MEETING THE PROBLEMS OF ALCOHOL ABUSE: A TESTABLE ACTION PLAN FOR IOWA

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This report re-examines the problem of alcohol abuse and describes an action program which: (a) is already underway, (b) is community based, (c) involves cooperation of the local community, the State Commission on Alcoholism, the Iowa Alcoholism Foundation and a University Training and Research Center, (d) offers more help to more problem drinkers with more benefit to the community at less cost than other approaches, (e) takes account of existing knowledge, and (f) has self-evaluation, and in turn, the potential for self-improvement built into it.

1. The state's 53,190 problem drinkers are classified into three categories according to: (a) their needs, (b) the problems they present to the community, and (c) appropriate community reaction.
2. Problem drinkers drink one-half of the alcohol consumed and currently contribute nearly $15 million to the state treasury annually.
3. The total cost of problem drinking approximates the state's revenue from the sale of beverage alcohol. Currently this is nearly $30 million annually. Still, problem drinkers lie and sometimes die in their own vomit, and the problem of alcohol abuse continues unabated. We can hardly afford not to seek a more effective, economical and humanitarian approach.
4. The disease concept is spawning treatment centers which are expensive, ineffective and unnecessary. As a promised solution to the "alcoholism problem," they work a deception on the problem drinker, his family and the larger community. They contribute nothing to prevention.
5. The utility of the disease-treatment-cure concept as an effective tool for coping with the problems of alcohol abuse is questioned. Alternatively, alcohol abuse is seen as both cause and consequence of a social process. The problem drinker is seen as having learned to use alcohol as a means of coping with his environment to the virtual exclusion of other less socially disruptive means. He becomes estranged from his wife, family, employer, clergyman, family physician, etc.—he is out of the social system. Becoming a recovered problem drinker is likewise a product of a social process—a reintegration process.
6. Every community has all of the professional services and other ingredients necessary for the reintegration process except one.
7. The missing ingredient is the catalyst—someone who can empathize with the problem drinker and who is trained to employ existing community services to initiate and expedite the process of reintegrating the drinker into the life of the community.
8. The bulk of the problem drinkers can be reached in the offices of the community service professionals—physicians, clergymen and lawyers—where they seek services for a problem *related* to drinking, *but not* for the drinking problem itself. Many can also be reached through the social welfare offices, the police and the courts. The service professionals have neither the time nor the know-how to assist the problem drinker beyond rendering their own special services.
9. Every local community needs a trained consultant to advise service professionals and a counselor to help motivate the problem drinker expedite his referrals, and assist him back into the social system. The consultant-counselor team acts as a catalyst to initiate and expedite the reintegration process. This plan has already been implemented in Cedar Rapids and is currently being evaluated.
10. If it costs $1200 per month per case for hospitalization and aid to dependents, an information and referral office with an annual budget of $30,000 need keep only five cases per year out of the hospital and employed for five months to pay for itself.
11. To further the program, the following cooperative action is proposed:
    a. The State Alcoholism Commission should provide grants-in-aid along with guidance for local communities.
    b. Local communities should develop local action and feed evaluation data to the University Research and Training Center.
    c. The University should provide training and research. Evaluation results would provide feedback to improve local action and input to improve the training program. Thus, the program has self-evaluation and the potential for self-improvement built into it.
    d. The legislature should fund the action program by 1) refunding $1 million of liquor profits annually to the counties, 2) appropriating $500,000 annually to the State Alcoholism Commission, and 3) by annual appropriations of $150,000 to the University Division of Alcohol Studies for training and research.
    e. The Iowa Alcoholism Foundation should funnel private funds into the program.

Although problems have often attended man's use of beverage alcohol, what is cause and what is effect is not clear. The Jewish and Italian societies have a high rate of alcohol users and the Italians have a high consumption rate, but both societies have low rates of alcohol abuse (cf. Bales, 1946: 480-499; Snyder, 1958; Lolli, et al., 1958). Apparently a society can evolve drinking customs and attitudes and transmit them to succeeding generations so as to informally but effectively control individual drinking behavior. Our society likewise controls the drinking behavior of over 90 per cent of the drinkers. However, the inconsistency and latitude of our attitudes toward alcohol and our informal rules for using it permit certain individuals to drink far beyond the norms.

Throughout our history approximately five per cent of the drinkers have been a problem to their community and the community has reacted. Mainly, the reaction has been a trial and error search for effective *legal* controls. We have outlawed drunkenness and we have outlawed alcohol. We have imposed

heavy taxes and enacted innumerable laws to regulate the manufacture, distribution and consumption of alcohol only to see such legal controls affect the drinking habits of the many who are not problem drinkers more than the few who are.

Name-calling has also been a part of community reaction to alcohol abusers. They have been called drunks, drunkards, inebriates, sots, lushes, dipsomaniacs, alcoholics, problem drinkers, etc. This variety of names and the willingness to accept new ones indicates uncertainty as to what is being dealt with and how to deal with it. The current fad employs the name "alcoholic" and attributes the disease "alcoholism" to them. Still, the basic problem remains. Regardless of what they are called (we prefer the term "problem drinker") (Mulford, 1969), too many people drink so much that they become a frustrating problem to the community, if not to themselves.

This paper examines the scope and the nature of the so-called "alcoholism problem," assesses the efficacy of the disease concept as a tool for coping with alcohol abusers, and proposes a practical plan whereby local communities in cooperation with the State Commission on Alcoholism, the Iowa Alcoholism Foundation, and a University Training and Research Center might evolve community action which would provide more help to more problem drinkers with more benefit to the community and for less expense than existing approaches.

THE SCOPE OF THE PROBLEM

Estimates, based on liver cirrhosis deaths and the Jellinek formula, indicate that of the one million drinkers in Iowa, 53,190 are "alcoholics." This is approximately five per cent of the drinkers and three per cent of the adults, with a male-female ratio of 5:1 (Mulford, 1965:45).

At the community level we have found that the drinking habits of 4.5 per cent of the 60,000 adults in Cedar Rapids are characterized by prolonged binges, sneaking drinks, morning drinking, neglected meals and uncontrolled drinking, and 5.3 per cent of them have drinking-related trouble in one or more major life areas. These two rates, one based on extreme drinking behavior and the other based on trouble due to drinking, both yield estimates of approximately 3000 alcohol abusers in Cedar Rapids (Mulford and Wilson, 1966:30-31).

Another study (Mulford, 1966a) interviewed the physicians, clergymen, lawyers, social workers, law enforcement officials, and other service agency personnel in Cedar Rapids regarding the number of persons whom they had seen professionally in the previous year and to whom they attributed a drinking problem, how many they thought were "alcoholic" and what services they rendered such patients or clients that was meant to help them with their drinking problem.

Physicians estimated that during the study year some 3900 persons came to their offices with a complaint related to drinking. The clergymen reported 1600 and the attorneys reported 1800 clients seeking services for a drinking-related problem. Approximately half of these cases were considered by the professional to be "alcoholic," but only one-fourth were reported to have a medical diagnosis of "alcoholism." The majority of the patients-clients coming to the service professionals were *not* seeking treatment for "alcoholism" or even help for a drinking problem. Only rarely did the professional attempt to relate his services to the drinking problem. For example, the physicians reported treating "alcoholism" in only one in ten of their problem drinkers. In addition, the police department, the sheriff's office and the municipal court each reported having dealt with approximately 2500 problem drinkers during the year. These were cases arrested for a drinking-related offense, usually intoxication or drunk driving, but most of them were not chronic skid row cases. Our best estimate is that only about five per cent or 150 of the estimated 3000 problem drinkers in Cedar Rapids are chronic police offenders (cf. Mulford, 1965:70).

Due to the overlap of cases, the number of cases reported by the professionals is only a rough indication of the magnitude of the problem of alcohol abuse as they encounter it. However, it is concluded that the figure 3000 is a usefully accurate estimate of the number of problem drinkers in Cedar Rapids. Other Iowa communities of approximately 100,000 population which are planning community alcohol abuse programs may use this figure as an estimate of the size of their target population.

The significant contribution of this study is that it locates the *bulk of the problem drinkers* at an *earlier stage* in their drinking careers, and locates them *in the offices* of service professionals. Here they can be contacted under conditions which are unusually favorable for motivating the drinker to help himself and for motivating and educating the professional to better understand problem drinkers and to relate his services to the drinking problem. Further attention will be given these points later.

The typical problem drinker reported by the service professionals in Cedar Rapids was married (74 per cent), male (84 per cent), and between 30 and 50 years old (62 per cent). He was seen by the professional to be using alcohol as a crutch to escape or solve life's problems (70 per cent) rather than drinking for sheer enjoyment (13 per cent). The drinking pattern varied being either regularly intoxicated (33 per cent) or frequent binges (16 per cent) or continuous drinking, but seldom intoxicated (21 per cent). Virtually all cases were seen to have one or more troubles due to drinking, most often family trouble (70 per cent) or trouble on the job (52 per cent). Nearly one-third were reported to be having trouble with police. Physicians reported that 65 per cent of their problem drinkers had a drinking-related health problem; other professionals reported only one-third of their cases had a health problem.

CLASSIFYING ALCOHOL ABUSERS

The state's estimated 53,190 problem drinkers may be classified into three categories according to: (1) their most urgent needs, (2) their motivation to do something about their drinking, (3) their personal rehabilitation resources, (4) the nature of the problem they present to the community, and (5) the community's reaction.

Type A – Chronic skid row police offenders. An estimated five per cent or nearly 3000 of Iowa's problem drinkers are the stereotype skid row cases for whom the jail door has become a revolving door (Mulford, 1965:46). They are the most visible cases. They are the most advanced in their alcoholic drinking career and have few personal rehabilitation resources remaining. They are without friends, family, job, job skills and finances. Their health is gone. Their only remaining motivation is another drink. They are highly resistant to rehabilitation efforts and are the most frustrating and the most costly for the community. Many have acute medical needs which the community could, but seldom does, meet with existing facilities.

This is the type of case upon which the arguments for the "disease" concept and the arguments for special medical treatment facilities have rested. In our desperation to obtain medical attention for the skid row case, to account for his drinking behavior and to explain his resistance to rehabilitation, we have attributed the disease "alcoholism" to him. We then leaped to the unwarranted conclusion that "alcoholism" could be diagnosed and treated, and the delusion that treatment centers would solve the "alcoholism problem."

If these cases and only these cases are the "real alcoholics" really suffering the "disease," then we have just reduced the "alcoholism problem" by 95 per cent, and the four State Mental Health Institutes are adequate to institutionalize these 3000 skid row cases.

Type B – Advanced cases who are not chronic police cases. An additional 10,000 to 12,000, or about 20 per cent, of the state's problem drinkers are also far advanced in their drinking

careers, but they are not yet on skid row. Although many of them may have physical complications needing medical attention, hospitalization, when necessary, usually need be only for a few days. They have more personal rehabilitation resources remaining. Many of them have jobs, families and homes however tenuous their hold on these might be. Their motivation to seek help or do something about their drinking is low.

These are the second most visible cases to the community. They, or their families, appear more often in welfare offices than in the police station. Individually they may cost the community less than the skid row drinker who is repeatedly jailed or hospitalized, but as a group they are more costly because they are more numerous. Some of them are jailed and some are hospitalized, but the main cost is welfare aid to dependents.

If these cases were added to the chronic police offenders as "real alcoholics" and those in the third category described below are considered to be "merely problem drinkers," then the "alcoholism problem" is only one-fourth the size it is usually claimed to be.

Type C–Problem drinkers without physical complications. The remaining three-fourths of the state's problem drinkers, some 41,000 in number, have not yet drunk to the point of serious physical complications. They have no unusual medical needs and no need for institutionalization; as we have seen, they still have access to, and actually appear in, the offices of the service professionals–physicians, clergymen, attorneys–rather than in the police station and welfare offices. They generally do not see their drinking as a problem. They do not go to the professional seeking help with it and are little inclined to do anything about it. Their greatest need is for friendly expert advice regarding the likely consequence of continued excessive drinking and guidance, along with appropriate firm pressure (e.g., threat of job loss, wife loss, jail) to do something about it. Motivating the drinker to modify his drinking at this stage of his drinking career is a move toward prevention which after all must be our ultimate goal.

These cases are less visible than the first two types of cases, and most of them are no great financial burden to the community. They are still employed and are paying their own way. They have fewer drinking-related problems, yet most of them do have such problems according to the reports of the Cedar Rapids professsionals. The idea of committing these cases for treatment for "alcoholism" is objectionable for many reasons, not the least of which is the threat to their civil liberties. We will not try to settle the issue of whether they are "really" alcoholics, but we will consider them part of the community problem of alcohol abuse. We will employ the term "problem drinker" to cover all three categories.

Costs of the problem. Another important fact having implications for community action is that communities have long been spending large sums of money to cope with problem drinkers. Most of it goes for law enforcement, hospitalization and aid to dependents although there are many other costs.

We have earlier calculated (Mulford and Waisanen, 1957:27) that the cost of problem drinking to the people of the state approximates the state's revenue from the sale of beverage alcohol. Thus, the current annual cost is nearly $30 million, or an average of $600 for each of the 53,190 alcoholics. Whatever the cost, most of it is attributable to less than 25 per cent of all problem drinkers, i.e., the first two types described above, and particularly the five per cent who are chronic police offenders.

Every community of the state has its share of problem drinkers. The estimated 3000 cases in Cedar Rapids probably cost the community more than $1.5 million a year. Two readily identifiable costs are welfare payments and hospitalization. Last year (1968) the Linn County Welfare Office spent $362,103 for Aid to Dependent Children plus $332,236 for general assistance programs, or a total of $694,339 for these two programs. Based on interviews with the case workers handling these cases, it is conservatively estimated that 11 per cent or approximately 100 of the families receiving these kinds of aid involved a problem drinker. Thus, problem drinkers and their families cost Linn County on estimated $76,377 for these two types of welfare aid. This does not include medical and other aid. In addition, the county spent $157,752 in 1968 for 177 admissions to the State Mental Hospital. Considering that it costs approximately $1000 a month to hospitalize a case plus $200 per month for ADC payments, a community can hardly afford not to seek alternatives which might rehabilitate even a few of these cases without institutionalization.

PROBLEM DRINKERS CONSUME HALF OF THE ALCOHOL CONSUMED

To be fair to problem drinkers, it should be recognized that they drink approximately one-half of the alcohol consumed and therefore account for half of the state's revenue from the sale of alcoholic beverages (Ledermann, 1956; deLint and Schmidt, 1965:670-673; 1968:968-973; Mulford, 1965:46; 1970). If the cost of problem drinking approximates the state's total revenue from beverage sales, then the state's one million drinkers are paying their own way. Although the heaviest drinker is the greatest burden to the community, he also pays the most.

Cities and towns currently receive about $6 million annually from the Liquor Control Commission profits. This is ten per cent of the net sales. The counties receive five per cent of sales, or about $3 million from Commission profits. Each incorporated town and city annually receives approximately $3.00 per capita; Cedar Rapids received $308,838 in 1968. Cities and counties tend to use these funds for nearly everything except a search for improved procedures to cope with problem drinkers. Last year Cedar Rapids budgeted $88,000 of these funds to the city arborist, presumably much of it to control Dutch elm disease, but allowed nothing for the Citizens Committee on Alcoholism. This is in spite of the fact that the city received $154,000 from problem drinkers and none from elm trees. On the other hand, Linn County, containing the city of Cedar Rapids, received $170,402 from liquor profits ($85,000 from alcoholics) last year and is currently supporting the Citizens Committee on Alcoholism with $36,000. It is not unreasonable to think of problem drinkers as being on a "pay-as-you-drink" social service plan. They have pre-paid any services the community might render them.

THE DISEASE CONCEPT OF ALCOHOLISM

The factor having greatest influence on community reaction to alcohol abuse in recent years is the increasing acceptance of the concept that alcoholics suffer the disease "alcoholism." Replacing yesterday's idea that "drunkards" are possessed by "demon rum" with today's idea that "alcoholics" are possessed by "alcoholism" means more humanitarian treatment of the alcohol abuser. However, medically oriented clinicians have not shown that they are any better prepared to exorcise "alcoholism" than the morally oriented clergy and courts were to exorcise the "demon." Jellinek (1960:35-41) has noted that neither alcoholics nor their presumed disease has been fitted into the medical model. "Alcoholism" has not been defined in terms that tell a physician what to do about it.

Acceptance of the disease concept has led to social action which has served the cause of the alcohol abuser in many ways, but it is not an unmixed blessing. Its acceptance has aroused public interest and sympathy to the point of funding programs of education, research and treatment. This disease concept has also meant the establishment of detoxification and treatment centers for problem drinkers. Such special institutions are defensible on humanitarian grounds. Problem drinkers, covered with their own vomit, are dying in doorways and jails for want of medical attention. So long as existing medical facilities refuse alcoholics, then the expense of building special facilities

is justified. Special treatment facilities are also justified to the extent that they contribute to research.

However, such institutions are *not* defensible as adequate instruments for attacking the problems of alcohol abuse. Treatment centers can be expected to reach about one-tenth of all problem drinkers. The five per cent who come before the courts can be committed for treatment and another five per cent may volunteer for treatment. But, the fact that Alcoholics Anonymous with its open door invitation to all problem drinkers reaches less than ten per cent of them suggests the need for something more than welcome signs. Admissions to the four State Mental Health Institutes, the Oakdale Treatment Unit and the Harrison Detoxification Center last year totaled approximately 3400; this includes both committed and voluntary admissions. Less than two-thirds of these admissions were first admissions. Given an annual first admission rate of 2000 cases, the last of the 53,190 cases to be admitted will have aged somewhat.

The enormity of the task of solving the problem with treatment centers is more vivid if we imagine that tomorrow the state's 53,190 problem drinkers were committed for 60 days treatment. They would occupy one-half of all hospital beds in the state for nearly a year at a cost of nearly $500,000 a day. Assuming a 25 per cent recovery rate, there would remain 40,000 active cases at the end of the first year. If the remaining cases were hospitalized for a second treatment and so on, we can calculate that after six years and an expenditure of more than $1 billion nearly 10,000 of the original 53,190 cases would still be active. This does not take into account new cases that would have arisen during the six years. It allows nothing for prevention and nothing for research to find a better solution.

Two historical facts of interest here are first, in 1903 Dr. Applegate, Superintendent of the Mt. Pleasant State Mental Hospital, treated "inebriates," as they were called at that time, as suffering from a disease. He claimed a recovery rate of 29 per cent, quite comparable to the figure reported by more recent follow-up studies (Mulford, 1965;12).

Also, in 1906, Iowa built its first special hospital for inebriates in Knoxville. Initially it had a daily average patient population of approximately 200 cases. However, 13 years later the population had dropped to 11 patients and the hospital was closed and sold to the federal government (Mulford, 1965:13). We can only speculate that the counties concluded that the low recovery rate was not worth the high cost of commitment. Hopefully, Iowa today will draw on this history lesson and will anticipate the day when communities will become fully disillusioned with the essential futility of spending $30 to $40 a day to keep alcoholics in treatment centers.

In other words, the disease "alcoholism" has not been defined and there is no specific treatment for it. Physicians can hardly be expected to apply a nonexistent treatment to an undefined disease in a population that denies the disease and rejects the treatment. The disease-clinic-treatment-cure concept is a propaganda achievement, not a scientific achievement. Attributing "alcoholism" to an individual to explain the behavior by which he is identified as an alcoholic has no more scientific merit than does attributing professorism to a professor or plumberism to a plumber to explain the behavior by which they are identified. Granting the humanitarian merit of a health approach as compared with the punitive criminal approach to alcohol abusers, still if it leads to the establishment of more and more treatment centers while both the disease and the treatment remain a mystery, it offers an expensive false hope which works a deception on the alcoholic, his family and the community. Sooner or later it will be realized that merely moving the revolving door from the jail where it revolves those called drunks and lushes to the hospital where it revolves the same persons now being called alcoholics may have humanitarian merit, but it is hardly a solution to the problem of alcohol abuse. We believe that problem drinkers and their communities deserve better. Society can ill-afford not to search for a better solution–especially when the problem drinkers are paying for it.

A COMMUNITY APPROACH TO A COMMUNITY PROBLEM EVOLVING EFFECTIVE COMMUNITY ACTION THROUGH EVALUATION

We now offer another view of the alcohol abuser and propose a cooperative, systematic search for more effective efficient community action. In an effort to move away from the idea that alcohol abusers are possessed by "alcoholism" and the idea that the abuser is a mechanical robot with malfunctioning components needing repair, we will call them "problem drinkers." The term is meant to cover the entire range of persons whose use of alcohol is of concern to themselves or others either because it is seen as a source of trouble or as being uncontrolled.

Problem drinker–the product of a social process. The term "problem drinker" is meant to connote the idea that the person's drinking is *at the same time a cause and a consequence of deteriorating interpersonal relations, self respect, physical health and normal living in general.* The term emphasizes the fact that such a person is recognized and reacted to on the basis of what he *does*, not what he *has* or *is*.

We view both problem drinkers and recovered problem drinkers as products of a social interaction process. Indeed, the two processes probably greatly overlap in time. In broad outline, the process of becoming a problem drinker involves the person's learning to drink, learning to drink heavily and learning to use alcohol as a means of coping with his environment. All drinkers learn to define alcohol use as a social activity (Riley and Marden, 1947; Mulford and Miller, 1960; Larsen and Abu-Laban, 1968). A few drinkers, especially if they interact with significant others who hold differing and conflicting views of how to behave with alcohol, learn to define it and use it to solve personal problems. Such a drinker uses alcohol to cope with an unsatisfactory conception of himself and of his environment, to forget his problems, to get along better with others, etc., or he fails to learn that one does not use alcohol for such purposes. If a person has learned to define alcohol for personal effects and has not learned to define himself as a socially responsible person or has not acquired other socially approved goals which he values more highly than the rewards of drinking, his use of alcohol will become a way of life in the sense that he increasingly uses it to achieve an increasing number of goals of a personal nature (cf. Mulford and Miller, 1960: 275; Mulford, 1955:46-51; 1967).

The use of alcohol to cope with the world is self-defeating in a social context where it becomes defined by significant others as disrupting interpersonal relations and interfering with the drinker's performance of his roles. While the person has been learning to use alcohol to cope with personal problems, it has been at the expense of learning more socially approved means. Hence, his reaction to significant others' negative reaction to his drinking is, quite rationally as he sees it, further drinking. He takes refuge in the behavior most familiar to him and which has so often served him so well in the past. He has learned a way of life which is no less and no more difficult for him to give up than it is for a devout church-goer to give up his way of life. As this process, which has become a vicious circle, proceeds, there is progressive deterioration of the drinker's relationships with others. He becomes estranged from his wife, family, employer, physician, clergyman, police, neighbors and friends. At the same time his health and finances deteriorate. His life becomes chaotic and unmanageable.

Evidence that beverage alcohol can be defined by a group so as to prevent deviant drinking is found in studies of drinking in the Italian and Orthodox Jewish cultures. The Jewish culture prescribes alcohol for social and religious use, but prohibits its use for such personal effects as we have been discuss-

ing. In Italy, alcoholic beverages are defined as food and, again, its use for personal effects is not tolerated.

If becoming a problem drinker is the product of a social interaction process, then becoming a recovered problem drinker is likewise the product of a social process rather than the results of a mechanical adjustment of the individual in an institution. Thus, to affect *recovery* the process of becoming a problem drinker must be reversed and turned into a reintegration process. The reintegration process then must involve other persons, and they will usually be most of the same persons involved in the process whereby he became a problem drinker. Certainly, it must involve something more than a therapist doing something *to* a patient, whether it be adjusting his liver or adjusting his psyche.

DEFINING THE PROBLEM

The problem of alcohol abuse in the community may now be resolved into these components:

1. Meeting the acute medical, housing and food needs of certain cases,
2. contacting the problem drinker with "empathetic understanding,"
3. getting his attention as early in his excessive drinking career as possible,
4. motivating him to do something about his drinking,
5. motivating and educating community service professionals and agency personnel to recognize problem drinking in their clients, to relate their services to the drinking problem, to assess the drinker's additional needs and to refer him elsewhere for additional help,
6. coordinating community services for problem drinkers, i.e., appropriate and meaningful referrals among professionals,
7. expediting the referred problem drinker's course through the referral system,
8. establishing social ties with family, employer, AA, clergyman, etc., and
9. evolving effective procedures for achieving the eight objectives listed above.

ATTACKING THE PROBLEM

Many persons in our society are living testimony that problem drinkers do "recover." Some have been through special treatment and some have not. Most studies show a recovery rate of 25 to 35 per cent regardless of treatment modality. There is growing evidence that less than one-half of these recoveries can be attributed to the treatment (cf. Storm and Cutler, 1969). Improvement has not been related to type of treatment. A recent work by Drew (1968) suggests that in many cases "alcoholism" is a self-limiting "disease." It may well be, as Storm and Cutler suggest, that at best treatment merely expedites a recovery process which is already underway at the time of intake. Indeed, it may be useful to think of the recovery process as having begun long before the process of becoming a problem drinker has ended. That is, as the drinker ages and his drinking career progresses, the negative reactions of others, the increasing trouble he encounters and the diminishing returns he gets from drinking slowly become components of a recovery process. This is occurring even before the process of becoming a "confirmed" problem terminates in his being institutionalized (Mulford, 1965; 1967). Perhaps, at best treatment hastens this process.

Although there is no widely accepted explanation of the recoveries which occur, several studies attribute recovery to a social relationship between the problem drinker and another person or persons in the community. Davies (et al., 1956:496) found favorable outcome associated with "close personal ties to at least some one person." Kendell and Staton (1966:35) report good outcome to be associated with "a good relationship with a relative or friend." Wallerstein and associates (1957:170) found similar recovery rates for four types of treatments and concluded that the recovered cases were distinguished by their ability to form "stable, predominantly positive attachments to doctor, hospital and program." Kissin and Charnoff (1967) attempting to explain the similarity of improvement rates obtained by drugs and placeboes concluded that treatment effect may be an expression of shared norms or common expectancies developed among the patients in the waiting room as they waited to receive treatment. In addition, several studies have reported recovery related to job, family and residence stability which again indicates the importance of social relationships for the recovery process. So few factors have been found related to recovery from problem drinking that we should make the most of those that have.

Therefore, we propose as *a procedure to be tested*, that every community establish a special office staffed by a person or persons who can relate to problem drinkers and who have the time and dedication to do so. The problem drinker needs someone to turn to who understands what he has been through and what he is going through; one who can share his feelings and who understands that he is overwhelmed by a multitude of problems which he is trying to solve in the only way he knows—alcohol. The problem drinker needs someone who cares and who talks his language—someone with "empathetic understanding." We cannot clearly define this concept. It is not scientific, but neither is "alcoholism" nor any of its "treatments." The parties involved know when it exists. Perhaps the concept deserves the comment attributed to Louis Armstrong about jazz music: "Man, if you have to ask what it is you ain't never going to know."

We submit that all of the professional services and other essential ingredients of the reintegration process, except one, presently exist in every community. The missing ingredient—"empathetic understanding"—is a necessary catalyst to initiate or expedite the reintegration process.

Meeting the acute medical, shelter and food needs. The most urgent unmet need in every community is medical attention for the acutely intoxicated problem drinker. Detoxification could be done in the general hospital if physicians would change their attitudes toward such cases and learn to treat them and if hospitals would change their admission policies (Brunner-Orne, 1967).

The local general hospital should set aside beds for short term detoxification and physical restoration of problem drinkers. Usually this can be accomplished in four or five days. The county could pay $40 a day for a few days hospitalization in the local hospital and realize considerable savings over paying the same amount per day for several weeks "treatment" in a state institution. To overcome the hospital's and physician's objections to frequent readmissions of the same patient, it should be made clear to the drinker that there is a limit to the number and frequency of admissions.

The only extra benefit to the alcoholic from a special treatment facility is the greater empathetic understanding he might receive. Even this is of little value unless it follows him back into the community in the form of an understanding person who helps him find a job, restore relations with his family and generally helps him back into the social system. After the patient has been restored physically he should be encouraged, even pressured, to take advantage of the services of the Alcohol Abuse Information and Referral Office. The cooperation of the employer, courts and other appropriate sources of pressure should be enlisted to induce him to modify his drinking.

Half-way Houses. Physical restoration can contribute much to the reintegration process, but for the patient who has only the street to return to, the process will abort unless shelter and food are provided until he can earn his own. This can be done through half-way houses; but a half-way house must be just that, and the drinker must understand that it is not a perma-

nent residence. He should be required and assisted to obtain employment and pay for his keep. While group meetings and other planned activities may be a useful part of half-way house routine, a half-way house should not be conceived of as a treatment center. Recovery is no more likely to occur within these four walls than any other four walls. He must learn to live in the real world outside of this sheltered environment.

Contacting and motivating the problem drinker. Chronic police offenders can be committed to expose themselves to assistance, be it nothing more than physical repair, clean sheets and regular meals, but the remaining 95 per cent of the problem drinkers are more difficult to reach. To extend the idea of commitment to all problem drinkers is neither wise nor feasible. There is another way to reach them, i.e., through the service professionals.

Having located the bulk of the problem drinkers in the offices of the community service professionals and agencies offers an opportunity to reach them at an earlier stage in their drinking careers, and under circumstances favorable for attacking the several aspects of the problem of alcohol abuse. These conditions involving a problem drinker in a professional's office seeking help for a drinking-related problem are unusually favorable for motivating the drinker, educating the professional, coordinating services to the drinker and initiating or expediting the reintegration process.

Although problem drinkers do not come to the professional for help for a drinking problem, whatever the complaint, it provides a base for building motivation in the drinker to do something about his drinking. A man with a painful liver may find advice about his drinking habits more meaningful. Presumably the professional, having rendered the specific services being sought, wants to help the drinker with his underlying drinking problem, but the professional has neither the time nor the know-how to do so.

A Consultant For The Professionals. In order to take fullest advantage of these optimum conditions for making meaningful contact with the problem drinker, we have earlier proposed that a trained consultant who is an expert on alcohol abuse should be brought into the office with the professional and his problem drinker client (Mulford, 1965:94). The consultant advises the professional upon the latter's request; he does not pretend to treat "alcoholism."

Educating the professional. The professional who requests the consultant's advice receives two kinds. First, advice on assessing the problem drinker's needs which may range from AA philosophy to psychiatric help, and from medical services to working out a budget; and secondly, advice on where to refer the drinker for further help. In helping the professional to define the situation, the consultant de-emphasizes the "disease-treatment-cure" concept and emphasizes the process of establishing social ties.

The consultant works with the problem drinker indirectly through the professional. He does not relieve the professionals of any of their responsibilities to problem drinkers. On the contrary, his task is to strengthen them in meeting their responsibilities. He resists becoming a "dumping ground" for the professionals and he is careful not to threaten to usurp the professional's prerogatives.

Coordinating community services. Problem drinkers need help with a variety of problems if they are to bring order to their lives and learn to cope with their environment without alcohol. After the professional has rendered his services according to his specific skills, he should recognize the drinker's other needs and make appropriate referrals. However, merely recommending that the problem drinker go elsewhere for additional help is not sufficient. The problem drinker, left on his own, seldom reaches the referral destination (Mulford, 1965:72-81). To expedite referrals and coordinate community services, we recommend a counselor who understands problem drinkers and the reintegration process.

A Community Counselor For Problem Drinkers. After leaving the professional's office, the referred problem drinker needs a kind of assistance the professionals can hardly be expected to provide. He needs the help of someone who not only cares and understands, but who also has the time and the ability to counter his excuses and to lead him by the hand if necessary to the next AA meeting or to an appointment with a clergyman, mental health center or other appropriate source of professional skill. In some cases the drinker may need the support of another person to face the ordeal of talking to his wife again or applying for a job and establishing the habit of going to work regularly. The counselor does nothing *to* the problem drinker, he works *with* him–he helps him help himself.

In other words, the consultant and the counselor work as a team to reach problem drinkers through the service professionals, to educate the professionals, to coordinate community services, to expedite the drinker's course through the referral system and to help him reintegrate himself into the social system.

COMMUNITY CONSULTANTS AND COUNSELORS: JOB DESCRIPTIONS AND QUALIFICATIONS

Consultant

Job Description

1. Implement policies of local Citizens Committees on Alcohol Abuse.
2. Consult with community service professionals and agency personnel at their request.
3. Serve professionals as a source of expert knowledge regarding problem drinkers, how to assess their needs, and where their needs can be met.
4. Strengthen service professionals in applying their particular skills in the service of the problem drinker and aid professionals to make more enlightened and effective referrals for additional help.
5. Resist the temptation to accept direct referrals from professionals.
6. Supervise the counselor and the manager of the half-way house.
7. Work with schools, professional groups, service organizations, etc., promoting public education regarding alcohol use and abuse.
8. Arrange regular group meetings for problem drinkers, e.g., court classes.
9. Manage Information and Referral Office–keep records, prepare budgets, make annual reports, forward intake data to University Training and Research Center.

Qualifications

1. The foremost qualification is empathetic understanding of the problem drinker.
2. If a recovered problem drinker, then "dry" at least two years.
3. One year's experience working with problem drinkers–AA Twelfth Step work or other such experience.
4. Evidence of ability to work with service professionals.
5. One year of administrative experience preferred.
6. High school graduate or equivalent; college work or degree preferred. May substitute additional administrative experience or counseling work with problem drinkers for formal education.
7. Resident of the community preferred.

Counselor

Job Description

1. Responsible to the consultant.
2. Work directly with the problem drinker.
3. Assist problem drinker to renew social ties. Act as "shoehorn" to fit drinkers into social system.
4. Expedite his course through the referral system.
5. Receive problem drinkers discharged from hospitals and other institutions.
6. Conduct "intake" interviews with clients for forwarding to University Training and Research Center.
7. Assist the consultant with public education programs.
8. Assist the consultant with group meetings for problem drinkers.

Qualifications

1. Empathetic understanding for the problem drinker.
2. If a recovered problem drinker, then "dry" at least two years.
3. One year of experience working with problem drinkers.
4. High school graduate or equivalent; evidence of ability to do college work preferred. May substitute a second year of experience working with problem drinkers.
5. Resident of the community preferred.

Community alcoholism workers are a special case of the ombudsman system. They are a special case in the sense that they concentrate on helping problem drinkers and most important, they are chosen, if not trained, to empathize with the problem drinker. Also, they perform many of the functions of the "ward-heeler" in yesterday's city political machines. They can also be thought of as providing the kindly understanding which was about the only "treatment" the traditional family physician had to offer but which today's physicians have little time to administer.

EVOLVING MORE EFFECTIVE COMMUNITY ACTION

As yet it has not been demonstrated that the community consultant-counselor plan will have a higher recovery rate than other "special attentions" given problem drinkers. Judging from previous follow-up studies, we can expect a recovery rate no less than the usual 25 per cent to 35 per cent claimed by a wide variety of "treatments."

The basic argument for the plan, and one for which evidence already exists, is that the consultant-counselor team reaches a greater number of problem drinkers at far less cost than do treatment institutions. Given the same recovery rate, more problem drinkers are helped and there is more benefit to the community. Evidence of this is emerging from a three-year follow-up study now underway comparing the Oakdale Treatment Unit with the Cedar Rapids Information and Referral Office. The latter has been staffed by several of our trainees, including the director, and it is being evaluated and developed as a prototype of community action.

Standard intake data have been obtained on admissions to both facilities and follow-up data are now being collected. As of March 31, 1969, Oakdale had been in operation just over three years, while the Cedar Rapids office had been operating only two years. In *three* years, 712 persons were treated at Oakdale for a cost of nearly $1 million. In *two* years, the Cedar Rapids office dealt with 750 adult problem drinkers plus 129 juveniles who had been arrested for a liquor law offense. In addition, the office handled 195 "contacts" with a spouse, employer, service professional or other third party seeking advice about a problem drinker who never appeared in the office. This was done at a cost of less than $57,000.

Preliminary analysis also shows that in the aggregate, the problem drinkers seen at Oakdale and Cedar Rapids are very similar in terms of the severity of their drinking, the number and kinds of drinking-related troubles they have, their job status, family status, and several socio-cultural attributes. In fact, the Cedar Rapids office dealt with a slightly less stable, more handicapped population.

Even if one-third of the Oakdale budget is assigned to education, the cost per patient treated was some $900. By comparison, the cost per adult problem drinker seen in Cedar Rapids was $76. Including the juvenile case load, the cost per case seen was $65. If the recovery rates for both populations prove to be the usual 25 per cent, then the cost per case rehabilitated is about $300 for the Cedar Rapids office compared with $3700 for Oakdale. If it costs $1200 per month per case for hospitalization and aid to dependents, an information and referral office with an annual budget of $30,000 need keep only five cases per year out of the hospital and employed for five months to pay for itself. The cost per patient at the Oakdale Treatment Unit is not atypical. Other treatment centers have similarly high costs per patient. Of course, a small portion of the cases contacted by the Information and Referral Office need detoxification or have other acute medical needs requiring hospitalization and this is an added cost to the community. However, as we have noted earlier, these needs can be met in most cases by a few days hospitalization in the local community rather than the usual four to six weeks stay in a treatment center.

Actually much of the Cedar Rapids budget could be allotted to education. Not only did the office personnel give numerous public talks, film presentations, etc., but they also engaged in a highly efficient form of education when they answered the service professionals' calls for advice. The office has had this kind of educational relationship with 37 per cent of the estimated 100 general practitioners, internists and psychiatrists in the community. A similar relationship was established with 36 per cent of the 180 lawyers and 41 per cent of the 130 clergy in the city. Several additional professionals from these three groups use the office as a "dumping ground"; that is, they simply send the problem drinker to the referral office.

In addition, the office has a close working relationship with the sheriff's office, the city police, the courts, the welfare office, the mental health center, the Division of Vocational Rehabilitation, the Salvation Army, Catholic Charities, Family Services, the Red Cross, the personnel offices of 12 industrial companies and a general hospital.

One can only wonder how the total impact of this education conducted by the community consultant and counselor compares with the impact of a few lectures given university students preparing for the professions, and even the postgraduate summer workshops and conferences we conduct for service professionals.

In summary. The community consultant-counselor concept stands in contrast to the usual notion that alcoholics bring their "alcoholism" to a clinic to be treated and cured. It offers these advantages: 1) It has the potential for reaching a large portion of the problem drinker population through service professionals. 2) Problem drinkers are contacted under conditions of distress which form a base for building motivation. 3) The professional is likewise contacted under conditions where he will be most attentive and can be motivated and educated to do his part. 4) After the consultant has advised a professional several times, the professional should have no further need for his services. Theoretically, the consultant will work himself out of a job. However, the problem drinker's needs for the helping hand of an understanding counselor will continue. 5) Each case that is referred and followed through by the counselor should contribute to an integrated, coordinated program of cooperation among local community service professionals and agencies. 6) In their work with professionals and problem

drinkers, the consultant and counselor have considerable educational impact on the community regarding problem drinking. This is in addition to their deliberate efforts at public education. 7) The consultant-counselor program appears to be quite in keeping with the concept of a trained community alcohol expert called for by Thomas Plaut in the Task Force Report on Drunkenness of the President's Commission on Law Enforcement (Plaut, 1967:128). For more than 20 years Selden Bacon, Director of the Rutgers Center of Alcohol Studies, has been arguing for treatment of the problem drinker on the social level. He reminds us that "the recovered alcoholic has to live with himself in a real world, not with a psychiatrist in a hospital" (Bacon, 1947:29).

RESEARCH, TRAINING AND DEVELOPMENT

The consultant-counselor proposal is not a tested plan; it is a plan to be tested, and is currently being tested. There is no proven curriculum for training community workers nor is there a tested blueprint to guide their activities in the community. It is planned that more effective community action and an improved training program will evolve from the interaction of the two. The interaction can be facilitated by employing the methods of science. We envisage a self-generating, self-correcting system whereby the training program and the action program each provides corrective feedback to the other. The process is in motion and much work has been done on it since it was first presented in embryo form some years ago (Mulford, 1965:87-98).

Dean Robert Ray of the University Extension Division gave early impetus to the plan in the fall of 1965 when the Extension Division agreed to fund a state conference to present the plan to local communities. Consequently, in October 1965, Dr. Leo Sedlacek, Gordon Nelson and this author organized a work-study conference to be held the following April (1966). The purpose of the conference was to introduce the consultant-counselor plan to local communities. Subsequently, community action was greatly stimulated by the Iowa Comprehensive Alcoholism Project with funds obtained by Governor Hughes from the U.S. Office of Economic Opportunity (OEO). It is now being furthered by the State Alcoholism Commission with appropriations by the 1969 General Assembly which currently amount to $500,000 per year.

The proposed community action to cope with alcohol abuse will either evolve into something the public sees as useful and worthy of continued support, or it will fail and be abandoned. Such public evaluation usually takes several years. We are in a position to apply the methods of science to facilitate the evaluation and to guide the plan toward success. Specifically, we intend to continue and expand the training and research work described below.

Training. In 1966, we were awarded a grant under Title I of the Federal Higher Education Act to establish a training program for community consultants and counselors at the Oakdale Treatment Unit (Mulford, 1966b). The grant provided limited (three months) fellowships for six trainees. Gordon Nelson was employed as training program coordinator to help develop the training program and to do liaison work with the local communities. All six persons receiving the initial fellowships plus one who paid his own way are still working with problem drinkers in Iowa. Two of them are operating the Cedar Rapids office and one is the Assistant Director of the State Alcoholism Commission. Subsequently, some 40 additional persons have been trained or are currently in training.

Although it remains to be seen what will be dictated by the evaluation of the work of those who have been trained, we intend to strengthen the training program. Probably the academic level of training will be raised. Trainees who are prepared for it should be offered college level work. We have initiated a regular University course on alcohol use and abuse which the trainees currently attend along with regularly enrolled students. However, candidates for training who have demonstrated their ability to work with problem drinkers but who do not possess the background preparation for college work should not be ignored simply for the sake of academic respectability. After all, the primary goal is the control and prevention of alcohol abuse. We would strive for higher academic standards only as a means to that end.

Training program content. We agree with Lemere's (1964) observation, ". . . the basic aptitude for treating alcoholics [relating to them?] comes only from interest, tolerance, common sense, dedication, understanding, patient and natural ability to deal with these difficult cases." Although we do not know how to teach attitudes of "empathetic understanding" or the ability to relate to the problem drinkers, by studying the work of the consultants and counselors who do possess the ability we may discover how to build it into the training or at least design training which does not weaken the ability.

This is a distinct possiblity, especially if the attempt is made to teach these community alcohol workers the counseling techniques of established professions. For example, if a trainee who enters training with the aptitude to relate to problem drinkers, learns to talk like a psychiatrist and think like a psychiatrist, he is likely to lose his ability to relate to problem drinkers and thereby make his own contribution to the field. If psychiatric, social work or other established counseling techniques had proven their worth to the alcohol abuser, we would not be proposing another kind of expert to work with them. We advise against a training program designed to turn out "non-professional" or "junior" psychiatrists, social workers or clinical psychologists. It is more important to *select* persons for training who have demonstrated that they already possess the desired attitudes and hope the training will not weaken them. Recovered problem drinkers are a source of trainees possessing empathetic understanding, but they are not the only source.

There are many skills and much useful knowledge that can be taught community alcohol experts. They can be taught to understand the social structure of the community and how to work with community service professionals and control agency personnel. In addition, the training program currently includes training in office management and public speaking, lectures on mental illness and on the broader aspects of alcohol use and abuse, the history of alcohol use, cultural differences in drinking patterns, current drinking patterns in our society, etc. The training also includes field experience in the Cedar Rapids Information and Referral Office, the Des Moines Detoxification Center and in the State Hospitals. Both consultants and counselors should know how problem drinkers are handled in clinics where they might refer cases and be better prepared to receive such cases upon their discharge from the institution. They should have field experience in the local community service agencies such as welfare offices, police stations and courts. They should also have training in the operation and management of half-way houses. The consultants and counselors can contribute feedback for the development of the training program by regularly returning for refresher training.

Continuation training. We hope to continue to conduct postgraduate education for community service professionals. Gordon Nelson organized and successfully promoted several workshops and summer short courses for teachers, social workers, clergymen and industrial managers. Although this is a relatively inefficient means of educating the professionals as compared with the education they receive from consultants advising them regarding the handling of a case at hand, we believe it is a worthwhile adjunct.

Research. Consultants and counselors can also contribute to the development of the training program, and in turn, the improvement of their own operations by routinely sharing records and other information with the University Training and Research Center.

A three-year grant was obtained from NIMH in 1968 to con-

duct a follow-up study and evaluate the work of these community workers (Mulford, 1968). Certain preliminary findings were presented above. One of the significant accomplishments of the evaluation study to date has been the development of a standard intake form which is being used at Oakdale and Cedar Rapids and is now available to any agency or facility that wants to use it. The intake form is designed to describe the problem drinker's drinking pattern, family status, work status, general health and the trouble he is having with alcohol. A follow-up form has also been developed to measure changes in the life areas covered by the intake form and thus establish recovery rates.

Proceeding from the experience gained to date in evaluating Oakdale and Cedar Rapids, we propose to analyze, describe and compare the action programs of all communities and agencies that will cooperate. Cooperation means that the agency or facility personnel accept the concept of evaluation, and willingly and conscientiously employ the standard intake form to obtain data on all admissions. If the completed intake forms were routinely forwarded to the University Training and Research Center, the data would be computer processed which provides standardized record keeping for comparative evaluation of the efficacy of different programs. Hopefully this would lead to improved community action. This record keeping and research procedure has already been established with the Cedar Rapids Information and Referral Office and with the Oakdale Treatment Unit. To complete the evaluation, standardized follow-up data must later be collected on discharged cases served by the community offices. This is also currently being done for Oakdale and Cedar Rapids.

To the extent that these procedures can be established, we will be able to conclude that one agency operating in a particular fashion saw "X" number of cases and obtained certain results, while another agency using different procedures saw a different population with different results. From such comparisons we should be able to distill the most successful procedures and eliminate others. The results can then be fed into the development of an improved training program which in turn would mean improved community action.

Several communities now have action programs and the State Alcoholism Commission is encouraging more. Not all of the community workers have been trained by us. Some have had no special training, nor are the several communities attempting to follow exactly the same blueprint of action. This we see as an advantage; indeed, the communities should be permitted, even encouraged, to be innovative and to develop their own style of operation because this provides more input into the process and greater opportunity to distill improved action procedures and an improved training curriculum. Finally, since we have conducted two state-wide studies of drinking habits and attitudes and several community surveys, baselines have been established against which changes in alcohol use and abuse can be judged.

IMPLEMENTATION

Local citizens committees. The problems attending alcohol abuse are essentially local community problems and the local community should assume major responsibility for dealing with them. The community should begin by organizing a *local Citizens Committee on Alcohol Abuse* composed of members representing many segments of the community and the committee should be incorporated. While strong arguments can be made to integrate a community alcoholism program with an existing community service agency, we oppose this because the problem drinker usually gets left out of any service not dedicated especially to him. For example, the organizers of community mental health centers have long talked of "treating" alcoholics. However, in 1968 Iowa's 24 centers reported seeing 106 "alcoholics." Unless the consultants and counselors are responsible to a governing body whose members are no less dedicated to the problem drinker than are the workers themselves, the funds meant for the problem drinker will be siphoned off for cases considered to be "more deserving."

Once it is organized, the Citizens Committee should proceed to raise funds—from local sources if possible—to employ a trained consultant and counselor. An argument can be made for selecting a local citizen for one or both of these roles and sending him to the training center. A local citizen has the advantage of knowing the community. Considering that one of the qualifications for both the consultant and the counselor is that they must have had experience working with problem drinkers, a local citizen would have the advantage of already being acquainted with many of the problem drinkers in the community. It is especially important that local communities raise local funds so they are not dependent on the political whims of federal or state governments.

State Alcoholism Commission. Although the problem is essentially a local problem, local communities are not likely to develop a local program without encouragement and guidance from a central agency. One source of assistance is the State Alcoholism Commission. Legislation enacted by the 1969 General Assembly of Iowa (Senate File 525) enables the State Alcoholism Commission to fund all parts of the program we propose. In fact, the proposed plan implements all of the provisions of section 17, paragraph 1 through 11 of SF 525. The Commission currently provides grants-in-aid to local communities to encourage them to establish local programs. It is recommended that when a local program has been established state funds be gradually withdrawn as the local program finds local support. The Commission should then use the money saved to generate action in other communities. The Commission should also carry on vigorous public educational programs, including work with the public schools.

The University. The University should bring its two major services—training and research—to bear on the problem of alcohol use and abuse. We have already gained experience in training community consultants and counselors; and for more than a decade the Division of Alcohol Studies has been conducting research seeking greater understanding of alcohol use and abuse in the state. However, the amount and range of research has been limited and many other dimensions of the problem deserve study.

We propose that a University center provide training and research services to the local community in much the same way that agricultural extension divisions have served agriculture. The center should not only provide initial training for community workers, but should also maintain two-way communication channels with them after they go to work in the field. Community action and a University Training and Research Center should be thought of as a system, each providing input for the other with research facilitating the interaction.

We also propose that the several university departments and colleges which train students to enter the service professions—medicine, social work, law, religion, etc.—employ a faculty member who has a special commitment to the field of alcohol abuse. Hopefully, he would develop appropriate training and research in his own department, or he might have a joint appointment with the Center. An example of this is a pastor who holds an appointment in the School of Religion and is employed at the Oakdale Treatment Unit where he has developed a training program for pastors.

If the community consultant-counselor concept proposed is more consistent with the philosophy of an extension division than with that of a medical college, then the training and research program should be located in the extension division. It should be located in the most fertile soil for its growth and development and where it need cope with the fewest antibodies.

Iowa Alcoholism Foundation. The Iowa Alcoholism Foundation was established as a vehicle to channel private funds into the attack on problems of alcohol abuse. We recommend

that the Foundation provide supplementary funds for certain community programs or certain aspects of the training and research activities which the Foundation deems worthy, but which are not otherwise adequately funded. The Foundation might also adopt certain special projects for regular funding such as a summer school on alcohol abuse or a specific research project. The Foundation might fund a research or teaching "chair" at the University. It might underwrite the cost of bringing a Visiting Professor who is an expert in the field of alcohol abuse to one of the University departments for a year.

FINANCING

Considering that problem drinkers consume approximately one-half of all of the alcohol consumed, it is proposed that approximately one-tenth of the $15 million which the state annually collects from problem drinkers in the form of beer taxes and liquor profits be used to fund the plan being suggested. Considering that social services have traditionally been a county function, we propose that the legislature make available to the counties (rather than the cities) an additional $1 million annually and make it mandatory that the county employ these funds to support local Citizens Committees on Alcohol Abuse. We also recommend enabling legislation to permit the use of county taxes to directly fund local Citizens Committees.

It is recommended that the legislature continue to appropriate $500,000 per year to the State Alcoholism Commission to be used to further local community programs through grant-in-aid. This would give a central agency a degree of leverage by which to guide and coordinate local action. However, there should be a maximum of local community participation, commitment and control with a minimum of dictum from the state. Attempting to impose an action program on local communities is no more feasible than trying to force the drinker to change his attitudes toward alcohol.

If the entire plan we have proposed for the state is to become fully operational, the training and research program must also be funded in the amount of approximately $150,000 per year. Although training and research should be funded through the University, the way should be left open for the State Commission and local communities to contract with the University Center for Research and Training.

PREVENTION

While the community action proposed is aimed primarily at those cases that have already become problem drinkers, we believe that such action will contribute to prevention. Hopefully, the consultants' work with the professionals and the counselors' work with the problem drinkers plus their public education activities will have an educational impact on the entire community which will eventually lead to greater consensus regarding who drinks what, when, where, with whom, how much, and especially consensus on how much is too much. For example, if employers begin to take a firm stand making it clear to all employees that when drinking begins to interfere with job performance, corrective action will be taken, this would be a step toward consensus regarding criteria for "how much is too much." If and when such consensus develops, we could then join the Italian and Jewish cultures as one of the societies that has reduced problem drinking to an irreducible minimum. Given the present state of our knowledge, this is the only real solution to the problem of alcohol abuse that we can foresee.

SUMMARY AND CONCLUSION

We have redefined the problem of alcohol abuse and proposed a community based attack on it involving the cooperation of the local community, the State Alcoholism Commission, the Iowa Alcoholism Foundation and a University Training and Research Center. The proposed plan would have a trained consultant and a counselor in every community. Together they contact the problem drinker through consultation with the service professionals; with empathy for the drinker and understanding of the community they initiate and expedite the process of reintegrating him into the life of the community. This plan is presented as one which offers more help to more problem drinkers and more benefit to the community at less cost. In any case, it is in operation, it is testable, and it is being tested.

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Burlington Hawkeye
Burlington, Iowa

Jul 20 '75

Memo from Mac

Forty years ago this summer, three drunks in Akron, Ohio, got together to help each other with their problem, thereby starting Alcoholics Anonymous.

For most of these four decades, during which tens of thousands of lives have been touched and made better, most of the work with alcoholics has been a lonely, unpaid, disorganized effort. Those who cared the most, who worried the most about all the other lives that might be saved, if only the resources were available, yearned for the time when society would invest massive amounts of talent and money in the attack on this major illness.

The time has come. This year, Iowa will spend $1.4 million in state funds, $1 million in federal funds and about one-half million in local funds to treat alcoholics through 21 community service centers.

Utopia! The great day has dawned. And it has turned as flat and sour as a day-old glass of beer.

Instead of celebration, there is chagrin; instead of happiness, horror. The concern in Iowa is rapidly approaching an explosion point.

What has happened, in the words of Dr. H.A. Mulford of the University of Iowa, is that "A network of efficient local community alcoholism programs being developed by concerned citizens over the past few years is rapidly being overtaken by a mindless, costly and indifferent state bureaucracy."

What has happened, is that with all this state and federal money has come the necessary state and federal control — necessary, because you can't spend the taxpayers' money without accounting for it — and that requires endless and growing reams of paper to be filled out and filed and analyzed and reported on.

What has happened is what Harold Hughes warned about last year when he assessed the bureaucratic monster that his own great concern for alcoholics helped bring about.

Hughes said the development was inevitable and "there is nothing intrinsically wrong with it as long as we can preserve our perspective, humility and professional integrity," adding:

"Constant self-analysis is necessary. Are we truly interested in helping human beings in need, or is our involvement a device for massaging our egos by regimenting people in the guise of helping them?

"Do we feel ourselves beginning to surrender to the false glory of bureaucratic empire building?

"Are we in the alcohol and drug treatment scene because we like the gamesmanship — the exhilaration of writing grant applications, running training programs, doling out money, traveling around giving advice, savoring the title of expert?"

This is not merely a case of spending more money than ought to be spent. The worse danger is that the end result will be fewer, rather than more, alcoholics helped.

One service center director illustrated the problem: He is required now, under the new system, to have the alcoholic client fill out a long form regarding his personal history, preparatory to interviews by social service personnel. He is also required to sign a waiver authorizing a physician to file a statement with the state agency, certifying the client's alcoholic condition, and authorizing his treatment.

This all may seem normal enough bureaucratic paperwork for qualifying for other kinds of state aid. But for the typical alcoholic it is terrifying; it is guaranteed to drive him to the nearest bar, for another snort.

The reason AA is such an effective organization is that it is totally disorganized. There are no officers or titles or dues or membership cards or forms to fill out, or anything to sign. One drunk helps another; one neighbor another. It is local, personal, grassroots. And it is anonymous.

The state program is totally the opposite. It is not going to work. It may well destroy much of the work already done. The money is going to be spent not on alcoholics, but on the people hired to spend the money.

The State Commission on Alcoholism is meeting this week. It should listen to those who have been in the field a long time, and try to find the perspective and humility Hughes pleaded for.

John Mc Cormick