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NIAAA Research Authorization Hits Record High

The Senate Labor and Human Resources Committee overrode the objections of the chairman of the Alcoholism and Drug Abuse Subcommittee and voted to raise the research authorization of NIAAA to the record level requested by the Reagan Administration next fiscal year. (See related story, page 8.)

The Committee, on a roll call of 14 to 2, approved an amendment by Sen. Paula Hawkins (R-FL) which would authorize $32.9 million for alcoholism research for the next two fiscal years—more than $12 million above the current appropriated level and $8 million more than recommended by Sen. Gordon Humphrey (R-NH), Alcoholism and Drug Abuse Subcommittee chairman.

At a May 6 meeting of the Labor and Human Resources Committee, Humphrey said he wanted to hold the line on federal spending because he viewed the "economic crisis as the overriding crisis to which all other matters must be subordinated." He appealed to his colleagues to show "political courage" and "not resort to the old arguments about why we must spend more money in the name of compassion."

In a written statement that he placed in the record but did not read at the session, Humphrey said oversight hearings by his subcommittee on both NIAAA and NIDA "found their work in the field to be of the highest caliber" and added: "there is no question in my mind that these Institutions are deserving of additional funding and could put it to effective use."

But the New Hampshire conservative said "that is not the question currently before us," citing projections of mounting federal budget deficits and the current federal debt ceiling of more than one trillion dollars. "I believe it is imperative that we defer increased spending to a time when the economy can accommodate it, and now is not that time," Humphrey said.

Hawkins, in introducing her amendment to raise the authorizations, said the Administration's recommended boosts for both alcohol and drug abuse research were framed "with consideration for the economy, and in response to the high cost of alcohol and drug related problems." She said she shared President Reagan's "determination that funding for alcohol and drug abuse research be increased."

The Hawkins amendment to Humphrey's renewal bill was approved with only Humphrey and Sen. Don Nickles (R-OK) dissenting.

In addition to reauthorizing NIAAA research at the $32.9 million level, the Hawkins amendment raised NIDA research to a ceiling of $46,356,000 over the next two fiscal years. Humphrey had recommended that NIDA research be held to a level of $41.3 million. The committee ordered the amended bill (S-2365) reported to the full Senate for consideration.

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New York City Conference Surfaces Insurance Issues

By James Ahern
Coordinator, Employee Alcoholism Rehabilitation Program
Board of Education, City School District of New York

The cut-back of alcoholism health benefits affecting approximately one-half the federal work force is a major setback in the treatment of the employed alcoholic. The elimination of the 28-day inpatient rehabilitation benefit will in many cases hinder the recovery process. Five-day coverage for detoxification treats only the acute manifestations of the illness and ignores its chronic aspects. Alcoholism is not a self-limiting illness and detoxification should be the beginning in a continuum of care.

During the last several decades, the dominant form of illness has shifted from acute to chronic. Medical care specific to the chronically ill is needed. In 1951, the Commission on Chronic Illness developed a definition for chronic disease which, in part, states that "such illnesses . . . require special training of the patient for rehabilitation; may be expected to require a long period of supervision, observation, or care." More than 30 years later, the Blues still offer insurance coverage as though chronic diseases were infectious or parasitic in nature.

Recognizing the problem of limited coverage for the alcoholic employee, the Employee Alcoholism Rehabilitation Program (EARP) of the New York City Board of Education recently hosted a conference of

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Dr. Walter Reichman presents Dr. Harrison Trice with a plaque recognizing Dr. Trice for his leadership and contributions to research in occupational alcoholism. The presentation was made at the ALMACA Conference on Research Methodology in Occupational Alcoholism. Story on page 8.

Plans Made for Elections

As a membership organization, ALMACA is governed by national officers who are elected by the membership. Sections four through seven of Article IV of the ALMACA National bylaws spell out the provisions for elections. It provides that elections are to be held in even-numbered years and that ballots must be mailed to the national membership at least eight weeks prior to the annual business meeting. This means that there will be an election of ALMACA national officers in 1982 and that the ballots have to be distributed to the membership eight weeks prior to the annual business meeting, November 2, 1982.

The officers that are elected are the president, vice president for operations, vice president for administration, secretary, treasurer and regional representatives. The regional representatives are selected by vote of the individual members of that region while the other positions are selected by a vote of all individual members of the association.

Candidates for election are selected by the nominating committee, which consists of one member appointed by each regional vice president. The 1982 nominating committee will have its first meeting in Kansas City on June 7, 1982. Its report will be made by July 20 so that ballots can be printed by August 10 and mailed to the membership by September 1.

Edward J. Dougherty represents the Central Region on the nominating committee. He is an employee assistance program consultant for the Bemis Company in Minneapolis, Minnesota.

Mary A. Ryan represents the Eastern Region on the nominating committee. She is the director of the employee assistance program for AMTROL, Inc. of West Warwick, Rhode Island.

Richard G. Hessler represents the Inter-

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Executive Director's Comment

By Tom Delaney
ALMACA Executive Director

In conjunction with the Occupational Program Consultants of America (OPCA), ALMACA will recognize the group of 100 or so consultants who received NIAAA-sponsored training in 1973 and 1974. I was one of that group and participated in the training at Pinehurst, North Carolina and the follow-up sessions in San Francisco and San Antonio. A concept that received a lot of attention in those days was pre-treatment. This referred to the notion that a well-run occupational alcoholism program could intervene in the development of an employee's alcoholism at an early enough stage that hospitalization or other formal treatment would be unnecessary. A correlary was that in-patient services would be needed for only a small portion of those employees requiring treatment.

I am sure there are many programs that have institutionalized the pre-treatment notion. For several years, however, little was heard of it. I had the impression that many of the newer program administrators thought that the objective of employee assistance programs was to hospitalize all employees with alcoholism, regardless of the stage of the disease. However, I now see signs of forces that are reinforcing the pre-treatment aspects, as well as the opportunity for employee assistance programs to refer employees to the level of care appropriate to their needs.

In planning programs, as well as in training employee assistance practitioners, consultants and trainers need to consider the work that goes on before an employee accepts an offer for help. We also need to design our programs to allow for the notion that employees may respond to the sessions with EAP staff without formal treatment. We should also design programs to account for the fact that good supervision and union participation in the program can divert people from early alcoholism without a referral to EAP. These aspects of a successful EAP are very difficult to measure and this may account for the fact that some programs concentrate their efforts on referrals to in-patient care, which is easier to count and evaluate.

What are the signs that indicate programs are re-discovering the employee who can fulfill his or her family, community, and work roles without identical in-patient care for all? First, there is more emphasis on training program administrators to become full-fledged members of the labor-management team. Secondly, programs are doing more of the triage themselves and are looking for alternatives to in-patient care, such as out-patient, day treatment and partial hospitalization. Some are even discovering Alcoholics Anonymous! Thirdly, the tightening economy is causing many programs to review their health benefits. Regardless of whether the coverage is through self-insurance or the insurance industry, the review of health care benefits provides EAP administrators the opportunity to use a wider variety of treatment modalities. An increasing number of insurance plans will approve other providers besides JCAH-approved ones. Finally, throughout the health care field, there is a trend to balance medical opinions with those of the patient and other professionals. This does not seem to be a case of laymen making medical decisions, but one of recognizing that a choice of modality involves more than medical factors.

There are risks in all this, of course; EAPs will continue to need in-patient medical model treatment. It is more expensive and we will have to fight to make sure that it remains a viable option. There is a danger that the disease concept will be challenged by people who equate disease with the medical model. There is still a huge number of people outside the alcoholism field who believe that alcoholism is only a symptom or result of some other problem. The increasing national sentiment to restrict the availability of alcoholic beverages will challenge the notion that alcoholism is a treatable disease. Ten years after Pinehurst, the EAP field, with its unique role to play between industry and the alcoholism field, has a leadership role in sustaining the wide range of options available to "treat" the alcoholic. □

President's Comment

by Ed Small
ALMACA President

Should our national ALMACA office be in the Washington, D.C. area? This question is asked of me occasionally. I recently visited with Dr. Carlton Turner, who is President Reagan's advisor on alcohol and drug problems, at the White House and came away believing there is an advantage to our office location, but I did think of the question again after our visit.

When I last visited this office two years ago, there were different pictures on the office walls in the White House as well as in our ALMACA office. This time, Tom Delaney, our executive director, and I were there with Bob Frederick from Xerox and George Chritton from the State Department. Dr. Turner could not have been more gracious and Tom Delaney will be following up with discussions with Dr. Turner to see where we can provide help from the ALMACA network to the current administration.

The strength of ALMACA is in the regions and the chapters, so it was agreeable to hear Dr. Turner reiterate the current philosophy of returning much of government to the 50 states. That's where ALMACA is now. He talked quite a lot about alcoholism and cannabis, which has been a specialty of his. Apparently his interest in alcoholism grew from young addicts who told him their first drug was alcohol.

Which brings me to our primary interest in the employee assistance field, alcohol. The development of our member programs from the original alcohol-only programs continues. There is no doubt we have a primary allegiance to occupational alcoholism programs, but another question I receive a lot is about the title of our association. Should we change it? We voted this down resoundingly at an annual business meeting one year (1977) but I am still asked that question. The answer, of course, is that we will call our association what you tell us it should be called. This is not, however, a new idea.

There are very few new ideas, only new members who think they are new, and to be fair, we should reconsider some of them to see, to coin a phrase, if some of them are ideas whose time has arrived.

Ideas such as: divisions for members with special interest; elite clubs within ALMACA or outside ALMACA; special administrators and consultants to labor and management; training programs run by ALMACA; accepting volunteers as voting members; taking over the entire alcoholism field (no foolin', it's been suggested often!), etc., etc., have been put forth again, and again, and again, usually as I said, by newer members.

Newer members are the future of ALMACA. Older members are the past and the present. The mix pushes us forward to our evolving future. We need the energetic member to make us rethink old issues and the balanced member to remind us of our heritage and help us avoid wasting too much time. No one academic discipline will ever run our association, and cliches about good old boys are simply never going to be true in our vigorous membership organization where members vote on the leadership.

Which leads me back to where I started. Should we change our office and our title? Well, I see positive advantages to our present geographic location. We have a listening post centrally located and staff that functions well in any political climate. Most of you seem to agree that our nation's capital is where our office should be now, and most members who talk about dropping alcohol from the title of our association admit to me that they keep the focus on alcoholism no matter what they call their programs. What would be the advantages of an easier title? Trendiness . . . a less ugly word to soothe the corporate mind, or would it be for accuracy? It is easy to lose alcoholism . . . but assistance might be more accurate.

Accuracy is what I wish for the members who are filled with the fizz of these ideas. They are not new. Will we ever do some of these bold and dashing new things? Maybe . . . certainly if the group conscience tells us to. Group conscience . . . that's slang . . . it means you. □

NYC (From page 1)

local municipal occupational program managers.

The meeting resulted in the following conclusions by the program managers:

- Recognition that the alcoholism rider being offered to private industry by Blue Cross of Greater New York is too costly for municipal employees and their families.
- Recognition that alcoholism should be treated in the same way as any other disease. Treatment benefits should be part of the basic benefit plan, and not a rider.
- Recognition that a treatment outcome, cost-effectiveness study done in conjunction with the Smithers Center of New York and the Blue Cross/Blue Shield of Greater New York showed strongly positive on treatment outcome. "The study showed that 65.9 percent of those treated were abstinent at the end of three years and furthermore, that the treatment was effective in reducing subsequent use of medical services, both in-patient hospitalizations and out-patient visits."
- Recognition that health insurance for workers in a municipal setting is a contractual issue as well as a health concern. □

ELECTIONS (From page 1)

national Region on the nominating committee. He is manager of the employee assistance program for the International Paper Company in New York City.

James B. Cox is the nominating committee representative from the Southern Region. He is the newly elected president of the Louisville ALMACA chapter. He works at the Kentucky Truck Works of the Ford Motor Company. He is the alcoholism program specialist for Local 862 of the United Auto Workers, AFL-CIO.

George Armes represents the Western Region on the nominating committee. He is manager of special health services for Standard Oil of California, San Francisco.

The nominating committee nominates no more than two persons for each regional representative spot, and for secretary and treasurer. It must nominate two people for vice president for operations and vice president for administration. The incumbent vice president for operations is automatically nominated to run for president and the nominating committee may nominate any other individual member to run for president.

The nominating committee picks candidates at its own discretion or from petitions signed by at least 50 individual members. The deadline for submitting petitions to the nominating committee is July 1, 1982. Nominations are subject to the approval of the Board of Directors. □

NIAAA (From page 1)

Before final approval, the committee adopted another amendment that would direct the Secretary of Health and Human Services to report to Congress on activities of treatment programs being administered by the states under the alcohol, drug abuse and mental health services (ADM) block grant.

The amendment, by Committee Chairman Orrin Hatch (R-UT), would require the HHS Secretary to work with the states in developing a uniform data collection system based on voluntary compliance.

In commending Hatch for his amendment, Sen. Hawkins stressed the need to monitor the progress of programs under the ADMS block. "I happen to come from a state that sometimes becomes more concerned with potholes than people," she said. "I think it is important to have some tracking, and to revisit this if it does not work."

Meanwhile, the House Health Subcommittee approved the NIAAA/NIDA renewal bill authored by chairman Henry Waxman (D-CA), who is calling for a $33 million authorization for NIAAA research next year, vaulting to $50 million in FY-84 and $75 million in FY-85. NIDA research would be authorized at $47 million next year, $53 million in FY-84 and $59 million in FY-85.

Before approving the provisions, the subcommittee beat back an attempt by Rep. Edward Madigan (R-IL) to amend the bill so as to allow the Administration to shift responsibility for the ADMS block from the level of the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) to the office of the Assistant Secretary for Health. Waxman's bill attempts to undergrid the statutory existence of ADAMHA by providing it with administrative responsibility for the ADMS block, among other measures.

The Waxman bill would also create an Assistant Administrator for Prevention at ADAMHA and Offices of Prevention at the three Institutes, in line with similar provisions for the National Institutes of Health, whose authorizations are also covered in the legislation.

The Reagan Administration unveiled its proposals at a hearing before the Health Subcommittee in April, recommending five-year authorizations for NIAAA and NIDA with the President's budget requests of $32.9 million for alcohol and $46.4 million for drug abuse serving as the authorized levels next year, and open-ended thereafter, in effect leaving it to the appropria-

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NIAAA (From page 3)

tions process. Assistant Secretary for Health Edward Brandt opposed Waxman's proposal for giving ADAMHA statutory responsibility for the ADMS block. He noted that the Administration wants both the ADMS and the Preventive Health block grants to be administered by a single unit in his office, and said:

"These two programs will have completed their transition to the block grant method of operations. We believe that consolidation at this time will streamline administrative procedures and simplify state/federal contacts while assuring maximum flexibility to the states in administering these health block grants."

• Blue Cross/Blue Shield (BC/BS) vice president James Gillman said he made the decision to eliminate the alcoholism rehabilitation benefit from the federal employee plan this year on the basis of what he called "good business judgment and what was going to be the least harmful to the most people in the program."

The BC/BS official in charge of the federal plan, which embraces about half the nation's 9.2 million federal workers, their families, and retirees, gave the first full public explanation of the controversial action at a May 3 meeting of the Interagency Committee on Federal Activities for Alcohol Abuse and Alcoholism.

The benefit was dropped as of last January 1 after being offered for just a year. Achieved as a result of a vigorous constituency effort, it provided two lifetime 28-day inpatient periods in either hospital-based or free-standing programs.

In response to questions by the interagency panel, which had expressed "grave concern" over the action, Gillman said that although the alcoholism benefit cost relatively little in 1981—about $7 million—utilization was growing rapidly.

Gillman, who said he played a lead role in installing the benefit originally, said it was scrapped last October when the Office of Personnel Management (OPM) ordered a 6.5 percent across-the-board reduction in costs for all the various health plans covering the federal workforce. Economies ordered by OPM previously had been met by BC/BS without eliminating the alcoholism benefit, Gillman said, but the further reduction last fall required dramatic cutbacks in benefits for all programs.

The BC/BS official insisted that the action did not signal any change in the BC/BS approach to alcoholism, and he contended that the federal plan still offered a "pretty full-blown alcoholism program." Gillman said detoxification is still covered with "no time frame."

"We do not say you have to be detoxed in two days or that when you are detoxed, it's done. . . . As long as you have to stay in there, it's permissible for you to stay, and we'll pay for it," said Gillman. □

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AA Groups' Dilemma: Those Other Addictions

Reprinted from "Box 4-5-9," a publication of the General Service Office of Alcoholics Anonymous.

The influx of nonalcoholic drug addicts into AA meeting halls is a matter of growing concern to AA groups in the United States and Canada. Groups are also concerned over the effect that alcoholics with dual or multiple addictions may exert on the substance of AA meetings.

Emma G., of Springfield, Mo., wrote of "the infiltration of narcotic addicts, who have the dual problem of narcotics and alcohol but lean more to the narcotic addiction. In meetings, they identify themselves as 'chemical dependents' and 'drug addicts.' We see the original alcoholic, whose total problem was alcohol, becoming less and less [visible]."

"The original alcoholic"? Yes, there does seem to be a widespread impression among the membership that the problem of dual addiction is new in AA. But on p. 32 of "Dr. Bob and the Good Oldtimers," we may read the following: "Instead of taking the morning drink, . . . Dr. Bob turned to what he described as 'large doses of sedatives' to quiet the jitters . . ."

Nor was alcohol the total problem of cofounder Bill W. In the article "Those 'Goof Balls' " in the November 1945 issue of the AA Grapevine, he had this to say: "Morphine, codeine, chloral hydrate, Luminal, Seconal, Nembutal, Amytal, these and kindred drugs have killed many alcoholics. And I once nearly killed myself with chloral hydrate. Nor is my own observation and experience unique, for many an old-time AA can speak with force and fervor on the subject of 'goof balls.' "

Apparently, changes taking place *outside* our Fellowship make the problem seem more urgent today. Referring to a local treatment center, an AA newcomer, Katherine L., of California, wrote G.S.O., "The physicians and counselors stressed the fact that all addicts, whether addicted to alcohol or to another chemical, were similar in personality and situation. We are all addicts; it is our drug of choice that varies." She went on to state her belief that the reason alcohol was emphasized early in the history of our Society was that it was the most commonly used drug at the time—other drugs were not so readily available.

In recent years, countless letters have arrived at G.S.O. about treatment centers where staffs view both the dually addicted alcoholic and the nonalcoholic drug addict as "chemically dependent." The centers may advise both to attend AA meetings.

Some groups, through their institutions representatives, have attempted to explain to such centers that it is not the intent of AA, as a fellowship, to be exclusive; rather, in order to be effective with alcoholics who seek help, AA must avoid multipurpose activity. They make it clear that dually addicted alcoholics are eligible for AA membership and may receive help with the *alcoholic* problem at AA meetings. They also point out that other fellowships exist to help with the drug problem — for example, Narcotics Anonymous and Pills Anonymous.

An often-heard cry from AA groups is that dually addicted alcoholics tend to dominate AA meetings, laying the emphasis on their drug problem. Some AA members who are not dually addicted become resentful, because they cannot identify; also, they feel that the meetings are being disrupted and divided. AA members are turned off, as well, by nonalcoholic drug addicts, who also tend to dominate meetings. Both concerns are reflected by the following excerpts from mail received at G.S.O.:

From Minneapolis, Minn., G.J.L. refers to "infiltration" by nonalcoholic drug addicts: "Many of our good members are leaving in disgust, because it is getting more difficult by the day to find a good AA group where the philosophy is not diluted to the point where our 'common problem' has become a phrase of the past. We are desperate!"

Brian S., of Sydney, Australia: "Can people who are addicted to drugs other than alcohol speak at an open AA meeting?"

From Lindsay, Ont., Ted H.: "Can persons who let it be known that they are using drugs other than alcohol carry the message to the still-suffering alcoholic?"

Letters pour in requesting G.S.O. to make rulings on such questions, as on many other problems. The office has received at least one letter addressed to the "Governing Body"! Of course, Tradition Two applies just as surely to the "trusted servants" at your G.S.O. as it does to those in your home group. Staff members asked for "rulings" often just point out where helpful guidance can be found in our Conference-approved AA literature, which is based on long and wide-ranging Fellowship experience.

The book "Twelve Steps and Twelve Traditions" is frequently cited, and the pamphlet "AA Tradition—How It Developed" provides an insightful introduction. "The AA Group" is another valuable source. For instance, it makes a distinction between a "meeting" and a "group" (p. 33) and even notes that special "meetings" can fill the extra needs of dually addicted members.

In the pamphlet "Problems Other Than Alcohol," Bill W. expresses his conviction that a drug addict with "a genuine alcoholic history" is eligible for AA membership, but also concludes that *"there is no possible way to make nonalcoholics into AA members.* We have to confine our membership to alcoholics, and we have to confine our AA groups to a single purpose. If we don't stick to these principles, we shall almost surely collapse. And if we collapse, we cannot help anyone."

"Problems Other Than Alcohol" is a reprint of an article first published in the AA Grapevine of February 1958. The principles Bill calls upon stand unchanged, but the scope of the problem has certainly increased, as our membership surveys show. Between 1977 and 1980, the percentage of AAs reporting dual addiction on survey questionnaires rose from 18 percent to 24 percent. Among those who had come to the Fellowship during that three-year time lapse, 27 percent identified themselves as dual addicts.

Again—neither G.S.O. nor the General Service Board nor the General Service Conference is going to issue any "rulings." G.S.O. is grateful for all the letters raising questions vital to the Fellowship. But the answers must come from the same source—the experience of the autonomous groups. □

Colorado ALMACA Undertakes Campaign On Fetal Alcohol Syndrome

The Colorado Chapter of ALMACA has launched a statewide public information campaign on fetal alcohol syndrome (FAS), one of three public service efforts the chapter plans for this year in cooperation with the National Institute on Alcohol Abuse and Alcoholism.

The FAS campaign, timed to get under way in conjunction with Mother's Day observances, will be followed later in the year with campaigns on women and alcohol and on youth and alcohol.

In a mailing to all Colorado Chapter members "and friends," chapter president Betty Warren and secretary Judy Vaughn distributed a suggested press release, an FAS fact sheet, a description of "the most consistent features of the fetal alcohol syndrome," a glossary of FAS terms "for nonmedical professionals," payroll envelope stuffers, and fillers for use in publications.

In the cover letter on the distribution of materials, the organizers expressed the hope that upon reading the material, "you'll have the same sense of commitment that we feel in trying to raise public consciousness about this totally preventable birth defect." The cover letter makes the point that the Colorado campaign "is being completely done with volunteer hours, dollars, and services."

ALMACA members on the distribution were urged to add their program identification and phone numbers to the material in order that anyone wanting more information would have a point of contact. □

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