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**ALCOHOL ABUSE AND ALCOHOLISM PREVENTION,
TREATMENT, AND REHABILITATION**

GOVERNMENT

Storage

HEARINGS

BEFORE THE

**SPECIAL SUBCOMMITTEE ON
ALCOHOLISM AND NARCOTICS**

OF THE

**COMMITTEE ON
LABOR AND PUBLIC WELFARE
UNITED STATES SENATE**

NINETY-FIRST CONGRESS

SECOND SESSION

ON

S. 3835

**TO PROVIDE A COMPREHENSIVE FEDERAL PROGRAM FOR THE
PREVENTION AND TREATMENT OF ALCOHOL
ABUSE AND ALCOHOLISM**

MAY 21 AND 25, 1970

Printed for the use of the
Committee on Labor and Public Welfare

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ALCOHOL ABUSE AND ALCOHOLISM PREVENTION, TREATMENT, AND REHABILITATION

THURSDAY, MAY 21, 1970

U.S. SENATE,
SPECIAL SUBCOMMITTEE ON ALCOHOLISM AND NARCOTICS
OF THE COMMITTEE ON LABOR AND PUBLIC WELFARE,
Washington, D.C.

The subcommittee met at 9:15 a.m., pursuant to notice, in room 1114, New Senate Office Building, Senator Harold E. Hughes (chairman of the subcommittee) presiding.

Present: Senator Hughes.

Staff members present: Robert O. Harris, staff director; Wade Clarke, majority counsel; Jay B. Cutler, minority counsel.

Senator HUGHES. The hearings of the Senate Subcommittee on Alcoholism and Narcotics will come to order.

This hearing is on S. 3835, the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970.

(The bill, with a summary, outline, section-by-section analysis, and departmental reports follow:)

(1)

IN THE SENATE OF THE UNITED STATES

MAY 14, 1970

Mr. HUGHES (for himself, Mr. JAVITS, Mr. MOSS, Mr. ANDERSON, Mr. BAKER, Mr. BAYH, Mr. BIBLE, Mr. BROOKE, Mr. BURDICK, Mr. CANNON, Mr. CHURCH, Mr. CRANSTON, Mr. DOLE, Mr. EAGLETON, Mr. FULBRIGHT, Mr. GOODELL, Mr. GRIFFIN, Mr. GURNEY, Mr. HARRIS, Mr. HART, Mr. HARTKE, Mr. HOLLINGS, Mr. INOUE, Mr. JACKSON, Mr. KENNEDY, Mr. MCCARTHY, Mr. MCGEE, Mr. MCINTYRE, Mr. MANSFIELD, Mr. MATHIAS, Mr. METCALF, Mr. MONDALE, Mr. MONTROYA, Mr. MURPHY, Mr. MUSKIE, Mr. PACKWOOD, Mr. PELL, Mr. PERCY, Mr. PROUTY, Mr. RANDOLPH, Mr. SCHWEIKER, Mr. SMITH of Illinois, Mr. SPARKMAN, Mr. TYDINGS, Mr. WILLIAMS of New Jersey, Mr. YARBOROUGH, and Mr. YOUNG of Ohio) introduced the following bill; which was read twice and referred to the Committee on Labor and Public Welfare

A BILL

To provide a comprehensive Federal program for the prevention and treatment of alcohol abuse and alcoholism.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SHORT TITLE**

4 This Act may be cited as the "Comprehensive Alcohol
5 Abuse and Alcoholism Prevention, Treatment, and Rehabili-
6 tation Act of 1970".

7 **TITLE I—FINDINGS AND DECLARATION OF**
8 **PURPOSES**

9 SEC. 101. The Congress hereby finds that—

10 (a) Alcohol abuse and alcoholism are rapidly increasing
11 throughout the country. Alcohol abuse can seriously impair

1 health and can lead to alcoholism. Alcoholism is an illness
2 or disease that requires treatment through health rehabilita-
3 tion services.

4 (b) Alcoholism treatment and control programs should,
5 whenever possible, be community based; provide a compre-
6 hensive range of services, including emergency treatment,
7 under proper medical auspices on a coordinated basis; and be
8 integrated with and involve the active participation of a
9 wide range of public and nongovernmental agencies.

10 (c) Existing laws have not been adequate to prevent
11 alcohol abuse or to provide sufficient education, treatment,
12 and rehabilitation of alcoholics. Increasing education, treat-
13 ment, and rehabilitation services, and closer coordination of
14 efforts, offer the best possibility of reducing alcohol abuse
15 and alcoholism. A major commitment of health and social
16 resources and Government funds is required to institute an
17 adequate and effective Federal program for the prevention
18 and treatment of alcohol abuse and alcoholism.

19 (d) Present Federal programs for alcohol abuse and
20 alcoholism are relegated to a low level of priority and remain
21 uncoordinated within the Government.

22 (e) Federal officials have failed to effectively handle
23 alcoholism among those for whom the Government has
24 special responsibilities—civilian employees, military person-
25 nel, veterans, Federal offenders, American Indians, and
26 Alaskan Natives.

1 (f) Existing Federal research, social, health, and re-
2 habilitation laws have not adequately been used to attack
3 alcohol abuse and alcoholism. Lack of Federal leadership and
4 funding has also contributed to the failure of public and
5 private State and local agencies to recognize their respon-
6 sibilities for meeting these problems.

7 (g) Dealing with public inebriates as criminals has
8 proved expensive and burdensome. The criminal law alone
9 is ineffective to deter what are basically major health and
10 rehabilitation problems.

11 (h) Establishment of modern public health programs
12 for the medical management of alcohol abuse and alcoholism
13 facilitate (1) early detection and prevention of alcoholism
14 and effective treatment and rehabilitation of alcoholics, (2)
15 diagnosis and treatment of other concurrent diseases, and
16 (3) uncovering and providing assistance with underlying
17 psychological and social problems.

18 (i) Handling alcohol abusers and alcoholics primarily
19 through health and other rehabilitative programs relieves
20 the police, courts, correctional institutions, and other law
21 enforcement agencies of an onerous burden that interferes
22 with their ability to protect citizens, apprehend law violators,
23 and maintain safe and orderly streets.

24 SEC. 102. The Congress declares that—

25 (a) There shall be established and maintained within

1 the National Institute of Mental Health of the Department
2 of Health, Education, and Welfare, a National Institute for
3 the Prevention and Control of Alcohol Abuse and Alcohol-
4 ism, through which the Secretary shall coordinate all Fed-
5 eral health, rehabilitation, and other social programs related
6 to the prevention and treatment of alcohol abuse and alco-
7 holism and administer the programs and authorities estab-
8 lished by this Act.

9 (b) Major Federal action and Federal assistance to
10 State and local programs shall be undertaken to engage in
11 and encourage planning, coordination, statistics, research,
12 training, and education with respect to alcohol abuse and
13 alcoholism, and to provide equal access to humane care, ef-
14 fective treatment, and rehabilitation for all alcoholics regard-
15 less of their circumstances.

16 (c) In addition to the funds provided for under this
17 Act, other Federal legislation providing for Federal or
18 federally assisted research, prevention, treatment, or rehabili-
19 tation programs in the fields of health, education, welfare,
20 rehabilitation, and highway safety shall be utilized to reduce
21 alcohol abuse and alcoholism.

22 TITLE II—DEFINITIONS

23 SEC. 201. For the purposes of this Act—

24 (a). "Alcohol abuse" means any use of any alcoholic
25 beverage that results in intoxication which endangers per-
26 sons or property.

1 (b) "Alcoholic" means any person whose repetitive use
2 of alcohol causes him physical, psychological, or social harm.

3 (c) "Alcoholic beverage" includes alcoholic spirits,
4 liquors, wines, beer, and every liquid or fluid, patented or
5 not, containing alcoholic spirits, wine or beer which is ca-
6 pable of being consumed by human beings and produces in-
7 toxication in any form or in any degree.

8 (d) "Alcoholism" means any condition characterized
9 by the repetitive use of alcohol to an extent that causes the
10 drinker physical, psychological, or social harm.

11 (e) "Courts" includes all Federal courts, including any
12 United States magistrate.

13 (f) "Department" means the Department of Health,
14 Education, and Welfare.

15 (g) "Emergency medical services" includes all appro-
16 priate short term services for the acute effects of alcohol
17 intoxication which (1) are available twenty-four hours a
18 day, (2) are community based and located so as to be
19 quickly and easily accessible to patients, (3) are affiliated
20 with, and constitute an integral (but not necessarily physi-
21 cal) part of, the general medical services of a general hos-
22 pital, and (4) provide detoxification and other appropriate
23 medical care and treatment, professional examination, evalu-
24 ation, diagnosis and classification with respect to possible
25 alcoholism, and referral for other treatment and rehabilita-
26 tion.

1 (h) "Inpatient services" includes all treatment and re-
2 habilitation services for alcohol abuse and alcoholism pro-
3 vided for a resident patient while he spends full time in a
4 treatment institution.

5 (i) "Institute" means the National Institute for the Pre-
6 vention and Control of Alcohol Abuse and Alcoholism within
7 the National Institute of Mental Health of the Department of
8 Health, Education, and Welfare.

9 (j) "Intermediate care services" includes all treatment
10 and rehabilitation services for alcohol abuse and alcoholism
11 for a resident patient while he spends part time in a treat-
12 ment institution (including but not limited to a halfway
13 house, hostel, or foster home) which is community based and
14 located so as to be quickly and easily accessible to patients.

15 (k) "Outpatient services" includes all treatment and
16 rehabilitation services (including but not limited to clinics,
17 social centers, vocational rehabilitation services, welfare serv-
18 ices, and job referral services) for alcohol abuse and alcohol-
19 ism provided while the patient is not a resident of a treat-
20 ment institution, which are community based and located so
21 as to be quickly and easily accessible to patients.

22 (l) "Prevention and treatment" includes all appropri-
23 ate forms of educational programs and services (including but
24 not limited to radio, television, films, books, pamphlets, lec-
25 tures, seminars, workshops, conferences, adult education,

1 and school courses) ; planning, coordinating, statistical, re-
2 search, training, evaluation, reporting, classification, and
3 other administrative, scientific, or technical programs or
4 services; and screening, diagnosis, treatment (emergency
5 medical care, inpatient, intermediate care, and outpatient) ,
6 vocational rehabilitation, job training and referral, and other
7 rehabilitation programs or services.

8 (m) "Secretary" means the Secretary of Health, Educa-
9 tion, and Welfare.

10 (n) "State" includes the District of Columbia, the Vir-
11 gin Islands, Puerto Rico, Guam, American Samoa, and the
12 Trust Territory of the Pacific Islands, in addition to the fifty
13 States.

14 TITLE III—NATIONAL INSTITUTE FOR THE PRE-
15 VENTION AND CONTROL OF ALCOHOLISM

16 ESTABLISHMENT OF THE INSTITUTE

17 SEC. 301. (a) There is hereby established within the
18 National Institute of Mental Health of the Department of
19 Health, Education, and Welfare, a National Institute for the
20 Prevention and Control of Alcohol Abuse and Alcoholism, to
21 administer the programs and authorities assigned to the Sec-
22 retary by this Act. The Secretary, acting through the Insti-
23 tute, shall develop and conduct a comprehensive health, edu-
24 cation, research, and rehabilitation program for the prevention
25 and treatment of alcohol abuse and alcoholism.

1 (b) The Institute shall be under the direction of a Di-
2 rector who shall be appointed by the Secretary.

3 (c) The Institute and its programs and services shall
4 be staffed with an adequate number of personnel, who shall
5 possess appropriate qualifications and competence, and some
6 of whom may be recovered alcoholics. Prior criminal arrests
7 or convictions shall not be a bar to such employment.

8 (d) In recognition of the increased responsibilities as-
9 signed by this Act, the title of the National Institute of Mental
10 Health is hereby changed to the National Institutes of Mental
11 Health.

12 ADMINISTRATIVE FUNCTIONS OF THE SECRETARY

13 SEC. 302. It shall be the duty of the Secretary, acting
14 through the Institute, with respect to his administrative
15 functions to—

16 (a) assist Federal departments and agencies in the
17 development and maintenance of appropriate prevention,
18 treatment, and rehabilitation programs and services in
19 accordance with section 304 (a) of this Act;

20 (b) review and provide in writing an evaluation of
21 the adequacy and appropriateness of the provisions re-
22 lating to the prevention and treatment of alcohol abuse
23 and alcoholism of all comprehensive State health, wel-
24 fare, and rehabilitation plans submitted to the Federal
25 Government pursuant to Federal law, including but not

1 limited to those submitted pursuant to section 35 (a)
2 (15) of title 29 and sections 246 (a) (2) (L), 291c (a)
3 (4), 1396a (a) (31), and 2684 (11) of title 42 of the
4 United States Code;

5 (c) administer the grants and contracts authorized
6 under title VI of this Act; and

7 (d) administer any other service or program, or
8 take any other action, consistent with the intent and
9 objectives of this Act.

10 PLANNING FUNCTIONS OF THE SECRETARY

11 SEC. 303. It shall be the duty of the Secretary, acting
12 through the Institute, with respect to his planning function
13 to—

14 (a) develop a detailed and comprehensive Federal
15 alcohol abuse and alcoholism control plan to implement
16 the objectives and policies of this Act. The plan shall be
17 submitted to Congress as soon as practicable, but not
18 later than one year after the enactment date of this Act.
19 Other responsibilities of the Secretary, as set out in this
20 Act, shall not be interrupted or delayed pending the
21 initial development of such a plan. The plan shall be
22 reviewed annually and submitted to Congress with any
23 appropriate revisions as part of the Secretary's annual
24 report. The Secretary shall, in developing the com-

1 prehensive Federal plan, consult and collaborate with
2 all appropriate public and private departments, agencies,
3 institutions, organizations, and individuals. The plan
4 shall specify how all available health, welfare, educa-
5 tional, and rehabilitation resources, and how funds, pro-
6 grams, services, and facilities authorized under existing
7 Federal legislation, are to be utilized;

8 (b) carry out a complete evaluation of existing
9 and ongoing alcohol education materials and programs,
10 and alcohol abuse and alcoholism prevention campaigns;

11 (c) develop models of alcoholism treatment and re-
12 habilitation legislation for State and local governments,
13 which utilize the concepts incorporated in this Act;

14 (d) develop model alcohol abuse and alcoholism
15 control plans for State and local governments, utilizing
16 the concepts incorporated in the comprehensive Federal
17 plan. The model plans shall be reviewed on a periodic
18 basis and revised to keep them current. They shall spec-
19 ify how all types of community resources and existing
20 Federal legislation may be utilized;

21 (e) provide assistance and consultation to State and
22 local governments and private organizations, agencies,
23 institutions, and individuals with respect to the preven-
24 tion and treatment of alcohol abuse and alcoholism; and

25 (f) encourage and promote, throughout the country,

1 public health procedures for the treatment of alcoholics
2 as alternatives to present criminal procedures.

3 COORDINATION FUNCTIONS OF THE SECRETARY

4 SEC. 304. It shall be the duty of the Secretary, acting
5 through the Institute, with respect to his coordinating func-
6 tions to—

7 (a) assist the Civil Service Commission, the De-
8 partment of Defense, the Veterans' Administration, and
9 other Federal departments and agencies in the develop-
10 ment and maintenance of appropriate prevention, treat-
11 ment, and rehabilitation programs and services for alco-
12 hol abuse and alcoholism pursuant to title IV of this
13 Act;

14 (b) serve in a consulting capacity to all Federal
15 courts, departments, and agencies, including those re-
16 sponsible for programs affected by title V of this Act,
17 and to be responsible for assisting in the development and
18 coordination of a full range of programs, facilities, and
19 services available to them for education, diagnosis, plan-
20 ning, counseling, treatment, and rehabilitation with re-
21 spect to the alcohol abuse and alcoholism problems they
22 encounter;

23 (c) coordinate all Federal social, health, rehabilita-
24 tion, and other efforts to deal with alcohol abuse and
25 alcoholism including but not limited to those relating

1 to vocational, rehabilitation, manpower development
2 and training, older Americans, law enforcement as-
3 sistance, highway safety, economic opportunity, health
4 research facilities, mental retardation facilities, and com-
5 munity mental health centers, juvenile delinquency,
6 health professions educational assistance, hospital and
7 medical facilities, Social Security, community health
8 services, education professions development, higher
9 education, Federal employee health benefits, compre-
10 hensive health planning, elementary and secondary
11 education, the Civil Service laws, and laws providing
12 for the treatment and discharge of the members of the
13 Armed Forces and support and treatment of veterans
14 of the Armed Forces;

15 (d) encourage and assist State and local govern-
16 ment programs and services, and programs and serv-
17 ices of public and private agencies, institutions, and
18 organizations for the prevention and treatment of alco-
19 hol abuse and alcoholism;

20 (e) stimulate more effective use of existing re-
21 sources and available services for the prevention and
22 treatment of alcohol abuse and alcoholism;

23 (f) cooperate with the Secretary's Advisory Com-
24 mittee on Alcohol Abuse and Alcoholism, the Federal
25 Intergovernment Coordinating Council on Alcohol

1 Abuse and Alcoholism, the Civil Service Commission,
2 and other appropriate Federal departments and agencies,
3 to develop a policy consistent with this Act with regard
4 to Federal employees who are alcohol abusers or alco-
5 holics, involving appropriate programs and services for
6 the prevention and treatment of alcohol abuse and alco-
7 holism among such employees; and

8 (g) assist State and local governments in coordina-
9 ting programs among themselves for the prevention and
10 treatment of alcohol abuse and alcoholism.

11 STATISTICAL FUNCTIONS OF THE SECRETARY

12 SEC. 305. It shall be the duty of the Secretary, acting
13 through the Institute with respect to his statistical func-
14 tions to—

15 (a) gather and publish statistics pertaining to
16 alcohol abuse and alcoholism;

17 (b) promulgate regulations specifying uniform sta-
18 tistics to be obtained, records to be maintained, and
19 reports to be submitted by public and private depart-
20 ments, agencies, organizations, practitioners, and other
21 persons with respect to alcohol abuse and alcoholism.
22 Such statistics and reports shall not reveal the identity
23 of any patient or alcoholic or other confidential
24 information.

1 RESEARCH FUNCTIONS OF THE SECRETARY

2 SEC. 306. It shall be the duty of the Secretary, acting
3 through the Institute with respect to his research functions
4 to—

5 (a) conduct and encourage all forms of research,
6 investigations, experiments, and studies relating to the
7 cause, epidemiology, sociological aspects, prevention,
8 diagnosis, and treatment of alcohol abuse and alcoholism;

9 (b) conduct, and encourage and assist others to
10 conduct, all forms of research, investigation, experi-
11 ments, and studies relating to the toxicology, pharma-
12 cology, chemistry, and effects on the health, of alcohol
13 abuse and alcoholism;

14 (c) coordinate such research with research con-
15 ducted by other Federal and State and local agencies,
16 public and private agencies, institutions, organizations,
17 and individuals. To facilitate this activity the Secre-
18 tary shall establish and maintain a complete and cur-
19 rent register of all practitioners and other qualified in-
20 vestigators engaged in any form of research on alcohol
21 abuse and alcoholism;

22 (d) make available research facilities and resources
23 of the Secretary to appropriate authorities, health
24 officials, and individuals engaged in special studies re-
25 lated to the purposes of this Act;

1 (e) make grants to, and contracts with, universities,
2 hospitals, laboratories, agencies, institutions, organiza-
3 tions, and individuals for such research;

4 (f) establish an information center on such re-
5 search, which will gather and contain, and disseminate
6 where appropriate, all available published and unpub-
7 lished data and information. All Federal departments
8 and agencies shall send to the Secretary any un-
9 published data and information pertinent to the cause,
10 prevention, diagnosis, and treatment of alcohol abuse
11 and alcoholism and the toxicology, pharmacology, epide-
12 miology, and incidence of alcohol abuse and alcoholism,
13 and studies, reports, and other research on other alcohol
14 problems such as those pertaining to traffic safety, and
15 the Secretary shall make such data and information
16 widely available;

17 (g) establish and maintain research fellowships in
18 the administration and elsewhere, and provide for such
19 fellowships through grants to public and private agen-
20 cies, institutions, and organizations;

21 (h) investigate methods for the more precise de-
22 tection and determination of alcohol levels in the blood
23 stream, or by analysis of breath or other means, and pub-
24 lish on a current basis uniform methodology and tech-
25 nology for such detections and determinations;

1 (i) any information obtained through investigation
2 or research conducted pursuant to this section shall be
3 used in ways so that no name or identifying characteris-
4 tics of any person shall be divulged without the approval
5 of the Secretary and the consent of the person concerned.
6 Persons engaged in research pursuant to this section shall
7 protect the privacy of individuals who are the subject of
8 such research by withholding from all persons not con-
9 nected with the conduct of such research the names or
10 other identifying characteristics of such individuals. Per-
11 sons engaged in such research shall protect the privacy
12 of such individuals and may not be compelled in any
13 Federal, State, civil, criminal, administrative, legislative,
14 or other proceeding to identify such individuals; and

15 (j) evaluate existing and proposed new programs
16 and services for the prevention and treatment of alcohol
17 abuse and alcoholism.

18 TRAINING FUNCTIONS OF THE SECRETARY

19 SEC. 307. It shall be the duty of the Secretary, acting
20 through the Institute, with respect to his training functions
21 to—

22 (a) establish training programs, including interdis-
23 ciplinary and bilingual training programs for professional
24 and paraprofessional personnel with respect to alcohol
25 abuse and alcoholism;

1 (b) encourage the establishment of training courses,
 2 including interdisciplinary and bilingual training pro-
 3 grams, for professional and paraprofessional personnel
 4 by State and local governments with respect to alcohol
 5 abuse and alcoholism; and

6 (c) establish and maintain training fellowships in
 7 the Administration and elsewhere, and provide for such
 8 fellowships through grants to public and private
 9 institutions.

10 EDUCATIONAL FUNCTIONS OF THE SECRETARY

11 SEC. 308. It shall be the duty of the Secretary, acting
 12 through the Institute, with respect to his educational func-
 13 tions to—

14 (a) develop model curricula which reflect social,
 15 geographic, and economic variables of the alcohol abuse
 16 and alcoholism problem, and which include relevant
 17 data and other information, for utilization by elementary
 18 and secondary schools for instructing children about
 19 alcohol abuse and alcoholism;

20 (b) develop model curricula which reflect social,
 21 geographic and economic variables of the alcohol abuse
 22 and alcoholism problem, and which include relevant
 23 data and other information, for utilization by parent-
 24 teacher associations, adult education centers, private

1 citizen groups, or other State or local sources, for in-
2 structing parents and other adults about alcohol abuse
3 and alcoholism;

4 (c) prepare a broad variety of educational ma-
5 terial, for use in all media and to reach all segments
6 of the population, that can be utilized by public and
7 private agencies in educational programs with respect
8 to alcohol abuse and alcoholism;

9 (d) establish a variety of learning units including
10 relevant data and other information, on the causes and
11 effects of, and treatment for, alcohol abuse and alcohol-
12 ism, for Federal law enforcement officials (including
13 prosecuting attorneys, court personnel, the judiciary, pro-
14 bation and parole officers, correctional officers, and other
15 law enforcement personnel), Federal welfare, vocational
16 rehabilitation, military, veterans, civil service, transpor-
17 tation, economic opportunity, housing personnel, and
18 other Federal officials who come in contact with alco-
19 hol abuse and alcoholism problems;

20 (e) develop a variety of learning units including
21 the provision of relevant data and other information, on
22 the causes and effects of, and treatment for, alcohol abuse
23 and alcoholism for use by appropriate State and local
24 government and private agencies, institutions, and orga-
25 nizations, for State and local law enforcement officials

1 (including prosecuting attorneys, court personnel, the
2 judiciary, probation and parole officers, correctional offi-
3 cials, and other law enforcement personnel), State and
4 local welfare, vocational rehabilitation, veterans, civil
5 service, transportation, economic opportunity, and hous-
6 ing personnel, and other State and local officials and
7 community leaders;

8 (f) serve as a clearinghouse for the collection, prep-
9 aration and dissemination of all information relating to
10 alcohol abuse and alcoholism, including State and local
11 alcohol abuse and alcoholism treatment plans, avail-
12 ability of treatment resources, training and educational
13 programs, statistics, research, and other pertinent data
14 and information. Preparation and dissemination of such
15 data and information shall reflect the social, geographic
16 and economic variables of the alcohol abuse and alco-
17 holism problem;

18 (g) recruit, train, organize and employ professional
19 and other persons, including recovered alcoholics, to
20 organize and participate in programs of public education
21 in relation to alcohol abuse and alcoholism;

22 (h) coordinate activities carried on by all depart-
23 ments, agencies, and instrumentalities of the Federal
24 Government with respect to health education aspects of
25 alcohol abuse and alcoholism;

1 (1) promote the implementation of bilingual educa-
2 tional programs in carrying out the provisions of this sec-
3 tion; and

4 (j) undertake such other activities as the Secretary
5 may consider important to a national program of educa-
6 tion relating to alcohol abuse and alcoholism.

7 REPORTING FUNCTIONS OF THE SECRETARY

8 SEC. 309. It shall be the duty of the Secretary, acting
9 through the Institute, with respect to his reporting functions
10 to—

11 (a) submit an annual report to Congress, which
12 shall specify the actions taken and services provided and
13 funds expended under each provision of this Act and an
14 evaluation of their effectiveness, and which shall con-
15 tain the current Federal alcohol abuse and alcoholism
16 control plan;

17 (b) submit such additional reports as may be re-
18 quested by the President of the United States or by
19 Congress; and

20 (c) submit to the President of the United States
21 and to Congress such recommendations as will further
22 the prevention, treatment, and control of alcohol abuse
23 and alcoholism.

1 TITLE IV—PREVENTION AND TREATMENT OF
 2 ALCOHOL ABUSE AND ALCOHOLISM FOR
 3 FEDERAL EMPLOYEES, MILITARY PERSON-
 4 NEL, VETERANS, AND FEDERAL OFFENDERS

5 ALCOHOL ABUSE AND ALCOHOLISM AMONG FEDERAL
 6 GOVERNMENT EMPLOYEES

7 SEC. 401. (a) The Civil Service Commission shall be
 8 responsible for developing and maintaining, in cooperation
 9 with the Secretary and with other Federal agencies and
 10 departments, appropriate policies and services for the pre-
 11 vention and treatment of alcohol abuse and alcoholism among
 12 Federal employees, consistent with the purposes and intent
 13 of this Act. Such policies and services shall make optional
 14 use of existing governmental facilities, services, and skills.
 15 Government employees who are alcohol abusers or who
 16 are alcoholics shall retain the same employment and other
 17 benefits as other persons afflicted with health problems and
 18 illnesses, and shall not lose pension, retirement, medical, or
 19 other rights. A good faith attempt shall be made to find
 20 appropriate nonsensitive work within the Government dur-
 21 ing the employee's rehabilitative treatment, rather than plac-
 22 ing him on sick leave: *Provided*, That acceptance of appro-

1 priate treatment shall be required as a condition of con-
2 tinued work.

3 (b) The Secretary, acting through the Institute, shall
4 be responsible for fostering similar alcohol abuse and alco-
5 holism prevention, treatment, and rehabilitation services in
6 State and local governments and in private industry.

7 (c) No person may be denied or deprived of Federal
8 employment or a Federal professional or other license or
9 right solely on the ground of prior alcohol abuse, except with
10 regard to extremely sensitive positions specified in regula-
11 tions promulgated by the Secretary.

12 HEALTH AND DISABILITY INSURANCE PLANS FOR FEDERAL
13 EMPLOYEES

14 SEC. 402. All health and disability insurance policies
15 and plans for Federal employees shall cover alcoholism in
16 the same way as other health problems, illnesses, and dis-
17 eases that are not self-inflicted.

18 ALCOHOL ABUSE AND ALCOHOLISM AMONG MILITARY
19 PERSONNEL

20 SEC. 403. (a) For purposes of chapter 61 of title 10
21 of the United States Code, alcoholism shall be regarded as
22 a physical disability and shall not be regarded as the result
23 of intentional misconduct or willful neglect. An alcoholic
24 shall retain the same rights and benefits as any other person
25 afflicted with illness, and shall not lose pension, retirement,

1 medical, or other rights because of alcoholism. This sub-
 2 section shall be retroactive.

3 (b) The medical care provided to military personnel and
 4 their dependents pursuant to chapter 55 of title 10 of the
 5 United States Code shall include appropriate treatment serv-
 6 ices for alcohol abuse and alcoholism.

7 ALCOHOL ABUSE AND ALCOHOLISM AMONG VETERANS

8 SEC. 404. (a) Appropriate treatment facilities and serv-
 9 ices for alcohol abuse and alcoholism shall be made available
 10 within Veterans' Administration hospitals as a matter of high
 11 priority.

12 (b) For purposes of chapters 11 and 17 of title 38 of the
 13 United States Code, alcoholism during military service shall
 14 be regarded as a service-connected disability, and shall not be
 15 regarded as due to willful misconduct.

16 (c) Section 602 of title 38 of the United States Code is
 17 amended to add "or alcoholism" in the title and in the body
 18 of the section after the word "psychosis."

19 (d) A dishonorable discharge prior to the effective date
 20 of this Act shall not be a bar to treatment for alcoholism if
 21 the discharge was the result of alcohol abuse or alcoholism.

22 ALCOHOL ABUSE AND ALCOHOLISM AMONG FEDERAL 23 OFFENDERS

24 SEC. 405. (a) (1) Any person charged with a criminal
 25 offense under Federal law and who appears to be intoxi-

1 cated or an alcoholic shall, after preliminary police process-
2 ing and an opportunity to consult with counsel, promptly be
3 taken for emergency medical services and diagnosis where he
4 shall either be admitted as a patient or transported to another
5 appropriate health facility for treatment and diagnosis. Upon
6 admission as a patient, such person shall immediately be
7 examined to determine whether (A) he is an alcoholic, and
8 (B) he is in need of emergency medical services. Any such
9 person may be so detained as long as is necessary to com-
10 plete this diagnosis and emergency medical treatment, but in
11 no event longer than three days after his admission. He shall
12 then be released and shall be handled as in any other criminal
13 case.

14 (b) The services established by this Act shall, when ap-
15 propriate, be used by the Bureau of Prisons and the Board
16 of Parole for alcoholic offenders (including persons sentenced
17 under the Federal Youth Corrections Act, chapter 402 of
18 title 18 of the United States Code) placed on work release,
19 probation, parole, or other conditional release. The Secretary
20 and the Bureau of Prisons shall cooperate in establishing
21 alcoholism prevention and treatment services in Federal cor-
22 rectional institutions.

23 PROVISION OF SERVICES

24 SEC. 406. The treatment and rehabilitation services
25 authorized by this title may be provided at any available

1 facility, including but not limited to Public Health Service
2 hospitals, Veterans' Administration hospitals, public and
3 private general hospitals, community mental health centers,
4 and public and private alcoholism treatment and rehabilita-
5 tion centers. Care and treatment for veterans shall be pro-
6 vided where possible in Veterans' Administration hospitals.
7 The Secretary may contract with any appropriate public
8 or private agency, organization, or institution that has proper
9 and adequate facilities and personnel in order to carry out the
10 purposes of this Act.

11 CONFIDENTIALITY OF RECORDS

12 SEC. 407. (a) All patient records prepared or obtained
13 pursuant to this Act, and all information contained therein,
14 shall remain confidential and may be disclosed, with the
15 patient's consent only to medical personnel and only for
16 purposes of diagnosis and treatment of the patient, or to
17 Government or other officials for the purpose of obtaining
18 benefits due the patient as a result of his alcoholism or, for
19 research purposes, to public or private research organiza-
20 tions, agencies, institutions, or individuals whose competence
21 and research programs have been approved by the Secretary.
22 Disclosure may be made for purposes unrelated to such treat-
23 ment, benefits, or research upon an order of a court after
24 application showing good cause therefor. In determining

1 whether there is good cause for disclosure, the court shall
 2 weigh the need for the information sought to be disclosed
 3 against the possible harm of disclosure to the person to whom
 4 such information pertains, to the physician-patient relation-
 5 ship, and to the treatment services, and may condition dis-
 6 closure of the information upon any appropriate safeguards.
 7 No such records or information may be used to initiate crimi-
 8 nal charges against a patient under any circumstances.

9 (b) All patient records and all information contained
 10 therein relating to alcohol use or alcoholism prepared or
 11 obtained by a private practitioner shall remain confidential,
 12 and may be disclosed only with the patient's consent and
 13 only to medical personnel for purposes of diagnosis and
 14 treatment of the patient or to Government or other officials
 15 for the purpose of obtaining benefits due the patient as a
 16 result of his alcoholism.

17 TITLE V—PREVENTION AND TREATMENT OF
 18 ALCOHOL ABUSE AND ALCOHOLISM UNDER
 19 FEDERAL HEALTH, WELFARE, AND RE-
 20 HABILITATION PROGRAMS

21 MEDICARE AND MEDICAID

22 SEC. 501. (a) An alcoholic shall be regarded as a sick
 23 or disabled person eligible for treatment under medicare
 24 and medicaid (the Social Security Amendments of 1965
 25 as amended).

1 (b) Section 1396a of title 42 of the United States
2 Code is amended to add:

3 “(a) (31) include provision for prevention and treat-
4 ment of alcohol abuse and alcoholism.”

5 SOCIAL SECURITY

6 SEC. 502. An alcoholic shall be regarded as eligible
7 for disability benefits under the Social Security Act, as
8 amended, and benefits shall not be barred on the ground
9 that alcoholism is a self-inflicted disability.

10 ECONOMIC OPPORTUNITY

11 SEC. 503. Alcohol abuse and alcoholism shall be a mat-
12 ter of high priority for programs undertaken under the Eco-
13 nomic Opportunity Act of 1964 as amended.

14 VOCATIONAL REHABILITATION

15 SEC. 504. (a) An alcohol abuser or alcoholic, or a
16 facility or program or service for the prevention or treatment
17 of alcohol abuse or alcoholism, shall be eligible for funds made
18 available pursuant to chapter 4 of title 29 of the United
19 States Code.

20 (b) Section 35(a) of title 29 of the United States
21 Code is amended to add:

22 “(15) provide for the uses of vocational rehabilita-
23 tion in the prevention and treatment of alcoholism.”

24 WELFARE

25 SEC. 505. Alcohol abuse and alcoholism shall, for the

1 purposes of all Federal welfare programs and all State wel-
2 fare programs that receive Federal participation, shall be
3 regarded as a major health and economic problem.

4 (a) State and Federal agencies charged with admin-
5 istering such welfare programs shall take action to reduce
6 the incidence of financial indigency and family disintegration
7 caused by alcohol abuse and alcoholism, and shall provide
8 for treatment and rehabilitation services for those persons
9 enrolled in welfare programs whose financial eligibility for
10 such assistance results, in part or in whole, from alcohol
11 abuse or alcoholism.

12 (b) Alcohol abuse and alcoholism prevention and treat-
13 ment programs and services for persons enrolled in such wel-
14 fare programs whose financial eligibility for such assistance
15 results, in whole or in part, from alcohol abuse or alcoholism,
16 shall, if approved by the Secretary under the same pro-
17 cedure and criteria used for approving programs under title
18 VI of this Act, be eligible for 75 per centum Federal fund-
19 ing participation. Application for funds under this subsec-
20 tion shall be made by the State agency charged with ad-
21 ministering the aid program, which may conduct the pro-
22 gram or may contract with any other appropriate State
23 agency or private organization for the provision of any of
24 the designated services.

25 (c) Persons otherwise eligible for such welfare assist-

1 ance shall not be ineligible for such assistance because
2 of alcohol abuse or alcoholism. Any person whose financial
3 eligibility for such assistance results, in whole or in part,
4 from alcohol abuse or alcoholism, shall be provided the
5 services of appropriate treatment and rehabilitation serv-
6 ices upon certification by a responsible medical officer that
7 (1) the services will more likely than not be appropriate
8 for the recipient, and (2) the services can accommodate
9 the recipient. After such certification, participation by the
10 recipient in the program shall be a requirement for con-
11 tinuing eligibility for such assistance, in the absence of good
12 cause for nonparticipation. A certification by the director
13 of the facility that the recipient is no longer amenable to
14 treatment shall constitute such good cause.

15 (d) Any alcohol abuse or alcoholism treatment facility
16 shall qualify as a medical institution within the meaning
17 of section 306 (a) of title 42 of the United States Code.
18 The Secretary shall promulgate regulations specifying how
19 such welfare benefits shall be used to contribute to the costs
20 of treatment and rehabilitation of an alcohol abuser or al-
21 coholic receiving welfare assistance so far as practicable
22 without imposing undue hardship on him or his family.

23 (e) Any recipient of welfare assistance whose inability
24 to work or to participate in a work training program is the
25 result of alcohol abuse or alcoholism shall be excused from

1 such participation only on condition that he accept appro-
 2 priate treatment and rehabilitation services made available
 3 to him.

4 (f) The Secretary shall promulgate appropriate regula-
 5 tions and offer technical assistance to States in providing,
 6 as part of the services rendered under section 705 of title
 7 42 of the United States Code, programs of education about
 8 alcohol abuse and alcoholism for children of school age and
 9 adults responsible for them, and appropriate treatment for
 10 children physically or mentally damaged or otherwise af-
 11 fected as a result of alcohol abuse or alcoholism on the part
 12 of adults with whom they have significant contact.

13 HIGHWAY SAFETY

14 SEC. 506. (a) Each State highway safety program ap-
 15 proved pursuant to the Highway Safety Act of 1966 shall in-
 16 clude provisions for the prevention and treatment of alcohol
 17 abuse and alcoholism among licensed drivers. Each such pro-
 18 gram shall provide for early screening, diagnosis, and treat-
 19 ment for alcohol abuse and alcoholism among intoxicated
 20 drivers, coordinated with and integrated into comprehensive
 21 community health and rehabilitation planning. Statistics shall
 22 be maintained with respect to the incidence of alcohol abuse
 23 and alcoholism among licensed drivers and individuals in-
 24 volved in automobile accidents, and whether alcohol abuse

1 or alcoholism was a probable factor in any automobile acci-
2 dent. Highway safety research conducted pursuant to that Act
3 shall include research with respect to the prevention and
4 treatment of alcohol abuse and alcoholism among licensed
5 drivers.

6 (b) Any Federal funds used to assist State and local gov-
7 ernments in the prevention and treatment of alcohol abuse and
8 alcoholism among licensed drivers shall be expended for the
9 purpose of education, treatment, and rehabilitation, and not
10 for the purposes of punishment. Such funds shall be expended
11 for programs and services that are coordinated with and
12 integrated into comprehensive community health and re-
13 habilitation programs and services.

14 GENERAL

15 SEC. 507. Alcohol abuse and alcoholism shall be re-
16 garded as a health problem, disorder, sickness, illness, dis-
17 ease, disability, or other similar term, for purposes of all
18 Federal legislation relating to health, welfare, and rehabili-
19 tation programs, services, funds, and other benefits. Any
20 Federal legislation providing for medical assistance, medical
21 care, treatment, rehabilitation, or other similar services, shall
22 be regarded as including programs and services for the
23 prevention and treatment of alcohol abuse and alcoholism.

1 TITLE VI—FEDERAL ASSISTANCE FOR STATE
 2 AND LOCAL PROGRAMS
 3 COMPREHENSIVE STATE PLANS

4 SEC. 601. Section 246 (a) (2) of title 42 of the United
 5 States Code is amended to add:

6 “(L) provide for services for the prevention and
 7 treatment of alcohol abuse and alcoholism, commensu-
 8 rate with the extent of the problem, such plan to (i)
 9 estimate the number of alcohol abusers and alcoholics
 10 within the various areas within the State and the extent
 11 of the health problem caused, (ii) establish priorities
 12 for the improvement of the capabilities of State and
 13 local governments and public and private agencies, in-
 14 stitutions, and organizations with respect to prevention
 15 and treatment of alcohol abuse and alcoholism, and (iii)
 16 specify how all available community health, welfare,
 17 educational, and rehabilitation resources, and how funds,
 18 programs, services, and facilities authorized under exist-
 19 ing Federal and State legislation, are to be used for these
 20 purposes.”

21 STATE HOSPITAL AND MEDICAL FACILITIES CONSTRUCTION
 22 PLANS

23 SEC. 602. (a) Section 291c (a) of title 42 of the United
 24 States Code is amended to add:

25 “(4) to projects for construction and modernization

1 of facilities for prevention and treatment of alcohol abuse
2 and alcoholism;”.

3 (b) Section 291d (a) (4) of title 42 of the United States
4 Code is amended to add:

5 “(F) the facilities needed to provide adequate serv-
6 ices for the prevention and treatment of alcohol abuse
7 and alcoholism;”.

8 STATE MENTAL HEALTH CENTERS PLANS

9 SEC. 603. (a) Section 2684 of title 42 of the United
10 States Code is amended to add:

11 “(11) provide for services for the prevention and
12 treatment of alcohol abuse and alcoholism, commensurate
13 with the extent of the problem.”

14 (b) Section 2691 (c) of title 42 of the United States
15 Code is amended by inserting after “mental illness,” the fol-
16 lowing: “alcohol abuse or alcoholism,” and by inserting after
17 “mentally ill patients,” the following: “alcohol abusers or
18 alcoholics;”.

19 GRANTS AND CONTRACTS FOR THE PREVENTION AND TREAT-
20 MENT OF ALCOHOL ABUSE AND ALCOHOLISM

21 SEC. 604. (a) The Secretary, acting through the Insti-
22 tute, is authorized to make grants and enter into contracts
23 for the prevention and treatment of alcohol abuse and alcohol-
24 ism to assist State and local governments and public and

1 private organizations, agencies, institutions, or individuals
2 to—

3 (1) meet the costs of constructing, equipping, and
4 operating treatment and rehabilitation facilities, includ-
5 ing but not limited to emergency medical, inpatient, in-
6 termediate care, and outpatient facilities for alcohol
7 abusers and alcoholics, and to assist them to meet, for
8 the temporary periods specified in subsection (b) of this
9 section, a portion of the costs of compensation of per-
10 sonnel for the initial operation of such facilities, and of
11 new services in existing facilities for alcohol abusers and
12 alcoholics;

13 (2) conduct research, demonstration, and evalua-
14 tion projects, including surveys and field trials, looking
15 toward the development of improved, expanded, and
16 more effective methods of prevention and treatment of
17 alcohol abuse and alcoholism;

18 (3) provide education and training for professional
19 personnel, including medical, psychiatric, vocational re-
20 habilitation, and social welfare personnel, in academic
21 and professional institutions and in postgraduate courses,
22 about the prevention and treatment of alcohol abuse and
23 alcoholism, and provide training for such personnel in
24 the administration, operation, and supervision of pro-
25 grams and services for the prevention and treatment of
26 alcohol abuse and alcoholism;

1 (4) recruit, educate, train, organize, and employ
2 community alcohol abuse and alcoholism prevention and
3 treatment personnel to serve with and under the direc-
4 tion of professional medical, psychiatric, vocational re-
5 habilitation, and social welfare personnel in alcohol abuse
6 and alcoholism prevention, treatment, and rehabilitation
7 programs. Prior alcohol abuse or alcoholism and prior
8 criminal arrests or convictions shall not be a bar to such
9 employment;

10 (5) provide services in correctional and penal insti-
11 tutions for the prevention and treatment of alcohol abuse
12 and alcoholism;

13 (6) provide services, in cooperation with schools,
14 law enforcement agencies, courts, and other public and
15 private agencies, for the prevention and treatment of
16 alcohol abuse and alcoholism among juveniles and young
17 adults. These services, where feasible, shall include cur-
18 ricula for alcohol education in elementary and secondary
19 schools, and among parents and other adults;

20 (7) provide programs and services, in cooperation
21 with local law enforcement agencies, the courts, and
22 other public and private agencies, for the instruction of
23 law enforcement officers, prosecuting attorneys, court
24 personnel, the judiciary, probation and parole officers,
25 correctional officials and legal aid, public defender, and

1 neighborhood legal services attorneys with respect to
2 the causes, effects, prevention, and treatment of alcohol
3 abuse and alcoholism. Such programs and services shall
4 include, where possible, a full range of services available
5 to State and local courts for diagnosis, counseling, and
6 treatment for alcohol abuse and alcoholism for persons
7 coming before the courts;

8 (8) provide services for outpatient counseling of
9 alcohol abusers and alcoholics to include employment,
10 welfare, legal, education, and other assistance, in cooper-
11 ation and coordination with welfare and rehabilitation
12 personnel;

13 (9) develop or evaluate curricula on alcohol abuse
14 and alcoholism prevention and treatment, including the
15 preparation of new and improved curricular materials for
16 use in elementary, secondary, college, and adult educa-
17 tion programs;

18 (10) develop or evaluate a program of dissemina-
19 tion of curricular material;

20 (11) provide training programs on alcohol abuse
21 and alcoholism (including courses of study, institutes,
22 seminars, films, workshops, and conferences) for teach-
23 ers, counselors, and other educational personnel;

24 (12) provide community education programs on
25 alcohol abuse and alcoholism (including courses of study,

1 institutes, seminars, films, workshops, and conferences)
2 especially for parents and other adults in the community;

3 (13) enable a State government agency to assist
4 local education agencies in the planning, development,
5 and implementation of alcohol abuse and alcoholism edu-
6 cation programs, and

7 (14) develop educational material and programs
8 about the prevention and treatment of, and problems aris-
9 ing from, alcohol abuse and alcoholism, for use or distri-
10 bution by any form of mass media.

11 (b) The amount of any Federal grant made under sub-
12 section (a) of this section, except with regard to certain
13 grants made under paragraph (1) of subsection (a), shall
14 not exceed 90 per centum of the cost of the program or proj-
15 ect specified in the application for such grant. The amount
16 of any Federal grant made under paragraph (1) of subsec-
17 tion (a) of this section to meet costs of compensation of
18 personnel may be made only for the period beginning with
19 the first day for which such a grant is made and ending with
20 the close of eight years after such first day; and such grants
21 may not exceed 90 per centum of such costs for each of the
22 first two years after such first day, 80 per centum of such
23 costs for the third year after such first day, 75 per centum of
24 such costs for the fourth and fifth years after such first day,

1 and 70 per centum of such costs for each of the next three
2 years after such first day.

3 (c) An amount, not to exceed 5 per centum of the
4 amount appropriated pursuant to the provisions of this
5 Act for any fiscal year, shall be available to the Secretary to
6 make grants to local public or non-profit-private organiza-
7 tions to cover up to 100 per centum of the costs (but in
8 no case to exceed \$100,000) of projects for assessing local
9 needs for programs of services for alcoholics or narcotic ad-
10 dicts, designing such programs, obtaining local financial
11 and professional assistance and support for such programs
12 in the community, and fostering community involvement
13 in initiating and developing such programs in the commu-
14 nity. In no case shall a grant under this subsection be for
15 a period in excess of one year; nor shall any grant be made
16 under this subsection with respect to any project if, for
17 any preceding year, a grant under this subsection has been
18 made with respect to such project.

19 (d) An amount, not to exceed 1 per centum of the
20 amount appropriated pursuant to the provisions of this
21 Act, shall be available to the Secretary for evaluation,
22 directly or by grants or contracts, of the programs authorized
23 by this title.

1 APPLICATION FOR FINANCIAL ASSISTANCE FROM UNITS OF
2 LOCAL GOVERNMENT AND PRIVATE ORGANIZATIONS

3 SEC. 605. (a) In administering the provisions of this
4 title, the Secretary shall require coordination of all applica-
5 tions for programs in a State and, in view of the local nature
6 of alcohol abuse and alcoholism, shall not give precedence
7 to public agencies over private agencies, or to State agencies
8 over local agencies.

9 (b) Each applicant from within a State, upon filing
10 its application with the Secretary, shall submit a copy of its
11 application for review by the State agency responsible for
12 administering the State comprehensive plan for treatment
13 and prevention of drug abuse, if such agency exists. Such
14 State agency shall be given not more than thirty days from
15 the date of receipt of the application to submit to the Secre-
16 tary, in writing, an evaluation of the project set forth in
17 the application. Such evaluation may include comments on
18 the relationship of the project to other projects pending and
19 approved and to the State comprehensive plan for treatment
20 and prevention of drug abuse. The State shall furnish the
21 applicant a copy of any such evaluation.

22 (c) Approval of any application by the Secretary, in-
23 cluding the earmarking of financial assistance for a program

1 or project, may be granted only if the application sub-
 2 stantially meets a set of criteria established by the Secretary
 3 that—

4 (1) provide that the activities and services for
 5 which assistance under this title is sought will be sub-
 6 stantially administered by or under the supervision of
 7 the applicant;

8 (2) provide for such methods of administration as
 9 are necessary for the proper and efficient operation of
 10 such programs or projects; and

11 (3) provide for such fiscal control and fund
 12 accounting procedures as may be necessary to assure
 13 proper disbursement of and accounting for Federal
 14 funds paid to the applicant.

15 APPROVAL BY NATIONAL ADVISORY MENTAL

16 HEALTH COUNCIL

17 SEC. 606. Grants made under this title may be made
 18 only upon the recommendation of the National Advisory
 19 Mental Health Council established by section 217 (a) of
 20 the Public Health Service Act.

21 SEC. 607. (a) Each recipient of assistance under this
 22 Act pursuant to grants or contracts entered into under other
 23 than competitive bidding procedures shall keep such records
 24 as the Secretary shall prescribe, including records which
 25 fully disclose the amount and disposition by such recipient

1 of the proceeds of such grant or contract, the total cost of
2 the project or undertaking in connection with which such
3 grant is given or used, and the amount of that portion of
4 the cost of the project or undertaking supplied by other
5 sources, and such other records as will facilitate an effective
6 audit.

7 (b) The Secretary and Comptroller General of the
8 United States, or any of their duly authorized representatives,
9 shall have access for the purpose of audit and examination
10 to any books, documents, papers, and records of
11 such recipients that are pertinent to the grants or contracts
12 entered into under the provisions of this Act under other
13 than competitive bidding procedures.

14 SEC. 608. Payments under this title may be made in
15 advance or by way of reimbursement and in such install-
16 ments as the Secretary may determine.

17 SEC. 609. No funds shall be available under this Act
18 unless the Secretary first determines that there is satisfactory
19 assurance that (A) the services to be provided will constitute
20 an addition to, or a significant improvement in quality
21 (as determined in accordance with criteria of the Secretary)
22 in, services that would otherwise be provided, and (B) Federal
23 funds made available under this part for any period will
24 be so used as to supplement and, to the extent practical, in-
25 crease the level of State, local, and other non-Federal funds,

1 including third party health insurance payments, that would
2 in the absence of such Federal funds be made available for
3 the program for which funds are being sought under this
4 Act by the applicant, and will in no event supplant such
5 State, local, and other non-Federal funds.

6 SEC. 610. (a) Whenever the Secretary finds a failure
7 to comply with the terms of a grant or contract made or
8 entered into under this title, he shall, after reasonable notice
9 and opportunity for a hearing, terminate payments until he
10 is satisfied that there will no longer be any failure to comply.

11 (b) The exclusive remedy of anyone adversely affected
12 by a final action of the Secretary under subsection (a) of
13 this section is to appeal to the United States court of appeals
14 for the circuit in which it is located by filing a petition with
15 such court within sixty days after such final action. A copy
16 of the petition shall be forthwith transmitted by the clerk
17 of the court to the Secretary. The Secretary thereupon shall
18 file with the court the record of the proceeding on which he
19 based his action, as provided in section 2112 of title 28 of the
20 United States Code. Upon the filing of such petition, the
21 court shall have jurisdiction to affirm the action of the Secre-
22 tary or set it aside, in whole or in part, temporarily or
23 permanently. Until the filing of the record, the Secretary
24 may modify or set aside his order. The findings of the Secre-
25 tary as to the facts shall be conclusive if supported by sub-

1 stantial evidence, but the court, for good cause shown, may
2 remand the case to the Secretary to take further evidence,
3 and the Secretary may thereupon make new or modified
4 findings of fact and may modify his previous action, and shall
5 file in the court the record of the further proceedings. Such
6 new or modified findings of fact shall likewise be conclusive
7 if supported by substantial evidence. The judgment of the
8 court affirming or setting aside, in whole or in part, any
9 action of the Secretary shall be final, subject to review by
10 the Supreme Court of the United States upon certiorari as
11 provided in section 1254 of title 28 of the United States
12 Code. The commencement of proceedings under this subsec-
13 tion shall not, unless so specifically ordered by the court,
14 operate as a stay of the Secretary's action.

15 ADMISSION OF ALCOHOL ABUSERS AND ALCOHOLICS TO
16 PRIVATE AND PUBLIC HOSPITALS

17 SEC. 611. (a) Alcohol abusers and alcoholics shall be
18 admitted to and treated in private and public hospitals on
19 the basis of medical need and shall not be discriminated
20 against solely because of their alcoholism. No hospital that
21 violates this section shall receive Federal financial assistance
22 under the provisions of this Act or any other Federal law
23 administered by the Secretary. No such action shall be taken
24 until the Secretary has advised the appropriate person or

1 persons of the failure to comply with this section, and pro-
2 vided an opportunity for correction or a hearing.

3 (b) Any action taken by the Secretary pursuant to
4 this section shall be subject to such judicial review as is
5 provided by section 609 (b) of this title.

6 TITLE VII—THE SECRETARY'S ADVISORY COM-
7 MITTEE ON ALCOHOL ABUSE AND ALCO-
8 HOLISM

9 SEC. 701. (a) The Secretary shall appoint an Advisory
10 Committee on Alcohol Abuse and Alcoholism to consist of
11 eighteen qualified persons, including (1) leaders from the
12 general public representing such areas as business and in-
13 dustry, professional and public training and education, medi-
14 cal and paramedical training, law, religion, State and local
15 government, public health, labor, urban affairs; and (2)
16 representative leaders from those with major concern for
17 alcohol abuse and alcoholism, including voluntary associa-
18 tions, governmental groups, and the universities. Some mem-
19 bers of the Advisory Committee must be recovered alco-
20 holics. The Advisory Committee shall advise and consult
21 with the Secretary and the Institute and assist them in
22 carrying out the provisions of this Act.

23 (b) The Secretary shall appoint a Chairman, who shall
24 serve a one-year term but may be re-appointed. The mem-
25 bers of the Advisory Committee shall serve without compen-

1 sation, except for expenses, for terms of three years, staggered
2 so that three vacancies occur every year. A member may be
3 reappointed if, in the judgment of the Secretary, his special
4 competencies are required by the Committee.

5 (c) The Committee shall meet at least once every two
6 months, and may meet more often. It shall consult at regular
7 intervals with representatives of the Secretary, the judiciary,
8 corrections, probation, vocational rehabilitation, public wel-
9 fare, parole, Economic Opportunity, the Department of
10 Transportation, the Department of Housing and Urban De-
11 velopment, the Department of Defense, Veterans' Adminis-
12 tration, the Civil Service Commission and such other agencies
13 as may become involved in a total effort to attack alcohol
14 abuse and alcoholism.

15 SEC. 702. The Committee may appoint one or more tech-
16 nical consultants from experts throughout the country to assist
17 in evaluating the progress of the Institute so that it will have
18 the best possible comprehensive programs for combating alco-
19 hol abuse and alcoholism.

20 SEC. 703. The Committee shall employ a full-time ex-
21 ecutive director with a secretary to assist the Committee and
22 coordinate its activities.

23 SEC. 704. The Committee shall consider at least the
24 following matters:

25 (a) the establishment of goals and priorities for the

1 alcohol abuse and alcoholism programs of the Depart-
2 ment;

3 (b) the development of policy concerning the role
4 of the Federal government in the development and
5 promotion of alcohol abuse and alcoholism programs;

6 (c) formation of structures and methods through
7 which the programs developed or in effect at the Fed-
8 eral, State, or local levels might have the broadest im-
9 pact; and

10 (d) review of allocation of funds and personnel for
11 the implementation of these programs.

12 TITLE VIII—INTERGOVERNMENT COORDINAT-
13 ING COUNCIL ON ALCOHOL ABUSE AND
14 ALCOHOLISM

15 SEC. 801. (a) For the purpose of coordinating all Fed-
16 eral Government prevention, treatment, and rehabilitation
17 efforts with respect to alcohol abuse and alcoholism, of co-
18 ordinating such Federal efforts with State and local govern-
19 ment efforts, and of developing an enlightened policy and
20 appropriate programs for Federal employees for the preven-
21 tion and treatment of alcohol abuse and alcoholism and the
22 rehabilitation of alcoholics, there is hereby established an In-
23 tergovernment Coordinating Council on Alcohol Abuse and
24 Alcoholism consisting of the Secretary who shall serve as
25 Chairman, the executive director of the Secretary's Ad-

1 visory Committee on Alcohol Abuse and Alcoholism, four
2 representatives of Federal departments or agencies, and five
3 representatives of State and local government departments
4 or agencies.

5 (b) The President shall designate the four representa-
6 tives of Federal departments or agencies who shall serve on
7 the Coordinating Council, and shall appoint the five repre-
8 sentatives of State and local government departments or
9 agencies. The State and local government representatives
10 shall serve for terms of five years, staggered so that one va-
11 cancy occurs each year. A State or local government repre-
12 sentative may be reappointed immediately after serving less
13 than a full term, and may be reappointed after a five-year
14 hiatus after serving a full term.

15 (c) The Coordinating Council may appoint such tech-
16 nical consultants as are deemed appropriate for advising the
17 Council in carrying out its functions.

18 SEC. 802. The Coordinating Council is authorized and
19 directed to—

20 (a) assist the Secretary in carrying out his func-
21 tion of coordinating all Federal prevention, treatment,
22 and rehabilitation efforts to deal with alcohol abuse and
23 alcoholism;

24 (b) assist the Secretary in carrying out his function

1 of coordinating such Federal efforts with State and local
2 governments;

3 (c) engage in educational programs among Federal
4 employees, and in other appropriate activities, designed
5 to prevent alcohol abuse and alcoholism;

6 (d) implement programs for the rehabilitation of
7 Federal employees who are alcohol abusers or alcoholics;
8 and

9 (e) develop and maintain any other appropriate
10 activities consistent with the purposes of this Act.

11 TITLE IX—GENERAL

12 SEC. 901. The Secretary may promulgate regulations,
13 pursuant to subchapter II of chapter 5 of title 5, United
14 States Code, to implement this Act.

15 SEC. 902. If any section, provision, or term of this Act
16 is adjudged invalid for any reason, such judgment shall not
17 affect, impair, or invalidate any other section, provision, or
18 term of this Act, and the remaining sections, provisions, and
19 terms shall be and remain in full force and effect.

20 SEC. 903. There are hereby authorized to be appro-
21 priated such sums as may be necessary to carry out the
22 provisions of this Act. Any appropriated funds shall remain
23 available until expended.

24 SEC. 904. (a) Section 7352 of title 5 of the United
25 States Code is hereby repealed.

1 (b) Paragraph (3) of subsection 8102(a) of title 5
2 of the United States Code is hereby repealed.

3 (c) Paragraph (2) of subsection 2504(d) of title 22
4 of the United States Code is hereby amended to repeal the
5 clause "or unless intoxication of the injured volunteer is the
6 proximate cause of the injury or death."

7 SEC. 905. This Act shall take effect upon the expiration
8 of one hundred and eighty days following the date of its
9 enactment.

SUMMARY—FEDERAL ALCOHOL ABUSE AND ALCOHOLISM PREVENTION, TREATMENT, REHABILITATION ACT OF 1970

This legislation would establish the administrative structure and authorization for an unprecedented, massive, across-the-board federal attack upon the problem of alcoholism in this country. The legislation would:

(1) establish a National Institute for the Prevention and Control of Alcohol Abuse and Alcoholism within the National Institute of Mental Health of the Department of Health, Education, and Welfare. The Secretary of Health, Education, and Welfare, acting through the Institute, would be given a completely comprehensive range of responsibilities with respect to the prevention, treatment, and rehabilitation of alcoholics, including administrative, planning, coordination, statistical, research, training, education, classification, and reporting functions, all of which are set out in detail. These powers would be utilized and directed in accordance with a specific and comprehensive alcohol abuse and alcoholism control plan which would be drawn up and carried out by the Secretary, acting through the Institute, and which would be submitted annually to Congress for review;

(2) require the establishment of programs of prevention and the recognition and encouragement of treatment and rehabilitation programs for all federal employees and members of the armed forces. It would require the establishment of treatment programs for veterans and the inclusion of alcoholism in group health and disability insurance policies made available to federal employees. It also would require that, when necessary, emergency medical services be provided to alcoholic Federal offenders and that alcoholism treatment services be provided for such persons in Federal correctional institutions.

(3) require the recognition of alcohol abuse and alcoholism as a significant health problem in a broad range of programs affecting health matters, including vocational rehabilitation programs, the Economic Opportunity Act programs, welfare programs, highway safety planning programs, medicare, Medicaid, and social security;

(4) authorize the Secretary of Health, Education, and Welfare, acting through the newly-created Institute, to make grants to and enter into contracts with State and local organizations, agencies, institutions, and individuals to carry out a comprehensive range of activities in the alcohol abuse and alcoholism prevention, treatment, and rehabilitation areas. These activities would include construction and staffing of facilities, development of model curricula, curricular materials, and curricular dissemination programs; training and education programs for medical schools, outreach workers, and other professional and paraprofessional persons; support of community planning and educational programs; organization of community personnel; support of services to juveniles and young adults; and support of services in correctional institutions;

(5) establish an independent Secretary's Advisory Committee on Alcohol Abuse and Alcoholism to advise and consult with the Secretary of Health, Education, and Welfare, to assist him in carrying out the purposes of this Act; and establish an Intergovernmental Coordinating Council on Alcohol Abuse and Alcoholism to coordinate all Federal prevention, treatment, and rehabilitation efforts dealing with problems of alcohol abuse and alcoholism.

SECTION BY SECTION ANALYSIS—COMPREHENSIVE ALCOHOL ABUSE AND ALCOHOLISM PREVENTION, TREATMENT, AND REHABILITATION ACT OF 1970

TITLE I.—FINDINGS AND DECLARATION OF PURPOSES

Section 101.—finds that alcohol abuse can seriously impair health, and can lead to alcoholism; that alcoholism is an illness or disease that requires treatment through health rehabilitation services; that a comprehensive and coordinated approach is needed; that existing laws have not been adequate to prevent alcohol abuse or to provide sufficient education, treatment, and rehabilitation of alcoholics; that increasing education, treatment, and rehabilitation services, and closer coordination of efforts, offer the best possibility of reducing alcohol abuse and alcoholism; that a major commitment of health and social resources and government funds is required to institute an adequate and effective Federal program for the prevention and treatment of this problem; that present Federal programs for alcohol abuse and alcoholism are relegated to a low level of priority and remain uncoordinated within the government; that alcoholism has not been handled effectively in regard to those for whom the Government has special

responsibilities; that existing Federal research, social, health, and rehabilitation laws have not adequately been used to attack alcohol abuse and alcoholism; that lack of Federal leadership and funding has also contributed to the failure of public and private State and local agencies to recognize their responsibilities for meeting these problems; that dealing with public inebriates as criminals has proved expensive, burdensome, and futile, since criminal law is ineffective to deter what are basically major health and rehabilitation problems; that removal of public intoxication from the criminal system and establishment of modern public health programs for the medical management of alcohol abuse and alcoholism facilitate (1) early detection and prevention of alcoholism and the treatment and rehabilitation of alcoholics, (2) diagnosis and treatment of concurrent diseases, and (3) assistance with underlying psychological and social problems; that handling alcohol abusers and alcoholics through rehabilitative programs relieves the police, courts, correctional institutions, and other law enforcement agencies of a burden that interferes with the protection of citizens.

Section 102.—declares that a National Institute for the Prevention and Control of Alcohol Abuse and Alcoholism shall be established within the National Institute of Mental Health to coordinate Federal alcohol abuse and alcoholism programs and to administer the programs and authorities established by this Act; that major Federal action and assistance to State and local programs shall be undertaken to encourage planning, coordination, statistics, research, training, and education with respect to the alcohol problems, and to provide equal access to care, treatment, and rehabilitation for all alcoholics; that other Federal legislation providing for Federal assistance in research, prevention, treatment, or rehabilitation in the fields of health, education, welfare, rehabilitation, and highway safety shall be more fully utilized to reduce alcohol abuse and alcoholism.

TITLE II.—DEFINITIONS

Section 201.—for the purposes of this Act—"alcohol abuse" means any use of any alcoholic beverage that results in intoxication which endangers persons or property; "alcoholic" means any person whose consumption of any alcoholic beverage consistently causes him physical, psychological, or social harm; "alcoholism" means the illness or disease characterized by a person's consumption of any alcoholic beverage to an extent that consistently causes him physical, psychological or social harm.

Other definitions include those for the terms "commissioner," "emergency medical services," "inpatient services," "Institute," "intermediate care services," "outpatient services," "prevention and treatment."

The remaining definitions are routine.

TITLE III.—NATIONAL INSTITUTE FOR THE PREVENTION AND CONTROL OF ALCOHOL ABUSE AND ALCOHOLISM

Establishment of the Institute

Section 301.—establishes a National Institute for the Prevention and Control of Alcohol Abuse and Alcoholism within the National Institute of Mental Health to administer the programs and authorities assigned to the Secretary by this Act. Remaining sections of this title set out the responsibilities of the Institute and the qualifications of its personnel.

Administrative Functions of the Secretary

Section 302.—sets out the assisting of other Federal agencies in developing and maintaining prevention, treatment and rehabilitation programs; the evaluation of adequacy and appropriateness of the provisions relating to the prevention and treatment of alcohol abuse and alcoholism of all State health, welfare, and rehabilitation plans submitted to the Federal Government; the administering of grants and contracts; and any other action consistent with the intent and objectives of this Act.

Planning Functions of the Secretary

Section 303.—sets out the planning functions of the Secretary. They include the development of a detailed and comprehensive Federal alcohol abuse and alcoholism control plan to implement the objectives and policies of this Act; the evaluation of existing alcohol education materials; the development of model alcohol abuse and alcoholism control plans and legislation for State and local governments; the providing of assistance and consultation to State and local

governments and private organizations, agencies, institutions, and individuals with respect to the prevention and treatment of alcohol abuse and alcoholism; and the promotion throughout the country of public health procedures for the treatment of alcoholics as alternatives to present criminal procedures.

Coordination Functions of the Secretary

Section 304.—sets out the coordination functions of the Secretary. They include assistance of the Civil Service Commission, the Department of Defense, the Veterans' Administration, and other Federal departments and agencies in the development and maintenance of appropriate prevention, treatment, and rehabilitation programs and services for alcohol abuse and alcoholism; service as consultants to courts, departments and agencies, including those responsible for programs affected by Title V of this Act; coordination of all Federal health and rehabilitation efforts to deal with alcohol abuse and alcoholism; encouragement and assistance of State and local government programs and services as well as public and private agencies, institutions, and organizations; stimulation for more effective use of existing resources and services; cooperation with appropriate federal departments and agencies to develop a policy consistent with this Act with regard to federal employees who are alcohol abusers or alcoholics; and assistance of state and local governments in coordinating programs among themselves.

Statistical Functions of the Secretary

Section 305.—sets out the statistical functions of the Secretary. They include the gathering and publishing of statistics pertaining to alcohol abuse and alcoholism, and the promulgation of rules and regulations specifying uniform statistics, records, and reports.

Research Functions of the Secretary

Section 306.—sets out the research functions of the Secretary. They include the carrying out and encouragement of research, investigations, experiments, and studies relating to the cause, epidemiology, sociological aspects, prevention, diagnosis, and treatment of alcohol abuse and alcoholism; encouraging and assisting others in conducting all forms of research, investigation, experiments, and studies relating to the toxicology, pharmacology, chemistry, and effect on the health, of alcohol abuse and alcoholism; coordination of the research conducted by the Institute with that done by other departments and agencies; establishment of a research register; availability of research facilities and resources of the Administration to appropriate authorities engaged in special studies related to this Act; awarding of grants to, and contracts with universities, hospitals, laboratories, agencies, institutions, organizations, and individuals for such research; establishment of an information center on such research; establishment and maintenance of a research fellowship program; investigation of methods for detection of alcohol levels; protection of individuals who are the subjects of such research, and evaluation of existing and proposed new programs and services for the prevention and treatment of alcohol abuse and alcoholism.

Training Functions of the Secretary

Section 307.—sets out the training functions of the Secretary. They include establishment of training programs for professionals and para-professionals; encouragement of such programs by state and local governments; and establishment of training fellowships.

Educational Functions of the Secretary

Section 308.—sets out the educational functions of the Secretary. They include development of model curricula for instructing children and for use by parent-teacher associations, adult education centers, private citizen groups, or other State or local sources, for instruction about alcohol abuse and alcoholism; preparation of a broad variety of educational materials for use in all media; establishment of a variety of learning units for use by Federal officials and state and local agencies on the causes of, and treatment for alcohol abuse and alcoholism; serving as a clearinghouse for the collection, preparation and dissemination of all information relating to alcohol abuse and alcoholism; recruitment, training, organization, and employment of professionals and para-professionals to organize and participate in programs of public education in relation to alcohol abuse and alcoholism; coordination of activities carried on by the Federal government relat-

ing to the health education aspects of alcohol abuse and alcoholism; and the undertaking of such other activities as may be important to a national program of education relating to alcohol abuse and alcoholism.

Reporting Functions of the Secretary

Section 309.—sets out the reporting functions of the Secretary. An annual report to Congress, specifying actions taken and services provided under each provision of this Act, and an evaluation of their effectiveness is required. Additional reports, as requested by the President of the United States or by Congress and appropriate recommendations to the President of the United States and Congress are also required.

TITLE IV.—PREVENTION AND TREATMENT OF ALCOHOL ABUSE AND ALCOHOLISM FOR FEDERAL EMPLOYEES, MILITARY PERSONNEL, VETERANS, AND FEDERAL OFFENDERS

Alcohol Abuse and Alcoholism Among Federal Government Employees

Section 401.—provides for the prevention and treatment of alcohol abuse and alcoholism among Federal government employees, by establishing that the Civil Service Commission shall be responsible for developing and maintaining, in co-operation with the Institute and other Federal agencies, appropriate policies and services for the prevention and treatment of alcohol abuse and alcoholism among Federal employees. That such employees will retain the same employment benefits as persons afflicted with illness, not losing pension, retirement or medical rights; that the Secretary shall be responsible for fostering similar alcohol abuse and alcoholism prevention, treatment and rehabilitation services in State and local governments and in private industry; and that no person may be denied Federal employment or a Federal license or right solely on the ground of prior alcohol abuse, except in regard to extremely sensitive positions.

Health and Disability Insurance Plans for Federal Employees

Section 402.—provides that all health and disability insurance policies and plans for Federal employees shall cover alcoholism in the same way as other health problems, illnesses, and diseases that are not self-inflicted.

Alcohol Abuse and Alcoholism Among Military Personnel

Section 403.—provides that alcoholism shall be regarded as a physical disability and shall not be regarded as the result of intentional misconduct or willful neglect; that an alcoholic shall retain the same rights and benefits as any other person afflicted with illness, and shall not lose pension, retirement, medical or other rights because of alcoholism (this shall be retroactive); that medical care provided to military personnel and their dependents shall include appropriate treatment and services for alcohol abuse and alcoholism.

Alcohol Abuse and Alcoholism Among Veterans

Section 404.—provides that appropriate treatment facilities and services for alcohol abuse and alcoholism shall be made available within Veterans Administration hospitals as a matter of high priority; that alcoholism during military service shall be regarded as a service-connected disability, and shall not be regarded as due to willful misconduct; that Section 602 of Title 38 of the United States Code is amended to add "or alcoholism" in the title and in the body of the section after the word "psychosis"; and that a dishonorable discharge prior to the effective date of this Act shall not bar a veteran from treatment if the discharge was the result of alcohol abuse or alcoholism.

Alcohol Abuse and Alcoholism Among Federal Offenders

Section 405.—provides that any person charged with a criminal offense under Federal law and who appears to be an alcoholic shall, after police processing and consultation with counsel, promptly be taken for emergency medical services, where he shall either be admitted as a patient or transported to another appropriate health facility for treatment and diagnosis; that upon admission as a patient, such person shall immediately be examined to determine whether (1) it is probable that he is not an alcoholic, and (2) he is in need of emergency medical services; that any such person may be detained as long as is necessary to complete this diagnosis, and emergency medical treatment, but no longer than three days after which he shall be released and handled as in any other criminal case; that the services established by this Act shall be used by the Bureau of Prisons and the Board of Parole for alcoholic offenders placed on

work release, probation, parole, or other conditional release; and that the Secretary and the Bureau of Prisons shall cooperate in establishing alcoholism prevention and treatment services in Federal correctional institutions.

Provision of Services

Section 406.—provides that the treatment and rehabilitation services authorized by this title may be provided at any available facility, including but not limited to Public Health Service Hospitals, Veterans Administration hospitals, public and private general hospitals, community mental health centers, and public and private alcoholism treatment and rehabilitation centers; that care and treatment for veterans shall be provided where possible in Veterans Administration hospitals; that the Secretary may contract with any appropriate public or private agency, organization, or institution that has proper and adequate facilities and personnel.

Confidentiality of Records

Section 407.—provides that all patient records prepared or obtained pursuant to this Act, and all information contained therein, shall remain confidential, and may be disclosed with the patient's consent only to medical personnel and only for purposes of diagnosis and treatment of the patient or to Government or other officials for the purpose of obtaining benefits due the patient as a result of his alcoholism; that disclosure may be made for purposes unrelated to such treatment or benefits upon order of a court after application showing good cause therefor (in determining this the court shall weigh the need for the information sought to be disclosed against the possible harm of disclosure to the person to whom such information pertains, to the physician-patient relationship, and to the treatment services, and may condition disclosure of the information upon any appropriate safeguards); that no such records or information may be used to initiate criminal charges against a patient under any circumstances; that all patient records and all information contained therein relating to alcohol abuse or alcoholism prepared or obtained by a private practitioner shall remain confidential, and may be disclosed only with the patient's consent and only to medical personnel for purposes of diagnosis and treatment of the patient or to Government or other officials for the purpose of obtaining benefits due the patient as a result of his alcoholism.

TITLE V.—PREVENTION AND TREATMENT OF ALCOHOL ABUSE AND ALCOHOLISM UNDER FEDERAL HEALTH, WELFARE, AND REHABILITATION PROGRAMS

Medicare and Medicaid

Section 501.—provides that an alcoholic shall be regarded as a sick or disabled person eligible for treatment under medicare and medicaid; that Section 1396a of Title 42 of the United States is amended to add: "(a) (31) include provision for prevention and treatment of alcohol abuse and alcoholism."

Social Security

Section 502.—provides that an alcoholic shall be regarded as eligible for disability benefits under the Social Security Act, as amended, and benefits shall not be barred on the ground that alcoholism is a self inflicted disability.

Economic Opportunity

Section 503.—provides that alcohol abuse and alcoholism shall be a matter of high priority for programs undertaken under the Economic Opportunity Act of 1964 as amended.

Vocational Rehabilitation

Section 504.—provides that an alcohol abuser or alcoholic, or a facility or program or service for the prevention or treatment of alcohol abuse or alcoholism, shall be eligible for funds made available pursuant to chapter 4 of title 29 of the United States Code; that Section 35(a) of title 29 of the United States Code is amended to add: "(15) provide for the uses of vocational rehabilitation in the prevention and treatment of alcoholism."

Welfare

Section 505.—provides that alcohol abuse and alcoholism shall, for the purposes of all Federal welfare programs and all State welfare programs that receive Federal participation, be regarded as a major health and economic prob-

lem; that State and Federal agencies charged with administering such welfare programs shall take action to reduce the incidence of financial indigency and family disintegration caused by alcohol abuse and alcoholism, and shall provide for treatment and rehabilitation services for those persons enrolled in welfare programs whose financial eligibility for such assistance results, in part or in whole, from alcohol abuse or alcoholism; that alcohol abuse or alcoholism prevention and treatment programs for persons enrolled in such welfare programs whose financial eligibility for such assistance results, in whole or in part, from alcohol abuse or alcoholism, shall, if approved by the Secretary, be eligible for 75 per centum Federal funding; that applications for funds under this subsection shall be made by the State agency charged with administering the aid program, which may conduct the program or may contract with any other appropriate State agency or private organization for the provision of any of the designated services; that persons otherwise eligible for such welfare assistance shall not be ineligible for such assistance because of alcohol abuse or alcoholism; that any person whose financial eligibility for assistance results, in whole or in part from alcohol abuse or alcoholism, shall be provided the services of appropriate treatment and rehabilitation services upon certification by a responsible medical officer that (1) the service will more likely than not be appropriate for the recipient, and (2) that the services can accommodate the recipient; that after such certification, participation by the recipient in the program shall be a requirement for continuing eligibility for such assistance, in the absence of good cause for nonparticipation; that a certification by the Director of the facility that the recipient is no longer amenable to treatment shall constitute such good cause; that any alcohol abuse or alcoholism treatment facility as a medical institution within the meaning of section 306(a) of title 42 of the United States Code; that the Secretary promulgate regulations specifying how benefits shall be used to contribute to the costs of treatment and rehabilitation of an alcohol abuser or alcoholic receiving welfare assistance; that any recipient of welfare assistance whose inability to work or to participate in a work training program is the result of alcohol abuse or alcoholism shall be excused from such participation on condition that he accept rehabilitation services and treatment made available to him; that the Secretary shall promulgate regulations and offer technical assistance to States in providing programs of education about alcohol abuse and alcoholism for children of school age and adults responsible for them, and appropriate treatment for children damaged mentally or physically as a result of alcohol abuse or alcoholism on the part of adults with whom they have significant contact.

Highway Safety

Section 506.—provides that each State highway safety program approved pursuant to the Highway Safety Act of 1966 shall include provisions for the prevention and treatment of alcohol abuse and alcoholism among licensed drivers; that each program shall provide for screening, diagnosis, and treatment coordinated with and integrated into comprehensive community health and rehabilitation planning; that statistics shall be maintained with regard to the incidence of alcohol abuse and alcoholism among licensed drivers and individuals involved in automobile accidents whether alcohol abuse was a probable factor or not; that highway safety research conducted pursuant to that Act shall include research with respect to the prevention and treatment among licensed drivers; that any Federal funds used to assist State and local governments in the prevention and treatment of alcohol abuse and alcoholism among licensed drivers shall be expended for the purpose of education, treatment, and rehabilitation, and not for the purpose of punishment; and that such funds shall be expended for programs and services that are coordinated with and integrated into comprehensive community and health and rehabilitation programs and services.

General

Section 507.—provides that alcohol abuse and alcoholism shall be regarded as a health problem, disorder, sickness, illness, disease, disability, or other similar term, for purposes of all Federal legislation relating to health, welfare, and rehabilitation programs, services, funds, and other benefits; that any Federal legislation providing for medical assistance, medical care, treatment, rehabilitation, or other similar services, shall be regarded as including programs and services for the prevention and treatment of alcohol abuse and alcoholism.

TITLE VI.—FEDERAL ASSISTANCE FOR STATE AND LOCAL PROGRAMS AND COMPREHENSIVE STATE PLANS

Section 601.—provides that Section 246(a) of title 42 of the United States Code is amended to add: "(L) provide for services for the prevention and treatment of alcohol abuse and alcoholism, commensurate with the extent of the problem, such plan to (i) estimate the number of alcohol abusers and alcoholics within the various areas within the state and the extent of that health problem, (ii) establish priorities for the improvement of the capabilities of State and local governments and public and private agencies, institutions, and organizations with respect to prevention and treatment of alcohol abuse and alcoholism, and (iii) specify how all available community health, welfare, educational, and rehabilitation resources, and how funds, programs, services, and facilities authorized under existing Federal and State legislation, are to be used for these purposes."

State Hospital and Medical Facilities Construction Plans

Section 602.—that Section 291c(a) of title 42 of the United States Code is amended to add: "(4) to projects for construction and modernization of facilities for prevention and treatment of alcohol abuse and alcoholism;" that Section 291d(a) (4) of title 42 of the United States Code is amended to add: "(F) the facilities needed to provide adequate services for the prevention and treatment of alcohol abuse and alcoholism."

State Mental Health Centers Plans

Section 603.—provides that Section 2684 of title 42 of the United States Code is amended to add: "(11) provide for services for the prevention and treatment of alcohol abuse and alcoholism, commensurate with the extent of the problem;" that Section 2691(c) of title 42 of the United States Code is amended by inserting after "mental illness," the following: "alcohol abuse or alcoholism," and by inserting after "mentally ill patients," the following: "alcohol abusers or alcoholics,".

Grants and Contracts for the Prevention and Treatment of Alcohol Abuse and Alcoholism

Section 604.—provides that the Secretary is authorized to make grants and enter into contracts for the prevention and treatment of alcohol abuse and alcoholism to assist State and local governments and public and private organizations, agencies, institutions, or individuals to meet costs of constructing, equipping, and operating treatment and rehabilitation facilities, to conduct research, demonstration, and evaluation projects, to provide education and training for professional personnel, including medical, psychiatric, and social welfare personnel; to recruit, educate, train, organize, and employ community alcohol abuse and alcoholism prevention and treatment personnel; to provide services in correctional and penal institutions for the prevention and treatment of alcohol abuse and alcoholism; to provide services for the prevention and treatment of alcohol abuse and alcoholism among juveniles and young adults; to provide programs and services for the instruction of interested individuals relating to the causes, effects, prevention, and treatment of alcohol abuse and alcoholism, and provide services for outpatient counseling of alcohol abusers or alcoholics; to develop or evaluate curricula on alcohol abusers and alcoholism prevention and treatment including the preparation of improved and new curricular materials; to develop or evaluate a program of dissemination of curricular material; to provide training programs on alcohol abuse and alcoholism for teachers, counselors, and other educational personnel; to provide community education programs on alcohol abuse and alcoholism; to enable a State government agency to assist local education agencies in the planning, development, and implementation of alcohol abuse and alcoholism education programs; to develop educational material and programs about the prevention and treatment of and problems arising from alcohol abuse and alcoholism, for use or distribution by mass media. Such programs shall not exceed 90% of the cost of the program or project; grants to meet costs of compensation of personnel in treatment and rehabilitation facilities shall not exceed eight years in duration, shall not exceed 90% of the cost for the first two years of the program or project, and shall be reduced during the following years.

An amount, not to exceed 5% of the amount appropriated pursuant to this Act is made available to cover up to 100% of the costs of local planning efforts; and an amount, not to exceed 1% of the amount appropriated pursuant to this Act is made available for evaluation of the programs authorized by this title.

Application for Federal Assistance from Units of Local Government and Private Organizations

Section 605.—provides that administering the provisions of this title the Secretary shall require coordination of all applications for programs in a State, and in view of the local nature of alcohol abuse and alcoholism shall not give precedence to public agencies over private agencies or to state agencies over local agencies; that all applications from within a State may be reviewed and commented upon by the State agency responsible for administering the State comprehensive plan for treatment and prevention of alcohol abuse and alcoholism, if such an agency exists; it also establishes the administrative and budgetary criteria which must be met by those seeking funds under this title.

Approval by National Advisory Mental Health Council

Section 606.—provides that grants made under this title may be made only upon the recommendation of the National Advisory Mental Health Council.

Administration of Grants and Contracts

Section 607.—provides that recipients of assistance under this Act keep such records as may be prescribed by the Secretary, and provides that the Secretary and the Comptroller General may audit and examine relevant books, etc. of such recipients.

Section 608.—provides that payments under this title may be made in advance or by way of reimbursement, and in such a way as the Secretary may determine.

Section 609.—provides that no funds shall be available under this title to any public or private agency unless the funds are used by the recipient to supplement and, to the extent practical, increase the level of funding for the program for which the funds are being sought.

Section 610.—provides that whenever the Secretary finds failure to comply with the terms of a grant or contract made under this title, he shall terminate payments until he is satisfied that there will no longer be any failure to comply; that the exclusive remedy of anyone adversely affected by a final action of the Secretary under the preceding subsection of this section is to appeal to the United States court of appeals for the circuit in which it is located by filing a petition with such court within sixty days after such final action. The procedures and conditions of filing such a petition are set out.

Admission of Alcohol Abusers and Alcoholics to Private and Public Hospitals

Section 611.—provides that alcohol abusers and alcoholics shall be admitted to and treated in private and public hospitals solely on the basis of medical need and shall not be discriminated against because of their alcoholism; that no hospital that violated this section shall receive Federal financial assistance under the provisions of this Act or any other Federal law administered by the Secretary; that no such action be taken until the Secretary has advised the appropriate person or persons of the failure to comply with this section, and provided an opportunity for correction or a hearing; that any action taken by the Secretary pursuant to this section shall be subject to judicial review as in the preceding section.

TITLE VII.—THE SECRETARY'S ADVISORY COMMITTEE ON ALCOHOL ABUSE AND ALCOHOLISM

Section 701.—provides that the Secretary shall appoint an Advisory Committee on Alcohol Abuse and Alcoholism to consist of eighteen qualified persons, including leaders from the general public representing business, medicine and government as well as leaders who have a major concern for alcohol abuse and alcoholism; that the Advisory Committee shall advise and consult with the Secretary and the Institute and assist them; that the Secretary shall appoint a Chairman who shall serve a one-year term but may be re-appointed; that the members of the Advisory Committee shall serve without compensation, except for expenses, for terms of three years; that the Committee shall meet at least once every two months and shall consult with various agencies and groups.

Section 702.—provides that the Committee may appoint one or more technical consultants from experts throughout the country to assist in evaluating the progress of the Institute.

Section 703.—provides that the Committee shall employ a full-time director with a secretary, who shall not be employees of the Institute, to assist the Committee and coordinate its activities.

Section 704.—provides that the Committee shall consider at least the following matters: the establishment of goals and priorities for the alcohol abuse and alcoholism programs of the Department; the development of policy concerning the role of the Federal government in the development of alcohol abuse and alcoholism programs; formation of structures and methods through which the programs developed or in effect at the Federal, State, or local levels might have the broadest impact; and, review of allocation of funds and personnel for the implementation of these programs.

TITLE VIII.—INTERGOVERNMENT COORDINATING COUNCIL ON ALCOHOL ABUSE AND ALCOHOLISM

Section 801.—provides that for the purpose of coordinating all Federal Government prevention, treatment, and rehabilitation efforts with respect to alcohol abuse and alcoholism, of coordinating such Federal efforts with State and local governments, and of developing an enlightened policy and appropriate programs for Federal employees for the prevention and treatment of alcohol abuse and alcoholism and the rehabilitation of alcoholics, there is hereby established an Intergovernment Coordinating Council on Alcohol Abuse and Alcoholism consisting of the Commissioner who shall serve as Chairman, the executive director of the Secretary's Advisory Committee on Alcohol Abuse and Alcoholism, four representatives of Federal departments or agencies, and five representatives of State and local government departments or agencies; that the President shall designate the four representatives of Federal departments or agencies who shall serve on the Coordinating Council, and shall appoint the five representatives of State and local government departments and agencies; that the Coordinating Council may appoint such technical consultants as are deemed appropriate for advising the Council in carrying out its functions.

Section 802.—provides that the Coordinating Council assist the Secretary and the Institute in carrying out its function of coordinating all Federal prevention, treatment, and rehabilitation efforts to deal with alcohol abuse and alcoholism; assist the Institute in carrying out its function of coordinating such Federal efforts with State and local governments; engage in educational programs among Federal employees, and in other appropriate activities, designed to prevent alcohol abuse and alcoholism; implement programs for the rehabilitation of Federal employees who are alcohol abusers or alcoholics; and, develop and maintain any other appropriate activities consistent with the purposes of this Act.

TITLE IX.—GENERAL

Section 901.—provides that the Secretary may promulgate regulations, pursuant to subchapter 55 of chapter 5 of title 5, United States Code, to implement this Act.

Section 902.—provides that if any section, provision, or term of this Act is adjudged invalid for any reason, such judgment shall not affect, impair, or invalidate any other section, provision, or term of this Act, and the remaining sections, provisions, and terms shall be and remain in full force and effect.

Section 903.—provides that there are hereby authorized to be appropriated such sums as may be necessary to carry out the provisions of this Act; that any appropriated funds shall remain available until expended.

Section 904.—provides that Section 7352 of title 5 of the United States Code is hereby repealed; that paragraph (3) of subsection 8102(a) of title 5 of the United States Code is hereby repealed; that paragraph (2) of subsection 2504(d) of title 22 of the United States Code is hereby amended to repeal the clause "or unless intoxication of the injured volunteer is the proximate cause of the injury or death."

Section 905.—provides that this Act shall take effect upon the expiration of one hundred and eighty days following the date of its enactment.

COMPTROLLER GENERAL OF THE UNITED STATES,
Washington, D.C., May 27, 1970.

B-158784.

HON. RALPH YARBOROUGH,
Chairman, Committee on Labor and Public Welfare,
U.S. Senate.

DEAR MR. CHAIRMAN: Reference is made to your letter of May 15, 1970, requesting our comments on S. 3835, the purpose of which, as stated in its title, is to provide a comprehensive Federal program for the prevention and treatment of alcohol abuse and alcoholism. If enacted, the bill would be cited as the "Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970."

The objectives of this bill and the manner of accomplishing them are matters of policy for determination of the Congress and we have no recommendations on the merits of the bill. However, we offer the following matter for your consideration.

Section 403 concerns alcohol abuse and alcoholism among military personnel. Paragraph (a) thereof provides that for purposes of chapter 61 of title 10 of the United States Code, alcoholism shall be regarded as a physical disability and shall not be regarded as the results of intentional misconduct or willful neglect. Consequently, an alcoholic would not lose pension, retirement, medical, or other benefits provided by said chapter 61 of title 10 of the United States Code. It is specifically provided that this subsection 403(a) shall be retroactive. We have some question whether such retroactive feature is intended to permit military personnel who previously have been denied the benefits of chapter 61 to now receive such benefits retroactively to the date when they were separated or retired from the military service, or whether it is intended only that such previously separated or retired personnel would become entitled to those benefits from the date that the bill is enacted into law.

Accordingly, we believe this matter should be clarified.

Sincerely yours,

ELMER B. STAATS,
Comptroller General of the United States.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
Washington, D.C., June 23, 1970.

HON. RALPH YARBOROUGH,
Chairman, Committee on Labor and Public Welfare,
U.S. Senate,
Washington, D.C.

DEAR MR. CHAIRMAN: This letter is in response to your request of May 15, 1970, for a report on S. 3835, a bill entitled the "Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970."

The bill provides for broad authorities and responsibilities for a Federal program aimed at the prevention and control of alcohol abuse, alcoholism and other alcohol related problems in the United States. I have enclosed a detailed commentary on the sections of the bill which are of particular interest and concern to the Department, omitting, however, consideration of those provisions contained in sections 403, 405, 610(b), and 611(b). Our comments on Title V will be forwarded to you in a separate letter very shortly.

The bill is wide ranging in scope and provides mechanisms to coordinate all health, welfare, educational, and rehabilitation resources which are, and would be by its own provisions be, available to the Federal Government. Entirely consonant with this objective are the Department's commitment and ongoing activities with regard to the improvement and expansion of our efforts in the alcoholism area. Over two years ago the Secretary's Advisory Committee on Alcoholism was established to make recommendations on ways and means to expand and improve activities of this Department relating to this important national problem.

The Committee has recently made a number of recommendations to the Secretary. The recommendations of the Advisory Committee, as we have pointed out in the enclosed analysis, are addressed to many of the subjects and problems which are covered by the bill. These recommendations have been reviewed and accepted by the Department.

One of the Committee's chief recommendations is that the alcoholism activities at the National Institute of Mental Health be given more visibility within the NIMH organizational structure so as to increase the effectiveness of such activities and assure better coordination and management. As the enclosed analysis points out we would prefer that this recommendation be implemented by the elevation of the National Center for the Prevention and Control of Alcoholism to the stature of a Division within the NIMH, over the directive contained in the bill that there be created a National Institute for the Prevention and Control of Alcohol Abuse and Alcoholism within the NIMH.

It is also pointed out in the enclosed analysis that the Department is committed to the concept that alcoholism prevention and treatment services should, wherever possible, be an integral part of community based comprehensive care. Strong reservations are therefore raised as to the provisions of the bill which authorize grants and contracts for such services which would be parallel and similar to authority already contained in the Community Mental Health Centers Act, but would not require that the treatment services and facilities be an integral part of the community mental health centers program.

Nevertheless, we feel that S. 3835 is commendable in its comprehensive approach to the development of a new national and Federal stance respecting the problem of alcohol abuse and alcoholism. With the modifications suggested in the enclosed analysis the Department, therefore, recommends enactment of the bill.

We are advised by the Bureau of the Budget that there is no objection to the presentation of this report from the standpoint of the Administration's program.

Sincerely,

Acting Secretary.

Enclosure.

COMMENTARY ANALYSIS OF S. 3835, THE "COMPREHENSIVE ALCOHOL ABUSE AND ALCOHOLISM PREVENTION, TREATMENT, AND REHABILITATION ACT OF 1970"

TITLE I.—FINDINGS AND DECLARATION OF PURPOSES

The statement of Congressional findings contained in section 101(f), which refers to a lack of Federal leadership and funding as being causative of neglect of the alcohol problems, is not constructive. Ongoing activities at the Federal level in the alcoholism area would negate such attribution to current efforts; and since the overall lack of national progress against alcoholism up to the present is the result of a variety of factors, we feel that it is inappropriate to attribute this past failure to a lack of Federal leadership.

TITLE III.—NATIONAL INSTITUTE FOR THE PREVENTION AND CONTROL OF ALCOHOL ABUSE AND ALCOHOLISM

Establishment of the Institute

The provisions of section 301, which would establish a National Institute for the Prevention and Control of Alcohol Abuse and Alcoholism within the NIMH, are opposed by the Department. It is the policy of the Department that the Secretary should be free to retain his flexibility to organize the Department in the way he finds most efficient to accomplishing his goals. We feel that the elevation of the National Center for the Prevention and Control of Alcoholism to the stature of a Division within the NIMH is a more desirable choice than would be the creation of a separate Institute with its own Director, even though within the NIMH. Steps are already underway to elevate the National Center to Division status and to increase and strengthen its staff, in direct response to a recent recommendation of the Secretary's National Advisory Committee on Alcoholism. Implementing this recommendation would accomplish the objective of giving alcoholism activities greater visibility and a more prominent place in the organization of this Department without duplicating managerial, administrative, and planning functions already being carried out by the Office of the Director of NIMH. Division status of the present Alcoholism Center within the NIMH would also assure its continuing ability to draw upon the considerable biological and behavioral science resources of the Institute as well as to assure that appropriate attention within the Community Mental Health Centers program will be accorded services for persons with alcohol problems. New staff is also to be added to the new Division of Alcohol Abuse and Alcoholism, thus

placing it in a position to better develop and implement a wide variety of necessary new programs. For these reasons, we recommended that the provisions of this section, as well as of sections 102(a) and 201(i), be deleted.

Functions of the Secretary

We feel that the provisions found in the remainder of Title III, which describe and define functions and responsibilities of the Secretary, provide a comprehensive base on which the Secretary can effectively carry out his duties which are related to the alcohol problems. These provisions generally are in accord with recommendations of the Secretary's Advisory Committee which the Secretary has reviewed and accepted.

We fear, however, that the great degree of specificity and detail which is employed in describing these functions and responsibilities will deny the Secretary the discretion he must have in order to most effectively organize and assign priorities. In addition, we feel that a proliferation of legally mandated duties, functions and responsibilities of so many varieties, such as is found in Title III, would overburden already limited manpower with a multiplicity of statutory functions; and would in the process adversely affect the flexibility and versatility which are obvious underlying goals of the bill.

We believe it is possible to achieve the intent of the bill of guaranteeing adequate attention to the alcohol problems by spelling out the Secretary's functions and responsibilities within a more general and less rigid framework. For example, the language contained in the General Management Instructions Manual which describes organization, functions and authority presently assigned to the National Center for Prevention and Control of Alcoholism is, we think, inclusive and broad enough to embrace practically all the different categories of functions which this bill uses numerous subheadings and considerable length to describe. The Manual in one instance prescribes that the Center is to collaborate with "other Federal agencies, national, State and local organizations and voluntary groups to facilitate and extend programs for the prevention of alcoholism and for the care, treatment and rehabilitation of alcoholics." This appears to us, for instance, sufficiently encompassing to constitute authority for most of the duties described in the seven subsections of section 304, which is concerned with Coordination Functions.

Section 306, in describing the Secretary's research functions, would provide specific statutory authority for intramural and extramural research in the alcoholism area. The provisions of that section parallel another specific recommendation of the Secretary's Advisory Committee which noted that since the problems of alcohol have been so long neglected, there exist serious limitations of basic knowledge and techniques and serious shortages of personnel with the competence, sophistication and motivation required to apply existing knowledge. In order to fill these gaps an intensive and immediate categorical investment was recommended by the Committee in basic research on alcohol problems, experimental or model programs of treatment, rehabilitation, and education; and training of professional personnel in a wide variety of areas such as medicine, public health, psychiatry, psychology, social work, educational, law, and law enforcement. We, therefore, endorse the intent of section 306.

Owing to a technical omission in section 306, however, we suggest a slight revision to it. Although there is authority for research grants contained in section 306(e), there is no provision made in that subsection for review of grant applications by the National Advisory Mental Health Council. We feel that it is critical that this distinguished group continue its function of serving as the statutory review body in the research grant area because of the great need to maintain a consistent high quality of grant supported research.

The prohibition of section 306(i) against information obtained through reports, investigation, or research conducted under section 305 (Statistical Functions of the Secretary) and section 306 (Research Functions of the Secretary) being used to reveal identities of alcoholics is, we think, an unnecessary provision in view of a similar confidentiality mandate contained in section 407(a) which applies in blanket fashion to "this Act."

Section 308, in describing the Secretary's educational functions, would also serve as a statutory base for activities recommended by the Advisory Committee and presently in preparation for implementation. A new activity to be initiated in FY 1971, pending Congressional approval for necessary expenditures, will be a program of public education and information on alcoholism. There is tremendous need for more and better programs and materials including publications, films, and TV and radio materials to educate the public about the

problem of alcoholism and to heighten public understanding that it is a treatable illness. On the basis of our experience in the area of drug abuse education we believe that this new program will stimulate more intensive awareness and action by State and local governments and agencies, as well as the media.

TITLE IV—PREVENTION AND TREATMENT OF ALCOHOL ABUSE AND ALCOHOLISM FOR FEDERAL EMPLOYEES, MILITARY PERSONNEL, VETERANS, AND FEDERAL OFFENDERS

Alcohol abuse and alcoholism among Federal employees

Contained in section 401 are provisions aimed at encouraging responsible personnel policies and attitudes within the Federal Government regarding alcoholism among civilian employees of the Executive Branch. In tandem with the elevation of the National Center for the Prevention and Control of Alcoholism to Division status within the NIMH, the Department, through the major leadership of the new Division, will implement another key recommendation recently made by the Secretary's Advisory Committee on Alcoholism. That recommendation calls for the development, promulgation, and implementation of an enlightened personnel policy on alcoholism for Federal employees. This program will involve every agency within the Department and will be accompanied by a clear policy statement by the Secretary. It will focus on recognizing that alcohol abuse and alcoholism are health problems, and alcoholism should be viewed as any other illness. At all levels, supervisory staff and other employees will be trained to better understand the signs and symptoms of alcoholism to allow for early identification and referral of persons with alcohol problems to appropriate treatment resources. Particular emphasis will be given to improving the ability and capacity of health units and Federal agencies to recognize problem drinking. Agencies will be encouraged to create a climate of understanding and encouragement in order to counteract the effects of the social stigma, which has been too long associated with alcoholism, on the customs, attitudes, and policies of the Federal Government; and which have acted as a barrier to constructive corrective action. The Department's specific concern for any individual's drinking practices, of course, will begin only when they appear to result in unsatisfactory job performance.

We defer to the views of the Civil Service Commission on the details of Title IV (and related provisions of Title III). Nevertheless, we question the wisdom of that provision contained in § 401(a) which would condition the continued employment of Federal civilian employees with alcohol problems upon their acceptance of appropriate treatment. Many considerations enter into a determination of whether an employee who is suffering from a possibly disabling physical condition, such as alcoholism or other illness, should be retained for employment. Among those considerations, will be the prospect for the employee's recovery or rehabilitation. To single out employees with alcohol problems for the purpose of imposing upon them a statutory requirement to accept appropriate treatment is inconsistent with the concept of alcoholism as an illness. We therefore recommend that the provision be deleted.

That portion of section 401(c) which would require the Secretary to specify in regulations those extremely sensitive positions in the various agencies of the Executive Branch which should not be filled with persons having prior alcohol problems is, we think, inappropriate. We recommend that the provision be changed so as to allow each agency of the Executive Branch, which would be in a better position to make such determinations, to make its own designation of positions within its organizational structure which are extremely sensitive.

Health and Disability Insurance Plans for Federal Employees

Section 402 would require all health disability insurance policies for Federal employees to cover alcoholism the same as other health problems and illnesses which are not self-inflicted. It is consistent with the recommendation of the Secretary's Advisory Committee that the Federal Government should assume leadership in assuring the specific inclusion of provisions for alcoholism in plans for prepayment of insurance of medical and hospital care. We wish to point out that in furtherance of these aims virtually all carriers participating in the Federal Employees Health Benefits Program have already provided, or are in the process of providing, nondiscriminatory treatment in their plans for persons with alcoholism problems; and that approximately 80 percent of Federal employees and annuitants already have such coverage. We defer to the Civil Service Commission as to the mechanisms of bringing about the aim of section 402, as well as to wisdom of there being a statutory requirement on the matter.

Provision of Services

Although the Department concurs with the objective of section 406 to assure access to needed treatment for the Federal beneficiaries specified in Title IV of the bill, we recommend against extending direct health services to achieve these objectives since, to do so, would controvert the current Federal policy of limiting such services to those for whom the Federal Government has had long standing direct care responsibilities. We feel it is more important to encourage and support the development of community resources.

TITLE VI.—FEDERAL ASSISTANCE FOR STATE AND LOCAL PROGRAMS

Grants and Contracts for the Prevention of Alcohol Abuse and Alcoholism

The Department, while concurring with the general aim of section 604(a) (1) which would provide for assistance to State and local governments and public and private organizations for the prevention and treatment of the alcohol problems through grants and contracts, is nevertheless constrained to point out its impropriety. For instance its grants authority is similar and parallel to that already embodied in the Community Mental Health Centers Act. Section 604, however, does not recognize the authority which already exists and which we feel is contained in the programmatic framework more effective than that found in the bill. Moreover, section 604 fails to require that its grant supported services be linked to form a comprehensive continuum of care. In this regard the bill is at odds with itself in that it contains an early finding of Congress in section 101(c) that alcoholism treatment and control programs should be community based and should, among other things, provide comprehensive services.

Should the bill be enacted in its present form it might be taken as a legislative sanctioning of the development of splintered, isolated, and fragmented programs. This would be inconsistent with the bill's underlying attempt to bring about coordination and integration of all resources.

The Alcoholism Rehabilitation Amendments to the Community Mental Health Centers Act were specifically motivated by a desire to provide continuity of care necessary for easy access and transfer between and among service components, thus avoiding the chronic problem of the patient's "falling between the cracks." In its present form, therefore, we feel the bill might jeopardize the core concept of our current alcoholism treatment and rehabilitation programs.

We feel that a principal obstacle which must be overcome in developing a more meaningful Federal effort in the alcohol problems area is the tendency to look for narrow and categorical solutions to a very complex medical, psychology, and sociology problem. At a time when the strain on our health resources has never been greater, it behooves us wherever possible to link the development of new program foci to existing resources. This serves not only to economize on staff and facilities but, even more important, to refocus the objectives of all health, social, and rehabilitation activities on the problem of alcoholism.

For these reasons we prefer the authorities for Federal assistance to communities for treatment and rehabilitation services for alcoholism as presently contained in the Alcoholism Rehabilitation Amendments to the Community Mental Health Centers Act to the program proposed in section 604(a) (1).

In prescribing the Federal share of the cost of projects section 604(b) would allow less than the Federal share which is currently available for these programs. We also object to the opening language of section 604 which would allow grants to private organizations unless it is altered to specify that these organizations be nonprofit.

There is contained in section 604(a) (4) a prohibition against a prior alcohol problem, as well as prior criminal arrests or convictions, constituting a bar to employment respecting Title VI community programs. These provisions, however, contain no qualifying language that such arrests or convictions must have resulted from, or have been connected with, alcoholism or alcohol abuse. We oppose such a blanket inclusion in the prohibition for the reason that many people who have been and will be criminally arrested and convicted are non-drinkers; and there are crimes which by their nature could reflect a person's unsuitability for certain work. Our comments in this regard would apply equally to a similar provision contained in section 301(c).

Application for Financial Assistance from Units of Local Government and Private Organizations

We object to the provision contained in section 606 that all Title VI grants can only be made if they are recommended by the National Advisory Mental Health Council. The Department has already documented its position that the procedure of requiring approval of this Advisory Council for each construction and staffing grant will complicate the decision process and create unnecessary barriers to the development of community health programs. While we support a role for the National Advisory Mental Health Council in the development of broad policy and recommendations on research and training grants, we feel that section 606 in its present form would burden this valuable advisory and policy-making body with cumbersome administrative tasks inappropriate to its role. We recommend, therefore, that section 606 be reworded so that the Advisory Council's approval shall be necessary only with regard to research and training grants authorized by the bill.

Admission of Alcohol Abusers and Alcoholics to Private and Public Hospitals

The Department supports the provisions of section 611(a) which would provide a penalty consisting of cessation of all Federal assistance under provisions of any Federal law administered by the Secretary to any private or public hospital which would refuse to admit an alcoholic solely because of his alcoholism.

TITLE VII.—THE SECRETARY'S ADVISORY COMMITTEE ON ALCOHOL ABUSE AND ALCOHOLISM

Sections 701 through 704 of this Title concern themselves with the creation of an Advisory Committee on Alcohol Abuse and Alcoholism to advise the Secretary on such matters; with permitting the Committee to hire a fulltime Secretariat; with authorizing it to hire expert consultants to help with evaluating the progress of the new Institute; and with spelling out the Committee's areas of concern and responsibility.

We concur with the objectives of Title VII. An advisory committee such as would thus be authorized, to be composed of leader representatives from such population segments as business, education, law, religion, and State and local government, could serve a highly useful advisory role to the Secretary in policy areas. We also agree with the provisions that some members of the Committee should be recovered alcoholics and that some should come from voluntary associations and groups which have a major concern with alcohol abuse and alcoholism.

We feel, however, that those provisions of Title VII which stipulate the frequency with which the Committee must meet and consult with others, and which detail its functions, are undesirable in that they would prevent the Committee from having the flexibility needed to most effectively carry out its advisory purposes. Additionally we are opposed to the Title VII provisions which equip the Committee with a full-time Secretariat; prescribe for it such duties as those of budget and personnel review; and authorize the use by it of outside consultants for program evaluation purposes. We feel that such areas as these are administrative in nature and, therefore, inappropriate to an advisory-policy group such as the proposed Committee.

TITLE VIII.—INTERGOVERNMENT COORDINATING COUNCIL ON ALCOHOL ABUSE AND ALCOHOLISM

Section 801 provides for the establishment of an Intergovernmental Council on Alcohol Abuse and Alcoholism to coordinate all prevention, treatment and rehabilitation efforts of the Federal Government with each other and with those of State and local governments; and to develop a policy and program for prevention and treatment of the alcohol problems among Federal employees. We support the concept that all such service programs, to assure uniformity of quality and avoid overlap and duplication, should be coordinated. In our judgment, however, such coordination may be achieved under § 304 of the bill, which expressly provides for such functions to be performed by the Secretary. Should the Secretary require advice on matters of policy relating to such coordination functions, he may obtain it from the Advisory Committee on Alcohol Use and Alcoholism established pursuant to Title VII of the bill. We therefore recommend that Title VIII of the bill be omitted.

TITLE IX.—GENERAL

The Department endorses the provisions of section 904(a) of the bill which repeal from the United States Code the prohibition presently found there against the hiring or retaining of persons who habitually drink intoxicating liquors to excess. Alcoholism stands alone as being the only illness statutorily singled out as grounds for dismissal from employment or refusing to hire persons in the Federal Government. Such a change would in no way deprive the Government of authority to separate or refuse to hire persons for good cause. It would, however, make the Federal law consistent with our stated policy that anticipated actual work performance as well as other standards regarding suitability, rather than the presence of illness, should be the principal criteria. The present law is a needless one and constitutes a formidable barrier to providing assurances of confidential handling of the diagnostic and treatment processes in the new Departmental approach to the alcohol problems.

VETERANS' ADMINISTRATION,
OFFICE OF THE ADMINISTRATION OF VETERANS AFFAIRS,
Washington, D.C., June 23, 1970.

Hon. RALPH YARBOROUGH,
Chairman, Committee on Labor and Public Welfare,
U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: I am pleased to furnish the Committee with the following comments in response to your request for a report by the Veterans Administration on S. 3835, 91st Congress.

The bill is designed to provide a comprehensive Federal program for the prevention and treatment of alcohol abuse and alcoholism. It would establish a National Institute for the Prevention and Control of Alcohol Abuse and Alcoholism within the National Institute of Mental Health of the Department of Health, Education, and Welfare. Such Institute would develop and conduct a comprehensive health, education, research, and rehabilitation program in the discharge of its wide-ranging responsibilities.

An independent Advisory Committee on Alcohol Abuse and Alcoholism, appointed by the Secretary of HEW, would consider the establishment of goals and priorities for alcohol abuse and alcoholism programs; the development of policy concerning the role of the Federal Government in such programs; the formation of methods and structures to insure the broadest impact of such programs; and review of the allocation of funds and personnel for implementation of these programs.

For the purpose of coordinating all Federal prevention, treatment, and rehabilitation efforts with respect to problems of alcoholism and of coordinating such Federal efforts with those of State and local governments, there would be established an intergovernmental Coordinating Council on Alcohol Abuse and Alcoholism consisting of the Secretary, HEW, the executive director of the Advisory Committee, four representatives of Federal departments or agencies and five representatives of State and local government departments or agencies designated or appointed by the President.

The Veterans Administration has a substantial interest in the rehabilitation of the alcoholic and welcomes support from any responsible source when the objective is the more effective prevention and treatment of alcoholism. We subscribe to the broad aims sought to be achieved by S. 3835 but will limit our comments to those provisions which relate to VA programs and responsibilities.

Section 404(a) provides that appropriate treatment facilities and services for alcoholic abuse and alcoholism shall be made available in VA hospitals as a matter of high priority. We have been giving increased attention in recent years to the need for a concerted program for the treatment and rehabilitation of alcoholic veterans. A medical position of Director of Staff for Alcoholism and Related Disorders has been established to coordinate and develop a quality program of service, research, and education in this field.

Currently, forty-nine hospitals are conducting research on this problem and thirty-seven units are in operation to provide special treatment programs for veterans with alcoholic conditions. In addition to our many other facilities which admit veterans for treatment of this disability, the units providing special treatment programs now have approximately 900 beds allotted for this purpose. We have planned for the funding of additional special units for alcohol-

ism treatment and rehabilitation in the next six years. These units may include sections for acute detoxification, psychiatric and medical treatment, post-hospital follow-up care, and vocational rehabilitation.

Section 404(b) provides that for purposes of disability or death compensation and for hospital, domiciliary, and medical care benefits, alcoholism during military service shall be regarded as a service-connected disability and not as due to willful misconduct. Similarly, section 404(c) would extend alcoholism the statutory presumption of service connection now applicable only to active psychosis which develops within two years from date of discharge or release from active duty, for purposes of entitlement to hospital or medical care.

Although the Veterans Administration recognizes the disabling effects of alcoholism, such condition, in and of itself, may not be accepted for adjudicative purposes as a basis for granting or increasing monetary benefits administered by this agency. If, however, alcoholism is secondary to and a manifestation of a psychotic, psychoneurotic or psychophysiologic disorder, then it is considered part and parcel of the disability and rated as one disease entity.

We do not favor proposals which seek to circumvent the normal adjudicative process for determining the origin of a disability. Generally, the Veterans Administration accepts service department findings that an injury, disease, or death was not due to willful misconduct unless patently inconsistent with the facts. The proposed legislation, apart from being discriminatory, usurps the professional judgment of the physicians as to the etiology of the disability.

We adhere to our long-standing position that a presumption of service connection regardless of the nature of the onset of the disability or whether from causes occurring prior to, during, or after service, is not medically justified. The expiration of a period of time which is computed in terms of one or two years, between an experience and the manifestations of symptoms of unknown pathogenesis would ordinarily rebut any concept of etiological relationship. We are concerned that the grant of a presumption of service connection for alcoholics would provide another precedent for demands for benefits on a similar basis by other groups with habits or diseases that could be suspected of being self imposed.

Section 404(d) provides that a dishonorable discharge prior to the effective date of the legislation shall not bar treatment for alcoholism if the discharge was the result of alcohol abuse or alcoholism. We understand that servicemen who have serious problems involving alcoholism are discharged administratively as unsuitable for continued service. A general discharge is ordinarily given unless service would otherwise warrant an honorable discharge. As veterans, and if otherwise eligible, they can be furnished VA hospital care for alcoholism whether or not the condition is determined to be service-connected.

Section 406 provides for use of VA facilities in providing the treatment and rehabilitation services authorized for various categories of persons under title IV of the bill and specifies that care and treatment of veterans included in those categories shall be provided where possible in VA hospitals. Several categories of alcohol abusers and alcoholics are contemplated by title IV including, in addition to veterans, those who are Federal employees, military personnel, and any person charged with a criminal offense under Federal law who appears to be intoxicated or an alcoholic.

Although it is not clear from the context, we assume that any person treated in a VA hospital pursuant to the provisions of title IV of the bill, not as a beneficiary of the Veterans Administration but as a beneficiary of HEW or another Federal agency, would be treated on a reimbursable basis at the reciprocal rates applicable under the Federal cross-service statute (31 USC 686). Of course, the problem of availability of VA beds for beneficiaries of another agency would have to be considered—in the light of our primary mission, i.e., the furnishing of authorized services and benefits to eligible veterans.

As to treatment of Federal offenders, it has been the long-standing policy and practice of the Veterans Administration not to admit a veteran, otherwise eligible for treatment in a VA hospital, who is held by civil authorities under charges or who has been convicted of a crime, unless the charges have been dropped or the veteran released unconditionally, or if paroled by a court, only if there is no obligation placed upon the Veterans Administration to restore him to custody. We cannot accept responsibility to return criminals to stand trial or complete sentences. VA medical authorities must be free to discharge veterans who have received maximum hospital benefits, consistent with sound medical practice. The Veterans Administration is neither authorized nor equipped to be an arm of the Federal penal system.

Because of the number of unknown factors involved in S. 3835, we are unable to provide a reliable estimate of the cost effects of the bill on the VA programs affected.

In summary, we believe that the broad objectives of the proposed legislation are in the public interest. To the extent that the bill would impose certain specific responsibilities on the Veterans Administration, we express the following views:

(1) The Veterans Administration will intensify its efforts to provide effective special treatment programs for veterans with alcoholic problems. Within the limits of its facilities and to the fullest extent compatible with accomplishment of its primary mission, the Veterans Administration will be willing to make its resources available for the treatment of beneficiaries of other Federal agencies, on a reimbursable basis.

(2) We reiterate our long-standing opposition to proposals which would avoid the normal adjudicative process for determining the origin of a disability by creating presumptions which are not medically justified and which arbitrarily accord preferential and discriminatory consideration to selected categories of persons. Accordingly, I do not recommend favorable consideration of the provisions of subsections (b), (c), and (d) of section 404.

We are advised by the Bureau of the Budget that there is no objection to the presentation of this report from the standpoint of the Administration's program.

Sincerely,

FRED B. RHODES,
Deputy Administrator

Senator HUGHES. The legislation we are considering today deals not with a new priority on our national scene but with an old one that has long been swept under the rug.

It is, Dr. Roger Egeberg stated in testimony before this subcommittee, our Nation's No. 1 health problem.

It is also, among many strongly competing forfeitures of responsibility by our society, our No. 1 neglect.

From ancient times, alcohol abuse and confirmed alcoholism have been major problems of mankind.

They have reached their zenith in the United States today—the most affluent Nation in history. We have a tendency as a people toward self-indulgence and we have the wherewithal to indulge ourselves in this socially accepted drug.

When you consider all of the people whose lives are affected by the excessive use of alcohol in our society—alcoholics, their families, business associates, and employers; the occasional but dangerous abusers of alcohol; the victims of auto accidents caused by drunken driving; the victims of crimes in which alcohol abuse was a factor—you are talking about more than 50 million people in our country.

Alcoholism is a problem of our entire society. It will take a total effort of our entire Nation, at all levels of government, to make any really significant inroads to control it.

When I introduced S. 3835 on the 14th of this month, I did not have any illusions about it being the utopian solution that would eliminate the blight of alcoholism from our society.

It is however the biggest and most realistic step thus far proposed.

The legislation is unprecedented in its comprehensiveness and its dimension and its realistic approach.

It is the carefully drawn product of the best information and guidance we have from medical science, psychology, sociology, psychiatry, hospital administration, rehabilitation experience, and legal wisdom.

In yesterday morning's Washington Post there is a story about the unveiling of a new device called a psychological tester, which is, in plainer words, a mechanism for testing a drunken driver.

The device uses a spot on the car dashboard. When the driver turns on the ignition, the device will flash a series of random numbers or symbols, these will disappear in 2 seconds.

The driver will have 6 seconds to push a series of buttons in corresponding order. If he is right, the car's engine will start automatically.

If the would-be driver is too disoriented to pass the test, the car won't start until he has sobered up enough to pass it.

It is an ingenious device for dealing with one phase of the multifaceted problem of alcoholism. It reflects our inventive nature as a people and our tendency to take technological approaches to our problems. It may or may not be of practical help in controlling drunken driving.

But the point I would like to make here is that there is no ingenious device or single method that will provide a quick, easy solution to the problem of alcoholism in our society.

It will require a multiple approach, the skill and experience of numerous professional disciplines, public patience, and understanding, and very substantial outlays of public funds. There is no short cut.

The encouraging part of the picture is that we have learned a great deal about the deadly and widespread illness we call alcoholism.

We know it is a blight that will kill if not arrested. We know what it does to individuals and families. We know that its cost in economic waste is astronomical—perhaps as high as \$7 billion annually.

We also know that we can successfully treat it. We can bring sick people back to health. We can also do a great deal about controlling it—given the proper facilities and professional help.

We know what to do, we simply have not done it. For a variety of reasons, we have refused to face this ancient, familiar blight which if not checked will result in the deterioration and possible destruction of our society.

Perhaps greater stress should be given to the relationship of this rapidly growing problem to our national security.

The weakening of the health and will of a people could be as serious a threat to our national security as the possibility of attack by a foreign power.

Recent reports from Russia indicate that the Soviet Government has become gravely concerned about the growing problem of alcoholism in that country.

Epidemic alcoholism could prove to be the Trojan horse of modern nations.

In any event the problem is symbolic. If we can't summon up the determination and resources to meet this well-known threat to our health and well being as a society, we can scarcely hope to meet such great problems of our times as the elimination of war and poverty and racial discrimination.

S. 3835, the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970, is a serious and realistic attempt to meet one of our Nation's most serious and treatable problems.

I just had a letter from a friend of mine yesterday in one of the African nations indicating their congress was considering a bill that provided capital punishment for anyone driving a car intoxicated that killed anyone.

This gives you an idea of the problems we are facing.

Even in the African country, they have taken an approach which I doubt will work with the alcoholic.

At this point in the record I order printed the statement of Senator Dominick.

**STATEMENT OF HON. PETER H. DOMINICK, A U.S. SENATOR FROM
THE STATE OF COLORADO**

Senator DOMINICK. Mr. Chairman, I sincerely regret that the press of other commitments precludes my being in attendance for the hearings to be conducted by the subcommittee on S. 3835 on May 21 and 25.

Alcoholism and alcohol abuse are health problems of immense importance, and far too little has been accomplished to date to meet the need. Had it not been for the fact that a copy of S. 3835 did not arrive in my office until it had already been introduced, I might have been a cosponsor. Nevertheless, I believe the bill contains many sound provisions, and I look forward to reviewing the hearing record and working with the Senator from Iowa in executive sessions on the bill.

As any new legislation is considered, it is only elementary to get a feel for what the Federal Government has been doing during the past few years concerning alcoholism. My own experience in trying to obtain such information has been very similar to that which the chairman and I encountered in the area of drug abuse—what programs there are, strong or weak, have generally been fragmented and hard to pin down.

There are two items, however, which I think will be useful to the subcommittee, and to those others who may use the hearing record.

The first is the summary of Federal efforts in alcoholism contained in the "Overview of the 1971 Budget" presented March 4, 1970, in hearings before the Labor-HEW Appropriations Subcommittee of the House of Representatives.

While more needs to be done, I was particularly encouraged to see that for that portion of the overall alcoholism program which is located at NIMH, President Nixon has more than doubled the fiscal year 1970 figure of \$6.9 million to \$14.5 million.

The second item, which I am also including for the hearing record, is a list which I requested from the Department of Health, Education, and Welfare identifying each community mental health center which is providing alcoholism services. There are 105.

While the hearings opening today are legislative, not general informational, it was my thought these two items would be a meaningful and necessary addition helping to update the informational hearings on alcoholism conducted by the subcommittee in 1969.

(The information referred to follows:)

ALCOHOLISM -- OVERVIEW OF 1971 BUDGET

The last few years have seen major changes in Americans' attitudes toward drinking and alcoholism. These years have been marked by a new frankness in discussions about drinking and alcohol by many groups, including churches, educational organizations and governmental agencies. Americans are slowly turning away from a condemnatory, moralistic view of alcoholism and are showing greater readiness to recognize that the alcoholic is a sick person who can be helped by treatment methods currently available.

The growing national awareness and concern about alcoholism and alcohol-related problems were dramatically demonstrated this year by three important events: 1) the establishment, as part of the Senate Committee on Labor and Public Welfare, of a special Subcommittee on Alcohol and Narcotics; 2) the "Report of the Task Force on Alcohol Problems" of the National Council of Churches, stressing the need for church groups to participate in the establishment of alcohol education programs; and 3) the recent "Joint Statement of Principles Concerning Alcoholism" made by the American Bar Association and the American Medical Association. This statement emphasizes the need for insurance coverage for alcoholism, the need for general hospitals to accept alcoholics on a non-discriminatory basis, the need for training, and perhaps most important, the need for State governments to adopt new comprehensive legislation on alcoholism which "should provide that public intoxication in itself is not a crime."

THE CHALLENGE OF ALCOHOLISM

The United States has one of the highest rates of alcoholism in the world. A person is an alcoholic if his repeated drinking significantly damages his physical health or interferes with his ability to be effective in his job, in his family, or in his community. The number of alcoholics in the United States is placed between 4 million and 6 million, and an estimated 200,000 new cases develop each year. The effects on family members of an alcoholic are direct and often devastating. Thus, as many as 20 million people, many of whom are children, are adversely affected by alcoholism.

Alcoholics account for a large proportion of the patients known to health and social welfare agencies. For example, in recent years more than one-fifth of all the men admitted to State mental hospitals and to the psychiatric wards of general hospitals have been alcoholics. Alcohol is a significant factor in almost half of all fatal motor vehicle accidents and it now is clear that a large number of these drinking drivers are alcoholics.

In addition to the human costs, the economic losses resulting from alcoholism are great. Losses to industry from absenteeism and other problems associated with alcoholism are about \$2 billion annually. The President's Commission on Law Enforcement and Administration of Justice estimates that the national cost for handling chronic drunkenness offenders is in excess of \$100 million per year. Costs for hospital care, welfare costs for alcoholics and their families and dependents exceed \$2 billion per year. Thus, the total annual cost of alcoholism to the country is at least \$4 billion.

The consensus of informed opinion is that alcoholism results from a complex interaction of social, psychological, and biological factors. Even the most enthusiastic proponents of any specific theory regarding the causation of alcoholism agree on the necessity of an eclectic approach to this illness. Even research carried out within a single discipline must be related to research conducted within other disciplines if it is to be meaningful.

Obligations for Programs on Alcoholism
(In thousands of dollars)

	<u>1967</u>	<u>1968</u>	<u>1969</u>	<u>1970</u> <u>estimate</u>	<u>1971</u> <u>estimate</u>
Environmental Health Service:					
Environmental Control					
Administration.....	75	80	100	135	135
Health Services and Mental					
Health Administration:					
National Institute of					
Mental Health.....	3,776	5,972	7,073	6,894	14,471
National Institutes of					
Health:					
Health Manpower.....	67	67	51	50	50
Social and Rehabilitation					
Service:					
Basic State grants.....	3,467	6,200	13,174	18,226	25,099
Innovation grants.....	188	220	261	324	350
Expansion grants.....	756	333	575	713	841
Rehabilitation					
facilities.....	0	0	83	70	64
Training.....	28	38	29	52	52
Rehabilitation research					
and demonstrations....	254	40	49	0	0
Special foreign currency					
program.....	45	218	21	100	300
Subtotal, Social and					
Rehabilitation					
Service.....	4,738	7,049	14,192	19,485	26,706
Total.....	8,656	13,168	21,416	26,564	41,362

ENVIRONMENTAL HEALTH SERVICE

Environmental Control Administration

The Community Environmental Management program is supporting research to determine the relationship between use of alcohol and accidental injury and death, alcohol measurement, epidemiological study relating to traffic accidents, and a study of patients admitted to hospitals to determine whether alcoholism or excessive alcohol ingestion may be a factor.

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION
National Institute of Mental Health

Just within the last few years a new climate of public attitude has been matched by bold new efforts to understand alcoholism and to increase facilities for caring for alcoholics. In recognition of the magnitude and social impact of the problem, the National Institute of Mental Health established the National Center for the Prevention and Control of Alcoholism in 1966. Since then, the amount of funds allocated for alcoholism programs by the National Institute of Mental Health have more than doubled. The Center was designed to coordinate and serve as a focal point for Departmental activities in the field of alcoholism, to formulate and support research and training programs throughout the country, and to conduct research studies in its own laboratories at Saint Elizabeths Hospital in Washington, D. C. In collaboration with other Federal agencies, with national organizations, with State and local governments, and with voluntary citizen groups, the Center is providing leadership in the planning and developing of national programs. The Center's activities are guided by five major goals: 1) stimulation of RESEARCH on the control and prevention of alcoholism; 2) leadership in improving TREATMENT services for alcoholics; 3) acceleration of COMMUNICATION and APPLICATION of research findings to service programs; 4) development of TRAINING programs for scientific, professional, and nonprofessional personnel; and 5) modification of public attitudes through an expanded program of EDUCATION.

RESEARCH ACTIVITIES

Significant advances have occurred in alcohol-related research during the past year: the number of scientists working in this area has increased and the quality of the work currently carried out is superior to that of past years. The high quality of the current research in the alcohol area is documented by the fact that four significant alcohol-related articles appeared in Science during the last year. The studies currently in progress seek answers to a broad range of questions about the nature of alcoholism and its biological, psychological, and sociocultural antecedents. In the area of treatment, controlled demonstration studies are pointing the way to more efficacious treatment techniques for the victims of alcoholism and their families. Still other kinds of studies are investigating methods for preventing alcohol abuse from starting. The great diversity of research activities reflects the fact that alcoholism involves man at every level of his functioning. Thus, biochemists, physiologists, neurologists, and pharmacologists are focusing on the impact of alcohol abuse on cells and tissues; psychiatrists and psychologists concentrate their studies at the level of interpersonal relations; and sociologists, anthropologists, and epidemiologists study the effects of alcoholism at levels of higher social functioning. Because of the urgent need for basic knowledge about alcoholism and alcohol-related problems, the research grants program is the largest segment, in budgetary terms, of the extramural activities of the NIMH Center for Prevention and Control of Alcoholism.

Grants for University-Based Centers

During the first three years of the Center's existence, major grants were made to seven organizations for the support of multidisciplinary research programs. These centers are engaged in a wide variety of research, including such areas as the effects of alcohol on the physiology and biochemistry of the body and the psychological and sociological aspects of drinking, drinking patterns and behavior of chronic alcoholics in an experimental setting, drinking problems among ghetto residents, relationship between metabolic and behavioral changes in alcoholics, effect of alcohol on behavior and on the central nervous system of animals, pharmacological studies to determine the physiopathology of alcohol

dependence, and clinical studies to evaluate the efficacy of various pharmacologic agents in the treatment of alcoholism.

The programs in these seven settings (Rutgers University, Boston City Hospital and Harvard Medical School, Barnes Hospital and Washington University School of Medicine in St. Louis, Baltimore City Hospital and Johns Hopkins School of Medicine, Oklahoma Medical Research Foundation and the University of Oklahoma Medical Center, the Texas Research Institute of Mental Sciences, and the State University of New York Downstate Medical Center in Brooklyn) already are utilizing the skills of a large number of scientists - few of whom were working in the area of alcohol problems prior to the initiation of this grant program. The seven centers combined employ well over 140 scientific workers from a variety of disciplines. The largest number of these workers are in the fields of psychiatry, psychology, biochemistry, physiology and sociology. Each of these centers is associated with a university or medical school that has demonstrated excellence in carrying out research. In addition to the broad range of studies underway, each center conducts an active program of research training at the pre- and post-doctoral level in medicine and other basic sciences. These research training programs have attracted highly qualified young scientists to work in the field of alcohol problems.

Physiological and Laboratory Studies

The continuing importance of physiological studies is seen in the fact that nearly one-half (45%) of the research grants awarded in the past year were in this area. This figure probably reflects the belief of many researchers that a better understanding of the causes of alcoholism and its medical treatment rests on a new knowledge of the effects of alcohol on biological and biochemical mechanisms, such as on the circulatory system, and on the brain. Results obtained last year from a project supported in part by a grant from the National Center may be a breakthrough - the discovery of a liver enzyme system, important in the metabolism of alcohol. This finding may be of great significance in understanding the pharmacological tolerance to alcohol developed by many alcoholics.

Many clinical studies are also underway. Investigators are examining such problems as the genesis of anemia in alcoholism, the effect of alcohol on the stomach, the effect of beer on the heart, the interrelationship between alcoholism and nutritional disease, and the use of aversive conditioning in the treatment of alcoholics. Such studies will improve both the diagnosis and treatment of alcoholism.

The early hopes that LSD would provide a unique and efficacious treatment method for alcoholics has, unfortunately, not been fulfilled. A number of reports from laboratories in the United States and abroad indicate that LSD treatment is no more effective than a variety of other drug therapies.

IMPROVING TREATMENT SERVICES FOR ALCOHOLICS

Despite the widespread occurrence of alcoholism, and the substantial contact that most persons in helping positions have with problem drinkers, alcoholics are likely to receive less adequate care than individuals with other kinds of difficulties. Although a somewhat larger number of alcoholics is being treated in general hospitals, substantial barriers still persist in admission policies. In most mental hospitals, as well as other psychiatric agencies, the level of interest in alcoholism is still low. Nor, have public welfare agencies provided financial assistance for indigent alcoholics as readily as to other indigent people, although this situation is beginning to change.

The very magnitude of the problem of alcoholism - and the fact that virtually all alcoholics have other medical, social and psychological problems - argues against the establishment of a special network of treatment services for these patients. Such specialized services could neither be adequately staffed, nor could they provide the broad range of services needed by most problem drinkers. The long term goal, therefore, is to have all helping agencies provide services to alcoholics on an equal basis with other patients. Because this goal is far from immediate realization, it is essential that financial incentives be offered to communities to give special attention to the needs of alcoholics and to extend existing services to them.

Community Services for Alcoholics

"The Alcoholic and Narcotic Addict Rehabilitation Amendments of 1968" (P.L. 90-574) to the Community Mental Health Centers Act were enacted as a result of a proposal by the Administration. This proposal provided special incentives to communities for the development and expansion of treatment services and preventive programs as part of community mental health centers (if centers existed in the community). These incentives were: 1) Federal participation in the costs of operation and maintenance, as well as in those for construction and initial staffing, 2) a greater degree of Federal participation in costs than that mandated under the original legislation, and 3) a longer period of support by the Federal government for the alcoholism services than mandated in the original Act. Although the Senate's version of the Bill included all the above provisions, the legislation, as finally passed in October 1968, removed all three types of incentives and modified only very slightly existing provisions of the Community Mental Health Centers Act. In its December 1968 "Interim Report," the National Advisory Committee on Alcoholism stressed the need for these special financial incentives "to encourage community mental health centers to develop services for alcoholics."

Even before funds were appropriated for the alcohol portion of P.L. 90-574, the National Center received a steady stream of requests from individuals and community agencies. Center staff and the NIMH Regional Offices have provided preliminary consultation to well over 100 applicants interested in Federal funding under these Amendments. In anticipation of the appropriation of funds to implement P.L. 90-574, substantial effort has been expended in developing regulations for these new Amendments. Meetings have been held with interested professional groups such as the North American Association of Alcoholism Programs, the National Council on Alcoholism, the American Psychiatric Association, and the National Association of State Mental Health Program Directors to obtain their assistance in the drawing of these guidelines.

The past year has seen an extension of activities designed to improve services for alcoholics in the community mental health centers being developed throughout the country. A plan has been developed with the Community Mental Health Center Support Branch for a joint study of physical aspects of community facilities for alcoholics. This study, to be conducted with the Architectural Section of the Division of Mental Health Service Programs, will be initiated shortly. It should provide valuable information regarding the environmental aspects of treatment programs for alcoholics.

Site visits for information and evaluation have been made to a number of NIMH-funded community mental health centers, such as in Denver, Florida, Kansas, Idaho and Los Angeles. Visits have also been made to community alcoholism programs, such as in Florida, New York and Philadelphia, in order to observe and study existing service programs as a basis for developing guidelines on services for alcoholics. Consultation has been provided to State mental health agencies and to numerous communities in Mississippi, Minnesota, Massachusetts, North Carolina, Texas and Oklahoma, to encourage them to include services for alcoholics in their community-based psychiatric services. "The Community Mental Health Center and Alcoholism Programs," as well as other materials on services, have been widely distributed to individuals and community groups throughout the country.

An increasing proportion of staffing grant applications under the Community Mental Health Centers Program include requests for special staff to work with alcoholics. Although fifty such applications have been approved and funded, many of them specify only one part-time person to work with alcoholics. Only about twenty operating community mental health centers have a substantial program or work with large numbers of alcoholics. The Center is undertaking a joint study with the Biometry Branch of NIMH in order to obtain more accurate information on alcoholism programs and numbers of alcoholics treated in all community mental health centers in operation as of January 1969. Community mental health centers that have pioneered in developing programs for alcoholics include the following: Mid-Missouri Mental Health Center (Columbia), Central State Mental Health Center (Norman, Oklahoma), and the Pennsylvania Hospital Community Mental Health Center (Philadelphia). Others that have developed alcoholism services as an integral part of their programs include the Rochester General Hospital (New York), the Rockland County Community Mental Health Center (New York), the Greenville Community Mental Health Center (Mississippi), Brevard County Community Mental Health Center (Florida), the Mental Health Center of Wake County (North Carolina), and the Community Mental Health Center of Prince Georges County (Maryland).

Despite this progress it appears unlikely that the majority of such centers will be able to develop services for alcoholics without special incentives. All too frequently, the centers have financial difficulties in meeting the requirements of the basic Community Mental Health Centers Act. In addition, many communities find that third party and insurance payments are often unavailable for alcoholics; and when they are, they do not meet all the costs of maintaining the service.

As part of the effort to strengthen the provision of preventive and treatment services at the community level, the National Center for Prevention and Control of Alcoholism convened a small conference in February 1969. This week-long workshop focused on issues in developing and organizing comprehensive community services for alcoholics and their families. It was attended by 40 persons representing a wide variety of State and local programs in all parts of the country and by representatives of the National Institute of Mental Health. The papers presented at this conference will shortly be published and distributed to interested groups throughout the country. A second publication, including more detailed statements on the planning and delivery of comprehensive alcoholism services, is being prepared and will be issued later in the year. It is anticipated that these two basic documents will be widely used by State and local groups interested in developing alcoholism programs. The workshop generated wide interest and has resulted in numerous requests for consultation, for participation in meetings, and for written materials.

Hospital Care for Alcoholics

The past year has seen progress in the admission of alcoholic patients to medical and surgical services of general hospitals. The experience of a number of hospitals is confirming the findings of a project at the Massachusetts General

Hospital that demonstrated that general hospitals can help alcoholics on an emergency basis and through followup care in appropriate outpatient settings. The excellence of the comprehensive care given to alcoholics by the general hospital challenges the idea that alcoholics need specialized detoxification centers and treatment units.

Hospital administrators are becoming increasingly aware of the need to provide adequate treatment services for alcoholics. For example, a recent Institute for Hospital Administrators of the State of Maryland was sponsored by the Alcohol Research Center at Baltimore City Hospital, Johns Hopkins University School of Medicine, one of the seven university-based research centers funded by the National Center for Prevention and Control of Alcoholism. The program showed hospital administrators how to organize services for alcoholic patients in the general hospital.

Another educational and training effort is being undertaken by the American Hospital Association, under a grant from the National Center. As part of this project, a series of State and regional conferences will be held in an effort to educate persons in administrative positions in general hospitals about planning and developing treatment programs for alcoholics. The program will depend heavily for its execution upon an advisory panel of nationally-known expert consultants in the field of alcoholism, appointed with the support of such national organizations as the American Medical Association, the American Psychiatric Association, American Nursing Association, National Association of Social Workers, and National Blue Cross Association, as well as staff of the National Center.

In many parts of the country the only substantial services for alcoholics are in the State mental hospitals. There has been a steady increase in the number of alcoholics admitted to these hospitals. In over one-third of all the States more patients are admitted to mental hospitals with a diagnosis of alcoholism than with any other diagnosis. Rates of admission of alcoholic patients have increased more rapidly than those for most other psychiatric diagnoses. In the age group 45 to 54, for example, almost half of the men admitted now are alcoholics. (About one-eighth of all the women admitted to State hospitals are alcoholics.)

Unfortunately, only a minority of State hospitals currently have any special treatment programs for alcoholics. An increasing number of such hospitals are starting to develop programs for alcoholics through the National Institute of Mental Health Hospital Improvement Program. One grant allowed a program serving the whole New York City area to expand its services. Three grants went to small institutions that are developing innovative approaches to the hospital-based treatment of alcoholics. One focused on the family of the alcoholic in both treatment and followup services. Another concentrated on counseling the alcoholic to make constructive use of his leisure time once he is released to the community. In the third project the length of inpatient care was sharply reduced by emphasizing continuous care in the community and extensive use of other agencies. In this program special attention also is being given to younger alcoholic patients, who are the most difficult cases to treat.

One major roadblock to adequate treatment for alcoholics in hospitals has been the lack of adequate insurance coverage. In its December 1968 "Interim Report," the National Advisory Committee on Alcoholism stressed the importance of removing insurance barriers to the care and treatment of alcoholics in general hospitals. Staff of the Center have taken the lead by preparing a report on hospital and insurance company practices relating to medical care for alcoholics. Center staff have also provided assistance to personnel from the United States Civil Service Commission who have responsibility for negotiating contracts with those group medical practice plans that provide medical care

for government employees. Most restrictions relating to alcoholism have now been removed from the insurance coverage for Federal employees by the major insurance carriers. Therefore, better service and care will be forthcoming to those individuals with alcohol-related illness, who in the past experienced discriminatory practices by service agencies and institutions.

Research on Treatment

The unfounded belief that alcoholics cannot be helped has limited interest in providing assistance for them. The belief persists despite ample evidence that many alcoholics have been helped to control their drinking and to function again in the community. Large numbers have been helped through the efforts of Alcoholics Anonymous, others by psychiatrists and other physicians, or by various health and welfare agencies. Numerous follow-up studies of the treatment of alcoholics show recovery rates, based on both abstinence and improved social functioning, ranging from one-third to two-thirds of the patients treated. These figures compare quite favorably with results reported in the treatment of general psychiatric conditions and other behavioral problems.

There has been an increasing interest in applied research projects designed to improve diagnostic, treatment and rehabilitation services for alcoholics. The previously mentioned project at the Massachusetts General Hospital provided around-the-clock diagnostic and treatment services for alcoholics within a comprehensive general hospital emergency ward service. Another important project involves the evaluation of a variety of drugs used in the clinical treatment of alcoholics. Still another approach to the problem of the treatment is being taken at the University of Iowa in a study of the effectiveness of specially trained lay counselors. Another project, which received initial funding last year, will evaluate the effectiveness of an alcoholism referral service. Hopefully, this study will make it possible to utilize referral and treatment services more effectively.

Programs for Alcoholics in Government and the Armed Forces

Staff of the Center have continued working very closely with the United States Civil Service Commission in developing programs to deal with the problem drinkers among the employees of Federal agencies. In 1967, the Center helped bring about a Civil Service Commission conference on drinking problems among Federal employees. As a result of the conference and later consultation with NIMH staff, the Civil Service Commission suggested that all agencies and bureaus establish programs to help employees with drinking problems. Since then, the Civil Service Commission has established the Division of Occupational Health and Safety. Center staff have assisted this new Division in organizing training institutes for newly employed staff of the Commission who will be working in the Commission's regional offices to develop occupational mental health and alcoholism programs for Federal agencies. Consultation has also been given to the States of New York and Pennsylvania, which have developed programs for problem drinkers among State employees. Finally, the National Center for Prevention and Control of Alcoholism staff have developed a detailed resource book for use by Federal agencies wishing to develop programs to help with problem drinking employees.

A new activity during the past year has been collaboration with medical and other personnel of the United States Army, Air Force, and Navy on the development of treatment and educational programs. Center staff have attended conferences sponsored by the Army and the Air Force dealing with alcoholism problems in the military. The Navy has requested consultation concerning alcohol and air accidents. A complicating factor in the treatment of alcoholism in all three Armed Services is that regulations, as written at present, state that a member of the

Forces may be discharged, without recognition of many years of service, if he has a drinking problem. Such regulations lead to concealment of drinking problems and make early preventive and treatment efforts impossible. There is increasing evidence, however, that the medical personnel of the three Armed Services would welcome further consultation with Center staff so that recent advances in alcohol education and in early detection and control of drinking problems can be brought to the notice of all concerned, Line and Staff Officers as well as the Medical Services.

Major priority activities for the immediate future are: 1) developing comprehensive services for alcoholics as parts of community mental health centers, 2) overcoming the discrimination against alcoholics still practiced by many helping agencies (hospitals, clinics, welfare departments, etc.), 3) encouraging the development of programs for alcoholics in government and the Armed Forces, and 4) greatly expanding knowledge - through both basic and applied research - of the effectiveness of various treatment methods.

THE SPECIAL PROBLEM OF CHRONIC DRUNKENNESS OFFENDERS

Arrests for public drunkenness account for nearly 40 percent of the five million arrests made each year for non-traffic offenses. Very many of the two million arrested for public drunkenness are socially isolated and homeless men. While these individuals, probably fewer than 300,000 in number, are only a fraction (less than 10%) of all alcoholics in the country, treating them as criminals is inhumane, ineffective and costly.

During the past year, there has been increasing interest in all parts of the country about the kinds of alternatives that can be found to the current system of handling chronic alcoholic offenders. Although the Supreme Court's decision in *Powell v. Texas*, handed down in June 1968, did not declare unconstitutional the current procedures regarding the criminal punishment of chronic alcoholics, it left the door wide open for State and local experimentation and modification of current laws and procedures.

Because of growing concern over public intoxication (Maryland, Hawaii, the District of Columbia and, most recently, North Dakota have new statutes dealing with public drunkenness), the National Institute of Mental Health awarded a contract to the Legislative Drafting Fund of Columbia University to examine the various State laws and to prepare a model statute that States could use as a guide in developing more humane and effective alternatives to the present system. Center staff have collaborated closely with the legal experts on the content of the Model Act, the "Alcoholism and Intoxication Treatment Act." The Act stresses that the chronic alcohol offender should be handled by appropriate medical-social services rather than within the criminal system. It also emphasizes that voluntary treatment is more appropriate than involuntary treatment and that civil commitment is an extraordinary remedy, which is carefully and strictly circumscribed.

A draft of the Model Act and accompanying "Draftsmen's Notes" has been distributed for comment to over 400 interested persons and organizations in the legal, medical, and social service fields. The Act has been revised and will soon be widely distributed to organizations and agencies in the fifty States, so that it can be adapted to fit into the variety of State statutes. The completion of the Act comes at a most opportune time because the American Bar Association and the American Medical Association have just released a "Joint Statement of Principles Concerning Alcoholism" in which they recommended that their State and local associations advocate "the adoption of model state legislation relating to the legal rights and medical management of alcoholics." They also declared that such legislation "should provide that public intoxication in itself is not a crime."

Several investigators are studying the chronic drunkenness offender. One is seeing whether reintegrative pathway institutions can cut recidivism in jails and welfare agencies. Another investigator is studying the relative effectiveness of various treatment approaches in dealing with chronic alcoholic offenders. Preliminary data suggest that such persons may be helped by a combination of inpatient treatment combined with adequate medical care, proper diet, guidance, and vocational rehabilitation.

Staff of the Center have met with officials in a number of cities to assist them in the planning of comprehensive services for homeless alcoholics. Emphasis has been placed on the necessity for involving a wide range of health, medical care, social service, and rehabilitation agencies in the planning and delivery of services for such men. In the coming year, the problem of the chronic drunkenness offender will be dealt with by emphasizing that public drunkenness should not be a criminal offense (the Model Act) and that health and social services must be developed as a more humane and effective substitute for the current criminal system. Comprehensive services must be planned and developed or easy, oversimplified solutions, such as "detoxification centers" and excessive reliance on civil commitment may prevail.

TRAINING PROGRAMS

On a long-range basis, the most important means of making up for past neglect of alcohol problems will be the development of training programs for both professional and non-professional personnel, in professional schools and "on the job." The National Advisory Committee on Alcoholism recognized this in its "Interim Report" of December 1968 when it stressed the "urgent need for a greater emphasis and enriched content relating to alcoholism in the education of professional and ancillary personnel in health, mental health, welfare, corrections and other pertinent fields." To increase interest in training opportunities, Center staff developed and widely distributed a special announcement on the training support programs in alcoholism available through the Center. Supplementary information on the Research Scientists Development Awards Program and how it can be related to alcoholism was distributed to research institutions, foundations and universities.

It is crucial that teaching about alcohol-related problems be incorporated into the curricula of medical schools. An important program has been initiated at Howard Medical School's Department of Preventive Medicine and Public Health. Under this project, a Behavioral Sciences Subdivision was established to serve as the vehicle for teaching about alcoholism not only to medical students but also to hospital staff physicians and community agency personnel. The study of alcoholism is also being introduced into the medical school curriculum and into residency training at the Loyola University Stritch School of Medicine.

Both social workers and public health workers can make significant contributions in the identification of and provision of assistance to alcoholics and their families. The Council on Social Work Education is developing a source book of readings and case materials on alcohol-related problems for use in schools of social work. The report of the American Public Health Association's conference on the review of teaching materials about alcoholism will be a valuable guide to schools of public health in furthering their educational efforts relating to alcohol problems. As was previously mentioned, the American Hospital Association is developing a series of State and regional conferences for hospital personnel in administrative positions. This is an

important first step in training hospital administrators to develop treatment programs for alcoholics. At Washington University, the Center is supporting a program designed to give policy-makers and community workers training in the organization and delivery of comprehensive services for alcoholics. It is anticipated that these individuals, already knowledgeable in organizational techniques, will serve as consultants and catalysts in helping their communities develop services for the alcoholic.

Clergy training in the alcoholism area has been supported through two grants. The first of these focuses on providing clinical training to clergymen in a large alcoholism rehabilitation facility. The other, based in a theological seminary, aims to improve the counseling skills of the clergy in order to better meet the needs of alcoholics and their families.

A program has been initiated in Boston to provide a year of comprehensive clinical and didactic leadership training to post-professional fellows in medicine, psychiatry, psychology, nursing and social work. This is the first program of its kind in the country. It is expected to produce a cadre of persons equipped to take on leadership positions in treatment agencies. The Massachusetts Health Research Institute, Inc. has been very successful in recruiting and training social and behavioral science predoctoral students in alcoholism research. Research training is also being provided to a substantial number of young scientists by the university-based multi-disciplinary centers described above.

Nonprofessional workers are being trained as alcoholism counselors in a six-month training program developed by the Baltimore City Health Department. Another project, in the Baltimore Inner City catchment area, is improving the quality of direct and indirect services to indigent alcoholics by training clergymen, physicians, nurses, social workers, policemen and VISTA volunteers.

Although the number of personnel trained in the alcoholism area is slowly growing, the need for persons knowledgeable about alcoholism is still acute among all core mental health personnel (physicians, psychologists, nurses, social workers). This training should be given not only in professional schools but also "on the job" to reach the very large numbers of persons who have completed their basic professional training and are now working in hundreds of service agencies throughout the country. Another, mainly untapped resource, is that of nonprofessional workers; only a very small part of this potential has yet been developed.

PREVENTION, EDUCATION AND PUBLIC INFORMATION

Problems of the magnitude of alcoholism can never be dealt with satisfactorily or brought under control by treatment efforts alone. It is for this reason that preventive activities receive high priority. A major study of American drinking practices is contributing data on methods of early case-finding. In the process of describing normal drinking practices in the United States, the investigators will seek to identify those individuals with a high risk of becoming alcoholics. One part of this study is a repeat survey of previously-interviewed individuals to determine changes that have occurred in drinking practices. Another part of the project is a national survey of drinking practices; it is providing baseline data which will be invaluable for preventive purposes. A special study of drinking behavior among urban Negro men is being conducted as part of a grant to Washington University. The investigators have found that heavy drinking occurs twice as often among lower class Negro men as among white men of the same urban social class origin.

The Center is working with the National Academy of Sciences on a collaborative study of the relationship between current heavy drinking and 1) prior military delinquency, and 2) demographic variables such as education, religion and social class. This study will utilize extensive existing data available to the National Academy of Sciences.

Teenage youngsters are the focus of five preventive and educational projects. In one, the children of alcoholic fathers are being studied to determine factors associated with successful psychological coping by these teenagers. In the second project, consultation services are being provided by a general hospital alcoholism program to various community "helping agencies" to assist them in evolving a coordinated treatment program for 14-to-16-year-olds who appear in court for alcohol-associated offenses. The agency's involvement in preventive activities starts with the identification of these youngsters so that there can be appropriate intervention to offset the further development of serious drinking problems. Findings indicate that such disruptive family factors as divorce, illness, rejection, or overindulgence appear frequently in the backgrounds of these youthful offenders.

The goals of preventive alcohol education are to modify dangerous and potentially harmful drinking patterns. Failure to make distinctions between acceptable and unacceptable drinking behavior complicates the problem. Americans are generally unwilling to interfere in the drinking behavior of others unless this behavior borders on alcoholism, an attitude that can be traced back to the Prohibition years. Ambivalent attitudes about drinking behavior are reflected, for example, in the frequent unwillingness of juries to convict persons for "drunken driving."

Alcohol education for youngsters has been a dramatic failure. Most of it is simply ineffective. A project in Mississippi is investigating the effectiveness of different informational techniques and materials in a junior and senior high school alcohol education program. Interviews of 1,000 high school students suggest that most of the students get their information about the use of alcohol from peers and that it is frequently of poor quality.

Another project, funded for the first time last year, will study factors in the development of problem behavior of high school students. Factors to be studied include personality, social relationships, and socialization processes insofar as they are associated with the development of drinking behavior.

To help incorporate appropriate types of alcohol education activities in school curriculums, Center staff have been working with groups such as the College Health Association and the Joint Commission of the National Education Association on Problems of Health Education. Staff of the Center have provided assistance to the Maryland State Department of Education in the revision of their health curriculum guide on alcohol.

A paper on alcohol education, presented by a staff member at a symposium sponsored by the Ohio State Department of Health Education, is being reprinted and distributed by a health sciences textbook publisher. Staff of the Center have participated in a number of conferences (such as the 39th National 4-H Conference and a conference of editors of college publications) in which drinking behavior has been discussed. Conference participants have stressed the need for more information on how to drink responsibly.

One of the year's landmark documents was the "Report of the Task Force on Alcohol Problems" of the National Council of Churches. This Task Force Report, written in response to the Report of the Cooperative Commission, strongly endorses the general recommendations of the Cooperative Commission on Alcohol Education. The Task Force specifically urges that national, State

and local church groups participate in coalitions with all interested professional, voluntary and governmental groups to develop effective alcohol education programs. This effort of the Council of Churches is historic in view of the divisiveness and ambivalence which have characterized most church activities in alcohol education since the days of Prohibition. A similar statement was issued by the Lutheran Church, and the Episcopal Church has established its own Task Force on Alcohol Problems. Collaboration between temperance and non-temperance groups on alcohol education now seems possible for the first time.

The publication, "Thinking About Drinking" developed with the Children's Bureau for use with teenage audiences continues to have wide acceptance; more than 750,000 copies have been distributed to school officials, parent-teacher organizations, and youth group leaders. The Center also has developed and distributed a discussion guide to be used with the pamphlet. An analysis to determine the utility of this material is now in progress. The monograph, "Alcohol and Alcoholism," prepared and distributed by the Center, continues to receive favorable publicity and over 80,000 copies have now been distributed. "Social Welfare and Alcoholism" continues to be requested and over 10,000 copies have been mailed to a variety of agencies.

Staff Participation in Scientific Meetings and Teaching Activities

One of the important goals of the National Center for Prevention and Control of Alcoholism is the communication of research findings and knowledge of alcoholism to as wide an audience as possible. To this end, staff have made many appearances on radio and television and have participated in meetings of the North American Association of Alcoholism Programs, the National Council on Alcoholism, the American Public Health Association, the American Psychological Association, the Eastern Psychological Association, the American Medical Association, the National Association of Social Workers, the American College of Neuropsychopharmacology, the American Psychiatric Association, Psychiatric Research Study, the American Academy of Neurology, the American Society for Pharmacology and Experimental Therapeutics, the Oklahoma State Medical Association, the Texas Medical Association, the Mental Hospital Institute, the Association of Halfway House Alcoholism Programs, the Alabama Rehabilitation Association, and the State and Territorial Mental Health Authorities. A grant from the Center also helped fund the International Congress on Alcohol and Alcoholism that was held in Washington, D.C. September 1968. More than 1800 participants from 32 countries attended this largest scientific and professional conference ever held in the field of alcohol problems. Plans are now well underway to publish proceedings of the Congress.

Center staff have been involved in formal teaching sessions at many medical schools including Harvard, Yale, Johns Hopkins, University of Maryland, University of Michigan, George Washington University, University of San Francisco, University of Kentucky, University of California, Stanford University, University of Hawaii, and the Universities of Kyoto, Tokyo, and Sapporo in Japan. Staff of the Alcoholism Center have participated as faculty members in numerous summer schools and special institutes of alcohol studies including the Midwest Summer School of Alcohol Studies, the International School for Alcohol Studies in Grand Forks, North Dakota, Texas Summer Studies on Alcohol, Southeastern School of Alcohol Studies, and the Rutgers Summer School of Alcohol Studies.

An exhibit on alcoholism and the activities of the National Center for Prevention and Control of Alcoholism was developed by the National Institute of Mental Health for display at professional meetings. During its first year the exhibit was used at meetings of the American Public Health Association, the American Psychiatric Association, the American Psychological Association, the National Conference on Social Welfare, and the American Hospital Association. It

will also be used at meetings of nurses, educators, and other professional groups. At any one of these professional conferences, well over 600 people stop at the exhibit to request publications, to inquire about the grant programs of the Center, to seek information about services for alcoholics, and to discuss problems related to alcohol.

LIAISON AND OTHER CONSULTATIVE ACTIVITIES

The original mandate given to the National Center for Prevention and Control of Alcoholism stressed its function as a coordinator of alcoholism activities throughout the Department and in other agencies of the Federal government. This year, a number of collaborative efforts started in prior years have continued, and some new joint activities have begun.

One of the most important continuing collaborative efforts of the Center is its work in the area of drinking and driving. The Center's continued work with the Department of Transportation has focused on efforts to develop effective programs to reduce the immense toll of alcohol-related motor vehicle accidents. Plans are underway for jointly funded experimental preventive and treatment programs in several communities. A special Task Force, composed of representatives of the Center, the Injury Control Program in the Consumer Protection and Environmental Health Service, the National Safety Council, and the American Medical Association, is developing a national educational program aimed at reducing motor vehicle accidents associated with alcohol. Another ongoing project seeks to determine whether the National Driver Registry of the Department of Transportation can be used together with psychiatric registers to identify those drivers arrested for drunk-driving who are alcoholics.

Center staff and the National Advisory Committee on Alcoholism continue to work closely with staff of the Social and Rehabilitation Service to further explore ways in which welfare and rehabilitation services can be made available to the alcoholic. Active collaboration has also continued both with the Central Office of the Veterans Administration and with a number of V.A. Hospitals in different parts of the country to make best use of their resources in setting up programs for alcoholics. The important work of the Center with the Civil Service Commission has been described earlier in this report. Center staff are also assisting Office of Economic Opportunity staff in planning a conference designed to train personnel who will be employed by local community action agencies and health centers to deal with problems of alcoholism.

Collaboration with the Bureau of Indian Affairs of the Department of Interior and the Indian Health Service has resulted in efforts to develop effective programs for dealing with serious drinking problems among various Indian groups, particularly those in Alaska. In conjunction with the Indian Health Service, materials are being developed to be utilized by public health, social work and other workers, as well as by Indian groups in developing local reservation programs.

An important new activity (described earlier in this report) during the past year has been the collaboration with medical and other personnel of the United States Army, United States Air Force and United States Navy in order to develop treatment and educational programs on alcohol problems.

The National Center for Prevention and Control of Alcoholism has taken a leadership role in convening regular meetings of all major National groups concerned with alcoholism. Representatives of Alcoholics Anonymous, the National Council on Alcoholism, the American Medical Association, the American Public Health Association, the North American Association of Alcoholism Programs, and the Smithers Foundation have met to discuss areas of mutual interest. Discussions have focused on topics such as hospital care of alcoholics, aid

to communities to help them cope more effectively and humanely with the problem of public drunkenness, and strategies to overcome manpower shortages in the field of alcoholism.

Center staff have played a larger role in the work of the National Advisory Committee on Alcoholism as a result of the appointment of the Assistant Chief of the National Center as Executive Secretary of the Committee. The Advisory Committee, which met four times during the last fiscal year, provides advice and guidance to the Secretary of the Department of Health, Education, and Welfare and includes representatives of social work, labor, industry, vocational rehabilitation, education, law and civic organizations concerned with alcoholism. In February 1969, the Department released the "Interim Report" from the National Advisory Committee which included in its recommendations to the Secretary 1) the need for appropriate attention to alcohol problems in many Federal programs, 2) the necessity of removing insurance and other barriers to care and treatment of alcoholics in general hospitals, and 3) the need for additional training programs in the field of alcoholism.

NATIONAL INSTITUTES OF HEALTH

Health Manpower

The Bureau of Health Professions Education and Manpower Training, through its short-term public health training program, enables professional health personnel to update their knowledge and skills relating to public health problems, one of which is alcoholism.

SOCIAL AND REHABILITATION SERVICE

Rehabilitation Services Administration

An increasing number of State vocational rehabilitation agencies have taken advantage of Section 3 of the Vocational Rehabilitation Act (Innovation) and Section 4(a)(2)(A) (Expansion) for the development of alcoholism rehabilitation programs while others have developed programs with the use of Section 2 funds. Through those programs about 9,200 alcoholics were rehabilitated in 1969. It is estimated that 11,100 will be rehabilitated in 1970.

A few examples of the various State rehabilitation activities in this area are as follows:

California continues to have the largest Statewide program under vocational rehabilitation, which is operated through a contract with the State Department of Public Health. There are now 11 treatment and rehabilitation centers throughout the State. The total cooperative program expenditures for 1968-69 were over \$2 1/2 million. All of the centers employ aides in addition to a full complement of professional staff. The aides are all recovered alcoholics, many of them suburban housewives, who are members of Alcoholics Anonymous. Approximately 2,000 were rehabilitated under this program in 1968-69. A number of the counselors working with alcoholics have completed the 6-months psychiatric internship program for counselors at the University of Oregon School of Medicine, where a special curriculum has been developed for counselors interested in the field of alcoholism.

In Georgia, the Emory University Rehabilitation Project for the Chronic Alcoholic ended June 30, 1969. A vocational rehabilitation staff of six counselors has been maintained to work in the area of alcoholics in metropolitan Atlanta and it is hoped that funds will permit operation of the program in other parts of the State.

The program of the Pennsylvania Bureau of Vocational Rehabilitation continues to expand, as indicated by the following statistics:

Alcoholic clients rehabilitated in 1967	-----219
Alcoholic clients rehabilitated in 1968	-----355
Alcoholic clients estimated to be rehabilitated in 1969	-----460
Alcoholic clients estimated to be rehabilitated in 1970	-----598

Each of the Bureau's district offices has at least one counselor specially trained and knowledgeable in the field of alcoholism and the rehabilitation of alcoholics. Several district offices have two or three counselors serving only those clients with the disability of alcoholism.

Bureau plans for the future in this field include: continued in- and out-service training for these special counselors as well as all counselors and supervisory staff and continued and improved working relationships with all private facilities providing services for the alcoholic.

In Iowa the Division of Rehabilitation Education and Services program for alcoholics can best be described by two terms--growth and cooperation.

Serving the alcoholic has become an integral part of the Iowa vocational rehabilitation program. It has grown from a few referrals in 1965 to over 1,200 in 1969. The program's success in working with the alcoholic has grown from 15 cases successfully rehabilitated in 1965 to 242 in 1968. The present rate of referral is that one out of ten referrals received by the State agency is an alcoholic, and the rate of rehabilitation is approximately 1 in 12. It should be noted that if the present trend continues--and it appears that it will--that the agency will approach the goal for additional services to this particular disability group, as indicated in the recently completed two-year comprehensive study of vocational rehabilitation needs in Iowa as of January 1, 1969. Of the 413 clients with the primary disability of alcoholism in the caseload, 149 were in a referred status and 264 were in an active status.

Indian Alcoholism Training

Two planning meetings were held in 1969 preparatory to a National Workshop on Alcoholism Among American Indians in 1970. Tribal leaders asked for help with this problem and the planning is being done entirely by Indians. The co-sponsor with RSA is the Association of American Indian Affairs. A grant of \$22,200 has been committed to that organization for December 1969 to December 1970.

Special Foreign Currency Program

Evaluation and reports on progressive community and group services in Poland and Yugoslavia are of value to the United States and other countries where there is concern about the increasing number of alcoholics and problem drinkers, greater recognition that these men and women need social and psychological rehabilitation and more interest in the socio-economic aspects and methods of treatment of alcoholism. New projects emphasize an interdisciplinary approach to ascertain the most efficient methods of bringing about vocational rehabilitation in community settings.

ALCOHOLISM—COMMUNITY MENTAL HEALTH CENTERS PROVIDING ALCOHOLISM SERVICES

- Bridgeport Mental Health Center, NA, Bridgeport, Connecticut.
 Bridgeport CMHC, Central Avenue., West Bridgeport, Connecticut.
 Connecticut Mental Health Center, 34 Park Street, P.O. Box 1842, New Haven, Connecticut.
 Howard University Community Mental Health Center, Area 8, Georgia Avenue between Bryant and W Streets NW., Washington, D.C. 20001.
 Area C Community Mental Health Center, 1905 E Street SE., Washington, D.C.
 Winter Haven Community Mental Health Center, 200 Avenue 2 NE., Winter Haven, Florida.
 Duval Medical Center, 2000 Jefferson Street, Jacksonville, Florida.
 Archbold Community Mental Center, Mimosa Drive and Gordon Avenue, Thomasville, Georgia.
 Pineview General Hospital Mental Health Center, Valdosta, Georgia.
 Hall County Community Mental Health Center, Gainesville, Georgia.
 Queens Hospital Community Mental Health Center, 1301 Punchbowl Street, Honolulu, Hawaii.
 Community Mental Health Center of Lasalle County, Pupak Route, Number 3, Ottawa, Illinois.
 High Plains Mental Health Clinic, 201 East 7th Street, Hays, Kansas.
 Wyandotte County Mental Health and Guidance Center, Inc., 250 North 17th Street, Kansas City, Kansas.
 Rainbow Mental Health Center, 36th and Rainbow Boulevard, Kansas City, Kansas.
 Comprehensive Care Center—Region 10A, 201 Mechanic Street, Lexington, Kentucky.
 Comprehensive Care Center—Region 10B, 201 Mechanic Street, Lexington, Kentucky.
 Community Mental Health Center of Western Kentucky, 208 Guthrie Building, Paducah, Kentucky.
 Mountain Mental Health Services, P.O. Box 384, Prestonsburg, Kentucky.
 Muscle Shoals Mental Health Center, 610 North Seminary Street, Florence, Alabama.
 Mobile Mental Health Center, 1616 St. Stephens Road, Mobile, Alabama.
 Calhoun-Cleburne Mental Health Center, 8th Street, Anniston, Alabama.
 St. Luke's-Jane Wayland Child Guidance Center, 1937 W. Jefferson Street, Phoenix, Arizona.
 Company of Marin—Marin Hospital District Community Mental Health Center, 250 Bon Air Road, San Rafael, California.
 Olive View Hospital Community Mental Health Center, 14701 Foothill Boulevard, Olive View, California.
 San Jose Community Mental Health Center, 77 North Fifteenth Street, San Jose, California.
 Gateways Hospital, 1891 Effie Street, Los Angeles, California.
 Kern View Hospital Community Mental Health Center, 3600 San Dimas Street, Bakersfield, California.
 Kings View Homes Community Mental Health Center, 42675 Road 44, Reedley, California.
 North Coast Regional Mental Health Center, 3147 Loma Vista Road, Ventura, California.
 San Luis Obispo Community Mental Health Center, 2180 Johnson Avenue, San Luis Obispo, California.
 Kedren Community Mental Health Center, 7760 South Central Avenue, Los Angeles, California.
 Ingleside Psychiatric Hospital Complex, 7518 East Hillman Avenue, Rosemead, California.
 Mission Mental Health Center, 101 Grove Street, San Francisco, California.
 Central County Mental Health Center Region III, 227 39th Avenue, San Mateo, California.
 Joseph S. Gallob Adams County Mental Health Center, 4371 East 72nd Avenue, Commerce City, Colorado.
 Southern Colorado Comprehensive Mental Health Center, 1600 W. 24th Avenue, Pueblo, Colorado.
 Bethesda Hospital Mental Health Center, 4400 East Iliff Avenue, Denver, Colorado.

- Pennyroyal Regional Mental Health Center, 313 East Seventh Street, Hopkinsville, Kentucky.
- Appalachian Comprehensive Care Center, 2024 Winchester Avenue, P.O. 790, Ashland, Kentucky.
- North Central Regional Mental Health and MR Board, Inc., PO Box 219, Elizabethtown, Kentucky.
- Comprehensive Care Center of Region IV, 403 W. Third Street, Suite 307, Owensboro, Kentucky.
- Hazard Appalachian Regional Hospital Mental Health Center, 1220 Harrodsburg Road, Hazard, Kentucky.
- Lake Charles Mental Health Center, NA, Lake Charles, Louisiana.
- CMHC of Prince George County, No. 1, 6715 Kenilworth Avenue, Cheverly, Maryland.
- Takoma Park-Silver Spring Mental Health Center, 7600 Carroll Avenue, Takoma Park, Maryland.
- Boston State Hospital, 591 Morton Street, Boston, Massachusetts.
- Mental Health Treatment Training and Research Center, 80 East Concord Street, Boston, Massachusetts.
- Cambridge-Somerville Mental Health and Retardation Center, 15 Ashburton Place, Boston, Massachusetts.
- St. Lawrence Hospital Comprehensive Mental Health Center, 1201 West Oakland Street, Lansing, Michigan.
- Community Health Center Compact, Altamont and Fisher Streets, Marquette, Michigan.
- St. Cloud Hospital, 1406 6th Avenue, St. Cloud, Minnesota.
- Zumbro Valley Mental Health Center, 2100 East Center Street, Rochester, Minnesota.
- Range Mental Health Center, Inc., 324 First National Bank Building, Virginia, Minnesota.
- North Mississippi Medical Center Mental Health Complex, 830 South Gloster Street, Tupelo, Mississippi.
- The Delta Habilitation Center, 319 May Building, P.O. Box 1045, Greenville, Mississippi.
- Mid-Missouri MHC and University of Missouri Medical Center, 803 Stadium Road, Columbia, Missouri.
- Western Missouri Mental Health Center, 600 East 22nd Street, Kansas City, Missouri.
- East Central Missouri Mental Health Center, 700 East Monroe, Mexico Missouri.
- Lutheran Hospital Community Mental Health Center, 2639 Miami Street, St. Louis, Missouri.
- Comprehensive Community Mental Health Center, Billings, Montana.
- Catchmen B Mental Health Center, 402 South 24th Avenue, Omaha, Nebraska.
- Bergen Pines Community Mental Health Center, East Ridgewood Avenue, Paramus, New Jersey.
- St. Mary's Hospital, 211 Pennington Avenue, Passaic, New Jersey.
- The Community Center for Mental Health, Inc., 50 Washington Avenue, Dumont, New Jersey.
- Bernalillo County-University of New Mexico Medical School CCMHC, 2600 Marble Avenue NE., Albuquerque, New Mexico.
- Rochester Mental Health Center, 1425 Portland Avenue, Rochester, New York.
- Dutchess County Community Mental Health Center, North Road, Poughkeepsie, New York.
- Rockland County Community Mental Health Center, Route 45, Pomona, New York.
- Niagara Falls Memorial Hospital, 621 Tenth Street, Niagara Falls, New York.
- Orange County Comprehensive CMHC at Arden Hill Hospital, Harriman Drive, P.O. Box 527, Goshen, New York.
- Samaritan Hospital, Peoples and Burdette Avenues, Troy, New York.
- Lef-Harnett County Community Mental Health Center, Sanford, North Carolina.
- Mid-East Comprehensive Mental Health Center, NA, Wilson, North Carolina.
- Blue Ridge Mental Health Center, NA, Asheville, North Carolina.
- Memorial Mental Health and Mental Retardation Center, 215 North Sixth Street, Bismarck, North Dakota.
- South Central Mental Health and Retardation Center, 424 Fourth Avenue NE., Jamestown, North Dakota.
- Jefferson County Mental Health Center, St. John's Heights, Steubenville, Ohio.
- Portsmouth Mental Health Clinic, NA, Portsmouth, Ohio.

Tulsa Community Mental Health Center, 1620 East 12th Street, Tulsa, Oklahoma.
 Northwest Oregon Community Mental Health Centers, 13777 SW. Farmington Road, Beaverton, Oregon.
 Temple University Community Mental Health Center, 3401 Broad Street, Philadelphia, Pennsylvania.
 Hahnemann Community Mental Health Center, 314 North Broad Street, Philadelphia, Pennsylvania.
 Pennsylvania Hospital Community Mental Health Center, 8th and Spruce Streets, Philadelphia, Pennsylvania.
 St. Francis General Hospital-CMHC, 45th Street and Penn Avenue, Pittsburgh, Pennsylvania.
 West Catchment Area Comprehensive MHC of Erie County, 232 West 25th Street, Erie, Pennsylvania.
 Aguadilla Community Mental Health Center, Yumet Avenue, Aguadilla, Puerto Rico.
 Spartanburg Area Mental Health Center, 149 East Wood Street, Spartanburg, South Carolina.
 McKennan Hospital Mental Health Center, 800 East 21st Street, Sioux Falls, South Dakota.
 Presbyterian Hospital of Dallas Community Mental Health, 8200 Walnut Hill Lane, Dallas, Texas.
 Mid-Houston Mental Health Center—St. Joseph Hospital, 1919 Labbranch Street, Houston, Texas.
 El Paso Center, P.O. Box 1000, El Paso, Texas.
 Mental Health-Mental Retardation Center-Austin-Travis County, 1616 Red River, Austin, Texas.
 Bell County Mental Health and Mental Retardation Center, Court House Annex, Belton, Texas.
 Wichita Falls Community Center for Mental Health, 2007 Wenonah Street, Wichita Falls, Texas.
 Harborview Center, 325 Ninth Avenue, Seattle, Washington.
 Eastside Community Mental Health Center, Inc., 11400 North East Main Street, Bellevue, Washington.
 Appalachian Community Mental Health Center, 201 Henry Avenue, Elkins, West Virginia.
 Northern Panhandle Community Mental Health Center, 2000 Eoff Street, Wheeling, West Virginia.
 Brown County Hospital Community Mental Health Center, 1320 Mahon Avenue, Green Bay, Wisconsin.
 Walworth County Mental Health Center, Courthouse, P.O. Box 290, Elkhorn, Wisconsin.
 Counseling Center of Sauk, Juneau, Richland Counties, 710 North Webb Avenue, Reedburg, Wisconsin.
 Fond Du Lac County Community Mental Health Center, East First Street, Fond Du Lac, Wisconsin.
 Northern Wyoming Mental Health Center, 50 East Loucks Street, P.O. Box 1464, Sheridan, Wyoming.

Senator HUGHES. The Chair calls Dr. Luther A. Cloud, president of the National Council on Alcoholism, as our first witness.

STATEMENT OF LUTHER A. CLOUD, PRESIDENT, THE NATIONAL COUNCIL ON ALCOHOLISM

Mr. CLOUD. Good morning, Mr. Chairman, and thank you.

Last year I had the privilege of testifying before this same committee on the general problem of alcoholism in this country.

Rather than repeat the details of that testimony I would like to cite certain shortcomings in our present approach to alcoholism as recently reported by the National Center for Prevention and Control of Alcoholism:

1. Medical care facilities, psychiatric agencies, social agencies, public welfare departments, etc., often are reluctant to provide

care and treatment for alcoholics; they tend to neglect and to reject these patients.

2. Certain services, generally available to patients with other disorders, often are denied to alcoholics by policy or practice. These include hospital insurance coverage, admission to general hospitals, assistance by public welfare agencies, voluntary admissions to mental hospitals, and participation in most mental hospital aftercare programs.

3. The understanding of the nature of alcoholism and of its management is often very limited in general helping agencies.

4. Where care and treatment is provided for alcoholics it may be narrow and segmented. That is inadequate assessment of the patient's total problems and potentialities. Only limited aspects of the patient's life situation and various problems are dealt with.

Continuity of care, especially between inpatient and outpatient services and between medical service and behaviorally oriented ones, usually is absent.

5. Agencies serving alcoholics generally prefer to work with the most motivated, the best educated, and the most socially intact patients.

Little care and treatment usually is provided to those who do not meet these criteria.

6. The specialized alcoholism services—mental hospital programs, alcoholism criteria, and half way houses often are isolated from the other community helping agencies.

Let us say we have reached a consensus: The problem of alcoholism is a massive one. We continue to turn out statistics, surveys and studies spelling out the dimensions of the real problem and the shoddiness of treatment services, but what are we actually doing in the way of developing action programs to contain the disease now?

At the present time, the National Institute of Mental Health is spending approximately \$6 million as its total investment in support of new knowledge and new treatment techniques to halt the ravages of America's third largest public health problem.

This obviously inadequate amount of money breaks down to less than \$1 a year in research expenditure for each known alcoholic in this country.

It is a drop in the bucket when compared to the multi-billion dollar cost to our Nation yearly in direct care outlays, losses in industrial productivity and heavy welfare expenditures to support alcoholics and their families.

Despite impressive testimony presented before this committee last year as to the shortages in both professional and nonprofessional workers in the field of alcoholism, we continue to operate a nickel-and-dime training program in this area.

For the coming fiscal year the administration proposes only a little more than \$1 million a year for training the many varieties of personnel needed in all the settings where alcoholics are seen.

I have been informed that during the current fiscal year the National Institute of Mental Health was forced to turn down more than \$1 million in scientifically approved training programs because of shortages of funds. Is it not really disheartening that we spend only about 15 cents per year in training funds for each known alcoholic?

We are grateful, Mr. Chairman, for the efforts you and your colleagues made in amending the community mental health centers legislation earlier this year to provide additional authority for alcoholism activities within these centers.

Although the new legislation authorizes \$30 million for the coming year specifically allocated to alcoholism and drug addiction, it is somewhat disappointing to note that the Administration requests only \$6 million for alcoholism during fiscal 1971.

This \$6 million is supposed to cover not only a higher percentage of Federal participation in the construction and operation of units for alcoholics within the centers, but it is also expected to cover education and consultation services for the community, initiation and development grants to permit our citizens to plan new services and, over and above this, 100 percent Federal funding in the form of special grants for the cost of training personnel, evaluating programs and carrying out demonstration cost projects relating to effective treatment and rehabilitation services for alcoholics.

Speaking for the officers and directors of the National Council on Alcoholism, I can state categorically that we have felt for a long time that the few Federal programs in the field of alcoholism are buried so far down in the governmental structure that they are barely visible to the American people.

To use an analogy from baseball, we feel like a bunch of bush-leaguers playing a night game lighted by 10-watt bulbs when we really should be up there in the big leagues performing in broad daylight in a stadium large enough to contain our potential.

We therefore heartily endorse the forthright language of S. 3835, which calls for "a major commitment of health and social resources and Government funds * * * to institute an adequate and effective Federal program for the prevention and treatment of alcohol abuse and alcoholism."

We think the vital question of visibility is adequately handled by the proposed creation of a National Institute for the Prevention and Control of Alcohol Abuse and Alcoholism within a newly designated National Institutes of Mental Health.

From our point of view it is a vast improvement over the present obscure status given the National Center for the Prevention and Control of Alcoholism.

Time does not permit this morning a detailed exposition of the numerous components of the bill which add up to a strongly mandated Federal, State and local attack upon alcoholism.

However, I would like to point out those features of the legislation which the National Council on Alcoholism regards as absolutely vital:

1. Section 303 deals with the planning functions of the Secretary of Health, Education, and Welfare. In light of the fact that the Federal Government has never developed a long range plan for the prevention, treatment, and rehabilitation of alcoholism, we applaud heartily the emphasis of the legislation on such planning and we are delighted that the Secretary is required under the legislation to submit an annual plan to the Congress for review.

2. Of almost equal importance is the establishment of an Inter-governmental Coordinating Council on Alcohol Abuse and Alcoholism.

We know that there are many widely separated programs on alcoholism in the Federal Government, including those in the Department of Defense, the Veterans' Administration, Civil Service Commission, the Vocational Rehabilitation Administration, the Office of Economic Opportunity, and many others.

There is a tremendous potential for cooperative activities across the board, in addition to working with similar agencies at the State and local level. A few of the States have done an outstanding job in pioneering programs in the field of alcoholism, and we are pleased that they will have strong representation on the proposed Coordinating Council.

3. We like the idea of giving the Civil Service Commission the responsibility for laying down policies for the prevention and treatment of alcoholism among Federal employees and assuring that these employees afflicted with the disease of alcoholism will not lose their earned pension, retirement, or medical rights.

4. Since the problem of alcoholism is most severe among our veterans, we realize the importance of the language in the legislation proposing that alcoholism incurred during military service shall be regarded as a service-connected disability.

We make the additional point that the Veterans' Administration as suggested in section 404 under the proposed legislation, be given a clear mandate to increase its research, training and treatment services in the field of alcoholism.

5. We also regard title V of the bill as very important. It expands the eligibility of the alcoholic for treatment and other services under various governmental programs—medicare and medicaid, the poverty program, vocational rehabilitation, Federal welfare programs and State welfare programs that receive Federal participation, State highway programs with similar Federal participation, and so on.

In essence all of these provisions remove age-old discriminations against the alcoholic which have allowed our governmental leaders and public officials to dismiss the alcoholic with a relatively easy conscience.

We cannot build a strong national program against alcoholism if we continue to concentrate upon the relatively few alcoholics who are eligible for treatment and services under our present very narrow grounds for eligibility.

Mr. Chairman, I want it clearly understood that there are many other provisions of S. 3835 which merit discussion and approbation. The fact that I have not been able to discuss them here this morning does not mean that I do not regard them as highly significant.

Finally on behalf of the National Council on Alcoholism whose affiliates across the country comprise the citizen movement in this field, may I offer my congratulations to you, Mr. Chairman, and to all of your colleagues who have cosponsored the most significant legislation on alcoholism ever to be introduced in the U.S. Congress.

I think it is no exaggeration to state that S. 3835 is truly an Emancipation Proclamation for the alcoholic in this Nation. Freed of servitude to alcohol, millions of our citizens can return to the mainstream of American life.

We of the National Council on Alcoholism pledge to all of you our fullest cooperation to see that this legislation is enacted during the current session of Congress.

Thank you.

Senator HUGHES. Thank you very much, Dr. Cloud.

We appreciate your willingness to be with us this morning and to give us the benefit of your thoughts and your analysis of this bill.

You indicated that NIMH was spending approximately \$6 million total in the field of alcoholism in the country. Could you estimate how much money could be effectively used in the development of new knowledge and treatment techniques for alcoholism, including adequate research?

Dr. CLOUD. This of course is nothing but a projection and an extremely difficult one to make. I believe it is more important to concentrate on what type of program would be necessary.

But I would think, rather than speaking of the \$6 million or \$10 million, it would be more in the general area of \$100 million. Certainly this would not be too large a sum to spend for the training programs and the research which is indicated. I feel our greatest deficit today is that we know a great deal more than we did in the past about alcoholism, but we do not have adequately trained people to bring this knowledge into use.

Senator HUGHES. You have practically answered my next question. I was going to ask you how much Federal money should be used for training personnel?

Dr. CLOUD. Again I think our two major problems are basic research, which must give us more knowledge, but it is rather useless to have a great deal of knowledge and not have people to put it into action.

I am not enough of an economist to know how this should be developed, divided, and this is a rough figure but I think \$100 million could be easily utilized in these two areas.

Then I think we would mount a good force against this illness.

Senator HUGHES. You spoke in passing about medicare and the medicaid, and title V of the act. Could you give us an estimate of what you think the additional cost of this would be if it included alcoholism?

Dr. CLOUD. Well, obviously, until we are able to intervene at an earlier stage—in other words, until we are able to intervene at a so-called secondary preventive stage, in the twenties and thirties, many of our elderly people, retired and so forth, will come under the medicare bill and are going to be afflicted with alcoholism, until such time as they die off and a new generation takes its place.

This is going to be a great cost, but one that I think must be borne. We would agree today that it is already being borne, only under different names.

We have people in hospitals today under various euphemisms who are afflicted with alcoholism. I don't know that we would be incurring a tremendous additional cost. We would be incurring a cost that is already being handled, but we would put it where it belongs.

Senator HUGHES. In other words, you thing the majority of these people are being cared for under some other name?

Dr. CLOUD. There is no doubt about it. Whether we speak of private or veterans hospitals, or whatever it may be, a great proportion, and the proportion varies depending on who does the study, of these beds are filled with people suffering from alcoholism.

We don't dare use the name. But it does not really matter whether you are paying \$60, \$70 a day for disease X or Y, or alcoholism.

I see a saving here, because I think when you are able to call a condition what it is and bring a certain amount of expertise to bear, you can probably shorten the disability period.

Senator HUGHES. Do you have any idea what percentage of the elderly on these programs are alcoholics?

Dr. CLOUD. I think that is one you pull out of the blue. I don't think anyone knows.

Senator HUGHES. Do you think the percentage would run the same as in the general population?

Dr. CLOUD. No, I don't. I think it will run a little bit less. We are dealing with a disease that in the last analysis is a killer, and I think many people do not survive to 65. Therefore, if we take the figure of 5 percent in the general public, or 6 or 7, we are speaking of a public between 30 and 50 years of age.

Speaking from my personal experience, many of my patients, despite what I can do, die in their fifties and sixties because of the various complications of alcoholism.

I think many people do not manage to continue their lives until such time as they would come under these provisions.

Senator HUGHES. Are the elderly as susceptible to treatment as younger persons?

Dr. CLOUD. No; I think with any disease condition, the older you get, the poorer the programs. The more optimally you pick your point of medical intervention, the better your chances. One chronically ill with alcoholism for 40 or 50 years is not as amenable to treatment as someone in their thirties, who can be turned 180 degrees.

This becomes a question of perhaps custodial care, of nutritional care, of this type of thing, very necessary and very indicated, but I think our thrust should be in the areas where we can do the most good.

Senator HUGHES. Do you agree that any hospital that refuses to treat an alcoholic should be cut off from Federal funding?

Dr. CLOUD. Yes; I do.

Senator HUGHES. Could you tell us how much the Federal Government is now spending on training of personnel in the field of alcoholism?

Dr. CLOUD. No; this is not a figure I am familiar with. I have no knowledge of the breakdown. I am going to answer this with a cliché, which simply is that I know it is not enough.

Senator HUGHES. They are not spending enough in New York City, or any one of our major cities.

Dr. CLOUD. Of course not.

Senator HUGHES. Some scientists who are doing research in the field do not agree on defining alcoholism as a disease.

This bill accepts that concept. Is that your concept, Dr. Cloud?

Dr. CLOUD. In my mind, there is no controversy. I have accepted this as a disease for a long time, and I think that much of the quibbling which is done, and I have been involved now in a great deal of it, has to do with "a disease has to fit certain criteria."

I think the entire health profession is in a changing era today, and I think certainly we are considering these diseases which did not fit the standard definition.

The definition that satisfies me and makes it easy for me to live with, is taking the word "disease" and dividing it into "dis" and "ease."

An alcoholic is certainly not comfortable.

Senator HUGHES. Sections 1 (g), (h), and (i) attempt to spell out the role of law enforcement when it comes to alcohol abuse and alcoholism. What do you feel their role properly is?

Dr. CLOUD. Again, if we accept, as certainly I do, the fact that the alcoholic is a sick, ill, and diseased person, whatever it may be, that this is a health problem then I think that certainly our law enforcement agencies must become helping agencies to bring this sick person to someone's attention so they can be treated.

I certainly don't feel that any ill person should be allowed to hurt other people with his illness, whether this is a communicable disease, or whether it is alcoholism, or whether it is mental illness.

I feel there must be some type of restraint put on the person for his good and for the good of society in which he operates, but I don't feel this should be a punitive action.

I feel this should be a positive action which uncovers, in a sense, the aberrant behavior or the sick or ill behavior and motivates, forces—use what word you will—this individual to undertake some form of rehabilitation. In that sense I feel this is perfectly valid.

As for punitive methods, history has shown us how badly this works.

Senator HUGHES. The bill provides that grants must be approved by the National Advisory Mental Health Council. How do you feel about this administrative structure?

Dr. CLOUD. I think this is fine, because certainly grants, whether they are for training, research, or whatever it may be, the Government's money, the citizens' money, cannot be used willy-nilly.

There must be very careful restraints put on this, and there must be a very strong and very knowledgeable type of advisory council, and I feel in this particular illness that we are now discussing this must come from various types of expertise, not only the medical profession but from the social workers, the sociologists, the psychiatrists and economists, et cetera, who all have a place in this disease.

The stronger the advisory council and the better and more direct the action and advice to the Secretary, the more able we are to get the type of grants and training that we certainly need.

Mr. Chairman, may I comment away from this paper for a moment?

Senator HUGHES. Yes; please do.

Dr. CLOUD. I was impressed in reviewing your introductory remarks when you introduced the bill, and without any prior discussion on this point I want to agree 100 percent with your statement, and I am not quoting it—I don't remember it verbatim, but the drug problem in this country, as we see, and with its visibility, and the attention that it has gotten, that the No. 1 drug being abused is alcohol, and I think this is something that needs to be reiterated whenever possible. Because too often we think of this particular material as a beverage, and we know full well it is not a beverage.

Whether it is used socially or addictively, this is a drug, and I won't go too far as to say I am annoyed, but I myself am confused about the tremendous clamor about the other drugs, and yet at the same time we sit complacently by and watch our neighbors misuse the most

familiar and most widely abused drug of all, alcohol, I feel this should be made a matter of record, that more than anything else this is where we must put our emphasis, as you have so wisely done.

Senator HUGHES. Thank you very much, doctor. You know my feeling about that.

Section 506 of the bill provides that Federal funds used to assist State and local governments in the treatment of alcohol abuse and alcoholism among licensed drivers should be expended for the purpose of education and rehabilitation, and not for the purpose of punishment.

The point has been raised that, as drafted, this provision could preclude funds spent for police traffic services, and driver licensing, if it was a case of driving under the influence of alcohol.

How far do you feel we can really go in this area?

Dr. CLOUD. I think this is a question that is pertinent to what you asked me before, about the punitive and the law-enforcement part of it.

I would feel, in my position as a physician and working with the National Council that I would like to see the limited funds, and all funds are limited, and all manpower is limited, utilized more, again, in positive rehabilitation rather than in the so-called law-enforcement types of activity.

I think law enforcement to a certain extent is going to go on apace with or without this bill, and I would feel again, that whatever funds, time, ability are legislated under this bill should be more in terms of the preventative aspect, teaching safe driving, and this sort of thing, rather than simply in perhaps building more jails, hiring more policemen, setting up more roadblocks, et cetera.

Senator HUGHES. Do you feel it would be better to break down the funding in a more specific way in the grant provisions of this bill?

In other words, should we break this down into segments for training, education, research, and treatment?

Dr. CLOUD. Yes. I think that—of course, I think that this is what will eventually happen, no matter how—at least in my own experience.

No matter how money is allocated, then it must be put into separate divisions, and as I said before, education in terms of training and research are very large areas, and if this is lumped together, I am afraid some one comes out on the short end.

It is easier in a practical way to do this in segments.

Senator HUGHES. Would it be better to add authority to the Community Health Centers Act, or provide a separate funding authority as is done in this act?

I mean, to add authority to the one already existing, or to provide separate general funding.

Dr. CLOUD. The mechanisms are already in existence under the Community Mental Health Act. I would think it would be better to continue this, and then to allow, perhaps or to suggest, that in the community mental health act centers themselves they then break it down for their own purposes.

Since it is an ongoing thing and since there is legislation for this, it might be simpler to continue in this way. But certainly in the practicality of doing it, it must be broken down.

If you have a dollar, a certain amount must go for training, a certain amount for education, and so forth, but certainly this is allocated in the individual community.

Senator HUGHES. Do you think there is anything left out of this bill that should be in it?

Dr. CLOUD. I think there is much left out of it. There is no such thing as a bill that will satisfy all people, any more than there is a God that will satisfy all people, so certainly there are things left out.

I don't feel that there is anything left out that is really needed—I think all the planks have been nailed down. I don't think there is any leakage in this particular bill, but certainly we could take them page by page and paragraph by paragraph and I could add my own bias and prejudice and add certain things that would suit me as a medical man.

Overall, I think it is probably the best bill I have seen in this particular area. I think with experience and time and so forth, we might change certain things, but nothing of a magnitude that concerns me at the present.

Senator HUGHES. Dr. Cloud, I thank you very much for your testimony. If, as you review this matter, anything comes to mind that you think would be helpful to the committee staff, please submit it to us in writing within the next week or 10 days.

Dr. CLOUD. I certainly will. Thank you for inviting me.

Senator HUGHES. The Chair calls Miss Marian Wettrick, member, board of directors, North American Association of Alcoholism Programs.

STATEMENT OF MISS MARIAN WETTRICK, MEMBER, BOARD OF DIRECTORS, NORTH AMERICAN ASSOCIATION OF ALCOHOLISM PROGRAMS; ACCOMPANIED BY AUGUSTUS H. HEWLETT, EXECUTIVE SECRETARY, NAAAP

Miss WETTRICK. I would like to have your permission to ask Mr. Augustus Hewlett to join me, please.

Senator HUGHES. Certainly, you may proceed as you like with your testimony.

Miss WETTRICK. Thank you.

I would like to read a brief statement, for the record, following which I would be pleased to attempt to answer whatever questions might be posed.

I am Marian J. Wettrick, special assistant on Alcoholism and Drug Abuse to the Commissioner of Mental Health of the Commonwealth of Pennsylvania, and as a member of the board of directors of the North American Association of Alcoholism Programs, I am here to state our organization's support for S. 3835, the Comprehensive Alcoholism and Alcohol Problems Act of 1970.

NAAAP is a professional organization composed of 158 governmental programs in the United States and Canada having a primary interest in the care and control of alcoholism and alcohol related problems.

Among these organizational members are 46 State programs in the field of alcoholism care and control along with more than a thousand individual members professionally concerned with alcoholism and alcohol problems in our society.

At the outset of my remarks, let me on behalf of our organization commend you, Senator Hughes, the members of your subcommittee,

and the more than 40 members of the Senate who are cosponsors of S. 3835.

During the brief period of this subcommittee's existence its chairman and membership have done a truly remarkable job not only of gathering information for the formulation of significant legislation, but also in dramatizing the magnitude of the socio-medical threat posed our society by alcoholism, the country's third ranking disease, and related alcohol problems.

The thrust of my remarks today will be directed at two important aspects of S. 3835.

First the significance of the bill's proposed establishment of an Alcohol Problems Institute with the Public Health Service of the Department of Health, Education, and Welfare; and, second, the question of how much, in dollars and cents, this will cost the taxpayers of America, related to the cost now being incurred as a result of alcoholism and alcohol problems throughout the Nation.

The coordination of Federal alcoholism and alcohol related programs with its potential for a truly comprehensive attack on these critical health problems, is probably the single most outstanding feature of S. 3835.

Indeed as authorities in the field have long pointed out the launching of a truly effective attack on these problems must necessarily begin with the establishment within the Federal Government of a high level center of responsibility as is provided by this bill.

There are many good reasons for this of course—not the least of which is the avoidance of conflict and duplication of efforts being made in the field by various Federal agencies.

In a public health area already stretched thin because of meager resources and manpower we can hardly afford wasteful expenditure of either tax dollars or human skills.

The Alcohol Problem Institute to be created by S. 3835 will in our opinion safeguard against such unnecessary waste. The avoidance of such waste in Federal Government resources is, of course, a paramount consideration at a time when national priorities are under intensive review.

For this reason I would like to address the remainder of my testimony to the question of how, in the overall, the enactment and implementation of S. 3835 will affect our Federal budget and the national economy.

To be sure everyone agrees that alcoholism and alcohol related problems in the United States are a serious health problem—the third ranking killer of human beings in our country, as has been previously stated.

But as those of us working in the field have learned over the years, recognition of the existence of a problem by the public and its elected leaders does not always lead to action to solve or remedy that problem.

In the field of alcoholism and also alcohol related problems the perennial hang up, if you please, has been the matter of costs. How much we are asked will a program to help prevent, treat, and remedy the disease of alcoholism and to curb the pernicious effect of alcohol related problems in our society—how much will such a program cost?

And even if the money is available, would such a program work? Can the disease be effectively attacked?

In this regard S. 3835 represents a realistic action program of attack. The character of this legislation is not simply theoretical and long range but pragmatic and immediate.

We have estimated—though this estimate is certainly not authoritative—that implementation of an effective national program under the terms of S. 3835 would cost \$75 to \$100 million annually * * * at least at the outset of the comprehensive attack this legislation envisions.

We believe that those who would question or challenge the expenditure of such an amount should first take time to analyze and understand the costs involved relative to other costs in dealing with health problems, both in this country and overseas.

First it would be well to determine what alcoholism and alcohol-related problems are costing us today—not simply in terms of remedial programs but in terms of the drain in human and material resources which the disease now places on the Federal budget and the American economy.

Would S. 3835 cost too much?

Before answering that question, Members of the Congress and the public should consider the following existing cost factors:

1. Last year more than 90,000 veteran patients in VA hospitals were discharged after having been treated for alcoholism related disorders, such as liver cirrhosis, delirium tremens, neuropathy, alcohol related brain damage, and other related complications.

This represents approximately 13 percent of the total VA hospital discharges for last year.

Projecting these figures in terms of dollars and cents the VA cost for medical care services is approximately \$1 $\frac{3}{4}$ billion annually—13 percent of which amounts to more than \$225 million currently being expended on late stage alcoholism complications for patients in VA hospitals.

A provision of S. 3835 would direct the Veterans' Administration to develop more specific alcoholism services to catch this disease at an earlier stage of development and to rehabilitate the alcoholic veteran.

The effect of this provision would be to reduce the likelihood of the patient becoming a hospital revolving door case for emergency treatment after he has reached the latter stage of alcoholism—as now occurs with costly and tragic frequency.

Certainly this would be a far better expenditure of funds than is currently the case.

The question then is not how much S. 3835 will cost the Federal Government and the taxpayer, but how much it will save them—not only in terms of dollars and cents, but of course, in human resources and values in our society.

2. It is estimated that more than \$4 billion annually is lost to U.S. industry as a result of wasted man-hours, inefficiency and other deleterious effects of alcoholism and alcohol related problems on the Nation's manpower at all levels of business management and labor.

How much will enactment and implementation of S. 3835 save the economy and thereby bring into the Federal Treasury through the curbing of this tragic and unnecessary drain of human resources?

Such a tabulation is most difficult to make.

3. In terms of comparative costs in the health field, 1970 Federal budget figures placed Federal program expenditures in the field of heart and lung disease—and this represents research alone—excluding services—at \$153 million.

Cancer research this fiscal year, excluding the amount invested by the Federal Government in actual treatment services comes to \$173 million.

For fiscal year 1970 a total of \$355 million was invested by the Federal Government in the comprehensive field of mental health, including research, treatment, and rehabilitation programming.

Less than 3 percent of this amount—\$10 million—has been allocated to the alcoholism and alcohol problem area, despite the fact which cannot be repeated too often, that alcoholism ranks with cancer and heart disease as one of the Nation's three leading killers.

By comparison it is notable that in this same fiscal year \$132 million in Federal Government funds have been given to research—and research alone—in the field of arthritis.

Indeed considering these cost figures in the health field, we may well ask, all priorities considered, whether the estimated initial \$75 to \$100 million per year amount projected for the implementation of S. 3835 would not be just about the best bargain the Federal Government has in the field of health care.

4. By way of international comparison, testimony before your subcommittee pointed out that in Communist Hungary, a nation of only 9 million people, approximately \$200 million is spent annually to treat alcoholics.

5. And finally testimony also pointed out that here in the United States, billions are spent each year in the wastefully unproductive arrest and rearrest of alcoholism victims.

The cost of this wasteful process to our law enforcement and judicial agencies cannot be fully estimated. Nor can the cost, in human as well as material terms, of the tragic annual toll of motor vehicle accidents attributed to alcohol abuse.

These points represent only a cursory comparative cost analysis of S. 3835, a bill which we know to be the result of one of the most intensive congressional studies ever undertaken in the field of alcoholism and alcohol related problems.

We have devoted our attention to the question of cost because we believe that more Americans need to understand the truly exorbitant cost our country as a whole, and our States and our communities are paying each year as a result of neglect in attacking this critical health problem.

Along with the chairman and other sponsors of S. 3835, the North American Association of Alcoholism Programs believes that the time has come to place our costs, as well as our public health priorities in realistic perspective and to begin to act and act effectively in dealing with alcoholism and alcohol problems.

We wholeheartedly endorse this legislation as being a major step in that direction.

Senator HUGHES. Thank you very much, Miss Wettrick.

Gus, do you have anything to add to that?

Mr. HEWLETT. Only to reiterate this association's strong support for your bill. This is by far the best piece of legislation that has ever been introduced in Congress concerning this very important health issue, and we are going to do everything we can to help you get it through the Congress.

Senator HUGHES. For the information of those present, there are at the present time 43 cosponsors of the bill. I hope there will be some more before we finally get to the voting.

This is a pleasing number.

You have gone over the bill, Miss Wettrick. What do you think of the provisions dealing with the setting up of local programs?

Do you think they are adequate to cover the problems that your association is attempting to meet?

Miss WETTRICK. I think it is very broad. I think in its breadth it has a considerable amount of adequacy. I do believe through the regulations and guidelines that would come about when the bill is finally implemented, that there would be more specific spelling out of the rules and regulations that States and so forth should abide by.

Certainly in its breadth it is very good. I am particularly interested in the aspect of the possibilities of prevention, and within that \$75 to \$100 million, which we proposed, we would allocate in our thinking a goodly amount to the whole educational process.

Over the years, we have often placed 99.9 percent of our money in treatment, and have rather tended to neglect some of the equally important measures.

Senator HUGHES. Do you feel it would be better to break down the funding in a more specific way?

In other words, funding for training, funding for education, funding for research and funding for treatment, rather than block funding?

Miss WETTRICK. From my experience in the area in which I function, it would seem to me that it would be better to so arrange it. In other words, to break it down into certain categories, with a maximum and minimum.

Certainly it would help, I believe, to know the extent to which expenditures could be made within certain confines or certain realms. It would establish parameters that perhaps make it easier to work within.

Senator HUGHES. The bill provides that the authority given must be administered by the Secretary through the National Institute of Mental Health and the grants must be approved by the National Advisory Mental Health Council. Do you feel that this is the best possible administrative structure for this program?

Miss WETTRICK. I am not sure that an association such as ours is really in a position to answer this question.

Senator HUGHES. One of the problems we have faced is that almost every one who has testified is presently receiving money from the Secretary of Health. They are hesitant to give us a cold, hard, statement because they don't want to offend anyone over there.

I realize that all of the States are going to be on a sharing basis, and I have had a great deal of concern myself about whether this is where it ought to be or not.

But I am not totally convinced that is where it ought to be, even though it is in the bill that way.

We are in the process of developing whether it should be there or should not be. If it should be, I am willing to go along with the best thought in the country on the subject.

I am not hung up on it. I am concerned, however, that in years past the track record of the National Institute of Mental Health in the field of alcoholism is practically zero. I would like some assurance that this will improve in the future.

MISS WETTRICK. Let me correct my testimony with relation to this total question.

I was referring to the, in my answer, to the movement of the bill through a national advisory committee, with which we have had no experience. To what extent does this prolong the period of time that it takes to get an application approved?

Now if we are to talk about whether this is the best place to put the Institute—in the National Institutes of Mental Health—I think that our organization without any doubt would thoroughly agree with the provisions of the act in this particular respect without any question.

SENATOR HUGHES. This seems to be where the professionals want it. For that reason, it is probably more acceptable there to the Congress than it is anywhere else. However, I am not interested in setting up a beautiful organization here that never gets help to the drunk in places like San Antonio, Tex.

You have heard the previous questions relating to civil service provisions. From your experience in Government, do you think every State should have a similar program?

MISS WETTRICK. The State of Pennsylvania has a program for alcoholics who are employees.

SENATOR HUGHES. Well, how many States have that?

MISS WETTRICK. I cannot answer that.

MR. HEWLETT. I think only Pennsylvania at this point. Other States are considering policies, Mr. Chairman. Minnesota, for one. Now I don't know how many others.

I think New York is considering a State program.

SENATOR HUGHES. Is it by law or by policy?

MR. HEWLETT. In Pennsylvania, it was under Governor Scranton, I believe, but it was his committee on alcoholism that came up with the recommendations and the policy was implemented administratively rather than legislatively.

MISS WETTRICK. The Governor's Council on Alcoholism, it was through their recommendations and a resolution. We do, of course, heartily approve of that particular aspect of the bill.

SENATOR HUGHES. I read an estimate in the paper recently that approximately 140,000 would be affected by this bill in Federal employment, and it sounds pretty low to me.

They have not been traveling around the corridors very much. [Laughter.]

SENATOR HUGHES. But in any event, you feel it is necessary?

MISS WETTRICK. Yes.

SENATOR HUGHES. Section 611 provides that hospitals which discriminate against alcoholics should not receive any Federal funds. Do you agree with that?

Miss WETTRICK. Heartily.

Senator HUGHES. Heartily?

Miss WETTRICK. Yes. I think there are probably no better ways to bring to their attention the necessity of giving the services which they are in business to give.

Senator HUGHES. Do you believe that alcoholism is a disease?

Miss WETTRICK. I do. Yes, indeed. There is no question about the disease aspects of the alcoholism problem.

Senator HUGHES. I believe that will be all. If you have any suggestions which you think might be helpful to us, please submit them to the staff within the next couple of weeks.

Thank you very much, Miss Wettrick and Mr. Hewlett.

Miss WETTRICK. Thank you, Senator Hughes.

Senator HUGHES. The Chair calls Dr. Marvin Block, member, committee on alcoholism and drug dependence, American Medical Association.

STATEMENT OF MARVIN A. BLOCK, M.D., MEMBER, COMMITTEE ON ALCOHOLISM AND DRUG DEPENDENCE, AMERICAN MEDICAL ASSOCIATION; ACCOMPANIED BY HARRY PETERSON, COUNSEL TO THE AMA

Dr. BLOCK. Thank you, Mr. Chairman.

Senator HUGHES. Please identify the gentleman accompanying you.

Mr. PETERSON. I am Harry Peterson, Mr. Chairman.

Senator HUGHES. You may proceed with your testimony as you desire.

Dr. BLOCK. Mr. Chairman, I am Dr. Marvin A. Block, a physician in Buffalo, N.Y., and a member of the committee on alcoholism and drug dependence of the American Medical Association's Council on Mental Health. With me is Mr. Harry N. Peterson, attorney in our legislative department. We appreciate the opportunity to present the views of the American Medical Association on S. 3835, on the subject of alcohol abuse and alcoholism.

Your bill, Mr. Chairman, to provide a comprehensive Federal program for the prevention and treatment of alcohol abuse and alcoholism, now before this committee, represents a major landmark in public policy. It sets forth the proposition that alcoholism is an illness which can and should be treated, and it commits national resources to the establishment and coordination of facilities and services necessary for treatment and rehabilitation. We are in general agreement with this legislation.

During hearings before this committee on July 25, 1969, on the subject of alcoholism, I remarked:

The crying need, aside from research and education is for community facilities to treat and care for the alcoholic patient who is entitled to the same rights and opportunities for treatment accorded other sick people.

We believe this legislation can provide the necessary stimulus for such community treatment programs.

Now, Mr. Chairman, we would like to offer comment on certain individual portions of the bill.

In section 101 it is stated that "Alcohol abuse and alcoholism are rapidly increasing throughout the country." Although there may well

be an increase in drinking in both percentage and in actual numbers, we are not aware of data to support the claim of "rapid increase." Nonetheless alcoholism has been a serious and extensive problem for years and warrants our concern.

Section 101 also contains the statement:

"Alcoholism treatment and control programs should, whenever possible, be community based." We believe this is an extremely important principle. Insofar as it is feasible and economically sound most alcoholics should be treated in their own communities and not be relegated to a distant centralized institution for treatment.

This section also states:

Handling alcohol abusers and alcoholics through health and other rehabilitative programs relieves the police, courts, and correctional institutions, and other law enforcement agencies of an onerous and inappropriate burden . . .

Although alcoholism is a health problem, it is not a matter exclusively for health professionals to contend with. Law enforcement still has a legitimate part to play bringing the intoxicated person into appropriate channels for treatment is one example. The courts will continue to have a necessary role. We would also suggest that the concept that the alcoholic is a special "onerous burden" should not be declared or perpetuated in the findings of the Congress. The alcoholic may be a difficult individual in many respects but there is nothing uniquely reprehensible and inherently unmanageable in his character or deportment to justify this characterization.

Section 301 establishes a National Institute for the Prevention and Control of Alcohol Abuse and Alcoholism within the National Institute of Mental Health to administer the provisions of the act. There now exists within the NIMH the National Center for Prevention and Control of Alcoholism.

We see no compelling reason for establishing another body either to subordinate and or supplant the existing National Center. The duties and responsibilities given to the Institute under this bill could be performed by the National Center. As important as alcoholism is, it should not be used to set a precedent for creating separate institutes within NIMH.

The remaining sections of title III set forth the duties of the Secretary of HEW, to be carried out through the Institute with respect to administration, planning, coordination, statistics, training, education, and reporting. We generally support these provisions many of which seek to strengthen local State and local activities and efforts. Particularly commendable is section 304(e) which cites as one coordinating function of the Secretary the duty to "stimulate more effective use of existing resources and available services" for prevention and treatment. The utilization of such resources in fact should be a prerequisite for obtaining Federal funds for building and equipping new facilities under section 604, and it should be demonstrated that in order to qualify for grants for new facilities, existing facilities, used to the fullest, are still not sufficient to meet the needs.

Another duty, this one with respect to the planning function, is to "encourage and promote throughout the country, public health procedures for the treatment of alcoholics as alternatives to present criminal procedures." We of course agree that alcoholism is an illness, not a crime, and that alcoholics are entitled to the same rights and privi-

leges in law and the same opportunity for medical treatment, which are accorded to persons with other illnesses. We would caution, however, that in shifting from a punitive to a treatment approach, States and communities see that facilities for treatment are available in sufficient numbers and quality to assure that the transition can be made with a minimum of disruption and confusion.

In section 305, the Secretary acting through the Institute, is directed to promulgate regulations specifying statistics to be gathered and reported by agencies and by practitioners.

This provision is identical to one contained in S. 3562 (The Federal Drug Abuse and Drug Dependence Prevention, Treatment and Rehabilitation Act of 1970) concerning which we testified before this committee on March 23, 1970.

I will reiterate the testimony given at that time by Dr. Henry Brill on this point:

We can readily understand the advantage to be accrued from maintaining good statistical data. However, we are concerned with the inclusion of practitioners under the compulsory requirements for reporting. We believe that such reporting should be voluntary, and we would be willing to work with those administering the program in developing a viable system.

It could be possible that reporting could prevent patients from seeking treatment.

Title IV of the bill deals with prevention and treatment of alcohol abuse and alcoholism, with regard to Federal employees, military personnel, veterans, and Federal offenders.

While a need exists for careful preemployment screening of prospective Federal employees, the attitude expressed in those provisions toward Federal employees who are alcoholic is a forward looking one, stressing as it does, continued employability predicated on acceptance of treatment. Major industrial firms already have similar practices but the enunciation of this policy by Congress could be a constructive influence on other companies and on State and local governments.

Section 405 provides for taking a person, charged with a Federal offense, "who appears to be intoxicated or an alcoholic" to a health facility for diagnosis and treatment. Even though there is opportunity for consultation with legal counsel, we believe the bill should explicitly provide for voluntary entry to diagnosis and treatment, except in those cases where the offender is incapable, by reason of his intoxication or otherwise, of making a rational decision as to whether he wishes to be diagnosed and treated.

This is an important point not only for the bill at hand but for subsequent legislation which may be developed later by States. No one should be forced into treatment against his will.

Title V is concerned with alcoholism as it relates to various existing Federal health, welfare, and rehabilitation programs.

We question whether alcoholics should be eligible to receive health care financial assistance under all of the named programs. The provision of a cash benefit would seem to offer some alcoholics a convenient subsidization of their habit. What the alcoholic requires is treatment of his problem and rehabilitation rather than just cash support with public funds.

As we interpret these provisions, they could expand upon the eligibility requirements, for example, medicare is a program for persons over age 65. Health care under medicare for alcoholic persons should be available to those who are otherwise eligible for the program—those over 65. By the same reasoning, the disabled class under social security should include alcoholics only if they otherwise qualify, as a disabled person, for the program. All these federally financed programs are currently having serious fiscal problems.

If consideration is to be given for their expansion to include more benefits, or to enlarge the eligibility class, it should be done in conjunction with an appropriate review of the program involved. In any case, the question of whether to include alcoholism as a medicare or medicaid benefit, or as a basis for determining disability is one which should be decided at the time Congress considers amendments to the Social Security Act.

Section 506 calls for programs of prevention, treatment, and rehabilitation with respect to drinking drivers. We endorse the principles set forth in this section but would note that the programs should not be restricted to drivers who are licensed. Some drivers who are most in need of help are not licensed. We believe that the Department of Transportation now has similar programs regarding alcohol and highway safety, and any new efforts or programs should be coordinated with those already in effect to avoid unnecessary waste and duplicated effort.

Title VI deals with Federal assistance for State and local programs and makes provisions for including alcoholism under comprehensive health planning, hospital and medical facilities, construction plans, and State mental hospital health center plans.

Although we endorse in principle the concept of such assistance where necessary, we have not had the opportunity to study thoroughly the provisions of the various sections of this title and to weigh their implications.

We therefore refrain from making specific comments at this time. We would call your attention however to section 605 (b) which directs a grant applicant to submit a copy of his application for review "by the State agency responsible for administering the State comprehensive plan for treatment and prevention of drug abuse, if such agency exists." In our opinion although alcoholism is a form of drug dependence, it is a problem of sufficient magnitude and with distinctive enough a parameter to deserve special attention. We believe that at the State level a single agency should have the responsibility for stimulating and coordinating facilities, services, education, and research on alcoholism.

Mr. Chairman, most of this bill is concerned with the operation of programs by public and voluntary agencies. We should not overlook, however, the role that the private physician has played, and can play, in this important area. More and more the physicians of this country are facing up to the problem of alcoholism in their daily practice. They are recognizing that, as difficult as alcoholism may be, it is an illness which responds to treatment, and that they can help their patients in cooperation with other professionals in the community.

Thousands of copies of the AMA's manual on alcoholism are now on the desks of practicing physicians. Thousands more are in the hands of medical students—the physicians of the future.

With the added encouragement provided by legislation of this kind, we have every reason to be hopeful about the future.

We now will be pleased to attempt to answer any questions which you may have.

Senator HUGHES. Do you have any additional statement, Mr. Peterson?

Mr. PETERSON. No, sir.

Senator HUGHES. As a matter of interest, on the last section you referred to, the treatment and prevention of drug abuse, there is a drafting error in the bill.

Dr. BLOCK. I did not get that.

Senator HUGHES. That is a drafting error in the bill which you were commenting on. It will be straightened out. It is not intended to be that way.

Dr. BLOCK. Oh, I see.

Senator HUGHES. I certainly agree with your statement on the onerous burden. I don't know how that got by me, but it did.

Dr. BLOCK. Dealing with these patients, exclusively in my practice, they are no more onerous than the patients I had before I specialized in this field.

Senator HUGHES. Where do you get your statistics from?

Dr. BLOCK. Mostly from the Government and statistics put out by the National Council.

Senator HUGHES. They have recently raised those.

Dr. BLOCK. I think the statistics on alcoholism are grossly inadequate.

Senator HUGHES. What is your opinion—

Dr. BLOCK. I say my opinion is that there are at least twice as many alcoholics as the figures indicate. I think the vast majority of the alcoholics are not aware they are suffering from the disease, nor are the people with them aware of it.

I am afraid a great number of alcoholics are allowed to proceed to critical phases in the disease, because they resemble heavy social drinkers.

These people are allowed to progress without being detected as compulsive drinkers.

Senator HUGHES. There is a fine line of difference as you know. How can we distinguish between the so-called problem social drinker and the alcoholic.

Dr. BLOCK. In my opinion, there should never be excessive drinking. If excessive drinking were to bring about social ostracism people would be very careful about it. Then the only ones who would drink excessively would be those who could not control it. How easily then we could pick out the alcoholics.

I think this is a matter of education, understanding, and propaganda, really, because I think that we could actually sell this to the American public if sufficient time, energy, and money were spent on it.

They have learned a great many other things.

They have made a great deal to do about underarm deodorant and spent a great deal of money on that and changed the opinion of the American public.

I think that could be done as well with excessive drinking.

Senator HUGHES. Do you think we could get the statistics from private physicians without names?

We are not interested in who; we are only interested in statistical information. One of the greatest problems, as you know, is the lack of documentable statistics to base our estimates on.

Dr. BLOCK. I think this can be done. I am in the process of my sixth year—my sixth survey of 1,400 physicians in our county. We do get a consensus from the individual members on the number of alcoholics they see, those they recognize as alcoholics who do not come to them for that purpose, and those who come for that reason.

So we get an idea how many there are in our area under private care.

Senator HUGHES. Do you believe there would be a higher percentage, a lower percentage, or the same percentage of alcoholics in the aged as there is in the general population?

Dr. BLOCK. Would there be that percentage in where?

Senator HUGHES. In the aged, those 65 and over.

Dr. BLOCK. Since the statistics show that the average alcoholic lives 12 years less than the average nonalcoholic, I dare say that Dr. Cloud was correct in saying that by the time they reach 65 a good many of them are not with us any more, so I would say the percentage would be lower in the above 65 age group.

Senator HUGHES. Your concern is about increasing the cost of the overall program, was that your basic concern in medicare and medic-aid?

Dr. BLOCK. I am not concerned with the cost at all. I am concerned with the treatment of these people, and prevention. I feel prevention is the most important factor.

Senator HUGHES. I am talking about the provisions under the Social Security Act right now. When I introduced the bill, I indicated that it should be rereferred to the finance committee for consideration of these points.

Mr. PETERSON. Mr. Chairman, if I might inject, one of the considerations with respect to medicare and under the general language of the bill was whether the intention here was to expand the services to those under 65 as to alcoholism, and this was the tenor of the general comment, that the illness is treatable and should be related to those 65 and over under medicare.

Senator HUGHES. That was my understanding, too.

I did not have any intention of doing more than that.

Mr. PETERSON. I just wanted to indicate that the language was general, and our concern was with the interpretation along that direction.

Senator HUGHES. I share your concern. We will review that again. If you have any drafting suggestions that would be helpful to us, I would appreciate your submitting them to the committee staff for consideration.

Doctor, can you give us an estimate on how much money could be effectively used for treatment for training personnel, prevention, education and so on.

Dr. BLOCK. The figures used as far as money is concerned are beyond me. I can't conceive of the amounts of money they speak of in these things. All I can say is that no where near enough is being spent on the training of personnel anywhere.

Senator HUGHES. You are familiar with medical schools, aren't you?

Dr. BLOCK. I certainly am, unfortunately, in this area.

Senator HUGHES. It is going to take quite a little money, isn't it?

Dr. BLOCK. Yes. The American Medical Association for years has presented the medical schools with a curriculum for treatment, but very few have implemented that.

Senator HUGHES. If there was money available for implementing curriculums, would it take place faster?

Dr. BLOCK. I think so.

Senator HUGHES. And if there was money available so that scientists and others would know they had a future in this——

Dr. BLOCK. Yes; if there were money available.

Senator HUGHES. You have disavowed any concept of what the figures mean, but do you think they are reasonable?

We need estimates to base this on, and we are going to have to fight for funding.

Dr. BLOCK. When I see the comparison with other fields of treatment, I think the figures are within—are inadequate.

Senator HUGHES. That was my feeling. If I had to put dollars in this bill, the bill would have been through. We have to get it structured, and then fight for funding.

Some members of the subcommittee feel that we should begin on a scale-up basis. We are going to have to train personnel and we can't expend all of the money in the first year, probably, as adequately as we could spend in the next 2 or 3 years.

The document you have presented in a very concise and analytical one, doctor, and I appreciate it very much.

If we had the time, I would go into it in greater depth, but I don't think it is necessary. If I feel it necessary, may I submit questions to you on some of these matters?

Dr. BLOCK. Yes.

Mr. PETERSON. Yes.

Senator HUGHES. Thank you very much.

The committee is going to recess for 5 minutes, and at the close of the recess we will call Morris Chafetz.

(Whereupon, a brief recess was taken.)

Senator HUGHES. We will resume the hearing.

You may proceed, Mr. Chafetz.

STATEMENT OF MORRIS E. CHAFETZ, DIRECTOR OF CLINICAL PSYCHIATRIC SERVICES, MASSACHUSETTS GENERAL HOSPITAL, BOSTON, MASS., ON BEHALF OF THE AMERICAN PSYCHIATRIC ASSOCIATION

Mr. CHAFETZ. I am Morris Chafetz of the Massachusetts General Hospital and the Harvard Medical School, and I am here today to represent the American Psychiatric Association and its 18,000 members who want to strongly support S. 3835.

I have a prepared statement to read, Mr. Chairman, and I will welcome any questions that you may wish to present to me at the conclusion, and I will try to answer them.

Senator HUGHES. All right.

Mr. CHAFETZ. That point in history when an idea's time has come is not easy to discern. And rationalizations, explanations, and predictions, though intellectually satisfying, are not what should concern us here.

What concerns us here is an important piece of legislation directed toward relieving the pain of millions of sufferers long neglected. It is encouragingly ironical to note that during one of the most stressful times in our history alcoholic people have their best opportunity finally to be treated as human beings.

This legislation cannot come too soon. It cannot come too soon because even those of us who have devoted most of our professional lives to dealing with alcoholic people are unaware of the severity of the problem and its ramifications.

For example, most of us for decades have used the often quoted figure of 4,500,000 to 5,000,000 alcoholic people in this country. But a recently completed scientific study shows the figure to be beyond 9 million.

And I may point out that many students confirm that the diagnosis of alcoholism is, for many reasons, made very late in the game. One must be terribly far gone before we or our society dare recognize the alcoholic illness.

Why this should be so is more a problem of the healthy than the sick. We are so unaware of what is responsible drinking behavior, we are so uncertain as to what role alcohol plays in our own lives, that we can only feel comfortable by holding up as a model for diagnosis and recognition, the very sick, the very far advanced.

Therefore, the bill's emphasis on early identification and prevention is essential if we are to control the alcohol problem. It is a basic principle of medicine, that no condition is brought under control by treating the casualties alone.

Furthermore, alcoholism, as a condition for a humane society to concern itself with, is neglected, and its afflicted ostracized because we cannot shake our fundamental belief that the action of the alcoholic person is willful and weak.

It is no such thing. It is the struggle to stifle all kinds of pain. In my 16 years of working with alcoholic people from all walks of life, I have never met a person who took pleasure and delight from the fact of his being an alcoholic person.

And as a representative of the American Psychiatric Association I wish to state that the many sections of this bill in which it is stated that alcoholism is not to be regarded as intentional misconduct or willful neglect, strike a blow for ill people not unlike the blow the French psychiatrist, Pinel, struck to free the chains from the mentally ill shackled in their prisons.

But words are not enough. For example in February 1965, a position statement authorized by the council of the American Psychiatric Association entitled "Concerning Responsibility of Psychiatrists and Other Physicians for Alcohol Problems" was issued.

It reads as follows:

An adequate attack on alcohol problems necessarily requires the application of the knowledge of many professionals reinforced by broad citizen support.

I might add that the term "alcohol problems" is used advisedly in preference to the terms "alcoholic" and "alcoholism" which in our

view are stereotyping and over simplifying and suggesting that all persons with alcohol problems suffer from the same affliction. They do not, except in the sense that drinking alcohol is contraindicated for them.

Psychiatrists, together with general physicians and other medical specialists have a continuing obligation and responsibility for contributing their relevant clinical knowledge and skills to the treatment and prevention of alcohol problems.

It is urgent and imperative that psychiatrists and other physicians better prepare themselves for their proper role in attacking these problems on a national scale that the medical contribution may become far more telling than it has been in the past.

Existing programs in the community for the management of alcohol problems are generally inadequate and need expansion and acceleration. General medical and psychiatric facilities, including general hospital and psychiatric facilities, commonly discriminate against the patient with alcohol problems.

Such meager services as they do even render are offered in a spirit of therapeutic pessimism. What is needed are properly equipped and adequately staffed wards prepared to offer prompt and adequate treatment of acute and chronic physiological and psychological and social disturbances associated with alcohol problems. And all of this in close collaborative relationship with other community agencies concerned with the management of such problems.

The principle of a continuum of services in the community applies here as well as to other kinds of disorders.

The statement goes on to say that:

All prepayment plans for defraying the cost of medical care through insurance would cover the person with presenting symptoms of alcohol problems who seeks treatment in medical settings on the same basis as for other illnesses.

Medically speaking, every person with alcohol problems should have the benefit of comprehensive diagnostic study including an assessment of his general health, his mental and emotional condition, and his social and economic adjustments.

To concentrate exclusively on the drinking problem per se is to neglect the possibility of related diseases and various social and economic factors of possible critical import.

Treatment should reflect closely the results of careful diagnostic evaluation. As treatment progresses furthermore, even therapists should maintain continuous surveillance of the effects of that treatment and of intercurrent changes in the patient's condition. Critical review should continuously determine whether treatment is effective, appropriate and adequate.

The statement goes on to say that:

The patient and his problems with alcohol are affected by his social environment but they also affect that environment.

Treatment programs should take this into account. Persons whose training is other than medical or psychiatric contribute substantially to the understanding and again of management of the patient.

The treating physician should be willing to consult and collaborate with nonmedical individuals and institutions involved without, and I

emphasize that word "without," assuming administration or other non-medical responsibilities in doing so.

Such individuals include clinical psychologists, social workers, nurses, clergymen, vocational rehabilitation, counselors, policemen and others with qualifying education and background.

Especially helpful with selected patients are organizations such as Alcoholics Anonymous. When collaborating or consulting with non-medical persons and organizations, the physician will of course be always mindful of his medical obligations to his patient.

He has neither legal nor moral authority to abandon those obligations.

The statement goes on to say:

Research activities investigating the nature and the causes of alcohol problems are both commendable and productive. They have not yet, however, reached levels commensurate with the magnitude of the alcohol problem and its threat to our society.

Urgently needed are greatly increased public and private moneys for research, expanded research institutes and programs, and large numbers of fully trained personnel to conduct these institutes and programs.

Procedures should also be developed which will greatly accelerate the adaption of research findings to the problems of patients and their promulgation to personnel involved.

The statement concludes by:

Urging members of the Association to work with others in their communities for more adequate services for patients with alcohol problems in the context of this statement.

We record our conviction of the need for undergraduate and graduate medical educators in general and psychiatric educators in particular, to orient medical students in these constructive directions.

This statement, now five years old, has accomplished little. As with many noble utterances the air is warm but the action is absent. Psychiatrists of today show little more inclination to soil their hands with those alcoholically afflicted than they did before the statement.

I raise the point about this difference between utterance and action not to castigate my colleagues whom I represent here today (for sadly most all groups have shunned alcoholic people and problems) but to caution all of us not to raise again false hopes in a population of ill people who always have had their promises shattered by the reality of meager delivery.

I humbly caution your committee not to raise their hopes unless a strong fight will be made to implement what this bill promises.

And this bill has great promise!

If this bill becomes law and is properly implemented I am certain that it will reverse in great measure the rising incidence of alcohol problems.

Unfortunately we must recognize the fact that nothing lends respectability to a health problem more than the infusion of large amounts of money.

The American Psychiatric Association wishes to go on record strongly endorsing the thrust, direction, and aim of this bill and is willing to offer any and all assistance to insure its passage.

Thank you.

Senator HUGHES. Thank you very much, Mr. Chafetz. Since you concluded on the subject of money, I will ask you to give me your estimates of the amount needed to implement this legislation.

Mr. CHAFETZ. Well I must confess, Mr. Chairman, as I heard you put the question to my colleagues, I was trying in my own mind to determine what figure I would give you.

In all honesty, I think that, coming from the small town of Boston, the large figures that are dealt with in this city overwhelm me, and I can't place a figure, except to agree that it is a large amount.

But I also feel that there are political realities, about which I suspect that you are much more expert than I, that lead me to believe that we have to be realistic in starting at reasonable levels and not try to do too much too soon, even though the cry is great.

Senator HUGHES. How much do you need in Boston?

Mr. CHAFETZ. Because Boston has the third or fourth highest alcoholism rate in the country, I would say to you, sir, that Boston would require 2.5 million. But as I pointed out in my statement, we have many studies that show that the diagnoses of alcoholism and the model for making an alcoholism diagnosis is that of the skid row population. In spite of everything people say to the contrary, and as we all know, this is a very small part of the alcoholic population the need may be greater than even we imagined.

Senator HUGHES. Do you agree with the concept that alcoholism is a disease?

Mr. CHAFETZ. You place me in an embarrassing position with respect to that question, but I will answer it. In scholarly discussions I have taken the position that I do not accept the concept that alcoholism is a disease.

I prefer the concept of an illness, and that is because of my medical background and what disease connotes to me. But for the purposes of what I understand the intent of the bill and the intent of all of us concerned with the problem is, I am not discomfited by the concept of alcoholism as a disease.

Senator HUGHES. That was a good recovery, Doctor.

I have the clippings here which quote your earlier statements on this. That is why I asked the question. I attempted to spell out in this bill the role that law enforcement has in alcohol abuse and alcoholism. What do you feel that role is?

Mr. CHAFETZ. I think that law enforcement has an important role to play in this condition but unfortunately I feel it has played an erroneous role to date. I think as is the case with so many health problems that we do not want to deal with directly, that it is easy to place the burden of alcoholism on the police force and expect it to take over, and in this they have been greatly misused.

But I do believe that the police, as community agents who very often know the structure and the individuals in a community much better than those of us who sit in ivory towers, are sensitive to people who get into trouble with alcohol, and can act as early identifiers. When they act as agents to steer people into health agencies, I think they have a very important role to play.

Senator HUGHES. Do you feel that the funding requirements of this bill should be broken down for training, education, research, treatment and so on separately, rather than block funding?

Mr. CHAFETZ. Sir, I think it would be a mistake on my part to talk about organizational and administrative matters of this nature, but one thing that bothered me a bit in the bill is that it is so specific that I am concerned that maybe it will lose some of the flexibility that I sense this bill hoped to have. That was my only question.

Senator HUGHES. The bill provides that the authority given must be administered by the Secretary through the National Institute of Mental Health and grants approved by the National Advisory Mental Health Council.

Do you feel this is the best structure?

Mr. CHAFETZ. Yes. The National Institute of Mental Health like all organizations has its failings, but I am very strongly in favor of this administrative structure, and I believe wholeheartedly, having had much dealing with the National Advisory Mental Health Council that this is an excellent kind of administrative arrangement. The National Advisory Mental Health Council has broad citizen and professional representation, and is an excellent peer review system.

Senator HUGHES. You have heard discussion on the social security provisions. Do you have any comment on those?

Mr. CHAFETZ. I would only comment, Mr. Chairman, that what we provide for other ill people, I want to see provided for people with alcoholic problems.

Senator HUGHES. Section 611 provides that hospitals which discriminate against alcoholics should not be allowed to receive Federal funds.

Do you agree with that?

Mr. CHAFETZ. Very strongly. As a matter of fact, Mr. Chairman, many years ago, when I served on certain committees, I wanted to have their accreditation revoked if they discriminated by diagnosis, such as alcoholism or other matters, but I was not successful in getting this across.

I hope we will have greater success here.

Senator HUGHES. I think it is a beginning, at least.

Mr. CHAFETZ. I have pointed out the pessimism that has prevailed; if I might add something, this does not mean I am pessimistic.

As a matter of fact, since the creation of the National Center, even though we have had hopes it could have done more, I believe that I see remarkable changes going on.

Psychiatrists who are doing good research, physicians and biochemists, a variety of people are coming into the field and having an awakening of interest in the field. If I may say so, sir, I believe your interest in alcoholism has contributed greatly to that development.

Senator HUGHES. Thank you. I can't speak for all of my colleagues, but I want to assure you that I am not raising hopes that I do not intend to follow through on.

If there is any way I can possibly get this bill through this Congress, it will be through.

The funding is something that is going to be more difficult. We are going to have to come back again and battle for more adequate funding, and I think at that point, if I might lecture my witnesses this morning, you had better rally around behind the cause, because it won't be before this committee at that point.

It will be before another committee that may not have the concerns about alcoholism that we have here today.

I want to thank you for your testimony today.

Mr. CHAFETZ. Thank you very much for your courtesy, sir.

Senator HUGHES. The Chair calls Dr. Bacon, director of the Center for Alcohol Studies, Rutgers University, New Brunswick, N.J.

Welcome, Dr. Bacon, to the subcommittee once again. You may proceed as you desire.

STATEMENT OF SELDEN D. BACON, PH. D., DIRECTOR, CENTER OF ALCOHOL STUDIES, RUTGERS UNIVERSITY, NEW BRUNSWICK, N.J.

Dr. BACON. Thank you, Senator.

I am in favor of what I believe to be the major purposes of this bill. It seems to me that it has recognized what can be termed the key weaknesses of attempts in the past to gain control over the massive problems related to abuse of alcohol and that it proposes means to overcome these weaknesses.

One of these key weaknesses has been the tendency to isolate some part of the problem, give it a special name, and then try to find a single-type answer for whatever one thinks is covered by that one word; this frequently results in one profession, subprofession, or even one small bureau being given the responsibility to control what is in reality a persistent, complex, and fantastically costly set of problems in our Nation.

For example the word "alcoholism" is substituted for all the problems related to alcohol; partly because of the "ism," it is then decided that this is something that doctors should handle; depending upon this or that medical philosophy, it is then further decided that one medical specialty, perhaps dealing with glands or perhaps with the liver or perhaps with personality problems, constitutes the appropriate group of technicians.

Because of the actual complexity of the problems encountered out in the community, this process of narrow labeling, followed by consequently narrow perception of causes, followed by adoption of a special type program and delegation of responsibility for action to a particular small group, is an inevitably inadequate and of course frustrating experience.

This has not occurred only in the sphere of health or illness definitions and consequent delegations of authority. This complex set of problems over the past 150 years has been defined as a moral weakness problem and turned over to the churches, defined as an economic problem and turned over to market and price control authorities, defined as a youth learning problem and turned over to educators, defined as a crime problem and turned over to law enforcement and correction agencies.

Although in each instance there is considerable justification, in no instances is there an adequate definition or even the possibility of successful resolution of the problems, and this is the case because in fact problems related to alcohol incorporate all of these elements and others that could be named. To make matters even more difficult most uses of beverage alcohol are not accompanied by problems even though the problem events are clearly of epidemic proportions.

What has happened is that our Nation has adopted several sets of what may be called programs for control of the alcohol problems. None of them are satisfactory. They are extraordinarily expensive. They operate independently and at times are even hostile to each other. The majority of the public has become disheartened and would like to forget the whole mess; however, the manifest problems are so many, so lasting, so painful, and so expensive that they are chronically reminded of them. The various program groups are also disheartened and also try to avoid the problems if they can. Two clear results of this situation are: (1) totally inadequate reports upon the scope and nature of this situation, and (2) an almost complete absence of any evaluation of the various programs, even an absence of any records to indicate what the programs in fact are doing about the problems or even how much they are spending.

By way of illustration I will note four or five of what I have called programs. One of these is the network of police, prosecution, courts, and corrections. It is estimated, quite amateurishly because adequate information is entirely lacking, that this program costs at least \$500 million per year. Its major accomplishment seems to be the temporary removal of drunken persons from public places—not only a very temporary but a frightfully repetitive task. Some perception of attitudes toward this massive operation may be gained from those operating it: They would like to get out of the business.

A second program network is that of market and price controls. This costs the taxpayers about \$100 million a year or, if the sales operations of this group are included, more than twice that amount. No one has yet been able to show that this system has any controlling effect whatsoever on any of the problems; for example, on alcohol-affected highway crashes, on youth drinking problems, on drunkenness, on the alcoholics.

A third program is that of education in the Nation's school systems. No one knows of what the program consists, what it costs, or what if anything, it accomplishes.

A fourth enormous system of responses to these problems might be called public and private welfare. Again there are almost no useful records. It seems reasonable to believe that at least 20 to 25 percent of the cases, perhaps a considerably higher proportion involve individuals having—or families in which a key member has—a continuing history of excessive and deviant use of alcohol. I do not imply that he or she is on welfare because of this use; it may be so in some cases; it may be the reverse causal relationship in other cases; in most cases it is probable that both welfare status and alcohol abuse stem from other causes. No matter what the history, the costs of this mode of response are enormously high. This system always almost surely has some humanitarian results for many of the individuals it serves; for some proportion—there are no records to allow evaluation—it may serve a rehabilitative function. That it serves in any way to control, change, or reduce the problems is at least doubtful.

A fifth, much, much smaller and quite recent set of programs, probably costing less than 5 percent of all the other programs, is the health-oriented alcoholism rehabilitation movement. Of this category it can be stated, sharply differentiating them from the others, they try to keep records which are relevant to their segment of the problems; they

alone try to evaluate their operations in terms of the problem; and it can be proven that they have helped hundreds of thousands of alcoholics. They are, however, a small set of programs not very effectively organized on a national level, constantly threatened by lack of even minimal funds, and unable to move much beyond treatment processes when the overwhelming need is, of course, prevention.

The fragmentation of efforts at control, efforts costing hundreds of millions of dollars a year, costs quite beyond and in addition to the costs of the problems themselves, efforts with one minor exception having little if any known impact on reduction and control, may be seen as stemming in large part from the narrow thinking, narrow labeling, and narrow delegations of responsibility. Described in negative fashion they represent all too frequently lack of coordination, lack of leadership, lack of knowledge of problems, lack of knowledge of programs, and almost total absence of evaluation of effort and expenditure and they fail except for impracticable wishes for total prohibition, to incorporate preventive goals—are limited to ameliorative and “tidying up” purposes.

I think the proposed bill incorporates considerable recognition of these inadequacies and proposes steps which will allow a more rational and constructive approach. In a field so long riddled with controversy and so ill equipped with attested knowledge, it would be unrealistic to expect complete agreement on any such bill by any significant number of persons from the many fields of relevant experience; it becomes difficult even to distinguish between legalistic nit-picking and significant differences of opinion. However, in its spirit and in its major thrust, as I interpret the document, I feel that it represents a real step in a highly desirable direction.

1. It places responsibility for meeting this enormous area of problems on a far higher level of authority than before giving needed visibility to problems and program and the first real possibility of action commensurate with the need.

2. It is not limited to one doctrinaire position or labeling. It specifies alcoholism but it does not limit itself to just that segment of the real problems.

3. Although placed in the realm of mental health (a positioning perhaps required by the extraordinary complexity of the Federal Government) it clearly recognizes that a much broader scope is required. To achieve this scope and still meet the needs of specific governmental positioning, it proposes two structural processes, each of which is to have adequate staffing and top governmental representatives.

The first of these is a committee consisting of leaders from the public at large, leaders representing experience, disciplines, responsibilities and motivations far, far broader than those just within mental health or just within health or just within the combination of health, education, and welfare, a group which will not be a mere appendage to the bureau or institute being established.

The second structure is that of a Federal intragovernmental coordinating group in which those many other Federal departments and independent commissions such as Treasury, Transportation, Defense, Justice, Civil Service, poverty programs, and on and on, all of which not only meet problems related to alcohol but even have their own relevant programs, will be able and will be formally called upon to play an increasingly cooperative and knowledgeable role.

Without the recognition that the proposed institute was concerned with more than a psychiatric definition for alcoholism, with more than any one abstracted and single labeled problem of alcohol, and without the provision for these two high-level structures guaranteeing more than a single type of definition or approach, this will in my opinion be of far, far less value.

4. In addition to its thrust toward broad scope and coordination of effort issuing from a source of prominence and authority, I think this bill correctly emphasizes the need for gaining information about just what the problems are and for gaining information about what is in fact being done by those organizations attempting to do something.

The bill's specification of many of the types of approach and of many of the agencies involved indicates the recognition of these fundamental needs.

5. I think the bill recognizes the need for prevention of these problems related to alcohol, not just tidying or covering up.

6. I think it proposes leadership not only leadership by the Federal Government as such but, more importantly, leadership through many, many segments of our Nation as well as of many separated segments of our National Government.

Such national leadership is to be stimulated and continuously reinforced by governmental enabling action, but is intended to become a sensitive, active and responsible leadership influence not just for government but for all institutions concerned with these massive and costly problems in our society.

I would strongly endorse the passage of this bill.

Senator HUGHES. Dr. Bacon, I thank you very much for this excellent testimony this morning. You are aware of the different opinions probably better than any single person in the country and the different prejudices we have to work with.

Would you care to give an estimate of funding on this bill?

Dr. BACON. I was very much in favor of a certain remark you made about starting at a certain level and going up, rather than starting with one set figure that would resolve all the problems forever.

The figure \$100 million has been mentioned. I would think that for a start, considering what personnel needs are, the breadth of the problems concerned, and particularly thinking of starting rather than meeting service needs all over the American country, you could effectively start out with \$100 million.

This is not going to meet the service needs of Boston, or New Jersey—that is most unlikely—but it would get us an idea how much the programs cost, and give the Federal Government a notion of what the ball park costs are for different sorts of programs and activities and how much it costs to evaluate them.

Senator HUGHES. In the field of valuation and statistical reference, which you spoke to adequately in your paper, is there really no reliable figure in America today that we can base ours on?

Dr. BACON. We use modifications of the Jellinek formula, but we only use it for developing what I call ball park figures, and in many areas of this country, say in a population area including half a million people, whether they have 4,000 alcoholics or 14,000 alcoholics really does not matter much. They really are not doing anything for

them. They really need to get started. It would be helpful to have the exact figure but the exact figure will follow upon their starting to do something, rather than vice versa.

Senator HUGHES. In your research do you accept the concept of illness with relationship to the alcoholic problem?

Dr. BACON. In a limited way, yes. I accept it as an illness, but it is much more than an illness. I think it is a great weakness to start arguing about whether it is or is not a disease or an illness.

I can live quite happily not being a professional in this field, with either. But I would refuse to agree that it was only an illness or only a disease. It is a condition which affects so many other people in so many aspects of life ordinarily considered to be rather beyond the direct responsibilities and know-how of medical and health professions.

I just can't allow that it is only a disease. It is more than that.

Senator HUGHES. Section 101 and several subsections would attempt to spell out the role law enforcement has in relation to this problem. What do you feel that role probably should be?

Dr. BACON. I would go a little beyond what I believe Dr. Chafetz said when he pointed out the police or law enforcement people could serve to find and send people toward help.

I think they have much more of a responsibility than that because I think alcoholism and other alcoholic problems are more than a disease. I think there is a disorder problem. I think there is a property safety problem, a life safety problem, in which the police are directly involved as such.

It really does not for that purpose matter whether the person is sick or not. I may be run over by an alcoholic or by somebody who for the first time in his life has had too much to drink.

It hurts just as much. I think these elements beyond individual health are very important. We must help the sick people. We must also help society.

Senator HUGHES. The bill provides that the authorities given must be administered by the Secretary through NIMH and the grants would be approved by the National Advisory Mental Health Council. Do you feel this is the proper place to put it?

Dr. BACON. I would like to feel that the mental health council for this area of problems had, in addition to what it already has, which is good, it have also, expertise, advice and counsel from many other professions or groups who are distinctly interested in these problems.

I don't think the mental health approach is the only approach to these problems, and therefore I would not want to see a narrow interpretation of policy from the group.

Of all of various groups you could pick, if you were going to pick one, I imagine you would pick this one. I would certainly feel that the public mental health aspects should be very strongly emphasized.

Senator HUGHES. I have been a little concerned about that myself. Do you think section 401, dealing with the Federal employees is one that is necessary?

Dr. BACON. I have not questioned that there is need for it. One of the major reasons for my supporting the bill is this intergovernmental coordinating council, is the plan to involve responsibility, thinking and action among all the many relevant Federal agencies.

Senator HUGHES. I have never yet been able to find out what all the departments are doing. I gradually uncover a program here and there.

Even the agency heads don't know what is being done. Right now the Post Office Department, on the basis of results of a pilot test program in the San Francisco Post Office, is expanding its program for alcoholics to 75 different post offices.

Do you feel the same way about insurance coverage as discussed in this legislation?

Dr. BACON. I would feel inasmuch as what we are talking about in an illness and a disease then on that level a program for medical insurance is fine.

I do feel that in the case of addictive materials, one has to discriminate between the people who will use such help for recovering and those who will use help to increase their disease. I believe Dr. Block mentioned something of this question. I think that one has to consider such provisions in terms of the great realities of the particular condition. We don't want to set up a bunch of drunks who are going to be getting checks to maintain their alcoholic careers. I don't think this provides any great objection, however, to the insurance plan. This possible fault can be controlled.

Senator HUGHES. It would be sad to deny those that need it for recovery because there will be some that will take advantage of it. I think there are ways it could be worked out.

Do you agree with the provision that Federal funds should not be given to a hospital that discriminates?

Dr. BACON. I would agree, certainly. I would put a postscript on that, that hospitals that train medical students should if they refuse to accept alcoholics be the first to have their funds taken away from them, because if hospitals attached to medical schools do not have alcoholics, I don't see how you are going to get more than classroom, didactic teaching for doctors, nurses and other therapeutic personnel.

I think those hospitals are in particular need of having alcoholics as patients. It does not excuse any of the others.

Senator HUGHES. Do you agree with the funding provisions of the bill, or do you think it would be better to break it down in more specific ways regarding training and education, treatment, research and so on?

Dr. BACON. I have a feeling that one can freeze in, not particularly the words one uses, but the way they are interpreted by particular bureau heads, so that I would like to see a certain amount of flexibility allowed.

We are always going to have this problem, and I am afraid I am going to retreat, the way some of your other witnesses retreated from coming out with a cut and dried statement. But I would like to have a great deal of breadth and statesmanship, if you like, at the top, with flexibility for the administrator.

Senator HUGHES. There is some thought that you can get more money when you make a breakdown.

The problem is how can we most influence the committees involved with it? How can we get the best funding?

That is what I am dealing with, rather than whether the man on the top is going to make the right decisions.

Dr. BACON. As long as it was not too rigid, I would not be uncomfortable with a certain amount of specification there.

Senator HUGHES. Would you prefer that we add to the authority under the mental health centers act, or would you prefer the provisions in this bill?

Dr. BACON. I would prefer this act. That is a particular and worthwhile system, but to put all confidence in one system for alcoholics and to have all groups in America adopt this system, this I find hard to accept. I would much rather have it done the way it is here.

Senator HUGHES. Is there anything further we ought to incorporate into this bill, Dr. Bacon, that we have left out?

Dr. BACON. I might make one comment because I don't believe anybody else has talked about it. There is quite a bit on education in this bill.

I find that all the educational thrust is toward teaching about alcoholism and alcohol abuse. In contrast I would say that the appropriate function for education is to teach about the phenomena, in this case alcohol and its use, including abuse.

If we restrict education to nothing but a recitation of evils, deaths, diseases, and the like, I think we will be right back where we were in the last 150 years of education.

I think we must teach about the use of alcohol. And this will of course include material on what we call problems. If the program is limited to evils, abuses, and illness, then there will be indoctrination, not education, and it will be viewed by teachers and students as straight propaganda of a punitive sort. I think this section could be helped by a mere change in words here and there so that in addition to abuse and "ism" one teaches youth about alcohol and drinking.

Senator HUGHES. Teaching is going to be a problem, really, and developing a curriculum for teaching.

If you have any further suggestions that might be helpful to us, I would appreciate your submitting them, in writing, to the committee staff.

Dr. BACON. Yes, sir.

Senator HUGHES. Thank you very much for being with us, Dr. Bacon.

We were scheduled to hold hearings tomorrow morning. Those hearings have been postponed until Monday morning at 9 a.m. in room 4232. I thank you all for being with us.

The hearing is closed.

(Whereupon, at 11:25 a.m. the Special Subcommittee on alcoholism and Narcotics adjourned, to reconvene at 9 a.m., Monday, May 25, 1970.)

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ALCOHOL ABUSE AND ALCOHOLISM PREVENTION, TREATMENT, AND REHABILITATION

MONDAY, MAY 25, 1970

U.S. SENATE,
SPECIAL SUBCOMMITTEE ON ALCOHOLISM AND NARCOTICS
OF THE COMMITTEE ON LABOR AND PUBLIC WELFARE,
Washington, D.C.

The subcommittee met at 9:15 a.m., pursuant to notice, in room 4232, New Senate Office Building, Senator Harold E. Hughes (chairman of the subcommittee) presiding.

Present: Senators Hughes and Javits.

Staff members present: Wade Clarke, majority counsel; Richard J. Spelts and Jay Cutler, minority counsel.

Senator HUGHES. The subcommittee will come to order. The Chair wishes to apologize to you gentlemen for canceling the hearing Friday but due to unforeseen circumstances, I had to cancel.

Senator Javits is on his way up here from another meeting but I would like to have his statement printed in the record at this point.

STATEMENT OF HON. JACOB K. JAVITS, A U.S. SENATOR FROM THE STATE OF NEW YORK

Senator JAVITS. These hearings on the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (S. 3835) sponsored by Senator Hughes, Senator Moss, and myself—and a bill with the backing of more than 40 Senators from both parties and the active support of the North American Association of Alcoholism Programs and the National Council of Alcoholism—mark a critical turning point in the way the American people choose to deal with alcoholism, America's third largest public health problem.

It is a major step forward in the campaign Senator Moss of Utah, myself, and others, both in the Congress and out, have been waging since 1966 to establish alcoholism as an acknowledged illness which needs to be treated on the basis of medical care, research, and rehabilitation—as well as cure—rather than on the revolving door basis of a police station, which is all too often the only form of treatment available today. Working toward this goal, Senator Moss and I had introduced the Javits-Moss Alcoholism Care and Control Act of 1969—a substantial portion of which has been enacted into law (Public Law 91-211)—and we must continue to move forward.

The energy, dedication, and leadership of Senator Hughes, Chairman of the Alcoholism and Narcotics Subcommittee—in conducting extensive hearings on the impact of alcoholism in New York and other major cities across the Nation—has now brought us to the point where we have before us a legislative proposal, S. 3335, which can establish a massive, all-out Federal commitment to treat, control and prevent alcoholism in the United States.

In order to view in proper perspective the urgent need for this legislation—to establish this commitment at the Federal level to meet the sociomedical challenge in the treatment of alcoholism—let's take a look at the facts.

The United States has one of the highest rates of alcoholism in the world. On the basis of several estimates, the number of alcoholics in the United States has been placed between 4 and 6 million; however, recent studies indicate that this often-cited figure more accurately should show 9 million Americans suffer from the compulsive overuse of alcohol. And none of this takes into consideration the effects on the families and the children of the alcoholics—the hopelessness and despair which exist in many of them—which continues day after day over a period of many years.

In addition to the human costs and the fact that the life expectancy of an alcoholic has been estimated to be about 10 to 12 years less than the average, the economic losses resulting from alcoholism are great.

In economic terms, a recent estimate prepared by the Health Department came up with these loss figures for New York City alone:

	<i>Millions</i>
Welfare costs.....	\$150
Lowered job productivity.....	260
Yearly death (loss of record).....	210
Traffic fatalities.....	50
Injuries and property damage.....	210

It is estimated that more than \$4 billion annually is lost to U.S. industry as a result of wasted man-hours, inefficiency, and other deleterious effects of alcoholism and alcohol-related problems on the Nation's manpower at all levels of business management and labor. The tragic and unnecessary drain of human resources should rightfully be labeled, "Industry's \$4 Billion Hangover."

The time has come for the Congress to deal with alcoholism. I believe the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 sets our health priorities in realistic perspective and allows us to begin to act effectively in launching a national attack on alcohol problems.

Senator HUGHES. I am glad you are able to be with us again this morning, Dr. Egeberg, Dr. Miller, and Dr. Novitch. You may proceed with your testimony as you desire.

STATEMENT OF DR. ROGER O. EGEBERG, ASSISTANT SECRETARY FOR HEALTH AND SCIENTIFIC AFFAIRS, U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE; ACCOMPANIED BY DR. MORTON MILLER, SPECIAL ACTING ASSOCIATE DIRECTOR FOR SPECIAL COLLABORATION PROGRAMS, NIMH; AND DR. MARK NOVITCH, SPECIAL ASSISTANT TO ASSISTANT SECRETARY FOR HEALTH AND SCIENTIFIC AFFAIRS, HEW

Dr. EGEBERG. Dr. Miller is the Associate Director for special and collaborative programs at the National Institute of Mental Health. I am sure you know both Dr. Miller and Dr. Novitch.

Senator HUGHES. Yes.

Dr. EGEBERG. Mr. Chairman and members of the subcommittee: I am very pleased to have the opportunity to appear before you today to present the views of the Department of Health, Education, and Welfare on S. 3835, a bill to provide a comprehensive Federal program for the prevention and treatment of alcohol abuse and alcoholism.

First let me state that the Department is in agreement with the intent of S. 3835, and with the modifications we shall recommend, we support this legislation.

The chairman may recall, as I vividly do, that the first opportunity I had to appear before a committee of Congress as Assistant Secretary for Health and Scientific Affairs came last July 25 when I gave this subcommittee my views on the same subject that concerns us today—alcoholism.

At that time I said that one of our major priorities must be to create a national program to bring the alcoholic patient into contact with the kinds of help he needs so that we can check the progress of alcoholism in the individual and in our whole society.

If anything, I am more firmly convinced than ever of the absolute necessity for this Nation to address alcoholism for what it is, one of the most prevalent, destructive, costly, and tragic forms of illness in the United States.

The objectives of S. 3835 closely parallel the recommendations of the Secretary's Advisory Committee on Alcoholism. This distinguished group of individuals has devoted more than 2 years to a careful assessment of this problem and of the Department's recommendations and responsibilities and opportunities to deal more effectively with it. I would be happy to provide the subcommittee a copy of the Advisory Committee's recommendations, which have been reviewed and accepted by the Department.

(The document referred to follows:)

PROPOSED PLAN FOR IMPLEMENTING THE RECOMMENDATIONS OF THE NATIONAL ADVISORY COMMITTEE ON ALCOHOLISM

This proposal is specific in its response to the National Advisory Committee on Alcoholism and the recommendations approved at its meeting on January 29-30, 1970.

The recommendations are sound and can be realistically adopted and implemented. This proposal contains specific plans to implement those recommendations and calls for action in the following ways:

1. Reactivation of the Intradepartmental Coordinating Committee on Alcoholism.

2. An expansion of existing research, training and education programs within the NIMH.

3. The development of more balanced priorities within the programs mentioned above.

4. The addition of adequate staff to assume new and necessary functions.

5. The implementation of a program to cope with alcoholism among DHEW employees.

6. The establishment of a Division of Alcoholism and Alcohol Problems within the NIMH.

The following is an outline of proposals in response to each recommendation made by the National Advisory Committee on Alcoholism:

I. GENERAL POLICY RECOMMENDATIONS

Recommendations

(1) The control and prevention of alcoholism requires the mobilization of the entire Federal enterprise. There is needed a systematic review of each relevant organization of the Federal government in order to identify current activities, obvious gaps and needed additional functions, necessary or desirable legislative or regulatory changes, budgetary implications and desirable liaison and coordination between departments. This will require a directive from the top level of government.

(2) There is need for greater involvement and more coordination of activity among all major units of the Department of Health, Education, and Welfare so that appropriate attention to alcohol problems can be routinely included in all relevant activities. This will require a directive from the Secretary and coordination through the Secretary's office.

(3a) The problems of alcohol are so *vast* and so interrelated with other serious human problems that their ultimate control and prevention depends on their inclusion as the responsibility of the *mainstream of health and welfare resources*.

(3b) At the same time, because the problems of alcohol have been so *long neglected*, there exists serious *limitations of basic knowledge and techniques* and serious *shortages of personnel* with the competence, sophistication and motivation required to apply existing knowledge. In order to fill in these gaps an *intensive and immediate categorical investment* must be made in

i. *Basic research* on alcohol problems

Proposed Action

(1 and 2) Reactivation of the Intra-departmental Coordinating Committee on Alcoholism at the impetus of a directive from the Secretary with an accompanying policy statement.

(3a) Reactivation of Intradepartmental Coordinating Committee on Alcoholism; additional liaison with NIMH alcoholism staff; training of State and community personnel; full implementation of the Alcoholic Rehabilitation Act (90-574) as amended.

(3b) Expansion and rebalancing of emphasis and priorities of existing programs administered by NIMH.

i. Expand existing extramural program by \$1 million and expand intramural research activities by \$200,000.

ii. *Experimental or model programs of treatment, rehabilitation and education.*

iii. *Training of professional personnel in a wide variety of areas; (medicine, public health, psychiatry, psychology, social work, police, education, law, etc.)*

ii. Expand existing program by \$4 million specified for experimental or model programs of treatment and rehabilitation; initiate concerted program to establish and evaluate experimental or model education programs through grants, contracts, and staff leadership (\$1 million).

iii. Expand existing training program pursuing a carefully planned strategy.

II. SPECIFIC RECOMMENDATIONS

Recommendations

(1) The Department of Health, Education, and Welfare should develop, promulgate, and implement an enlightened personnel policy on alcoholism for its employees. (This is #1 priority and was discussed with Secretary Finch and Assistant Secretary Egeberg by Jim Kemper and T. P. Pike.)

(2) All departments of the Federal Government should be directed to develop model plans for the prevention and treatment of alcoholism among their employees.

(3) General hospitals receiving Federal funds should be required to eliminate any discriminatory policies or practices toward alcoholic patients and to assume their appropriate and vital role in the spectrum of community resources available to treat alcoholism on a continuing basis.

(4) The Federal Government should assume leadership in assuring the specific inclusion of provisions for alcoholism in plans for prepayments or insurance of medical and hospital care.

(5) The National Advisory Committee has recommended that funds supporting the Center for Control and Prevention of Alcoholism should be increased from seven to twenty million dollars per year. This is still a very small investment in an attack on one of the Nation's most severe problems with its millions of victims and devastating economic loss.

Proposed Action

(1 and 2) Establishment of formal program for DHEW employees; possible legislation; Intradepartmental Coordinating Committee; liaison with other Departments.

(3) Intradepartmental Coordinating Committee; full implementation of Community Mental Health Centers Act; training programs and projects.

(4) Leadership by example (DHEW employee program); leadership and consultation by expanded NIMH staff.

(5) Expansion of existing programs; initiation of new programs; creation of funding balance between support of training and support of research.

Because the Committee is informed that a large volume of approved training grant support has been approved but not funded, it recommends that the current ratio of approximately \$6 in research support to \$1 in training support be readjusted to provide greater support of training commensurate with the ratio of approved grants for research and training in other areas. With even a modest increase in funds, this adjustment could be accomplished without compromising support for important and essential basic research.

In order to most effectively implement all the Committee's recommendations, a Division of Alcoholism and Alcohol Problems should be established within the NIMH.

NATIONAL ADVISORY COMMITTEE ON ALCOHOLISM

- Dr. David B. Auran, 242 Lowry Medical Arts Building, St. Paul, Minnesota, Expiration: June 30, 1971.
- Honorable Karl Davis, Retired Judge, Superior Court, 1307 Marian Lane, Newport Beach, California, Expiration: June 30, 1971.
- Dr. Harold W. Demone, Jr., Executive Director, United Community Services of Metropolitan Boston, 14 Somerset Street, Boston, Massachusetts, Expiration: June 30, 1971.
- Mr. G. Carlton Edmonds, Route 2, Box 79, Chapel Hill, North Carolina, Expiration: June 30, 1971.
- Dr. Raymond Dalton Fowler, Chairman, Department of Psychology, University of Alabama, University of Alabama, Expiration: June 30, 1972.
- Dr. Douglas Ewing Jackson,¹ Professor, Sociology of Religion, Perkins School of Theology, Southern Methodist University, Dallas, Texas, Expiration: June 30, 1970.
- Mr. John G. Jasper, Director, New Mexico Health and Social Service Department, P.O. Box 2348, Santa Fe, New Mexico, Expiration: June 30, 1972.
- Mr. James S. Kemper, Jr., President, Kemper Insurance Group, 4750 North Sheridan Road, Chicago, Illinois, Expiration: June 30, 1972.
- Dr. LaSalle D. Leffall, Jr., Assistant Dean, College of Medicine, Professor of Surgery, Howard University, Washington, D.C., Expiration: June 30, 1972.
- Mrs. Marty Mann, Founder-Consultant, National Council on Alcoholism, 2 Park Avenue, New York, New York, Expiration: June 30, 1970.
- Dr. John R. Philp, Orange County Health Officer, P.O. Box 355, Santa Ana, California, Expiration: June 30, 1970.
- Mr. Thomas P. Pike, Chairman, The Fluor Corporation Ltd., 611 West Sixth Street, Los Angeles, California, Expiration: June 30, 1972.
- Mr. Ernest A. Sheperd, Chief, Alcohol & Drug Abuse Division, Connecticut Dept. of Mental Health, 51 Coventry Street, Hartford, Connecticut, Expiration: June 30, 1970.
- Dr. John S. Sinacore, Chief, Bureau of Health Education, The University of the State of N.Y., The State Education Department, Albany, New York, Expiration: June 30, 1972.
- Dr. Cecil L. Wittson, Dean, College of Medicine, University of Nebraska, Omaha, Nebraska, Expiration: June 30, 1972.
- Dr. Edwin M. Lemert, Professor, Department of Sociology, University of California at Davis, Davis, California.

Dr. EGEBERG. The very fact that this group of advisers saw the need for actions very similar to those proposed in S. 3835 is the basis for our welcome support of the bill now under consideration.

Mr. Chairman, we have had a relatively brief time to examine S. 3835 and to assess its implications, which are indeed wide ranging, and we are now preparing a comprehensive report on the bill and we will provide that report as soon as possible.

¹ Mailing Address—7344 Fieldgate Drive, Dallas, Texas 75230.

(The departmental report from Health, Education, and Welfare may be found on page 60.

Dr. EGEBERG. In the meantime, however, I would like to outline some initial changes in the bill that we believe are both necessary and appropriate. Our recommended changes are aimed at two objectives: to render the Department of Health, Education, and Welfare better able to carry out the purposes of the legislation and to reconcile more effectively our present authorities with those proposed in S. 3835.

I hope that the changes we are recommending will be considered by the subcommittee in the spirit in which they are made, namely a desire to develop the most effective legislative base for necessary expansion and improvement of Federal alcoholism activities. We would welcome the opportunity to work closely with the members and staff of the subcommittee toward that objective.

At this point, Mr. Chairman, it would probably be appropriate for me to launch into a sweeping description of the nature and the extent of the alcoholism problem in the United States.

But I think you will agree that is hardly necessary.

The members of this subcommittee, under your dedicated leadership, Senator Hughes, have developed a thorough body of knowledge about the problem of alcoholism and the scope and effectiveness of efforts throughout the Nation to deal with it.

I could cite statistics on the probable number of alcoholics, on the economic impact of alcoholism, on the demand that this health problem places on our health care system, and on the extent that Federal, State, and local agencies are able—or are unable—to meet their responsibilities for prevention, treatment, rehabilitation, public education and a host of other essential activities.

To do all that is I think, at this point in time, unnecessary. If this subcommittee were not well aware of these facts and deeply troubled by the picture they paint, the chairman would not have introduced S. 3835 and we would not be here testifying on it today.

As I have indicated, the bill covers many of the subjects and problems that have concerned the Secretary's Advisory Committee on Alcoholism and on which the committee has made firm and constructive recommendations.

For example, the Secretary's committee has recommended that the alcoholism activities of the National Institute of Mental Health be given a more prominent place within the structure of NIMH in order to increase their effectiveness and assure better coordination and management.

Doubtless these same concerns underlie the provision in S. 3835 that would establish a National Institute for the Prevention of and Control of Alcohol Abuse and Alcoholism within NIMH.

Mr. Chairman, I am pleased to report that we are now taking steps to elevate the National Center for the Prevention and Control of Alcoholism to the level of a division within NIMH, immediately under the NIMH Director.

We feel that this is a more desirable choice than would be the creation of a separate institute. We would prefer to give alcoholism activities a more prominent place in the organization of the Department without duplicating managerial and planning functions now being carried out by the Office of the Director of NIMH.

With the addition of much needed staff, the new Division of Alcohol Abuse and Alcoholism will be in a much better position to develop and implement a wide variety of necessary programs.

As part of the NIMH it can continue to draw upon the considerable biologic and behavioral science resources of the Institute as well as see to it that the Community Mental Health Centers program will accord appropriate attention to providing services for persons with alcoholism problems.

Since Division status would accomplish these objectives, we recommend that the provision of title III calling for a new institute be deleted.

We have no major objections to the provisions of title III concerning the functions and responsibilities of the Secretary under the bill. In fact, they generally reflect recommendations expressed by the Secretary's Advisory Committee which the Secretary has reviewed and accepted.

Title III presents the duties of the Secretary in rather great detail, and we will, in our report, offer some suggestions to simplify and clarify the Secretary's responsibilities under the legislation, particularly his responsibilities for coordination of Federal activities.

However, we feel that this title provides a comprehensive base on which the Secretary could effectively carry out his responsibilities related to alcoholism.

Title IV of the bill concerns the problem of alcoholism among Federal employees to which we and the Secretary's advisory committee have also devoted considerable attention. We defer to the Department of Defense, the Veterans' Administration, and the Department of Justice on the aspects of this title that fall directly within their jurisdiction, that is, those portions of the bill pertaining to military personnel, veterans, and inmates of Federal correctional institutions.

I do have some general comments to make with respect to alcoholism and the civilian employees of the Federal Government. We endorse the proposals in S. 3835 that are aimed at making the Federal Government a more responsible employer insofar as the personnel policies and attitudes regarding alcoholism are concerned.

More detailed comments on these aspects of the bill will be furnished by the Civil Service Commission, which has statutory responsibility for Federal employee benefit programs, and for Federal employment policies generally.

If I may again refer to my statement before this subcommittee of last July 25, at that time I said:

There is a crying need for employee health programs to help detect and care for alcoholics. I think it is only reasonable for the Federal Government, one of the nation's largest employers, to strengthen its efforts toward the care of chronic alcoholics. . . . We ought to be a model for all of industry. I hope that we will be.

Under the leadership of the new Division we plan to implement a key recommendation of the Secretary's advisory committee which reflects, I think the clear intent of S. 3835. We intend to implement an enlightened personnel policy on alcoholism for employees of the Department of Health, Education, and Welfare, as a guide for other Federal agencies, State and local government and other public and private employers.

This program, which would involve every agency of the Department and will be accompanied by a clear policy statement by the Secretary, will focus on recognizing alcoholism as an illness symptomatic of underlying emotional disturbance, and should be viewed for all intents and purposes as any other illness.

We do not fire or refuse to hire persons with diabetes or heart disease. The same principle will be applied to those with alcoholism problems. At every level, supervisory staff and other employees will be trained to understand the signs and symptoms of alcoholism so that persons with alcoholism problems can be referred to appropriate treatment resources.

Particular emphasis will be given to improving the ability of health units in Federal agencies to recognize problem drinking. Agencies will be encouraged to follow the lead of the Secretary in creating a departmentwide climate of the understanding and encouragement to eliminate the social stigma that has too long been associated with alcoholism and has acted as a barrier to constructive action.

I want to make it clear, however, that the Department's specific concern for any individual's drinking practices will begin only when they appear to result in unsatisfactory job performance.

A key first step has been taken to insure that employees referred for counseling and treatment will have no financial barrier to obtaining needed services.

Almost all carriers participating in the Federal Employees Health Benefits Program have already provided, or are in the process of providing nondiscriminatory treatment for persons with alcoholism problems. Approximately 80 percent of Federal employees and annuitants already have such coverage.

An extremely important consideration in developing a new departmental approach to the alcoholism problem lies in the need to provide confidential handling of the diagnostic and treatment process. To this end we believe that the provisions of the United States Code which bar the hiring or the retention of persons who habitually drink to excess should be repealed.

We strongly endorse this provision of S. 3835. Such a change would not deprive the Government of its authority to separate or refuse to hire persons for good cause.

It would, however, make the Federal law consistent with the concept that work performance as well as other standards regarding suitability—not the presence of an illness—should be the principal criteria governing Federal employment.

I would like to point out that section 401(c) would make the Secretary responsible for identifying sensitive positions in the Federal agencies.

This function should remain the responsibility of the Civil Service Commission and the individual agencies.

Although we concur with the objectives of sections 405 and 406 that would assure access to needed treatment to Federal civilian employees as well as to persons charged with the commission of Federal offenses, we would recommend against extending direct Federal health services to achieve these objectives; to do so would controvert the current Federal policy of limiting such services to those for whom the

Federal Government has had longstanding direct health care responsibilities.

We feel that it is more appropriate to encourage and support the development of community resources to aid the individuals covered under this title.

Mr. Chairman, the Department must defer, for the time being, its comments on title V of the bill. Obviously beneficiaries of federally aided health and welfare programs must have full access to alcoholism treatment and rehabilitation services.

More than 30 million people are covered by these programs. Although we are, within the resources available to us, providing alcoholism treatment and rehabilitation services to the elderly, the indigent, and the disabled, the expansion of these activities envisioned by title V requires the most careful advance consideration.

We simply have not had sufficient time to assess the implications of the title and for this reason we must defer our specific comments until a later time. We will present our comments on these provisions to you as soon as practicable as a part of our formal report on S. 3835.

I would like to make one observation about title VI of the bill concerning Federal assistance for State and local programs. Section 604, which provides for grants and contracts for the prevention and treatment of alcohol abuse and alcoholism contains provisions most of which are already embodied more effectively in the Community Mental Health Centers Act.

Our principal objection to the language of the bill is that it fails to require that services be linked to form a comprehensive continuum of care.

There would be no legislative sanction to preclude the development of splintered, isolated, and fragmented programs. Thus section 604, if enacted, in its present form, would fail to promote—and indeed in this might hinder—the development of rationally organized services.

The alcoholism rehabilitation amendments to the Community Mental Health Centers Act were specifically designed to provide continuity of care, to preclude the chronic problem of the patient's "falling between the cracks."

By not providing for easy access and transfer between and among service components, S. 3835 would even jeopardize the core concept of our current alcoholism programs.

Additionally, the bill would provide less than the currently available Federal share for support of certain activities, which we feel is inadvisable. We must also oppose the provision of section 604 which would allow grants to private organizations unless it were altered to specify that these organizations be nonprofit.

With respect to titles VII and VIII of the bill, we clearly favor improved coordination within the Department of HEW and among Federal, State, and local units of government. In our formal report, we will offer some specific recommendations intended to clarify the responsibilities outlined in these titles.

Mr. Chairman, when I appeared before this subcommittee last July, I pointed out that our lack of research knowledge was exceeded only by our inadequate efforts to apply what we already know to the

detection, prevention, treatment, and rehabilitation of the victims of alcoholism.

Our budget request for fiscal year 1971 is a clear indication that we are moving to fill these gaps. We have singled out research on alcoholism as a high priority area and are recommending an increase of over \$1 million for this work.

We are convinced that only through the careful and systematic investigation of the biologic, psychologic, and sociologic aspects of alcoholism can we be assured of finding the key to understanding the cause of and cure for this serious problem.

To facilitate the development of adequate community resources we are requesting \$6 million in fiscal year 1971 to implement the Alcoholism Rehabilitation Amendments Act of the Community Mental Health Centers Act.

These new funds, together with funds appropriated late in fiscal year 1970, which are available for 2 years, mean that we will have over \$9 million to initiate and improve badly needed prevention, treatment, and rehabilitation services at the community level.

If Congress makes the requested funds available, a new program of public education and information in the area of alcoholism will be initiated in fiscal year 1971.

There is a tremendous need for more and better programs and materials including publication, films and TV and radio materials to educate the public about the problem of alcoholism and to heighten public understanding that this is a treatable area.

On the basis of our experience in the area of drug abuse education we believe that this new program will stimulate more intensive awareness and action by State and local governments and agencies and the public.

Overall the budget of the NIMH National Center for Prevention and Control of Alcoholism will be doubled over 1968 if our budget request is approved.

Mr. Chairman, I will be the first to admit that I have been talking about only the beginning of what should become a much larger effort. At the same time I think that we're building on very firm foundations.

By the development of our alcoholism program in conjunction with the mainstream of health and mental health services we shall avoid, I trust, the unnecessary and expensive overlap and duplication of very scarce resources.

One of the principal obstacles that we have had to overcome in developing a meaningful Federal effort in this area has been the tendency to look for narrow and categorical solutions to a very complex medical, psychologic, and sociologic problem. At a time when the strain in our health resources has never been greater it behooves us wherever possible to link the development of new programs to existing resources.

In conclusion, Mr. Chairman, I want to reiterate our support for the objectives and many of the specific provisions of the legislation you have introduced.

As I have indicated, this legislation is aimed at many of the same goals identified by the Secretary's Advisory Committee on Alcoholism, which we also support. The need for effective action is clear. We look forward to working closely with you and your colleagues toward the

development of legislation that will gather wide public and congressional support and result in prompt enactment.

I will be pleased to answer any questions that you and members of the subcommittee may wish to ask.

Senator HUGHES. Do your colleagues have anything additional to offer before I start questioning? I look at this for the first time since you and I have been conferring on bills as a friendly statement, which supports generally the directions we are going, and I appreciate that very much.

How soon can you have this report ready for the subcommittee?

Dr. NOVITCH. I should think in the next 2 weeks, sir.

Senator HUGHES. I am intending to have markups on this legislation rapidly, Dr. Novitch, and I am hopeful that this bill will get through the Congress this year.

Dr. NOVITCH. Title V involves not only the Federal Government but all of the State jurisdictions, and we have to look at that title closely. We shall have the report for you as soon as we can.

Senator HUGHES. Thank you. I want to assure you that the members of the staff of the subcommittee will be more than happy to work with you as we go along.

I realize, Dr. Egeberg, that you have to put up a battle anytime you seek new funds for anything, with the Bureau of the Budget.

I am sure, also that all three of you are aware that the Office of Economic Opportunity has received in Congress earmarking of funds of \$10 million for this fiscal year, and \$15 million for the next, fiscal year.

Don't you feel that the Department of HEW should do better than OEO in the field of alcoholism?

Dr. EGEBERG. We are going to do things which are not going to take much budgetary help to get started in the Government. We feel if we can get started with this base, it will give us a chance to move forward quickly.

I would like to move forward as quickly as I can. Most of the institutes began this way, and most of the divisions under NIH began this way, and once they established their foundation, they grew rapidly.

One could always want more money, and I can't deny that I would like more money for this and other things.

Senator HUGHES. I intend to see that you get more money than you asked for in this, I assure you. I appreciate very much your general support of this legislation, and I realize that there has been an extreme tightening up of funding of programs in the overall governmental system. I think I know some of the pressures you are under, though I don't know all of them. I know, also, there is some reluctance to upgrade health programs in the midst of this funding battle.

What do you understand the administration's support of this legislation to involve? Does it mean that we can expect your active assistance and that of the advisory committee in moving the legislation through the Senate and the House?

Dr. EGEBERG. Well when I showed the Secretary the recommendations of the advisory committee, which came out within the last few weeks, and I think, by their coincidence with your aims, give added breadth and strength to what you are asking for, he was delighted.

He said, "I intend to make this something that I will work for personally," and I think you will find the Secretary will support this, and do everything he can to forward it, as quickly as he can within his power and along with his other responsibilities.

But he was particularly interested and pleased to be able to go ahead.

Senator HUGHES. Does this mean we can rely on your technical assistance also?

Dr. EGEBERG. I am sure. This would come from the NIMH and from the research going on in biochemistry, from pilot projects and other research. Is that what you mean?

Senator HUGHES. Yes.

Dr. EGEBERG. Yes, we would certainly be very happy to be helpful there.

Senator HUGHES. You have mentioned modifications which you feel ought to be made in this legislation. Would you be willing to provide those to us in writing.

Dr. EGEBERG. Yes.

In general. I covered them briefly, but they will come in the final report.

Senator HUGHES. These will be included in the report that Dr. Novitch has already mentioned?

Dr. EGEBERG. Yes, sir.

Senator HUGHES. Could you or members of your staff, Dr. Egeberg, explain in more detail why the creation of a division within NIMH is more preferable to you than the creation of an institute within NIMH, as is done in S. 3835?

Dr. EGEBERG. It is essentially for the same reasons I believed on the population studies issue. I think one can get off to a faster start. I think one can make use of the people already interested in the program and thereby draw others to it. I think the opportunities for education in an area, in which we are very short on personnel, are better if it has that attitude of belonging that goes with a division as opposed to an institute.

Now would you, Dr. Novitch, like to add to that, or would you, Dr. Miller, like to add to that?

Dr. NOVITCH. Not really. As Dr. Egeberg said earlier, most of the National Institutes started as categorical programs and then grew to institute status.

I think that it would be very difficult from an administrative standpoint to confer institute status on what represents, really, a new departure in alcoholism research treatment and prevention with an institute.

It would be easier, administratively, to start at division level and as it grows, perhaps consider establishing an institute at a later time.

Senator HUGHES. What sort of status would this division have, Dr. Egeberg?

How would it compare, for example, with cancer and heart disease and other major killers in America? You stated before this subcommittee last year that you considered alcoholism one of the major problems in America.

Dr. EGEBERG. Population, and alcoholism.

As you may have noticed, in our efforts to try to get off to a good start in population, we did not create an institute. At least not so far during this Congress.

But our efforts have been toward strengthening the ability and in that case a split ability within the Health Services and Mental Health Administration for services and within the National Institutes of Health for research.

To get a good start, Dr. Louis Hellman, who is Deputy Assistant Secretary for Population Affairs, believes that he has worked out something that is going to get him going much faster than if he had an institute, and the same arguments, I think, apply here.

Senator HUGHES. Describe this division to me. What will be its status, who will run it?

Dr. EGEBERG. It will be a part of the NIMH organization. Maybe you can tell them, Dr. Miller.

Dr. MILLER. It is hard to say at this point, Senator Hughes, what the organization of the division would be. In comparison the Institute has, I believe, eight major divisions, one of which is the Division of Narcotic Addiction and Drug Abuse.

The alcoholism center is at branch level. Its elevation to division status as well as increase in staff would permit us to develop a more expanded and vigorous program in all the areas which are covered in the legislation. It would certainly provide increased visibility which I think is important both from a symbolic and a programmatic standpoint.

Senator HUGHES. How about funding?

Dr. MILLER. From the standpoint of funding, all of the divisions within the institute by and large come within the broad budget of the Institute. We do not have specific line items, except with a few exceptions within the institute.

Senator HUGHES. What are those exceptions, Dr. Miller.

Dr. MILLER. There are some relatively small accounts. Basically, we have research, training and a service line item in the budget. There are some smaller accounts for information and public education for narcotic addiction, which is a line item, but basically, the budget is just divided into research, training and services, and each year when we appear before the appropriations committees, in our congressional submission, we detail the budget for that purpose by the programs in the institute.

Actually, within the last 3 years, since I have been in my current job, the budgets for each of the special emphasis centers has been separated out for appropriations purposes, so that we report on our past year's expenditures and accomplishments in these areas as well as our future year's requests.

Senator HUGHES. I want to assure you that every question I am asking you this morning is friendly. Some of it may sound a little beligerent at times, but it is not intended this way. But I have been pushing for years. It is 10 months today, I believe, since you testified for the first time before this subcommittee, Dr. Egeberg—and we have been pursuing this subject, as you have. I have been pleased to see the comments you have made concerning alcoholism around the country in your speeches. It has helped elevate public cognizance and attention to this problem.

Until we get public support, we are not going to get the adequate programs that this country needs, and I know you have recognized that. You have recognized it by the testimony you have given here this morning.

Prior to this time, I had actually been prejudiced against putting any of this into NIMH as such, but preferred putting it under the Secretary. I feel I made a major concession in this bill by simply assigning it to NIMH, because in my opinion, the National Institute of Mental Health's track record in the field of alcoholism has been very poor.

I realize the pressures you had in development, and where you have gone with it.

Perhaps Dr. Miller can answer this question. What can we expect in the future?

Senator JAVITS. Mr. Chairman, could I have a minute?

Senator HUGHES. Yes. I want to defer to the Senator from New York, because I know he has problems that are pressing.

Dr. EGEBERG. Thank you.

Senator JAVITS. I regret that another commitment prevent my remaining at this hearing. I would like to do two thing; first, to pay tribute to the energy, dedication, and leadership of our chairman, Senator Hughes. I tried for years, with Senator Moss of Utah to establish a Federal commitment to fight alcholism and our efforts were well received and much discussed, but I regret relatively unproductive until Senator Hughes of Iowa came along.

I consider his action to be a real blessing for the country, and I give him all the credit in the world for it.

Secondly, I agree with him that things in NIMH can either live or die. It depends on who is running them. I have great confidence in Dr. Egeberg as Assistant Secretary for Health, with his concern about alcoholism, and I think we may have the touchstone there, as we did with Senator Hughes himself, for action.

But I do hope very much, because we are having the same problem in other areas, that when you finally do come up with your design, that adequate provision is made for the voluntary agencies around the country, and for the need to stimulate State agencies to action.

We now have examples in the consumer protection fields where we are going to encourage the State agencies with matching funds. et cetera.

We have had success on behalf of the national arts endowment, because of the very modest stimulus we gave them by disbursing Federal matching funds to the State arts agency. I hope very much that that will be done in the fight against alcoholism.

Finally, I think that there is an enormous amount of cooperative effort possible out of American business, and again, the Federal Government ought to more and more consider itself to be the lever rather than the operating arm exclusively. I hope enormous resources can be marshaled for this purpose and that the great need will be thought about. Because without adequate funding we will have very ambitious programs without, I am sorry to say to Senator Hughes because of his dedication here, ridiculously inadequate appropriations, and mountains of bureaucracy.

I want to see what he has so brilliantly initiated succeed, not be frustrated. Even though it may be written in law very eloquently, nothing happens unless you have the money and the organization and the will to do it.

Mr. Chairman, I would like to ask unanimous consent that at the opening of today's hearing my prepared statement may be put in the record.

Senator HUGHES. It will be included at the appropriate place in the record and I am sorry your plane was late.

The chairman wishes to recognize that the Senator from New York has pioneered in this field ever since he has been in the Senate of the United States, and he has contributed personally to almost every hearing we have held. He has continuously had members of his personal staff assigned to work with us.

It has been one of the great helps that we have had here. Our legislation is completely bipartisan. In addition, Senator Javits' human compassion carries over to many other areas, also.

I thank the Senator from New York.

Senator JAVITS. Thank you, Mr. Chairman.

Dr. EGEBERG. May I thank the Senator for his suggestions and assure him that we are going to pursue industry and everything.

Senator HUGHES. I think you share, my concern, Dr. Egeberg, that our history in alcoholism has been poor in this country at every level: National, State, community and even private organizations. I don't think we have to have perfection in every instance. I don't view that as possible. I don't know how you view it. I assume we are going to make some mistakes, and in making those mistakes, we will gain knowledge.

I want to congratulate you for your intention to implement the personnel program. I think it is a fine step, and I think HEW should be the agency to lead the way. I know we are all aware of splendid programs in various agencies that are doing a lot of good without any overall agency direction. The Post Office Department is a prime example. I know you are aware of their pilot program in San Francisco, and now their planned expansion of that into other areas of the country.

I feel, however, that the coordinating council is necessary, in order to make sure the agencies' programs work. Your agency will have a voice in all of the programs rather than merely developing an in-house program. I realize you don't have any statutory authority to do that, but certainly your influence ought to be used in a coordinating agency to do that.

On page 10 of your testimony, you mention that almost all carriers in the Federal health benefits program are in the process of providing nondiscriminatory treatment for persons with alcohol problems, and that approximately 80 percent of Federal employees and annuitants have such coverage.

What cost would be entailed if 100 percent of these persons were covered, as provided in this act?

If you are not able to answer that right now, you could submit it to us in writing.

Dr. EGEBERG. You mean that if, instead of 80 percent, it were 100 percent?

Senator HUGHES. Yes.

Dr. EGEBERG. Dr. Miller can answer that.

Dr. MILLER. Senator, I don't believe cost is a real issue. I think it is basically a question of negotiation of contracts with, primarily the prepaid group carriers, relatively small comprehensive health plans, which apparently need some time and help in gearing up of programs to handle alcoholics.

We have been working for some time now, with the Civil Service Commission in encouraging them to drop their discriminatory provisions regarding the mentally ill, and actually it was a result of that work in the area of mental illness which produced the change in the policy toward alcoholism.

That is, when they made their switch and dropped the provisions against the mentally ill, that they also drop them against alcoholism. To my knowledge, it is not a cost factor that relates to the other 20 percent, but merely a programmatic one.

Senator HUGHES. As a matter of fact, Dr. Miller, or Dr. Egeberg, don't most carriers cover the basic expenses under some other name anyway? What I am trying to say is that they are probably already covering 98 percent of it, and we are not talking about much in the way of cost. We are talking about the truth that alcoholism is the problem.

Dr. MILLER. This has been our experience, Senator Hughes. I tend to agree. I think it is not only healthier, but it makes programmatic sense to identify the actual cause of the illness rather than to use a subterfuge.

I think it is true that many carriers have provided this benefit under different guise, however, I think there is great advantage in bringing this out into the open and dealing with it on a direct basis. I think this is helpful not only to the statistical functions, but to the patient as well.

Senator HUGHES. Wouldn't it be helpful to national security as well? Doctors are putting people who are alcoholics into the hospital under some other diagnosis. They are worried about job security. If we can just correct the personnel practices it will be a lot easier for the physician to diagnose the illness for what it is, if the carrier provides the coverage.

What do you think, Doctor?

Dr. EGEBERG. I agree with you, Senator Hughes, that we should be honest. We should try to get the facts out, so that we can learn the size of the problem and have a ready, open, aboveboard acceptance of any kind of a problem and treatment.

There has been in the past a certain amount of subterfuge in many areas of health insurance notably, for instance, in order to get a gastrointestinal series, one has to find some way of getting a patient into a hospital, which makes the cost two or three times more than if it were done in the physician's office.

These things, I believe, are being more generally faced, and we would work with you toward trying to see to it that these things are changed.

Now, this business of the insurance comes really under civil service, doesn't it?

Dr. MILLER. They negotiate the contracts.

Dr. EGEBERG. Civil service does the negotiating, and we certainly will open discussions with them on this. You may have them come up before you later on in your hearings.

Senator HUGHES. Not at this time, Doctor, we won't.

Dr. EGEBERG. Then we will open discussions with them on it.

Senator HUGHES. Some people in the Congress are a little hesitant because of the cost factor involved in insurance coverage, for one thing, as well as the cost factor involved in care for the aged that we were talking about earlier, and which I will get to in a little bit.

But I think it is an insignificant cost factor. The coverage in fact is almost always being provided, and where it isn't being provided, personnel practices are to get rid of the person. That is an unwritten savings clause for the carrier and the Government.

I agree with your analysis that when you talk with someone about a drinking problem in your in-house programs, it is when it has an effect on their ability to work and produce and be what they should be. We are not trying to run around trying to dry up the world, nor should programs do that. I haven't seen your program, and I hope you will furnish a copy of it to me when you have a written project program for HEW on this, and the policies that will be followed, because it would be helpful to us.

In discussing the grant provisions in the bill, you mention that your principal objection to the language in the bill is that it fails to require that services be linked to formula comprehensive continuum of care. Section 101b states that alcoholism treatment and control programs should, whenever possible, be community based, provide a comprehensive range of services and be integrated with and involved with active participation by a wide range of Government and local agencies.

Are you suggesting adding language along this line, or are you suggesting that we drop the grant language and rely on the community mental health centers grants?

Dr. EGEBERG. I think we are looking toward building it up. But let me put in a word for community mental health centers. At the present state of development of the interest in alcoholism, I think one would get not enough people to handle the problem if we said, "Come in and work only on alcoholism." If we can associate it with other problems, emotional problems, many, many other problems, we will get people who probably will find an increasing interest in alcoholism, and after a while I think we will have a large pool to draw on to look at the problem, to help us solve the problem, to work on it, and to help train other workers at various levels. For that reason I think that when we use the words "community mental health" we are trying to get it in a setting where it will have strength, and I think it would probably take years to gain that kind of strength if we started it up alone.

Just this morning, I implied to Dr. Miller that scientists hadn't been adequately interested in alcoholism, and he took umbrage.

I must say that what has been done in the NIMH in looking at this problem, and bringing it to light, toward beginning to solve it, has been on a very solid base, and maybe I will let him mention that, because I think it is pertinent to our thoughts here of separating one thing from another.

Do you want to mention that and make your case?

Senator HUGHES. I think you had better, Dr. Miller. [Laughter.] I would like to hear your observations on it.

Dr. MILLER. This was not meant to blow my horn, Senator, as I am sure you know. I think that psychiatrists and the rest of medicine, as you have pointed out so frequently and persuasively have been like the rest of the Nation to the extent that attention has been paid to this problem.

There are many physicians who have not paid adequate attention to this problem. I do feel that we have made some—we have built a firm foundation in our program activities in the past 3 years. I do believe that, particularly now, with the great scarcity of health and mental professionals, it makes best sense to establish new activities within the context of service organizations which are already existent at the community level.

Basically, this is the point I have made before this committee, and have tried to make consistently. Our track record is indeed not the best, but across the board the track record has not been good in this area.

Dr. EGEBERG. What he said was, "What have the internists, specialists, or anyone else done?"

Senator HUGHES. Most of us have not done much. Admitting that is helpful, and now, given the capacity to do more, maybe money will be available. Part of that is the fault of the general citizenry, because they haven't been interested in the drunk, the guy sliding down the scale.

Dr. MILLER. I would concur with Dr. Egeberg that with an appropriate beefing up, which I think is the term to use, then the concerns that we have expressed can be taken care of.

As you know, in addition to the provisions of the Mental Health Centers Act which provides for support of services for alcoholics within community health centers, there are two other parts to that legislation, one which provides grants to programs where there are no mental health centers in the area, and a third, direct grants, which I believe was inserted at your suggestion in the last set of hearings.

We provide grants for new innovative activities.

I think my principal concern is that, as I read the bill, there is not enough sanction from the administrative standpoint behind the concept of comprehensiveness and continuity of care within title VI. This is my principal concern.

Senator HUGHES. You will have some suggestions to offer, I hope, along those lines, that we can consider, Dr. Miller.

Dr. MILLER. Yes, sir.

Senator HUGHES. You know, I am impatient. We have had approximately 5,000 years of recorded history in which the alcoholic is condemned. I agree we need a bill with a firm foundation.

But I would like to see some of them start living, and I don't want to spend the next 3,000 years building. I would like to see something done in the next year or two.

You mention you are requesting \$6 million in fiscal 1971 to implement the alcoholism portion of the Community Health Centers Act.

Four of our witnesses indicated last Thursday that, because money is so tight, we ought to be talking of only \$75 million to \$100 million.

I thought they were talking about pin money, myself, in relationship to what the real needs in this country are.

A psychiatrist testified he thought Boston alone needed \$21½ million. If we want to go around to the other big cities we can project that from there.

So, we have more than a slight difference of opinion on the needs of implementing this bill.

I would like to cite figures you are aware of, authorizations under the Community Health Centers Act. For fiscal year 1969, the authorization was \$15 million, and in the present budget, zero.

For 1970, it is \$15 million, and in the present budget, \$3 million.

For 1971, the authorization was \$30 million, and the present budget \$6 million. In 1972 it would be \$35 million, and in 1973, \$40 million.

The difference between the authorizations and the appropriations is always glaring. We all recognize that fact. As I have listened to the chairman of our committee state so many times, the Bureau of the Budget has 275 technical people competent in the Department of Defense, but they have four in the field of health.

Dr. EGEBERG. What?

Senator HUGHES. That is what I was told, Dr. Egeberg. I am not talking about your division, I am talking about the Bureau of the Budget.

Dr. EGEBERG. No; I am interested, however.

Senator HUGHES. If that is a fact, I think you ought to take a great interest in it. Am I accurate in quoting the Chair?

Maybe he said it was none, according to minority counsel, Mr. Cutler, that actually have any knowledge of needs in health funding.

Dr. EGEBERG. I am appalled at what you just said, and infuriated.

Senator HUGHES. I was appalled too, because we can't expect appropriations until we get someone in the Bureau of the Budget who recognizes what health needs are. I say that only in an advisory capacity. You may want to take note of it and follow through to see that there is someone in the Bureau of the Budget who has the technical knowledge to fight for what you need. I think you have been falling far short of what you have been fighting for, even though it may not be as much as I have wanted.

I point these things out because of the wide need. We recognize that in the beginning of powering up a program such as this we can't take vast sums of money and use it properly. Senator Dominick has pointed that out and Senator Javits. We can't use the same amount of money next year that we would use the next year in a program like this.

But if we are ever going to get into the act at all, we need enough money to gear up properly to do a decent job.

In section 101 g, h, and i, an attempt is made to spell out the role of law enforcement when it comes to alcoholism.

What do you feel that role properly is?

Dr. EGEBERG. You are referring to your bill here?

Senator HUGHES. Yes; section 101 g, h, and i.

Dr. EGEBERG. Yes; I see that. Criminal law is ineffective to deter what are basically health and rehabilitation problems, and so forth.

I come from a city where they were doing their best to turn even the acute alcoholic over to the department of hospitals and health, rather than to the police, and I haven't been able to find out how that has progressed lately, but I think that gives you the attitude of some of the bigger cities. They are beginning to make up to this.

If you have a personality who seeks solution to some of his problems in alcoholism, and you have another personality who seeks solutions to his problems in intense emotional efforts to solve other people's problems, or butting into them, one ends up sick with alcohol, and one sick with a stroke, and you have two sick people.

I think we have to repeat these things over and over again. I think we should say that when we mention this subject we are talking about something broader. I think when I testified before that I mentioned tuberculosis. It used to be considered very shameful to have what was then called consumption and people concealed it, and concealed the cough and helped spread the disease until about the turn of the century, or perhaps 10 or 12 years later, they began to bring this out into the open, and that is when they began to conquer tuberculosis.

We are in the same situation and I think that section 101g refers very much to that.

I think what I spoke to just now applies to section 101h, also, and it is going to take a lot of money locally. The communities still have responsibilities for health, and many of them are perhaps disproportionately high on alcoholics, and if we can give encouragement and backing, I think we will find them able to take broader care of alcoholics.

Certainly in Los Angeles County, with which I am familiar, if you were an alcoholic with any kind of a complication, you got good care. If you were acutely intoxicated, I don't believe that the proper method has yet been established for taking care of the poor who are acutely intoxicated.

In so many cases, if they are middle class, their families take care of them, or they have a place they can go. So, the poor suffer the most there, and we are trying to help the poor.

Senator HUGHES. If I understand you properly, Dr. Egeberg, what you are basically saying is that unless there has been some criminal act by the intoxicated person that the intoxicated person ought to have decent services as an alcoholic.

Dr. EGERBERG. I think it becomes a legal and financial maneuver to take that responsibility over to medicine. They say that to book a man in Los Angeles County costs \$100. All right, if the man has been booked 100 times for acute alcoholism, he has cost the county a lot of money that could have been used to a much better purpose if we had used a medical approach.

Senator HUGHES. I was sent a copy of the research project in Los Angeles, which showed a staggering financial burden on the county. I put it in the Congressional Record.

Dr. EGERBERG. That is how I became aware of the problem and very much interested in it.

Senator HUGHES. It shows, in one concentrated area, the extreme burden of alcoholism on the tax rolls, not to mention the human needs of the patients.

I think when we get enough of this sound research done, that people will be less reluctant to invest a little money into other methods of recovery.

Section 506 provides that Federal funds used to assist State and local governments in the prevention and treatment of alcohol abuse—can you find it there, section 506?

Dr. EGEBERG. Yes.

Senator HUGHES. It provides that use of Federal funds, and this applies to licensed drivers, will be used for the purpose of rehabilitation and so forth, and not for the purpose of punishment.

The question has been raised that this provision could preclude funds being spent for driver licensing and police courts and so on.

Do you have any opinion as to how far we should attempt to go in this area?

Dr. EGEBERG. I look back to what they did in Norway and Finland, and while they take extremely good care of the alcoholic, while they have a tremendous number of volunteers, probably ex-alcoholics who run an infinite number of clinics all over Finland, they still, in the case of driving, treat them very strongly. You may find one of your professors making little rocks out of big rocks on the highway, who was found guilty of driving with alcohol in his system.

The combination of efforts to correct, to treat, to get at the basic causes and to support make that a very important thing. We could, if we did something like that in this country, perhaps save half our traffic deaths.

Senator HUGHES. I agree that a lot can be done. The only question is, how. If you have any ideas in reviewing this legislation, please present them to us.

There is a provision in the bill under section 611 which provides that hospitals which discriminate against alcoholics should not be allowed to receive Federal funds. Do you agree there is a need for such provisions?

Dr. EGEBERG. Yes. I think if you are going to use alcoholism as a reason for not admitting a person to a hospital, I would agree with that. I think one has to realize that some hospitals are so full that they may have to use priorities such as degree of illness submitted by Senator Javits.

Senator HUGHES. I have a list of questions here that Senator Javits asked me to put in the record at this point and to give you a copy, Dr. Egeberg, and ask you to supply the answers. It probably would be more convenient for you and for us.

(The information referred to follows:)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
Washington, D.C., June 19, 1970.

HON. JACOB JAVITS,
U.S. Senate,
Washington, D.C.

DEAR SENATOR JAVITS: This letter is in response to the questions you raised on May 25, 1970, on the legislative objectives of S. 3835.

In regard to the issue raised by question number two, we would defer to the opinions of the United States Civil Service Commission.

Question 1: "What level of Federal funding would you estimate could be effectively used to meet each of the following legislative objectives of S. 3835:

- a. To stimulate research on control and prevention of alcoholism.
- b. To improve treatment services for alcoholics.
- c. To accelerate communication and application of research findings to research programs.
- d. To develop training programs for scientific professional and nonprofessional.
- e. To modify public attitudes through expanded programs of education."

Answer: The needs implied by the legislative objectives of S. 3835 are extremely substantial. A history of neglect by the Nation's health service system

creates a need for rather enormous Federal investments to seek solutions to the problems of alcohol abuse and alcoholism. A degree of professional judgment is required to estimate the level of Federal funding which could be *effectively* used to meet the legislative objectives of S. 3835. It is recognized that the Department has not requested authorizations or appropriations with these specific objectives in mind, and the following estimates are made exclusively on the basis of professional judgment relating to the *effective* use of Federal funds.

Objective:

Fiscal year
1972

(a) To stimulate research on control and prevention of alcoholism -----	\$2, 000, 000
(b) To improve treatment services for alcoholics -----	18, 000, 000
(c) To accelerate communications and application of research findings to research programs -----	1, 000, 000
(d) To develop training programs for specific professional (a) and nonprofessional (a) -----	5, 000, 000
(e) To modify public attitudes through expanded programs of education -----	1, 500, 000

Question 3: "Will the cost of Medicare and Medicaid programs be increased by declaring an alcoholic as eligible for coverage as provided for by Section 501 of the bill? If so, to what extent? If not, is this because in practice, alcoholism is already covered but defined as another form of illness?"

Answer: Medicare: Assuming that Section 501 applies only to alcoholics who are age 65 or over (since no provision is made to change the age requirement for eligibility under Medicare) and only to the hospital insurance plan (since essentially all persons age 65 or over are now eligible to enroll in the medical insurance plan), there would be no significant additional cost to the Medicare program. Possibly a small number who are ineligible under present law might be eligible under Section 501. Essentially, however, to the extent that alcoholics age 65 or over have need of the services covered under the hospital insurance plan and a physician certified to such need, the services are presently being provided.

Medicaid: Section D-5140 (Interpretation of Regulations) of the Handbook of the Public Assistance Administration states that "Limitations may not be set by eliminating certain groups of patients or certain diagnoses, from coverage." Thus, if an eligible Medicaid patient receives one of the basic five services or an additional service included in the State plan, coverage for his care and treatment is subject only to the usual limitations on such services. Therefore, if treatment is provided by a clinic which meets the State standards for licensing, it would be covered under Medicaid if clinic services are included in the State plan.

Section 501(b) of S. 3835 would mandate inclusion in State plans of a provision for the prevention and treatment of alcohol abuse and alcoholism. We question the advisability of singling this category of diseases out for mandatory coverage at the potential expense of other equally important disease categories. Enactment of this section would involve an increase in costs in those States which do not currently cover additional services (particularly clinic services). Information is not available at this time which would allow us to accurately forecast this cost increase.

Question 4: "Will the cost of social security disability benefits be increased by declaring an alcoholic eligible (as provided for by Section 502 of the bill)? If so, to what extent? If not, is this because in practice, alcoholism is already covered but defined as another form of illness?"

Answer: To be eligible for social security disability benefits a worker must be disabled as defined in the law and must meet the disability insured status requirements.¹

Section 502 of S. 3835 states that an alcoholic shall be regarded as eligible

¹ The social security law defines disability generally as the inability to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment that has lasted or is expected to last at least 12 months, or to result in death. A disabled worker is insured for disability benefits if (1) he has at least as many quarters of coverage as the number of calendar years that elapsed after 1950 (or the year he reached age 21, if later) and up to the year in which he became disabled; and (2) he had substantial recent work covered under social security before he became disabled. To meet the latter requirement, a worker disabled at age 31 or later needs at least 20 quarters of coverage during the period of 40 calendar quarters ending with the quarter in which he became disabled. (Workers disabled before age 31 can be insured with quarters of coverage in half of a period shorter than 10 years.)

for social security disability benefits and the benefits shall not be barred on the ground that alcoholism is a self-inflicted disability. As we see it, this language would not change the effects of present law and thus would not increase the cost of the social security disability provisions. However, if the language of this section were modified or were to be interpreted to permit an alcoholic to qualify for social security disability benefits without meeting the requirements of present law it would significantly increase the cost of the disability program. Moreover, there would be serious objections on grounds that provisions giving special treatment under social security to one category of impairment would be inequitable to persons with other types of serious conditions who do not meet the definition of total disability or the insured status requirements of present law.

Question 5: "Will the cost of vocational rehabilitation benefits be increased by declaring alcoholism as eligible for coverage (as provided for by Section 504 of the bill)? If so, to what extent? If not, is this because in practice, alcoholism is already covered but defined as another form of illness?"

Answer: Under the Federal-State program of vocational rehabilitation, alcoholics are accepted as eligible because alcoholism is recognized as an illness in itself and services are provided on the same basis as for any other disability. As is true for any disability category, costs increase as numbers accepted increase. However, alcoholism is not one of the more expensive disabilities for the rehabilitation program. While alcoholics require a substantial amount of counseling and other specialized services, relatively little physical restoration is involved.

Question 6: "Would you agree that a hospital has a community responsibility to admit and treat alcoholics on the basis of medical need and if it fails to meet this community responsibility, the facility should be 'cut-off' from any further Federal financial assistance (as provided for under Section 611 of the bill)? If not, why?"

Answer: Section 611 of S. 3835 provides that "alcohol abusers and alcoholics shall be admitted to and treated in private and public hospitals on the basis of medical need and shall not be discriminated against solely because of their alcoholism." The same Section further provides that "no hospital that violates this Section shall receive Federal financial assistance under the provisions of this Act or any other Federal law administered by the Secretary."

Federal policy which prohibits discrimination on the basis of diagnosis is valid and justifiable. It is our opinion that alcoholics should be admitted to medical care facilities on an equal basis as persons who suffer other illnesses and that alcoholics should not be refused admission on the basis of their alcoholism. We fully agree that hospitals should admit and treat alcoholics on the basis of medical needs.

Sincerely yours,

ROGER O. EGEBERG, M.D.,
Assistant Secretary for Health and Scientific Affairs.

U.S. SENATE,
Washington, D.C., June 2, 1970.

HON. ROGER O. EGEBERG,
*Assistant Secretary (Health and Scientific Affairs),
Department of Health, Education, and Welfare,
Washington, D.C.*
(Attention Dr. Mark Novitch, Room 4628 North).

DEAR DR. EGEBERG: When you recently appeared before the Senate Subcommittee on Alcoholism and Narcotics, I submitted a number of questions which Senator Javits had furnished to be answered for the record.

I would like to add the following questions to that list:

Federal emphasis has been placed upon a variety of major health problems, including heart and lung disease, cancer, alcoholism, mental illness, narcotics addiction and drug abuse, child health, allergy and infectious diseases, neurological diseases and stroke, and arthritis and metabolic disorders. How does the federal financial commitment to alcoholism compare with the commitment made to these other major health problems?

Thank you again for your positive expression of the Administration's attitude toward S. 3835. We will look forward to receiving your more detailed report on that legislation.

Sincerely yours,

HAROLD E. HUGHES,
Chairman, Special Subcommittee on Alcoholism and Narcotics.

(The information requested by Senator Hughes subsequently supplied can be found on p. 180.)

Senator HUGHES. There are things that we could pursue here all morning, but since our staffs are going to be working together on this legislation, I won't consider this any longer at this time.

I do want to thank you, and your colleagues also, for your interest and your dedication.

I hope when we come to the mark-up, we will have something we can all support, and that we won't be alienating one another.

One final question. I have given considerable consideration to joining this legislation with the drug legislation that you testified on earlier.

Do you think there should be a joining of the two problems? I know you are proposing a separate division now, rather than joining the two.

Previously I wouldn't even have considered this, but after a year of hearings there are so many basic similarities between the two problems that I have given it serious thought. I realize there are prejudices on both sides. Most alcoholics in the country and people working with them don't want anything to do with a narcotics addict or other drug dependent person.

We need both. If I join them, is it going to cause difficulties in your agencies?

Dr. EGEBERG. First, I think alcoholism is far too important to hang on the coattails of drug addiction. We have many millions of alcoholics in this country, and addicts are probably less than half a million. The users of other drugs is perhaps great, but not in the terms of alcoholism. I feel alcoholism should go forward on its own, and that we will gradually collect the others about it. I feel that at the present time trying to join the bills together might be difficult because we share with the Department of Justice quite a bit of our effort as far as drugs are concerned, and though we go along independently on many of the aspects, we do have a cross over there that I think might make it a practical difficulty to combine these bills.

Most of all, I think alcoholism itself is so desperately important to the whole country that one doesn't need to tie it with something else, and at the present time, the public feeling is all on drugs, and it would certainly look as if we felt we needed the strength of the drugs. I think this is strong enough of itself, and we can work up a real ground swell about this.

While I am talking, may I assure you that through all the verbiage that I have read to you today, which was never familiar to me until I came to Washington, I do personally feel dedicated to this, to helping you and this committee with this, and that our staff will work with yours. I think this bill is an excellent bill, with a few things that we have discussed here that we think might make it a little more awkward to do our job, and I assure you that the Secretary is deeply interested in this, and I thank you for the lead you are taking here.

Senator HUGHES. Thank you very much, Dr. Egeberg. I also believe that alcoholism should stand alone. I think it is of prime importance. There is a lot of stigma in both areas. Most people don't want to view alcohol as a drug for one thing, and they don't want the stigma attached to that.

I am more concerned about the fact that we are in a battle over here in the Congress over the administration's drug bill, and the bill I propose, and the differences between the two—I don't want to lose this piece of legislation in the process of battling over that one.

In all honesty, that is my basic concern right now. I do want to get all the funding we can get for both. I want to get the best workable programs for the people of the country we can get.

In the final analysis, I want to assure you that in spite of my antagonistic attitude sometimes, I want to work with you in both these areas.

Dr. EGEBERG. I thought you loved me all the time.

(Laughter.)

Senator HUGHES. I do, but I didn't agree with a lot of the things you were told to say over here. I hope you note the way I said that.

Thank you very much, gentlemen.

Dr. EGEBERG. Thank you, sir.

Senator HUGHES. The Chair calls Mr. Maxwell N. Weisman, director, Division of Alcoholism Control, Maryland State Department of Mental Hygiene, representing the National Association of State Mental Health Program Directors, and Harry C. Schnibbe, executive director of the National Association of State Mental Health Program Directors.

STATEMENT OF DR. MAXWELL N. WEISMAN, DIRECTOR, DIVISION OF ALCOHOLISM CONTROL, MARYLAND STATE DEPARTMENT OF MENTAL HYGIENE, ON BEHALF OF THE NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS; AND HARRY C. SCHNIBBE, EXECUTIVE DIRECTOR, NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS

Mr. SCHNIBBE. The State commissioners for the 50 State mental health programs have asked Dr. Weisman to represent them this morning. Dr. Weisman is recognized among us, among the commissioners of the State programs, as one of the most prominent authorities on alcoholism in State programs, so we are privileged to have him here, and he is speaking for the 50 State mental health programs.

The directors in the States, we are now treating in the State programs about 1.5 million patients a year. In the State of Maryland, and Dr. Weisman will probably tell you, almost 50 percent of the admissions in the State of Maryland are for alcoholism.

In several other States, it is almost as high, or is as high. I would say the average, probably then 30 percent of the admissions now into State mental health programs are alcoholics, which means that we are probably treating 400,000 or 500,000 alcoholics a year in the State mental health programs.

By the way, Senator, in regard to this, in the alcoholics treatment programs, in the State mental health systems, in virtually every case there they are separated and unrelated to the drug treatment programs.

I can't think of any place where they are combined. One other remark that I feel obligated to make: When we first received your proposed legislation, the first reaction of the commissioners was that, again, we were going to have a big Federal program here, possibly in

the terms that some of your colleagues have used, "raising false hopes" unless it is adequately funded.

This, as an ex-Governor, you note problems that the State program people have in working with legislatures on funding matching programs with Federal money, unless we have pretty good assurance in advance that there is real Federal money.

This makes it very difficult working with the legislature and I hope, and I know that Dr. Weisman will say that he is pleased with this legislation, regardless of the funding aspects of it, but I hope that we will all be able to work together and put money into the program, because the program, as you know, we have had several alcoholism programs through NIMH and they have been badly funded and as a result we have gotten very little going under these programs in the States.

We are especially pleased to see the section you have got which puts alcoholism formally into the medicaid programs and other programs, and ties them together, because 90 percent of the service money, the dollars that come into the State for treatment of the mentally ill, alcoholics, drug addicts, and so on, comes out in NIMH.

Ninety percent. It comes through medicaid, vocational rehabilitation, model cities, and the welfare programs. I know you have included a large section on welfare.

A lot of the money that comes in for treatment of patients comes in through these programs. As a final note, I am not so sure that the commissioners—I don't want to put the burden on Dr. Weisman—I am not so sure the commissioners agree with the section of your bill in which you put grant approval in the National Advisory Mental Health Council.

We have just resolved, only 7 or 8 days ago in San Francisco in a meeting that approval of these types of grants should be at the regional level, made by regional people, and not the National Advisory Mental Health Council.

One other thing, I do not notice now in the bill any percentage, 1 percent or 2 percent, or whatever it might be, to be dedicated to the States for administration of alcoholism programs.

What we traditionally get is a lot of work in these programs to develop State plans and so on, but then frequently very little money that can be used by the Governor at the Governor's level.

With that, Senator, I would like to have Dr. Weisman present his statement.

Dr. WEISMAN. Thank you, Mr. Chairman.

I must apologize for not having had time to prepare a written statement for submission to you, Senator, and the committee, and will beg your indulgence for speaking extemporaneously.

We, in the State programs throughout the Nation, feel strongly that your bill will actually be a "Bill of Rights" for the sick and suffering alcoholics in our country.

But I would like to reiterate Mr. Schnibbe's statement. We have often been promised beautiful programs in grandiose terms, without the opportunity to implement them effectively by realistic funding.

Now, having said that, I would like to add, as one who has worked closely with sick patients in treatment, that these millions of alcoholics across the land must be very tired of hearing professionals like myself hide behind any lack of funding as a rationalization for their

own ineptness in developing programs and their own deep lack of motivation.

I speak from sad experience for we were faced in the State of Maryland with a similar situation. Our Comprehensive Intoxication and Alcoholism Control Act was passed in 1968, and went into effect on July 1 of that year without a single cent appropriated toward the excellent program delineated in the law.

I applaud Dr. Egeberg's and Dr. Miller's statements that existing resources can and must be used in the service of alcoholics because that is precisely what we had to do. Without any funding during that first year, we went directly to the local health departments, to the grass-roots, where alcoholics live and work and get sick, and worked with them in developing the necessary programs.

It might be informative to examine some of the lessons we learned from this activity in Maryland. In Baltimore City, in 1964, there were more than 15,000 drunken arrests. In the first 10 months of 1969, only slightly more than 3,000 alcoholics came in contact with the police and correctional agencies and only about 500 of them were charged with disorderly conduct. Of those remaining, half were sent home by the police and the other half brought to general hospitals for treatment because they were incapacitated.

This, then, was a significant and welcome relief for the police and law enforcement agencies, but because the lack of funds prevented the development of services needed locally to treat alcoholics, there was an enormous increase in State hospital admissions of alcoholics. As Mr. Schnibbe indicated, in the State of Maryland, more than 50 percent of the admissions to State hospitals are alcoholics! It represents the largest single diagnosis and dramatically exceeds admissions for schizophrenia or any other diagnosis.

Our small staff of three professionals in the division of alcoholism control focused on educating the community about alcoholism. This, too, resulted in enormously greater case finding and referral of alcoholics for treatment than had taken place before the law was passed. Unfortunately adequate alternative facilities were not yet available in the community and admissions to State hospitals swelled. From the inner city, 66 percent of all admissions to State hospitals are for the diagnosis of alcoholism!

The communities certainly felt the pressures because in the second year the Maryland Legislature did appropriate a small sum. As a result, services are now proliferating for alcoholics. Outpatient services, for example, have quadrupled as of December 1969, compared to what they were in December of 1968.

Fifty percent of the general hospitals in Maryland are now admitting alcoholics under that diagnosis, a phenomenon which had not existed before our law was passed.

Perhaps the greatest lesson we have learned in Maryland from our need to develop services without funds lay in the innovative staffing pattern we developed perforce and by design.

We are utilizing nonprofessional alcoholism counselors in addition to other more traditional professional groups such as the clergy, the public health nurses, the general practitioners, the probation officers, the social workers, et cetera, to staff alcoholism clinics.

In Hagerstown, the alcoholism clinic operates without a single expensive psychiatrist or physician. It is staffed by one public health nurse, one trained alcoholism counselor, who is a recovered alcoholic, and a volunteer.

This one, small clinic, within a year and a half, has 60 alcoholics on its rolls and I am not sure that the results of this treatment are inferior to other clinics where more expensive personnel are employed. In fact, my clinical impression is that it is quite effective.

What I think is indispensable is the appointment, in every local health department, of an alcoholism coordinator, full time, who will be responsible for doing exactly what Dr. Egeberg and Dr. Miller have asked for—the exploration and the utilization of local facilities that are already available for alcoholics—the utilization of existing services for the treatment of people who desperately need them and who have been neglected so long.

Let me cite one southern county in the State of Maryland, St. Mary's, with less than 45,000 population. Within 1 year, what resulted from the appointment of an alcoholism coordinator in the county health department is that every general practitioner now treats alcoholics.

He has made arrangements with these general practitioners not to turn alcoholics away, because the general hospital will now also routinely admit them for treatment in the regular medical services. Moreover, it is staffed by the regular hospital personnel.

In the first 3 months of 1970, 38 patients were admitted to this hospital, and 10 were seen in the emergency room and discharged from the emergency room.

The alcoholism coordinator visits the hospital daily and gets referrals from the nurses, throughout the wards, of those admitted patients who are alcoholics, so that case finding is immediately done, and the coordinator then can counsel with these alcoholics and their families.

He has also been able to use members of Alcoholics Anonymous as "hospital sitters" with alcoholics and lighten the burdens of the scarce nursing personnel, not to mention transmitting some of their own expertise as alcoholics in handling other alcoholics.

Likewise, in that county, there were 215 referrals to the coordinator from State hospitals of discharged alcoholics back to the community, from the courts, from the general hospital, from the Department of Social Services, from public health nurses, clergy, and schools. In every case this coordinator counseled not only the alcoholic, but where a family was available, the families as well.

He reports that more than 3,000 junior and senior high school students were involved in discussions about alcoholism. This is not simply alcohol education, about the effects of alcohol, et cetera, in the regular school curriculum but goes beyond this into discussions of alcoholism per se and the development of responsible behavior in a drinking society.

He has organized single-day training programs for the professionals, and in that small county, more than 100 professionals have attended such day-long training programs.

He has also had open, public, town hall forums about alcoholism with more than 250 in attendance, and I am informed he is sending 16

of the county residents to our weeklong Institute of Alcohol Studies to be held next month at Hood College in Fredericksburg.

Now I must tell you this man, himself, is a recovered alcoholic, and has been doing the kind of job we hope to see duplicated throughout the State in every other county. Already, in the city of Baltimore, where the problem is, of course, vaster, a similar program is being introduced with a much larger group of personnel, of course.

I would like also to relate the experience of the Johns Hopkins Hospital, which had not been known in the past for the treatment of alcoholics, although there were many alcoholics admitted throughout the hospital. There was, however, no specialized focus on this illness anywhere in the hospital.

In a similar development at the Johns Hopkins Hospital alcoholism counselors were appointed to the staffs in addition to an alcoholism nurse-coordinator. In the present fiscal year of 1970, 920 alcoholics specifically were referred to these counselors for treatment; 64 percent of them came from the emergency room, 34 percent came from the medical service, and 2 percent came from other services in the hospital.

Two-thirds of all these alcoholics accepted referral for followup care, 127 of them were sent to what we call a quarter-way house, really in the nature of an extended care facility from the Johns Hopkins emergency room. Actually it is a Flynn Christian Fellowship Home, a private, nonprofit group in the Johns Hopkins vicinity which has made a contract with the hospital so that 12 beds are set aside for referrals from the hospital. Those patients who are too sick to be sent out in the street, but are not sick enough to occupy a hospital bed, are accepted in this home, and to date 127 of them have been treated.

The department of social services pays \$5 a day for the care of these patients in this quarter-way house, which compares with the State hospital rate of \$13 a day, and the Johns Hopkins Hospital bed of \$92 a day.

From July 19 to December 31, 1969, the hospital estimates that close to \$6,000 have been saved through this program. There is also an Alcoholics Anonymous group which now meets in the Johns Hopkins Hospital. Incidentally, in most places I'm familiar with Alcoholics Anonymous groups meet in the basements, but at the Johns Hopkins Hospital they meet in the plush surroundings of the doctors' dining room.

A year ago, no such program existed at the Hopkins to take care specifically of alcoholics for their disease of alcoholism. We are now duplicating this pioneer program at the University of Maryland Hospital and in the short time we hope similar quarter-way houses will be set up in other general hospitals, including the Providence Hospital and the city hospitals.

These are some of the lessons that we have learned. From reading your bill, Senator, I miss reference to the important lesson we have learned from answering the question, "Who is to do the job set out in your program?"

It seems to me essential that State and local responsibility for the care of alcoholics must be assigned, and when you assign such local responsibility, I feel it must be in the mainstream of American medicine and social welfare.

I would like to briefly outline some guidelines that we have been utilizing in the State of Maryland.

As law enforcement and correctional agencies are being phased out of the management of alcoholics, there needs to be authorized personnel to pick up alcoholics and to direct them into the channels of health and social welfare agencies.

These, as I have said, should be in the mainstream of health and social welfare agencies. I am only too well aware of the fact that psychiatry has in the past also neglected alcoholism, but it has often been the principal light focusing on this program as a disease entity. It is listed as alcoholism addiction in the American Psychiatric Association diagnostic manual.

I think psychiatrists must continue to be involved, but we must also galvanize the vast health and social welfare personnel in our country as well.

Because the present generation of health personnel are not prepared to help alcoholics through having been relatively uninformed, even misinformed, in the past—I learned very little about alcoholism in the schools I attended—priority must be given to education so that these professionals can play their appropriate roles.

At one of the first meetings we held in Maryland, a social worker complained that no funds were available for her activity in the field of alcoholism. One of our local legislators arose and refused to accept this criticism stating the social worker was already being paid to help sick and troubled people, and alcoholics came under that category. What was needed was to learn how to help these people.

This, then, is a necessary priority, to educate those people who are already involved, and to introduce alcoholism consent into the curriculum of professional schools.

Since this is a public health problem as Dr. Egeberg has brilliantly pointed out, it has seemed to us as a guideline that local leadership should be vested in the local health programs, and emphasis should be given to alcoholism and the treatment of alcoholism in this area of programing.

With the experience of community mental health centers and comprehensive health centers, decentralizing the treatment of illness into the community, the treatment of alcoholics should likewise be decentralized. I agree with Mr. Schnibbe, and the decision of the State mental health directors, that the funding should be much more closely determined by the local and regional personnel than in more distant national areas.

The community mental health centers should make a full range of services available to alcoholics preferably by the addition of alcoholism counselors on their staffs. Because of the valuable experience of AA and Alanon, and the fellowships generally I think nonprofessional staffs should be added to every health department and agency.

While AA will continue to be the primary agency in this country to help alcoholics I think it is important for public health leadership to develop its own expertise to do the things in program development that Alcoholics Anonymous cannot, and perhaps should not, provide.

These include early casefinding, early diagnosis, management of the drinking alcoholic who perhaps will continue to drink in spite of the proliferation of services, medical care, which Alcoholics Anonymous certainly cannot give, training of professional personnel, and focus on research so that we may learn more about the fascinating mysteries of alcohol addiction.

I would like to say here that all alcoholics are motivated for treatment. In my experience, I have never come across a drinking alcoholic who is not hurting and who does not want help. I think it is time to motivate the professionals to take their rightful place in the treatment of alcoholism.

The time is certainly ripe, Senator, for a massive attack on alcoholism with the work of your subcommittee and the interest of Congress as a whole, with the concern of the courts, with the focus industry is beginning to place on uncovering its alcoholic employees, and treating them as sick people, with the proliferation of community mental health centers throughout the country and with the development of model legislation in the other States—and here I cannot refrain from saying that I hope the other States will take the lead of Maryland, since I am very proud to be a Marylander because of our State's leadership in this area.

I think, too, we have an enormous advantage that no other illness I know of can lay claim to—that is the existence of hundreds and thousands of volunteers, many of whom are themselves recovered alcoholics or the wives and husbands of alcoholics who are ready to place their knowledge and their devotion in the service of suffering humanity.

Thank you.

Senator HUGHES. Thank you very much, Dr. Weisman. I am rather glad you did not have a prepared statement. It was an eloquent presentation.

I think, Mr. Schnibbe, if you would put in writing for the committee staff the recommendations you made, it probably would be helpful to us.

Mr. SCHNIBBE. I will do that, Senator Hughes.

Senator HUGHES. Dr. Weisman, if you could do the same, it would be helpful to us.

Dr. WEISMAN. I will be happy to.

Senator HUGHES. I want to extend my congratulations to you for your program in Maryland, and the enlightened approach to alcoholism in many of the cities in Maryland.

I could not disagree with much of anything you have said, Dr. Weisman, how much Federal money could the State of Maryland effectively use for these programs?

Mr. WEISMAN. I think any figure I might give you would probably be an underestimation, sir.

I am not prepared at this moment to evaluate precisely how much. We have been toying with thoughts of getting some \$3 million at the very least for alcoholism programing, but I am sure this would simply be a drop in the bucket after the first year.

We would, as soon as we develop services, and many more services are needed.

Senator HUGHES. What do you think of the statement by Dr. Egeberg that in 1971 they are going to have \$9 million nationally?

Dr. WEISMAN. That is pitifully small, sir.

Senator HUGHES. What do you think we need nationally to tool up?

Dr. WEISMAN. I have heard anywhere between \$75 and \$100 million as being much more realistic than the paltry sum of \$9 million.

Senator HUGHES. You have heard of the provision in the bill that cuts off funds to hospitals that fail to provide treatment for alcoholics.

Dr. WEISMAN. I must say I feel very strongly that some teeth must be placed in provisions for the development of services for alcoholics and I would heartily endorse and support such a provision.

Senator HUGHES. You use the terminology "illness" and "disease" throughout your statement in referring to alcoholism.

Dr. WEISMAN. Yes, indeed.

Senator HUGHES. Your statement dealt with the way you have been handling alcoholism with respect to law enforcement.

Dr. WEISMAN. I think we must phase out the active involvement of law-enforcement agencies with people who are displaying the symptoms of an illness in becoming intoxicated when they have committed no other crime.

Senator HUGHES. You have stated your position on NIMH, but do you feel this should be placed in NIMH?

Dr. WEISMAN. I have given that a great deal of thought. The National Institute of Mental Health has been the outstanding Federal agency in pursuing alcoholism programs. I recognize, however, that alcoholism is more than a psychiatric disease.

Most of my patients are not mentally ill, and I don't think that the focus should be on the mental health aspects, although it does represent a significant portion of the treatment, of alcoholism. There are many additional factors involved, and it seems to me that every other health and social welfare agency must be coordinated. Where the leadership is nationally or even on a State level is less important to me than the leadership locally, which I feel should be in the mainstream of American public-health medicine, the health department. But here, too, a comprehensive, coordinated health and social welfare orientation is essential.

Senator HUGHES. You have heard the testimony that the department would prefer a division of alcoholism as compared with the Institute of Alcoholism in the present bill. What do you think of their division of alcoholism?

Do you think this would be adequate?

Dr. WEISMAN. I would hope that the most brilliant spotlight could be placed on the problem of alcoholism in this country and the need to develop services.

I was pleased with the section in your bill which created a separate institute, and, if this is the most appropriate way of providing that focus on alcoholism, I would support that proposal.

Senator HUGHES. Maybe you testified about the percentage of funds being marked for carrying out the programs at the State level. You felt very strongly about this, I take it, about the fact that there is difficulty in getting the funds.

I have experienced that myself. Do you think there ought to be in the bill a specific percentage of that purpose?

Mr. SCHNIBBE. Yes, I think so, Senator.

It has been put in several other bills now in the last few years, and the percentages vary 2, 3, 5 percent to administer a program at the

State level with Federal money involved, that it is administered much more efficiently if some Federal money is dedicated to the State office, specifically for that purpose, to administer the program.

Otherwise, we are diverting State money to do that, and as you well know, some legislatures simply won't furnish us with the money that we think is needed, or that is needed to properly administer a sizable Federal program.

I am assuming that you are going to come up with something like \$100 million for the alcoholism program.

Senator HUGHES. I am assuming that myself.

Mr. SCHNIBBE. If the \$9 million, I don't know that we need worry too much, because you divide \$9 million among the States, and when you start coming up with \$100,000, \$200,000 going into a State for an alcoholism program, the States, generally speaking, and I think I can reflect the attitude of most of the State mental commissions, their attitude is, keep the money we don't need it.

It is more of a headache than a help to State government. You know that well enough, if you have got \$40, \$50, \$60 thousand for an alcoholism program, it is so much of a bother to try to integrate that into the regular State program that most of the time you would just as soon not be bothered with the whole thing.

So we are hopeful that you will provide the leadership to get that \$100 million, Senator.

Senator HUGHES. I can't believe that a Congress that would earmark \$10 million in the Department of OEO in this fiscal year and \$15 million for the next, would say to HEW that they are only going to get \$9 million for the country.

Surely they will be wanting to look at this on a realistic scale. If you took the \$9 million and put it in Maryland, you could probably do a satisfactory job with it.

Mr. SCHNIBBE. That is right.

Senator HUGHES. Do you believe the intergovernmental council provided for in this bill is necessary?

Dr. WEISMAN. I would think it a highly desirable development to have this council, because one of the real difficulties is a need for coordination. The council would be a boon to the program and a fillip to joint activity.

Mr. SCHNIBBE. May I comment on that, Senator, then?

If I remember correctly, and I have not read the bill in a while, but if I remember, you have something like five slots on there for State and local government. Is that correct?

Senator HUGHES. I can't recall myself.

Mr. SCHNIBBE. I hope that by making this record here, or perhaps in the report of the committee at the time the bill again was reported, that it be recommended to HEW that at least one of these State people be a State mental health commissioner.

Our experience with NIMH and HEW with the advisory alcoholism conference is that the people who are responsible for a substantial amount of the treatment programs in the United States, namely the mental health directors, are not represented on these advisory groups, and eventually, after raising a lot of hell with the agency, we did get State representation, but at the outset the advisory group was made

up of largely academic types, and the service people are frequently not represented by these groups.

We feel the State mental health commissioners and the State health officers should surely, if possibly by name, be mentioned as mandatory members of such an intergovernmental committee.

I don't see how they can really operate without the mental health commissioner and the State public health officer on there, and as I say, our experience in the past has been that they leave both of us off.

Senator HUGHES. Dr. Weisman, you talk extensively about the paramedical personnel in all of these programs. Do you think there is adequate room in this bill for that?

Dr. WEISMAN. I think the bill ought to specifically mention desirability of developing paramedical personnel, because these are indispensable to our program, and the lessons we have learned from our State, I think, could be applied throughout the country.

I don't think the focus has been on developing this kind of personnel. We must, I think, get away from the traditional concept of care given to people in the alcoholism area. We have discovered a resource that is indispensable.

Senator HUGHES. I appreciate that. That has been my personal observation around the country. In many instances, the supervision can be very helpful, but the paramedical personnel conduct and carry out vast programs that really reach the problem, such as you describe in your program in Maryland. The community based programs alone, without funding from any other levels, where four or five counties have gone together, is there provision in this bill for support and help of those?

Dr. WEISMAN. I did not discover it, unless I read it superficially. This is precisely the point I wanted to make, there must be a better focus on local leadership in the grassroots.

I did not come across that in the bill, and I would think it would be an improvement if this were stressed.

Senator HUGHES. If it were not, I made a mistake I did not intend to make. I believe that it is there. We will make sure that the language is made clear.

I don't know how the man you described covered the ground he did.

Dr. WEISMAN. He is fantastic.

Senator HUGHES. Gentlemen, thank you for coming to testify. I have asked you to submit some comments in writing.

Dr. WEISMAN. Thank you, sir.

Senator HUGHES. The Chair is going to take a 5-minute recess and then we will call Daniel L. Howe, director, Alcoholism Information Center, Helena, Mont.

(Whereupon, a brief recess was taken.)

Senator HUGHES. The hearing will resume.

STATEMENT OF DANIEL L. HOWE, DIRECTOR, ALCOHOLISM INFORMATION CENTER, HELENA, MONT.

Senator HUGHES. Mr. Howe, you may proceed with your testimony as you desire.

Mr. Howe. Thank you, Senator.

I am sure that there has been much testimony prior to mine which has given you some insight and some indication on the direction which you would like to take, either in implementing or making changes in your bill, and I hope that my unique involvement in the area of alcoholism and its treatment and rehabilitation can be of some assistance in giving you some clear indications and some other indications as to what can be done and what might be done on the national level to help implement programs and services on the local level.

It seems to me that somewhere in the journals of American history there is a statement made that the government of the people was a government by the people, and in working in the area of alcoholism so many of the present ideas and philosophies that are stated are being issued by people and, as a result, I think some ineffective programming was issued by people who are really not that completely aware of the severity of the problem of alcoholism, and as a result, I don't think we are finding the adequate legislation nor the adequate concern on the national level for the problem.

My unique involvement is that I am director of a program in Helena, Mont., carried out under a Public Health Service grant by authority of 314(e)1, which is a grant to try to develop comprehensive health services.

Our expressed purpose in carrying out this pilot project was to demonstrate that through a comprehensive and extensive approach to the problem, the sickness which now controls the lives of so many of our people might be eradicated.

Despite the problem of bureaucracy, it seems to me if we are sincere in our statements that the No. 1 social problem and the No. 3 health problem in the United States is the problem of alcoholism, then I am really surprised, and it also seems to be ironical that our statements to this effect certainly are not followed by our actions and by our dedication.

I think that the bill which you have proposed is one which should be heartily endorsed, and is heartily endorsed by those working on the grassroots level with the alcoholic, and experiencing so many of the difficulties and so many of the vacuums that are now present in the treatment of this particular problem.

It seems that if each one of those who are involved in this bill and are going to be involved in its passage would have spent the last year, day after day, exerting their energies in trying to put together an attack against the problem, then they would understand that each point made in your bill is not without relevancy.

There would be no doubt in their minds as to the tremendous havoc that is being created by this problem, and yet it is very evident to me that it is only if you are associated closely with the problem that you are able to understand the severity of its nature, and I am sure that this is due to the fantastic stigma that has been attached to the problem down through the years.

But it is only when one begins to look for help for a person, not just for one, but for many persons, that one begins to realize how little help is available. It is only when one begins to question why this is so that one begins to understand the repercussions of the stigma that America is now laboring under.

It is only when one examines closely, as we have done in our pilot program, and talks personally with the heads of our local and communal social services, as we have done in our pilot program, that one begins to see the real vacuum of any relevant direction that exists in this field of alcoholism.

The direction which you have clearly given in your bill is the direction which, as a director of the pilot program for HEW, I wholeheartedly endorse.

One statement which I would like to make a comment on is the statement that you have made in section 101(f), when you stated that lack of Federal leadership in funding has contributed to the failure of public and private State and local agencies to recognize their responsibilities for meeting these problems.

I think, like it or not, the thoughts and beliefs and directions of our local leaders are controlled by the people on the Federal level. It is for this reason that I would recommend strongly, from our vantage point of working on the local level, and trying to involve local leaders, both State and city, to try and take some initiative in setting up alcoholism programs, in our effort to involve them and the very lackadaisical and apathetic attitude they have shown, I would strongly endorse the establishment of an institute, if for no other reason, to dispel the feeling that alcoholism is not a disease, but a free will choice, something brought upon themselves by the individual themselves.

Many talks have been given about putting alcoholism on the level of a disease. This concept is still not believed, I don't think, on the local level. It is still not endorsed. The reason I think it is safe to make this type of statement is precisely what we have heard this morning, considerations of placing approximately \$9 million for its treatment.

The dichotomy between what we state and what we do is rather tragic.

In your bill, you call for a role of planning and coordination, one which I think is critical. The reason for this is because on the local level, from what we have experienced, there is today apparently a convenient cop out in that there is nothing set up on the Federal level. There is nothing which can give us sufficient guidelines so as to make our investment feasible, and I think this is precisely one of the reasons that State and local governments are not contributing and endorsing local legislation to deal with the problem in an effective manner.

They feel that if the Government cannot set down some guidelines, then it would probably not be feasible for them, nor would it be worth their investment. There seems to be a feeling that without the support, the very strong support from the Federal level, that anything that is adopted on the State and local level is going to be looked at as something with four heads by people in the communities, that such procedures don't seem to have the professional backing that Federal legislation lends to them.

I am not saying that this is true in all cases, but I think in a majority of them it is, and certainly it is in the case which I represent.

If I could comment briefly on the situation we found ourselves placed in when we began our program, a situation which I believe is typical of most communities in America, despite the fact that I do admit of exceptions in given areas and under given circumstances, perhaps

maybe one might realize how severe the problem is, and how much direction and how much emphasis should be placed toward the eradication of this problem on a Federal level.

When we first began our program in Helena, we found amongst the general populous a very sick and apathetic attitude toward the alcoholic and his or her well-being, a very immature concept of alcoholics. In surveys we took we recognized that the people were stating that there is a problem, and they felt that something should be done about it, but their personal actions did not follow their beliefs.

Hospitals that we dealt with saw the need for emergency care, but they always found excuses why they themselves could not establish treatment facilities.

Law enforcement agencies, courts and prisons in the State, and in the county and on the city level, stated that alcoholism was causing more than 75 percent of their workload, but in our efforts to establish programs for them in the beginning, they were hesitant to change their present mode of dealing with the problem drinker.

High school administrators stated 90 percent of their students were drinking, but they were at a stalemate as to what to do.

Churches and civic organizations bemoaned the severity of the problem, but refused to speak about it from their pulpits and to the local press.

The welfare departments and social agencies claimed that their caseloads were more and more the result of alcoholism, but only voiced a loud lament as a solution.

On the city and county level, the officials mumbled in confusion.

It was in this state of affairs that we found the community, and in which we began our pilot program. This, I am sure, is nothing new to you, Senator Hughes, but I feel that in our day of national programs, in our days when so much of our local legislation, so much of our feeling of people's attitudes, so much of our direction in society is set by direction from the national level, it seems to me at this time that it would be fitting that an institute for the concern of this massive problem of alcoholism in the United States should be established.

I state that not from one who is faced with bureaucracy which one must deal with in setting up such an institution. I state it from the needs of the people, from the people with whom I and many others are working to attempt to eradicate this problem.

It is a problem that deals not only with the individual, but because of its social implications is affecting probably one-fourth of our society. It is difficult for me, and I think it is difficult for most volunteers in the United States working with the problem, and most of the people such as yourself, that a program of this extent, and a problem with so many repercussions is met with such ignorance and apathy by those in a position to do something about it.

I have brought with me today a copy of a program that we are now carrying out for your perusal at a later date, and I also brought an evaluation that was done by the Health, Education, and Welfare Department regional office in Denver. It was a 6-month evaluation of our program and what we had accomplished, and I feel this has meaning, because I think it shows what can be done in a community where no services were established, but after our beginning, after a relatively short period of time, 6 months, there is now enthusiasm,

there is now a concern among all those agencies which I formerly mentioned showed such apathy, showed such ignorance.

This has come through the dedication of my staff, and I think it probably has come from the fact that we are a pilot program and do have the auspices and do have the concern of the Federal Government behind us.

When we first introduced ourselves to State official or local social agency dealing with the problem, they would ask us if we were AA, as if it were a bad word. We told them no, that we supported it, but that our main backing was that we were a pilot project for the Health, Education, and Welfare Department. The minute we made that statement there were open ears. There was acceptance of our presence, and there was an immediate concern, and this is why I am so insistent in my support of this bill, and this is the reason I called and asked to support it, and took the opportunity to come this distance.

I do believe that the establishment of an institute, and the passage of this bill would enable communities which at the present time, even though they may have sufficient personnel, are lacking the direction and particularly the image that they need could be rendered by the creation of such an institute.

I would like to make one further comment, and that is, I believe, and of course I know this can be disputed, but I do believe that the institute should be established purely for the problem of alcoholism. I believe there is a cop out on the adult generation to place an exaggerated emphasis on the problem of drugs so as to avoid the real issue, alcoholism.

I am not trying to minimize the problems drugs create, but to say that the problem of drugs is going to become an increasing problem in the United States and therefore we ought to look at that instead of alcoholism is naive, because alcoholism is growing at a rate far faster than that of drugs.

The testimony I furnish you is a simple synopsis, and I would be happy to present anything else in writing you want, and I would be happy to answer any questions you might have.

Senator HUGHES. Thank you very much, Mr. Howe. Your dedication to the problem of alcoholism in Montana is obvious, and I appreciate your willingness to come and testify before the subcommittee. It will be helpful to us.

In section 101 of the bill, we stated alcoholism is a disease. Do you agree with this concept?

Mr. HOWE. Yes, I do very much.

Senator HUGHES. There is a section in the bill which provides that hospitals which discriminate against alcoholics should not be allowed to receive Federal funds. Do you agree there is a need for such a provision?

Mr. HOWE. I do. Because in the area we have been working, this has been a very difficult problem. The hospitals in the area which are not county hospitals found a great hesitancy in taking alcoholics, and as a result a couple died in jail.

I realize this is a small area, and that most places do have county hospitals which do accept alcoholics, but nevertheless, I think in county hospitals there must be a better acceptance of the alcoholics, for I am

not sure of the sincerity and the intensity with which they are taken care of at the present time.

Senator HUGHES. Would you agree with the concept of the program to prevent alcohol abuse among Federal employees?

Mr. HOWE. Yes. This I would describe particularly in the section dealing with veterans. Prior to taking this directorship at Helena, I was involved with the veterans hospital in Kansas City, and have been successful in establishing an alcoholism program in the veterans hospital in Helena. Prior to that, however, there was fantastic reluctance on the part of the doctors on the admitting portion of a hospital to admit alcoholics.

I think it is interesting that in the Veterans' Administration, in which we are trying to render service for people who have served this country, that there should be discrimination. There is, however, discrimination.

In the veterans hospital in Kansas City, there was no specific group therapy or counseling for the alcoholic. They were simply classed as mental health patients. There was an animosity because of it, and it is precisely for this reason that I would add this statement, that I do not feel that the incorporation of the bill under NIMH is going to really be the type of thing we need simply because if one understands the alcoholic personality one realizes their hesitation and their dislike with being associated with mentally ill patients.

That doesn't mean, of course, that we are doing this, but when you say alcoholics are being treated under the National Institute of Mental Health, I don't think it describes it with the particularity it needs to be effective.

Senator HUGHES. Do you think the establishment of a new division will give it the identity necessary?

Mr. HOWE. I don't think so. Look at the subdivision that is now present. You have got NIMH, HSMHA—nobody knows what these things are, and I don't think they are influential at all. If you talk about the National Institute, then there is support, and this is seen when we introduce ourselves. If we say we are an agency that has been funded by the Public Health Service, it doesn't sell, so we simply say we are from HEW, and people are ready to listen.

It is not falsification of our background, and it does have the weight needed to introduce one to gain the time and attention that is needed in a community to carry on the local and city participation that was mentioned by Dr. Weisman.

Senator HUGHES. Does the State of Montana have any alcoholism program of its own?

Mr. HOWE. They have one State treatment center, which is at Galen, and everyone who goes there must be admitted through the State mental hospital, and, of course, as a result of this there is a tremendous hesitancy. The only people going there are mostly people being committed. There is no other treatment center in the State of Montana, save what we have been able to elicit from the people through our program.

Senator HUGHES. Is your community-based program in Helena the only community program in Montana?

Mr. HOWE. Yes, it is.

Senator HUGHES. Do you have a statewide alcoholism commission?

Mr. HOWE. It has just been established. Interestingly, it has only \$12,000 in funds for 2 years, which, of course, makes it almost inoperative.

Senator HUGHES. They can hire a secretary, and that is about it.

Mr. HOWE. That is right.

Senator HUGHES. Do they have a delineation by law of what their responsibilities are?

Mr. HOWE. Supposedly, in the beginning, to coordinate what is being done in the State and make recommendations to particular locales as to what can be done. But this seems to me to be a delineation of objectives which is ridiculous, because there is no possible way of carrying it out.

Senator HUGHES. There is no program directed toward the Indian population?

Mr. HOWE. Only what we have, to establish a pilot program among the Indians to see what can be done. There are now some programs being started by the reservations themselves—this is only in two cases, and there are five reservations in Montana. There are two reservations which have sent individuals to the State treatment center for alcoholism to learn and do something in their locale, but as far as real State support, it is nonexistent.

Senator HUGHES. Do you think a community mental health center can reach the Indian population on the reservation?

Mr. HOWE. I don't think so. We have a community health center on the western side and on the eastern side, but because there has been no emphasis on alcoholism, they don't even have the alcoholism counselors in the centers.

Coordination is imperative, because even most doctors and most psychiatrists have not the faintest idea of how to deal with the personality of the alcoholic.

Senator HUGHES. It just came to my attention last week on one of the Sioux reservations, out of 400 and some Indians there were 15 attempted suicides among teenagers in January, many of them related to alcohol.

Mr. HOWE. I can attest to this. We have 4,000 off-reservation Indians in the city, and among those better than 1,000 we have contacted, we have found among the 1,000 there is an alcoholism incidence of 600 among the 1,000. This perhaps sounds exaggerated, but it isn't.

Senator HUGHES. Not to me. In the Education Subcommittee research indicated that 85 percent of the Indian youth were arrested for use of alcohol. Of the total numbers of youth, 85 percent of the teenagers had been arrested because of use of alcohol, and while under the influence of alcohol.

Yet, we have few programs in this country, if any, that specifically aim at what is truly an ethnic problem, a cultural problem, and perhaps even a religious problem.

But it is going to require money, and I hope you have enough money in your project to analyze carefully the Indian population you are dealing with. The Indian alcoholism problem is a unique problem in America, as in many instances is the black problem of alcoholism. The programs for reaching whites are not reaching blacks in the major cities.

Mr. HOWE. That is right.

Senator HUGHES. We need to have enough latitude in this legislation to reach in with specific programs publicly based and operated by the people themselves.

I want to thank you again, Mr. Howe, for your willingness to come and your concern and dedication to this problem in America. If you have any other ideas you feel might be helpful to us in the legislation, if you could submit it in writing in the next week it would be helpful to us.

Mr. HOWE. Thank you very much.

(Prepared statement of Mr. Howe follows:)

PREPARED STATEMENT OF DANIEL L. HOWE, DIRECTOR, ALCOHOLISM INFORMATION AND REFERRAL CENTER, HELENA, MONT.

Many distinguished men have preceded me to render their views on the proposed Senate Bill 3835 entitled "Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970". Their testimonies have, without question, assisted greatly in enlightening you and, hopefully, in furnishing you with the tools necessary to arrive at an intelligent decision on this very comprehensive piece of legislation prepared and introduced by the Honorable Harold E. Hughes, Senator from Iowa. I hope that my unique involvement in the field of alcoholism will add to your existing knowledge.

As director of an alcoholism program in Helena, Montana, a program operated under the auspices of the Department of Health, Education, and Welfare, we are carrying out a Public Health Service Grant by authority of 314(a) (1) PHS Act. The purpose of 314(e) (1) grants are to develop health services—in this case in the area of alcoholism. Our expressed purpose is to demonstrate that, through a comprehensive and extensive approach to the problem of alcoholism, this serious sickness which now holds so many of our people in it's grip can be dealt with in a successful manner. Our activities are in miniature what Senator Hughes is proposing in his Bill to be carried out on a national level. Our program was intended and is intended to be a pilot project, a resource manual and a testing ground on the actual manifestation of the philosophies expressed in the Senate Bill before us today. It is with this brief introduction and the utmost concern for the American people suffering from the disease of alcoholism that I testify in support of this vitally needed Bill.

If each one of you here today would have spent the last year, day after day, exerting your energies in trying to put together an attack against the mushrooming disease of alcoholism, you would understand every word and direction that is contained in this Bill. There would be no doubt in your minds of the havoc that is being created each day by this terrible disease. It is only when one is closely associated with the problem of alcoholism that one sees the physical, psychological, and social destructiveness of this disease. It is only when one begins to look for help, not for just "a" person, but for "many" persons, that one begins to realize how truly little help is available for such a massive problem. It is only when one begins to question *why* this is so, that one begins to understand the stigma that we have been laboring under for so many years. It is only when one examines closely and talks personally with the heads of our local and communal social services departments that one sees the vacuum of any relevant direction in the area of alcoholism. Senator Hughes has captured it perfectly in Section 101(f) when he says "lack of federal leadership and funding has contributed to the failure of public and private State and local agencies to recognize their responsibilities for meeting these problems." Like it or not, the thoughts, beliefs and directions of our local leaders and servants of the people are determined by the thoughts, beliefs and directions set on the national and federal level. I speak from experience when I state that the hesitations, doubts and fears, on the local level, of entering the all-out struggle against alcoholism is in part due to the lack of precedence on the national scene.

The urgency and feasibility of establishing a National Institute for the prevention and control of alcoholism has reached its apex, not only in building a healthy image toward the problem of alcoholism, but also to make a concerted and successful effort to overcome this disease. The role of effective planning and coordination called for in the workings of the Institute would likewise be a boom to those searching for leadership and direction on the local level. Accurate statistics com-

ing from the Institute would help dispel the present doubts and resulting apathy that exist in so many. The severity of alcoholism, which has been with our society for so long, demands that we, who are proud of our successes in so many areas, establish the necessary research facilities to eventually effectively combat this problem with like success. In addition we need trained professional and paraprofessionals and a general education program for our entire society if efforts in the areas of planning, coordination and research are not to be in vain for at this time in our lives, alcoholism has as many social abnormalities as it does physical and psychological.

In an effort to urge passage on this Bill through enlightenment of each of you present today, I feel that if you know some of the obstacles and inconsistencies that we have found in carrying out our pilot program, you will more readily see the need for each phase of the Bill. What we have found existing in Helena is typical, I believe, of most communities and cities in the United States, accepting the fact that there are exceptions in given areas on given points. Basically, however, it is safe for us to state that we found, amongst the general populace, a very sick, apathetic and ignorant attitude toward the alcoholic and his or her well-being, and a very immature and unreal concept (almost a deification) about alcohol itself. In surveys that we took people recognized the problem and felt that something should be done about it, but their personal actions were inconsistent with their beliefs. Hospitals saw the need for emergency care for the alcoholic and the establishment of special treatment facilities but found excuses why they could not do it themselves. Law enforcement agencies, courts and prisons on the state, county and city levels stated openly that alcohol and alcoholism was causing 75% of their workload, but were hesitant to change their present mode of dealing with the problem drinker. High school administrators openly admitted that 90% of their enrollment drank, but were at a stalemate as to what to do. Churches and civic organizations bemoaned the severity of the problem but refused to speak out openly about it. The welfare departments and social agencies claimed that their case-loads were more and more a result of alcoholism but only voiced a loud lament as a solution. City and county officials mumbled in confusion and exasperation but went no further. It was in this state of affairs that we found the community and in which we began our pilot program. In only eight short months, through carefully laid plans all of the above mentioned groups have come alive to the problem. Each has begun to take steps in a positive and therapeutic direction. They are amazed at themselves and at what can be done with a sense of direction and a goal in mind. There is now a vibrant enthusiasm in each group about doing something about the problem rather than just "talking" about it.

I have brought with me today, for your perusal, a copy of our program's objectives and our success to date and, in order to bring credibility to our work, I have likewise brought a recent evaluation of our program—an evaluation that was done by the regional Health, Education and Welfare office in Denver, Colorado. My purpose in pointing out these facets of our experience is to shed light on the authentic need, the *terrible* need that is expressed in the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970, and to demonstrate that if this Bill is passed and each section of the Bill is put into operation, then we can assume that alcoholism will lose its now unsavory reputation as No. 1 social problem and No. 3 health problem in the United States and the death grip that it now has on so many Americans will become once again the hand of life.

For everyone who is actively engaged in a small or large way in working to combat the disease of alcoholism, I ask that this group of leaders who control the lives and destinies of so many people in the palms of their hands, give their affirmation to this revered piece of legislation that Senator Hughes has prepared for you and introduced for all Americans.

PROGRESS REPORT FOR THE PROJECT ALCOHOLISM INFORMATION AND REFERRAL
CENTER PHS GRANT NO. 83013-01-70

In order to properly evaluate the program of the Alcoholism Information and Referral Center project, the objectives of the grant must be kept in mind at all times. In order that this may be done, we shall list the project objectives and then show what project elements the Alcoholism Information and Referral Cen-

ter has developed in order to accomplish these objectives. In addition to delineating the project elements felt necessary to successfully meet the objectives of the program, we shall give a statistical breakdown of each project element with accompanying remarks where noteworthy. Please note well the column marked "Objectives Activated"—this will indicate which project objective has been carried out by the various activities we have chosen to initiate.

PROJECT OBJECTIVES

1. To provide information about the disease of alcoholism to individuals concerned with alcoholism in their lives and to make referrals to appropriate treatment facilities where available. It is expected that within five years all alcoholics who were willing could be reached.

2. To develop and put into operation after the first six months a systematic and comprehensive treatment approach to the alcoholic and his family by providing an inter-related continuum of service. Cooperation with all other health groups to develop comprehensive health and mental health programs will be emphasized.

3. To reach the entire population of the area with a program of public education geared to prevention of alcoholism and a better understanding of this illness by the public.

4. To provide stimulation and education on alcoholism to all professional groups who deal with individuals with alcoholism problems.

5. To demonstrate to the State of Montana that a comprehensive alcoholism program can be effective in reducing the incidence of alcoholism and increasing potentials for vocational rehabilitation.

Project elements in operation	Output measures	Units activated	Project objectives activated	Remarks
Staffing-----	Number of people-----	7	1, 2, 3, 4, 5-----	The staff has been developed to 7 members, 5 are being paid out of PHS grant and 2 are being paid out of Model Cities, in kind, cash money.
Volunteers (active)-----	do-----	12	1, 2, 3, 4, 5-----	The training of volunteers has assisted the development of the program. After an 8-week intensive education program, the volunteers are assigned to various phases of program activity.
Local council on alcoholism-----	do-----	30	1, 2, 3, 4, 5-----	An advisory council on alcoholism has been established to lend advice and support to the development and expansion of our program. Members have been drawn from all facets of the community. Monthly meetings are held to discuss pressing issues at hand.
Brochures and pamphlets-----	Number produced----- Number distributed-----	170,000 165,000	1, 3, 4, 5-----	To effectively convey the necessary knowledge about alcoholism the Alcoholism Information and Referral Center has produced and published many pieces of literature which is distributed at our lectures, seminars, educational, programs and on literature racks set up throughout the city. We have likewise received many requests from individuals and groups for the information we have produced.
Films-----	Number purchased----- Number shown-----	2 21	1, 3, 4, 5-----	The use of films at our seminars and lectures and various educational programs has enhanced the effectiveness of our educational endeavors. We feel we have acquired the best 3 films available in the country.
Seminars-----	Number held----- Number attendance-----	11 1,135	1, 3, 4, 5-----	The response of the community in attending seminars that have been conducted by the Alcoholism Information and Referral Center has indeed been rewarding. Our seminars have gained professional recognition, the proof being that we were accredited by Carroll College for our seminars held on their campus. We also were asked by the VA hospital to conduct a seminar specifically orientated for hospital personnel.
Library (a collection of educational material used in various programs).-----	Number books available----- Number borrowers-----	105 35	1, 3, 4, 5-----	We have as well been asked to participate in 3 statewide seminars dealing with the problem of alcoholism. The development of our library and participation by the community and its use was slow in the beginning, but it is picking up considerably. Many people will stop in and browse around and then rather than borrow the book, they will ask for the publisher's name and buy it.
Teen council-----	Number of members----- Number of meetings----- Number of projects----- Number of State and national recognition-----	26 28 22 2	1, 3, 4, 5-----	The development of the teen councils on alcoholism is indeed an innovating idea and the only kind of its nature, to our knowledge, in existence. Members are solicited on a volunteer basis, the only requirement being that they are teenagers. At the present time there are 3 teen councils in existence in Montana, 1 in Helena, 1 in Townsend and 1 in Boulder. Meetings are held once a week in each town with each group planning and carrying out its own activities. The activities and projects consist of radio and TV appearances; participation in seminars held by the Alcoholism Information and Referral Center; educational programs in grade and high schools and the conducting of social events to raise money for the weeklong School of Alcohol Studies at Utah University. The teen councils have received statewide recognition in that they have been requested by outlying communities to participate in school educational programs and the establishment of their own teen councils in those localities. They have received national recognition in that they have been requested not only to attend the Utah School of Alcohol Studies at the University of Utah, but they have also been asked to participate in the many presentations that are given.
School education-----	Number of schools participating----- Number of classes----- Number of students reached-----	10 125 3,750	1, 3, 4, 5-----	Through the excellent cooperation of the school administration board we have been able to establish an alcoholism education program within the school system. The program covers grades 5 through 12 and upon completion will have reached all of the children. We have received excellent reception from the children and many fine commendations from the principals and school board. Our school education program is carried out by Dick Wecker, our teen director, who continues to amaze everybody with his ability to relate to the teenagers.
Communication media-----	Number of TV spots----- Number of radio spots----- Number of newspaper releases-----	6 12 18	1, 3, 4, 5-----	The Alcoholism Information and Referral Center has received excellent cooperation from the entire news media which has enabled us to effectively announce our presence to the community and disseminate valuable information concerning the problem of alcoholism and the steps that the community must take to overcome it.

Project elements in operation	Output measures	Units activated	Project objectives activated	Remarks
Group lecture series.....	Number held..... Number of participants.....	36 1,275	1, 3, 4, 5.....	From the number of requests we have received to speak at service groups, social organizations, and government agencies it appears to us that the problem of alcoholism is of concern and interest to a large facet of our community. We have received many requests to speak outside our 3-county area which, although not covered in the grant, does indicate the effectiveness and the acceptance of our program.
Special training courses.....	Number of hospital personnel units..... Number of participants..... Number of social worker groups..... Number of participants..... Number of ministerial groups..... Number of participants..... Number of volunteer groups..... Number of participants..... Number of individual cases..... Number of individual sessions..... Number of family cases..... Number of family sessions.....	1 30 2 33 3 25 3 27 175 480 82 235	1, 2, 3, 4, 5..... ----- ----- ----- ----- ----- ----- ----- ----- ----- ----- ----- -----	Since the problem of alcoholism has repercussions in so many areas of our community and since there are so many different organizations dealing in one manner or another with this particular problem, we felt it feasible and necessary to conduct special training courses for those fields. The acceptance and the participation of all concerned has been gratifying and as a result excellent working relationship with most professional agencies in our community exists. While there are still professions to be contacted and educated we feel that in the near future we will have reached all of them.
Counseling.....	Number of participants..... Number of individual cases..... Number of individual sessions..... Number of family cases..... Number of family sessions.....	175 480 82 235	1, 2, 5..... ----- ----- ----- -----	The bulwark of our direct service to the alcoholic and family is without question in the area of counseling. A considerable amount of the entire staff's time, both during working hours and after hours and on the weekends is taken up in individual and family counseling. At the present time the caseload and the demands that it makes on us heavy and burdensome to say the least. This is not a complaint, however, as the objective of our program is to get people to reveal, and seek help for, their problems. The extensive number requesting counseling services is indicative of the confidence that the entire community is placing in us. At the present rate and growth of requests we should have come into contact with close to 1/3 of the alcoholics in the community by the end of the year.
Group therapy.....	Number of groups..... Number of sessions..... Number of participants.....	4 67 297	1, 2, 5..... ----- -----	Another important element in our direct service endeavor is our group therapy sessions. The dynamics of group therapy are found to be most efficacious and stimulate the withdrawn alcoholic to new perspectives of the future and bigger and brighter images of himself. With some patients the support of the group enables them to ascertain more quickly the picture of the present and the steps that must be taken to plan a program for the future.
Followup program.....	Total number of cases counseled.....	175	1, 2, 3, 5.....	We feel that for the 1st year all of our cases must be followed up. One of our staff members has this task assigned to him which he carries out on a systematic basis. The cases which he handles are those that are not involved in weekly counseling sessions; thus it becomes clear that all of our cases at the present time are being followed up in one manner or another.
Indian programs.....	Number of Indians contacted..... Number of Indians counseled.....	140 33	1, 2, 3, 5..... -----	Due to the extensive alcoholism problem which exists amongst our Indian population in and around Helena we have assigned one of our staff members full time to this task. Being an Indian himself, we feel that he relates well and has done an excellent job in a most difficult area. He is also involved in a volunteer way, in State and local Indian affairs boards. This gives him an opportunity to stress the critical nature of the alcoholism problem amongst the Indian people, and as a result we have gained considerable recognition and assistance from State and local bodies concerned with the Indian problem.
Probation and parole program.....	Judicial entire commitment.....	1, 2, 3, 4, 5.....	-----	The cooperation of all the judges within our 3 county area in the parole and probation program has helped to make this program very successful. We now have men under parole anywhere from 1 week to 6 months. While the number of participants in this program is rather small, the success with these men has been extremely encouraging, to say nothing of the savings to the taxpayer. We estimate that through this program we have saved the taxpayer close to \$8,000 in custodial care; but more important has been the response of the men themselves in working together with us to develop a new future.

Halfway houses.....	Number of houses..... Number of participants.....	2 1, 2, 4, 5----- 64 -----	Through the efforts of the Alcoholism Information and Referral Center the halfway house in existence at the beginning of our program has now become part of our program and is under our supervision. The Alcoholism Information and Referral Center, in addition to this, has developed a second halfway house in Boulder, Mont. All participants entering the halfway house are screened through the AIR Center thus enabling better coordination of services. House rules are drawn up by the AIR Center and the house directors are screened and chosen by us. The length of stay for each participant is determined by a joint decision between the director of the house and me.
Hospitals.....	Number participating.....	3 1, 2, 3, 4, 5-----	Both private hospitals and the Veterans' Administration hospital have been most gracious in assisting us in the direct service detoxification. At the present time, however only the Veterans' Administration hospital has, in our estimation, a sufficient and feasible program. Much improvement is needed at the 2 private hospitals. Despite numerous plans that I have submitted, it is apparent that extensive education is going to be required to bring them to top efficiency in the area of detoxification and treatment of the alcoholic. Hopefully the present program that we are participating in at VA hospital can become a pattern upon which the private hospitals can develop a more feasible program.
Surveys.....	Number conducted..... Number of people reached.....	15 3, 4, 5----- 3,795 -----	In order to assess the direction that the program should take which is necessary to determine the need and the feeling that exists in the community, surveys have been a valuable resource in accomplishing this. They also serve as a feedback to help determine our influence to date. While we have conducted numerous specific surveys, we are also conducting a continuous survey in the entire area.

PROJECT ELEMENTS PRESENTLY UNDER DEVELOPMENT

Project	Project objectives activated	Remarks
1. Detoxification center.....	1, 2, 3, 4, 5-----	Plans are presently being made to establish a detoxification center within, or in the close proximity to, one of the local hospitals. Some hesitation and fear has been manifested by both professional and lay members of our community and thus we find it necessary to proceed with caution so as not to deepen the stigmatic scars of alcoholism that still exist in the minds of many. Our estimated time of accomplishment is September of this year.
2. Court school for understanding alcoholism.....	1, 2, 3, 4, 5-----	Beginning Apr. 29, 1970, the Alcoholism Information and Referral Center will conduct a court school for those convicted of the charge of driving while intoxicated (DWI). The highway traffic safety board, in conjunction with the magistrate judges are supporting this program and we hope to prove through this educational program that the recidivism now present in DWI violations can be reduced.
3. Business and industry program.....	1, 2, 3, 4, 5-----	A preliminary survey of the major businesses and industries in the area as to their willingness to sponsor a program within their firms, we have set May as the target date for our business and industry program. This will entail a statement of policy from top administration and the training of frontline supervisors by the AIR Center and the eventual counseling and followup of sick employees. Each company will take a great deal of time and thus this will be a continuous program in the months to come.
4. Awareness house.....	1, 2, 3, 4, 5-----	Under consideration by many interested groups in the community is the development of an awareness house for teenagers. This would be a place for teens to drop in (anonymity preserved) and discuss the problems and pressures that lead them to drink. The response of the teenagers in the community toward this idea has been an unanimous "Yes." There are still cobwebs that must be brushed aside before this can become a workable program and thus we are planning its beginning in January 1971.

Each project element now in operation and those under development have been chosen as positive ways of meeting the objectives of the Grant. It is our feeling, and was the feeling of the HEW quarterly evaluation, that we had, for the most part, properly chosen and carried out those elements which were needed to accomplish the grant objectives.

I have to a degree, it may seem, painted an extremely rosy picture, and that I have, because I believe it. In most cases the necessary cooperation for launching and carrying out the elements of the program have been present. Despite the positive tones of the evaluation, there are still many facets of it to be developed and perfected. This, coupled with the overwhelming fear and stigma still present in many, spells out the great need for a continuing education program and a refined effort of program development.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE REGIONAL OFFICE,

January 28, 1970.

Reply to attention of: Program Evaluation of Health Services Development Project No. 83013.

To: Robert B. Hickman, Regional Program Director, OCHP.

Subject: ("Alcoholism Information and Referral Center"), Helena, Montana—January 22-23, 1970.

1. Participants:

Center Staff.—Mr. Dan Howe, Director; Mr. Joe Stewart, Assistant Director; Mr. Dick Meeker, Teen Council Director; Mr. Ed Belgard, Indian Liaison Officer; Mrs. Jeanne Legler, Secretary-Accountant; Mrs. Lorene Nelson, Clerk-Typist.

Others.—Mr. Maynard Olson, Assistant Superintendent of Schools; Mr. Mike Murray, Executive Director, Rocky Mountain Development Council; Mr. Emil Honka, Lions Club representative; Mr. George Possee, VA Hospital Social Worker; Mr. Gary Blewitt, Model Cities Program Analyst; Mrs. Kathleen Sinclair, Counselor for Court Conciliation; Mr. Robert T. Cummins, Lawyer; Father John Bauer, Director—Catholic Charities.

2. The Alcoholism Information and Referral Center, in a short period of four months, has already begun implementing (1) a program of education for community "care givers" such as welfare department, nurses, courts, schools, etc., about the disease of alcoholism; (2) a systematic counseling and/or referral treatment approach for problem drinkers; (3) a coordinating mechanism among community service agencies to assist problem drinkers and their families; and (4) an outreach alcoholism program for off reservation Indians.

3. The Center serves three counties (Lewis & Clark, Broadwater, and Jefferson) with a population of 38,000 and 6,412 square miles. The program uses funds available from DHEW (\$48,455) and Model Cities (\$15,000). The Assistant Program Director described the Center's approach to the problem drinker. He indicated that staff time and resources are not directed solely at the alcoholic but that concomitant efforts are also concentrated on educating the problem drinker's immediate family, employer, and community to the ramifications of the disease.

4. The Center's staffing pattern deviates from that originally proposed. Present staff include (1) a Director, (2) Assistant Director who also counsels, (3) a Teen Council Director who works full time in the schools, (4) a counselor working in the Catholic Charities halfway house for alcoholics, (5) an Indian Liaison Officer, who counsels off reservation Indians, (6) a secretary-accountant, and (7) a clerk-typist. Reactions to the Center staff performance thus far from individuals I interviewed were unanimously positive and complimentary. The Assistant Superintendent of Schools passed out special plaudits to the Center's school education program and Teen Council.

5. The Center Director's experience thus far has indicated the importance of a complete and total education of the three counties to the problem of alcoholism. He also regards community involvement as a prerequisite to an effective program. Several methods are used to involve the community, such as the Center's supervisory board, the Teen Council composed of junior and senior high school students, and the Indian Liaison Officer who holds membership on the Indian Alliance and Inter-Tribal Policy Board.

6. It appears the uniqueness of this program is already recognized by out-of-staters. The Center Director has been invited to participate as a principal speaker

in a symposium next summer sponsored by the Utah University School of Alcoholism Studies.

7. The evaluation mechanism was initially considered the weakest aspect of this program. However, the Director has enlisted the expertise of the Helena Model Cities Program Analyst to develop an evaluation approach for measuring outputs against inputs: This should be an effective method for measuring objectives.

8. Additional comments: Because the regional review committee prohibited expenditure of Federal funds for Center accounting expenses, it is recommended that Model Cities money be used for this purpose. There also appears to be a need for the Center Director to spend additional time spelling out the alcoholism Center's long-range objectives to the Rocky Mountain Development Council's governing board. Since education of community service agencies to the problems of alcoholism is of primary importance and a major Center objective, the means of accomplishing this end should be particularly emphasized.

AUBREY M. HALL, Jr.,

Consultant in Program Development—NIMH.

Senator HUGHES. The Chair calls Dr. Williams Peeples, representing the American Public Health Association, and Jay N. Cross, consultant on alcohol problems and member, American Public Health Association.

Welcome to the subcommittee hearings. You may proceed with your testimony as you desire.

STATEMENT OF WILLIAM PEEPLES, M.D., AND M.P.H., ON BEHALF OF THE AMERICAN PUBLIC HEALTH ASSOCIATION, AND JAY N. CROSS, M.P.H., CONSULTANT ON ALCOHOL PROBLEMS AND MEMBER, AMERICAN PUBLIC HEALTH ASSOCIATION

Dr. PEEPLES. Thank you, Senator Hughes.

Mr. Chairman and members of the committee, the bill that is under consideration today focuses attention on one of our Nation's most critical health and social problems. The ravages of alcoholism, with its toll in individual suffering, family disruption, industrial and economic loss have defied exact measurement. That alcoholism affects large numbers of people is well accepted. Even cursory measurements have shown us this.

However, in spite of the lipservice that has been given to the need for efforts to deal with alcoholism by all levels of government and by nationally respected authorities—in spite of the vastness of the impact of alcoholism and other alcohol problems in our Nation—the efforts to deal with these problems have been, for the most part, only token efforts.

The American Public Health Association applauds the concern and vision that this committee has shown in confronting this vital health issue. The association is an organization of more than 25,000 professional health workers.

In addition, 53 State public health organizations are affiliates of APHA and 191 agencies are members. The membership includes physicians, nurses, behavioral scientists, occupational health and medical care personnel, health educators, and others who have concern for the social, emotional, and physical health of persons in their communities. The association has been particularly interested in alcoholism as a health problem for a number of years.

In 1962, the APHA Governing Council adopted a resolution which recognized the importance of alcoholism as a public health problem and which stated, in part :

The American Public Health Association urges all State and local health departments to initiate programs aimed at securing public acceptance of the available scientific knowledge and advancement in the field of alcoholism so that appropriate preventive and treatment programs can be established.

Through the adoption and publication of this resolution, the association intended to provide the stimulus and endorsement that would lead to increased alcoholism program activity in community health departments.

During the years 1963 through 1968, with funds granted by the National Institute of Mental Health, APHA sponsored special alcoholism projects. These projects, conducted by a subcommittee of the Committee on Chronic Disease and Rehabilitation, were designed to provide community health workers with useful resource materials for programs development and to promote training opportunities in this critical health problem area.

Publications resulting from these projects include the "Guide to the Community Control of Alcoholism" and a monograph entitled "Teaching About Alcoholism in Schools of Public Health."

The guide, in addition to APHA's bookshelf of program development and implementation materials, presents basic information to persons concerned about the planning of community alcoholism programs. The monograph provides models for teaching about alcoholism that were developed by faculty members of schools of public health.

In addition, the Association, through its western and southern regional offices, has conducted a number of short term training programs intended to sensitize health professionals to their appropriate roles in developing community alcoholism programs.

The American Public Health Association has also been active in efforts to bring about effective programs to deal with alcoholism in other ways. The counsel and support of its staff has been made available to organizations with special interest in alcoholism.

From time to time, it has expressed the concern of its members that administrative structures and programs for mounting an effective attack on alcoholism must be developed by the Federal Government. We have urged that a specific agency within the Public Health Service of the Department of Health, Education, and Welfare be given the responsibility, authority, and financing to plan, coordinate, and develop appropriate alcoholism program activities.

We are convinced that the Federal Government must provide the leadership and support which will result in vigorous and expanded programs of research, training, and service. The role of the Federal Government in directing national attention to alcoholism and alcohol abuse as important health and social problems is apparent.

However, to date, Federal leadership in these areas has been minimal. Programs that have been initiated have been piecemeal and limited. These activities have been hampered by lack of funds, paucity of qualified professional staff, and limitation of scope. These matters, together with our concern for the health of the citizens of our Nation, have moved us to testify on behalf of S. 3835.

The bill that is before this committee today provides the framework in which a national effort to effectively deal with the problems of alcoholism and alcohol abuse can be mounted. It should enable the Federal Government to assume its appropriate leadership in the combat against the health and social problems created by alcoholism and alcohol abuse.

The bill should make it possible for the Federal Government to assist local communities to develop alcoholism programs and services relevant to their needs. For these reasons, the American Public Health Association is pleased to endorse the Proposed Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970.

In reviewing the proposed legislation, two issues of importance to the effectiveness of efforts to implement the provisions of the bill were observed. Therefore, we respectfully request consideration of the following recommendations:

1. The Secretary of Health, Education, and Welfare should be urged to provide competent, trained field consultation staff in each regional office of the Public Health Service. These regional personnel would provide a means for stimulating the development of meaningful State and local alcoholism and alcohol abuse programs. Regional consultants would also be able to interpret and disseminate information concerning grant programs to relevant organizations and agencies in the region.

2. Although the program proposed in S. 3835 is ambitious and comprehensive, no specific funding authorization has been made to enable the organization and implementation of the provisions of the bill. We strongly recommend that substantial funding be designated in the proposed legislation. The American Public Health Association concurs with previous testimony on behalf of the bill by the North American Association of Alcoholism Programs that a minimum of \$75 million be authorized for the first year of the proposed program.

Finally, in summary, the American Public Health Association believes that alcoholism and other problems related to the inappropriate use of alcoholic beverages are of critical community health importance. We believe that current levels of activity in the Nation are extremely inadequate.

The association is convinced that the Federal Government must provide leadership and support if an effective attack on this health and social problem is to be mounted. The bill that is being considered by this committee provides for the development of the needed comprehensive programs by appropriate agencies in the Federal Government. We urge passage of the bill, with the changes that we have recommended by Congress, and its signing into law by the President.

Senator HUGHES. Thank you, Dr. Peeples.

Mr. CROSS. Mr. Chairman, I have some remarks relating to previous testimony that have relevance to our deliberations today. I shall anticipate some of your questions in my statement.

Alcoholism is a multifaceted problem requiring the skills and services of a variety of social and health resources in the community. Although the present trend to support services in community mental health centers is admirable, the fallacies of putting total reliance on the one community structure must be pointed out. Community men-

tal health centers are a new (federally supported and conceived, for the most part) community facility. They do not exist in every community. Few of the operational centers have included special alcoholism services. In view of the possible predominant orientation of the mental health professionals toward the care of patients or clients, it is possible that most of the efforts in the community mental health centers will be expended in diagnosis, treatment, and maintenance of continuity of care for individual alcoholics—certainly necessary, but not enough to be effective in other alcohol problem areas or in prevention of alcoholism.

It is important to reemphasize the importance of the community health department in the development of programs aimed at the amelioration of health and social problems. Over 1,500 local health departments are presently serving nearly every community in the United States. These agencies have the advantage of having provided for the health concerns of their constituencies over long periods of time. Public health is the scientific diagnosis and treatment of the body politic. The essence of this definition by E. G. McGavran, formerly dean of the School of Public Health of the University of North Carolina, is that professional health personnel are responsible for the scientific diagnosis and treatment of the community as a whole, not necessarily for individuals living within it. Community health professionals must be sensitive to all of the problems of the populations they serve and must have the skills to deal with them. Alcoholism and alcohol problems affect the whole community. In a community health department, professional health workers in disciplines which provide care to individuals are available as well as those whose expertise includes skill in dealing with environmental problems, educational programs, community organization, laboratory work, et cetera. For these reasons I would endorse Dr. Weisman's comment that the community health department should be considered as a vital link in providing broad-based service in communities. I would reemphasize the statement that the provisions of the Community Mental Health Act provide only one of the many resources that should be available.

With respect to funding under the proposed bill, careful consideration should be given the need for providing adequate moneys to insure that appropriate plans can be developed for implementing the Federal, State, and community aspects of the program. I would suggest that substantial funding be made available immediately for the development of a comprehensive alcoholism and alcohol problems control plan by the Federal Government and by the States and regions in which alcohol related problems exist. It would appear that at least 100 regions (State and larger metropolitan areas) would need funding for planning at the level of at least \$60 to \$80 thousand per year. Funds for demonstration projects should be made available for promising programs in areas which already have structures and services for dealing with alcohol related problems. Substantial funding should be made available for intramural research by agencies of the Federal Government and to support extramural research by competent institutions and organizations. Budgetary allocations should be made for the employment of competent trained consultant personnel in the regional offices of the Public Health Service as we discussed in our recommendations. Funds for training activities by the Federal Government should be expanded greatly. We compliment you on your foresight for in-

cluding in the bill special training for a variety of target groups. If dollar values were assigned to the above programs, it is readily seen that the \$75 to \$100 million appropriation that you have suggested would be a bare minimum.

Dr. PEEPLES. One other suggestion that I would like to make, Senator Hughes, is that the funded money for facility construction should be separated from funding for service programs and training.

If there is planning, say, for a 1- to 2-year period by all the States and local communities, to determine the number of alcoholics (an epidemiological study, so to speak) and the types of facilities needed, I am afraid that the facilities are going to be in such great need that the whole amount that would be appropriated might easily be required for building these facilities.

My opinion is—and I think it has been expressed here by the others today—that general hospitals provide for treatment of acute problems, and are not the major resource for treatment and rehabilitation of the alcoholic.

I don't think that the medical profession or the psychiatric group has been successful in the rehabilitation of alcoholics; however, others who have had less training and maybe more patience and understanding have done considerably better. I think it is these people we should try to train, hopefully not in the same modality of treatment that has been used so unsuccessfully in the past.

Senator HUGHES. You have heard me ask the question many times earlier today. Do you believe that hospitals that discriminate against alcoholics patients should be denied Federal funding?

Dr. PEEPLES. I think they should, and I think general hospitals should be specified. There are many specialized hospitals that might not be in the realm of accepting the acute alcoholic or the chronic alcoholic.

Senator HUGHES. You have already, between the two of you, dealt pretty adequately with the general questions I would have asked you.

I think you have anticipated them and gone through them pretty well. You have heard the testimony this morning. We have dealt with suggestions for funding, which I agree would be minimal.

This would be a start of funding, and only that. It would not reach out anywhere in depth.

So we are talking about the possibility of getting an appropriation of \$75 to \$100 million. We are talking about the startup and gearing up to really get out and do a job which probably would run 10 times that in 2 or 3 years, if we do it adequately.

But right now, we have no adequate funds to begin the training and begin the research. That has been a shock to me, also. I was surprised to find out that we spend less than a million dollars in something that is costing us a staggering economic drain, not to mention the loss of human lives and the drain of human dignity that is involved.

If you have additional suggestions on this legislation, it would be helpful to the staff if you would supply them in writing.

Senator HUGHES. I thank you very much for being with us, and for your patience in waiting.

Dr. PEEPLES. Thank you.

Senator HUGHES. At this point I order printed all statements of those who could not attend and also all other pertinent material submitted for the record.

(The material referred to follows:)

AMERICAN HOSPITAL ASSOCIATION,
WASHINGTON SERVICE BUREAU,
Washington, D.C., May 21, 1970.

HON. HAROLD E. HUGHES,
Chairman, Subcommittee on Alcoholism and Narcotics,
U.S. Senate,
Washington, D.C.

DEAR MR. CHAIRMAN: This letter is in response to your request for the views and comments of the American Hospital Association on S. 3835, the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation bill which you introduced last week.

First we would like to commend you highly for your great concern and leadership in pressing for a broad scale attack on alcoholism, which ranks fourth among the causes of illness and disability in the United States today. At your invitation, the Association last year was pleased to provide two panel members for your Subcommittee's hearings on alcoholism, both of whom are high officials of hospitals that have outstanding programs for the treatment of alcohol patients. They testified in considerable detail on the current status of treatment services for alcoholics in the general hospitals of the country and some of the ways hospitals are seeking to improve and expand the availability of care for alcoholics.

As you stated when you introduced S. 3835, the American Hospital Association has long recognized that alcoholism is an illness. Attached hereto is a copy of the latest revision of the Association's statement concerning the admission of patients with alcohol and other drug problems to general hospitals. The major thrust of this statement is that alcoholic patients require the best in diagnosis and medical treatment, that general hospitals should develop programs for the care of alcoholic patients, and that decisions concerning admission of such persons should be based on the needs of the individuals.

Since the admission and treatment of patients in hospitals are matters that call for medical decisions by health professionals on the scene after consideration of the medical requirements of the patient in each case, we do not believe the admission of patients to hospitals should be dictated by law. We, therefore recommend deletion of Section 611 of S. 3835. Alcoholic patients should compete on an equal basis for all other patients (medical, surgical, etc.) for use of hospital beds and should not be discriminated against because of their diagnosis. On the other hand their admission to hospitals should not be compelled by law but should be determined on the basis of their medical need.

We would emphasize that the Association does intend to continue to urge general hospitals to develop programs for the care of alcoholic patients and to provide for referral to specialized or aftercare treatment resources. As an example, the Association funded by grants from the National Center for the Prevention and Control of Alcoholism of the National Institute of Mental Health has developed a two day conference entitled "The Hospital Care of the Alcoholic." A principal objective of the program is the correction of misunderstandings about alcoholism that affect hospital staff attitudes with regard to alcoholic patients. Included in the materials for this conference is a filmed presentation by Mr. Mark Berke, President of the American Hospital Association on the "Implications of the Admission of Alcoholic to the General Hospital." A transcription of Mr. Berke's talk is attached hereto, which we are sure you and your Committee will find of great interest. Two pilot conferences have been held and both were successful. A third pilot conference is to be conducted in June and ten additional States have been selected to participate in the second year of the project.

The Association is now preparing a proposal for development of programmed instructional materials for hospitals to train their professional staffs, including physicians, nurses, social workers and other hospital personnel in the treatment of alcoholic patients. A similar proposal is being developed for a community education program to be conducted by schools, churches, and other interested community groups.

We will appreciate you having this letter made a part of the record of hearings on S. 3835, and you and your committee's consideration of the Association's views.

Sincerely,

KENNETH WILLIAMSON,
Deputy Director.

IMPLICATIONS OF THE ADMISSION OF ALCOHOLICS TO THE GENERAL HOSPITAL

(By Mark Berke)

My name is Mark Berke; I'm the executive director of Mount Zion Hospital and Medical Center in San Francisco. I'm the 1970 president of the American Hospital Association.

I want to talk a little today about the problems of the admission of the acute alcoholic into the general hospital, and I hope to allay some of the fears I know everybody feels—administrators, physicians, nurses, social workers, everybody else—about admitting that alcoholic patient into the hospital without some sort of special program. I think one of the things you must bear in mind is that of paramount importance—there are a number of problems of course—but of paramount importance is the role of the medical staff in this. If you have a large medical staff such as I have in Mount Zion Hospital, you are never going to get the entire medical staff interested in, or even perhaps sympathetic to, the problems of the alcoholic. What is important though, that you get at least one, perhaps a small group of physicians who are interested and who make this their program. Now, this is not really very difficult to do.

In my own case for example, I was walking down the corridor of the hospital one day wondering whom I could get involved, and passed a young internist who was a good friend of mine. I saw him, I tapped him on the shoulder and said: "Jack, you're in charge of our alcoholic program." He didn't know much about alcoholics but he decided he would take it; as a result, today he is a really skilled alcoholic physician who really understands the problem of the alcoholic.

We have been in the program at Mount Zion since 1956, and we have had some real experiences.

Let me go through some of the questions that I know are uppermost in your mind at this time. First of all, there is always the question, is the patient really manageable; what do we do about this unmanageable patient who is going to go running down the corridors wild-eyed and shouting all over the place. It doesn't happen! It really doesn't happen! Today, especially with the use of drugs and especially with the use of trained personnel—and that is a key factor; one must train one's personnel in these programs—patients can be sedated quite adequately before they ever get up to the floors. You take care of them in the Emergency Room, and by the time you get them up to the floors, as I say with the use of the necessary trained personnel and drugs, they are really quite sedate, quite quite and really no more trouble to manage than any other patient.

I suppose in the entire time since 1956 we have had this program going, we have had only 4 or 5 patients all told who are what you and I would call unmanageable. In the first two cases these patients were suffering from a real psychosis and should not have been hospitalized in a general hospital. And had we then had the experience we would have recognized this. In the other 2 or 3 cases, these were patients whom we refused to accept into the hospital, or whom we discharged very quickly. Again, with the experience we gained afterward and our after-knowledge, we recognize now that those were patients that we could easily have handled if we had done it properly. It was just that we were not really that familiar with the program at that time.

Another question that has been raised is whether one should have these patients on the same nursing units as other patients, and I think quite unequivocally one can say here that the answer is, yes. We have had experience with patients in private rooms, in semi-private rooms, in four-bed rooms and twelve-bed wards, and I think under all these circumstances, again with proper management, medical management, of the patient with proper understanding by the nurses and other personnel, they have represented no more of a problem than any other problem patient that you may have had. We've all had problem patients, after surgery for example, emotionally disturbed patients; as a matter of fact we've all had alcoholic patients in the hospital without a frank diagnosis of alcoholism; that's really where the problem comes up. If your personnel are being asked to handle alcoholic patients without really understanding the problems, then you have trouble. But not when they are trained, and not when you understand them; I think this is the key. The necessary staff training in the program and the necessary indoctrination of the personnel is really the key to this whole affair.

In our own case, as a matter of fact, our orthopedists have told us that they suspect that 50% of all orthopedic admissions to the hospital—and we have a rather large orthopedic program—50% of these admissions have been admitted

to the hospital because of some involvement with alcoholism, usually a relatively large involvement.

A related question that's come up, and that I am asked very frequently, does one need to use restraints with patients who are admitted with an alcoholism diagnosis. We do not like to use restraints; as a matter of fact, we believe that when we are forced to use restraints—which is very rare except in cases of psychosis, which are also quite rare—if we were forced to use restraints, this would be considered by us a failure in treatment of the patient. If you have to use restraints you are simply not handling that patient properly and appropriately.

As an administrator of course I am as concerned as everybody else is about the financing of all programs, and certainly the financing of programs for the alcoholic. So let me deal with several of the questions that seem to come up quite consistently about this. In the first place, there is the question of the availability of funds for the construction of facilities for rehabilitation of the alcoholic; and such funds are available, public funds are available for this purpose, although I want to reiterate again my feeling that the inpatient phase of alcoholism should not be separated out, the patient should not be separated out from any other type of patient. There are however, needs for outpatient rehabilitation facilities and I repeat, such funds are available.

The sort of question that's usually asked is whether third party payments, private insurance company payments, are available for the case of the alcoholic in the general hospital. And I must say that this is still a rather hazy area.

The insurance companies are moving more and more toward making such payments available for hospitalization. Certainly the hospitalization of the patient with a related illness, perhaps not the alcoholism itself but related illnesses, is now available and the insurance companies are becoming more and more liberal in this regard.

The question is always raised as to whether the alcoholic can pay for his own hospitalization, and the truth is that many alcoholics can. Many alcoholics do not come from the skid row type; they are private patients and they can pay for their own care. A related question by the way, is the question of credit and collections on alcoholics, and there seems to be a myth that the credit problems of the alcoholic are greater than the credit problems of the nonalcoholic other type patient. I think this is not true; our own experience shows this not true. The alcoholic patient and his family are so looking for help that they are really very grateful for the help they get from the hospital when they get a fair and appropriate hospitalization, and in our experience the credit and collection problem is certainly no greater and probably less great, than with other types of patients.

A question that many people of course are interested in, is whether Blue Cross contracts cover the hospitalization of the alcoholic in the general hospital, and at this time of course many local Blue Cross contracts do not cover this; but I am very happy to say that in May of 1969 the national Blue Cross contracts eliminated the alcoholic exclusions so that they now do accept the alcoholic patient in the general hospital. And as you know, this is really a pace setter toward the local plans. And it is our hope that the local plans will in the near future also cover the admission of the alcoholic to the general hospital.

One point that is frequently asked is how we justify the admission of the patient with the primary diagnosis of alcoholism to the general hospital, and I think I might say in this regard that the statistics of admissions of such patients to the hospitals are really pretty unreliable and I repeat, so many alcoholic patients are admitted to the hospital with other diagnoses, we really don't know how many patients we are admitting in the field. However, I think the question of the justification, sometimes I think we use it as an escape in terms of a moral question, people raise it as a moral issue. The fact is that the alcoholic patient is a sick patient and has as much right to a hospital bed as any other patient does. This is something that your medical staff must determine, and must have as a philosophical point of departure. In our own case interestingly enough, it was our own chief of surgery, who had very little acquaintance with the type of problems that alcoholics bring into the hospital, or in his own private practice, for example. But he felt very strongly that we were dealing with sick people, and therefore one must bring them into the general hospital regardless of the fact that in our own case our occupancy of medical and surgical units annually exceeds 92%, which means that we really have no beds available, and what we were doing was bringing in a new group of patients into the hospital who would compete with all other patients, medical

and surgical alike, for the use of the beds. Nevertheless he felt, and our medical board and board of directors agreed with him, that they had as much right to these beds as anybody else has.

A related question that comes up frequently is if we bring such patients in will they not overcrowd our facilities, and should we not add separate facilities for the care of the alcoholic. This was a question that was raised in our own case in light of the occupancy that I already discussed with you. We feel very strongly, I personally believe very strongly, that the use of separate facilities would completely defeat the objective of the program. Even where you have a psychiatric facility I submit that the patient should not be placed in the psychiatric facility, but should be placed in the general hospital bed. I think you will find, as you get experience with this, that the alcoholic patient, even the one with mild management problems, placed in the general hospital bed, treated as a human being who is sick, as is any other human being in the hospital, will respond much more favorably than one who is placed in a separate facility. It is when you place such patients in separate facilities that they really tend to become unmanageable. And I think that when you hear these stories of unmanageable patients, you are really hearing stories about patients who were not treated adequately, who were not treated appropriately, who were not treated *equally*—if you want to use that phrase—I think this is where you would really find this sort of problem. I might add here too that I am talking about all groups of patients; we have skid row patients; the majority of our patients are middle class patients because that's where the majority of alcoholics come from anyway; but you run the entire spectrum. The hospital, today's hospital, cannot address itself to a single factor of society; it must treat the whole of society, and I think you must reconcile yourself to this in your program.

Another question that is very often asked, if we admit alcoholics with a frank alcoholic diagnosis, will we not need additional staff, will we not need additional nurses, will we not have to give additional care. I think the answer is no, not generally, at any rate. I think the answer again lies in the adequate and proper training of personnel by people who are competent to give that training. It's a question really of attitude of staff, both physicians, nursing staff and all other personnel, social service staff and so on, it's a question of their attitude toward the care of the patient rather than it is one of physical facilities or additional personnel, and I think this is very important.

A related question is whether or not the hospital should have the services of a knowledgeable physician available to it, and I enthusiastically endorse that with a "yes" answer. You should have a physician who is competent in the care of the alcoholic; if you have no physicians competent in the care of the alcoholic it is not difficult to get one or two physicians who will very quickly become skilled, very quickly become knowledgeable, very quickly become the outstanding people in their community for the care of these patients; but it is important that there be a physician or group of physicians in the hospital who are familiar with this type of care.

I want to tell you how pleased I am to have participated in this program which I think is so important. I don't want you to feel that there are no problems in taking care of the alcoholic in the general hospital; there are problems, but that's what administrators are for, to meet problems. And I don't think the problems are anywhere near as major as many people have made them out to be. I think it's a good constructive program that the community needs, I think it's a program that hospitals have to get involved in; I think it's a program that will merit you nothing but the confidence and applause of the community. I endorse it, and I hope you work very hard to make it a success.

Thank you very much.

STATEMENT ON ADMISSION TO THE GENERAL HOSPITAL OF PATIENTS WITH ALCOHOL AND OTHER DRUG PROBLEMS

Alcoholism ranks fourth among causes of illness and disability in the United States today, and other drug problems also are becoming serious medical concerns. Like other medical emergencies, alcohol and other drug emergencies require the best in diagnosis and medical management.

Courts and legislative bodies increasingly recognize that alcoholism *per se* is an illness and not a criminal activity, but although improved methods of treatment are available for all patients with drug problems, the majority of hospitals still deny admission to such people.

The reluctance of hospitals to admit patients with alcohol and other drug problems is often based on the misconception that, because these patients are uncontrollable and disruptive, special facilities and staff are required for their care. The truth is they are not. Professional knowledge is required, not special units; the successful management of such patients in regular units is well documented.

Further, the health insurance industry is beginning to support the admission of alcohol and other drug patients to the general hospital. The Blue Cross Association, for example, has eliminated from its national contracts discriminatory clauses excluding coverage for mental illness, alcoholism, and drug addiction.

Failure to admit alcoholics and patients with other drug problems denies them the benefits that would be available in cases of poisoning due to other causes; similarly, it denies hospital personnel and house staff the opportunity for education in the management of such cases.

Since 1944, the American Hospital Association has recognized alcoholism and addiction to other drugs as medical problems requiring broad-scale attack. In that year a special committee of the Association recommended that "the primary point of attack (on alcoholism) should be through the general hospital."

The Association urges general hospitals to develop programs for the care of alcohol and other drug problem patients. Decisions concerning admission of these persons should be based only on the needs of the individual. Hospitals should accept their community responsibility for the appropriate admission of persons acutely ill as a result of any drug intoxication, and also their responsibility for the subsequent referral of these persons to specialized and/or aftercare treatment resources. The number and availability of such resources are increasing.

Although the hospital is not expected to provide all rehabilitation services required by these patients, it does have the responsibility to stimulate the development of such services and/or the resources to provide them, if they are lacking in the community.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
Washington, D.C., June 30, 1970.

Hon. HAROLD E. HUGHES,
United States Senate,
Washington, D.C.

DEAR SENATOR HUGHES: Thank you for your letter of June 2, 1970, requesting a list of Federal funds committed in various categorical disease areas.

The information requested is summarized for fiscal year 1970 in the following table:

Federal commitments by selected categorical area—fiscal year 1970

	<i>Millions of dollars</i>
Heart and lung disease.....	174
Cancer	195
Mental health (exclusive of drugs and alcohol activities).....	306
Child health.....	1, 443
Allergy and infectious diseases.....	104
Arthritis and metabolic diseases.....	147
Neurological diseases and stroke.....	108
Narcotic addiction and drug abuse.....	70
Alcoholism	39

It has not been possible in this table to include all Federal funds for the categories listed. Such information is not available even within this Department because of the growth of comprehensive and combined programs in recent years. The Regional Medical Programs, for example, include \$78.5 million for heart disease, cancer and stroke, but this amount is not susceptible to a break by each of these diseases. We have not, therefore, included this program in the figures given. Health care costs under Medicare and Medicaid cannot be identified on a categorical basis, and no estimates for these programs are included. Except as noted below, we have not attempted to provide estimates for other agencies, such as the Department of Defense or the Veterans Administration.

The President's budget does include identification of total federal outlays by all Agencies for child health care, and we have provided that estimate.

Figures for narcotic addiction, drug abuse and alcoholism include estimates for the Justice Department, Office of Education, Office of Economic Opportunity, and the National Institute of Mental Health.

Amounts for the other categorical disease programs represent funds included in the 1970 appropriations to the National Institutes of Health and the Health Services and Mental Health Administration.

If I can be of further assistance, please contact me.

Sincerely yours,

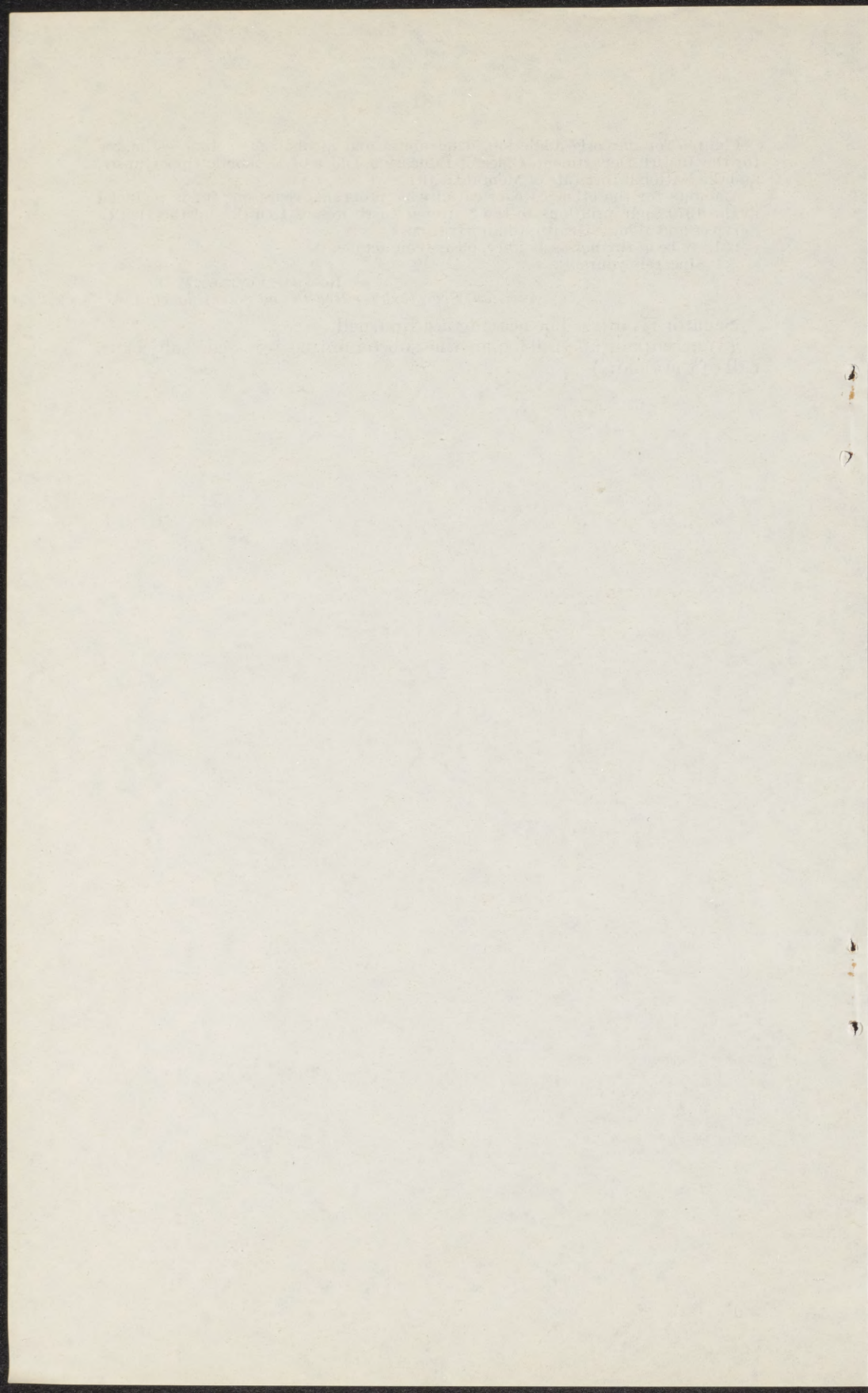
ROGER O. EGEBERG, M.D.,

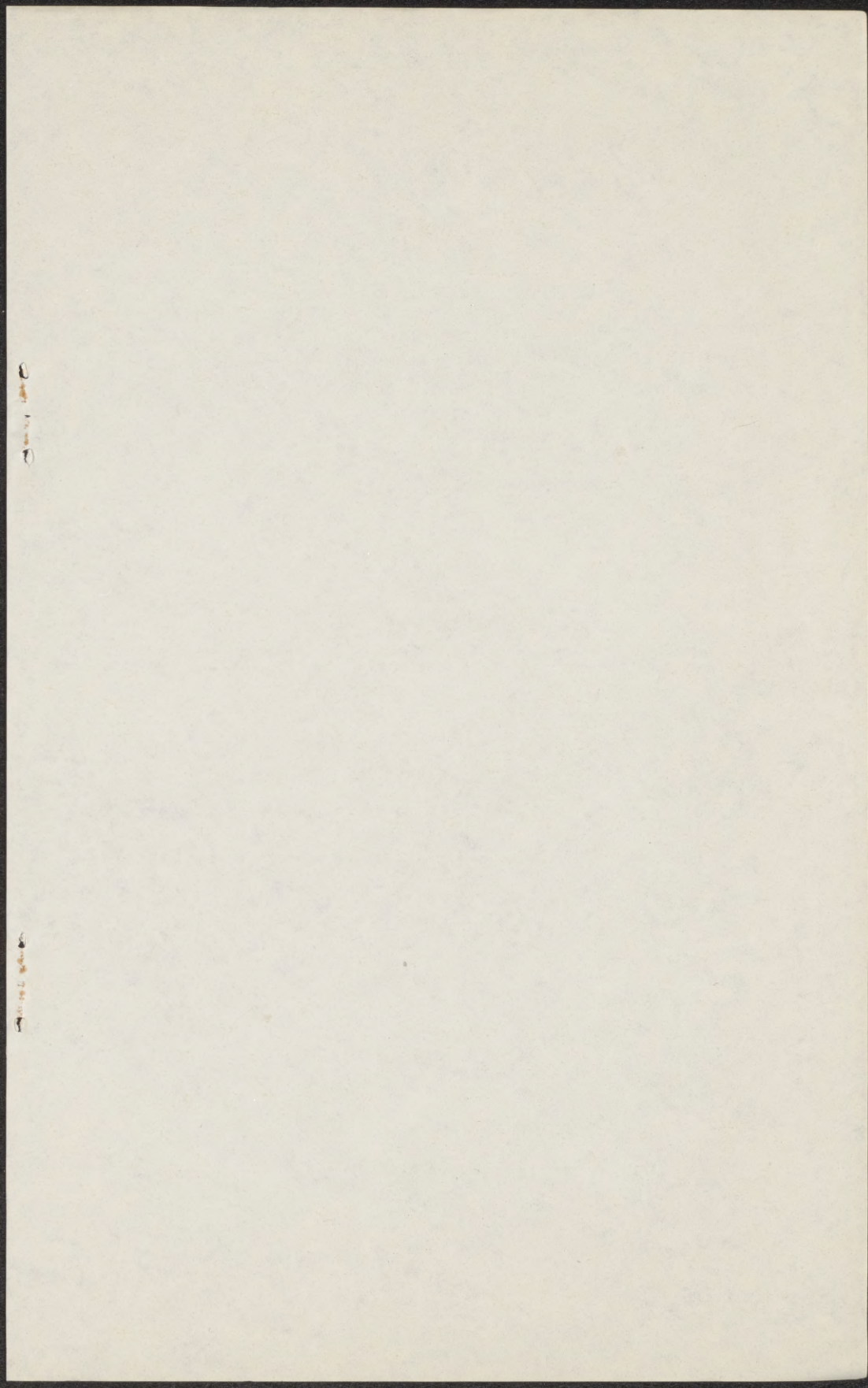
Assistant Secretary for Health and Scientific Affairs.

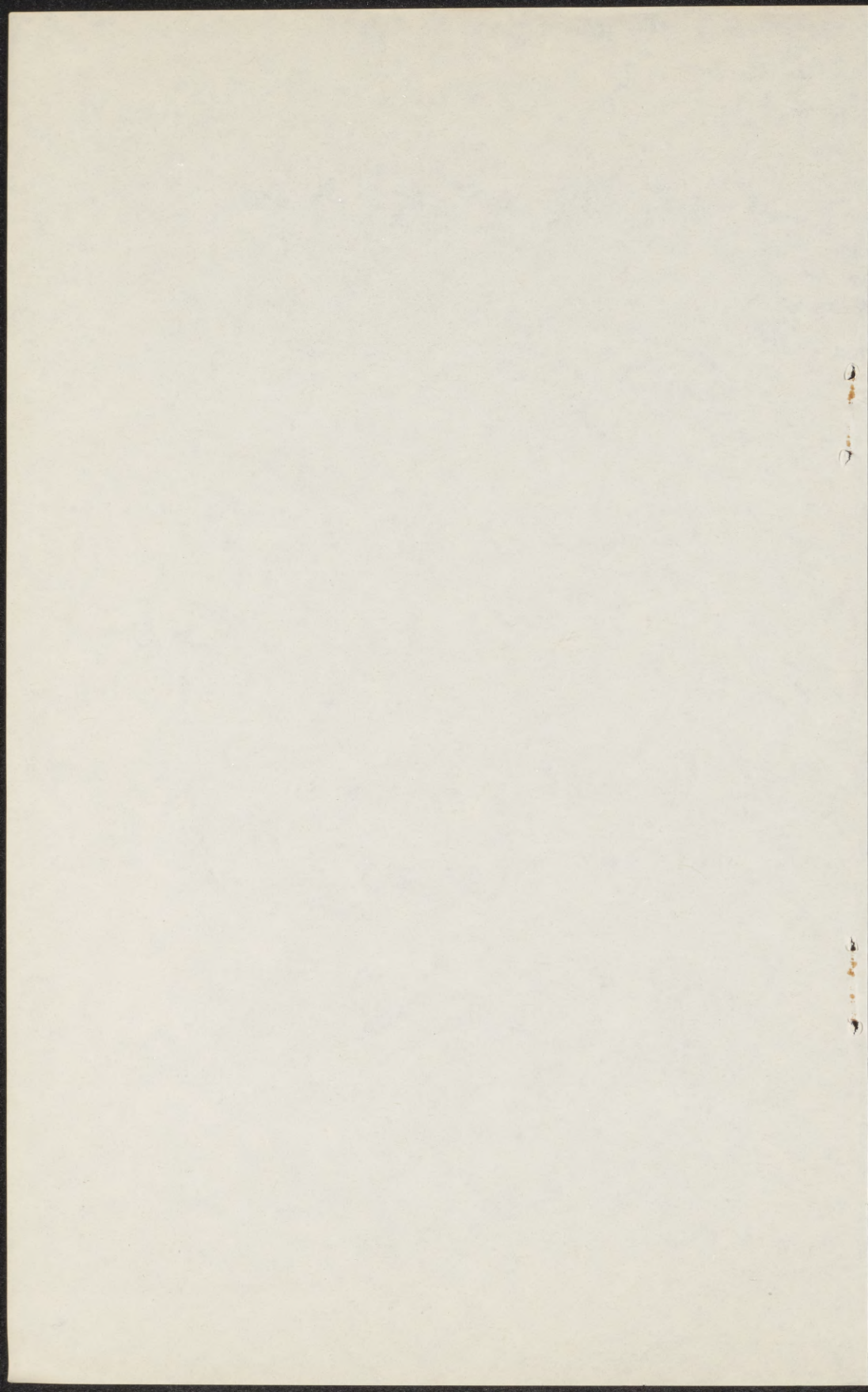
Senator HUGHES. The hearing is adjourned.

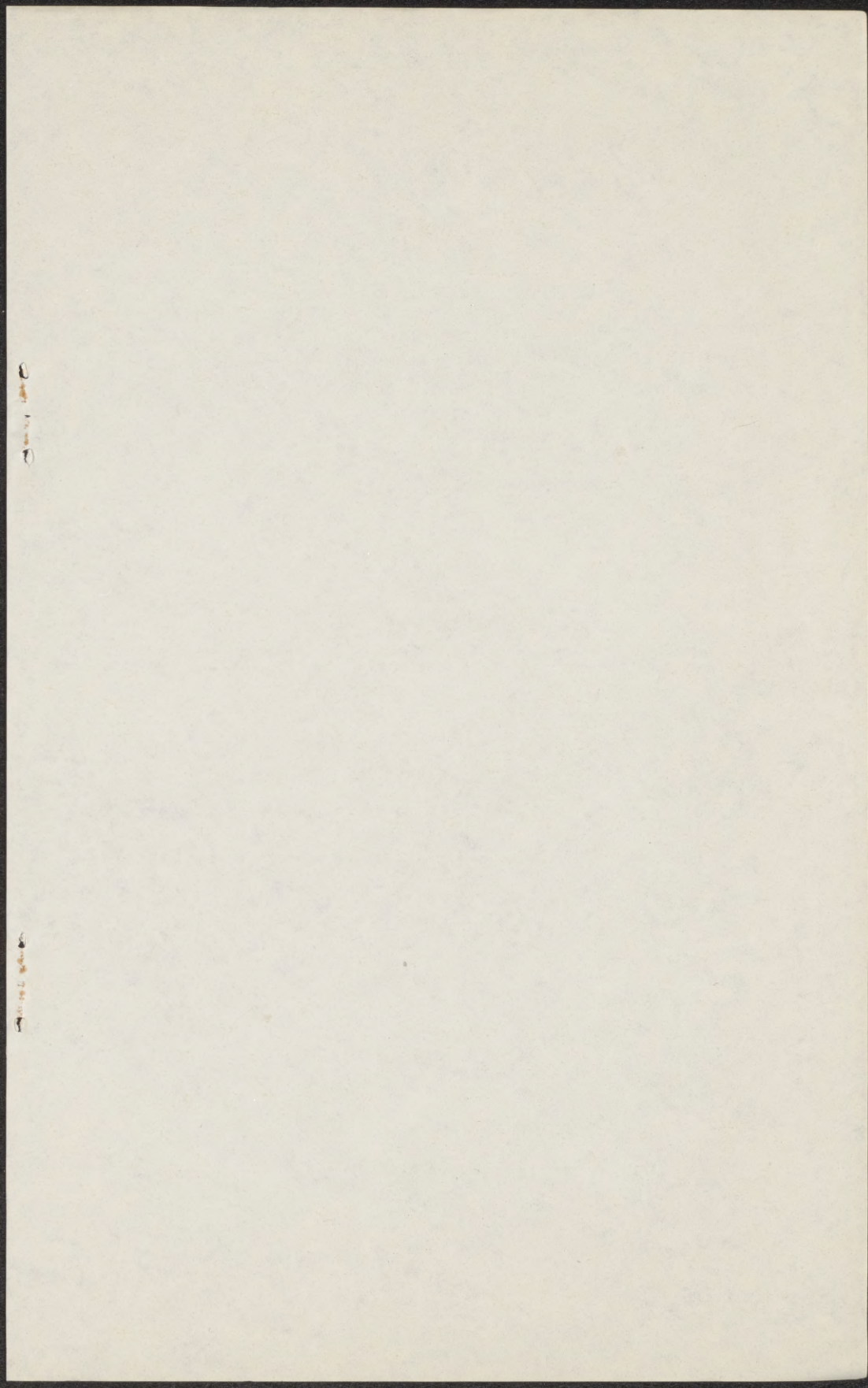
(Whereupon, at 12:08 p.m. the subcommittee recessed, subject to call of the Chair.)

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