

# Accelerating the Natural Alcoholic Recovery Process

by

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Alcoholism movement running out of time and support. In the wake of the ill fated prohibition movement, the alcoholism disease concept emerged to generate public support for another formal movement to combat alcohol abuse. Consequently, public reactions to alcoholics are generally more humane today, community services are more available to them and more of them are being hospitalized, undoubtedly saving lives. Nonetheless, the reconvening of this Congress underscores the failure of the movement to achieve its major goals.

The movement has failed to prevent more drinkers from drinking more alcohol, more irresponsibly and with more problems than ever before (Whitehead, 1976; Popham, 1976; Keller, 1976; de Lint, 1971; Keller, 1974). In the State of Iowa, for example, after generations of stability, average consumption began to rise in 1958. Since then, annual per capita alcohol sales have nearly doubled (Iowa Beer and Liquor Control Dept.); and rates of liver cirrhosis deaths (with mention of alcohol) have increased approximately 150% (Iowa State Dept. of Health).

Rehabilitation efforts have failed. The hopes of defining alcohol abuse as a technical problem, and of finding a "quick techno-fix" have not been realized. The definition, etiology, diagnosis, treatment, prognosis and prevention of alcoholism all remain a mystery. Evidence accumulates that recovery rates are independent of the type, duration and intensity of alcoholism treatments. It remains to be shown that any formal treatment adds anything of special benefit to the alcoholic's natural maturing out process. (Emrick, 1974, 1975; Armor, 1976; Edwards, 1977a; Clare, 1976).

Harmless? Activity. Furthermore, there is no evidence that treatment effectiveness is improved by enlarging administrative structures; constructing buildings and staffing them with costly, highly trained professionals; implementing program accreditation, staff certification, and licensing standards; conducting training programs to improve management and therapeutic skills; tightening accountability, with increased documentation, and constant program review; or even employing consultants. Although such activity may temporarily improve the image of the alcoholism movement, no amount of it can compensate for an ineffective treatment; and there is evidence (presented later) that the activity is not entirely harmless.

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Also, the alcoholism disease concept and the action it has spawned may be contributing indirectly to increased consumption and increased problems. For want of a technical prophylactic the alcoholism movement has made little effort to prevent alcohol abuse, much less restrict consumption. The idea that alcoholics are a species apart whose drinking is attributable to a "disease" not effecting other drinkers has provided a rationale for liberalizing liquor control laws, resulting in increased consumption and more irresponsible drinking (Popham, 1976; Schmidt, 1976; Robinson, 1976; Makela, 1970). In Iowa, when liquor by the drink became available in 1963, the annual per capita sales growth rate doubled. When the drinking age was lowered in 1972-73 the rate doubled again. As already mentioned, liver cirrhosis deaths more than kept pace.

When the State or Federal Government establishes a center promising to solve a problem that has vexed the community as long as alcohol abuse has, the local citizens welcome the excuse to disengage themselves from the problem. Moreover, the presence of a center to treat the health consequences of alcohol abuse tends to weaken the individual's sense of responsibility to control his own (and other's) drinking behavior (Knowles, 1977). One even hears older Alcoholics Anonymous members complain of the growing tendency for newer members to "shirk their responsibilities" by considering 12th step work as merely a matter of transporting alcoholics to a treatment center.

It is hardly an exaggeration to characterize the alcoholism movement, so far, as a proliferation of treatment centers without a treatment and (a few) prevention programs without a preventative. Rehabilitation is largely the indiscriminate application of the center director's favorite (but unproven) treatment to an undefined disease in a target population that denies the disease and rejects the treatment. (Perhaps alcoholics know something we experts don't.)

Little wonder, then, that responsible voices are calling for reassessment and redesign of today's action (Clare, 1976; Edwards, 1977a; Reid, 1977). The Lancet (1977b) has editorially suggested that it is time to "radically recast" today's alcoholism treatment package. It is understandable too that local communities are becoming disenchanted with promises unfulfilled by a growing army of State and Federal administrators and technocrats. Taxpayers are becoming impatient and local governments are beginning to withhold financial support.

Public support for the alcoholism movement, like that for the prohibition movement, rests upon the shifting sands of public emotions and politics. They were propaganda not scientific achievements. The concurrent growth of the alcoholism movement, and the problems it is supposed to solve, makes it a vulnerable, early victim of any taxpayer revolt. Unless it soon begins to fulfill its promises the movement will self-destruct. History will record it as another formal effort to combat alcohol abuse, that proved even less successful than the prohibition movement it replaced.

Reasons for Failure of the movement include: 1) There is little rationale for it beyond the belief in the disease concept, blind faith

that a technical solution will soon be found, and the delusion that an effective treatment is already at hand requiring an elaborate, sophisticated, administrative structure for "proper" execution. 2) Like other formal efforts before it, the movement ignores the obvious success of the informal, natural forces and processes already controlling alcohol abuse. As a matter of survival, societies have always evolved "responsible" drinking norms with effective (if imperfect) informal controls of individual consumption. In this way our own society already accomplishes some 90% of the prevention task as well as a large part of the task of rehabilitating abusers (Room, 1975; Clare, 1976; Armor, 1976; Cahalan, 1970; Storm, 1969; Clark, 1976). How else are we to explain the considerable "spontaneous remission" rate? However, today's centers generally rely exclusively upon their own direct treatment, ignoring the likelihood that an alcoholic's experiences before and after treatment effect his drinking behavior to an extent that far outweighs the treatment itself (Reid, 1977; Armor, 1976; Pittman, 1969; Clark, 1975). 3) The history of formal efforts to further reduce alcohol abuse below that achieved by the drinking norms is a succession of presumed single causes and unitary remedies. When consensus has developed regarding "the" causal mechanism (e.g. the devil and moral weakness, deliberate misconduct, alcohol, a disease) then a unitary remedy (e.g. religious salvation, punishment, prohibition, medical treatment) has naturally followed. The results have invariably proven to be disappointing and the next generation has turned to another cause and another formal remedy. The time has come to shift from a static, unidimensional model to a multifactored, process model. It has been wisely said, "A problem properly defined almost solves itself."

An Alternative Model. There has been increasing speculation that alcoholics and recovered(ing) alcoholics represent dynamic processes (not static entities), which are influenced by a multitude of weak, interacting forces (not a unitary cause) (Jellinek, 1952, 1960; Trice, 1956; Chafetz, 1962; Plaut, 1967; Horn, 1969; Cahalan, 1970; Kissin, 1977; Tarter, 1976; Bacon, 1973; Armor, 1976).

Our own conceptualization of alcohol abusers (Mulford 1967, 1969, 1970, 1972, 1977a, 1978) can be summarized in terms of these propositions: 1) Becoming an alcoholic and becoming recovered are concurrent, lifelong, dynamic, progressive processes. 2) The two processes are not sequential as in Jellinek's (1952) phases model. Instead, the individual simultaneously progresses in both of them. Even as he becomes more alcoholic, forces are building toward recovery. 3) Both processes are influenced by partially overlapping sets of multiple social, psychological and physiological factors. Many of the same forces are common to both processes. 4) No single causal force, including any of today's treatments, exerts more than a weak influence on either process. 5) No single factor, except alcohol, is necessary, and none is sufficient, to cause alcoholism or recovery. 6) The forces influencing the processes are not static. Their presence, strengths, and direction of influence vary through time and from person to person. 7) The effects of the several forces are not simply additive, they interact. The effect of one variable often depends on the presence and strength of one or more of the others. 8) Whether the person is an "alcoholic" or a "recovered

alcoholic" at any given time depends upon the balance of forces. 9) The individual and the community have some control over these natural forces. 10) Given appropriate assistance they could manage them more effectively.

The Alcoholic/Recovery Processes. Elsewhere, we have presented the two processes in more detail (Mulford, 1972, 1977a, 1977b, 1978). Suffice it here to present an illustrative true case history. Mr. X was arrested and jailed, charged with drunk driving, after an auto accident early one morning. His wife called me at home that evening desperate for help. Mr. X had, for the first time, admitted a drinking problem, and agreed to talk with someone about it. She was concerned that the next day he would change his mind. I gave her the phone number of an Alcoholics Anonymous (AA) member who visited her husband within the hour.

The significance of this, all too familiar case, for present purposes is the glimpse it gives of the late stage (the "labeling" subprocess) of the recovery process and the workings of the natural forces involved. The alcoholic did his part. He got drunk and wrecked his car. The police did their part. They arrested and jailed him. This undoubtedly reenforced his motivation to do something about his drinking, as did the possibility of losing his wife and a hangover more severe now than when he was younger. The wife did her part. She recognized, and acted on, his readiness for help. I played a role by referring the wife to an AA member, who made his contribution. Even the local newspaper contributed by running a story on alcoholism, which is where the wife got my name.

Entering a 30-day inpatient treatment center was an option seriously considered by Mr. X and the AA 12th step worker. A few days later he went so far as to visit one for a few hours guided tour, an experience that probably became another force in his recovery process. In any event, Mr. X is still abstinent today, several months after his wife's call for help. He would generally be classed as a "spontaneous remission", since no formal treatment was involved.

The Labeling SubProcess. If Mr. X. resumes drinking, as do a large majority of alcoholics following any treatment, the "labeling" subprocess will intensify. He will be increasingly pressured, coerced and finally forced by some combination of wife, police, court, employer, physician, clergyman, etc. to "do something" about his drinking. At this point, he may enter a treatment center, by which time, he may be so far advanced toward recovery that little added force would be necessary to tip the balance to "recovery". Apparently, on the average, about one-third of those reaching treatment center admission desks are already "recovered." This would explain the "normal" recovery (abstinence) rate of about 30% for a great variety of treatments (Emrick, 1974, 1975). It would explain the Rand Report (Armor, 1976) findings that patients who did little more than sign into a treatment center had "remission" rates (liberally defined) of 53%. It would also explain the Edwards (1977a) experimental study findings that one session of advice by a treatment center staff achieved the same results as one year of treatment, including a six-week hospitalization when indicated. Twelve months

after intake "...about a third of the patients in either group had a 'slight or no' drinking problem". This study confirms the findings of earlier controlled studies (Mosher, 1975; Willems, 1973; Stein, 1975). Formal treatment, then, is just another weak force in the recovery process. Like the several other forces, it is neither necessary nor sufficient for recovery. Its contribution depends upon its coordination and interaction with the other recovery forces operating long before, and long after, the treatment experience.

Help or Frustration? Another aspect of this case illustrates a major growing weakness of today's alcoholism centers. Just before phoning me, Mrs. X had called the "Alcohol and Family Counseling Center." As one of Iowa's state controlled outpatient treatment centers, it has become a tightly structured, "professional" operation, fully accredited by The Joint Commission on the Accreditation of Hospitals (JCAH, 1974). However, it has also become less attuned, and less responsive, to the needs of alcoholics and their families. Mrs. X found little comfort and much frustration when a taped voice at the center answered her call for help. Had she called the center before it closed at 5 o'clock she would have been invited to come in the next day, fill out some forms, and enroll in an eight-week "coping group," after which Mr. X would be expected to come in, complete more forms and commence treatment - if he had not drunk himself to death in the meantime. Because of its narrow, highly structured approach, the one agency in the community specifically charged with helping alcoholics missed an opportunity to do so. Later, we shall consider evidence that many such opportunities are missed.

Alternative Action. The one recovery force most often missing today, the one most needed by alcoholics, and the one seldom found in today's formalized alcoholism centers is a catalytic agent - an understanding friend to help the alcoholic, and those about him, more effectively manage the natural recovery forces and accelerate progress in the recovery process.

For Mr. X, and for countless other alcoholics, AA 12th step workers function as the catalyst. For all its success, however, AA has not demonstrated any great capacity to substantially penetrate the target population or, on the average, reach alcoholics very early in their drinking careers. Aggressive outreach and follow-up are not part of the AA philosophy. The counselors in Iowa's community centers performed the outreach, follow-up and catalytic functions before the State restructured them into formal treatment centers. Now it offends the "professional" image of the centers to do more than expect alcoholics to seek out their treatment and then express a grateful, final good-bye at discharge. Efforts to be "professional" are to be applauded, so long as they are relevant and productive to the task at hand.

In recasting the alcoholism movement, let us suspend the alcoholism disease concept as a guide for action, but retain it as a guide for research. Conceivably, as suggested in a World Health Organization Report (Edwards, 1977b; Lancet, 1977a), the large and growing population of persons with drinking related problems contains

a small subgroup who are "alcohol dependent" and for whom science/technology will eventually find relief.

X A Community Alcoholism Agent. Meanwhile, as a supplement to AA, and as an alternative to formal treatment, we have proposed a "Community Alcoholism Agent" (CAA) to reach out to alcoholics and become an added (catalytic) force in their recovery process (Mulford, 1970; See also Hunt, 1973). As the catalyst in the individual's recovery process, the Alcoholism Agent functions as an outreach, motivator, advisor, empathic friend, confidant and "follow-upper" providing a long-term continuum of emotional support and common sense advice, all tailored to the individual case. As a catalyst for the larger community process, he is an educator, mobilizer, coordinator and motivator for anyone and everyone he can get involved in the individual's recovery process.

The objectives of the Community Agent include: 1) contact alcoholics, "If you don't see 'em you can't help 'em"; 2) contact them early in their drinking careers to maximize secondary prevention; 3) contact them under circumstances where there is a motivation base and where they are most receptive to someone becoming involved in their recovery; 4) maximize community involvement in each alcoholic's recovery; and 5) promote primary prevention by facilitating the ongoing community process of evolving more responsible drinking norms and strengthening informal controls.

Reaching Out. Toward these ends, the ideal place to contact alcoholics is through the community service professionals, social service and law enforcement agencies and employers. During the course of a year most alcoholics appear in the office of a community professional or service agency for one reason or another, but seldom including help for their drinking problem (Mulford, 1965). Rather, they seek services for a problem which turns out to be related to their drinking. Not only can alcoholics be found concentrated in these places, but contacting them there has advantages for the Agent's efforts to become a positive force in their recovery. Since they appear here in early, as well as later, stages of the alcoholic/recovery processes there is more opportunity for secondary prevention. Also, there is a motivation base to build on, viz., the health, job, law, marital or other drinking related problem that brought the person to the agency. Also there is no infringement of the alcoholic's civil liberties. In the final analysis, the alcoholic decides whether the Alcoholism Agent becomes involved in his life.

Contacting alcoholics in these places also creates an opportunity to promote primary prevention. Enlisting the community professionals, service agency personnel, employer, spouse, et. al., to become positive forces in the individual's recovery, means that the community is taking responsibility for alcohol abusers rather than leaving it to a government center. If the citizens must regularly deal with the consequences of alcohol abuse they will be less tolerant of excessive drinking and will tend to develop informal sanctions encouraging moderation.

Self-Help. To maximize community involvement, the catalyst does nothing for the alcoholic he can get someone else in the community to do. To maximize the alcoholic's involvement in his own recovery, the agent does nothing for the alcoholic that he can get the alcoholic to do for himself. At the same time, the alcoholic is assured that support for the long haul is readily available. Rather than viewing his client within the narrow parameters of the medical model, the alcoholic is seen through a wide angle lens in his day to day social, behavioral, economic and psychological environment. The CAA does not pretend to "counsel" alcoholics in the conventional sense of professional psychotherapy. He impresses on the alcoholic that recovery is not a thing to be purchased at the "treatment store". There is nothing anyone can do to or for him to bestow recovery. Treatments can be bestowed by government, recovery cannot. Recovery must be earned. The alcoholic benefits from the help of others in proportion to his own contribution to the process.

The agent emphasizes helping his client "act his way into new ways of thinking rather than think his way into new ways of acting." For example, the alcoholic is helped to fit himself back into community life through job, family, church, AA, etc., again depending upon the case. Initially the Agent may be the alcoholic's only friend. However, he begins immediately to help the alcoholic rebuild a support system in order to gain independence. In so doing, the Agent helps others in the community to relate to alcoholics in a constructive manner, e.g., advising them not to feed the alcoholic's dependency or let him use them to further his drinking. They are advised to manifest tough love and not to kill the alcoholic with kindness. The qualifications of the successful Community Agent include an abundance of intuition, empathy, tough concern, common sense, an ability to work with all kinds of people and a general competence to get things done (Lemere, 1964).

Given present knowledge, helping alcoholics is more art than science, involving a large "human element". Therefore, it would further the development of an alternative action strategy to suspend our religious-like faith that a technical "quick fix" for the problem of alcohol abuse is eminent, and give up the pretense that today's treatment centers already possess one. This will not be easy since our society's dependence on science and technology to solve all problems has become an addiction, not unlike the alcoholic's dependence on alcohol as a "quick fix" for all of his problems. However, alcohol abuse is mainly a human, not a technical problem. Like educating the next generation, for example, it involves human values and judgements for which there is no techno-fix (Schumacher, 1977).

Critics flatter the Community Alcoholism Agent approach by saying, "It isn't really treatment." We prefer to call it "helping alcoholics." Today's "real treatments" barely deserve to be called "helping alcoholics," especially considering the insignificant numbers being reached.

## Does It Work?

Performance Comparisons. The Community Agent, self-help approach has accumulated several years of experience in Iowa. The first center was opened by a local citizen's committee on alcoholism in 1966 with \$600 of borrowed money. Soon other communities followed suit. By January 1975, when a reorganized Iowa State Alcoholism Authority firmly established control of the centers, there were 43 of them. Early financing came mostly from local government and private sources. As more Federal and State funds were appropriated for alcoholism programs, they were, in effect, used by the State Alcoholism Authority to buy out the citizens' interest in the community centers and the centers lost their informal, flexible modes of operation.

Data from the State Monitoring System allows certain performance comparisons. Performance trends can be compared before and after State control of the centers. Also the performance of one center, which has maintained its independence and flexibility, can be compared with a contemporary State controlled center in an adjoining county.

Performance Measures. Accurate measures of the centers' overall impact are not available. There are no valid comparative counts of the total number of alcoholics served - much less the number actually helped. The Monitoring System Quarterly Reports do, however, contain reasonably valid measures of the centers' penetration of the target population and the unit costs, viz., the number of new client "Intake Schedules" forwarded to the monitoring system by the centers, and their quarterly expenditures. Regarding the comparative effectiveness of the approaches, it will be assumed, with good reasons, that on the average, the Community Agent's efforts to help alcoholics are no less effective than those of any other approach. Follow-up studies before the State took control of the centers found no difference, in several measures of outcome, for a six-week hospital based treatment and three community centers (Mulford, 1972; Fitzgerald, 1974; Mulford, 1974). These findings are consistent with the weight of evidence from hundreds of other follow-up studies evaluating alcoholism treatments (Emrick, 1974, 1975; Armor, 1976; Edwards, 1977a; Hill, 1967; Baekeland, 1975; Clare, 1976).

Before vs. After. A steady growth in the total number of new clients served by the centers (Mulford, 1975) continued through 1975, the first year of State control, and into the first quarter of 1976. As shown in Chart 1, the number of new clients declined markedly from 2,452 in the first quarter of 1976 to 1,193 for the December, 1977 quarter. (In fairness, the true figure for the December 1977 quarter may not be quite this low, reflecting a lag in reporting by some centers and delays of several months in the State's processing of the paper work. Evidence of this from one center will be seen below.)

While services were declining, center expenditures climbed from \$1.2 million to \$1.9 million - an increase of 58% in two years. Average unit costs, i.e. expenditures per new client, per quarter, more than tripled during this time from \$501 the first quarter of 1976 to \$1,638 the last quarter of 1977.



These trends were pervasive among the State controlled centers. Nor are the trends unique to Iowa's centers. The NIAAA National Monitoring System Quarterly Reports show that, for 31 centers across the nation with comparable data, quarterly expenditures increased 29% from the last quarter of 1974 to the last quarter of 1977. At the same time, new client intakes declined 17% and unit costs increased 55%, reaching \$2,133 per new client per quarter.

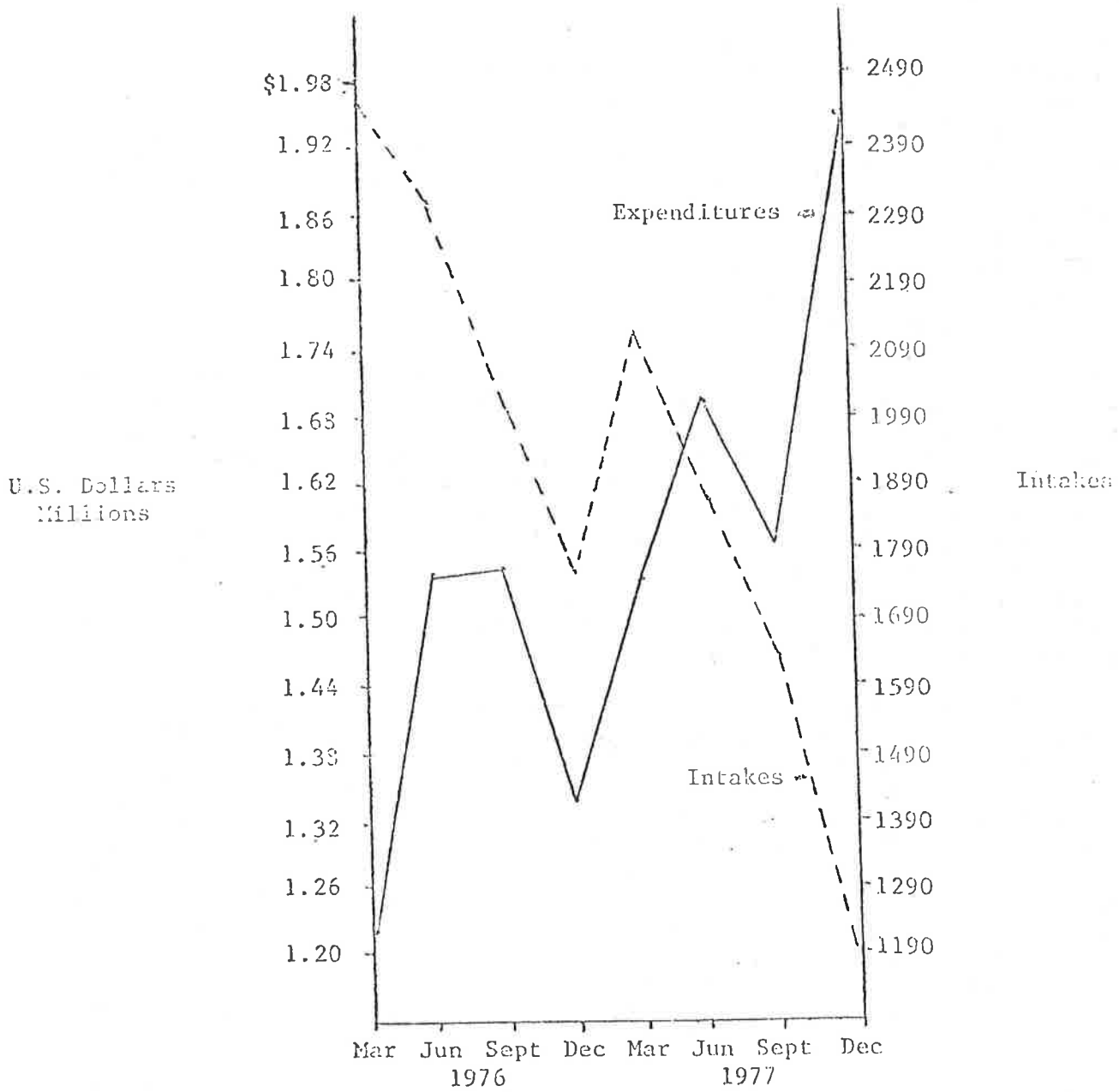
State Control vs. Independent Action. These steep trend lines for the State centers contrast with the consistently efficient performance of the independent center which still follows the Community Agent model, the Washington County Outreach Center. Although it specializes in helping persons with drinking problems it does not call itself, or pretend to be, an alcoholism treatment center. Staffed by a trained Alcoholism Agent and secretary/assistant the center serves one county of 19,000 total population. It is responsible to, and funded by, the county government with a budget of \$24,000 for fiscal year 1978. Financial management is handled by the County Auditor. There is a three-person citizen advisory board.

Unencumbered by State and Federal regulations and excessive paper work this flexible operation gets on with the task of helping alcoholics utilize community resources and build a social support system to further their own recovery. The Agent employs such common sense (some say "unprofessional") procedures as reaching out to contact alcoholics, making house calls (even after hours), initiating follow-up contacts with clients and sometimes inviting them to go fishing or hunting with him. The paper work, largely designed to tap client, rather than program variables, is minimal, yet quite adequate for documentation and accountability purposes, as well as contributing to the client/agent relationship.

Since 1975, its first full year of operation, the center has, with little variation, averaged 112 new clients per year or approximately nine per month. More than 200 individuals are served annually. During the six months ending, March 1978, the center saw 53 new clients, served 134 individuals and maintained an average monthly active case load of 77. Nearly half of them had contact with the center an average of once a week or more. The annual cost per individual served has been less than \$100. For the six-month period just mentioned it was \$90. The annual cost per new client, which has averaged approximately \$200 since the center opened, was \$226 during the recent six month reporting period. This is less than one-fourth the average for all centers, \$993 for 1977; it is less than one-seventh their average cost for the last quarter of 1977.

No less striking are the differences between the Washington Center performance and that of a State controlled center located in an adjoining county - the Mid-Eastern Communities Council on Alcoholism (MECCA). During 1977 MECCA served three times as many counties containing five times the total population, employed eight times the number of staff and had expenditures (\$243,466) ten times that of the Washington Center. Yet during the year it served only 204 new clients, with annual expenditures per new client (\$1,193), more than five times that of the Washington Center.

DOLLAR EXPENDITURES AND NEW  
CLIENT INTAKES, BY QUARTER  
MARCH 1976-DEC 1977, IOWA



SOURCE: Iowa Division on Alcoholism Quarterly  
Monitoring Reports

Contrasted with the fairly flat four year cost-benefit trend lines of the Washington Center are the sharply rising costs and declining services of MECCA since the second quarter of 1976. Its new client intakes declined a total of 68% in two years, from 91 during the March, 1976 quarter to only 29 during the last quarter of 1977. (Here too, part of the exceptionally low figure for the last quarter of 1977 partially reflects a paper work lag. According to MECCA's monthly reports to its policy board the decline was 43%). Giving MECCA the benefit of the doubt, and assuming that it actually served 52 new clients during the December 1977 quarter, its cost per new client would be \$1,088. In either case, it is a dramatic decline in efficiency.

Community Support. The community support earned by the Washington Center again contrasts with MECCA's loss of support. Interviews with Washington County and city officials found widespread, strong support for the Community Agent's work. The community is especially proud of an award the center received. In 1976, the U. S. Dept. of Housing and Urban Development (HUD) cited the center as a Bicentennial project exemplifying a model community self-help effort (U.S. Dept of HUD, 1976). By contrast, the declining efficiency of the MECCA Center has prompted its home county government to discontinue funding, a loss amounting to one half of the center's income.

How Did It Happen? What explains the above trends, especially the sudden, dramatic reversal in early 1976 of the number of alcoholics being served? How could this occur at the same time that: 1) the total number of centers nearly doubled (from 43 in 1974 to 73 today); 2) expenditures by the centers more than doubled (from \$2.8 mil. for CY 1974 to \$6.8 mil. for CY 1977; 3) the State Alcoholism Authority administrative staff and budget have both increased approximately 10 fold; 4) much time, effort and expense have been expended formulating, and annually updating, a State Plan and conducting countless conferences, workshops and training programs to improve administrative and counseling skills; 5) the centers have been under close scrutiny and constant review by the State; 6) accountability has been tightened, paper work ("documentation") has multiplied by an estimated factor of five; and finally, 7) all of the centers have received, or have been seeking, JCAH accreditation. (Incidentally, the initial cost of this accreditation would support the Washington County Center for over two years, thereby, serving 400 additional alcoholics.) Meanwhile, the one center which has remained independent of all the State's "upgrading" efforts continues a steady pace of delivering cost-effective help to alcoholics, their families and the community.

How can it be that well intentioned, intelligent, capable policy makers and administrators have apparently been doing "all the right things"; only to have the State's Monitoring System document such dramatically declining services and rising costs? Anticipating these developments in 1974, Senator Hughes warned of the "Alcohol and drug industrial complex" likely to grow at the expense of the alcoholics and the taxpayers (Alcoholism Report, 1974). What is worse is the growth in alcohol consumption and alcohol related problems that has accompanied all of this activity.

Why? Expenditures increase simply because the money is there. The bureaucracy sustains itself and grows by spending the money for activities most consistent with the basic premise underlying the initial appropriations, thereby, increasing the chances of continued funding. This self-perpetuation will continue until the public takes notice that: 1) the basic premise - i.e. the alcoholism disease concept - is merely an assumption; 2) nearly all initial promises remain unfulfilled; 3) while costs climb, services decline; and 4) the problem of alcohol abuse is getting worse.

What's in it for the alcoholic? Here is a classic example of "goal displacement." The State Alcoholism Authority's efforts to organize and tightly administer the centers culminated in early 1976 with the State requirement that the centers meet JCAH accreditation standards. It is probably more than coincidence that the reporting quarter in which services began to decline is precisely the quarter that the centers began preparing for accreditation. Many of them are still attempting to qualify even as the JCAH standards are about to be superseded by similar, more demanding, State licensing standards.

Apparently as the centers became immersed in efforts to gain accreditation, form displaced substance. Administrative needs superseded the needs of alcoholics. Centers previously committed to seeing and helping alcoholics - to prove their worth to the community if nothing else - soon discovered that obtaining State approval (necessary for State funding) involved new rules of the game. Under the new rules, the centers establish their claim to funding, not by serving alcoholics, but by correctly interpreting and implementing State directives and satisfactorily completing ever more paper work. To the extent that the centers turned to face the State Capitol, they turned their backs on the alcoholics and the communities they had been serving.

Before the reporting procedures were modified in April, 1977, the Monitoring System Reports showed the lopsided distribution of center expenditures and staff effort. The March 1977 quarterly report shows that, State-wide, only 37% of center expenditures, and 59% of staff time, were being devoted to direct services to alcoholics. The MECCA Center was devoting only 14% of expenditures and 36% of staff time to direct services. Consequently, throughout the State, several counselors who had been carrying large case loads resigned out of frustration.

The most unfortunate aspect of all of the State administrative activity (and expense) is that none of it has been demonstrated to benefit alcoholics, either individually or in the aggregate. Clearly, there is no benefit to alcoholics in the aggregate, since only one-half as many are being served today. The accumulated research gives us no reason to believe, and certainly there is no direct evidence, that treatment effectiveness for the individual has been improved. If so, it would represent a major breakthrough deserving to be verified and widely publicized.

One of the arguments for State control was local mismanagement of the centers. However, several center directors could have absconded

with their entire annual budget and the loss would not equal what the State central office spends to police them. This is not to mention the added cost to the centers themselves. Furthermore, there is no guarantee against mismanagement at the State level on a grander scale. Indeed, the recent performance trends for the centers suggest that State level management leaves much to be desired if cost-effective services to alcoholics is still the major program objective.

What to do? One thing that might be done about the cost-benefit trends revealed by the State Monitoring System is to again modify the reporting procedures to make the trends less obvious. Of more benefit to alcoholics, however, would be replacing the State Alcoholism Authority with a State Coordinating Agency to provide leadership, not directorship, for local centers - at least until there is a proven treatment or something of substance to direct. The model we suggest is the county Agricultural Extension Agent, who since the turn of the century, has been helping, but not directing, farmers to solve their agricultural problems (Cooperative Extension Service, 1976).

The three major components of a State program - services, CAA training, and monitoring/research - should be closely integrated by the State Coordinating Center with each of the three components providing feedback for the other two. What is learned from monitoring and research would be fed into the CAA training program. Graduating Agents would go into the field and provide feedback into the monitoring system. The monitoring system would collect data useful to the agent/client relationship, as well as for ongoing research. It would serve as a built-in, self-correcting, self-improving mechanism for gradually evolving more effective, efficient action. An experimental attitude should prevail throughout the entire program (Smart, 1972).

Rather than creating another bureaucracy as administratively complicated as that of the Cooperative Extension Agent we propose that the Alcoholism Agent be funded by, and be largely responsible to, the County government. To gain citizen input and involvement, there would be a local citizen's advisory council. A portion of the Alcoholism Agent's salary would come from the State central coordinating agency, so that the program would be a cooperative venture of local citizens and County and State government.

A version of the Alcoholism Agent approach can be found in a large metropolitan area. In Kansas City, Missouri, a central office employs nine community Alcoholism Agents who serve different community agencies, helping them to assist alcoholics. The cost effective performance of this urban operation rivals that of the rural Washington County Center. In fiscal year 1977, the nine Agents served 2,231 alcoholics with expenditures of \$243,129 and a unit cost of \$109 (Coughlin, 1978).

Summary. We have suggested that the alcoholism movement, generated by the disease concept, has about run its course. Evidence was offered that the movement is more promise than performance at ever greater expense. It does not deliver what it pretends to deliver to alcoholics - either individually or as a group. We have proposed an

alternative conceptual model leading to a simpler, more flexible, self-help, action strategy - The Community Alcoholism Agent. This approach pretends less but delivers more and for a fraction of the cost.

Recasting the alcoholism movement as proposed would involve very little trade off for anyone (except the growing army of administrators of today's programs):

1. The individual alcoholic loses nothing of proven benefit. He gives up exposure to a formal treatment - a fleeting experience of questionable value - for an ongoing social support system which includes the whole array of community services fitted to his particular needs.

2. Alcoholics in the aggregate lose nothing and gain much. Four to five times as many alcoholics could be served in Iowa if the funds currently being spent on formal alcoholism treatment centers and central administration were instead used to support centers of the informal Washington County type. In addition, the larger number of alcoholics served would, on the average, be reached earlier, allowing for secondary prevention.

3. The community at large and the taxpayer give up nothing and gain much. Beside the obvious economic savings and the greater penetration of, and impact on, the problem drinker population, there is a potential benefit of utmost importance for the long run. The Community Agent's modus operandi (i.e. getting the community involved in the individual alcoholic's recovery) should contribute to primary prevention.

## REFERENCES

- Alcoholism Report, Vol. III, No. 5, December 27, 1974.
- Armor, D.J., J.M. Polich and H.B. Stambul, Alcoholism and Treatment, Santa Monica, Cal.: The Rand Corporation, 1976.
- Bacon, S.D., "The Process of Addiction to Alcohol," Quart. J. Stud. Alc. 34:1-17, 1973.
- Baekeland, F., L. Lundwall, and B. Kissin, "Methods for the Treatment of Chronic Alcoholism: A Critical Appraisal," in Research Advances in Alcohol and Drug Problems. R.J. Gibbins, Y. Israel, H. Kalant, R.E. Popham, W. Schmidt and R.G. Smart (eds.), Vol. 2, London: Wiley, 1975.
- Cahalan, D., Problem Drinkers, San Francisco: Jossey-Bass, Inc., 1970.
- Chafetz, M.E. and H.W. Demone, Jr., Alcoholism and Society. New York: Oxford University Press, 1962.
- Clare, A.W., "How Good is Treatment", In Alcoholism: New Knowledge and New Responses, G. Edwards and M. Grant (eds.) Baltimore: Univ. Park Press, 1976.
- Clark, W., "Conceptions of Alcoholism: Consequences for Research," Addict. Dis. Flushing, N.Y. 1:395-430, 1975.
- Clark, W., "Loss of Control, Heavy Drinking and Drinking Problems in a Longitudinal Study," J. Stud. Alc. 37:1256-90, 1976.
- Cooperative Extension Service, Iowa State University. Background of...Cooperative Extension Work in Iowa and Provisions of the County Agricultural Extension Law. Iowa State University, Ames, Iowa, 1976.
- Coughlin, G., Personal Communication. Jackson County Public Hospital, Kansas City, MO 1978.
- de Lint, J. and W. Schmidt, "Consumption Averages and Alcoholism Prevalence; A Brief Review of Epidemiological Investigations." Br. J. Addiction, 66: 97-107, 1971.
- Edwards, G., J. Orford, S. Egert, et al., "Alcoholism: A Controlled Trial of 'Treatment' and 'Advice'," J. Stud. on Alc. 38:1004-1031, 1977a.
- Edwards, G., M. Gross, M. Keller, J. Moser, R. Room (eds.), Alcohol Related Disabilities. Offset Pub. No. 32, Geneva: World Health Organization, 1977b.
- Emrick, C.D., "A Review of Psychologically Oriented Treatment of Alcoholism. I. The Use and Interrelationship of Outcome

- Criteria and Drinking Behavior Following Treatment," *Quart. J. Stud. Alc.* 35:523-549, 1974.
- Emrick, C.D., "A Review of Psychologically Oriented Treatment of Alcoholism: II. The Relative Effectiveness of Different Treatment Approaches and the Effectiveness of Treatment Versus No Treatment," *J. Stud. Alc.* 36:88-108, 1975.
- Fitzgerald, J. and H.A. Mulford, *The Jackson County Alcoholism Program: A Follow-up Evaluation.* Div. Alc. Stud., Univ. of Iowa, Iowa City, 1974.
- Hill, M.J. and H.T. Blane, "Evaluation of Psychotherapy with Alcoholics: A Critical Review." *Quart. J. Stud. Alc.* 28:76-104, 1967.
- Horn, J.L. and K.W. Wanberg, "Symptom Patterns Related to Excessive Use of Alcohol," *Quart. J. Stud. Alc.* 30:35-58, 1969.
- Hunt, G.M. and N.H. Azrin, "A Community-Reinforcement Approach to Alcoholism," *Behav. Res. and Therapy* 11:91-104, 1973.
- Iowa Beer and Liquor Control Dept. Annual Reports, Des Moines, Iowa.
- Iowa State Dept. of Health, Statistical Services, Des Moines, Iowa.
- Jellinek, E.M., "Phases of Alcohol Addiction," *Quart. J. Stud. Alc.* 13:673-684, 1952.
- Jellinek, E.M., *The Disease Concept of Alcoholism.* New Brunswick, N.J.: Hillhouse Press, 1960.
- JCAH, *Joint Commission on Accreditation of Hospitals, Accreditation Manual for Alcoholism Programs,* JCAH, Chicago, 1974.
- Keller, M. (ed.) *Second Special Report to the U. S. Congress on Alcohol and Health: New Knowledge.* Rockville, Maryland: HEW, NIAAA, 1974.
- Keller, M. and C. Gurioli, "Statistics on Consumption of Alcohol", New Brunswick, N.J.: *J. Stud. Alc. Inc.*, 1976.
- Kissin, B., "Theory and Practice in the Treatment of Alcoholism" in *The Biology of Alcoholism, Vol. 5, Treatment and Rehabilitation of the Chronic Alcoholic,* Kissin, B. and Begleiter, H. (eds.). New York: Plenum Press, 1977.
- Knowles, J.H., "Responsibility for Health," *Science* 198:1103, 1977.
- Lancet, "W.H.O. and a New Perspective on Alcoholism", *The Lancet*, pp. 1087, May 21, 1977a.
- Lancet, "The Alcoholism Treatment Package," *The Lancet*, pp. 488, September 3, 1977b.



- Lemere, F., "Who is Qualified to Treat the Alcoholic? Comment on the Krystal-Moore Discussion." *Quart. J. Stud. Alc.* 25:558-560, 1964.
- Makela, K., "The Frequency of Drinking Occasions According to Consumed Beverages and Quantities Before and After the New Liquor Laws," *Alkoholipolitukka* 35:246, 1970 (as reported in Robinson, 1976).
- Mcsher, V., J. Davis, D. Mulligan and F.L. Iber, "Comparison of Outcome in a 9-Day and 30-Day Alcoholism Treatment Program." *J. Stud. Alc.* 36:1277-81, 1975.
- Mulford, H.A., "Alcohol and Alcoholics, in Iowa, 1965." Iowa City, Iowa: Univ. of Iowa Press, 1965.
- Mulford, H.A., "Alcoholism: A Concern (and Creation of Every Community," in Selected papers. Washington, D.C.: North Amer. Assoc. Alc. Programs, 1967.
- Mulford, H.A., "'Alcoholics,' 'Alcoholism' and 'Problem Drinkers': Social Objects-in-the-Making," A Report to the National Center for Health Statistics, U. S. Dept. HEW (Contract No. PH-86-65-91), 1969.
- Mulford, H.A., "Meeting the Problem of Alcohol Abuse: a Testable Action Plan for Iowa," in Selected papers, San Antonio, Texas, North Amer. Assoc. Alc. Programs, 1970.
- Mulford, H.A., "Becoming an Ex-problem Drinker," Paper read at the 30th Inter. Cong. on Alc. and Drug Depend., Amsterdam, 1972. *Div. Alc. Stud., Univ. of Iowa, Iowa City, 1972.*
- Mulford, H.A. and M. Hansel, A Follow-up Evaluation of Iowa's Community Alcoholism Centers, *Div. Alc. Stud., Univ. of Iowa, Iowa City, 1974.*
- Mulford, H.A., Fourth Annual Report to Directors, Iowa Alcoholism Programs for the Period January 1 - December 31, 1974: A Comparative Analysis of New and Return Client Caseloads and Five Year Trends. *Div. of Alc. Stud., Univ. of Iowa, Iowa City, 1975.*
- Mulford, H.A., "Stages in the Alcoholic Process: Toward a Cumulative Nonsequential Index," *J. Stud. Alc.* 38:563-583, 1977a.
- Mulford, H.A., "Women and Men Problem Drinkers. Sex Differences in Patients Served by Iowa's Community Alcoholism Centers," *J. Stud. Alc.* 38:1624-1639, 1977b.
- Mulford, H.A. and H. Moessner, "Alcohol Abuse and the Family Physician," in *Family Practice*. Rakel, R.E. and Conn, H.F., (eds.), Phila.: W.B. Saunders Co., 1978.

- Pittman, D.J. and R.L. Tate, "A Comparison of Two Treatment Programs for Alcoholics." *Quart. J. Stud. Alc.*, 30:888-899, 1969.
- Plaut, T.F.A., *Alcohol Problems: A Report to the Nation by the Cooperative Commission on the Study of Alcoholism.* New York: Oxford University Press, 1967.
- Pcpham, R.E., W. Schmidt and J. de Lint, "The Effects of Legal Restraint on Drinking," in *The Biology of Alcoholism*, Vol. 4, Social Aspects of Alcoholism, Kissin, B. and Begleiter, H. (eds.), New York: Plenum Press, 1976.
- Reid, A., *Alcohol and Drug Treatment in Ontario: A Review of Current Programs.* Report prepared for the Task Force on Treatment of the Addiction Research Foundation of Ontario, Univ. of Manitoba, Winnipeg, Manitoba, 1977.
- Robinson, D., "Factors Influencing Alcohol Consumption," in *Alcoholism: New Knowledge and New Responses.* Edwards, G. and Grant, M. (eds.), Baltimore: University Park Press, 1976.
- Rcom, R., "The Measurement and Distribution of Drinking Patterns and Problems in General Pcpulations," WHO paper OMH/C/75.5, 1975.
- Schmidt, W., "Cirrhosis and Alcohol Consumption: An Epidemiological Perspective," in *Alcoholism: New Knowledge and New Responses*, Edwards G. and Grant, M. (eds.), Baltimore, Maryland: University Park Press, 1976.
- Schumacher, E.F., *A Guide for the Perplexed.* New York: Harper and Row, 1977.
- Smart, R. G., "Trapped Administrators and Evaluation of Social and Community Development Programs." *Addictions*, Vol. 19 (winter), pp. 46-57, 1972.
- Stein, I., J. R. Newton and R.S. Bowman, "Duration of Hospitalization for Alcoholism," *Arch. Gen. Psychiat.* 32:247-252, 1975.
- Storm, T. and R.E. Cutler, "Treated and Untreated Alcoholics: Some Reflections on the Role of Treatment in the Process of Recovery from Alcoholism." Paper presented by Thomas Storm at the 1969 meetings of the North American Association of Alcoholism Programs, Vancouver, British Columbia, Canada, 1969.
- Tarter, R.E. and D.U. Schneider, "Models and Theories of Alcoholism," in *Alcoholism: Interdisciplinary Approaches to an Enduring Problem*, Tarter, R.E. and Sugarman, A.A. (eds.) Mass: Addison-Wesley Publishing Co., 1976.
- Trice, H.M., "Alcoholism: Group Factors in Etiology and Therapy," *Human Organization* 15:33-40, 1956.

U.S. Dept. Housing and Urban Development, "Horizons on Display: A Catalogue of Community Achievements," Stock No. 023-000-00312-1, Supt. Doc. U.S. printing office, Washington, D.C., 1976.

Whitehead, P.C. and R.G. Ferrence, "Women and Children Last: Implications of Trends in Consumption for Women and Young People", in Alcoholism Problems in Women and Children, M. Greenblatt and M.A. Schuckit (eds.), New York: Grune and Stratton, Inc., 1976.

Willems, P.J.A., F.J.J. Letemendia and F. Arroyave. "A Two Year Follow-up Study Comparing Short with Long Stay In-patient Treatment of Alcoholics." Br. J. Psych. 122:637-648, 1973.