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their lives. Alcohol is a drug with many appealing properties. It relieves anxiety and tension. It is an anesthetic which can relieve physical and emotional pain. It helps release inhibitions. It can be made into a tasty and readily available beverage.

It is no wonder, then, that people who find themselves in a chronically stressful situation which can be "temporarily relieved" by drinking alcohol gradually begin depending on alcohol as a source of relief. Whether the chronically uncomfortable situation stems from the individual's own psychological problems, whether it comes from chronic environmental stresses, such as a unhappy marriage or extremely frustrating job, or whether it comes from chronic physical pain or poor health, alcohol offers temporary relief for all these conditions. Unfortunately though, alcohol is an addicting drug; and, as its use is repeated over the months and years, the drinker gradually develops alcoholism.

NATURAL HISTORY OF THE DISEASE OF ALCOHOLISM

The final area to discuss in understanding the disease of alcoholism is its natural history, i.e., the course the illness usually takes if untreated. This disease very predictably progresses through four distinct phases, as originally described by E. M. Jellinek.[14]

Phase I: The Pre-alcoholic Phase

This phase lasts from six months to ten or more years, and has two main features:

1. The future alcoholic attempts to alleviate everyday tensions of life by drinking. This type of drinker is not regarded by any close friends or acquaintances as a problem drinker. He has begun to use alcohol as a drug to treat his "nerves," relax, gain a general sense of well-being, etc., rather than a beverage consumed at a social occasion or with a meal, but he experiences no progressive social or physical deterioration.

2. He begins drinking progressively larger amounts of alcohol to gain the same effect that less alcohol used to give, and he begins drinking on more frequent occasions.

Phase II: The Early Alcoholic Phase (Non-addictive Alcoholism)*

The drinker imperceptibly slips from the non-alcoholic Phase I to the alcoholic Phase II. As he firmly establishes himself as an early alcoholic, he will exhibit at least several, if not all, of the following five characteristics:

1. *Blackouts* may occur. These are brief periods of amnesia which occur during or immediately following a drinking episode. Although the drinker may appear to be moderately alert and behaving normally while drinkin[g]

*Drug dependence, alcohol, psychological type.

upon sobering up he will not remember the events which took place during the previous drinking episode. He begins worrying that he may have done something foolish during the blackout period, and therefore tries to avoid talking about it. These blackouts become more and more frequent. Many alcoholics do not develop blackouts until later years, and still others never experience blackouts.

2. He begins *sneaking drinks.* This takes several forms. He may start having a few extra drinks at a party, gulping the first few drinks, drinking it "on the rocks," having a few drinks before the party begins and a "nightcap" afterward, etc. In later stages, he may actually hide a bottle and sneak drinks from it when no one is looking.

3. He develops a *preoccupation with alcohol.* He becomes worried that he won't get enough at a party, so he will bring his own bottle. His key consideration regarding any activity is whether there will be a plentiful supply of alcohol or not.

4. He becomes plagued by *feelings of guilt* about his drinking behavior. He realizes his drinking has become abnormal; and, as a defense, he becomes overtly angry when approached on the subject.

5. He consequently *avoids reference to alcohol* in conversation, particularly when sober. He tries desperately to deny that he has any problem with alcohol, and therefore he certainly does not need to feel guilty about continuing to drink.

The person at this phase is called by many of his associates a "heavy drinker," but is not yet considered an alcoholic by them. But the person himself and his immediate family realize things are getting out of control. He experiences fleeting insight into the fact that he is becoming sick and needs help, but he tends to rationalize this away. This phase lasts from six months to five years for those alcoholics who ultimately become addictive alcoholics. Other alcoholics apparently stay in this stage indefinitely and never become addictive alcoholics.

Thus, Phase II can also be called the nonaddictive phase, as the alcoholic has become psychologically dependent on alcohol, but has not become physically dependent. He can still control, with great effort, his drinking on any given occasion, if he sets out to. But his drinking pattern is one of drinking too much, too often, resulting in all the previously mentioned symptoms of this phase, i.e., he begins developing new problems associated with drinking in the areas of his family, job, friends and health.

During Phase II the alcoholic exhibits a greatly exaggerated usage of four main mechanisms of defense which he had formerly used less. These defenses or "alibi systems" serve to relieve his anxiety, blot out unpleasant reality and continue his sick drinking behavior. They are the following:

1. *Denial.* This is the most basic of the alcoholic's defense mechanisms.

It is precisely his inability to face unpleasant reality which in the beginning leads him to use alcohol to excess. And as his illness becomes progressively more severe, so must his denial become progressively stronger. An example of the alcoholic's denial is evident in the oft-quoted phrase, "I can take it or leave it alone." It is painfully apparent to everyone else but the alcoholic that this statement is nothing more than an attempt at blanket denial of his great drinking problem.

2. *Rationalization.* When faced with reality, simple denial of the existence of a drinking problem is difficult to maintain. Therefore, the process of rationalization, i.e., twisting the illogical until it appears logical, is a handy device. An example is the following: "It was a sunny, hot day; and when I finished mowing the yard, I went to the icebox for a drink. When I saw that ice-cold beer there, I knew that was the best thing I could take to quench my thirst." The obvious question one must ask is: "Wasn't there any icewater or sodapop or milk or something else that would quench your thirst?"

3. *Projection.* Another overworked mechanism of defense when fra[illegible] denial tends to break down is to project the guilt for drinking from the [illegible]coholic to another person, usually a family member or an employer. "If my wife would just quit nagging me about drinking too much, I wouldn't do it anymore." Question: "Is there some unpleasant change that takes place in your personality when you drink that causes your wife to complain?"

4. *Fragmentation.* This is an extremely useful and overworked mechanism of defense in which the alcoholic fragments reality into small bits which he then focuses on as if they were the whole. This helps him blot out unpleasant reality. For example, a newly admitted patient on an alcoholism ward was asked the question: "How much do you drink a day on an average?" His answer: "Some days I don't drink anything!" This is an excellent example of the alcoholic's fragmenting his behavior into brief periods of time, and then focusing only on those periods of time when he was not drinking at all. He then tries to pretend that this brief sober period is an accurate sample of his general living pattern, i.e., sober. One of the important aims of treatment is to help the patient integrate all parts of his behavior, pleasant and unpleasant, and make them readily accessible to his conscious thought processes.

Phase III: The Crucial Phase (Addictive Alcoholism)*

The most prominent characteristic of this phase is development of loss of control over the use of alcohol; i.e., if the alcoholic takes one drink, he will continue to the point of drunkenness. It is during this phase that everyone

*Drug dependence, alcohol, psychological and physical type.

who has any repeated contact with the alcoholic becomes painfully aware of the seriousness of this person's problems. It is called the *crucial phase,* because the alcoholic stands in great danger of losing everything he holds near and dear to him (his family, his job, his friends, his health) unless he succeeds in arresting his illness.

Additional prominent characteristics of the alcoholic in this phase are the following:

1. He exhibits *grandiose behavior;* i.e., he begins telling extravagant stories of fantasied great accomplishments in his life in order to cover up for his great feelings of failure and low self-esteem.

2. He exhibits *marked aggressive behavior* as he convinces himself that all his troubles are due to his wife, his friends or his debtors.

3. He may well have periods of *total abstinence to prove* to himself he can "take it or leave it alone." Social drinkers do not need to prove to themselves that they do not have a drinking problem, and consequently will not find it necessary to undergo a prolonged period of self-enforced sobriety.

4. He will *change* his *drinking pattern* to prove to himself that he has no drinking problem. For instance, he resolves never to drink before dinner, because only alcoholics drink earlier in the day than that. Or he will change from drinking bourbon to drinking scotch, because scotch gives less of a hangover, or to beer, because he earnestly believes one can't become alcoholic on beer, or to vodka, because it isn't supposed to smell on his breath, etc.

5: He will *change his associates* as he convinces himself they are responsible for his problem. Thus, he ends up divorcing his spouse and cutting off old friendships.

6. If the alcoholic stops drinking suddenly, he will go through a *withdrawal syndrome* consisting of the "shakes," delirium tremens or alcoholic hallucinosis.

Thus, Phase III fulfills the criteria of a true addiction, i.e., craving for a drug, development of tolerance to the drug and a withdrawal syndrome upon sudden cessation of the drug. The symptom of loss of control over the use of alcohol appears to be a symptom of this physical dependence on alcohol.

Phase IV: The Chronic Phase

By the time the patient's addiction has reached this chronic phase, he finds himself going on prolonged, unplanned drinking sprees which last for many days. These are called, in the alcoholic vernacular, "benders." Formerly the addict has been able to reserve his heavy drinking periods for the weekends; but with the onset of this unplanned heavy drinking, lasting throughout his waking hours, he finds himself confronted with grave social condemnation from all segments of society except the lower social-class al-

coholic with whom he drinks. His health also suffers rapid deterioration due to the fact his diet is made up mostly of alcoholic beverages rather than nutritious foods.

He undergoes marked *ethical deterioration*, and will, possibly for the first time in his life, engage in stealing, writing worthless checks, and inflicting severe injuries on himself and/or others. Some female alcohol addicts begin engaging in prostitution.

His thinking becomes chronically impaired in such a manner that, even if he has been withdrawn from alcohol and been sober for several weeks, he will still be unable to assess himself and the world about him accurately. He can think on only a superficial level, and thus finds it difficult to realize the severely deteriorated state he has come to, or to make sound plans for rehabilitating himself in the future. This blunting of intellect constitutes a *mild chronic brain syndrome* which may not clear up for many months. In some cases it never disappears. Chronic alcoholic psychosis also occurs in a small percentage of these addicts.

Commonly noticed at this time is a *loss of alcohol tolerance*. It now takes much less alcohol to arrive at a severely intoxicated state. He also *begins drinking any type of alcohol* or alcohol substitute which is available, including shaving lotion, rubbing alcohol, Sterno, cough medicine, barbiturates, certain tranquilizers, etc. The severe medical complications of alcoholism become manifest including cirrhosis of the liver, brain damage, esophageal varices, etc.

One final important observation must be made about the natural history of alcoholism. The predictable downhill progression can, in a large percentage of cases, be arrested at any stage, usually with the aid of some therapy modality.* Occasionally, alcoholics do "quit on their own," but, for many, special therapy is necessary. The goal of therapy is abstinence from all alcohol use and social and psychological reintegration. Reports in recent years have indicated that some alcohol addicts can return to social drinking. This must be an uncommon phenomena in light of the experience of most workers in this field.

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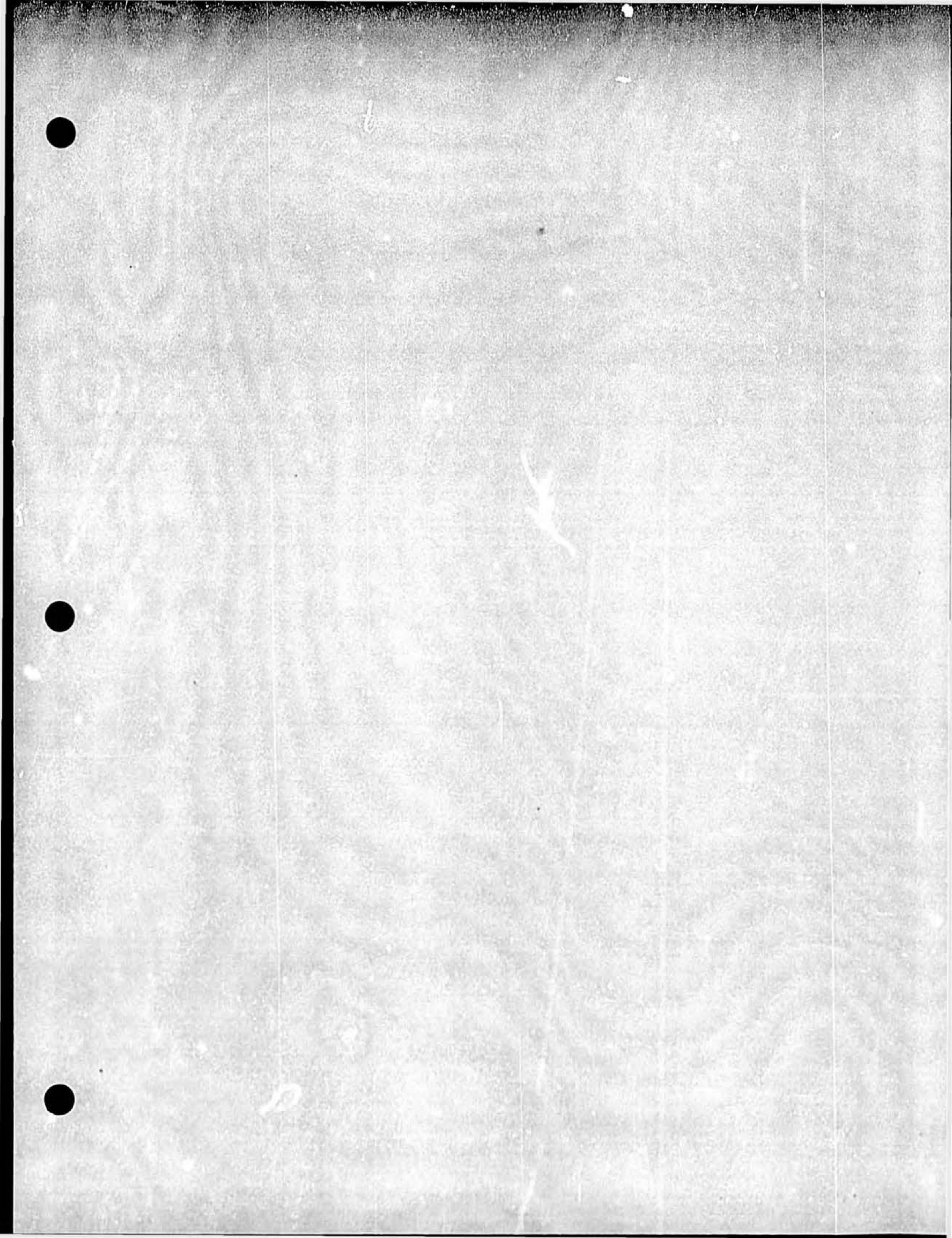
*Although numerous references will be made in this book to the effectiveness of rehabilitation efforts with alcoholics, the reader's specific attention is called to the follow-up study reviewed in the chapter by James H. Williams.



SEVERITY OF INTOXICATION IN RELATION TO CONCENTRATION OF ALCOHOL IN THE BLOOD

To gauge the degree of intoxication by the symptoms alone is unsatisfactory, and even physicians fail to agree when using such a basis. But the great mass of evidence on the correlation of driving impairment with blood alcohol levels affords better criteria to estimate the severity of intoxication. Formerly the value of 150 mg of alcohol per 100 ml of blood was taken as the lower limit for dangerous driving in the United States. But many years have passed since the standard of 150 mg per 100 ml, was set, and it is now thought to be too high. The additional information which led to this conclusion was obtained by the actual operation of a car or a "dummy" automobile and also by laboratory tests. Some subjects showed driving impairment with alcohol levels as low as 50 mg per 100 ml. All were impaired when the blood alcohol levels reached 100 mg per 100 ml. In 1960, therefore, the House of Delegates of the American Medical Association recommended that the zone of dangerous driving should begin at an alcohol level of 100 mg per 100 ml of blood as indicated in Figure 2-1. Persons with concentrations of less than 50 mg per 100 ml are not to be regarded as under the influence of alcohol. But those with concentration between 50 mg per 100 ml and 100 mg per 100 ml should be judged according to the circumstances, including the results of physical examination as indicated in Figure 2-1, which also depicts the volumes of whiskey or beer necessary to produce the values of 50 mg per 100 ml and 100 mg per 100 ml respectively in a person weighing 150 lb (68 kg). Most individuals are unmistakably inebriated at levels of 200 mg per 100 ml. All drinkers are intoxicated with a level of 350 mg per 100 ml, and the intoxication is severe at 450 mg per 100 ml. Levels of 350 to 450 mg per 100 ml have caused death, while those above 550 mg per 100 ml are usually fatal in untreated individuals.

Though the level of blood alcohol is a determining factor in estimating the degree of intoxication, blood analyses do not always afford the method of choice to obtain this information because of problems in obtaining and analyzing blood samples. In New York State, for example, the services of a licensed physician are demanded in the collection of the blood sample. It is therefore advantageous that we may rely on samples of urine, saliva, and breath to estimate alcohol concentrations. The blood values can then be calculated because of an equivalence between the concentration of alcohol in blood with that of urine, saliva, and breath as indicated below.

Urine: blood	1.25:1
Saliva: blood	1.12:1
Blood: alveolar air	2,100:1

These figures mean, for instance, that, when alveolar air is in equilibrium with the blood with respect to alcohol, 2,100 ml of alveolar air will contain

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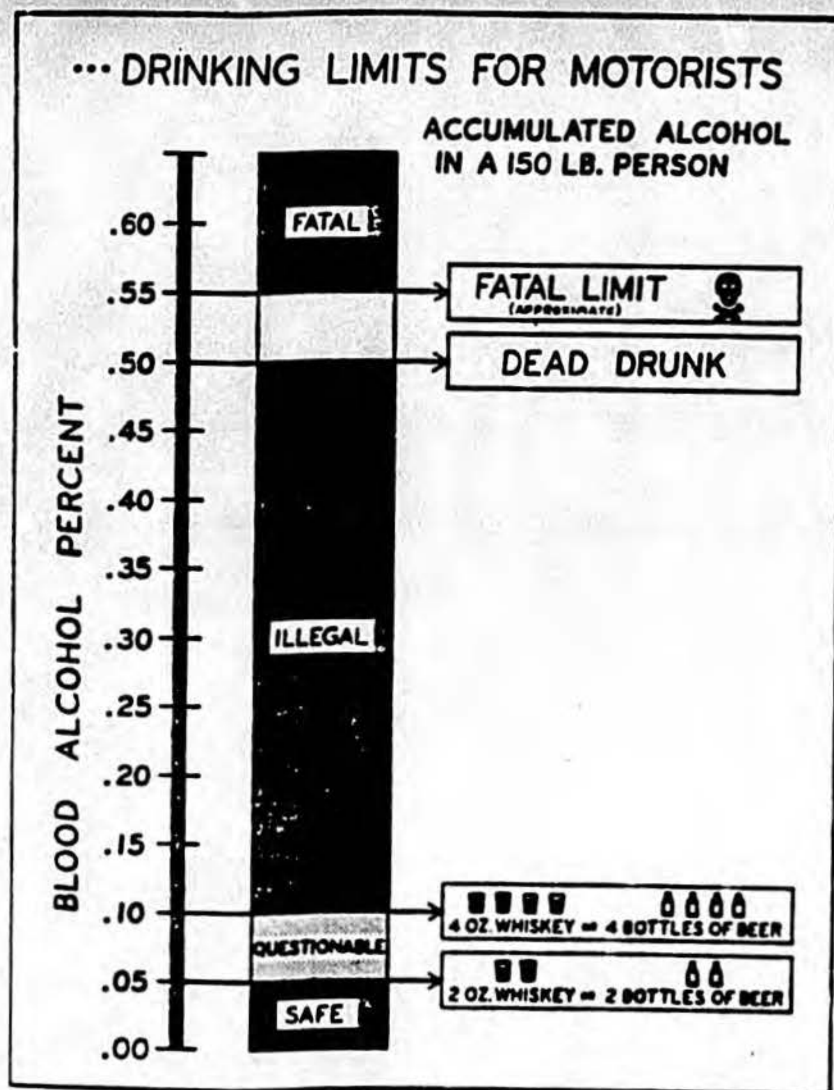
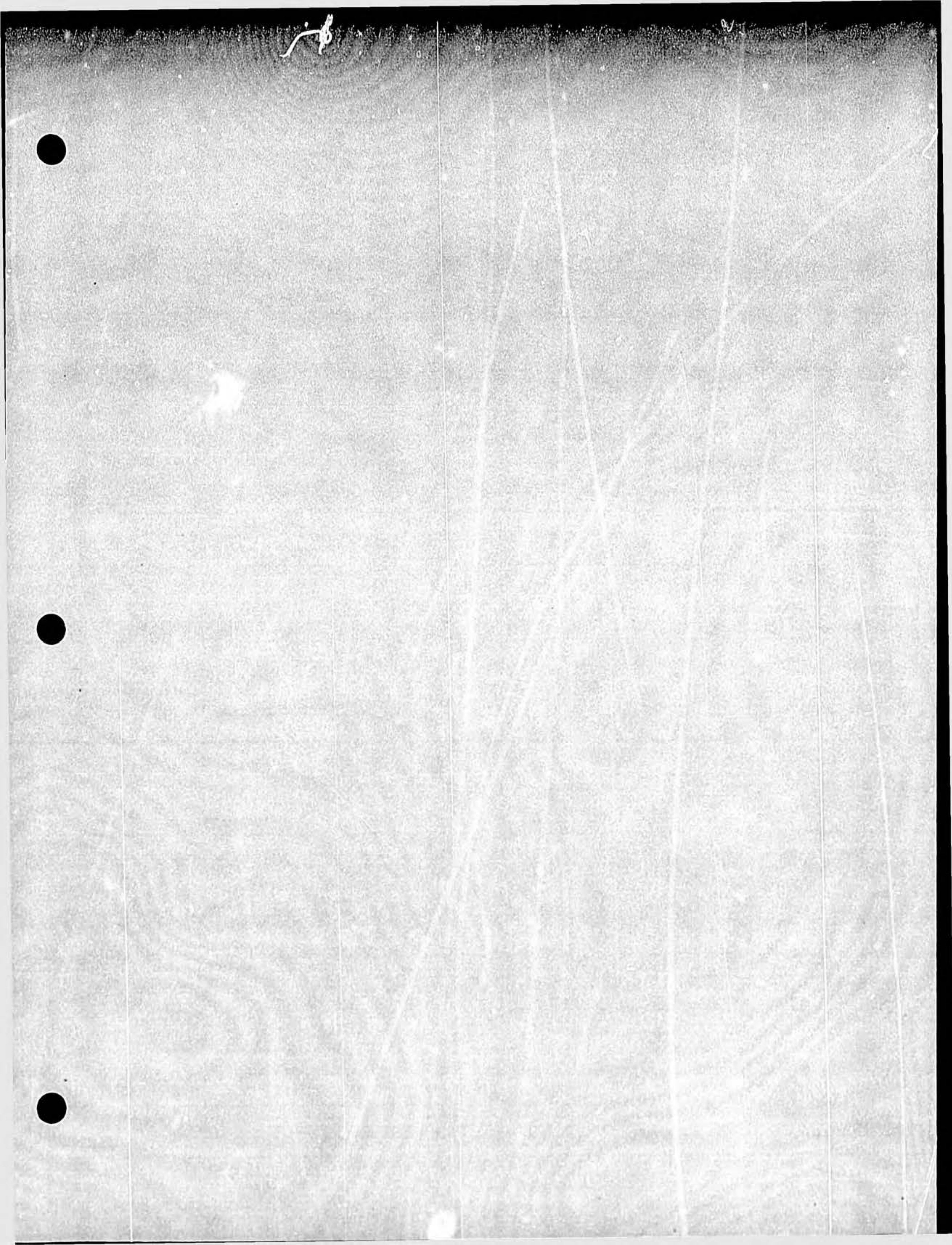


FIGURE 2-1. This figure is adapted from R. N. Harger and H. R. Hulpieu, and is reproduced with their permission from *Alcoholism*, edited by G. N. Thompson and published by Charles C Thomas, Publisher, Springfield, Illinois, 1956, Chapter 2.

as many milligrams of alcohol as does 1 ml of blood. On comparing these sources of alcohol it must be emphasized that analysis of the alcohol in the breath possesses many practical advantages, not only over those of urine and saliva but also of blood. The collection of the air samples requires less cooperation on the part of the subject, and the actual determination for alcohol can be made most rapidly on the air sample. Most important, the



The toxic symptoms and signs induced by disulfiram and citrated calcium carbamide are largely due to interferences with removal of acetaldehyde, which accumulates as its combustion is inhibited. Normally Stage 1, from alcohol to acetaldehyde, is the slowest phase of alcohol oxidation. With these drugs, however, Stage 2, from acetaldehyde to acetyl CoA, becomes even slower. As a result, acetaldehyde is retained in the body and produces the toxic changes described above.

A real advantage afforded by these drugs is that the patient has to make a decision not to drink alcohol only once a day instead of many times. In general, disulfiram has greater effectiveness and is correspondingly less safe than citrated calcium carbamide. If the patient takes a drink of alcohol, the symptoms are much more severe with disulfiram, which therefore serves as a greater deterrent than citrated calcium carbamide. In any event, the patient's willingness to take either of the drugs is a sign that he is strongly motivated in his desire for relief from his disease.

SUMMARY

Alcohol is chiefly a brain depressant and seems to act from above downward. The clinical picture of acute alcoholic intoxication reveals a progressive march starting in cortical functions and gradually descending the brainstem to the medulla oblongata. Thus the most complex faculties of judgment, memory, learning, self-criticism, and environmental awareness are among the first to be impaired. Similarly, the release of lower brain centers from cortical control is evident in the excitement characteristic of one phase of alcoholic intoxication. The mechanism involved in this progressive march of symptoms is complex, and two different explanations are offered, probably each one being partly correct. As discussed in the text, not all areas of the brain are equally susceptible to alcohol; some parts of the cerebral cortex, for example, are more sensitive than a subcortical area, the reticular formation. On the other hand, the reticular formation succumbs earlier to the effects of alcohol than other cortical areas.

Alcoholic beverages can induce a mild degree of depression of cortical functions, a depression that serves as a relief from the cares of the day and secures relaxation before dinner. A drink before bedtime may break a vicious cycle, so that one need not take his troubles to bed. Similarly, alcohol facilitates interpersonal relationships and performs many other valuable services. On the other hand, when alcohol is not taken as temporary relief, but is habitually used instead of more appropriate methods to resolve difficulties at work or at home, the drinker invites future addiction. Similarly, alcohol employed to allay inner conflicts, as in an individual with a

schizophrenic personality, may serve to complicate further the pathologic picture. In this event, first functional and then structural changes take place in the body as alcohol assumes the role of a necessary foodstuff and the patient becomes an addict.

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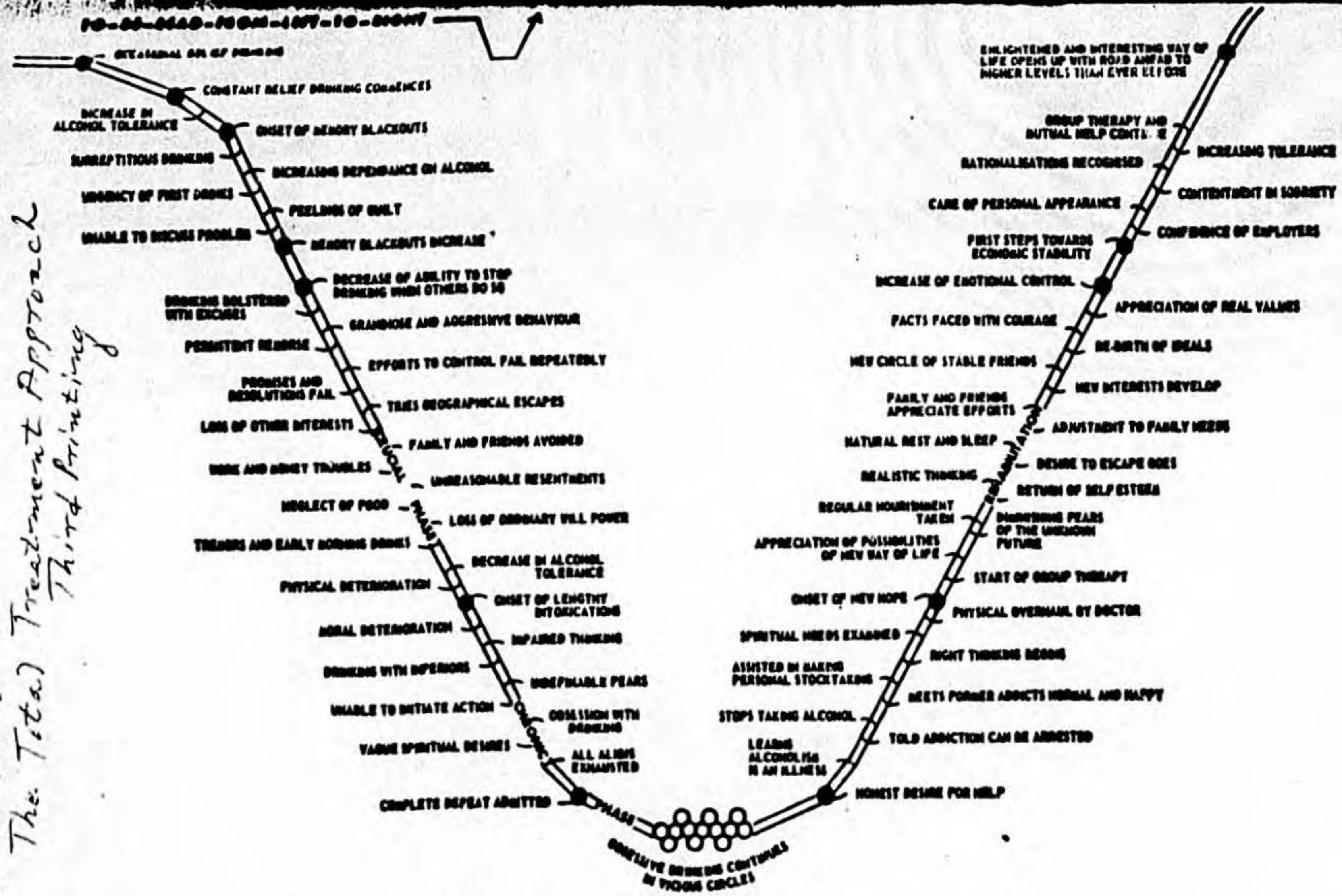
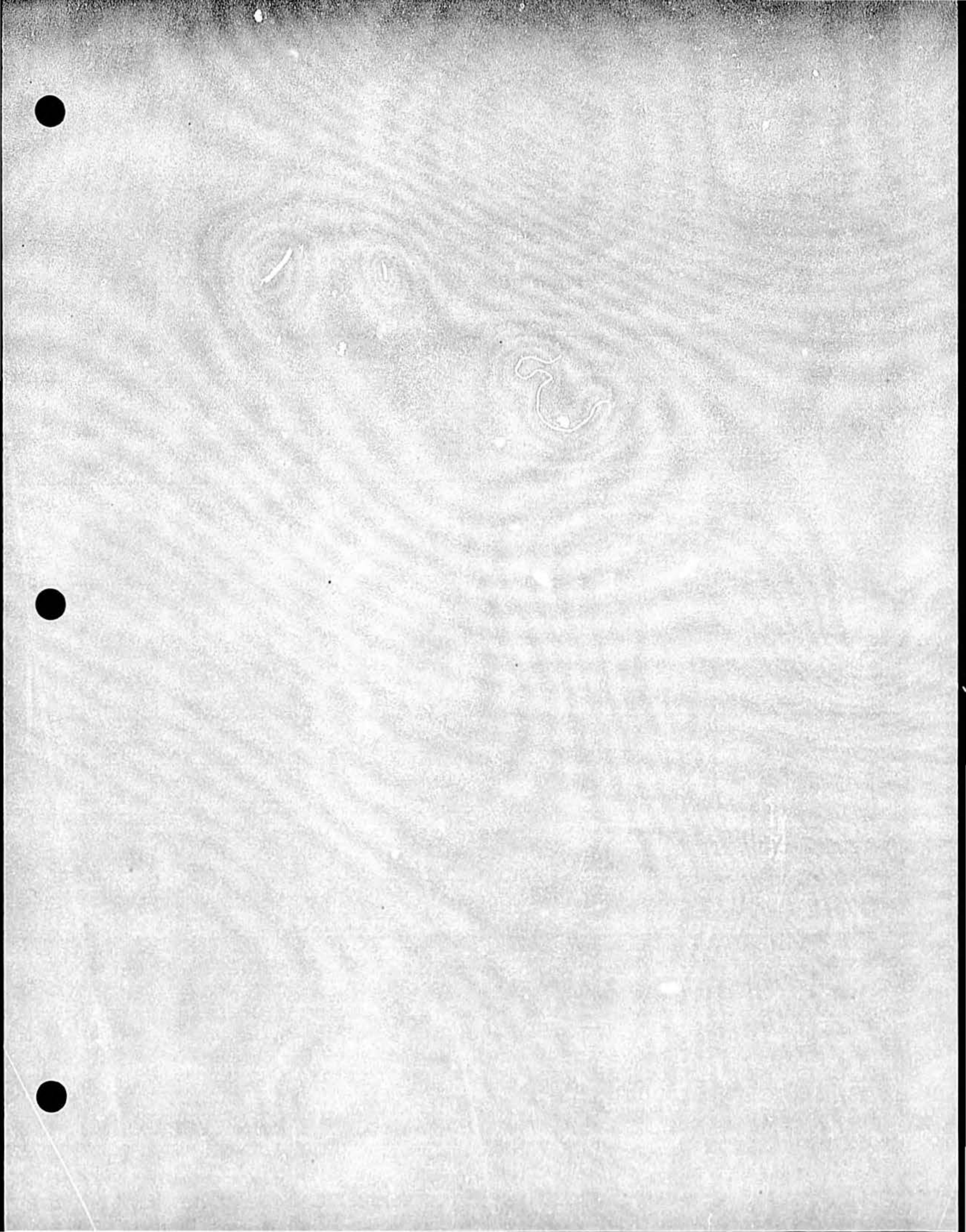


A CHART OF ALCOHOL ADDICTION AND RECOVERY

*Reprinted by special permission of the author of this chart, Dr. M. M. Glatt.



Alcoholism
The Total Treatment Approach
Third Printing

CHAPTER 16

SOCIAL CASEWORK WITH THE ALCOHOLIC AND HIS FAMILY*

LAURA ESTHER ROOT

VARIOUS TYPES of therapy have been used in the treatment of alcoholics, including Alcoholics Anonymous, chemotherapy with various tranquilizers, antidepressants and disulfiram, and group therapy to name a few. Some have been more successful than others. The most successful approaches appear to be centered around Alcoholics Anonymous and group therapy, inasmuch as more alcoholics maintain their sobriety through these types of treatment than others. Individual counseling and family group therapy are also useful in helping the alcoholic and his family to maintain his sobriety.

Social workers in their practice could be of invaluable help in this field of treatment where there are too few facilities and too few professionals willing to invest themselves in working with the alcoholic. Social workers need to be concerned about the lack of treatment available to this large segment of our population, 10 per cent of whom are alcohol-dependent, and 5 per cent of whom are alcoholic.[1]

Alcoholism has been moving from an area of moral stigma into the field of scientific investigation. With this change a body of objective information has come concerning alcohol, alcoholics, and alcoholism. Research in treatment techniques, in drug therapy, in types of treatment facilities, and the like have uncovered much factual knowledge where previously only myth existed. As yet no definitive studies have been done to isolate a specific variable as the cause of the disease, nor is there any known cure. Social workers then, are confronted with a disease whose etiology remains unknown, whose number of victims is increasing at the rate of some 200,000 annually, as well as the fact that treatment facilities and personnel have lagged far behind the current need.

What can social workers do? They can accept the challenge now in the

*Material for this report was gained from a study supported (in part) by a Mental Health Project Grant (MH 657) from the National Institute of Mental Health, United States Public Health Service.

field of alcoholism as did the early professionals with the then-unpopular problems and invest themselves in treatment of alcoholics.

It must be noted that, as a profession, Social work has not been overly enthusiastic in seeing the alcoholic client. Although this is not as popular a field as community organization, group work, settlement-house work, welfare and medical/psychiatric social work, still there have been a few social work leaders, such as Margaret Cork, Jean Sapir, Catherine Peltenberg, Margaret Bailey, and Gladys Price, who have pioneered and made outstanding contributions in the field of alcoholism.

The few social workers who have had some contacts with alcoholics are generally those in hospitals, welfare agencies, and probation and parole offices. Some settlement-house workers and a few workers in family agencies have also had contacts with alcoholics. Social workers are being presented with a challenge to help alcoholics, and in so doing help to roll back the "curtain of ignorance," moral condemnation, and lack of acceptance of alcoholics which is found rooted in community attitudes throughout the country. The "revolving-door" alcoholic and the tuberculus alcoholic are rarely seen by social workers for any length of time. Now is the appropriate time to accept this challenge and do something about it. Many other professions have said that social workers are threatened by working with alcoholics, since alcoholics force them to question their traditional case methods. This is not always the truth. It is my feeling that if we had followed one of our earlier pioneers, Mary Richmond, we would have long ago been working with alcoholics, since she early identified this type of patient as of appropriate concern for social workers. Social workers have much to give to this field, but first they must have a knowledge of the disease of alcoholism.

Attitudes of Social Workers

One of the barriers which has kept social workers from entering this field has been their own attitudes about alcoholism. This is documented in the Bailey and Fuchs study, "Alcoholism and Social Work," in which they observe that social worker's attitudes have often negatively affected their work with alcoholics.[8] It is necessary, then, for social workers to modify their views, as well as incorporate current knowledge about alcoholism into their practice. The importance of their own attitudes toward alcoholics has a tremendous effect on their ability to work with these people. Most alcoholics are extremely sensitive people who have low self-esteem, which usually accompanies this progressive disease and generally makes them search for rejection. Indeed, they may overtly try to provoke a professional into rejecting them, since they are anticipating moral condemnation. Many times they are in fact rejected; otherwise, a great many

of the 6,500,000 alcoholics in the United States today would be seeing professionals in the many social-work agencies in existence.

Learning begins when one commences to understand the chronicity of the disease of alcoholism and what this entails. Many social workers will say that they understand the concept of chronicity in diseases because of their work with the tuberculus patient, or heart patient, or diabetic patient. They may feel that, because of their experience as medical social workers or as welfare workers, these are types of patients which they understand very well. They can accept and deal with the relapses which occur with these chronic types of patients. Generally they are very supportive and accepting, explaining to the patient and their families that the patient has overdone himself and that he probably was not as cautious as he should have been in following his diet and prescribed routine of medical care. They interpret, both to the patient and the family, this *matter of chronicity*.

However, the attitude which many professional social workers hold towards alcoholics is quite different. When an alcoholic is returned to a treatment facility with a relapse, or comes into the office with evidence of imbibing, if the social worker automatically thinks, "Oh, not again," I question whether this is an objective or moralistic attitude. Therefore it is extremely important for the *social worker* to accept the fact that alcoholism is a chronic *disease*, which can be arrested by proper treatment, before the worker can hope to deal successfully with the alcoholic patient. If social workers refine their casework methods and utilize them in their relationships with alcoholics, they will be able to handle the relapses which occur in this chronic illness and use them constructively in their total treatment goal.

COUNSELING THE ALCOHOLIC

Social workers are noted for their ability to communicate to patients. One of the techniques of their profession is an ability and skill in interviewing and communicating. However, in working with alcoholics, their communication must be at a different level. Many clinicians fail in the treatment of alcoholics because they are unable to, and/or fail to, communicate. Learning to interact with alcoholics is something that comes with time. As one learns about the disease, one begins to understand and accept the chronicity factor; and one eventually realizes the impact of the disease upon the individual in his total milieu. It is most important that the therapist understand the patient's drinking problem and how his life with this progressive addiction to alcohol affects him as an individual. He is not "an alcoholic personality," but changes do occur in personality traits with the onset of the chronic phase of the disease. The more one learns, the more one understands, accepts, and gains insight and knowledge

in learning to communicate with alcoholics. Ultimately, one learns to speak "his language."

The Intake Interview

One of the most important skills of the social worker is an ability to help people when they come to the agency with a problem and to make them feel comfortable during the "intake interview." This is an interview in which the patient or client presents a problem, and the social worker, with her training, helps him express his need without being too traumatic to the patient. However, if the "social worker regards the intake interview as a study or exploratory process and the applicant conceives of it as a help-getting experience,"[1] difficulties will ensue before the agency's service is extended to a client who needs help. Conception, as well as expectations, of the roles of the social worker and client are not the same. A method of interpretation and communication is necessary if the goal of service is to be achieved in most agencies. The intake situation is even more confused if the social worker has a poor attitude toward alcoholics, as well as a lack of knowledge of the disease, while the alcoholic not only has an inability to acknowledge his disease, but greater difficulty in asking for help. One can begin to see the barriers which have been erected between social workers and alcoholics and have prevented a needed service from developing.

It is difficult, at best, for many people to request help. But for an alcoholic patient to acknowledge that he needs help with his drinking problem is almost an impossible task, for often he cannot accept the fact that he is indeed an alcoholic. To come to an agency or a clinic and request help requires a great deal of courage for alcoholics, because in so doing they are admitting that something is "wrong." This is extremely threatening to them, and many have to get drunk in order to seek help.

In the "intake interview" the social worker focuses upon the alcohol problem by obtaining a complete drinking history. This should be done in a frank and open discussion with the individual. If one obtains a comprehensive drinking history, he will have a very adequate social history of the individual, since drinking cuts across all areas of the alcoholic's life. The following information should be included in the drinking history:

1. Age at first drink; what beverage was it, did parents drink, or were they abstinent?
2. If parents drank, what were their drinking patterns? Did they keep liquor in the home?
   Did they make wine or beer at home?
3. If parents drank, what type of drinkers were they? social? Did one or both parents have a problem?

4. How old was the patient when he or she:
   a) Was first intoxicated?
   b) Had his first blackout (a brief period of amnesia while drinking)?
   c) Took his first morning drink?
   d) Had increase in frequency of blackouts?
   e) Lost control of his drinking?
   f) Started to protect his liquor supply?
   g) Started daytime drinking?
   h) Began going on binges?
   i) Began drinking alone?
   j) Had his first hallucination or delirium tremens?
   k) Thought for the first time he was going to die?
5. How many jobs has he had in the last three or four years?
6. What job did he hold the longest?
7. How many times has he been arrested for intoxification and/or alcohol-related offenses?
8. Has he left his family, or have they left him?
9. If he is still with his family, do they have their meals together?
10. Does he have shared activities with the family?
11. Who makes the decisions at home?
12. Does his wife work? If so, how long has she worked?
13. How long ago did she start calling in to cover for him on his job or with his friends?
14. Has he lost any property as a result of his drinking?
15. Has he taken any personal articles of his own, his family's, or articles from his home to sell when he needed a drink and did not have cash?
16. How many bar bills, liquor stores, and friends does he owe money to, and for how long?

These and other similar types of questions will provide information concerning the impact of the drinking problem upon the individual patient and his total milieu. If the interviewer obtains a complete and detailed drinking history, it will provide a basic social history of the patient. An all-inclusive drinking history is a must in making a treatment plan for the patient.

In most private family agencies, the clients are more apt to be middle-class alcoholics who are in the earlier phase of alcoholism, rather than in the later chronic phase when addiction has occurred. The earlier phase is the optimal time for intrusion for treatment. The therapist's approach to this patient would have to be different than it would be with one who is "downed" by the chronicity of his disease, as is the "revolving-door" alcoholic, who may have been arrested some two hundred times or more, and who has served half or two-thirds of his lifetime in jail on the "installment plan."

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Motivation for Help

Let us next consider the motivations which bring patients to our offices in our regular practice and the manner in which we evaluate his motivation for seeking help. We wish to know why he has come; and if he has come of his own volition; or if he has been forced to do so because of whatever is occurring in himself or within his family. Does some type of illness, problem, etc., bring him in for help? The motivation of an alcoholic to come seeking help is usually the force of his illness. He might, however, come as a result of pressure from a family member, employer, or friend; but, whatever the reason, we must first deal with the feelings which have been aroused. We must work also with any other barriers which might be present, such as a morbidity of personality. We need to identify these factors. For an alcoholic to come of his own volition for an initial contact is the optimum for long-rang goals in treatment. If, however, he comes as a result of force, this injects a resistance factor into the situation which usually acts as a deterrent to his ultimate goal of sobriety.

Sometimes it is not only hard to acknowledge, but also difficult to accept, the fact that we are unable to help a client. If the agency does not handle the type of problem the client presents, we usually say that "we are sorry, but we cannot help you," and we generally try to make a referral to some other agency which would be able to provide the necessary service. It is somewhat different with an alcoholic when he comes to an agency, as we must evaluate whether or not he has come because of pressure. If he comes "with a gun at his back," and we accept him without acknowledging this, we will be erecting a barrier which will interfere with his sobriety as previously indicated. It is quite conceivable that the patient may not yet be ready for help. If this is true, we must help him to identify this, explaining to him that we will be glad to help him when he is ready.

There have been several articles written on "motivation" of the alcoholic and on the concept of motivating the alcoholic. The Pittman-Sterne article in the *Quarterly Journal of Studies on Alcoholism*[4] points out that when too much stress is placed upon motivation it may mask the disinterest of the professionals or their desire not to be involved with this different type of patient. Many social workers have permitted themselves to accept a common myth that alcoholics cannot be helped unless they seek help themselves. In my clinical practice I find this not true. More important, I feel that when we use this excuse we are hiding behind it. We might do well to examine our own motives for using this objection. Do we really want to work with alcoholics? I submit that we must not accept the myth which insists that alcoholics must request help before they can accept treatment effectively. I think that it is a challenge for us to help to motivate alcoholics sooner, and to help their families, as well, to understand and to

learn to live with the alcoholic member, so that they, in turn, can support him to seek help at an earlier period.

Additional Important Information

After we have a drinking history and have ascertained why the patient has sought help, we should then further evaluate the alcoholic to see if he considers himself an alcoholic, or if it is his family or his employer who does so. Second, we need to know if he has ever had treatment; if he has had sobriety we also want to know what type of sobriety it is, as well as the duration of the period he maintained it. There are several types of sobriety, and it is important for us to know which type the patient has experienced before he came to us for treatment. The chronic addictive alcoholic generally stays sober longer if he has achieved sobriety which he himself sought. Alcoholism is a selfish disease, and the sobriety which must be achieved by an arrested alcoholic is sobriety for himself, to the exclusion of anyone or anything else. In other words, his sobriety has top priority above any other factor or person in his scheme of life. For, if he is not sober, he can achieve little in terms of work, family, or the community.

There are, as I indicated, several types of sobriety. There is what I choose to call "reluctant sobriety," during which kind the patient remains sober, not because he wants to, but because of the pressure from either his family, employer, or friends. When a patient is attempting to maintain his sobriety without investing himself to the fullest extent, he is a patient who will probably relapse within a short period of time. Conversely, I call the other type of sobriety "peaceful or happy sobriety," and yet this is actually a misnomer, because in the beginning or earlier stages of sobriety, it is not at all peaceful. Let us say rather, for the alcoholic who has decided to stay sober, wishes to work at it, invests himself in maintaining his sobriety, this could then be considered a more tranquil sobriety in comparison to "reluctant sobriety." Still, one must be aware that, in the beginning, no sobriety is tranquil; it is a fight for the alcoholic every minute of every hour of every day in the beginning to keep from drinking. We must understand, therefore, how imperative it is for social workers to be aware of any sobriety which the patient might have achieved prior to his coming to the agency.

At the same time that we obtain a drinking history, as indicated previously, the various data that are needed for a complete diagnostic background history of the patient can be obtained. It is at this time that we must be sure to have a complete diagnostic workup done on the patient, including medical, neurological, psychiatric, and sociocultural evaluations. It is best to know what the positive attributes of these patients are, rather

than just the negative ones. It seems that many professional people, when evaluating a client or a patient, tend to stress what he has not done, rather than what he has done. An evaluation should be made of the positive ego strengths which the patient has, rather than emphasizing the negative ego deficits, in making an effective treatment plan for the alcoholic.

Initial Therapeutic Suggestions

In my clinical experience with alcoholics I have found that if you focus first upon their reason for drinking, you fail. Therefore it is better generally to request that all ingestion of ethyl alcohol be stopped at the beginning of treatment, rather than later on. If there are any underlying emotional problems, and indeed there are with some alcoholics, it is best for these to wait until the patient has begun to achieve some measure of control over his alcohol intake. It has been my experience that should you reverse this procedure and attempt to find out why the patient drinks, to search out what problems or reasons he had for drinking before he became chronically addicted, it is usual for the patient to continue drinking and for some to increase their ingestion. Therefore I think it is imperative that in casework with alcoholics you must first help them to stop drinking. Should you wish to approach them from an analytical standpoint thereafter, you can still do so. But equate the drinking with acting out, and have them stop any ingestion of alcohol first.

In my clinical experience, when I attempted to ease tension by first helping the patient resolve his conflicts, I found that the addiction remained. When I speak of addiction here, I am referring to the physical addiction to alcohol which is found in the chronically addicted alcoholic. This means that there is a physical compulsivity to drink, with an inability to control alcohol ingestion once the alcoholic begins drinking. Many social workers have failed in working with alcoholics because they have concentrated on the underlying problem, while the drinking has increased in its intensity.

Social workers in working with alcoholics, need to give educational information to them about alcoholism. This is somewhat unique in our field, but it is imperative that the alcoholic patient or client be given as much factual knowledge about his disease as possible. With each session you may be somewhat didactic for a part of the time by conveying knowledge about the disease to the clients or patients. This helps the individual gain some insight and understanding of his chronic illness. Florence Hollis has said: "Insight is a technique of social work whereby the client is made to see himself and his problem."[8] Imparting of information is a good way to begin the insight process.

Furthermore, we may need to modify the environment so that the alco-

holic may achieve a new design for living without alcohol. The technique of modification and manipulation of the environment to help the client is one of the most basic techniques of social work. For an alcoholic to change his life completely, in terms of a new design for living without alcohol, is a tremendous task. To do this he must have continued positive support from his therapist. Social workers are specially trained in using supportive techniques. They "help the client to help himself."

Common Problems of Treatment

One of the things which will aid social workers in their work with alcoholics is an understanding of some of the characteristics of alcoholic behavior. The alcoholic will test his therapist by coming late or missing his appointment. If psychologically difficult areas have been brought up in treatment he may start to "nibble" (ingest a few drinks). He may even suggest that he has done this to "get enough courage to come to the office for another visit." On such an occasion the social worker has to make it clear that if the patient continues to show up for visits under the influence of alcohol, the visits will have to stop. At the same time skill will have to be used to make the patient understand that this is not rejection, but rather is a necessary requirement for successful treatment.

Social workers are skilled in using either a diagnostic or functional approach, or a combination of both in building relationships with clients within which they are able to work. Some workers feel that the diagnostic approach is the most appropriate, while others feel that the functional is the only right method. In terms of working with the alcoholic, it is appropriate to use both diagnostic and functional approaches. Accurate diagnosis and realistic assessment of current problems and assets are both necessities for success with the alcoholic client.

Alcoholics, particularly those who are in the chronic addicted phase, have learned to employ to a pathological extent some of the defense mechanisms which have been used to excess in other types of clients with which social workers are familiar. The major defenses are projection, rationalization, denial, and manipulation. The alcoholic, however, uses these for one purpose, i.e., to reinforce his drinking patterns. The therapist must help him to understand and be aware of his pathologic defenses, identifying with the client why he uses these specific defenses and his purpose in doing so.

Some time ago, when I was conducting a group session with alcoholics, one of the patients was speaking about his problem, rationalizing his reasons for drinking. His rationale was that he drank when he was happy, and that as years went on he continued to drink while he was happy, but eventually he became an uncontrolled drinker. I stopped him at this point and

asked him, "Who do you think you are kidding?" The patient stopped short and responded, "Well, I guess I'm not kidding anyone but myself." A discussion ensued among other patients which reinforced this point. The individual patient began in that session to gain some insight into his problem, and from that day on he began to make progress in his treatment. This happened four years ago. The other day the patient stopped by my office, and he remarked that throughout his years of sobriety, every now and then, when he is rationalizing about some other things in life, he recalls my comment, "Who do you think you are kidding?" and he said that he always replies, "Really, only myself."

Long-Term Treatment Plans

In addition to the manipulation of environment, the patient must be helped to plan a new design for living. One of the most difficult things for the alcoholic is just staying sober for an hour at a time for the first year. Trying to get through life "dry" utilizes all his effort and energy, which leaves him without anything to invest in other areas. Playing the role of a father, of a husband, of an employee, is a tremendous demand upon an individual for strengths he does not have. When helping an alcoholic to try to find a new way of life, one must give support and help in planning the things which will assist him in making new constructive life goals. Also, plans must be devised for him to spend his free time constructively.

The alcoholic is always concerned about the time when he is not working which used to be devoted to drinking: What should he do with it now that he is drinking no longer? He wants things to do. He must be helped to set up realistic goals. For example, he should be helped to assume his rightful role within his family milieu if he is fortunate enough to be returning to live with his family. If he is working, he must be helped with his employment situation and attitude to see that he performs adequately on the job. He will need continued support and encouragement. He must also be assisted in trying to rebuild his life in the community so that it is meaningful to him and his family. Furthermore, a suggestion that he join Alcoholics Anonymous and attend several meetings a week is usually quite helpful. The fact to keep uppermost in mind is that this patient must invest so much of himself just to maintain his sobriety alone that he is frequently incapable of making the right decisions. During the initial months of sobriety he cannot be left alone to become lost in the many tasks which make up his daily life. Supportive therapy by the social worker is imperative during this period of treatment.

It is quite feasible that some social workers will feel that working this closely with alcoholics will increase their dependency to the degree they

will never be able "to cut the ties that bind." This is not true! At an appropriate time, treatment can be discontinued and remain only on a "when-necessary" basis. I have done this repeatedly with alcoholics with whom I have worked, and have encountered no great difficulties.

As treatment continues, plans must eventually be made "to cut the umbilical treatment cord." As the length of sobriety increases, clients begin to pick up the threads of their lives and weave them back into a meaningful fabric. Appointments are spread further and further apart, so that, instead of seeing the patient once or twice each week, gradually he is seen once a month, and ultimately is told to come back any time in the future he feels the need. This is a new design for living which helps him to manage his life realistically. As the alcoholic learns to live with his sobriety, he gains strengths and a greater feeling of independence.

The patient and his family need to understand that not all problems disappear when the alcohol ingestion is stopped. Rather, there are often many more problems, sometimes of a deeper nature than those which were present while he was drinking. One cannot work with the alcoholic in a vacuum. Total family therapy is a necessary part of his treatment. At times the social worker may not see any member of the client's family or may see a family member in a separate individual session. But to work effectively with the alcoholic, a different type of approach must be used. Family group counseling is often a necessity, as well as alcoholic group therapy. This family group therapy often should include the entire family, i.e., spouse, children, and even parents who may be living in the same household.

COUNSELING THE FAMILIES OF ALCOHOLICS

What is the family's role in the treatment of the alcoholic? Many people have written about various types of families of alcoholics; they have given them a number of labels. Some have been called "sick families," "maladjusted families," "neurotic families," etc. However, in my experience I prefer to see them as *disorganized families* in which the disruption of the family milieu occurs with the progression of the alcoholic member's disease. The dynamic interaction between the family members breaks down because of the chronic addiction of the alcoholic spouse. It has been said that most families wait at least nine years from the time the spouse first begins to have difficulty with drinking until they seek some type of help. During this period a process of disorganization is occurring as the problem increases, together with the fact that the family must also handle the stigma which society places upon the disease of alcoholism.

Initial Evaluation and Planning

In working with the family of an alcoholic, one must see the nonalcoholic spouse and the children as well. Of course, it is taken as a given

fact that the very young children will not be seen, but it is my belief that children as young as nine or ten years of age should be included in the family evaluation. One of the best evaluation techniques is a home visit by the social worker. This provides a diagnostic evaluation of the family in a familiar setting. It should be scheduled at a time when all the family members will be present, especially the alcoholic spouse. The worker is then able to evaluate the family dynamics—the interaction which is occurring within the family milieu in their usual setting, not in an artificial office setting. After the initial home visit and evaluation, there is no reason why subsequent meetings could not be held in the worker's office, agency, or facility.

Following the evaluation at the home level, in which an attempt is made to find out about the family dynamics, the stability of its interpersonal relationships, its psychosocial functioning, the roles of family members and their places in the community, an important question must be asked, i.e.: "When am I going to start to work with this family, and how frequently will I see them?" It is generally good practice not to see the family too soon (before the alcoholic is ready), since timing is an important aspect of work with alcoholics. The reason for this is as follows: If the family of the alcoholic has become involved in treatment before the alcoholic has been able to feel comfortable with his therapist, he will be threatened by the family's comments and accusations during the treatment session. This is not to say that one should never see the family initially for an evaluation, just as was done for the patient. It is wiser, however, to bring the family in at a later point in time if possible. Ultimately, sessions should be held with all the family members present, both the alcoholic spouse and the non-alcoholic spouse, together with the children. If necessary, the non-alcoholic spouse can be seen on an individual basis as well as in the family group therapy session.

In trying to evaluate what is occurring within the family milieu, the social worker must ask the family members how they view the problem of the alcohol ingestion by the client. Do they see this only as an annoyance, or are they partly satisfied with his behavior when drinking and only wish to get him to cut down on his intake? If this is the case, then it is certain that the family has little or no knowledge about the disease of alcoholism, and that when they try to help, they will, in many instances, create more difficulties for the alcoholic member, which in turn often lead him to a greater ingestion of alcohol.

It is imperative for the social worker to impart factual knowledge about this disease to the family. Furthermore, the family must be aware that when the individual stops drinking, it does not mean that everything is fine, that there are no longer any problems, or that all crises are over.

They must understand the nature of the disease, its implications, and the fact that crises will occur and can in fact be anticipated to occur more frequently following the stopping of ingestion of alcohol. Furthermore, the family must not see the cessation of drinking alcohol as a "cure" to all of its problems.

Effect on the Children

It is most important in working with alcoholics to evaluate the interaction between the family members and to find out how the various members view each other's roles in relation to this problem. In general, children tend to see the father in the role of "someone" who is in the background; this is the case when the father is the alcoholic, with the mother assuming the authoritarian or "head-of-the-house" role. Many times she is forced to be the father, the breadwinner, the arbitrator, and so on for the family. If the children are going through puberty and adolescence during this period, this in itself makes for a great deal of difficulty in their adjustment to life, and must be considered as well. Children are most affected by this disease and its impact upon the role of the mother, as well as that of the father, since invariably the mother's role becomes stronger as the father's weakens; frequently he becomes as another child in the family. I recall one patient who, when he was trying to work toward sobriety, and had been sober for some time, was sitting at his dinner table when his older boy asked his mother for the keys to the car for that night. Father was extremely insulted and said, "How dare you ask your mother, and why shouldn't you ask me?" and he proceeded to scold his son for disrespect, since he, the father, was head of the household, etc. The boy left the table in tears, and the mother later on commented to her husband, "Won't you realize that this is one of the infrequent times that you have been at the dinner table sober and aware of what is going on."

It is important for families, especially the children, to understand what is occurring during this time of treatment. The children need to be aware that there are going to be times when the parent will be extremely irritable and upset because of his difficulty in maintaining his sobriety. This is where interpretation to the family, support, and encouragement can be very beneficial, not only to them but to the alcoholic member of the family. They, in turn, are able to give him the necessary support and encouragement which he needs to stay sober. He must have this understanding and support of his family along with the support and understanding of the social worker, his employer, and the community.

Planning Long-Term Goals

One of the most important factors families must learn is the "setting of goals" during this period of sobriety. Sometimes families have been in

such stages of distress and discomfort during these years that when the alcoholic member has stopped drinking and has returned to work, family members tend to set too high a goal for themselves and the alcoholic member. This is self-defeating to the alcoholic. Families must know that only realistic goals can be planned in terms of what can be expected and achieved by someone who has this illness and is striving for his sobriety. Many times, in working with the family, we have to let them know that the alcoholic wishes to obtain things for them, desires a better home, better furniture, or whatever the economic needs might be, but he isn't capable of this as yet. Things must be taken slowly, for if the goals are set too high they become overwhelming to the point that a relapse occurs. When this happens the family generally will revert back to their old way of handling the alcoholic member when he was drinking—"rejection." It is important, then, for family members to be aware of all the many factors which must be considered while the alcoholic is being treated. They must be aware that when the alcohol ingestion is stopped it sometimes takes a year or longer for "alcoholic thinking" to disappear. This simply means that the patient was used to handling things in a rigid and extremist manner while he was drinking, that there was a certain compulsiveness about everything he did, that he was impulsive and tended to rush into things. This is a learned pattern of behavior which occurred with his progressive addiction to alcohol. These behavior patterns tend to continue after sobriety occurs. Family members must learn to understand and handle this alcoholic thinking, being realistic in their approach to its gradual diminution over a long period of time.

CONCLUSION

Social [illegible] if they are willing to accept the challenge to use their skills and techniques in working with them and their families. It is my belief that our traditional casework methods are appropriate to use in working with the alcoholics in our population. Caseworkers in private or public agencies, in hospital settings, or elsewhere will all encounter alcoholics or members of their family who need help.

Some of the traditional methods, with modification, are very useful tools in helping the alcoholic and his family to regain their place in society. Interviewing, counseling, insight, supportive therapy, to name a few, together with an acquired knowledge of the disease and a willingness to understand and accept the alcoholic as a sick person, will permit social workers to make contributions in this vast area of need.

For years our profession has been "urging that social work expand on the basis of a needed service. . . . social workers are now found in industry, research, urban renewal, peace corps, as consultants to many federal, state

and local governments, as well as in the anti-poverty programs."[4] Since social workers have in the past risen to accept the challenges on the basis of need, are we now to ignore the millions of alcoholics and their families who could benefit from our help?

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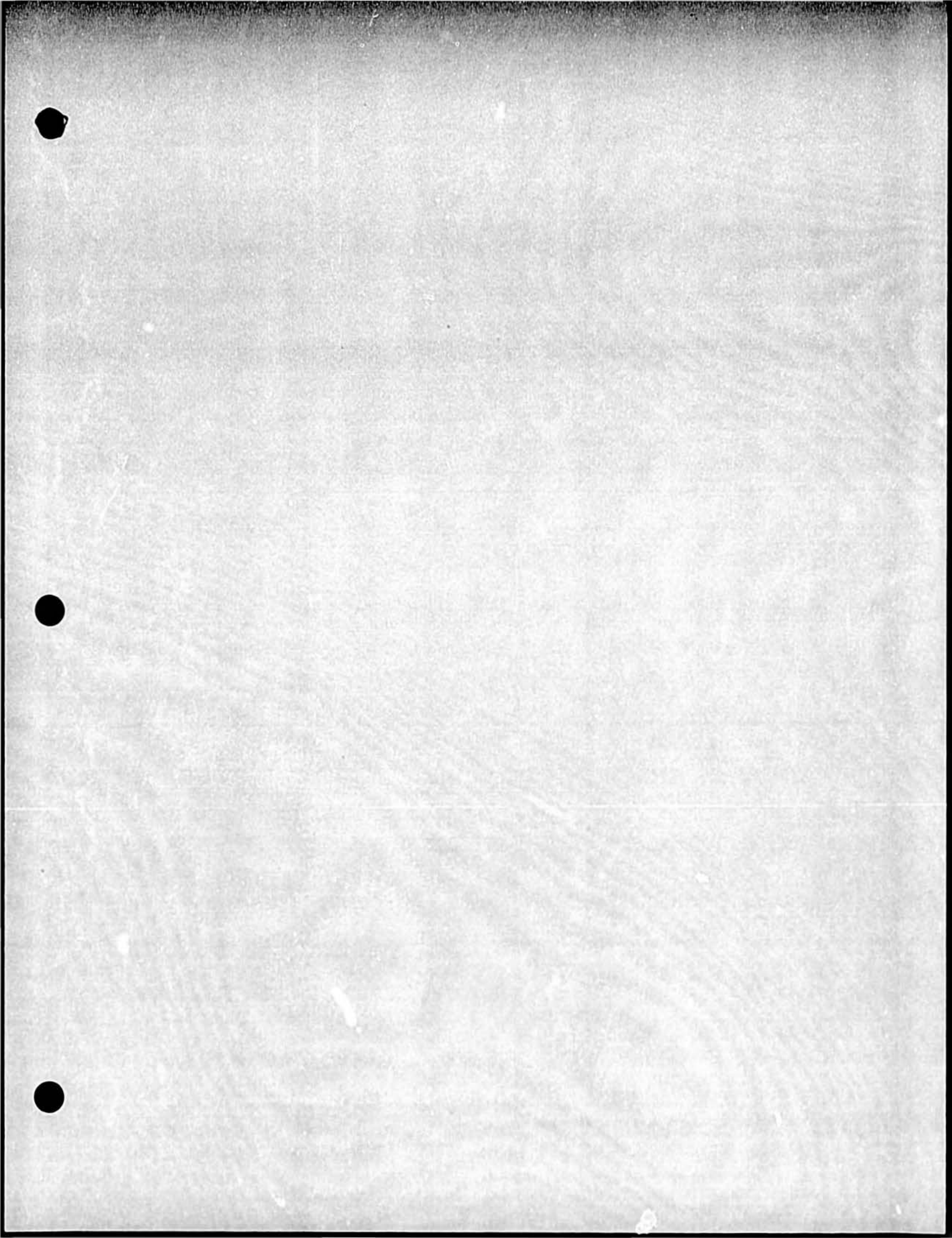

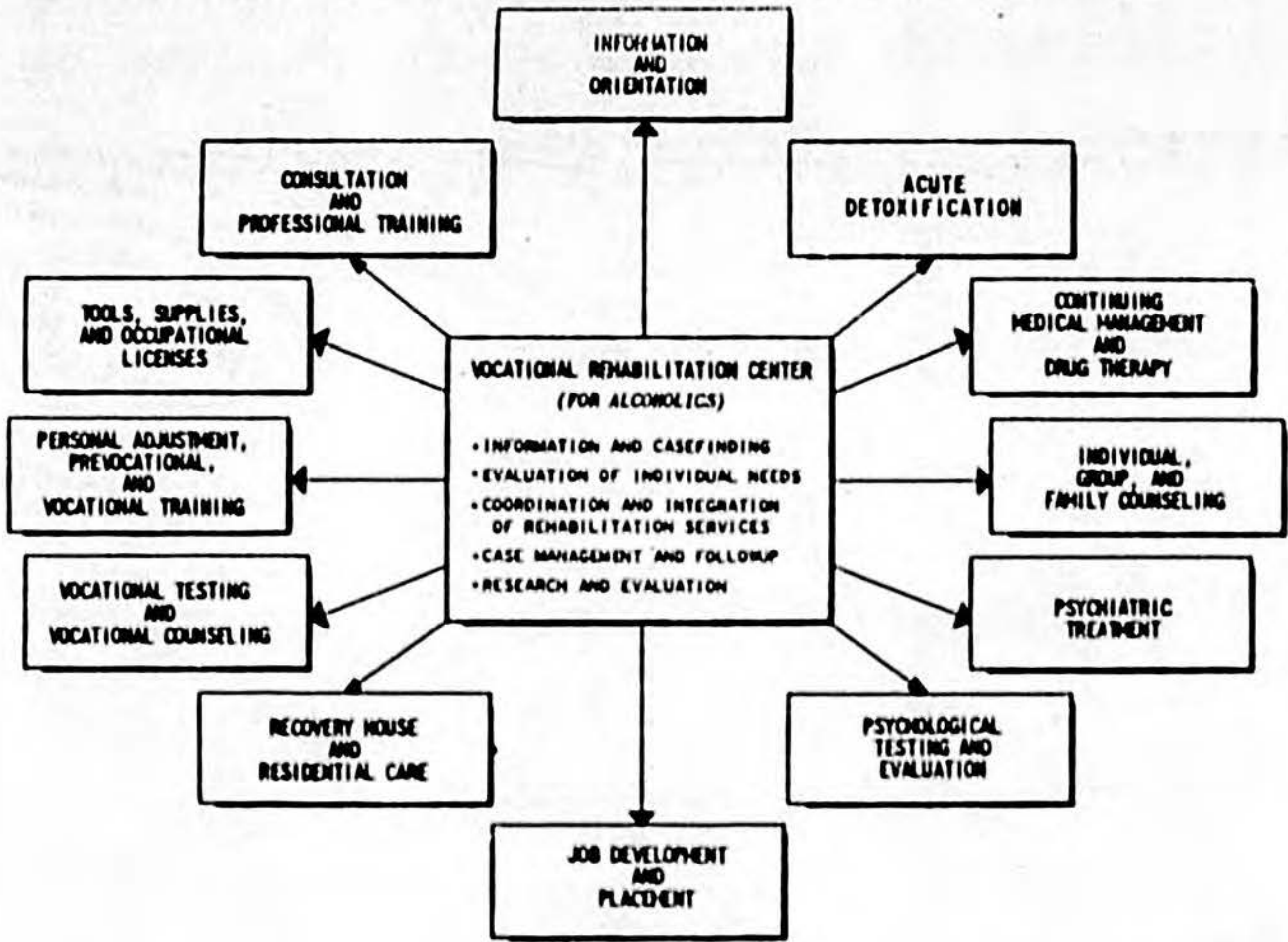

Chart 17-1.

some training, can often conduct groups effectively where the goal is to guide the alcoholic in dealing with reality situations. It is helpful, wherever possible, to employ rehabilitated alcoholics as ward personnel provided they have been dry a sufficient length of time and have demonstrated enough basic personality strength to be of assistance to the patients. It is important in maintaining morale to be certain that the opinions, observations, and feelings of all levels of personnel be shared, respected, and incorporated into the program when a consensus shows that they are acceptable. The director of a program of this sort has a grave responsibility in maintaining a high level of morale, in promoting respect for and acceptance of the patients, and the employment of his personnel to maximum effectiveness in keeping with their own personality attributes.

General Goals of a Rehabilitation Program

The general goals of a state hospital program for alcoholics may be epitomized as follows:

1. *To promote efforts which will help to reveal to the alcoholic his basic failure to handle anxiety, hostility, and depression effectively.* This is best done in constant interaction with others, because at the time the problem is brought into consciousness he has the group available both to clarify his thinking and to make suggestions as to how he can better handle his feelings.

2. *To encourage the alcoholic to ventilate his feelings, especially rage, and at the same time continue in maintaining his acceptance by the group.*

3. *To establish in the alcoholic the recognition that he has levels of tolerance for his own feelings, that these levels of tolerance can be heightened, and that the feelings can be drained off effectively without recourse to alcohol.*

4. *In group and in individual discussions, to encourage the alcoholic to see what aspects of his life, what environmental circumstances, and what personal relationships have led him to intolerable rage and anxiety reactions which have been assuaged only by alcohol.*

5. *To get the alcoholic to accept the realities of his relationship with people and events in his environment, to reinforce his personality strengths, and to understand the advantages and desirability of remaining sober.*

6. *To get him to understand while he is in the hospital that sobriety alone will not solve all his problems.* He must be helped to realize that financial, social, and cultural stresses will continue to arise in his external environment, but that there are methods available for translating his feelings into actions which are acceptable to himself and to the community without recourse to alcohol.

7. *Above all, to recognize that alcoholism as a problem and as an illness must be approached directly.* Indirect approaches through personality defects are futile and time-wasting. In this regard, Moore, quoting from Shea, has stated: "First of all alcoholism must be tackled directly; it cannot be expected to perish by attrition when the fundamental neurotic roots are crushed. Such technique, in my experience, always fails. The alcoholism flourishes protectively and the neurosis is never cornered. The surest way to tackle the alcoholism directly is to make non-alcoholism an affective issue with the patient."

THE CENTRAL ISLIP PROGRAM

History and Development

Central Islip State Hospital at Central Islip, New York, is a nine-thousand-bed State hospital with a variety of specialized services including two resident treatment centers for children, a geriatric rehabilitation unit, narcotic addiction unit, research unit, and general psychiatric intensive care admission service. Prior to 1957, certified psychotic male alcoholics were domiciled in the admission unit or in continued treatment wards without special facilities. In that year an antiquated building was partly refurbished; male alcoholics only were admitted to the building; an interested psychiatrist supervised the building in addition to other duties; and Alcoholics Anonymous contacts were encouraged. The results were encouraging, and by 1962 the New York State Department of Mental Hygiene had made available additional funds for greater improvement in the building and a full-time staff of medical and paramedical workers. Thus it became possible to admit nonpsychotic alcoholics directly on a voluntary basis. In 1965, Federal funds were made available to supplement the project, and, in 1966, a unit was opened for women which operates along the same general lines as the male unit. Although State law permits the certification of voluntary alcoholics, the patients selected for admission to the special rehabilitation units are either voluntary or have been converted to voluntary status while in the hospital. Each unit has sixty beds, and each is in a separate building with its own recreational, occupational, classroom, and meeting-room facilities.

Staffing

Each rehabilitation unit has its own staff, consisting of a supervising psychiatrist, two senior psychiatrists (male unit)—one senior psychiatrist (female unit). Each unit has a full-time psychologist, recreational therapist, charge nurse, and psychiatric aides in a one-to-five ratio with patients. Two alcoholism counselors are assigned to the male unit, and one to the

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Alcoholism
The Total Treatment Approach

2. There has been very little difficulty with drinking during the patient's stay in the units. Despite their freedom to roam about the hospital grounds and to enter the nearby community with a pass, less than 3 per cent of the patients indulge in drinking while staying in the hospital.

3. Recidivism is a problem, in a sense, but patients are encouraged to return to the hospital as soon as possible if they encounter difficulties on the outside, preferably before they start to drink or shortly after drinking has occurred. There is evidence that with this liberal policy drinking bouts tend to become shorter, and periods of sobriety tend to become longer.

4. Because of difficulty in evaluating the success of the unit by follow-up procedures in a drifting population, the members of which are often lost in the large New York metropolitan area, it has been necessary to use psychological questionnaire techniques to determine whether or not a change in attitude toward alcohol occurs while the patient is in the hospital. Present evidence shows that there is a statistically significant change in attitude, with more realistic acceptance of the drinking problem, establishment of definite goals directed toward sobriety, and rudimentary understanding of emotional factors involved in drinking.

5. By the use of frequent informal conversations between personnel, the encouragement of the patient to engage in decision-making, the free exchange of opinion between staff and patients, and the combination of structured and unstructured programming, morale is high in both patients and staff. Patients tend to develop a healthy dependency on the unit and its staff members, are reluctant to "let the unit down," and often incorporate the unit morale into their defense against subsequent drinking.

6. Estimates of effectiveness are difficult, but it appears that between 15 and 20 per cent of the patients are remaining dry for periods up to a year after leaving the unit; many are now dry for as much as four years; and many others return to the hospital periodically and continue to get help even though they do lapse into drinking while outside. The latter group constitutes about one-third of the admissions, but they also constitute a group which, hopefully, will ultimately achieve complete sobriety.

SUMMARY

[illegible] established both in practice and in theory. Experience has shown that it is practical to establish rehabilitation units in state hospitals which are helpful in avoiding the chronicity and deterioration formerly seen in the state hospital alcoholic population. These units carry considerable promise for the future in reversing these processes and in producing functionally competent, socially acceptable citizens out of what formerly constituted one of the most hopeless segments of the hospital population.

Alcoholism
The Total Treatment Approach

planning and organization is being supplanted by the development of services to the individuals who need them.

Each community mental health center will decide on the manner in which it provides services for alcoholics and other problem drinkers, but, in making those decisions, the staffs of the centers can now request technical assistance from the National Center for the Prevention and Control of Alcoholism. The Consultation and Training Section of the National Center is responsible for liaison with community mental health centers programs and the state grants-in-aid programs to provide encouragement for, and advice on, the inclusion of alcoholism components in their service programs. As this liaison develops, alcoholism programs—developed locally—can receive the benefits of knowledge collected nationally as it relates to research, the training of manpower, and the content of service programs.

ALCOHOLISM AND MENTAL HEALTH

By establishing the National Center for the Prevention and Control of Alcoholism within the framework of the National Institute of Mental Health, the Federal government has decided, for its practical purposes, that there is a major relationship between alcoholism and mental health services.

Some individuals and organizations do not agree, and maintain that alcoholism is not a mental health problem, but one of "drinking," or of willpower, or religious conviction. However, when one accepts the premise that alcoholism is indeed a mental health problem, the relationships between mental health and alcoholism are diverse, and are still based on a variety of specific points of view.

Clinically, alcoholism is seen as an effect and/or a cause of mental disorder or emotional problems—for the individual whose drinking is uncontrolled, for his family, his colleagues, and any others affected by his actions.

Administratively, alcoholism programs, financed in whole or in part by state funds, are in some cases supervised by the state mental health agency and in other instances are independent of it.

Legally, the alcoholic is, in some jurisdictions, considered to be ill and mentally disabled, while in other places and circumstances he is subject to statutes delineating such matters as commitment or a jail sentence.

When he desires treatment, or when treatment is ordered, the problem drinker may be encouraged to seek treatment or other mental health services in a general hospital psychiatric ward or an outpatient psychiatric clinic. On the other hand, such facilities, by their admission and service policies, may expressly refuse to treat him.

Because of these, among many other reasons and attitudes directed toward him, the problem drinker, confused at best, is faced with confusion

among the health facilities, the health services, the social agencies, the courts and the correctional personnel, and the vocational rehabilitation programs existing and operating within his community, as well as by conflicting policies of voluntary organizations.

THE ROLE OF THE COMMUNITY MENTAL HEALTH CENTER

The community mental health center, taking all these factors into account, must decide the size, scope, and content of its program of services available to the problem drinker. There can be no doubt that services *will* be available to him, if the mental health center receives financial support from the Federal government, since that support is predicated on the equal availability of mental health services provided by the center to all residents of the area served by it.

The regulations of the Community Mental Health Centers Act, under which grants are awarded to centers, require that the center provide services of high quality to community residents, without discrimination as to race, ability to pay or not to pay, length of residence in the area, or the type or severity of emotional disturbance or mental disorder.

Before deciding, then, how to serve the patient whose primary diagnosis may be alcoholism, schizophrenia, mild anxiety, deep depression, or an acute suicidal crisis, it is first necessary to understand the concepts on which the entire national mental health program and the community-based service program were developed.

By 1963 it was obvious that treatment of the mentally ill was, in large measure, ignoring the available knowledge about treatment, and was settling in too many instances for impersonal care that was primarily custodial and, by its focus on large and isolated institutionalized settings, often harmful rather than curative.

Very simply, the concepts of the community mental health center were developed on these premises:

> That a community could and should provide treatment for mental illness and services to promote mental health within that community;
>
> That at least five basic services were necessary—inpatient service, outpatient service, partial hospitalization, emergency service, and consultative and educational services;
>
> That each individual patient should be treated at any given day in the service most appropriate for him in terms of the nature and severity of his illness, and that he should be transferred without delay to any of the other services when his recovery or regression indicated need for such a transfer.

When a community mental health center provides these elements of

HEALTH INSURANCE COVERAGE FOR ALCOHOLISM:

STATE LEGISLATIVE AND REGULATORY ACTIVITIES

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HEALTH INSURANCE COVERAGE FOR ALCOHOLISM:

STATE LEGISLATIVE AND REGULATORY ACTIVITIES

I. INTRODUCTION

This report is one of a series whose purpose is to explore and provide information on the various facets surrounding health insurance coverage for alcoholism.[1,2] These reports have been prepared for and sponsored by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) as a part of their effort to enhance third-party payments for alcoholism treatment.[2]

The NIAAA and its predecessor, The National Center for Prevention and Control of Alcoholism, have long maintained an acute interest in the development of health insurance coverage for alcoholism. Preliminary studies in 1968 and 1972 served to provide baseline information on the nature and extent of health insurance coverage for alcoholism; importantly they identified major factors critical to more effective utilization of this health service payment mechanism.[1,2] For example, the 1972 study concluded that: (1) public and private insurers lag behind expressed or implicit service needs; (2) the insurance industry emphasizes hospital care as the treatment arena for alcoholism in spite of other less expensive alternatives; (3) the insurance industry frequently applies sanctions against claims for <u>alcoholism treatment</u> <u>per se</u>, yet appears to condone the use of pseudo-diagnoses which are used as a cover for alcoholism treatment; and (4) the costs of treating alcoholism (which are in fact poorly known) are frequently used as arguments against underwriting this condition.

Following these studies the NIAAA in late 1972 began to formulate a comprehensive work program designed to ultimately maximize third-party

payments for alcoholism focused on the development and costs of model health insurance benefit provisions, and the development of alcoholism treatment standards.* Another element of the work program which is the subject of this report, concerns the development and status of state insurance regulations specifically dealing with insurance benefits for the treatment of alcoholism. This report details the findings of a national survey of state insurance regulatory agencies as well as interviews with legislators from states in which legislation pertaining to health insurance coverage for alcoholism is pending or has been enacted.

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*See for example J. B. Hallan, "Health Insurance Coverage for Alcoholism: Model Benefit Provisions," unpublished report prepared for the National Institute on Alcohol Abuse and Alcoholism, 1973.

II. SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

This study has examined the nature and extent of state legislative and regulatory activities concerning health insurance coverage for alcoholism. State insurance regulatory agencies were queries via a mailout questionnaire. Legislative activities were examined through structured interviews with state legislative officials.

The study revealed that only four states (Illinois, Massachusetts, Minnesota, and Wisconsin) have passed some form of enabling legislation or statute concerning mandatory inclusion of health insurance benefits for alcoholism. Comparison of enabling legislation between these four states reveals that all require mandatory inclusion of alcoholism treatment benefits for group insurance plans while only one state (Massachusetts) requires such coverage in individual plans. Actual benefits provided by the enabling legislation among the four states range from no specification to a fixed number of inpatient days of care; only one state requires outpatient care. State regulations promulgated from existing statutes contain essentially the same language as the enabling legislation, i.e. there has been no expansive or narrow interpretation of enabling legislation by regulatory agencies.

Six states (Alaska, Michigan, Mississippi, Nebraska, Oregon, and Washington) were found to have legislation pending concerning health insurance coverage for alcoholism. The pending legislation is encouraging inasmuch as a) four out of the six states will require coverage in individual plans (as well as group plans), and b) four states will require the provision of outpatient benefits.

Finally, only one state (Arkansas) which has no new or pending legislation concerning health insurance coverage for alcoholism is planning the development

of regulations in this area. Apparently sufficiently broad statutory authority exists for the Arkansas Insurance Department to take this step. About 90 percent of the state respondents however do not currently have such authority. It should be noted that none of the states with existing regulations or pending legislation make any explicit provisions for intermediate care.

Regulatory agency information needs, operations and perceptions regarding health insurance coverage for alcoholism may be summarized as follows:

(1) Those states with existing regulations have used information from a variety of sources as an aid in regulation development: uniform regulatory language was considered useful in such efforts,

(2) Little useful information concerning treatment costs, benefit payments or carrier effectiveness in handling claims is being collected,

(3) A majority of respondent states not only perceive that health insurance should provide coverage for alcoholism but also that statutes/regulations are necessary to assure such coverage, and

(4) Most states felt that current regulations do not assure adequate coverage for alcoholism coverage.

Interviews with legislative officials of eight states revealed:

(1) Legislation in most cases was originated by persons with a professional or intense personal interest in this area.

(2) Legislators operate from a less than ideal position inasmuch as little information is available to them which allows for adequate preparation of legislation.

(3) The insurance carrier industry has in general moved from a position of active opposition of health insurance coverage for alcoholism to a position of providing useful information and aid in the preparation of legislation.

(4) Labor and management groups have been supportive of this type of

legislation and have in general not expressed concern with treatment costs.

(5) Hospital and physician groups have favored legislation which specified hospital treatment by qualified physicians.

(6) In the past outpatient benefit provisions have received little support although the picture is changing as evidenced by pending legislation in the various states.

Thus in summary it appears that state efforts to achieve health insurance coverage for alcoholism are only beginning. While only four states have enacted legislation and six states have pending legislation, the majority of state regulatory agencies indicated the desirability of such legislation. Unfortunately the benefits assured by either passed or pending legislation are quite varied with minimal emphasis on individual contracts and more importantly on care received in an outpatient setting.

Conclusions suggested from the study include

(1) that there is indication of the carrier industry responding to the expressed concern of the public,

(2) that traditional health care providers are advocates of only traditional forms of care (i.e. inpatient, physician based treatment),

(3) that there is a need to provide legislators with accurate and timely information on the status of health insurance consumers and the emerging forms of care which are <u>not</u> of an inpatient nature,

(4) that state legislation is perhaps the most promising method of assuring adequate third-party payments from the private health insurance sector for alcoholism treatment, and

(5) that state legislation concerning health insurance coverage for alcoholism should have as a minimum provision which requires that alcoholsim be covered as any physical disease is covered and as a

maximum precise specifications for inpatient <u>and</u> outpatient coverage. Draft model regulatory language embodying these conclusions will be found in Appendix C to this report.

It would appear that an effective program concerning third-party payment mechanisms for alcoholism can best be mounted in an arena of cooperation and sharing of information; therefore,

(1) It is recommended that the National Institute on Alcohol Abuse and Alcoholism consider the establishment of an in-house staff position and a consultation group to actively seek out and provide consultation to states which are considering or have legislation pending concerning health insurance coverage for alcoholism. It will be the function of this group to

   (a) develop a background package of materials (including a glossary, treatment cost data, experiences of other states, legislative language, etc.) to aid in the development of legislation appropriate for the state,

   (b) to schedule meetings (on a routine basis) with the various legislators to provide information and support, and

   (c) provide an interface between the insurance carrier industry and the National Institute on Alcohol Abuse and Alcoholism.

(2) It is also recommended that the National Institute on Alcohol Abuse and Alcoholsim consider the sponsoring of a series of regional seminars concerning the development of legislation for health insurance coverage for alcoholism. Potential attendees would be legislators and regulatory agency officials. The seminars would include a didactic presentation of existing and pending legislative efforts and their ramifications, alternative methods of treatment of alcoholics, treatment costs, and desirable health insurance coverage for alcoholism.

III. BACKGROUND

As alluded to above, interest in state regulation of health insurance coverage for alcoholism stemmed from recognition of (1) state authority and ability to impose or specify minimum health insurance benefits vendered by carriers operating within state boundaries, and (2) a growing interest by state legislatures in promulgating statutes which deal with health insurance coverage for alcoholism. For the purpose of this report, it is useful to explicate several salient aspects of the establishment and operational history of state regulatory insurance agencies or insurance departments. (More detailed explanations can be found in the many texts concerning insurance regulation, taxation and investments -- see for example: E. J. Faulkner, Health Insurance, New York: McGraw Hill Book Co., 1960.) During the early history of the United States the regulation of insurance was viewed as a power reserved for the states and beginning in the 1850's state agencies were charged with the responsibility of insurance regulation. In 1945, the McCarron-Ferguson Act (P.L. 15 of the 79th Congress) formally recognized the right of states to regulate and tax the business of insurance.[2] Because of the potential regulatory diversity among the various states, the National Association of (State) Insurance Commissioners was formed and over the years has done much to establish adequacy and uniformity.

In general states are empowered to regulate the nature and extent of insurance contracts, the cost of insurance and the conduct of the insurance carrier (i.e. policy, price, and procedure). In the area of policy, the National Association of Insurance Commissioners has been instrumental in the development of uniform guides for accident and sickness benefit provisions; it has not, however, recommended minimum benefit provisions because of a

feeling that public needs can better be met in a competitive market place. In the area of insurance costs there is also a tendency to let the competitive market place act as the regulation. The procedures or conduct of health insurance carriers on the other hand are rather strictly regulated through various state laws and rulings more or less uniform throughout the United States. Finally, state insurance departments have state statutes or laws as the legal basis for regulatory activities. The statute language may range from a broad to a highly explicit nature and from that authority various administrative rulings or interpretations are made. Thus actual regulation of carriers is accomplished through both statutory and administrative rule language.

During the past several years legislatures of the many states have displayed increasing interest in the consideration of legislation which mandates through regulation that insurance carriers provide some form of benefits for treatment of alcoholism. This report examines the nature and extent of enacted or pending legislation, regulations emanating therefrom and regulatory agency activities and perceptions related to health insurance coverage for alcoholism.

IV. METHODOLOGY

State regulatory activities concerning health insurance coverage for alcoholism were determined through the use of a survey instrument mailed to the regulatory agencies. The survey instrument was designed to gather information about the following:

(1) Agency functions and current or planned regulations concerning health insurance coverage
(2) The regulatory development process
(3) Agency operations
(4) Agency perceptions concerning health insurance coverage for alcoholism

Questionnaires were sent to all the states, the District of Columbia and to the territory of Puerto Rico. Telephone followups were made to non-responding states about three weeks following the questionnaire mailout. Overall response to the questionnaire was good with 47 out of 52 returned. In spite of repeated calls, the District of Columbia and the states of Massachusetts, New Jersey, New York, and Washington did not respond. A facsimile of the instrument used to survey the states will be found in Appendix A.

In addition to information gathered by the survey instrument, legislators were interviewed in eight states which had passed or were considering legislation concerning health insurance coverage for alcoholism. States in which the interviews took place included Alaska, Illinois, Massachusetts, Michigan, Mississippi, Nebraska, Washington, and Wisconsin. The interviews were of a structured nature, were designed to assess legislative activities as well as gather information on lobbying activities and perceptions of legislative needs. A copy of the structured interview guide will be found in Appendix B.

V. FINDINGS

A. Nature of Health Insurance Regulated by Agency Respondents

Table 1 provides a summary of health insurance regulated by the various 47 state agency respondents. Better than 90 percent of the respondents indicated that they regulate disability and hospital care insurance and about 70 percent indicated regulatory authority over health personnel insurance. Only about 57 percent indicated that they had regulations covering health maintenance organizations.

TABLE 1

NATURE OF HEALTH INSURANCE REGULATED BY STATE AGENCIES

Type of Insurance	Percent of 47 Agency Respondents
Disability	96
Hospital Care	
Group	93
Individual	91
Physician or Other Health Personnel Services	
Group	70
Individual	67
Health Maintenance Contracts	57

Source: Health Insurance Coverage for Alcoholism Survey data, 1974.

B. Status of State Legislation Concerning Health Insurance Coverage for Alcoholism

The current status of state legislation relating to health insurance coverage for alcoholism as of February, 1974 is presented by state in Table 2; Tables 3 and 4 provide summaries of existing and pending state legislation respectively. As may be seen from Table 2 a majority of the states have neither enacted nor have pending legislation concerning health insurance coverage for alcoholism. Only four states (Illinois, Massachusetts, Minnesota, and Wisconsin) have passed some form of enabling legislation or statute concerning mandatory provision of health insurance benefits for alcoholism (see Table 3). Comparison of existing legislation between these four states as shown in Table 3 reveals that all require mandatory inclusion of alcoholism treatment benefits under group insurance plans while only one state (Massachusetts) requires such coverage under individual plans. Each of the four states requires inpatient benefits in their regulations, while only the state of Massachusetts requires outpatient benefits. The nature of the benefits provided for by the regulations is quite variable from state to state. Two states (Massachusetts and Minnesota) specify a minimum number of days of care, while the state of Illinois provides no specification. The state of Wisconsin specifies that alcoholism treatment benefits must be substantially equal to existing policy provisions for mental and nervous conditions or other general conditions. Outpatient coverage as provided for by the state of Massachusetts establishes a $500/year minimum benefit. Legislation enacted by these four states in general requires that care be provided in a hospital or other facility licensed by the state.

As shown in Table 4 legislation concerning health insurance coverage

TABLE 2

STATE LEGISLATION RELATING TO HEALTH INSURANCE COVERAGE FOR ALCOHOLISM AS OF FEBRUARY 1974

State	No Legislation in Process or Enacted	Legislation in Process: Senate	Legislation in Process: House	Legislation Enacted Into Law	Nature of Planned or Existing Legislation
ALABAMA	X				
ALASKA		Passed	Pending		Requires that all group health and disability insurance policies provide benefits for inpatient alcoholism care in a hospital or treatment facility licensed by the state as a comprehensive intensive treatment care facility for alcoholics.[1]
ARIZONA	X				
ARKANSAS	X				
CALIFORNIA	X				
COLORADO	X				
CONNECTICUT	X				
DELAWARE	X				
FLORIDA	X				
GEORGIA	X				
HAWAII	X				
IDAHO	X				
ILLINOIS				1973	Requires all group accident and health insurance to provide inpatient hospital coverage for alcoholism treatment. Covered treatment must be provided in a state licensed hospital or state approved alcoholism treatment facility.[2]
INDIANA	X				
IOWA	X				
KANSAS	X				
KENTUCKY	X				
LOUISIANA	X				
MAINE	X				
MARYLAND	X				

TABLE 2 continued

State	No Legislation in Process or Enacted	Legislation in Process		Legislation Enacted into Law	Nature of Planned or Existing Legislation
		Senate	House		
MASSACHUSETTS				1973	Requires group health insurance policies, group or non-group employee health and welfare funds, individual or group hospital service contracts and individual or group medical service contracts provide minimum inpatient benefits of 30 days per year and minimum outpatient benefits of $500 per year. Facilities must be so licensed by the State Department of Public Health.[3]
MICHIGAN		Pending	Passed		Requires individual insurance policies to offer coverage for inpatient treatment of alcoholism and drug abuse, and requires all group disability insurance policies to provide coverage for inpatient and outpatient treatment of alcoholism and drug abuse. Facilities must be approved by the Department of Public Health.[4a]
					Requires non-profit medical care corporations to offer benefits for group subscribers for the inpatient or outpatient treatment of alcoholism and drug abuse by a licensed physician or osteopathic practitioner in a facility approved by the Department of Public Health.[4b]
					Permits non-profit hospital service corporations to enter into contracts for alcoholism and drug abuse treatment with a licensed facility approved by the Department of Public Health which provides inpatient or outpatient care for alcoholism and drug abuse and which meets the standards set by the non-profit hospital service corporation for such contracting facilities.[4c]
MINNESOTA				1973	Requires all group health, medical, hospitalization, accident or sickness insurance policies or plans to provide for treatment of alcoholism in a licensed hospital or a licensed residential primary treatment program. Coverage shall be a minimum of 20 percent of total patient days allowed by the policy and must be at least 28 days per year.[5]

State	No Legislation in Process or Enacted	Legislation in Process		Legislation Enacted Into Law	Nature of Planned or Existing Legislation
		Senate	House		
MISSISSIPPI		Passed	Pending		Requires that all group and nongroup accident or health insurance policies provide benefits for the care and treatment of alcoholism on the same basis as other health service benefits. Individual policy holders have the option to reject alcoholism benefits.[6]
MISSOURI	X				
MONTANA	X				
NEBRASKA		Pending in the single Nebraska legislative body			Requires group and individual accident and sickness insurance contract, policy, or certificate to provide hospital treatment of alcoholism. A hospital as used here is any facility providing inpatient alcoholism treatment and licensed by the Department of Health.[7]
NEVADA	X				
NEW HAMPSHIRE	X				
NEW JERSEY	X				
NEW MEXICO	X				
NEW YORK	X				
NORTH CAROLINA	X				
NORTH DAKOTA	X				
OHIO	X				
OKLAHOMA	X				
OREGON		Pending			Requires group health insurers to provide benefits for mental and nervous conditions. Benefits must include a minimum of 30 inpatient hospital days per year and 50 percent of major medical expenses (up to a maximum of $500 per year) while receiving non inpatient care.[8]
PENNSYLVANIA	X				
RHODE ISLAND	X				
SOUTH CAROLINA	X				
SOUTH DAKOTA	X				
TENNESSEE	X				
TEXAS	X				
UTAH	X				
VERMONT	X				
VIRGINIA	X				

TABLE 2 [illegible]ntinued

State	No Legislation in Process or Enacted	Legislation in Process		Legislation Enacted into Law	Nature of Planned or Existing Legislation
		Senate	House		
WASHINGTON		Pending	Passed		Requires all group disability insurance contracts (including those of a health maintenance organization nature) to provide benefits if care is received in an approved treatment facility or a facility accredited by the State's Department of Social and Health Services. All extended or major medical policies whether group or individual must contain similar benefits.[9]
WEST VIRGINIA	X				
WISCONSIN				1972	Requires all group accident and sickness contracts to provide inpatient hospital care benefits for alcoholism of a "substantially" equal nature to those provided for treatment of mental or nervous conditions or other general conditions.[10]
WYOMING	X				
DISTRICT OF COLUMBIA	X				
PUERTO RICO	X				

[1] Alaskan Senate Bill No. 35, Alaskan Senate, 1973.
[2] Public Act 78-767, General Assembly State of Illinois, 1973.
[3] Chapters 175, 176A, 176B, General Laws of the Commonwealth of Massachusetts, 1973.
[4a] House Bill #5263, Michigan House of Representatives, 1974.
[4b] House Bill #5390, Michigan House of Representatives, 1974.
[4c] House Bill #5391, Michigan House of Representatives, 1974.
[5] Senate File No. 1895, Minnesota State Senate, 1973.
[6] Senate Bill No. 1746, Mississippi Senate, 1974.
[7] Legislative Bill 127 and amendments, Legislature of Nebraska, 1973.
[8] Senate Bill 176, Oregon Legislative Assembly, 1973.
[9] House Bill No. 1077, Washington House of Representatives, 1974.
[10] Chapter 325, Laws of 1971, State of Wisconsin, 1972.

TABLE 3

SUMMARY OF EXISTING STATE LEGISLATION CONCERNING HEALTH INSURANCE COVERAGE FOR ALCOHOLISM AS OF FEBRUARY 1974

State	Insurance Contracts Covered	Individual Coverage	Group Coverage	Inpatient		Outpatient	
				Benefits	Place of Care	Benefits	Place of Care
Illinois	Accident & health	No	Yes	Not specified	State licensed hospital	Not covered	---
Massachusetts	Health insurance	Yes	Yes	30 days minimum	Facility licensed by state	$500/yr. minimum	Facility licensed by state
	Employee & welfare funds	Yes	Yes				
	Hospital service	Yes	Yes				
	Medical service	Yes	Yes				
Minnesota	Health	No	Yes	Minimum of 20% of total days provided for in policy. Must be a minimum of 28 days/year.	State licensed hosp. or state licensed residential primary treatment program	Not covered	---
	Medical	No	Yes				
	Hospitalization	No	Yes				
	Accident or sickness	No	Yes				
Wisconsin	Accident & sickness	No	Yes	Substantially equal to policy provisions for mental or nervous conditions or other general conditions	Hospital	Not covered	---

TABLE 4

SUMMARY OF PENDING STATE LEGISLATION CONCERNING HEALTH INSURANCE COVERAGE FOR ALCOHOLISM AS OF FEBRUARY 1974

State	Insurance Contracts Covered	Individual Coverage	Group Coverage	Inpatient		Outpatient	
				Benefits	Place of Care	Benefits	Place of Care
Alaska	Health & Disability	No	Yes	Not specified	Hospital or state licensed comprehensive intensive treatment care facility	None	---
Michigan	Health & Disability	Yes	Yes	Not specified	Facility approved by State Dept. of Public Health for hospitalization or treatment	(Group only) Not specified	Care provided by licensed physician or osteopathic practitioner in facility approved by State Dept. of Public Health
Mississippi	Accident & Health	Yes (But may be rejected by purchaser)	Yes	Same as other health service benefits in policy		Same as other health service benefits in policy	
Nebraska	Accident & Sickness	Yes	Yes	Not specified	State licensed hospital or facility which can provide inpatient alcoholism treatment	None	---
Oregon	Health	No	Yes	30 days minimum	Not specified	50% of major medical care up to $500/yr.	---
Washington	Disability & Prepaid Contracts	No	Yes	Not specified	Approved treatment facility or a facility accredited by the state	Not specified	Approved treatment facility or a facility accredited by the state
	Extended Care Policies	Yes	Yes	"	"	"	"

for alcoholism is pending in the states of Alaska, Michigan, Mississippi, Nebraska, Oregon, and Washington. Should the pending legislation pass in the current form, each of these states will provide for alcoholism treatment benefits under group insurance plans; in addition, the states of Michigan, Nebraska, and Washington make such benefits mandatory under individual insurance plans. While all of the states specify inpatient coverage for alcoholism treatment, only the states of Alaska and Nebraska do not provide for outpatient care. Four of the six states with pending legislation do not specify actual inpatient benefits to be provided; Oregon specifies that a minimum of 30 days of inpatient care must be provided while Mississippi requires that such benefits be equal to that of other health service benefits in a given policy. Outpatient benefits are in general not specified by these states, with the exception of Mississippi which requires that policies must provide the same outpatient benefits as provided for other conditions in a given policy. In general proposed legislation specifies that treatment must be provided in a hospital or facility which has been approved or licensed by the state to operate as such. The pending legislative efforts among the various states are encouraging inasmuch as (1) four out of the six states require coverage under individual plans (as well as group plans), and (2) four states require the provision of outpatient benefits.

C. Status of State Regulations* Concerning Health Insurance Coverage for Alcoholism

The status of regulations concerning health insurance coverage for alcoholism is presented in Tables 5 - 10. As can be seen from Table 5,

*State regulations are to be distinguished from state statutes or enabling legislation. Legislation is in effect a precursor of regulations; regulations are promulgated (in this instance by state insurance regulatory agencies) and as such are subject to expansive or narrow interpretation.

TABLE 5

STATUS OF STATE* REGULATIONS CONCERNING
HEALTH INSURANCE COVERAGE FOR ALCOHOLISM

Regulation Status	Number of States
Existing regulations	4
Planning regulations	2
No regulations in effect	42
Unknown	4

*Includes District of Columbia and Puerto Rico

Source: Health Insurance Coverage for Alcoholism Survey data, 1974.

42 of the states have no regulations, two are currently planning regulations, and four have existing regulations: no information is available on four states. Table 6 provides summary data on existing and planned regulations concerning health insurance coverage by state. Tables 7 and 8 provide information on the nature of existing state health insurance regulations by type of care, i.e., inpatient or outpatient. It should be noted that each of the four states shown (Massachusetts, Illinois, Minnesota, and Wisconsin) have regulations which closely resemble the legislation described in earlier tables. Only two states indicated that state health insurance regulations were in a planning stage (see Tables 9 and 10). Interestingly enough there is no legislation pending in the Arkansas Legislature thereby indicating that the State Insurance Department in Arkansas apparently has existing statutory authority of a broad nature. Thus, in summary, state regulations apparently contain essentially the same language as enabling legislation, i.e., there has been no expansive or narrow interpretation of enabling legislation by regulatory agencies to date.

Finally, in response to a series of questions regarding status of regulations:

(a) about 90 percent of the state regulatory agencies indicated that it would be necessary to change or augment existing statutes in order to implement or develop regulations providing health insurance coverage for alcoholism,

(b) about 70 percent of the respondents indicated that they had no regulations which in any way specified, delimited or affected health insurance benefits for mental conditions,

(c) none of the three respondent states that have existing regulations

TABLE 6

SUMMARY OF EXISTING AND PLANNED REGULATIONS CONCERNING HEALTH INSURANCE COVERAGE BY STATE

State	Has Existing Regulations	Regulations are being Planned	Group Contracts: Inpatient Care	Group Contracts: Outpatient Care	Group Contracts: Other Care	Individual Contracts: Inpatient Care	Individual Contracts: Outpatient Care	Individual Contracts: Other Care
Illinois	Yes	---	Yes	No	No	No	No	No
Massachusetts	Yes	---	Yes	Yes	No	Yes	Yes	Yes
Minnesota	Yes	---	Yes	No	No	No	No	No
Wisconsin	Yes	---	Yes	No	No	No	No	No
Arkansas	---	Yes	(In early planning stages -- no specific information available)					
Mississippi	---	Yes	(Enabling legislation allowing development of regulations was enacted after receipt of questionnaire.)					

Source: Health Insurance Coverage for Alcoholism Survey Data and Interviews at State Legislatures.

TABLE 7

NATURE OF EXISTING STATE HEALTH INSURANCE REGULATIONS CONCERNING INPATIENT CARE FOR ALCOHOLISM

State	Type of Insurance Contracts Covered	Applies to Group Contracts Only	Applies to Individual Contracts Only	Both Group and Individual Contracts	Nature of Benefit: Minimum Dollar Benefit	Nature of Benefit: Minimum Days of Care	Nature of Benefit: Place(s) of Care
Illinois	Accident & Health	X			Unknown	Unknown	State licensed hospital or state approved alcoholism treatment facility
*Massachusetts	Health Employee & Welfare Funds Hospital Service Medical Service			X	Not specified	30 days	Facilities must be licensed by the State Dept. of Public Health
Minnesota	Health Medical Hospital Accident or Sickness	X			Not specified	20% of total days provided for in policy or min. of 28 days/year	State licensed hosp. or state licensed residential primary treatment program
Wisconsin	Accident & Sickness	X			Not specified	30 days	Hospital

*No questionnaire received. Information derived from legislation.

Source: Health Insurance Coverage for Alcoholism Survey Data and Interviews at State Legislatures.

TABLE 9

NATURE OF EXISTING STATE HEALTH INSURANCE REGULATIONS CONCERNING <u>OUTPATIENT</u> CARE FOR ALCOHOLISM

State	Type of Insurance Contracts Covered	Applies to Group Contracts Only	Applies to Individual Contracts Only	Applies to Both Group & Individual Contracts	Nature of Benefit: Minimum Dollar Benefit	Nature of Benefit: Minimum Number of Outpatient Visits	Nature of Benefit: Place(s) of Care
Massachusetts	Health Employee & Welfare Funds Hospital Medical			X	$500/yr.		Facility licensed by state

Source: Interview at State Legislature.

TABLE 9

NATURE OF PLANNED STATE HEALTH INSURANCE REGULATIONS CONCERNING INPATIENT CARE FOR ALCOHOLISM

State	Type of Insurance Contracts Covered	Applies to Group Contracts Only	Applies to Individual Contracts Only	Applies to Both Group & Individual Contracts	Nature of Benefit: Minimum Dollar Benefit	Nature of Benefit: Minimum Days of Care	Nature of Benefit: Place(s) of Care
Arkansas	(In early planning stages -- no specific information available.)						
Mississippi	Accident & Health			X	Same as other health service benefits in policy		

Source: Health Insurance Coverage for Alcoholism Survey Data and Interviews of State Legislatures.

TABLE 10

NATURE OF PLANNED STATE HEALTH INSURANCE REGULATIONS CONCERNING OUTPATIENT CARE FOR ALCOHOLISM

State	Type of Insurance Contracts Covered	Applies to Group Contracts Only	Applies to Individual Contracts Only	Applies to Both Group & Individual Contracts	Nature of Benefit: Minimum Dollar Benefit	Nature of Benefit: Minimum Number of Outpatient Visits	Nature of Benefit: Place(s) of Care
Arkansas	(In early planning stages -- no specific information available.)						
Mississippi	Accident & Health			X	Same as other health service benefits in policy		

Source: Health Insurance Coverage for Alcoholism Survey Data and Interviews at State Legislatures.

are considering any plans to modify such regulations during the next two years, and

(d) among those states in which regulations currently exist none provide for any form of care other than inpatient or outpatient, i.e., transitional or intermediate care have not yet been specified within the regulations.

D. Regulation Development

Only three states with existing regulations responded to the questionnaire section dealing with the development of regulations. (Note that Massachusetts which has regulations did not return the questionnaire.) That section was designed to provide insights into information sources which may be useful in the development of regulations concerning health insurance coverage for alcoholism. Because of the low response rate the information source data will not be presented in tabular form. Information sources which appeared to have been the most useful in the development of regulations concerning health insurance include professional organizations or societies, consumer sources and the National Association of Insurance Commissioners. Further, those state regulatory agencies responding feel that information on health insurance regulations concerning coverage for alcoholism in other states would be useful as well as model regulatory language. Draft model regulatory language of potential utility to the states was developed subsequent to analysis of survey data and is attached to this report as Appendix C.

E. Agency Operations

Agencies were queried concerning the conduct of their agency and in particular how they were able to gauge the nature of carrier operations

within their state. The majority of the regulatory agencies indicated that they monitor the provisions in insurance carrier policies. Forty-six agencies indicated that they made routine or special examinations of health insurance carriers operating within the state and a majority of agencies indicated that they routinely collect data on carrier income and carrier benefit payments. Nearly half of the agencies responding indicated that they review and approve insurance rates, and a majority indicated that rates are in effect set or established by the competitive health insurance market place.

Table 11 provides a summary of data routinely collected by state insurance agencies which concerns health insurance coverage for alcoholism. As it may be seen only a small proportion of the states collect information related to benefits, cost of alcoholism treatment, or the effectiveness of carriers in handling claims concerning treatment for alcoholism. Three states (or some 6 percent of respondents) indicated that they had in the past collected data concerning the cost of alcoholism treatment. Specifically, these included (1) collection of data from a local institution which provided treatment for state employees, (2) collection and analysis of studies on the cost of alcoholism to employers, and (3) data generated by the Kemper Insurance Company concerning alcoholism costs. A single state, Wyoming, indicated that it collected state hospital reports concerning how carriers handled claims for alcoholism treatment. In general, it may be surmised that the states do not routinely collect illness specific data related to costs, benefits or carrier effectiveness.

TABLE 11

SUMMARY OF DATA COLLECTED BY STATE INSURANCE AGENCIES CONCERNING HEALTH INSURANCE COVERAGE FOR ALCOHOLISM

Data Area	Percent of States Collecting Data
Benefits paid out for treatment of alcoholism	0
Cost of alcoholism treatment	6
Effectiveness of carrier in handling claims	2

F. Agency Perceptions of Need for Health Insurance Coverage for Alcoholism

A series of questions were asked regarding perceptions of state insurance agencies concerning health insurance coverage for alcoholism as shown in Table 12. It should be noted that about 85 percent of the insurance agencies responding indicated that not only should health insurance provide coverage for alcoholism but that statutes and/or regulations are in fact necessary to ensure such coverage. Interestingly only about 23 percent of respondents indicated that their regulations assure adequate coverage for alcoholism treatment. Finally, about three-quarters of the responding agencies indicated that health insurance coverage for alcoholism should be provided for both individual and group policies (see Table 13).

TABLE 12

SUMMARY OF AGENCY PERCEPTIONS CONCERNING HEALTH INSURANCE COVERAGE FOR ALCOHOLISM

Area	Percent of States	
	Yes	No
Should health insurance provide coverage for alcoholism?	87	13
Are statutes and regulations necessary to assure health insurance coverage for alcoholism?	85	15
Do current regulations assure adequate coverage for alcoholism treatment?	27	73

TABLE 13

AGENCY PERCEPTIONS REGARDING ALCOHOLISM COVERAGE UNDER GROUP OR INDIVIDUAL CONTRACTS

Desired Form of Contract	Percent of Respondents
Group only	15
Individual only	9
Group and Individual	76

G. Legislative Interviews

Legislators in eight states which have considered or are considering legislation concerning health insurance coverage for alcoholism were interviewed to gather information on various facets of the legislative process. States visited included Alaska, Illinois, Massachusetts, Michigan, Mississippi, Nebraska, Washington, and Wisconsin. Although the sample of states interviewed is small a picture emerges as follows:

(1) Origin of Legislation

The origin of the various passed or pending is quite variable. In one instance dissatisfaction with a state employee insurance plan which provided no health insurance coverage for alcoholism was a basis for legislation. In another state there was an expressed feeling that Federal alcoholism programs were of a demonstration nature or hard to find by the general public and could be terminated at any point in time--therefore, some third-party payment mechanism had to be developed. In two states legislation came about as a result of special study commissions. Finally, it appears that state senators or representatives who originated this type of legislation have either a professional or intense personal interest in the area of alcoholism.

(2) Technical Information Used in Preparation of Legislation

Little technical information concerning health insurance coverage for alcoholism has been available to those legislators who have sponsored or originated legislation in this area. In a number of cases the Wisconsin bill was used as a general guide inasmuch as it was the first legislation passed in the United States. Other states have relied on reports from insurance carriers, and the National Council on Alcoholism. Most of these reports apparently presented the problem

of alcoholism in general terms; in certain instances the costs of treatment were estimated. In several instances information provided by one professional organization focused on the hard core alcoholic and failed to indicate the potential benefits of early intervention.

(3) Legislation Provisions

Considerable variation existed in the benefit provisions developed and supported by legislators. Legislators seemed supportive of a range of views concerning the nature and extent of health insurance coverage for alcoholism, i.e. benefit provisions run from specifying that alcoholism must be covered in a manner similar to physical diseases to an outright specification of days of care or a number of outpatient visits or dollar expenditures. A majority of interviewees favor inpatient coverage only.

(4) Legislative Peer Support

Those legislators interviewed indicated that there was generally an expression of support for this legislation from legislative peers; most nonsupportive comments have concerned the area of costs of treatment and insurance carrier costs. Arguments by peers concerning treatment costs have frequently been overcome through discussion of the cost advantage of early intervention.

(5) Lobbying Activities

Interviews also focused on identification of lobbying groups either for or against such legislation. In general there has been no strenuous opposition to the legislation either passed or pending. In several states the insurance carrier industry has apparently moved from an initial position of opposition to such legislation to an ultimate position of support. Their positions reflected preference to

aid in the development of plausible legislation as long as a groundswell of support for such legislation exists. Support of a formal and an informal nature have included the National Council on Alcoholism, various religious groups, labor unions, management, hospital associations, medical societies, mental health societies, and other alcoholism professional groups. Little concern over treatment costs has been expressed by labor or management groups. Certain groups have informally pressed for either expansion or narrowing the proposed legislation. In certain cases religious and AA groups have opposed legislation from the standpoint that pending legislation was too restrictive and have pressed for expanding of legislation. In other instances, hospital associations and medical societies pressed for the narrowing of the pending legislation to limit coverage to hospital inpatient treatment under the care of a qualified physician.

(6) <u>Legislative Process</u>

A key factor associated with either passage of the bill or movement of the bill from one legislative house to another has been the extent and intensity of followup by the originators of the legislation. Many of the legislators interviewed indicated that extensive meetings and discussions were necessary to assure effective processing of the legislation.

REFERENCES

1. Hallan, J. B. "Health Insurance Coverage for Alcoholism." Unpublished Report prepared for the National Institute on Alcohol Abuse and Alcoholism, 1972.

2. Rosenburg, N. "Survey of Health Insurance for Alcoholism: Inpatient Coverage." National Center for Prevention and Control of Alcoholism, Washington, D. C.: National Institute of Mental Health, 1970.

APPENDIX A

SURVEY OF HEALTH INSURANCE COVERAGE FOR ALCOHOLISM

Agency name: ______________________

Dept. or division: ______________________

Street address: ______________________

State & zip code: ______________________

Telephone No.: ______________________

Name & title of person completing form: ______________________

A. AGENCY FUNCTIONS AND REGULATIONS

(1) Please summarize, as briefly as possible, the major functions of your department: ______________________

(2) Please indicate the nature or type of insurance that is regulated by your department:

	Yes	No
a) Life	___	___
b) Automobile	___	___
c) Disability	___	___
d) Hospital care		
Group contracts	___	___
Individual contracts	___	___
e) Physician or other health personnel services		
Group contracts	___	___
Individual contracts	___	___
f) Other-Please specify ______________________		

(3) Would it be necessary to change or augment the existing statutes of your state in order to develop or implement regulations requiring that health insurance contracts provide some form of coverage for the treatment of alcoholism? ___No ___Yes (please explain) ______________________

(4) Does your agency have regulations which specify, delimit, or in any other way affect health insurance benefits or coverage for treatment of mental conditions?

___Yes (if possible, please attach a copy of the regulations)
___Planned but not in effect (if possible, please attach a copy of the draft regulations)
___None in effect

(5) Does your agency have regulations which specify, delimit, or otherwise affect health insurance benefits or coverage for treatment of alcoholism?

___Yes (if possible, please attach a copy of the regulations)
___Planned but not in effect (if possible, please attach a copy of the draft regulations)
___None in effect (skip to Section C)

(6) Please indicate the type of health insurance contracts which are affected by your existing or planned regulations concerning treatment of alcoholism.

____Individual health insurance contracts
____Group health insurance contracts
____Both types of contracts
____Regulation does not specify type of contract
____Other (please specify)____________

---

(7) Do your existing or planned health insurance regulations concerning treatment of alcoholism specify provision for:

a) INPATIENT CARE? ____Yes ____No. If yes, please check places of treatment specified by the regulation and describe any minimum benefits which must be provided by an insurance contract.

1) Please check place(s) of inpatient treatment
____General hospital
____Mental hospital
____Community mental health center
____Alcoholism treatment center
____Other (please specify)____________

2) Please describe any minimum inpatient benefits which must be provided in an insurance contract:____________

b) OUTPATIENT CARE? ____Yes ____No. If yes, please check places of treatment specified by the regulation and describe any minimum benefits which must be provided by an insurance contract.

1) Please check place(s) of outpatient treatment
____Outpatient department of hospital
____Physician's office
____Other (please specify)____________

2) Please describe any minimum outpatient benefits which must be provided in an insurance contract:____________

c) OTHER FORMS OF CARE? ____Yes ____No. If yes, please indicate the other forms of care specified by the regulation and describe where each care takes place and any minimum benefits which must be provided by an insurance contract.

____

(8) If your agency has existing regulations concerning health insurance coverage for alcoholism do you have any plans to modify these regulations during the next two years? ____No
____Yes (please describe)____________

DEVELOPMENT AND STATUS OF REGULATIONS

(1) Please check the sources of information which have been (or are expected to be) useful in the development of regulations concerning health insurance:

_____ Professional organizations or societies
_____ Lobbying groups
_____ Consumer sources
_____ Expert consultants
_____ Federal government
_____ National Association of Insurance Commissioners
_____ Other (please specify)____

(2) Would information concerning alternative methods of regulating health insurance coverage for alcoholism be of use to your department? ____No ____Yes.
If yes, in what form would the information be most helpful? (Check all that apply.)

_____ Reports on activities in other states
_____ Expert consultation and advice on specific problems
_____ "Model" regulations
_____ Other (please specify)____

(3) Please indicate the status of your state legislation concerning health insurance coverage for alcoholism:

_____ No legislation considered within the past year
_____ Some legislation already in existence prior to one year ago (please describe briefly below)
_____ Legislation planned, or pending (please describe briefly below)
_____ Legislation rejected during the past year (please describe briefly below)
_____ Legislation enacted during the past year (please describe briefly below--including the date on which it goes into effect)

(4) Please indicate the legislative committees which are or have been active in developing legislation concerning health insurance coverage for alcoholism:

Name of Committee	Name of Committee Chairman if known