

THE FUTURE OF GOVERNMENTAL SUPPORT
FOR ALCOHOL AND DRUG TREATMENT SERVICES

Speech at

Annual Convention, Alcohol and Drug Problems Association of North America

Palmer House, Chicago, 10:30 A.M. Tuesday, September 16, 1975

General Concurrent Session II-K

by

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In the limited time at my disposal, it is most difficult to discuss in adequate depth many of the exciting challenges in the field of governmental support for alcoholism services. I make no attempt in this paper to discuss drug abuse, because I do not have the expertise to do so.

However, in the interest of economy of presentation, we believe a fruitful dialogue can be generated around the following items:

(1) The very title of this session leads naturally to a discussion of adequate levels of Federal and state financial support for alcoholism treatment services. Some of us have been stunned by recent statements of present and former officials of the National Institute on Alcohol Abuse and Alcoholism, that we might be "very close to peaking out in terms of our ability to generate the necessary visibility and concern in Congress -- even with a good vocal and articulate constituency."

For those of you who read COMMENT, the legislative newsletter of the

National Council on Alcoholism, I think we have dealt with this undocumented assertion in the July 17, 1975 issue. Support for increased funds for alcoholism and a realization of the importance of the problem has never been at a higher peak, as we pointed out in COMMENT Number Fifty-six. Letters in support of our objective have tripled in the past year, both from the Congress and from our Councils out in the field.

Therefore, negative utterances from "experts" from Washington, D.C. have a most discouraging effect, and they have been going on for a number of months. For example, as far back as March, I received a call from a local alcoholism director in a large state in the Midwest, pointing out that the negative remarks that day by a NIAAA official had a very dampening effect on the efforts of all the alcoholism Councils within that state to raise by 20 percent the stand-still budget presented by the Governor in January for alcoholism.

I can understand this. This second-tier official sounds as if he were enunciating official government policy when he states that because of the "mood of Congress present and potential Administrations, that, in nuclear terms, the half-life of the Institute may have been reached."

In the first place, I thought policy was determined by the Executive and the Congress and carried out by administrative agencies. In my 25 years in Washington, I have never seen a flat policy like this set down in this way, especially by a "nuclear expert" who happens to also work for the NIAAA.

I am more disturbed by the fact that a number of ADPA and CSTAA people were present at some of these meetings but did not speak up in protest. How can you testify for a budget of \$232 million for the NIAAA for Fiscal 1976 while you

remain silent while officials of the Agency talk about peaking out?

Maybe you are right. Maybe we have solved all the research, training, project grant and formula grant needs in the area of alcoholism. If we have, it is a spectacular development for an Institute which is only four and one-half years old and has been constantly held down in its budget allocations. I don't know about the "half-life" of the National Cancer Institute, but it was established in 1937 and has a current budget exceeding \$700 million and does not have any officials or nuclear experts going around the country proclaiming it is losing the support of the Congress and the people of this country. It has many mountains still to climb, and so do we.

(2) Formula Versus Project Grants

About a year ago, the NIAAA started to put out propaganda proposing converting practically all project grants into state formula grants. I want to pay tribute to their vision, and to yours -- it fell in with Administration policy, but it would have destroyed the very visibility and strength of the alcoholism constituency which the nuclear expert from NIAAA has been so worried about in recent months.

May I quote from my testimony before the Senate Appropriations Subcommittee on the vital importance of project grants:

Mr. Chairman, here again the Administration has announced its intention over the past three years of getting rid of any Federal contribution to these project grants. The project grant is the heart and guts of the whole alcoholism effort, since it helps to support hundreds of grass roots projects in many of the areas which I have cited previously in my testimony -- programs for the drunken driver, the teenager, the Indian alcoholic, poverty groups, the public inebriate, labor-management and many others

too numerous to cite here.

For these project grants, the Administration proposes only enough money to phase out on-going programs -- \$45,451,000. This Committee voted approximately \$74 million for these project grants last year, as against the authorization in the Hughes Alcoholism Act of 1974 of \$95 million.

I have checked with budget officials at the Department of Health, Education and Welfare, and they have not denied the fact that if the Administration budget is sustained, approximately 200 of these grass roots programs would go out of business immediately. Furthermore, those projects which will remain in existence until their abrupt termination will have their budgets cut by approximately 20 percent in Fiscal year 1976.

May I ask what a comparable 20 percent cut would do to the Department of Defense budget for Fiscal 1976?

We therefore recommend a minimum of \$85 million for these grass roots projects in Fiscal 1976, again realizing that even this amount of money will not save many projects in which the local citizens have put in a great deal of their own money and effort.

Who supports project grants? First of all, 535 members of Congress.

They want treatment services in their own backyards, serving their own constituents.

Where are the local people in all of this? In many cases I have checked out, local people going back as far as three years have brought together a number of alcoholism agencies in an effort to set up a grass roots treatment facility. They are still waiting for their money because of inadequate Federal budgets, continually changing ground rules at the NIAAA, and so on.

But the fundamental thing is the stigma still so tragically attached to alcoholism. How do you break it down? Not really by pamphlets, brochures, statistics,

etc. I think the fundamental change must come through people in the community directly involved with an effort to establish an alcoholism treatment facility. Here's how you get volunteers, media coverage and, most important, community acceptance.

The National Council on Alcoholism is not against the state formula grant for alcoholism. On the contrary, we have testified strongly each year for an increase in its budget, because we know that the states must have help in planning and developing sound state-wide alcoholism programs.

However, we do not intend to stand idly by while Federal officials and private organizations in the alcoholism field attempt to wipe out project grants and put all of our eggs in the state formula basket. This would be a tremendous disservice to the entire alcoholism field. We, who have had so little in the past, need a balanced program in which we encourage both state and local efforts. Attempts to wipe out local project grants are only the first step; the next step will be the elimination of state formula grants. I don't think I have to remind any of you in this audience that there have been, and still continue to be, efforts on the part of Federal officials and others to lump all separate categorical formula grants into one amorphous grant to the states.

(3) The Troubled Employee Versus the Straight Alcoholism Approach

This is another problem which has been kicked around for the last several years and deserves some clarification.

The President of your organization, Mr. Leonard Boche, wrote the House Labor-HEW Appropriations Subcommittee this year protesting its criticism of the NIAAA and the Troubled Employee approach. In that letter, Mr. Boche quotes

some very strange documentation. First of all, he claims that the work rehabilitation rate with the Troubled Employee approach is 72 - 90 percent, and that this approach contrasts to no more than ten percent by other methods, and is reaching up to 50 percent or more of the estimated number of workers with a serious alcohol drinking problem, and reaching them earlier. Most telling is his comment that the Troubled Employee program "shifts the focus from a single alcoholic hunt with all its stigma, no matter how well intentioned, to a program concerned with helping citizens effectively on the job."

Documentation is not supplied in support of these truly unbelievable contentions, and no one whom I contacted at ADAMHA could supply me with a single statistic supporting Mr. Boche's position. By way of contrast, the National Council on Alcoholism has constantly pursued the identification of the alcoholic. In 1964, the NCA issued a publication entitled, "A Cooperative Labor-Management Approach to Employee Alcoholism Programs" which outlined a comprehensive program based upon identifying alcoholics through unsatisfactory job performance. This was a pioneer concept and a sharp departure from the then current practice of asking supervisors to become amateur diagnosticians by training them in the medical and behavioral symptoms of alcoholism.

In other words, the supervisor did not do the diagnosing; he referred the case to the medical unit which made a clinical determination. Management, of course, had to be willing to accept the clear cut diagnosis of alcoholism if it were so determined. We know that job performance can be affected by many factors -- marital problems, financial problems, etc. We know that the last thing the alcoholic will admit is that he is one, and he has a beautiful cover when he can just

be classified as a "troubled employee," and that he can lay off all his booze problems on his wife, his children, his boss and practically everything else.

In contrast to Mr. Boche's "documentation," we have reams of evidence that a straight alcoholism program with job performance as the criteria for entrance into treatment does not stigmatize the individual. As an example, the Labor-Management Committee of the NCA approved the following position paper in this area on June 11, 1975. Here are the pertinent excerpts from that position paper:

(1) The most effective method of counteracting social and moral stigma associated with alcoholism is to forthrightly identify it by name in all preventive, educational and program activities.

(2) Alcoholism is a specific clinical entity and should be identified as such in occupational alcoholism programs.

(3) The primary objective of the NCA Labor-Management Committee is to deal constructively with the problem of alcoholism. It is beyond the scope of the Committee's work to attempt to deal with the broad range of non-alcohol related problems which lie outside the recognized professional qualifications and experience of the National Council on Alcoholism.

In other words, call a spade a spade. We all know that there exists in many sectors of our population a stigma against the alcoholic, but that is the challenge. We have to wipe out this stigma and educate the community that it is a highly treatable disease, so recognized by the American Medical Association, the American Psychiatric Association, the American College of Physicians, the World Health Organization and other recognized scientific bodies.

The example of cancer is a revealing one. When I was a newspaperman many years ago, you couldn't mention cancer in any obituary; it was just an unwritten rule of publishers and managing editors of the country. The reason given

was that people just didn't want to read about it; it had all the stigma of leprosy. Therefore, if you didn't mention it, it didn't exist. A few enlightened minds attacked this position and were finally allowed to describe the disease by its proper name. You will note that the largest voluntary organization in that field is called the American Cancer Society -- not the Society for Healthy Cells.

I could cite other examples of trying to disguise the specific disease under terms which would allow the people to avoid any confrontation with the disease itself. I have had this experience for many years in the field of mental illness. The same technique also existed within recent history in tuberculosis, venereal disease, and so on.

As to Mr. Boche's contention that methods other than the Troubled Employee approach have a batting average of less than ten percent, I asked Ross Von Wiegand, Director of NCA's Labor-Management Services, to give me just a few examples of companies which have straight and clearly identifiable alcoholism programs.

This is the list he supplied me:

1. DuPont - 33 years. Frank Lawlor, Program Administrator, reports recovery rates over 85%.
2. Eastman Kodak - 28 years. Dr. Gordon Hemmett reports 85% recovery rate.
3. Burlington Northern Railroad - 24 years. Les Vaughn, Program Director, reports over 90% recovery rate.
4. New York Transit Authority - 18 years. Joe Warren, Program Director, reports over 80%.
5. U. S. Post Office Program - 7 years. Stan Day, originator of the program, reports 75 to 80%.
6. Reynolds Tobacco Co. - 5 years. Ray Jernigan, Program Administrator, reports 65%.

Interestingly enough, after the communication from Mr. Von Wiegand, Doctor John L. Norris, Chairman of the Board of Trustees of Alcoholics Anonymous, sent me an unsolicited copy of a letter he had written to Senator Thomas McIntyre which, apart from its plea for more funds for alcoholism, described in detail how he had originated at Eastman Kodak one of the first programs in industry in the United States which concentrated upon the identification and treatment of the alcoholic. Because management was willing to accept a straight, undisguised alcoholism program, the community was quick to follow. To quote from Doctor Norris's letter:

In 1945 we established in Rochester, New York one of the first councils on alcoholism and under the aegis of that council there were established a clinic for out-patient treatment, one of the first half-way houses in the United States, a rehabilitation program in the penitentiary, the acceptance of alcoholics for treatment in all but one of the local hospitals and payment for such treatment by the local Blue Cross-Blue Shield organization.

(4) Health Insurance Coverage of Alcoholism

This topic is deserving of a paper in itself, so all I can do is to give you a few highlights and impressions in a rapidly changing situation.

First of all, there has been a very positive change in the thinking of the American people as to coverage of alcoholism under a national health insurance program. In a Louis Harris poll conducted in 1974, 73 percent of those polled thought alcoholism should be covered, ten percent were not sure, and only 17 percent felt that it should not be included.

In a discussion of the several national health insurance bills introduced in 1975, Doctor Jerome Hallan, of the University of North Carolina who has worked

with the NCA and the NIAAA in gathering data on present national health insurance coverage of alcoholism, writes in an April, 1975 report discussing the major bills introduced:

"It is important to note that for the first time alcoholism does not fall under mental illness. It is covered directly as a disease -- as any other physical illness and, unlike mental illness, is not singled out for limitation of both inpatient and out-patient benefits."

As an example, Hallan cites the Health Security Act of 1975 (H. R. 21) which has the following benefits:

1. Inpatient Benefits - Unlimited. Treated as any other physical illness. No deductibles or coinsurance.
2. Physicians' Services - Unlimited as in the case of all other physical illnesses covered by the bill.
3. Outpatient Benefits - A person diagnosed as alcoholic would be able to receive services not only from hospitals, mental health centers and other providers who offer alcoholism services, but he also may now be treated as an outpatient in a free-standing ambulatory center.

While somewhat less generous, the bill introduced by Rep. Al Ullman, Chairman of the House Ways and Means Committee, follows the same principle of identifying alcoholism as a disease on a par with any other physical illness.

Rep. Daniel Rostenkowski, Chairman of the Health Subcommittee of Ways and Means, held some preliminary hearings in July of this year devoted to rather philosophic questions about a national health insurance program in relation to present forms of health delivery. After brief hearings on Medicare amendments this month, he has announced that he will turn to public hearings in the fall of the year with a bill to be introduced in January of 1976. It is hoped that every organization here will either testify personally or draft a statement in favor of full coverage

of alcoholism under any national health insurance plan.

It is problematical as to whether any national health insurance bill can be passed in the 1976 session of the Congress. The Administration did not introduce a bill in 1975, and we have no present knowledge of its intentions in 1976. In any case, even if a bill is passed in 1976, the earliest it could be implemented would be 1978.

At the state level, considerable progress has been made over the past several years toward coverage for alcoholism treatment in group health insurance policies. At the present time, approximately ten states have mandated such coverage. However, as Doctor Hallan has pointed out, most of this coverage is restricted to in-hospital treatment in either a general hospital or a licensed residential treatment center. Out-patient care is mandated in only two states -- Massachusetts and Wisconsin, and in only one state -- Massachusetts, is there mandatory provision for individual coverage of alcoholics. In sum, then, the challenges before you at the state level are also very great in the years ahead.

The private health insurance industry, once resistant to coverage of alcoholism, has moved forward quite perceptibly in the last several years toward realistic coverage of alcoholism. As reported by Hallan, Kemper Insurance Company has broadened its accident and health policies to provide for inpatient and out-patient treatment of alcoholism in hospitals and state licensed alcoholism treatment facilities. Employers of Wausau also now provide coverage for both inpatient and out-patient treatment. Last year the Hartford insurance group announced that treatment for alcoholism will be covered on the same basis as any other disease in its group policies. The Prudential Insurance Company of

America has deleted its standard exclusion of alcoholism treatment in a facility for the care of alcoholics alone.

Blue Cross has been moving too, and a number of examples could be cited, such as Blue Cross of Maryland and Capital Blue Cross of Harrisburg, Pennsylvania.

The final charge given me by the Moderator of this Task Force was "possibilities for increasing public awareness and support for alcohol-drug services at the local level." I can think of a few offhand:

(a) Stop having NIAAA officials running around the country talking about peaking out when we are reaching only a maximum of 10 to 15 percent of the alcoholics in this country and are just beginning to achieve progress.

(b) Build up grass roots identification by helping to locate an alcoholism project in the heart of the local community. Make it their project, and use volunteers from their community. We can learn a great deal from Alcoholics Anonymous in this regard -- its emphasis on small groups holding out a helping hand to one another.

(c) If alcoholism is still stigmatized at the state-local level, challenge it with factual material. Just look back at the reduction in the stigma against alcoholism since 1970 as an example for further efforts.

(d) Adopt a more aggressive stance in the fight for more state and local funds for alcoholism; top-quality insurance coverage; a fair portion of all general and special revenue sharing programs, and so on.

We go around talking about alcoholism as America's third largest public

health problem. If we believe what we say, let's act like it. No one is going to hand us the tools to do the job. This has not been true of any other disease category and will not be true of alcoholism.

Let us stop our minor bickerings and unite in a national fight against this pervasive and agonizing disease.