and women was barely $2 million ($6,000 per year per client). Moreover, they currently return through their combined income, based upon an average annual salary of $15,000, over $4.4 million to the economy of this nation and make a tax contribution in excess of $880,000.

I would like to discuss briefly the false economy of reducing treatment funding, using therapeutic communities as an example. The courts utilize residential drug-free treatment as an alternative to incarceration. Not only is treatment far more productive in rehabilitating our youth, but it is far less expensive than incarceration.

A survey of a sample group of National Institute on Drug Abuse funded therapeutic communities indicates that approximately one out of every three clients is mandated into a treatment program as an alternative to prison. Of 13,530 clients 4,510 are in treatment as a court mandated alternative to incarceration. Therapeutic communities are funded at a total of $6,010 per slot, per year for 24-hour residential treatment. Of that amount, the federal government contributes only $3,606 with the balance provided by other than federal funding. The total cost per year for 4,510 clients is $27,105,000. If imprisoned at $20,000 per year, the same number of individuals would cost the tax-payer $90,200,000.. Treatment saves more than lives -- it saves tax dollars.

There is a widespread misconception that drug treatment agencies do not provide prevention services. Not only do we advocate prevention, but we also find ourselves in the unfortunate position of providing the "safety net", for those individuals who fall through the cracks of the prevention system.

Drug abuse is a contagious disease. A study conducted in London indicated that one addict will "turn on" 200 new users each year. We know that the same holds true amongst adolescents abusing marijuana and other substances. A Stanford study on the phenomena

of peer pressure indicated that drug abuse among adolescents follows patterns similar to fads like long hair and bell-bottomed jeans. The study points out that if 20 children in a class are using marijuana and ten are not, the behavior of the ten children is more pathological (non-conformist) than the rest. Stated simply, it is extremely difficult for the average child or adolescent to hold up under peer pressure, and this factor is frightening given the prevalence of drug abuse in the younger age groups.

We strongly believe that by removing substance abusers from the street, classroom and work place, therapeutic communities are providing an effective form of secondary prevention. Furthermore, over 90% of our member agencies provide prevention services in the form of free community and educational activities. In your home state of New Hampshire, Mr. Chairman, one of our member agencies provide a variety of prevention services including seminars, radio/T.V. public service announcements and more than seventy speaking engagements per year in their surrounding community.

Drug abuse is a national problem of far reaching magnitude requiring a national response. A few states have joined the federal government in their effort to stem the tide. The five largest contributors to drug abuse funding: New York, California, Pennsylvania, Texas and Illinois, spend $196 million annually -- an amount equal to the entire federal appropriation for treatment/prevention services through NIDA. At the same time, Florida, a state which experiences one of the more severe drug abuse problems, contributes only 3% of the amount allocated by the federal government.

As already stated, private, not-for-profit providers of drug treatment and prevention are recognized for their cost effectiveness and efficiency. The fact that many states and counties run their own treatment programs presents serious difficulties to private providers who must submit funding applications to those very same government agencies. The result is often a conflict of interest which favors the less efficient bureaucratically run state and county programs.

We the private, community-based treatment and prevention programs make the following recommendations:

- Retention of categorical funding of drug abuse programs. If categorical funding is no longer possible, we would endorse a single purpose block grant if it included language that set forth guidelines requiring the utilization of the private sector .

- Funds should be distributed to states based on target population, not per capita population. In this respect we differ from alcoholism concerns.

- We oppose an arbitrary formula which sets a 25% minimum for prevention and recommend a reduction in that amount and a broadening of the definition to include secondary prevention.

We urge the committee to incorporate these recommendations in the re-authorization legislation. I thank you for your time and welcome any questions.

Senator HUMPHREY. Mr. Smedes?

Mr. SMEDES. Senator, I appreciate the opportunity to address you today. I am president of a private, nonprofit, charitable drug and alcohol abuse agency in Grand Rapids, Mich. We operate 125-bed residential programs for adolescent teenagers and young adults, addicts and alcoholics, in western Michigan. We also operate a prevention program that offers support and training for parent groups in our area, as well as to schools and school districts. Our prevention unit will impact on the lives of about 8,000 young adults in our high schools and junior highs this year.

Others here today have testified and can testify far better than I to the profound impact that proposed changes in Federal drug policy will have on individuals. I would like to talk a little bit and elaborate a bit on the theme that seems to be running through the administration here in Washington today—that of economic revitalization or recovery.

The administration has proposed a plan for the economic revitalization of America. It is designed to rein in inflation, spur investment and productivity of American business, reduce Government spending, and stimulate enough growth in the economy such that the total tax receipts will increase despite dramatic cuts in tax cuts.

I would like to suggest to you today that an increased Federal role in drug and alcohol abuse treatment and prevention should be a key part of any economic recovery plan that the Congress approves. An increased role in substance abuse treatment and prevention is consistent with the administration's economic goals as well as its stated policy with regard to drug and alcohol abuse.

The appropriation of Federal funds for substance treatment and prevention is not inflationary, is an investment that will increase American productivity, will reduce total government spending, and will stimulate economic growth, and increase total tax receipts.

Senator HUMPHREY. Excuse me. Will you hold? I have to take care of another matter.

[Pause.]

Senator HUMPHREY. Go ahead.

Mr. SMEDES. I would like to break down some of the statements from our single State agency into some numbers that I can understand, and I think that would be helpful in understanding what the Federal investment in drug and alcohol abuse does.

In Michigan, for every individual that successfully completes a drug abuse or alcohol abuse program, average personal income increases by approximately $2,800 a year. Federal and State funds purchase from the private sector treatment services at a cost of $700 per client. That $2,800 increase in personal income, assuming a Federal and State tax rate of 25 percent, returns $700 in tax revenues, the cost of treatment. That $700 does not take into consideration the reduced Government spending in other areas, like unemployment insurance, medicaid for health problems created by substance abuse, and corrections costs in the Federal system as well as the State system.

We would pose to you that for every 10 dollars that is spent on substance abuse—Federal dollars that are spent on substance abuse—those 10 dollars will be returned to the Government through Federal income and social security taxes. We would pose that another $20 return on that investment in reduced Government spending will occur.

Let me now address the block grant proposal that is implicit in the bill under consideration by your subcommittee. As a treatment program, I am concerned about the block grant approach, the way it is, with drug and alcohol abuse being lumped into one single block grant with all other health issues.

I am afraid that our experience in Michigan and other States would indicate that two things occur when money comes into our State governments, and particularly when it comes in lumped with so many other worthwhile causes. The stigma attached to drug and alcohol abuse does not make treatment of that disease very politically attractive.

Furthermore, drug and alcohol programing at the State level is relatively, you might say, the new kid on the block. We have not had time to develop political constituencies and the bureaucratic power of other public health and mental health efforts.

As a result, I would suggest to you that a separate block grant, lumping at least drug and alcohol into one grant, or possibly combined with mental health, makes more sense and will increase the probability that the Federal dollars appropriated for drug and alcohol abuse will reach effective treatment agencies.

In closing, let me say one thing. The American people, the taxpayers, are going to spend money on drug abuse; that is inevitable. The question then is, is the U.S. Senate and the Congress going to abrogate its responsibilities and contribute to inflation and increase Federal spending on public welfare, unemployment benefits, prisons, increased medical care and disability costs, in addition to allowing some $20 billion of lost productivity that is currently hemorrhaging out of our economy as a consequence of drug addiction across the United States, or is the U.S. Senate and the Congress going to invest in America's future through a partnership with the private sector that will help assure America's economic

revitalization and military preparedness? Mr. Chairman, the choice is yours.

Thank you.

[The prepared statement of Mr. Smedes follows:]

Project REHAB

PREPARED TESTIMONY

UNITED STATES SENATE

COMMITTEE ON LABOR AND HUMAN RESOURCES

SUBCOMMITTEE ON ALCOHOLISM AND DRUG ABUSE

MARCH 30, 1981

Robert Smedes, CPA, President
Project REHAB
200 Eastern, SE
Grand Rapids, MI 49503

Mr. Chairman, distinguished members, I appreciate the opportunity to address you today.

I am Bob Smedes, President of Project REHAB, a private, non-profit charitable health and human service agency in Grand Rapids, Michigan. Project REHAB . . .

- Provides a wide range of substance abuse prevention, treatment and rehabilitation services to individuals, families and institutions.
- Is accredited by the Joint Commission on Accreditation of Hospitals.
- Last year impacted the lives of 18,000 citizens throughout the western half of Michigan, as well as numerous businesses, schools, labor groups and other institutional clients in our communities.
- Will spend $1.5 million in 1981 on direct services to clients . . . people . . . our families . . . friends . . . associates and neighbors.
- Our services are financed through an effective partnership of the private sector - charitable contributions, client fees and activities and private insurance - with the public sector - Federal, State, and local government grants and fees.

I am also a member of Therapeutic Communities of America, a national association of over 300 drug-free residential treatment programs across America.

Others here today can testify far better than I to the profound impact that the proposed changes in Federal drug abuse policy and reductions in domestic health and social spending will have on the 10 million American citizens and their families whose lives are ravaged by substance abuse.

I would rather talk to you about. . . .

- Economic revitalization,
- Military preparedness,
- And an emerging National Crisis equal in proportion to the Energy Crisis.

The Administration has proposed a bold plan for the Economic Revitalization of America. A plan designed to

- Rein in devastating inflation,
- Spur investment in productivity of American business,
- Reduce government spending,
- Stimulate enough growth in the economy such that total tax receipts will increase despite dramatic cuts in tax rates.

I would like to suggest to you that an "increased" Federal role in substance abuse treatment and prevention should be a key part of the Economic Recovery Plan that Congress approves. An increased Federal role in substance abuse treatment and prevention is consistent with the Administration's economic goals. The appropriation of Federal funds for substance abuse treatment and prevention . . .

- Is <u>not</u> inflationary,
- <u>Is</u> an investment that will increase American productivity,
- <u>Will</u> reduce total government spending,
- <u>Will</u> stimulate economic growth and will increase total tax receipts.

Each Federal dollar spent on substance abuse treatment and prevention will return three dollars . . .

- One dollar in increased Federal and State tax receipts,
- Two dollars in
  - Reduced government spending,
  - Increased economic productivity.

Let's review the facts . . .

- Substance abuse costs America in excess of $45 BILLION annually . . . that's equal to the inflationary 1982 Federal Budget deficit proposed by President Reagan . . .

twenty billion dollars in lost production alone . . . another twenty-five billion in health care, welfare and criminal justice expenditures.

- Our experience in Michigan illustrated how an investment in substance abuse treatment can substantially reduce the inflationary drain on the economy resulting from substance abuse.

  - Over 40 unemployed, addicted Michigan citizens are returned drug free to the active work force each week,

  - The personal income of those rehabilitated workers increases by an average of $2,800 per year against an average treatment cost of $700 per client,

  - That all translates into a $56 million increase in total personal income in Michigan alone,

  - And that $56 million increase in personal income results in . . .

    * Federal income and social security tax revenues of some $14 million (more than Federal spending in Michigan for substance abuse),

    * State tax revenues of $2.5 million,

    * Reduced unemployment benefits of $3.8 million.

That's almost $20 million in increased tax revenue and reduced unemployment cost in Michigan alone . . . and we haven't even considered the other economic benefits

- Increased productivity,

- Reductions in medical and disability insurance and benefit claims,

- Reductions in public welfare costs,

- Reductions in crime and criminal justice costs.

What's the bottom line . . . a three for one return on investment . . . not bad by anyone's standards . . . and truly consistent with any Economic Revitalization Plan.

The administration has also proposed a bold new plan for regaining American military superiority, a bold plan to improve

the effectiveness and preparedness of our Armed Forces. While much of the focus has been on new military hardware and sophisticated military technology, we must remember that our National defense ultimately depends on the young Americans who operate all that sophisticated weaponry.

Those young Americans in the military and of military age have the highest prevalence of illicit drug use (well over 60%) and drug addiction. It is no secret that "drug abuse" is a way of life for all too many young airmen, soldiers and sailors.

Drug treatment and prevention must be a key part of any plan to restore American military superiority. Ultimately, the success with which we wage the war against drug addiction will determine the success of America's defense in our war against those who would take away the freedom of people around our globe.

You have before you today legislation that will change what is already working well. It seems to me that instead of applying a meat axe to Federal spending on substance abuse treatment and prevention and to the system of disbursing and administering those expenditures, you might well apply a surgeon's knife instead.

Frankly, the "Block Grant" approach to funding drug abuse treatment is frightening to us in the private sector who daily wage the war against drug abuse.

Drug treatment funds will be rolled into a single "block grant" with a myriad of other physical and mental health programs. Responsibility for deciding how much will actually be spent on drug abuse treatment will be left up to the states.

And that's where our fears begin -

- Experience indicates that many state bureaucracies are not as enlightened as the UNITED STATES SENATE . . . they don't yet realize that a dollar invested in drug treatment returns three dollars.

- Experience indicates that state and local governments are not fundamentally more efficient or effective in administering drug treatment dollars . . . In Michigan, for example, state and local government take 20 cents of every public dollar appropriated for drug treatment services to administer those services . . . the private sector spends less than 6% on administration.

- Experience indicates that states generally attempt to treat addiction in expensive, relatively ineffective government institutions rather than turning to the private sector . . . which has developed the most effective drug treatment technologies . . . and applies effective technologies to the problem at far less cost than do government run programs.

Because we believe

- That drug addiction is national in scope . . . a threat to the national security, both economic and military,

- That state and local government do not have a good track record in responding to the problem,

- That the private sector has and will continue to provide the most effective and least expensive response to drug addiction among America's young and families,

- In the key role drug treatment can play in national economic recovery and military preparedness, we propose that:

  1. NIDA be reauthorized for three years. Assurance that Federal drug abuse policy will be consistent for three years will induce further local private and public investment in drug treatment programs.

  2. $150 million in spending earmarked for drug treatment be authorized; $150 million approximates current spending on drug treatment.

  3. That NIDA contract directly with private sector drug treatment providers based on demand for drug treatment services in particular geopraphic areas . . . and based on services actually rendered at reasonable costs rather than in the form of grants that don't necessarily relate to results, as is altogether too typical of grants to state and local governments.

  4. That if the "block grant" approach is adopted

a. A separate block grant be designated for drug and alcohol treatment and prevention,

b. The "block grant" specify that the single state agency shall

- Maintain at least the current level of investment in drug and alcohol treatment services,
- Contract with the private sector for those services,

c. That the allocation of the "block grants" to the states be based on a formula that

- Reflects "need" or demand for drug treatment services; i.e., targeted to geographic areas of highest need,
- Reflects state and local efforts rather than on basis of population alone.

In summary, NIDA authorization legislation must---

- Result in stable, consistent Federal drug abuse policy over the next three years,
- Insure continuing investment in drug treatment,
- Guarantee a full partnership with the private sector . . . the most efficient and effective response to the economic drain and threat to the national security of continuing drug abuse.

I'd now like to turn for a few moments to something that frankly scares me to death . . .

A problem that will emerge during the eighties as a national crisis as serious in its consequences to the future of America as today's energy and water shortages.

I'm talking about teenage alcoholism and drug addiction. The problem is serious enough now . . . young lives being short circuited and ravaged by their addictions. But when we add up all of those personal tragedies, the problems America will face as the young of today become the adults of tomorrow are magnified

into a National Crisis . . . A SHORTAGE OF EDUCATED, MOTIVATED, HEALTHY WORKERS AND PRODUCERS . . . AND PARENTS.

Drugs including alcohol inhibit physical and mental development. Youth drug abuse results in

- Learning disability evidenced in lower test scores,
- Lost productivity,
- Lack of will and drive to succeed
- Violent criminal activity,
- Family disintegration and violence.

We know that behavior patterns that young people establish during adolescence continue into adulthood . . . and that's what's so scary.

What are the drug use patterns of our young people? From a recent study of 4,000 junior high and senior high students in Grand Rapids (results are similar to those of national studies) frightening patterns emerge . . .

- Kids in seventh grade are already using illicit drugs in alarming proportions.
  - Forty percent have used alcohol, five percent use regularly.
  - Twenty percent have used marijuana and other drugs--two percent are using marijuana daily.

These are "children" we're talking about, seventh graders.

Use increased with each grade until tenth grade when

- Seventy percent of kids are using alcohol.
- Thirty-two percent, almost one/third of all tenth, eleventh and twelth graders, are problem drinkers . . . that means they consume a lot of alcohol each time they drink . . . and they drink a lot . . . and their drinking causes problems . . . driving . . . blackouts . . . low grades . . . truancy . . . promiscuous sex . . . vandalism . . . violence . . . family problems . . .

- Fifty percent of high school kids are currently using marijuana . . .

- But even more serious . . . 25% of high school kids smoke marijuana regularly . . . at least several times a week . . . and 6% of kids smoke three or more joints per day . . . that means in an average classroom of 30 kids . . . two kids are stoned most of the time.

- Lest you think all this substance abuse occurs only in inner city schools, let me assure you that use and abuse patterns among Grand Rapids area teens cross all social and economic lines. In fact, use and abuse of the so called hard drugs, the more dangerous drugs . . . and the more expensive drugs . . . cocaine . . . tranquilizers . . . hallucinogens . . . PCP . . . amphetamines . . . barbiturates . . . and even heroin is more prevalent in the more affluent neighborhoods and suburbs of Grand Rapids and more prevalent among white children than minority children.

- Today's youth drug use isn't that innocent cigarette behind the barn or that six pack consumed with our buddies of yesteryear, it's a serious problem for our children, our nieces and nephews and our grandchildren.

- Youth drug use threatens the very quality of life that makes our country the greatest. There is something else that makes our country great . . . something that contributes to the quality of life here . . . our Federal government responds to youth drug use . . . our country in partnership with the private sector developed a quality drug treatment network to help kids get off drugs and alcohol.

Let's make sure that in our rush to reduce the Federal budget we don't destroy the Federal drug treatment and prevention program that saves our kids and will help insure our future.

Remember . . . the American People . . . tax payers are going to spend money on drug abuse . . . that is inevitable . . the question then?

- Is the United States Senate and the Congress going to abrogate its responsibility, contribute to inflation and increase government spending on
  - Public welfare,
  - Unemployment benefits,
  - Prisons,
  - Increasing medical care and disability costs

- In addition to letting $20 billion dollars of lost productivity hemorrhage out of our economy as a consequence of an ineffective response to drug addition across America?

OR

- Is the United States Senate and the Congress going to invest in America's future through a partnership with the private sector that will help assure America's
  - Economic revitalization,
  - Military preparedness . . . a continuing investment in drug abuse treatment and rehabilitation?

Mr. Chairman, distinguished members . . . THE CHOICE IS YOURS!

Senator HUMPHREY. Thank you, Mr. Smedes.

We always save the best for last, and I want to emphasize that Ms. Marcus' place in the lineup here is by no means a reflection on the importance of prevention. Perhaps by that standard, we should have had you on the first panel.

Ms. Marcus, thank you for your patience.

Ms. MARCUS. Thank you, Mr. Chairman. For however brief a moment, I am very pleased to be here and to represent prevention.

I have actually summarized my remarks to the degree that I will briefly tell you what I am not going to talk about. I was going to explain the technical assistance system, entitled "The Pyramid Project," of which I am one of the directors. But the first panel this morning mentioned the name "Pyramid" a number of times, to my delight.

Suffice it to say that all of the States, all of the territories, and many, many parent groups across the Nation use this system; they get help from it. It is a simple system; they use it, they like it, they need it.

Many programs talk about operating on very little money or no money; but money does come to these programs in the form of technical assistance through projects like Pyramid which are funded at the Federal level.

I am not going to talk about the need for applied research. I was going to talk about a program in Napa, Calif., that is taking a preliminary look at their evaluation results. These findings show prevention strategies having a significant impact on tobacco use, alcohol use, marihuana use, discipline, and academic achievement. This is one example of a program whose final analyses will likely never be done and never be disseminated across the country due to cuts in Federal spending.

Finally, I was going to talk about another national program which has encouraged more than 40 American businesses to become involved in a substantial way in prevention at the local community level, led by the Prudential Insurance Co. of America, which is surely one of the largest American corporations.

I was going to explain how important a Federal role is in initiating these kinds of programs. Let me instead refer to the first two panels and say that the parents represent what I think is one of the most important movements for prevention in many years. They need the kind of Federal programs which can support the impor-

tant work they are doing. They need the support; if they do not get it there, they do not get it anywhere.

I think the second panel of State people make it clear that in most States, people in the localities are not going to be able to turn to the States for the kind of support they need. Certainly, they will get it in terms of moral support, but in terms of the kinds of resources needed at the local level, it does not look good.

I would like to commend you, on behalf of many of the people across the country who work with Pyramid, for having placed in your bill some emphasis on prevention at the Federal level. I would like to say, however, that your proposed $5 million set-aside translates into less than one-third of the current budget needed to support the national prevention programs which I was going to describe.

I will leave it at that. Thank you.

Senator HUMPHREY. Thank you very much. What is this prevention strategy you talk of?

Ms. MARCUS. What is a prevention strategy?

Senator HUMPHREY. Yes.

Ms. MARCUS. This is a technique, a method whereby one can take a group of people and influence their attitudes and their potential behavior in terms of drug use. For example, the panel of young people were talking about peer group influence. There are peer group strategies, peer counseling strategies, family life strategies, and career strategies, among others. There are many educational techniques whereby we can influence the attitudes and the future behavior of young people in regard to drugs.

Senator HUMPHREY. I see; thank you. I wonder if you could submit for the record a little bit more detail on these various programs that you talked of.

Ms. MARCUS. I would be delighted.

Senator HUMPHREY. For my own curiosity, I would like to read about them.

Mr. Pruss, what percentage of your funds, historically over a period of years, comes from the Federal level?

Mr. PRUSS. Well, my program is located in New York State. New York has the most State dollars in comparison to the number of Federal dollars that they receive. So, approximately, 30 percent of our funding is Federal dollars at this time.

One of our problems, however, is that the reduction of the formula money which is currently utilized by the State for administration—if that money is reduced, State treatment and prevention dollars will then flow into the State administration and there will be a trickle-down effect.

The State of Florida, to my knowledge, sir—the Federal dollar represents something like 97 percent of what the private, not-for-profit provider receives; 3 percent is State money. There is a very uneven approach when you go from one State to another State; that is one of the problems.

Senator HUMPHREY. What about in Michigan, Mr. Smedes?

Mr. SMEDES. Our total budget is $1,700 million; $200,000 of that is Federal funds. Another $500,000 of that is State money and the rest is client fees, contributions, and results of client activities. It represents a substantial, important part. The Federal role has

allowed us to raise funds from the private sector. The Federal funds act as an incentive to raise private funds as well as funds committed by our local government agencies.

Senator HUMPHREY. How are people accepted into your program? There must be far more people in need of treatment than you are able to accept. How does that work?

Mr. SMEDES. That is accurate. We currently have, as I mentioned, 120 people in our residential programs; that is about 108 percent of our theoretical capacity. We have waiting lists in our teenage program of 3 to 4 months, and in our young adult program of about 2 months.

Most of our clients are in our program as an alternative to being incarcerated in a juvenile detention facility or a State prison. We work primarily at trying to intervene in the process very early on so that people are diverted from the criminal justice system into a treatment setting.

We have a strong demand for voluntary admissions into our residential adolescent program. However, because of the funding mechanism for that program, we are not able to accept those children. They must be wards of the State of Michigan prior to being accepted into our program.

Senator HUMPHREY. I see. Well, certainly, the theme of the testimony of this panel is concerned about funds continuing to flow to your organizations if we shift over to giving the States a role for apportioning these funds versus the Federal Government. So, I want you to know that I have heard what you are stressing.

Unfortunately, I have to go to the floor now; there is another matter on the floor in which I have a vital interest and they are waiting for me to come and speak. But I want to thank you for coming, and especially for your patience. It has been very enlightening and very helpful. Thank you.

Mr. SMEDES. Thank you.

Mr. PRUSS. Thank you, Senator.

[The prepared statement of Ms. Marcus follows:]

Statement by
Carol Marcus
Vice President
Pacific Institute for Research and Evaluation

Concerning
S.755
Comprehensive Alcohol and Drug Abuse Amendments
of 1981

Before the
Senate Subcommittee on Alcoholism and Drug Abuse
Gordon J. Humphrey
Chairman

March 30, 1981

Mr. Chairman and Members of the Subcommittee, I thank you for the opportunity to appear today to discuss drug abuse prevention.

I come to speak to you from a unique perspective regarding the needs of the prevention field in the coming years. I have been the Co-Director of the PYRAMID Project, a national prevention technical assistance and information sharing program for the past five years. During this time, this project, funded by the National Institute on Drug Abuse, has provided more than 4,000 days of assistance, responded to more than 10,000 requests for information, and provided countless hours of telephone consultation to literally thousands of people in the field at the State and local levels. More than 14,000 individuals and organizations receive information from PYRAMID on a regular basis.

As a result of working with individuals and program clients over the years, the staff of PYRAMID has been able to keep on top of the needs of the field as they have developed and to monitor prevention trends in schools, communities, the work place and in families. The remarks which follow are based on our experience in working with these individuals and groups. We believe that the field would be best served by addressing three points:

1) that a national program to serve State and local prevention needs is vital to the future of drug abuse prevention;
2) that a block grant mechanism is not likely to be sufficient to satisfy the needs for information, research findings, and technical assistance for most of the States;
3) that while the amendments to the Drug Abuse Prevention, Treatment, and Rehabilitation Act accommodate these needs, the proposed funding level is inadequate.

Prevention is a young field which only in the past few years has begun to show significant results. For years, prevention people came to these hearings and extolled the virtues of their programs. They talked of improving self-esteem, of increasing decision-making skills, of young people's lives being turned around, of communities and parents and educators who were seeing positive changes in their young and in their institutions. Always they were asked the question: Can you prove it works? Finally, in the last few years the answer to that question is beginning to emerge. The answer is yes. At the point in prevention history when the field is developing significant data, services, strategies, and information to have an impact on the lives of Americans, the leadership, coordination, research, and technical assistance are in jeopardy. Unlike other fields, the prevention of drug abuse is in danger of losing ground rapidly should these functions cease to exist at the Federal level.

Because of the new and dynamic nature of this field, in particular, it is essential that all States and territories and those people whom they serve be given the opportunity to benefit from cost effective national programs providing information and support which cannot be replicated at the State level. For example:

Research Findings. Only recently has the field of drug abuse prevention been able to secure sufficient funds and talent to undertake long term demonstration research programs to answer the questions of what works and where. These efforts, a small number of them currently funded by NIDA, are extremely expensive and time consuming. They demand sophisticated

techniques, and require an extensive amount of planning. It is unlikely in the scramble for funds at the State level, which has in fact already begun in the light of the repeal of 409 funds, that any State will place its sorely needed dollars in such programs. Yet the information derived from this research is the very key to solving the drug abuse problem. Research demonstration at the Federal level, on the other hand, is cost effective, and can be disseminated through a national system which enables all States, all programs to benefit from the results.

Technical Assistance. Again, in a field as young as prevention, it cannot be assumed that knowledge and expertise about this fast growing field exist at all levels and in all geographical areas. The essence of successful technical assistance involves the provision of people, information, resources, and materials to programs based on the best and the latest information and skills. A national technical assistance program has enormous advantages and cost effective factors. For example:

1) The information for dissemination to programs in a national system is a synthesis of knowledge gained throughout the country. The State of Utah can benefit directly from what has been learned in New Jersey and vice versa. And information and skills generated at the Federal level can be shared equally with all States and localities.

2) The pool of people with expertise in the needed areas for the survival and growth of prevention and the efficacy of programs can be garnered from across the United States.

A national system can locate people to provide assistance that States and localities often do not have access to, do not know of, and do not have the time or the resources to search out on their own.

3) A national system of information and technical assistance can address the needs of special populations in a cost-effective manner. It can provide the largest and the most up to date store of knowledge and skills, and make it available to those in need.

4) A national system can assure some standardization and accuracy in information and research findings dissemination.

Leadership and Coordination. At this point in time, and in the foreseeable future, national leadership and coordination is essential to ensure that drug abuse remains on the national agenda. It is the proper and fitting role of the Federal government to provide a central focus which does not lose sight of the complexities of the problem and which maintains a national framework for the effective delivery of programs to all segments of society.

This Subcommittee's proposed amendments to the Drug Abuse Prevention, Treatment, and Rehabilitation Act respond directly to those needs we have perceived through our involvement in the field. Specifically, that a Federal response is necessary -- one that is constructive, cost effective, and well coordinated; reserves appropriate and practicable authority for the States; encourages the participation of the private sector; and is truly national in scope.

The Amendments further emphasize that a high priority should be placed on prevention and intervention in the award of grants and contracts, and that such programs should emphasize technical assistance, education, training, demonstration research on new prevention techniques, with special consideration for the underserved populations.

With these criteria in mind, it has been our experience that NIDA's national prevention programs have indeed filled a number of these roles and have been widely supported by the field as essential to the goal of reducing the abuse of drugs.

For example, in addition to the technical assistance efforts of PYRAMID, NIDA has sponsored a State Prevention Coordinator Program, providing a staff position at each State agency to coordinate prevention activities. These State employees, called SPC's have been crucial in supporting the development and maintenance of prevention programs in their States. The vast majority of States did not support such a position before the NIDA program, and it seems unlikely that these positions and funds would remain intact if the NIDA program disappears.

Another national program which exemplifies both coordination and encourages the participation of the private sector is the Channel One Project, which we at PYRAMID have been working very closely on. Channel One is an innovative program which has brought together the Federal government, the States through their SPC grants, local community people and private sector representatives in a process to develop and maintain local prevention programming. At present, this consortium has created more than 100 sites throughout the United States which are developing youth initiated prevention programs suited to local needs. The major private sector contributor to this program has been the Prudential

Insurance Company of America. In addition, more than 40 other private sector representatives have become involved in the program, contributing their time, manpower, and in some cased limited funding. This program depends on national and centralized leadership, training, and support for its impetus and continued growth.

A third program which advances the knowledge of prevention is NIDA's evaluation research program which is beginning to show long awaited results -- findings which can answer questions on the most effective strategies and techniques. One example of this program is a grant entitled the NAPA Experiment, a program administered by The Pacific Institute for Research and Evaluation in Napa, California. The NAPA program began three years ago to test seven prevention strategies through a series of 12 different studies. This program currently involves more than 8,000 students from elementary through senior high school grades. The preliminary analysis of data shows significant impact on tobacco use and marijuana use, as well as on academic achievement and discipline, the number one problem in schools for the past seven years according to administrators. The final data analysis and dissemination of information from this project, as well as from others, is crucial to the development of prevention programming and can provide States and local programs with sorely needed information and direction. Unfortunately, the fourth year of NAPA, which was approved for funding and called "the most important study ever conducted in prevention" by its reviewers has been cancelled because of frozen 1981 funds.

Other national programs NIDA has supported and planned to support for 1981 included the following:

1) An evaluation system to assist States and local clients in planning and carrying our evaluations of their programs entitled "NPERN".
2) The Center for Multicultural Awareness which has provided materials, information and assistance to States for the past five years on prevention issues related to Blacks, Mexican Americans, Native Americans, Puerto Ricans, and Asian American/ Pacific Islanders.
3) Training workshops for parents and families focusing on the organizing of parent groups to fight drug abuse, parenting skills and family development.

It would be a serious mistake, and a great step backwards for this field if such programs as those described above cannot continue to serve the States and localities. It is our strong belief and conviction based on our experience that prevention must have a national focus, that the field must have a central information center, that national leadership and coordination must be continued to allow prevention as last to make some inroads. The five million dollars set aside for prevention at NIDA proposed by this Subcommittee will be inadequate to support such programs. In these times when cutting in spending is necessary, and resources will be severely limited at all levels, prevention is our most cost effective hope. Whatever the ultimate funding the Congress proposes for Federal drug programs, it is essential that sufficient funds be set aside for prevention.

Senator HUMPHREY. At this point, I order printed all statements of those who could not attend and other pertinent material submitted for the record. The hearing record will remain open for 15 days for the submission of additional material, including information specifically requested by the subcommittee during this morning's hearing.

Incidentally, if we may, we would like to submit the balance of the questions we had for you in writing. Unfortunately, there just was not time to ask all of them.

This hearing is now concluded. Thank you.

[Whereupon, at 12:33 p.m., the subcommittee was adjourned.]

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