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as a trainer to deliver those same skills to others as a certified Cottage volunteer. This contact also increases his or her on-going access to newly identified community resources and thereby enhances and expands the referral process for future service delivery to himself or herself and others.

VOLUNTEER TRAINING

The Cottage Program has designed and implemented a nationally replicated volunteer training and utilization model. The volunteer component of the Cottage Program is singly, the most crucial area of focus. There is a highly structured volunteer hierarchy which is correlated with comprehensive, on-going training. This volunteer service delivery hierarchy is paralleled to staff positions requiring corresponding skill levels and the delivery of program services.

The volunteer training model itself is concerned with delivering skills which will, in effect, train volunteers to become effective trainers. A great many Cottage trained volunteers consequently, are not involved in direct service delivery within the actual Cottage facility or program structure. Many function as trainers autonomously within there own organization roles; for example: church and civic leaders, educators, management personnel, industrial employees, students, human service delivery specialists and community members at large. Designing and implementing the volunteer training model and program as such, there are multiple community benefits in the expansion of services to a maximum number of community members in a cross section of the total community.

Volunteers who do remain in the service delivery capacity within the Cottage facility are given an opportunity to increase their personal and training skills through experimental learning models and progressively advanced training experiences. Also, formal academic credit is available through several in and out-of-state universities for participation in the Cottage Volunteer Training Workshops. The training is intensive, skill-oriented and on-going throughout the volunteer experience.

EFFECTIVE LIVING SKILLS

The Cottage Program offers a series of progressive skill training models which are available to all program participants, volunteers and interested community people. Effective Living Skills is a culmination of these advanced training models. It provides the learner a simple structured guide or model for effective living while simultaneously illustrating the deficits caused by the lack of any of the skills. This model focuses on the entire life process of the individual and trains him in a methodology to significantly improve his overall level of functioning with regard to self and others.

The premise of the model is that there are specific skills essential to effective living. These skills are: attending, ovserving, listening, responding to feeling, responding to meaning, personalizing, understanding, goal definition, program development and program initiation. The lack of these skills conversely, leads to denial, home treatment, chaos and reacting roles. In order therefore, to remove these deficits the action required is simply to implement the aforementioned skills. In the training process, the primary emphasis is on internalizing and personalizing the model in its entirety. This is an essential aspect to the training process that reaffirms the necessity for focus on self as being the only means of ultimately achieving self directionality and constructive living.

This model provides a basis for primary prevention of destructive living which is illustrated in the myriad of national identified social problems. It is, therefore, applicable to the entire community as prevention modality.

SURVEY RESULTS AND COMMENTS

Accreditation: On October 16, 1976, the Cottage Program was awarded accreditation by the Joint Commission on Accreditation of Hospitals. J.C.A.H. surveyed the Cottage for consultation and education. The following results reflect the surveyors' comments:

"Excellent - could be used as a model for other programs. The consultation and education component has a written plan describing the procedures by which the consultation needs of community groups and/or agencies are assessed and goals and objectives derived and implemented.
For this Service:
Out of a possible 116 points, 116 points were scored (100%)
Surveyor recommendation: substantial compliance."

"Excellent - could be used as model for other programs. The consultation and education component has a written plan describing its philosophy, goals, services, and the procedures by which the community's awaremess and acceptance of alcohol use/abuse is increased."

"Excellent - could be used as a model for other programs. The education service has a written plan which includes documentation verifying accommodation for and participation with relevant organizations, individuals and agencies on a regular and planned basis throughout each year."

"Excellent - could be used as a model for other programs. The education service has documentation of the implementation of measures taken to educate the general public to needs that remain unmet, and to stimulate social action.
For this service:
Out of a possible 177 points, 177 points were scored (100%).
Surveyor recommendation: substantial compliance."

In 1972, the Cottage Program conducted a door-to-door survey based on the Gallup Poll method with a 95% level of confidence that the information received was indicative of the total community. This original survey indicated that 8.1% of the people contacted responded affirmatively to questions regarding an alcohol misuse or alcoholism problem within the family. In 1976, this survey was re-conducted and the results indicated that 31.3% of the people readily admitted the same. This is a direct reflection of the Cottage Program's impact in initiating community awareness of the necessity to confront denial before effective problem resolution can occur. This confrontation of denial reflects a significant attitude change regarding acknowledgement of alcohol related problems. Education Commission of the States: On July 14, 1976, the Cottage Program received the formal endorsement of the ECS. The following statement reflects this endorsement: "We believe that the Cottage Program's direction is in keeping with the recommendations of the ECS Task Force on Responsible Decisions About Alcohol and reflects a standard of excellence that will serve well as a model for other prevention efforts."

Marty Mann, Founder/Consultant, National Council on Alcoholism states: "The Cottage Meeting Program is a unique and extremely important program. I think it addresses the problem of prevention more directly than any other technique I know and I venture to predict that its success will be overwhelming wherever it is undertaken."

Reverend Milton S. Hunt, President of the Gastineau Alaska Council on Alcoholism, after participating in Cottage training on March 21 and 22, 1976, states "The Cottage Meeting Program is the most important contribution to Alcoholism since the founding of the National Council on Alcoholism in 1944."

James Emmert, Executive Director, National Council on Alcoholism, North Carolina, writing of the Cottage Program on May 17, 1977, states: "There are three major factors which make it an excellent program. First, it is demonstrably effective with all age groups. Second, the program model can be easily exported. Third, it is cost effective."

PRIMARY PROGRAM RECOMMENDATION

In spite of all of the Cottage Program's documented success in service delivery, the inherent weakness has been the lack of a rigid well planned comprehensive research and evaluation component. Although the program has had more research and evaluation service than the majority of other human service delivery programs, there is a wealth of research and evaluation possibilities available given the extensive data base collection process implemented since 1972. This base provides an excellent opportunity for the development of relevant longitudinal studies to be conducted.

The original grant award did not provide adequate funds to conduct the research and evaluation as extensive as would have been desired. Since August 1976, however, the State Agency has provided assistance from their research specialists who have a grasp on the program concepts. The Cottage Program would, consequently, urge the expanded continued involvement of the State Agency in this manner.

Although serious consideration has been given to the replication of the program in non-Mormon communities, it would be preferable to first consider the advisability of funding extensive research and evaluation of the operational program and its existing massive data base.

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THE COTTAGE MEETING PROGRAM

(Cited from a summary report to NIAAA, January, 1977)

The Cottage Meeting Program is a two-session, small, highly intensive, but informal group process aimed at promoting greater knowledge and awareness about alcohol and alcoholism within the community and establishing attitudes congruent with a preventive, healthful approach to the problems and challenges of involvement with alcohol. The family is identified as the primary target for training.

The Training of Participants

The Program has been shown to be positively received and valued by a clear majority of participants, by adolescents in Report #2, as well as by adults in Reports #1, 4 and 5, representing a variety of social, educational and employment backgrounds. The principal measures employed to evaluate Program response and attitude change in these studies, however, have been subjective measures allowing ratings relative to perceptions and feelings about alcohol and alcoholism, but providing virtually no substantive data about change in knowledge and attitudes. The principal measure used, however, was shown to be highly reliable, as in Report #3, and, therefore, is seen as effective in assessing shifts in ratings made by participants. Unfortunately, the instrument did not permit assessments of "direction" or desirability of change, nor did it permit assessments other than the "feelings" of participants. It may be noted, however, that the "shifts" demonstrated were interpreted as reflective of greater tolerance and less rigidity, as in Reports #2, 4 and 5, on the part of participants following Program training. The "meaning" attached to the changes, however, was admitted to be "speculative". The absence of control comparisons also raised the spectre of motivation as an uncontrolled factor governing the positive reception and valuations made by participants.

Report #8 was an attempt to objectify the claims made in the reports cited above. The outcomes assessed in this study involved knowledge about alcohol and substances of abuse, opinions and attitudes about such substances and self-reports of behavior relevant to alcohol and other drug use or misuse. A post-test only design was employed, involving: (1) A group of former participants who were exposed to the Program in a "mixed" fashion (such participants did not necessarily attend both Program sessions, nor did they necessarily participate in the small, intensive group process characteristic of the Cottage approach, i.e., a number of participants were involved in large group, less interactive presentations of the Program); (2) a separate group of participants known to have attended two

small group, interactive sessions; and (3) control subjects "linked" to the participants on the basis of residential proximity. The controls were generally seen as "matched" socially and economically. A subset of the controls was identified as wanting to receive Cottage Program training. This group was presumed to be similar to participants prior to Program training and was identified to serve as a "motivational" control group, i.e., a group needed to assess (admittedly "after the fact") the effects of Program training.

A comparison of the "motivational" control subjects with the rest of the controls revealed no differences on the measures gathered, suggesting that "motivation", operationally defined in this study as interest in Program training, did not interact with the measures administered. Consequently, the control subjects were treated as a unit in comparisons with former participants.

The findings of Report #8 clearly indicate that participants in general have greater knowledge about alcohol, about Program-related material and about substance abuse resources than control subjects. Additionally, participants involved in both sessions of the small, interactive group process were superior to participants in the "mixed" group. Pertinent to opinions and attitudes, "mixed" participants were essentially no different from controls. On the other hand, participants involved in the two session, small group process displayed significantly greater agreement with judgements about alcohol and other drug use made by a norm group composed of alcohol treatment personnel, and showed greater affect and reactivity to concepts relating to alcohol education, alcohol, alcohol abuse and drugs than control subjects. Comparing these participants to those in the "mixed" participants group, the few differences obtained were on the semantic differential items, suggesting that affect and reactivity were likely influenced by conditions associated with the two-session, small group process. This implication is offered tentatively.

Differences in self-reports pertaining to behavior were negligible. While this is not surprising, given the nature of the Program (i.e., only two sessions are involved), the measures obtained were generally in expected or desirable directions, suggesting that behavioral changes occur, but require greater experimental control for purposes of detection, more sensitive measures, more subjects to reduce error, or a longer period of observation. Ostensibly, refined replications of this study are needed. Overall, the findings indicate that the Program produces change, and that change is better accomplished via the samll, interactive group training process. The changes are substantial, clearly with regard to knowledge and information gains. Opinion and attitude changes also occur, although apparently requiring small-group training. Concerning behavioral change, the findings present nothing of a reliable nature. Although one is tempted to say that expectations of behavioral changes are possible, it is probably unrealistic to expect such change on the basis of a brief training program.

Additional findings of particular note from Report #8 include:

1. An attempt to assess the "persistance" of Program effects was made by including participants trained 6-12 months, 13-24 months and 25-36 months prior to initiation of the study. Differences among the participants from these three periods were not found, suggesting that Program impact upon knowledge and other informational gains, as

well as upon the attitudes and opinion changes found, occur primarily within six months of the Program training and "persist" at least over a three-year period.

2. Twenty-four and one-half percent of the controls involved in this study expressed a desire for Program training. This finding is seen as lending substance to the basic Cottage outreach procedure, i.e., "knocking on doors". It also indicates that there is a substantial demand for alcohol education and prevention training in the Salt Lake County area.

3. Thirteen percent of the participants on this study arranged one-hundred additional Cottage Meetings. Employing the median size of households in this study, it is estimated that these meetings resulted in the training of three hundred persons. This amount of subsequent Program activity is seen as a highly desireable, behavioral "spin-off" from Program training, an effect which has significant consequences for the "spreading" of education and prevention training into a community.

Volunteer Involvement

A perusal of Report #5 indicates that volunteers may be used effectively as Cottage Program trainers. It was evident, however, that the method of selection, the structuring of activities and the adaptation of program assignments and roles to correlate with volunteer skills and abilities, were variables crucial to the effective use of volunteers. Additionally, the Program was seen as needing to provide supportive experiences designed to maintain volunteer interest and to trigger volunteer activity since high-turnover and low productivity are typically manifested among volunteers.

The current involvement of volunteers is substantially improved, as reflected by a lower turnover rate and greater volunteer activity. Additionally, the Cottage organizational structure has been altered to allow greater administrative, supervisory and training participation by volunteers.

Effective Living Skills

Report #7 introduces an additional education and prevention service provided by the Cottage. The "Effective Living Skills" program is presented as a means to further the education and prevention objectives of the Cottage Program. This program focuses upon four skill areas, basically how individuals deal with self, with others, with the "world", and with drinking in a "drinking society". Report #7 compared Cottage Program participants with participants who received the additional "Effective Living Skills" program. The principal measure involved in this study was the attitude measure earlier alluded to as highly subjective. The results obtained were difficult to assess, primarily because of the subjective measure employed, but also becuase the unique features (i.e., the "Effective Living Skills") were not considered in the comparison of these groups. Motivational differences also appeared to classify subjects who sought the additional training but were not considered in the experimental design employed. Plans are underway to evaluate the Effective Living Skills Program, employing refinements of the more objective measures used in the outcome study of the Cottage Program, and including measures relevant to the unique skills ostensibly imparted by the "Effective Living Skills" program.

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SCOMM

#6:17

CREATIVE CONCEPTS

IN

COMMUNITY PREVENTION

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Why do teens turn to drugs? Why do young people get into trouble? How do our communities react to troublesome youth? How are youth in general seen in and by the community? How do our communities use their resources for youth development?

These can be complicated and perplexing questions. Too often they are left to the "professional" to deal with. Unfortunately, however, the professionals have not been productive in developing practical and effective approaches to solving community problems such as juvenile delinquency or substance abuse.

At times, it is useful to look in some new directions and ask some new questions about old and pervasive problems. Sometimes changes in our attitudes can open new avenues and suggest new alternatives.

If you will join me, let's undertake such a venture. Let's be so bold as to try to suggest a methodology that can bring positive change in the community. Let's look at substance abuse and juvenile delinquency where it really happens - in the home - in the neighborhood - in the school. Let's develop <u>something</u> that will be lively and appealing.

This thing is called a "CLYDE". And it's essentially a living room discussion group that has grown into a grassroots-level community-wide concept to help prevent juvenile delinquency and substance abuse.

The CLYDE is roughly derived from Community Leadership for Youth Development and it began with a group of professionals who were concerned with finding a new way to help youth.

One of the activities that CLYDE focuses on is to form neighborhood groups in which neighbors discuss the needs of their local areas and figure out ways to solve the local problems.

The CLYDE's primary function is to provide an opportunity for young people to become involved in their neighborhoods.

To make the youth involvement meaningful, the groups are taught problem-solving techniques within an informal structure.

The CLYDE group first conducts a "needs assessment" in which individual members throw out ideas that may be problems in their neighborhoods such as curfew complications or a lack of recreational facilities or youth-sponsored activities.

Then the group goes through a four-step process to determine what the members know about the individual problem, what they don't know, what they need to find out, and what resources would be available to find the information they need.

Finally, the group members conduct a role-playing session in which they assume the identity of special interest groups in the community who would have formed attitudes towards the particular problem. For instance, in a CLYDE session recently, the group members discussed curfew in their community by dividing into small groups representing the police, students who fall under the community's 11:00 p.m. curfew rule, and a PTA group whose members are interested in curfew violators.

By assuming the separate interest-group identities, the CLYDE members learn "a sensitivity" to other groups' points of view.

The CLYDE concept, although it was started with a focus on youth problems, can be used by any group. It provides a means to examine neighborhood problems. Eventually, as group members learn the techniques and conduct CLYDE sessions of their own with new people, the concept has spread into a broadly based system of community involvement.

The hope is that the individual CLYDE groups, once they spread community-wide, could link up for their own common interests.

WHY DOES CLYDE WORK? The main reason is due to the tremendous trust level that is found through its weekly training process. Whether it is used with families or youth agencies staff or Boards of Directors, CLYDE's technique is based on values, communication and decision making skills that so often are lacking in the community structure.

When a community is facing problems like thefts, vandalism, drug abuse, truancy, dropouts and youth with nothing to do, then maybe it is time for residents of a neighborhood to sit down together for some "responsive listening".

The causes of most of these problems are right <u>in the community itself</u>, and the solution also has to come from the community.

New conditions in the home, the neighborhood and the school have to be created to change attitudes that lead to juvenile delinquency and youth behavioral problems. CLYDE was formed to figure out "how".

A major problem is that nearly the entire decision-making process in these institutions is by adults. CLYDE is a "grassroots" training process where adults and youths can acquire leadership skills to improve community conditions for youths.

CLYDE's purpose is to improve communications between youths and adults, reduce delinquency by providing positive alternatives, and to insure "youth's meaningful participation in the decision-making process".

Before we look at the training process, let's begin by asking ourselves several questions. First, what do we believe to be the underlying causes of substance abuse?

Secondly, do the conditions exist in our communities that promote the best interests of young people? Consider this question it relates to the most important arenas in the lives of young people - the home, the school, the neighborhood.

Who would object to that? Everyone wants those positive, healthy, and growth-producing conditions to exist. But where do you begin? Before we get to that, let's ask another question.

Who makes the decisions that determine the nature, scope and quality of the programs and opportunities for youth in the community? In other words, who holds the power and the purse strings in the schools, the recreation opportunities, the service programs, the economic institutions?

The answer is easy. A variety of elected officials, school superintendents, principals, teachers, administrators of various sorts, social workers, board members, parents, and probably numerous others. All of these people have one thing in common - they are all adults.

Consider this statement and ask if it is true of your community: Young people are systematically excluded from participating in the planning, operation and evaluation of programs and opportunities that exist for their wellbeing!

There is strong evidence to support the notion that one of the basic causes of delinquency or substance abuse is alienation. Alienation can result from a variety of conditions and experiences. It exists for youth where there is little or no access to meaningful participation in the events and experiences of the home, the school, and the neighborhood. But youth all too often are excluded from helping to shape those conditions.

Does this suggest what it seems to? Could it be that the conditions for alienation have been promoted by those adult decision makers we identified? Are the very people who were chosen and hired to fill the positions, make the decisions, and lead the way in developing better opportunities for youth a part of the problem after all?

One final question - knowing what you do about your community, if you could take all the resources for youth development that exist - financial physical, human - and redeploy them to best meet the needs of young people, would they be used as they are at present?

These questions may, if they are asked honestly and seriously, begin to suggest an approach to a program of community development that can turn the tables on juvenile delinquency and substance abuse.

In most communities there are many barriers to creating the conditions that promote the best interests of young people. The exclusion of youth from meaningful participation in decision making about youth opportunities is one barrier. The poor allocation of existing resources is another. The failure of adults in responsible positions to communicate with one another is a common barrier. Competition and territoriality

between youth serving programs exist in most communities. The over-dependence of profcssionals upon their own resources leads to failure to use the many resources that exist in every community for problem solving. Perhaps the greatest barrier is a lack of imagination on the part of leaders in engaging community people in using their talents and skills in promoting the development of youth.

This is by no means a comprehensive list, but as a start it points to some needed changes if we are to turn the tables on substance abuse. The encouraging thing about this list is that it is focused totally on the organizations and leaders of our communities. These are programs and people with whom we stand a good chance of effecting some change. Hopefully, these people are motivated to change and can provide leadership for change.

This is encouraging, because in the past when we have focused our attention upon such matters as poverty, psychopathology, remediation, and control of acting out behavior, we have failed rather miserably.

So our approach to turning the tables on youth problems will begin with engaging the appropriate leaders of our communities in creating the conditions that promote the best interests of young people.

And we suggest an obvious, simple, straightforward first step in this new and exciting direction - LISTEN TO YOUTH! The CLYDE approach, responsive listening, does just that.

For many adults, this will be new and unexplored territory. It will prove to be risky. It will be hard not to appear phony at first. And the young people will probably be skeptical! But let's try it.

Listen first to some high school students as they talk about their school. Does it really turn them on? Do they find learning to be exciting and challenging? Which teachers do they like, and why? Is the Principal a person with whom they can relate? Don't just listen to the achieving student. Talk to the failure-prone as well.

Ask these youth what kinds of changes they would like to see in their school. Ask that they help identify the barriers in the school that stand in the way of positive change.

Then move to the middle school. These students may seen a little young to many adults to have responsible opinions of their own. But you may be surprised. You may even consider talking with some elementary students!

Branching out from the schools, the inquiry can then be expanded to other resources for youth in the community. How do young people feel about the recreation centers, if such exist? Do they like to go there? How is the atmosphere? Is the center open when they want to use it? Do the leaders relate well with youth? The CLYDE neighborhood training course assists parents and leaders in creating a better atmosphere.

What about the service programs? Where can young people turn when they have a problem? Where can they find adults they can trust? Are they comfortable talking across a desk to a social worker in a family counseling agency? Or would they rather relate to a helping person with a different style under circumstances more natural to them?

Where are the favorite gathering places in the community for different groups of youth? Why do they like to go there? Does it cost? If they could create a new gathering place, what would it be like, and where would it be?

Any adult who listens - truly listens - to a sizable group of young people about these and many more matters important to youth, will find a new world opening up. That person will become a new resource in the community. When we talk about listening to youth, we do not mean just the "straight" kids. To listen honestly, one needs to listen as well to the delinquent in the juvenile jail, the drop-out, the runaway, the alienated. The more one listens, the better the resource one becomes. An adult who does this usually finds he or she becomes a real friend of young people.

When adults become engaged in this kind of experience, they make a new discovery. They learn that the important thing is not the answers they give to young people, but rather the questions they ask, and the way they ask them. Adults are supposed to have the answers, but to turn the tables on youth problems, it is far more important to ask the right questions. And to ask them of the right people.

By this time, we have begun to see young people as a resource, while we had previously seen them more as the problem.

If we have taken other adults with us on this quest, we have generated a new cadre of informed people, friends of youth, new leaders ready to promote changes in the community. We have learned to become advocates for youth because we dared to listen to what young people had to say. And we learned that the most important change needed is with the responsible adult leaders of the community.

Now the momentum is building. Young people and adults have locked arms. They have become co-workers, resources to one another, fellow problem solvers. The discovery has been made - It's not the answer that is important, it is the question!

Elected officials, administrators, professionals can be approached differently now. They will have to change and they will have to promote changes to create the new conditions in the community we are after - conditions that promote the best interests of youth in the home, the school, and the neighborhood.

Another discovery we begin to make is that turning the tables on youth problems does not depend upon a small group of highly trained individuals with specialized skills. Almost everyone has something to offer. Youth and adult. Delinquent and law-abiding. Rich and poor. Everyone has a vantage point, and everyone has insight. Our primary limitations are in our attitudes and in our skills to provide imaginative leadership to the use of these new resources for change.

The dynamic we have been considering need not be a fantasy - it can become a reality. The shape it takes will be unique to each community. There is no blueprint to determine its outcome, no model to install to insure its success, but the CLYDE concept is a beginning and one that can effect a social upheaval in this country.

CREATIVE CONCEPTS IN COMMUNITY PREVENTION

COMMUNITY LEADERSHIP FOR YOUTH DEVELOPMENT

THE CLYDE TRAINING PROCESS

CLYDE training is a means of motivating, organizing and training citizen representatives of a specific community.

The training process will be initiated by requests from communities to participate in this type of community organization and community development. The training is available to existing groups as well as potential, newly forming CLYDE groups.

TRAINING PROCESS - ONE APPROACH

I. Organization and Preparation

A. CLYDE TRAINING MEMBERS - A team of members of the CLYDE Training Committee will be assigned to a specific community group.

B. The team will meet with the community representatives requesting training to discuss the following items:

1. Explain purpose and process.
2. Set date, time, place, and desired group size for all sessions.
3. Begin to develop a list of possible participants - should be about 50% youth and 50% adults.
   a. Develop strategy and method of getting participation.
   b. Types of publicity, etc.
4. Be sure each person understands their specific role and responsibility.

II. Workshops - Four or Five Sessions

Get Acquainted and Value Determination

Outline of Series - Who are we, and Why?

First Session:

Each workshop begins with a get-acquainted exercise. The purpose of the first session is to develop that trust level that may be missing in parent-adult-youth relationships. This trust building approach develops to a high energy response by the end of the four or five sessions.

Second Session emphasizes communication and listening skills.

Third Session is heavy on decision making and how to develop the needed skills.

Fourth Session - Identification of Problems - A needs assessment is conducted and simulation of the problem-solving experiences is held. This helps the group members to develop an awareness of community problems and how citizens can have input into solutions for the problems.

Since measurable results in a program like this are difficult, there is, however, increasing evidence that the name of the game for the CLYDE concept is success. More and more youth are getting turned on to the fact that they are the leaders of tomorrow and can relate to the notion that adults do listen when they know how.

Everyone is a potential leader - some have higher abilities than others, but the fact remains that, given a little time, the CLYDE concept and training process can provide that leadership which is so desparately needed for community change.

FINALLY, if the CLYDE concept were to be summed up by activities, it would be encompassed in the following areas:

CLYDE emphasizes prevention:

..... helps young people learn how to make decisions

..... focuses on things adults and youth can do together

..... trains leadership teams of students and adults

..... works with schools to plan substance abuse programs for local school districts.

CLYDE believes that young people have

..... positive concepts of good physical and emotional health

..... personal resources to turn to in time of stress or trouble

..... rewarding relationships with others

..... challenging and fulfilling experiences in schools and

..... had experience in making personal decisions based on the examination of information, their own values and consequences of risk behavior,

they are less likely to turn to the substance abuse solution.

CLYDE

..... conducts training workshops for leadership in the school setting and in the home

..... arranges training on communication and values clarification

..... works

The CLYDE motto, which was designed by one of the youth who is now a community leader, sums up the whole CLYDE philosophy.

"THE POWER OF POSITIVE CHANGE FOR YOUTH AND ADULTS IN THE COMMUNITY LIE WITH EACH OTHER."

Try it, you'll like it.

SCOMM

#6:18

Alaska Criminal Justice Plan 1978
by Criminal Justice Planning Agency, Pouch A-J
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ALCOHOL ABUSE AND ALCOHOLISM

Continuing efforts to deal with the impact of alcohol abuse on the quality of life in Alaska resulted, during 1976 and 1977, in a number of approaches and suggestions. A "Governor's Interdepartmental Coordinating Committee on Alcoholism" made its final report to the Governor in January, 1977.

Many of the recommendations were incorporated in an extensive package of bills prepared as a part of the CJPA's Standards and Goals project. This legislation, which emphasized issues of taxation and local control as prevention measures, was not passed by the Tenth Alaska Legislature and is in committee to be heard in the second session.

The CJPA has identified seven areas of immediate concern to the criminal justice system.

1. Establishment of non-medical detox centers

The Uniform Alcoholism Act (which decriminalized public intoxication) was adopted in 1972 without adequate development of facilities to serve as alternatives to jails. The resulting problems were particularly acute in rural areas, where detox and sleep-off facilities were virtually nonexistent. The ninth Alaska legislature passed what was intended as remedial legislation which provided that public inebriates may be taken into protective custody and, as a last resort, held involuntarily for up to twelve hours in a "state or municipal detention facility", i.e. jail.

No data is available concerning the effect of this legislation on jail intake in either urban or rural areas. One innovative application is found in the operating procedures of the North Slope Borough Department of Public Safety, which describes its "Drunk Release Program" as follows:

Operating Procedures Manual Reference: Chap. 214 and 301

A. "Drunk Release Program"

A major part of our crime prevention program is the detention of those persons so intoxicated as to represent a definite threat to themselves and a lesser threat to others. Of the following purposes behind this program, one additional feature will be added:

1. Protection of the person intoxicated
2. Protection of others from intoxicated persons
3. Non-criminal detention, processing and release

The additional feature will be an attempt to reduce "returnees" to this system by making referrals to the Barrow Council on Alcoholism for interviews, counseling and treatment. While it is assumed that no enforcement of this diversion method can be made, there is room for a very light push in the general direction--that push being in the form of "voluntary referrals" directly from their release. These referrals will be a consistent part of this program.

The method of "voluntary referrals" will be as follows:

A. At time of release by any officer, the person detained will receive a direct invitation (with officer assistance) to meet with personnel of the Barrow Council on Alcoholism presently located in the Youth Center. They are to be encouraged to go directly from release to BCA for initial intake.

B. Since there is no legal provision for enforcement of referrals, a strong recommendation by the officer releasing will be encouraged.

C. An alternative method is to call up the BCA and ask for a staff person to come to the station and make the request and invitation directly to the person released from detention.

The Governor's Inter-departmental Coordinating Committee on Alcoholism made the following recommendations:

- Amend the Uniform Act (AS 47.37) to allow sleep-off facilities to hold "intoxicated persons" and/or "incapacitated persons" for up to 72 hours involuntarily.
- Provide the funds to operate a statewide network of sleep-off facilities...
- Require all sleep-off facilities to employ at least one person with Emergency Medical Training on each shift seven days a week.
- Require an initial medical examination within 24 hours.
- Require hospitals and physicians to admit intoxicated persons to hospitals if they also present other severe complicating medical problems.
- Require sleep-off facilities to conduct an evaluation for the purpose of disposition and referral of the patient prior to his release at the end of 72 hours.

The Committee recommended the establishment of sleep-off centers in Juneau, Ketchikan, Valdez, Yakutat, Wrangell, Petersburg, Seward, Unalaska, Cordova, Kotzebue, Barrow and Kenai. An estimate for establishment of these centers in single or double-wide trailers was $439,050 in capital expenditures and $2,193,750 in annual operating expenses (including 117 total staff).

The report also recommended a needs assessment to determine whether sleep-off centers should be established in Dillingham, Galena, Fort Yukon and Glenallen-Copper Center, should funds be available. The report encouraged other communities without jails or sleep-off centers to develop statistics which could be used to determine the need for and probable utilization of sleep-off centers.

At a June, 1977 meeting of the Governor's Advisory Board on Alcoholism, it was decided to establish detox facilities in Kenai, Kotzebue and Juneau, and to expand the existing facility in Bethel.

2. Establishment of alcohol prevention and rehabilitation programs in rural areas

The lack of effective alcoholism treatment programs in rural areas is widely acknowledged. The Alaska Federation of Natives, in their 1976 Resolutions, point out that:

- there are inadequate and inefficient alcoholism treatment centers in rural Alaska
- there are no current alcoholism prevention programs
- there is a lack of emphasis in existing alcoholism, drug abuse and mental health programs specifically relating to the treatment of juveniles
- group homes, receiving homes, and alcoholism treatment facilities are not available for the treatment of non-delinquent youths in most of the regional service centers of Alaska.

Among the AFN recommendations were:

- that the Department of Health and Social Services establish as a top, on-going priority, alcoholism prevention programs for rural Alaska, and that the Department work closely with local communities to determine the kind of treatment facilities needed and the appropriate kind of alcoholism services.
- that the problem of treatment of alcoholism as it relates to juveniles and families in rural Alaska be addressed; that more emphasis be placed on research and treatment of juveniles.

- that group homes, receiving homes and alcoholism treatment facilities be made available on a regionalized basis and that the Legislature make financing available so that small communities can develop programs that will deal with juveniles before these children enter the juvenile justice system, and that they be funded on a regionalized basis (i.e., Nome, Kotzebue, Ft. Yukon, Bethel, Dillingham, Barrow, Kodiak, Yukon Delta, Copper Center and Ketchikan, etc.,

Information provided by the State Office of Alcoholism, the National Council on Alcoholism/Alaska Region and the Alaska Native Commission on Alcohol and Drug Abuse shows that there are "prevention" programs of one type or another in a number of rural areas, and that more are planned in the near future (see Available Systems and Resources for Prevention/Diversion). Thus the AFN statement that "there are no current alcoholism prevention programs" must reflect a sense of frustration with the performance of current programs, or perhaps with the fact that no one, as yet, has actually found an effective way to prevent alcoholism which has universal, or even widespread, application.

The Governor's Interdepartmental Coordinating Committee on Alcoholism noted that nationally some of the most successful residential treatment programs are those that do not use government grants for funding, but which rely primarily on reimbursement for services given. They add:

> The size and stability of existing rehabilitation programs in the state are not adequate to meet the needs of this type of service. Patients who can pay and/or who have insurance coverage for this kind of care are typically transported "outside". It would be a functional and economic benefit to the State to have such a facility/program available within Alaska. It would afford existing smaller local programs with an inpatient resource within the State. It would also keep the money paid for treatment within the State.

The Coordinating Committee recommended:

- The State should provide funding for the establishment of a quality, short-term residential, intensive treatment program which is directed primarily toward those rural and urban clients who are covered by public or private insurance or able to pay their own way.

- This facility should be centrally located but not directly adjacent to a large metropolitan area.

- This facility should not exceed 70 beds and should have an average patient stay of 30 days.

- The program should be available to residents from throughout Alaska and serve both urban and rural populations.

The report also recommended establishment and initial operation of a long term domiciliary care and rehabilitation facility for the chronic public inebriate.

- The primary client population for this program should be the court-committed chronic public inebriate and/or those addicted individuals in need of long-term in-residence care who choose to commit themselves voluntarily for a period of 90 days or longer.

- The program should be operated by the State for a period of five years, at the end of which the program should be evaluated to determine whether or not it should be contracted to the private sector.

Realistically, perhaps, Alaska should work to get one stable residential facility in a central location, and then move to establish community-operated residential facilities in the regional service areas.

The Interdepartmental Coordinating Committee on Alcoholism made the following recommendation: "Because of the predominance of alcoholism problems in rural communities, because of the limitation on available resources in rural communities, and because of the importance of skilled help for the alcoholic:

- It is recommenced that the primary direction and identity of the Community Mental Health outpatient program be that of an alcoholism treatment service.

- Rural alcoholism, drug abuse, and mental health professionals and paraprofessionals should be cross-trained in all three areas.

- It is our recommendation that rural alcohol, drug abuse, and mental health outpatient services maintain their separate identities and budgets but that they colocate in order to facilitate cooperation in patient care and facilitate cross-training for personnel in all areas.

- Existing local community alcoholism programs should provide information and referral services on an ongoing basis as part of their normal activities.

- Existing local community alcoholism programs should be required to develop formal referral networks with all health, social services, judicial and law enforcement agencies in their local catchment area.

Currently, the strategy of the State Office of Alcoholism is to establish major rehabilitation centers in Fairbanks, Anchorage, and an as yet to be determined site in Southeast. Existing programs in Fairbanks and Anchorage will provide the nucleus for these programs. Programs in other areas will utilize these treatment centers.

A spokesman for the State Office of Alcoholism indicates that most rural areas share a set of social/cultural/economic/political processes which have created conditions leading to high rates of alcoholism but which are not amenable to rehabilitative efforts. The Office recognizes two major areas for prevention efforts as (1) local control and (2) an apparent lack of recreational opportunities, particularly during the winter months.

3. Establishment of screening and treatment programs for alcohol offenders

There are a variety of programs in urban areas in Alaska which presently provide or have the potential to provide alcohol screening treatment services. Presently these programs operate independently and may be duplicative or may leave gaps in services needed in a particular community. Through an LEAA discretionary grant the Criminal Justice Planning Agency has recently funded a TASC (Treatment Alternatives to Street Crime) program for the Anchorage area. One of the major functions of this project is to coordinate the efforts of the many alcohol-related services in the Anchorage area. The State Planning Agency should monitor the project closely to determine if its techniques can be transferred to other communities or regional areas through the use of the State's Technical Assistance Program.

Very little is known about the extent of alcohol screening and treatment programs available in smaller cities and rural areas of Alaska. Existing data does demonstrate the need for these services. According to surveys conducted by the Corrections Task Force for Standards and Goals and the Public Opinion surveys conducted by the Criminal Justice Planning Agency, the problem of alcohol related crime is more severe in rural areas than it is in urban areas. In a survey of police chiefs throughout rural Alaska, the Corrections Task Force found that rural communities attributed from 36% to 98% of all arrests to the problem of alcohol abuse. Victimization rates in rural northwest Alaska were higher than Southeast, Anchorage or Fairbanks. Also, rural respondents in the statewide survey of public opinion felt that alcohol was a basic cause of crime (22% for crimes against people; 13% crimes against property) whereas less than 3% of the respondents from more urban areas surveyed identified alcohol as a basic cause of crime.

The Criminal Justice Planning Agency should compile all data regarding alcohol abuse programs in all regions of the state which may provide screening and/or treatment services to the criminal justice system. The gaps in services should be identified, and a method for coordinating existing services must be established.

4. Development of alcohol abuse curricula

There is general agreement that long-range planning in the area of alcohol abuse must focus on primary prevention and that the schools provide the logical focus for such efforts. At present three approaches are being taken to the development of alcohol abuse curricula, and are at various stages of development.

The core of a kindergarten through 12th grade curriculum has been developed by the National Council on Alcoholism/Alaska Region, and is currently in use on an experimental basis in Kenai and Fort Yukon. The curriculum has also undergone preliminary review in the Anchorage area. The Council estimates that it would take one year of work by an educator (who would consult with students, parents, educators and agency staffs statewide) to complete the curriculum, prior to training teachers to use it.

A sub-committee of the Governor's Interdepartmental Coordinating Committee on Alcoholism recommended the development of an academic curriculum package by the State Department of Education. This is seen as a three-year program with the first year devoted to the initial development of the curriculum and the beginning of teacher training, the second year for field testing and further teacher training, and the final year for duplication of multi-media curriculum packages and on-site regional training. The three-year program would have a price tag of somewhat over $300,000 and would aim at reaching 52 school districts and 93,000 students in grades K through 12. The curriculum would coordinate other existing programs (including the NCA curriculum described above and a program currently in use in Anchorage, described below).

Wonder Park Elementary School in Anchorage is currently using a curriculum prepared in Washington and which may be made available free of charge by the National Institute of Alcohol Abuse and Alcoholism in the near future. This program, which has been enthusiastically received, is called, "Here's Looking at You" (Teachers Edition) and is now available for $15.00 from:

Educational Service District #110
1410 S. 200th St.
Seattle, Washington 98148

Wonder Park is one of seven Anchorage elementary schools participating in a Teacher Training Program prepared by the University of Alaska Center for Alcohol and Addiction Studies. This program provides instruction in the dynamics of human behavior and how they relate to alcohol and drug use and other forms of deviancy. The approach is aimed at providing incentives for the development of community programs and involves both parents and teachers. It is currently being broadcast by KAKM in Anchorage once a week for ten weeks. Parents were invited to participate and may either view the programs in their homes or go to the schools where they participate with the teachers in group discussions and activities related to the training materials. Participating teachers receive graduate credit from the University. The complete training program has also been provided in Tok.

An Office of Alcoholism FY '78 budget item to provide a curriculum was not funded, but will be resubmitted in FY '79.

5. Improvement of correctional treatment programs

The Interdepartmental Coordinating Committee on Alcoholism recommended to the Governor that the Division of Corrections should:

- provide treatment within correctional facilities for alcoholic inmates
- ensure that appropriate aftercare and follow-up are provided for all alcoholic inmates upon their parole
- make referral and aftercare available to alcoholic inmates who have completed their full sentence.

It is the position of the Criminal Justice Planning Agency that while alcoholism training should certainly be made available to correctional personnel, it would be counterproductive for the Division of Corrections to have to develop a cadre of trained alcoholism counselors. Both management of treatment and continuity of care can be improved by the use of existing community resources. Corrections' clients should have access to services funded either through the state Office of Alcoholism or by local communities. These services should be provided within institutions, and should also be available to clients when they return to their communities. The role of Corrections personnel should be to make referrals and encourage participation in community programs. The State Office of Alcoholism agrees with this position, and has instructed all local programs to work closely with the Division of Corrections and other components of the criminal justice system.

The Criminal Justice Planning Agency is presently funding two alcoholism counseling programs in Corrections as described in "Available Resources". In one, funding has been provided for a Corrections staff member to establish and run A.A. groups (and related courses and activities) in the Anchorage area. It is the intent of the grant that inmates will be encouraged, on their release from jail, to return to the A.A. meetings as community members.

The second approach, currently being used in Juneau, is to provide funds to a local alcoholism treatment agency (the Juneau Alcoholism Central Agency) to make services available to the population of the Juneau Correctional Center. Continued service is thus automatically available when an inmate is released on parole or completes his sentence. Community services are available to probationers as members of the community.

The eventual success of either of these approaches will depend on the involvement and support of probation/parole officers, who can do a great deal to ensure continuity of the programs.

During 1979 CJPA will support a comparative evaluation of the two approaches to include recommendations for the course of future development of alcoholism programming in corrections.

6. Strengthen enforcement capacity of the Alcoholic Beverage Control Board

At present the Alcoholic Beverage Control Board has a staff of five investigators with three based in Anchorage and two in Fairbanks. Licensed establishments are distributed as follows:

1st Judicial District (Southeast)	252
2nd Judicial District (Northwest)	26
3rd Judicial District (Anchorage, Valdez)	663
4th Judicial District (Fairbanks)	245

The Board's investigators work with local and state law enforcement agencies to investigate applications before licenses are issued. They perform routine surveillance of licensed establishments and investigate complaints.

Although no statistics are available, ABC staff estimate on the basis of complaints and observations that 75% of licensed establishments serve intoxicated persons and about 25% are serving minors.

Revenue sharing provides that municipalities with law enforcement capability will receive the revenues from their licensing fees for the purpose of enforcement. This is seldom carried out, however, and enforcement is generally seen as the responsibility of the ABC Board.

Various resolutions to the problem of enforcement have been proposed: the Governor's Management and Efficiency Review (May, 1975) indicates that, "the activities mandated to the Board are being carried out effectively. However the investigative staff needs to be enlarged to provide adequate coverage for Southeast Alaska." The Review Committee recommends the addition of one investigator.

On the other hand, Convention Resolution #76-27 of the Alaska Federation of Natives (1976) states that the "level of staffing and funding is absolutely disgraceful considering the ABC Board's statewide enforcement responsibilities--especially in rural Alaska." The resolution recommended:

- that the Governor and the Legislature increase the ABC Board's funding to at least $1,000,000; and
- that sufficient positions of that funding be devoted to providing adequate enforcement of State and local alcohol beverage control laws in rural areas, and
- that sufficient portions of that funding also be devoted to investigate and overhaul the present alcohol control procedures and to develop new and better coordination of control procedures throughout the State; and
- that such procedures should be enacted as law and fully funded no later than July 1, 1978 (FY 79).

The recent Director of the ABC Board recommended, in April 1977, the reorganization of the enforcement staff to include an upper level administrative position (Range 21 or 22) to be responsible for the activities of five investigators in Anchorage, three in Fairbanks and two in Southeast. She feels that the administrator of the enforcement unit should be experienced in investigation of "white collar" and organized crime.

The State Office of Alcoholism and the CJPA concur regarding the need to strengthen the ABC Board, and to diversify its membership to represent a broader spectrum of interests.

7. Use of alcohol as a mitigating circumstance; penalties for driving while intoxicated

The law states that voluntary intoxication is not to be used as a mitigating circumstance except in "specific intent" cases. It is commonly felt, however, that it is quite frequently used by both judges and juries. There is less agreement as to whether or not it is appropriate.

Senate Bill 206, "An act relating to sentencing", currently in committee, attempts to strengthen the existing law and to address the issue of whether intoxication is "voluntary" in the case of an alcoholic. This bill, commonly referred to as the "Presumptive Sentencing Bill", defines conditions that may be considered aggravating or mitigating in the determination of sentences.

> In no event may punishment be mitigated or reduced because of voluntary alcohol or other drug intoxication or chronic alcoholism or other drug addiction.

Current pending legislation also addresses penalties for operating a motor vehicle while intoxicated. Senate Bill 38, "An act relating to driving under the influence of intoxicating liquor or drugs", amends AS 28.35.030 as follows:

1st conviction--a minimum sentence of not less than three days shall be imposed (in addition to the previous fine of not more than $1,000 or imprisonment for not more than one year or both).

2nd conviction--within five years of first, imprisonment not less than ten days (from three days presently required).

3rd or subsequent conviction--within five years of second, imprisonment not less than 30 days (from ten days presently required).

The Division of Corrections estimates the impact of this legislation on their facilities in the first year at an average of six prisoners a day x 365 days x $48 a day per inmate, or a total expenditure of $105,000. This cost estimate does not address the issue of already-crowded short-term holding facilities. Neither does it address the problem of small communities where the state does not have contracts for jail services.

The proposed legislation does nothing to reduce discretion on the part of police and D.A.'s, and thus to ensure that those with money and/or influence are as likely to be prosecuted as those with "nothing going for them".

Problem Statements

20. At present there are a total of seven alcoholism programs in the state (only one in a rural area) with either detoxification or sleep-off capability. In other areas intoxicated individuals who are held in protective custody must be housed in local jails where they may be held for twelve hours.

21. There is a need for coordination and consolidation of efforts to ensure that at least one quality curriculum is available for use on a statewide basis. This should involve careful evaluation of already available materials and approaches.

22. Effective prevention and rehabilitation programs are generally not available in rural Alaska. Additional emphasis needs to be placed on juvenile problems of alcoholism and drug abuse.

23. There is a need to provide alcohol screening and treatment services throughout the State of Alaska and to coordinate the efforts of existing services.

24. The present enforcement capacity of the Alcohol Beverage Control Board is insufficient to regulate and control the liquor industry.

25. Many feel that the use of intoxication as a mitigating circumstance is contrary to a perceived "sense of justice". Proposed legislation which increases penalties for OMVI is an attempt to force the public to take the issue of drinking and driving more seriously. To be effective, the legislation should be amended to reduce opportunities for plea-bargaining, sentence reduction, and discretion in charging.

26. Alcoholism treatment programs are generally inadequate within correctional settings, and must be provided by the Division of Corrections when community services are not available. Community-based programs, funded locally or by the State Office of Alcoholism, should be extended to provide services within correctional institutions, as well as upon the offender's return to the community.

SCOMM

#6:19

Education and Mass Persuasion in the Reduction of Alcohol Problems

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It is with great pleasure that I address the 1975 Alumni Institute today - and the pleasure is particularly full because the Institute meets this year as a Festschrift for Selden Bacon to honor him on the occasion of his retirement as Director of the Center of Alcohol Studies. The timing of this Institute is especially appropriate in view of the debt the remarks I am about to make owe to Selden's seminal influence. He has consistently and vigorously insisted on the necessity of viewing alcohol and its use in a total societal context, as a socially defined, socially patterned, and socially regulated behavior. It is only within this kind of broad perspective that we can hope to control alcoholism and to minimize alcohol problems. To derive policy and the actions that flow from it solely from an understanding of a pathological extreme provides at best lopsided solutions with minimal effects and at worst unanticipated deleterious outcomes.

A few years ago, I addressed myself to an assessment of then-current and promising trends in the prevention of alcoholism (Blane, 1968; Chafetz, Blane, and Hill, 1970). In regard to mass persuasion, I found no consistent, coherent approach. In regard to education, I was able to identify only a single program of potential merit in the area. It was a program based on a responsible drinking approach developed by Thelma Unterberger and Lena DiCicco and evaluated by Allen Williams, and it operated out of the Massachusetts Division of Alcoholism (Williams, Unterberger, and DiCicco, 1968). Today I am happy to report that the situation is quite different. There is a veritable explosion of programs - of great variety, and many of imaginative design. I wish to share with you some of the major current trends and problems as I see them - first about education and then about mass persuasion - without making any pretense of being exhaustive about either.

First, there seems to be a general moving away from the term "alcohol education," with greater emphasis being placed on such non-specific terms as

"youth programs" and "youth education." While the shift of words is not terribly important in and of itself, it reflects significant changes in conceptualization and direction. Perhaps because of its linkages with post-Repeal legislation which made teaching about the dangers of alcohol mandatory and also because of linkages with the later post-World War II preoccupation with the accurate presentation of facts about alcohol, the term "alcohol education" has come to have a negative, school-marmish connotation. Alcohol education is also a categorical term associated with value-laden exhortations, the simple provision of information, and convenient compliance with the law. Further, it implies that the locus of learning is the school, and specifically the classroom. The more recent use of non-specific terms is in keeping with broad trends in the field of education generally that represent attempts to create alternatives to the increasing obsolescence of the traditional school as an institution capable of meeting the varied and complex demands now placed upon it. Some of these alternatives are taking place within a traditional institutional framework, while others represent attempts outside that framework. There is also an increasing awareness that the socialization of values, beliefs, and behaviors about alcohol among young people does not occur in isolation from other crucial aspects of growing up. This is not to say that there are not facts and factors that are specific to alcohol and to alcohol only, but that, generally speaking, learning to live with - or without - alcohol is just one of many growth issues that young people face. Thus, whether formal learning about alcohol occurs within the school or outside it, that learning is tending more and more to be embedded in some larger educational enterprise.

Along with this relative decrease in emphasis on the categorical nature of education about alcohol, increased attention is being paid to the definition of target groups and to desired outcomes (Blane, in press, a, b). Both of

these in turn are related to underlying conceptions about the most productive and economical ways to prevent alcohol problems and about the very nature of alcohol problems themselves.

Target groups of alcohol and youth endeavors may be specified in many ways, but they fall broadly into one of two classifications: general population groups or groups that are at-risk, i.e., subpopulations whose members are at hazard with regard to the development of alcohol problems. These include delinquents, dropouts, and children of alcoholics, among others. Among supporters of the general population approach, there is controversy as to the ideal age range for education as well as the most effective length of programs. This is mostly guesswork now, because little hard data are available. While at-risk and general population programs are usually separate, there is no necessary incompatibility between them. In public health terms, at-risk programs proceed from a secondary prevention approach - that is, intervening with a group that is infected but not yet ill in order to abort a disease - while general population programs proceed from a primary prevention approach which attempts to change the very conditions which bring about infection, thereby minimizing its onset. It has been argued by analogy to the infectious disease model of prevention that secondary prevention has only minimal effects on reducing alcohol or other social problems, and that we should therefore place our money on primary prevention. There is, however, little evidence to support or refute the notion as far as social problems are concerned. It does appear that alcoholism treatment personnel are more attracted to at-risk programs, while educators and social-behavioral scientists are more attracted to general population approaches. In actual operation, as we shall see, programs which focus on each target have their own difficulties to contend with.

More attention is also being given to the outcomes that are sought by educational endeavors. These outcomes are far more varied than the target groups

and are complicated by moral, ethical, and community concerns about youth and alcohol. In many regions of the country and in many communities, controversy over "wet" or "dry" is still a potent influence. Most programs are, however, based on the assumption that youth are growing up to become adults in a drinking society, and goals are established within that framework. Some goals are quite specific, while others are so vague as to be articles of faith. For example, it used to be assumed that one goal of education about alcohol was to provide information; given that information, the young person would make a healthy decision. It has been demonstrated that it is relatively easy to increase informational level about alcohol and to maintain that increase over time. But, no evidence exists to indicate that the increased level of knowledge affects behavior in any way - and such goals are increasingly becoming secondary. Outcomes are also open to varying interpretations; this is well-illustrated by a program in which it was found that an experimental group reported more initiation into drinking but relatively fewer episodes of intoxication than a control group. One critic (Goodstadt, 1974) interpreted the finding as showing that the program was a failure because it increased the numbers of persons who drink, while another (Blane, in press, b) saw it as a success because the relative proportion of intoxication decreased even though the numbers of drinkers increased.

Desired general outcomes may be classified in four ways: (1) promoting integrated drinking; (2) reducing deviant drinking; (3) clarifying values and increasing decision-making skills, with or without specific reference to alcohol; and (4) improving psychological and social coping skills so that resort to alcohol as a coping mechanism will be less likely. While there can be a great deal of overlap here, the first two outcomes - integrated drinking and reduction of deviant drinking - tend to be more alcohol-specific than the others. As

such, target behaviors for them include such factors as the frequency, pacing, quantity, timing, and place of drinking and the companions with whom one chooses to drink.

The goals of integrated drinking are that drinking should be subordinated to other activities and occur in situations of restraint. More particularly, alcohol should not be consumed solely for its effects nor to become intoxicated, nor as a proof of identity. Drinking is further a matter of individual choice, and no value should accrue either to drinking or to non-drinking. Integrated drinking is based mainly on the notion that there is common agreement in a society that drunkenness is bad but alcohol as a substance is morally neutral. Integrated drinking as a goal in the United States represents a reform position and is thus idealistic, if not Utopian. Nevertheless, its specific behavioral and attitudinal goals can be stated in clearer form than those of the other programs.

The reduction of deviant drinking approach aims to reduce drinking behaviors in young people who may already be drinking in pre-pathological modes. Many of the specific goals - not drinking for effect, not getting drunk, not drinking in settings where the context provides minimal constraints on fast, heavy drinking - may be the same as for integrated drinking. But, since the target group is usually composed of multi-problem youngsters, there may be other goals that have an impact on drinking behavior but which are quite separate from it - such as greater scholastic achievement or obtaining a job. Reduction of deviant drinking also does not encompass the revisionist quality of integrated drinking. It tends to work more with groups, individual members of which are seen as potential if not actual outsiders who are to be brought back into the fold. But reduction of deviant drinking programs are basically not concerned with the way Americans typically pattern their use of alcohol.

With regard to programs which aim at clarifying values and increasing decision-making skills, it should be noted that while the terms value-clarification and decision-making are often used interchangeably, they in fact represent two separate educational technologies which strive for a common goal - helping people to arrive at courses of action that are satisfying and produce growth. It is often assumed that people who have had the opportunity to become affectively aware of their values and know how their values - including conflict among them - affect their behavior in concrete situations will relate to alcohol in a satisfying and healthy way - whether they drink or not. In the same fashion, it is assumed that people who have been taught cognitively how to size up the main elements of any given situation and to make a rational decision which satisfactorily balances risks, benefits, and wishes will also use alcohol in a healthy way. It should be understood that for all the popularity both techniques now enjoy, their assumptions find little empirical support - whether the target behavior is drinking, smoking, using drugs, or other private but health-related actions. Unlike alcohol-specific approaches, however, these techniques recognize and accept the extreme social ambivalence that characterizes alcohol and drinking in American society. Rather than reforming society, they tend to work with what is. They therefore attempt to make people more aware of their own internalization of pluralistic values and social forces in order to help them take the most self-consistent course of behavior.

Even more general programs are those which aim to increase and strengthen psychological and social coping skills. Indeed, to the extent that value-clarification and decision-making programs increase coping mechanisms, they might be included under this rubric. However, to do this would miss the main point on which this essentially mental health approach rests; that is, that

the deviant use of alcohol is essentially a coping response individuals use to handle conflict and the feelings - anger, anxiety, depression, and loneliness - that are engendered by conflict. In this view, individuals who have a broad repertoire of resources for coping with conflict and handling feelings are less likely to turn to alcohol in times of stress. There is little question that alcohol is used by many people in response to stress; there is, nevertheless, little evidence to indicate that if coping skills increase, alcohol abuse decreases.

Given the kinds of desired outcomes listed - integrated, responsible drinking, reduction of deviant drinking, and increasing and strengthening coping skills - what kinds of youth education programs are now being mounted? Earlier, I mentioned the responsible drinking approach developed by Unterberger and DiCicco over a decade ago. Their work has continued, with emphasis on small-group student discussions led by specially-trained regular classroom teachers (DiCicco and Unterberger, 1973, 1974; Unterberger and DiCicco, 1968). A long-term program based in an urban community in Massachusetts not only involves the school system but attempts to generate support and change throughout the community (Unterberger and DiCicco, 1975). The focus is on the general population of students and an integrated drinking outcome. The core of the program is based on in-service training of classroom teachers. The goal of this training is to help teachers examine their own attitudes, values, and experiences in small groups so that they can clarify their feelings about their own drinking and teen-age drinking. Equipped with self-knowledge, they can be effective alcohol educators with their students. Such training, costly and time-consuming, is felt by its proponents to be absolutely necessary for effective alcohol education. It may be noted, however, that some observers believe that classroom teachers have such low credibility among students as instructors

about personal, private behaviors like drinking that their impact is minimal (Stacey and Davies, 1970). Nevertheless, some support for the Unterberger-DiCicco approach has already appeared (Williams et al., 1968), and the results of their current large-scale program will provide further evidence relative to the value of employing classroom teachers as instructors. Should the demonstration prove effective, the problem of widespread implementation is complicated by the high cost of in-service training relative to training in teacher preparation institutions where receptivity to introducing training of this sort has never been great (Blane, in press, a, b).

Other attempts at promoting education for integrated drinking or non-drinking have included the embedding of information about alcohol in the curriculum at all levels - its chemical, physiological, and pharmacological effects, its role in history, economics, and literature, and the social and cultural patterning of its use. This trend is manifest in several curriculum guides for students from elementary through high school levels. Another particularly important move in attempting to change attitudes about alcohol has been NIAAA-supported efforts to influence national voluntary and professional youth-oriented organizations to adopt a stance favorable to integrated drinking - as, for example, the national PTA, the JAYCEES, and the Educational Commission of the States.

In many states, the state authorities on alcohol and drug abuse have developed education programs. Pennsylvania, for instance, has an active service, demonstration, and research program that emphasizes value-clarification and decision-making techniques in a general substance abuse format that includes both alcohol and drugs. Individual programs are offered in schools for varying lengths of time, but usually not for more than once a week for seven weeks during the school year. Instructors are specially-trained counselor-

educators in contrast to the classroom teachers of the Massachusetts program. Research on program effectiveness is carefully conducted, but a recent review (Swisher, 1974) offers only modest evidence for optimism. "There is very limited evidence that any program has been successful in altering drug use patterns at any educational level." Some limited evidence suggests the usefulness of value clarification among high school students, but the greatest evaluation need is seen as the conduct of long-term follow-up of intended outcomes. It has been suggested that there may be a "long-delay" effect of health education that only becomes manifest in early adulthood, thus indicating the need for longitudinal and cross-sectional studies over time. The programs just described are conducted within the school system and generally attempt to elevate the quality of life for young people, thereby indirectly reducing problems associated with alcohol.

Minimization of abuse programs directed towards members of particular youthful populations may be found in a variety of settings outside the school system, including neighborhood youth centers, YMCA's, community mental health centers, and residences for runaways. One example is an age-staggered peer counseling work program with ghetto youth in Philadelphia (Mander, 1974). Here much of the program is in the hands of the youngsters themselves, with professionals acting as consultants and resource persons. The orientation is to raise the level of social and psychological coping skills, with the prediction that psychological strength will increase and deviant behavior, including alcohol abuse, will decrease. College students counsel high school students, who in turn counsel younger students in a neighborhood youth center. Participants are paid for their work which is full-time in the summer and part-time in the winter. Exposure to appropriate adult role models and gradual shaping of responsible behavior are central to the program. Preliminary evaluation

suggests that the program is having a positive impact, although data on alcohol use have not yet been reported.

Another program that is still in the planning stage is one that will use the philosophy and orientation of Junior Achievement to attempt to socialize delinquent teen-agers into middle-class values (Golin, 1975). Junior Achievement is an organization that is to the world of business as 4-H is to the world of agriculture - that is, it attempts through doing and achievement to introduce young people to adult occupational roles. Adults themselves serve as role models for the young people. The program will attempt to help delinquent youngsters to learn through doing about business procedures and practices and to open the opportunity structure to them. With regard to alcohol abuse, it is assumed that should the program be successful in curtailing delinquent behavior, excessive use of alcohol will also decrease.

Another approach that is possible, but to my knowledge has not been tried, is the application of behavioral approaches to individual control of drinking. Social learning approaches to weight control and control of smoking have had some success. Contingency management approaches of various types have been used in experimental settings for chronic alcoholics, with controversial results. Their application to social drinkers who express concern about their drinking seems a natural extension. Models based on self-monitoring, self-evaluation, and self-control in combination with knowledge of BAC's may provide the basis for individual control programs.

At the University of Pittsburgh, my colleagues and I have outlined a school-based program that combines primary and secondary preventive approaches and aims at generating a self-perpetuating, peer-stimulated program that may have implications for combining effectiveness with low cost. The primary preventive aspect will focus on the entire student body of a senior high school, while the secondary preventive component will center on students who have recently dropped out

of school or who show high potential for doing so.

The primary prevention thrust is relatively unique in that it will initially provide individual instruction for one to six class sessions to students who have any question about alcohol or drinking by themselves, their friends, or members of their family. Individual instruction will be provided by specially-trained instructors who are knowledgeable about the major aspects of alcohol and its use and who possess counseling skills. Pilot experience indicates that students will present a wide variety of questions and concerns, ranging from straight informational questions (e.g., Do beer and whiskey have different effects?) to more interpersonal concerns (e.g., I don't like to drink but my boyfriend wants me to - what should I do?) to highly personal concerns (e.g., I am afraid I like to drink too much). The instructor will be equipped to deal effectively with all such questions and issues and will be able to aid the student in obtaining further help if indicated. From among the students who participate in the individual instruction program, those who express a continuing interest will be encouraged to form a group which will study alcohol and its effects in a more structured, formal educational program, including the initiation of student projects and demonstrations. On the basis of this experience, juniors and seniors will conduct individual instructional sessions under supervision with freshmen and sophomores. On the basis of past experience, there is reason to believe that student interest in such an endeavor will be high, and it appears feasible that if students can provide much of the instructional manpower after an initially large investment by professional personnel, one professional would be able to supervise this component of the program once it was fully underway, even in a reasonably large school. The emphasis here is alcohol-specific, yet the program aims at short-term input during a stage of normal development in which plasticity and the capacity for change and

growth are extraordinarily great and responsiveness to a trusted adult or older peer is remarkably high. We expect that much healthy restructuring of cognitive, affective, and behavioral sets can be accomplished with a relatively small amount of input. We also expect that student interest and involvement will reverberate through the system with an ultimate impact on more students than actually participate in the instructional program. In order to evaluate such hypothesized general effects, all students in the participating high school as well as those in a non-participating comparison school will be surveyed annually about self-reported use of alcohol and attitudes towards the temperate and intemperate use of alcohol. These surveys will extend over a period of years and will include classes that have graduated so that information will be available on program effects into young adulthood. In order to examine the effects of individual instruction itself, a concerns-about-alcohol scale, in process of being developed, will be administered before and after participation. The scale will cover a wide range of feelings, attitudes, and beliefs about alcohol - e.g., "I worry about my drinking," "A drink every day is bound to be dangerous," or "Being able to hold your liquor is the important thing." We expect that scores on this scale will decrease with exposure to individual instruction.

Secondary prevention in the school will center on students who, on the basis of their school record or by self-designation, indicate that they will leave school before graduation, and secondary prevention in the community will focus on students who have recently dropped out of school. The basic objectives of this part of the program are general rather than alcohol-specific. The first objective is to keep the potential dropout in the system and to help the actual dropout to return to it. When this aim becomes a matter of fitting a round peg into a square hole for a particular youngster, alternative strategies will be attempted. The major mode of working with these teen-agers

will be the development of a relationship with a counselor who has the skills to assess personal, social, family, educational, and vocational aspects of the individual's life space. For those who cannot or will not stay in or return to the school, educational and vocational alternatives will be developed. Meaningful work experience will be sought and special education instructors will help to prepare the person to receive the GED. Young men and women who dropped out of school but who later achieved educationally and vocationally will be hired on a part-time basis to serve as peer models for the potential and actual dropouts. Peer models and teen-agers will work together on projects involving sports, cars, and other activities of mutual interest. Where indicated, the young people and family members will become involved in helping relationships with appropriate community agencies. The notion with regard to alcohol that underlies this approach is one I discussed earlier, i.e., if coping skills are increased there is less need to use alcohol abusively. Further, to the extent that program activities reduce the availability of free, unstructured time, there is less opportunity to engage in drinking. This aspect of the program will be evaluated by examining changes on a number of psychological measures of self-worth, responsibility, and socialization, as well as by measures directly related to the use of alcohol. Thus, we will be able to cast some light on the assumption that preventive programs aimed at increasing coping mechanisms result in increased mental and social well-being.

As attractive as this program may appear on paper, in practice it has its problems. Past research with delinquents, dropouts, and others who have been designated as deviant outsiders indicates, for example, that careful precautions must be taken in order to insure that intervention does not reinforce negative and distancing labelling, thus accentuating rather than ameliorating the problem. In the project we are planning, we hope to keep labelling aspects programmatically

as minimal as possible both within the school and the community. Schools, of course, welcome programs which concentrate on visible problem students and tend to be extremely receptive to having them in their schools. Problem students have usually long been defined as deviants and outsiders and therefore are considered legitimate candidates for special purpose programs by both the school and community. Special purpose programs for the general student body, on the other hand, do not have this kind of legitimacy. Quite to the contrary, such programs - in the present instance, the individual instruction component - are often seen by the school and community as intruding upon personal privacy and as being offensive to community values. School administrators are apt to view them with considerable apprehension and suspicion. Such programs must be preceded by lengthy periods of community education and community organization if they are to become viable within the school system. For our project, we are planning to have a community panel, composed of students, school personnel, and reputational leaders in the community, to serve in an advisory and advocacy capacity and also as a nucleus for developing community support over the long term when external support is no longer available. A major problem of many externally-funded human service programs is that they fail to build in provisions for institutional continuity via community support over the long term, and thus come and go with little effective impact on social change. Our program aims at developing such continuity.

Thus far I have discussed trends and developments concerning alcohol and youth. It is, however, a mistake to think of education solely in relation to schools and solely in regard to youth. Mass persuasion techniques can play an extraordinarily influential role in any preventive health program, although thus far there is little evidence to indicate their effectiveness in modifying health-related behaviors (Blane, in press, b). The reasons for this failure

may be found in many factors, among them being the assumptions that if we borrow a few Madison Avenue techniques, use the public service announcement provisions of radio and television, and address the total population, we can influence behavior. That these assumptions have little validity in practice should be amply clear from the failure of anti-drug abuse and anti-smoking campaigns to attain their basic goals. Even long-term programs, such as the 20-year "Drink, don't drive" campaign, do no more than raise public consciousness, which is admittedly a first step in molding public opinion and behavior - but only a first step. Madison Avenue techniques can have impact on behavior if they are part of a large-scale, consistent, coherent program with a specific target group receiving well-timed messages. But because public service announcements on electronic media are subject to local option about what messages will be aired when and because there is tremendous competition for public service spots, it is virtually impossible to mount geographically widespread programs. Further, there is great reluctance on the part of governmental agencies to target messages differentially according to the values, customs, beliefs, and other characteristics of definable target groups. The result is that campaigns such as that mounted by NIAAA address themselves to a generalized, mythical American, thus diffusing credibility and personal relevance. A basic problem that confronts anyone who wishes to mount an effective mass persuasion campaign in the public health area is how to meet the conditions necessary for a successful campaign within the constraints of a free enterprise mass media system that places low value on financially unrewarding public service activities.

These conditions include immediacy and personal relevance of messages. Immediacy means that the message is received when and where the target behavior occurs, while personal relevance means that the message is framed so that it

is seen as being directed to oneself rather than to someone else. The source of the message should also have high credibility. In addition to these conditions, well-designed campaigns must be intensive, have geographic breadth, and be of long duration. Intensity refers to the repeated presentation of a message under conditions of good timing to the same audience over a period of time. These techniques, used in advertising by presenting different ads with the same message at the beginning, middle, and end of a program, have never been used with public service campaigns. Rather, public service announcements are presented once or twice a week at times that vary and when audience composition varies. Multiple exposure to a single audience is thus reduced, although many in the audience may have seen a message once, twice, or even a few times.

Other conditions of importance are that programs should be congruent with pre-existing attitudes and touch fundamental trends in society; they should be consonant with the facts, and they should pronounce judgments on the facts. Effective mass persuasion is not composed of a few films, pamphlets, speeches and posters, but consists of an integrated campaign of psychological bombardment. Ideally, the campaign must center upon issues that strike a responsive chord in the audience - a chord that may even require a pre-campaign consciousness-raising effort to bring it about. Indeed, the current NIAAA and drinking-driving campaigns may be viewed in this light.

But intensive, saturation methods are not possible in our society. As a result, we have no national concerted mass persuasion effort to reduce alcohol problems. Nevertheless, there are several programs that are being initiated around the country at the local level with local community participation and backing.

One of the most clearly-stated recent mass media programs is that designed

to reduce alcohol-related crashes in Vermont (Waller, Worden, and Maranville, 1972; Worden, Waller, Riley, and Flowers, 1973). The campaign, begun in 1972 and addressed to an audience of young men who are at least occasional heavy beer drinkers and known to be frequently involved in alcohol-related accidents, is known as the "Beer and Consequences" campaign, and stresses four points of knowledge: (1) the serious consequences of getting caught and arrested while driving "under the influence"; (2) how to avoid getting caught (having someone else drive, taking time to sober up); (3) that drink for drink, beer contains as much alcohol as liquor; and (4) how to identify behaviors indicative of problem drinking. While the immediate aim of the campaign is to increase knowledge in the target population about the above points, attitudinal and behavioral changes are also anticipated, especially when the campaign is coupled with enforcement countermeasures. "The behavioral changes that might be anticipated are a reduction in heavy beer consumption, especially while driving, because of a) fear of arrest . . ., b) recognition of the potency of beer, and c) perception of one's self as a potential problem drinker. The major motivating influence in the campaign is the arousal of mild fear regarding arrest and problem drinking. Information concerning one of the above points is then presented in campaign messages as alternatives to arrest and problem drinking, with the intention that audience members will retain such information in an effort to overcome the threat." Attention has been given to timing, spacing and placement of the messages; for example, they are aired on radio at night over stations which members of the target population are known to listen to, as well as on TV; the campaign becomes more intensive on Friday and Saturday nights; and posters and slogans are placed in bars and retail sales outlets for beer. A field experiment that proceeds directly from the conceptualization underlying the campaign has been

designed to test its effectiveness. As yet the results are not in.

Another program which demonstrates the potential effectiveness of locally-initiated and locally-supported campaigns is one that was conducted a number of years ago as a one-year demonstration at Lackland Air Force Base (Barmack and Payne, 1961). The Lackland campaign was a countermeasure campaign designed to reduce accidents caused by drinking and driving. A mass media approach was used to disseminate 18 items to all personnel by means of meetings, bulletin boards, and the base newspaper. They included a description of the countermeasure program; three informational items about social drinking, alcoholism, and drinking and driving; three items about social responsibility and the distinction between normal and disturbed drinking behavior; and 11 items containing snatches of conversation with an accident victim which portrayed the events leading up to drinking and driving accidents and the consequences of those accidents. As in the Vermont campaign, there was a mild fear element in the campaign, but the basic message - "drinking drivers are disturbed" - was designed to undercut favorable images of "tanking up and taking off" in a car, images associated with personal courage and masculinity. During the campaign, airmen involved in accidents were referred to the base psychiatrist and also received an administrative review of their record in the service. Evaluation of the campaign showed a marked reduction in accidents compared to another neighboring base. However, the design of the evaluation was such that the reduction could have occurred on the basis of other factors. Nevertheless, this early, locally-developed approach can serve as a model for a relatively low-cost, high saturation mass media program in a small community.

A number of short-term intensive programs have been initiated, and this seems to represent something of a trend - and an unfortunate one in my view. These are highly intensive and technically skilled programs that occur for a

few days, a week, or even a month. Holiday campaigns conducted in the United States, Canada, and Great Britain are examples. More recently, month-long series of programs during prime time on educational TV have been occurring. There is little question that such short-term campaigns play an important consciousness-raising function and that they may even have a short-term impact on target behaviors, but I suspect that they may have a counterproductive aspect as well. They have a dutiful quality about them that suggests that once duty is done, we can all relax and have some fun. In Pittsburgh, a month-long series of TV programs aroused considerable positive discussion and comment in the community. However, when the month was up, the level of interest dropped markedly and other topics came to the fore. Programs such as these are excellent when they serve as springboards or as one element in the kind of orchestrated, long-term campaign I mentioned earlier, but offered in isolation, they may do more harm than good in the long run.

The difficulties in mounting effective national mass persuasion campaigns in the United States and the consequent necessity and value of mounting local campaigns pose some problems. Without some national coordinating mechanism, we may find ourselves in the position of reinforcing the very social ambivalence we are hoping to resolve. Some sense of broad but not necessarily exclusive consensus about the proscription of drunken behavior along with the moral neutrality of alcoholic beverages themselves would seem a needed element in locally developed programs. Also, provision must always be made for competing or differing points of view.

Another aspect of mass persuasion relates to the role of private advertising in reinforcing and consolidating myths about alcohol. Producers and distributors of alcoholic beverages have every right to sell their products

within the control system as set up by law. However, it is reasonable for us to question advertising which links drinking with he-man images, fast-paced activities, and physically excessive pursuits, among others. Such associations tend to reinforce the very factors that a public health mass persuasion campaign aims to subvert. More particularly, they tend to encourage rapid drinking and heavy consumption on any given occasion, both of which are conducive to alcohol problems. The producers have an advertising code, but the code appears to run contrary to a public health approach. It may be time for those interested in the minimization of alcohol problems to argue for external review and control over advertising of alcoholic beverages.

In this paper, I have attempted to provide some idea of the ferment and wide variety of activities that are now taking place in education and mass persuasion to reduce alcohol problems in our society. Two basic trends are apparent, the one aiming at containment and control, the other holding out a vision of a society in which alcohol is a morally neutral substance, the use of alcohol is integrated into activities that reflect and symbolize social solidarity, and in which drinking comportment is not associated with social hazard.

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#6:20

CHRISTIAN CENTURY 9/17/75

Federal Alcohol Policy: Captive to an Industry and a Myth

If society is to bring alcohol abuse under control, we need a policy that restricts (not forbids) the use of alcohol, one that encourages people to use alcohol infrequently and as a relatively minor part of their lives.

DAN E. BEAUCHAMP

+ THE FEDERAL AGENCY charged with addressing this country's alcohol problems cooperates with an industry committed to increasing its profits by raising the level of alcohol consumed in the U.S. A public-policy controversy is brewing, for the agency seems bent on disregarding the need for alcohol controls; its approach is directed toward finding out why problem drinkers are unable to control their drinking.

Last year when that agency, the National Institute of Alcohol Abuse and Alcoholism (NIAAA), released its second Alcohol and Health report, two bleak facts emerged. First, alcohol problems cost this nation a staggering $25 billion annually in illness, family disruptions, arrests, property destruction, loss of productivity, and death. It is alcohol — not heroin or marijuana — that ranks as the nation's leading drug problem. Second, the NIAAA, an agency of HEW, has virtually no alcohol policy. Except for some pious slogans aimed at encouraging "responsible drinking," the NIAAA has more or less ignored the need for a policy to curb the steady rise in per-capita alcohol consumption (up by one-third over the past 15 years) and the ominous implications of the increase. In fact, the NIAAA operates as if controlling alcohol problems in no way involves controlling alcohol.

A 'Hands Off Alcohol' Policy

At a press conference announcing the release of the new alcohol report, NIAAA director Morris Chafetz was asked to define the level of "safe" drinking. He responded by endorsing the findings of a 19th century actuarial study showing that persons who drank no more than three ounces of whiskey or its equivalent daily did not appear to suffer an increase in health problems or mortality. Interestingly enough, less than 10 per cent of the people in the U.S. drink as much as three ounces of whiskey daily. In fact, a prestigious survey of drinking behavior conducted in the 1960s — the American Drinking Practices Survey — would have classified a daily intake of three ounces of whiskey as heavy drinking!

What is going on here? On the one hand we are faced with steady increases both in the per-capita consumption of alcohol and in critical alcohol problems. On the other hand, the director of the national agency presumably responsible for controlling these problems is endorsing a norm for safe drinking that far exceeds existing drinking practices. It would be easy to accuse the NIAAA of being a captive of the alcohol industry. It is clear that Dr. Chafetz and the institute are cooperating with this $27 billion industry and are pursuing what amounts to a "hands off alcohol" policy.

However, the NIAAA is more a captive of the myth of alcoholism — a myth that diverts attention from the nation's obligation to institute tighter controls over alcohol. It is of course no myth that some 9 million persons in the U.S. are — because of the amount of alcohol they drink — risking serious physical, psychological or social damage. The myth is that more stringent controls over alcohol, the alcohol industry and drinking are not needed to combat the nation's mounting alcohol problem since those problems are caused by a minority of individuals who suffer from a "disease" called alcoholism. In other words, it is because of the concept of alcoholism that alcohol controls remain a neglected issue.

Blaming the Alcoholic

Alcoholism theories assign responsibility for the huge social costs of alcohol to the make-up of individuals. Such theories start with the common-sense observation that the vast majority of drinkers do not experience alcohol problems. It is then concluded that most people have an ability or capacity to use alcohol without problems. Only a minority fail as drinkers. Many alcoholism theorists see this failure as a disease predisposed by psychological, genetic, social or cultural factors. Thus these theorists tend to agree with the alcohol industry slogan that "the problem lies in the man, not the bottle."

The clear implication is that society should no

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prevent alcohol problems with little attempts to limit the availability and use of alcohol, but rather should concentrate on discovering why a minority of drinkers (9 million) are unable to control their use of alcohol. Thus the concept of alcoholism serves to relieve all drinkers — and the alcohol industry — from the burdens and inconveniences of an effort to curb alcohol problems by means of stricter controls over alcohol.

A strikingly different theory argues that the primary factors contributing to alcohol problems are inadequate legal, social and cultural controls over the availability and use of alcohol. This alcohol-control approach contends that protection of the community from rising alcohol problems can be accomplished only as the result of community and societal rules designed to limit and control the use of alcohol and to minimize the problems for the largest feasible group.

In sharp contrast to alcoholism theories, the alcohol-control approach regards all who manufacture, distribute, market, sell and consume alcohol as subject to fair and just regulations that serve to minimize problems. According to this approach, the control of alcohol is analogous to the regulation of other public health hazards — tobacco, handguns or pollution.

The alcoholism approach has been the dominant paradigm for alcohol problems since Repeal — and it is no coincidence that alcohol as a community issue has virtually disappeared from the scene except in areas where temperance sentiment remains strong. Nonetheless, recent and impressive scientific research strongly suggests that the alcohol-control approach has the better argument.

A group of scientists at the Addiction Research Foundation in Canada has demonstrated persuasively that it is the low overall or per-capita consumption of alcohol in society (and by implication the factors that influence this low consumption) that produces low rates of such major alcohol problems as cirrhosis. The Canadians have gathered data showing a clear relationship: in countries where average consumption of alcohol is high, alcohol-related cirrhosis rates are high. In countries where average consumption of alcohol is lower, rates of alcohol-related cirrhosis are lower. Further, as the per-capita consumption of alcohol rises, so do the rates of heavy or damaging drinking.

These findings suggest that we are not likely to succeed at controlling the excessive consumption of alcohol unless we establish more effective limits over its manufacture, sale and consumption. The concept of alcoholism has in effect saddled the alcoholic with sole blame for the huge social costs of alcohol. Alcohol problems are seen as the failure of individuals rather than as the failure of inadequate legislation governing the availability and use of alcohol. Alcohol-control measures would be designed to affect all who produce, sell or use alcohol; thus the industry and all drinkers would share the costs of preventing problems. In other words, the control of alcohol problems implies a new alcohol ethic — *a preventive ethic* — obligating a powerful industry and all drinkers to accept their fair share of the burdens of more stringent alcohol controls.

'Responsible Drinking'

The NIAAA has virtually ignored this impressive new evidence indicating a need for stronger alcohol controls and has instead offered a prevention campaign of its own: "responsible drinking."

The essential points of the responsible-drinking campaign are these: Alcohol and drinking are here to stay. Instead of placing tighter controls on the availability of alcohol, Americans must learn how to use alcohol more "responsibly." "Responsible drinking" means learning how to use alcohol in a nonharmful manner, learning to recognize the signs of impending intoxication and becoming intoxicated very seldom — no more than three times a year, advises Chafetz. The agency director has even suggested that students be taught in school how to drink properly, much as they are now taught how to drive!

The concept of "responsible drinking" is premised on naïve — if not cynical — assumptions about public policy and human capacities: that society's alcohol problems can be solved or controlled by promulgating vague pronouncements to the effect that individuals should not abuse alcohol. Those familiar with ethical debates will recognize "responsible drinking" as another variant of what Reinhold Niebuhr perennially criticized as "voluntarist" ethics. The assumption is that if people can be sufficiently apprised of the facts bearing on their own and society's welfare, they will voluntarily follow that standard — especially if society devotes enough money and resources to training and education.

This view of our ethical obligations is depressingly sentimental and optimistic about human capacities and abilities. It may well be that the NIAAA still retains this pious belief in the efficacy of ethical persuasion; it is hardly likely that the alcohol industry is so naïve. (Not surprisingly, the industry has rushed to endorse the responsible-drinking campaign.)

What is needed is a more realistic view of human nature and of the powerful interests implicated in the widespread and growing use of alcohol. If we are to begin to control alcohol problems, realism demands adequate governmental and nongovernmental structures to control the availability of alcohol. While we cannot now specify the details of a sensible alcohol control structure, we can broadly outline its major assumptions.

The key ingredients of a new alcohol policy are

with the use of alcohol, it can never serve as the guide for public policy. A prohibitionist stance ignores the essential fact that an adequate social ethic for alcohol must be forged in justice and must seek to weigh competing claims.

The tragic reality is that we cannot hope to eliminate alcohol problems; the best we can do is to control or reduce them. New leadership and new policies from the NIAAA are needed if we are to change a situation that is strongly biased in favor of the industry and inadequate for controlling rising rates of alcohol problems.

The NIAAA is not likely to act, however, until powerful voices call for control measures. The churches are uniquely qualified to remind the nation of its obligations to share the burdens as well as the benefits of society — including the burden of reducing the tragic losses due to alcohol and the burden of creating a more balanced and fair policy for all drugs. □

After Auschwitz: 'A Certain Script'

An Interview with Elie Wiosol

HARRY JAMES CARGAS

Jewish writer Elie Wiesel is a nominee for this year's Nobel Prize for literature. Since 1975 marks the 30th anniversary of the uprising in the Warsaw Ghetto, many feel that this is a particularly appropriate year to honor the 47-year-old Romanian-born author, a survivor of the Nazis' Auschwitz and Buchenwald concentration camps. He and Dr. Cargas met while doing a television program the latter hosted for the Central Education Network. Their friendship grew; one result is a volume to be published this fall by Paulist Press: Conversations with Elie Wiesel. *This interview is an edited excerpt from that book. Wiesel, now a naturalized U.S. citizen, is the author of 13 books, including his memoir,* Night; *a drama,* Zalmen, or the Madness of God; *a report on Soviet Jewry,* The Jews of Silence; *and the novels* A Beggar in Jerusalem, The Gates of the Forest *and* The Oath.

Q.: CAN JEWS and Christians have a meeting ground after Auschwitz?

A.: They can because they should. But before that meeting can take place, certain words must be said. I think that Jews must first say certain words which hurt Christians: that Christianity did not "come true" during Auschwitz. Auschwitz would not have been possible without Christianity — and this is something that John XXIII understood: the fact that Hitler was never excommunicated, the fact that more than 20 per cent of the S.S. killers were practicing Christians, the fact that Pius XII never spoke up. Christianity's role, or the Christian church's role — both Protestant and Catholic — was dominant in the fact that it was possible for so many Jews to be killed. All that has to be said. And I think that Christians must recognize these truths, as Pope John did. Once all this has been said and done, I think that there can be a meeting ground between Christian and Jew — provided, of course, that one does not try to convert the other. We must understand that conversion is not a solution; authenticity is the solution. And if Christians give up their dream to convert Israel (Israel never tried to convert the church), then I'm sure that we can find some common ground.

I

Q.: Historically, has the role of the Christian been that of persecutor?

A.: Unfortunately, for many centuries the Christian defined himself by the suffering he imposed on the Jew. The more the Jew suffered, the better a Christian his persecutor was. Of course theologically the Christian regarded himself as *the* Jew, the true Jew, the true Judaea. The true Israel was the church; in the beginning that's what they said. The others had to suffer for not becoming part of that new concept of Judaism. Again, despite that suffering, I think a ground *can* be found, *should* be found. And that possibility must be voiced first, in honesty, without hidden thoughts, without rancor. But these ideas must be explored; these truths must be confessed — on both sides.

Q.: Georges Bernanos may have begun a kind of recognition. He said that Buchenwald was not a chance phenomenon but the culminating abscess collecting pus.

A.: Yes. So did many others in France. François Mauriac returned again and again to such themes. And we became very close because of his recognition. He understood the part Christianity had played, and he was the first to come out against Pius XII. It wasn't Rolf Hochhuth; it was Mauriac who did it. But then, French literature was influenced greatly by Christianity, and the entire right wing had the courage to accept, after the war, the fact that it was anti-Semitic before the war. Those writers grew up in a Christian milieu, and therefore they grew up with anti-Semitism. Even the great writers were anti-Semites. André Gide himself recognized that he had been anti-Semitic — without knowing it, without wanting it. This honest approach must be made first, and it requires a willingness to say, "Yes, we were guilty; we were guilty — not directly, because we didn't participate in it. But we as Christians — the Christian part, the past Christian part in us, made us guilty." If it is said, I think that something can be done — something important.

II

Q.: So you are not automatically pessimistic about the future of Christianity?

A.: If it goes the way it is going, then of course I am pessimistic. But then, the Christians themselves are more pessimistic than I. The crises occurring now within Christianity are [illegible]

Dr. Cargas, chairman of the English department at Webster College in St. Louis, writes a fine arts column for the National Catholic Reporter.

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SURVEY ON ALCOHOLISM AND TREATMENT FACILITIES
Interviews in Foodland Shopping Center, Juneau
September 24, 1977

	YES	NO	NO OPINION	PSYCHOLOGICAL PROBLEM
Do you believe alcoholism is an illness?	88	10	7	5
Do you think we should have treatment centers for alcoholics?	93	8	9	

Where should we obtain funding for construction and maintenance of treatment centers?

Any source of tax money	65
Solely from an increase in the tax on alcohol	31
No opinion	14
If funding from an increase in the tax on alcohol is not sufficient, funding should come from any source or a combination of tax money	13

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Gentleman: Whatever tax on alcohol ought to be spread among all of the users. We have a tax on alcohol right now and it suffices. If it doesn't suffice, then it ought to be changed.

Sen. Ray: Do you think we should have treatment centers, the money should come from treatment centers irrespective of where?

Response: No. Wherever the treatment centers are needed they ought to be there, and they ought to be paid for there.

Sen. Ray: Do you mean the people within the districts themselves should pay for them?

Response: That's right. If the individual communities or programs want to have a big alcoholism rehabilitation program, whatever kind of program, they ought to pay for it themselves just like we pay for the schools or anything else.

Sen. Ray: O.K. Thank you very much.

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Gentlemen: Well, I think it's a wonderful program, myself.

Sen. Ray: Alright. Where do you think the money should come from?

Response: Actually, I think the money should come from the state.

Sen. Ray: Irrespective of an increase in taxes?

Response: Irrespective of an increase in taxes -- right.

Sen. Ray: In other words, it's a problem that we have that has to be taken care of.

Response: Right. Must.

Sen. Ray: Then we've got to take care of it.

Response: Right.

Sen. Ray: Anything else?

Response: That's all I can say.

Sen. Ray: Thank you very much.

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Sen. Ray: What I'd like to do is ask you about the alcoholism program. Do you think that the state should have an alcoholism program?

Response: Yes.

Sen. Ray: Where do you think the money should come from, sir.

Response: Liquor taxes.

Sen. Ray: Only liquor taxes. Do you mean if the taxes on liquor are not increased or not enough, then you don't believe we should have the centers?

Response: I believe that . . .

Sen. Ray: Or do you believe we should have the centers irrespective of where the money comes from?

Response: We have to have the centers, and if the liquor tax is the only way to get it, then liquor taxes should be used in that.

Sen. Ray: Do you consider alcoholism a disease? An illness?

Response: Yes.

Sen. Ray: Do you have anything else you would like to say?

Response: No.

Sen. Ray: You got it? That's it? Thank you very much.

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Sen. Ray: Do you think that alcoholism is a disease?

Response: Yes, it is.

Sen. Ray: And where do you think . . . do you think we should have treatment centers?

Response: Yes.

Sen. Ray: Where do you think the money should come from?

Response: From the people. Taxes.

Sen. Ray: Do you think it should just be confined to tax on liquor or should treatment centers be built irrespective of an increase in taxes on alcohol? In order words, should we have the treatment centers even if we don't get an increase in the tax on alcohol?

Response: Yes.

Sen. Ray: Got anything else to say about that?

Response: No.

Sen. Ray: Thank you very much.

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Sen. Ray: Do you believe that alcoholism is a disease?

Response: Yes, sure do.

Sen. Ray: Do you believe in treatment centers for the illness of alcohol?

Response: Yes, I do.

Sen. Ray: What do you think . . . do you think the state should provide these treatment centers in the various communities? How do you think they should do this? With tax money?

Response: Well, yes, I guess so.

Sen. Ray: Do you believe an increase in the tax on alcohol, or do you believe that there should be treatment centers irrespective of any increase in taxes?

Response: Well, I don't know how good that's going to do, the tax on alcohol.

Sen. Ray: That's what I say. Do you believe that we should have the centers even if we don't have an increase in the tax on alcohol?

Response: Yes, we need them.

Sen. Ray: And we should have them?

Response: Yes.

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Sen. Ray: Do you believe alcoholism is a disease or an illness?

Response: Yes, I do.

Sen. Ray: Do you believe we need treatment centers?

Response: I do.

Sen. Ray: How do you think we should pay for these? By an increase in the tax, or do you believe we should have treatment centers irrespective of any increases?

Response: Well, if it could be done without increasing the taxes, of course. But, if necessary, then make allowances for them.

Sen. Ray: The point is that the Governor said he will not approve of any capital improvements unless there is an increase in the liquor tax, and what I'm asking you is do you believe that these centers should be in the state whether they increase the tax or not?

Response: I believe so. When a state can have an alcoholic named after the state, Alaskaholics, I think -- and I drink....

Sen. Ray: It's time we did something?

Response: So -- yes.

Sen. Ray: Do you have anything else to say, ma'am?

Response: No.

Sen. Ray: Thank you very much.

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Sen. Ray: Do you believe that alcoholism is an illness?

Response: I do think it's an illness.

Sen. Ray: Do you believe that we should have treatment centers throughout the state to take care of this illness?

Response: I think there should be places where people can go to get help.

Sen. Ray: Programs and treatment centers, something of this sort?

Response: Yes.

Sen. Ray: Do you believe that this money should come from any place, irrespective, the need is great enough that it should not just be an increase in the tax on alcohol but it should come from some place so that we can take care of these poor unfortunates?

Response: From a welfare agency, I would think it could come from there.

Sen. Ray: What I'm getting at is that the Governor said that unless we increase the taxes on alcohol that he's not going to approve any treatment centers. Do you believe the need is greater . . .

Response: But the increase in tax on alcohol . . . where would the increase go?

Sen. Ray: Nobody knows. Thank you, ma'am.

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Sen. Ray: Do you believe that alcoholism is a disease or an illness?

Response: Yes, I do.

Sen. Ray: Do you think we should have treatment centers?

Response: Yes, we do. We need treatment centers for them.

Sen. Ray: The Governor has said that unless we increase the taxes on alcohol that he will not approve the building of treatment centers unless there paid for by an increase in the tax. Do you believe this is right or we need them irrespective?

Response: The increase on alcohol tax? Yes, I'm very much for it. I think if the people want to drink they should pay for their treatments then.

Sen. Ray: But, irrespective of that, even if we don't put the tax on, do you believe that we should still have the treatment centers and the money should come from some place?

Response: Yes, it should come from tax money because people have to be helped.

Sen. Ray: We have to build them regardless of where the money comes from.

Response: They have to be helped.

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Sen. Ray: Do you believe that alcoholism is a sickness or a disease?

Response: I believe it is a disease.

Sen. Ray: And do you believe that we should have treatment centers?

Response: Yes, I do.

Sen. Ray: And where do you think the money should come from? Do you think it should come from an increase in the tax on alcohol or it should come from some place, just as long as we have the centers?

Response: Probably from the increase in the tax on alcohol. It would be a good start.

Sen. Ray: But if you couldn't get the increase, then you wouldn't be in favor of the centers? What I'm saying is the Governor said or has indicated that unless we increase the tax on alcohol that he will not approve the building of treatment centers. Do you believe that that is a proper approach, or do you believe we should have the centers regardless of where the money comes from?

Response: I think we should have the centers.

Sen. Ray: Regardless of where the money comes from.

Response: Yes.

Sen. Ray: Thank you very much, ma'am.

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Sen. Ray: Do you think alcoholism is a disease?

Response: Yes, I really do.

Sen. Ray: Do you believe we should have treatment centers for the care of these people?

Response: That's right.

Sen. Ray: And where do you believe the money should come from? An increase in the taxes on alcohol or do you believe the money should come irrespective?

Response: I think it should come from the taxes on the alcohol. Let the alcohol pay for the treatment.

Sen. Ray: Well, the Governor has said that unless we increase the taxes on alcohol that he will not approve building the treatment centers. So, if we cannot get the tax on alcohol raised, then you don't believe that we should use the oil revenues or any of the other tax measures in order to build the treatment centers?

Response: I think we should have them.

Sen. Ray: In other words, we should have the treatment centers regardless of where the money comes from.

Response: Right.

Sen. Ray: Thank you very much.

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Lady: I think that they have a strong enough power. I think they definitely need help. This I definitely think.

Sen. Ray: Do you mean it's a psychiatric or a . . .

Response: Problem. Right. I think that if they, I mean we all have problems, but I definitely think that they have problems and they need help somewhere.

Sen. Ray: It's a psychological problem rather than a . . .

Response: Than a disease.

Sen. Ray: Do you believe that we should have treatment centers for these people?

Response: Well, unless they go up there and are continually staying in these problems all the time. I think this doesn't help them.

Sen. Ray: In other words, you think we should have a positive program designed to cure them of whatever is bothering them.

Response: Yeah. If they stay on the program once they are cured.

Sen. Ray: Where do you think the money should come from, ma'am?

Response: This I don't know.

Sen. Ray: We should have the program. You don't care where the money comes from as long as . . .

Response: I like my tax money to go to places, but . . .

Sen. Ray: But you don't have any idea on the tax money itself. Do you believe there should be an increase in the tax on alcohol in order to pay for it?

Response: No. No.

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Sen. Ray: Do you believe that alcoholism is a disease?

Response: I really don't know, Bill. I'm not that well acquainted with it.

Sen. Ray: Alright. Do you believe that they should have treatment centers for those people you see suffering from alcoholism?

Response: I guess so.

Sen. Ray: Do you believe that there should be an increase in the tax on alcohol to pay for these centers, or do you believe that there should be treatment centers regardless of where the money comes from. In effect, the Governor has said that unless we increase the tax on alcohol that he will not approve of the construction of any of the treatment centers, and do you believe that this is justified or that we need the treatment centers regardless of where the money comes from?

Response: I really have no opinion.

Sen. Ray: You have no opinion on that. Thank you very much.

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Sen. Ray: Do you believe that alcoholism is a disease?

Response: What is this for anyway?

Sen. Ray: This is ... I'm a member of the Interim Committee on Alcoholism and this is research and we're trying to make a determination on what the feelings of the people of the State of Alaska are.

Response: O.K. Yeah, I believe it's a disease.

Sen. Ray: Do you believe they should have treatment centers?

Response: Yeah, I do.

Sen. Ray: Where do you believe the money should come from?

Response: The state.

Sen. Ray: Do you believe they should increase the tax on liquor in order to pay for this? What I'm saying is the Governor has made a determination that unless they increase the tax on the sale of alcoholic beverages, that he will not approve the construction of any new treatment centers. Now, do you believe that is the correct approach? Do you believe they should have treatment centers regardless of where the money comes from? Whether it comes from oil money or your other tax money or anything else?

Response: Yeah, that sounds pretty good.

Sen. Ray: Where do you think it should come from? We should build it or not?

Response: Yeah, I think so, I think it would be a good idea.

Sen. Ray: Regardless of where the money comes from.

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Sen.Ray: Sir, do you believe that alcoholism is a disease or an illness?

Response: Yes, yes. I think it is.

Sen. Ray: Do you believe we should have treatment centers for these?

Response: Yes.

Sen. Ray: And do you believe, where do you believe the money should come from?

Response: Well, that's hard to say, there's only one place it will probably come from and that's government, but federal or state . . .

Sen. Ray: Well, the Governor has in the past last year red-lined or refused to agree to the expenditure of money unless there was an increase in the tax on alcohol, and the question I guess would be do you believe we should have the treatment centers regardless of where the money comes from if the people need help.

Response: They need the help and it should come from the government, regardless.

Sen. Ray: Thank you very much.

Response: If the Republicans can't do it, maybe the Democrats can, eh?

Sen. Ray: Thank you.

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Sen. Ray: Sir, do you believe that alcoholism is a sickness or a disease? An illness?

Response: Is this a choice . . . sickness, disease or illness?

Sen. Ray: Well, what do you believe that alcoholism is? Some people rate it as an illness. . .

Response: Oh, it's a sickness, I suppose.

Sen. Ray: Alright. Do you believe they should have treatment centers for people who have alcoholism?

Response: I suspect they should, right.

Sen. Ray: And do you believe there should be an increase in the tax on liquor to provide this?

Response: Absolutely.

Sen. Ray: And if there is not an increase in the tax on liquor, as an example, last year the Governor did not, he red-lined the improvements or the treatment centers because he said that unless there was an increase he would not approve of the construction of any facilities. Do you believe that that approach is proper or do you believe we need the treatment centers irrespective of where the money comes from?

Response: That's a pretty tough one. I guess we should have the treatment centers, but, by golly, I think the alcoholics should pay for them. They're the ones who are causing the problem and they're the ones . . .

Sen. Ray: Yeah, but not all people who drink are alcoholics.

Response: That's true. Yeah, well, there should be a tax on alcohol.

Sen. Ray: An increase in the tax on alcohol?

Response: Absolutely, I think that's where the money should come from.

Sen. Ray: Very good. Thank you very much, sir.

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Sen. Ray: Do you believe that alcoholism is a sickness or a disease?

Response: Yes, I do.

Sen. Ray: Do you believe that we should have treatment centers?

Response: I do, and enforce it.

Sen. Ray: And where do you believe that the money should come from to build these?

Response: From the alcohol. Stores themselves.

Sen. Ray: Do you think there should be an increase in the tax on alcohol?

Response: Yes. The people that do the drinking should pay for it.

Sen. Ray: But last year there was a moderate increase and Governor Hammond said that was not sufficient and, as such, he would not approve of the construction of the treatment centers. Do you believe that the treatment centers should be constructed irrespective

of where the money comes from?

Response: Yes, I do. We need help. Yes, we do. But let's not . . .

Sen. Ray: Let's tax the liquor if we can, right?

Response: Yes, and make these people get better.

Sen. Ray: Thank you very much.

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Sen. Ray: Do you believe that alcoholism is an illness?

Response: Well, it's a spiritual sickness, I know that. Yeah, it can be.

Sen. Ray: And do you believe we should have treatment centers for people who are suffering from alcoholism?

Response: Definitely.

Sen. Ray: And where do you think the money should come from? Do you think the money should come from an increase in the tax on liquor?

Response: Definitely.

Sen. Ray: And if there is no tax on liquor, Gov. Hammond has stated that he would not agree to the construction of treatment centers unless there was an increase in the tax on alcohol. Do you believe that we need the treatment centers regardless of where the money comes from?

Response: I really think that the liquor industry should be the one to pay for it.

Sen. Ray: That they should be the only one that should pay for it?

Response: Right, right. I certainly do. They're the cause of it and they should be the ones that should pay for it.

Sen. Ray: Very good. Thank you very much.

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Sen. Ray: Do you believe that alcoholism is an illness?

Response: I believe it is.

Sen. Ray: Do you believe that we should have treatment centers for these people that are suffering from alcoholism? Some place to put them, see if we can make them well?

Response: I think we should because it's so prevalent.

Sen. Ray: Alright. And where do you think the money should come from? Do you think the money should come from an increase in tax on liquor? Or do you believe that we should have the treatment centers irrespective of where the money comes from?

Response: Probably irrespective of where the money comes from.

Sen. Ray: Thank you very much.

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Sen. Ray: Do you believe that alcoholism is an illness?

Response: I think, yes, it progresses to the point at least where it's an illness.

Sen. Ray: And do you believe that we should have treatment centers for these people?

Response: Very definitely.

Sen. Ray: And do you think treatment centers should come from an increase in a tax on alcohol? Or do you believe that the money should come, irrespective of where it comes from, oil money or tax money from any other source?

Response: I agree with the latter.

Sen. Ray: We need the treatment centers irrespective of where the money comes from?

Response: We need treatment centers, yes.

Sen. Ray: Alright.

Response: We don't want just a flophouse treatment center.

Sen. Ray: No. Not a dry-out house.

Response: No.

Sen. Ray: Do you have anything else to say?

Response: No.

Sen. Ray: Thank you very much.

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Sen. Ray: Do you believe that alcoholism is an illness?

Response: Yes.

Sen. Ray: Do you believe we should have treatment centers for this?

Response: Yes.

Sen. Ray: Do you believe that there should be an increase in the tax on alcohol to pay for these, or do you believe the money should come from some place else, as long as we have the treatment centers?

Response: I think it should come from the alcohol, the purchase of alcohol.

Sen. Ray: Alright. The Governor said last year he refused to, or he red-lined some construction projects which would allow treatment centers because he said the tax on alcohol wasn't sufficient. Do you believe that if it goes to that again and the legislature does not increase the tax on alcohol, then we should not have the treatment centers? Or that the money should come from some place, that we need them bad enough that the money should come from some place?

Response: I think this state needs them pretty bad. That's pretty evident.

Sen. Ray: It should come from some place.

Response: Yes.

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Sen. Ray: Do you believe that . . .

Response: I don't think alcoholism is a sickness.

Sen. Ray: You don't think it is?

Response: Of course I don't drink myself. Maybe that's the difference. If anybody would want to drink, if he knows it's a sickness, he should not drink. Simple as that.

Sen. Ray: Do you believe we should have treatment centers for people who are suffering from alcoholism? Some places where ... could help them?

Response: I think so.

Sen. Ray: Where do you think the money should come from? Do you think it should come from a direct tax on liquor or do you think it should come from any tax revenues we have as long we get the treatment centers?

Response: It should come from the liquor itself because they're the ones that making it.

Sen. Ray: Them alone. Alright. Now Governor Hammond has said that if they do not increase the tax enough to build these, then he will not allow them to be built. In other words, do you believe that unless we can raise the taxes directly from the liquor industry then we just forget the treatment centers?

Response: Right.

Sen. Ray: Very good. Thank you very much, sir.

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Sen. Ray: Do you believe that alcoholism is an illness?

Response: Yes, I do.

Sen. Ray: Do you think we should have treatment centers?

Response: No, I don't. I think that there's too many other important things the state has to provide for; for instance, education of the young and it's just ... if we're going to go into that it would just be too expensive an effort.

Sen. Ray: If we did have treatment centers, do you think all the expenses should come from the liquor industry or it should be, on increased taxes, or do you believe that if it's necessary to build the treatment centers they should be built irrespective of where the money comes from?

Response: I think that if they're going to be built at all it should be general taxes that build them.

Sen. Ray: O.K. Thank you very much.

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Sen. Ray: Do you believe that alcoholism is an illness?

Response: For some people it is, yes.

Sen. Ray: Do you believe that we should have treatment centers for these people?

Response: Well, has it shown whether it's going to do any good?

Sen. Ray: Alright. If it can be proven that it can do some good, do you believe there should be an increase in the tax on alcohol to