a "certifying" body will work to gain acceptance of the standards and to implement the certification of nondegreed alcoholism counselors.

In an effort to stimulate health insurance coverage and third-party payments NIAAA is exploring the possibility of using incentive contracts with profitmaking organizations. The Institute hopes to demonstrate that contractual incentives can yield facilities of a nature satisfactory both to the alcoholic population and to health insurers covering this population. This should attract enough third-party payments to enable the contractor to become self-sustaining in a relatively short time. Contractor fees will be determined by the level of third-party payments they are able to generate. For example, a contractor would receive the most profit if he were able to generate 25 percent of his total receipts from third-party payments by the end of the first 6 months of the contract, 50 percent by the end of the first year, and 75 percent by the end of the second and final year.

Other current NIAAA activities are the development of a model cost-accounting system for use by alcoholism programs and an examination of legislation and licensure requirements for State facilities.

Alcoholism Care Costs

The costs of treating the several million Americans who manifest drinking problems cannot be supported by government funds alone. One of the more financially viable means to ensure that alcoholic people receive timely and appropriate care is through the mechanism of third-party reimbursement. Yet cost is often the reason cited for not including alcoholism treatment in health insurance plans. For example, data from the NIAAA Alcoholism Treatment Center Monitoring and Evaluation System *(20)* indicate that these Centers currently receive only 7 percent of their income from third-party reimbursement, of which approximately 2 percent is from private health insurance.

Determining alcoholism treatment costs is especially difficult because they vary greatly from program to program. Information from the recent preliminary study *(5)* of the costs of different types of alcoholism treatment (table 1) may be applied tentatively to a model benefit package. It should be noted that this model does not represent a policy statement by NIAAA concerning an appropriate treatment program but is merely a practical measure, obtained by analysis of present treatment programs, to provide insurance companies with some basis for projecting a reasonable range of possible costs in all the settings in which alcoholism treatment is delivered. This model is seen as part of an experimental effort rather than as a plan ready for wide implementation, and NIAAA urges recognition of the fact that selected aspects of the proposal have not been thoroughly tested.

The model benefit package projects, as the basis for treatment in each type of setting, the following maximum lengths of stay:

Inpatient emergency	6 days
Inpatient care	14 days
Outpatient care	30 visits
Intermediate care, short term	30 days
Intermediate care, long term	60-90 days

The results of the study *(5)* obtained by site visits to 27 alcoholism treatment programs throughout the United States, covering a total of over 60 treatment settings, are as follows (table 1):

Inpatient Emergency Care. Within the inpatient emergency care modality, the general hospital treatment settings cost from over 2 to 10 times as much as settings in specialized alcoholism hospitals, other specialized hospitals, hospital-affiliated medical emergency care centers, and hospital-affiliated nonmedical emergency care centers.

Inpatient Care. The specialized alcoholism hospital is the least costly of the four inpatient treatment settings.

Intermediate Care. The partial-hospitalization treatment setting costs more than twice as much as the other three settings—specialized alcoholism hospitals, recovery home or halfway houses, and other 24-hour nonmedical residential centers.

Outpatient Care. Costs varied greatly in the three treatment settings analyzed (family or neighborhood alcoholism centers, hospital-based outpatient clinics, and community mental health centers), but costs in family and neighborhood alcoholism centers tended to be the lowest.

A preliminary conclusion from this study is that it is reasonable and economical to provide

care for alcoholism through the vehicle of the model benefit package in certain types of settings. However, it should be noted that the costs shown in table 1 indicate trends rather than exact values (the number of sites in the different categories varied from 2 to 11) and, for the reasons cited previously, may be conservative. Eventually, further studies based on this model should provide valuable information to health insurance purchasers, labor unions, and insurance companies, and facilitate the design as well as the negotiation of alcoholism policy benefit provisions.

Summary

Public opinion favors the inclusion of alcoholism in health insurance plans, in line with growing awareness of alcoholism as an illness and of the fact that insurance companies can cover alcoholism without incurring excessive additional costs.

The insurance industry is becoming more sensitive to the needs of alcoholic individuals. Nevertheless, the majority of policies which currently cover alcoholism limit benefits to treatment in accredited general hospitals, thus excluding more economical treatment programs. Some health insurance companies are beginning to bring about change within the industry. With new developments in the areas of treatment effectiveness, cost data, licensing of facilities, certification of personnel, it is anticipated that health insurance companies will expand their benefits to meet the needs of alcoholic persons.

As State and Federal legislation addresses itself more substantially to insurance activities in the alcoholism field, significant changes are occurring. Currently a number of national health insurance proposals have been introduced in Congress which should have a profound effect on third-party reimbursement if enacted. The removal of financial barriers through national health insurance will almost certainly increase the demand for frankly labeled alcoholism services, including manpower and treatment resources, and many more alcoholic persons will become eligible for treatment.

The extent to which a recent movement in some States to regulate the health insurance industry will continue may depend on the measures taken by the industry to include alcoholism benefits provisions, as well as on the direction taken by national health insurance.

For the alcoholic person considering treatment the availability of effective health insurance coverage can in many cases make the difference between seeking and not seeking help, and between seeking it sooner rather than later.

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TABLE 1

AMERICAN ATTITUDES TOWARD ALCOHOL FROM 1971 TO 1973

	1971	Sept. 1972	March 1973	Sept. 1973	% Change, 1971 to Sept. 1973
Heavy drinking is a very serious problem in the country today:	59%	64%	67%	72%	+22%
Alcohol is a drug:	61%	67%	71%	72%	+18%
No known cure for a hangover:	45%	52%	53%	50%	+11%
Drunkenness is usually like an overdose of drugs:	31%	38%	41%	43%	+39%
Host who encourages heavy drinking by guests can be described as a					
— drug pusher:	19%	31%	33%	33%	+74%
— bad host:	50%	58%	56%	58%	+16%

Source: Louis Harris & Associates (12)

lives where wise interventions can assist them vitally.

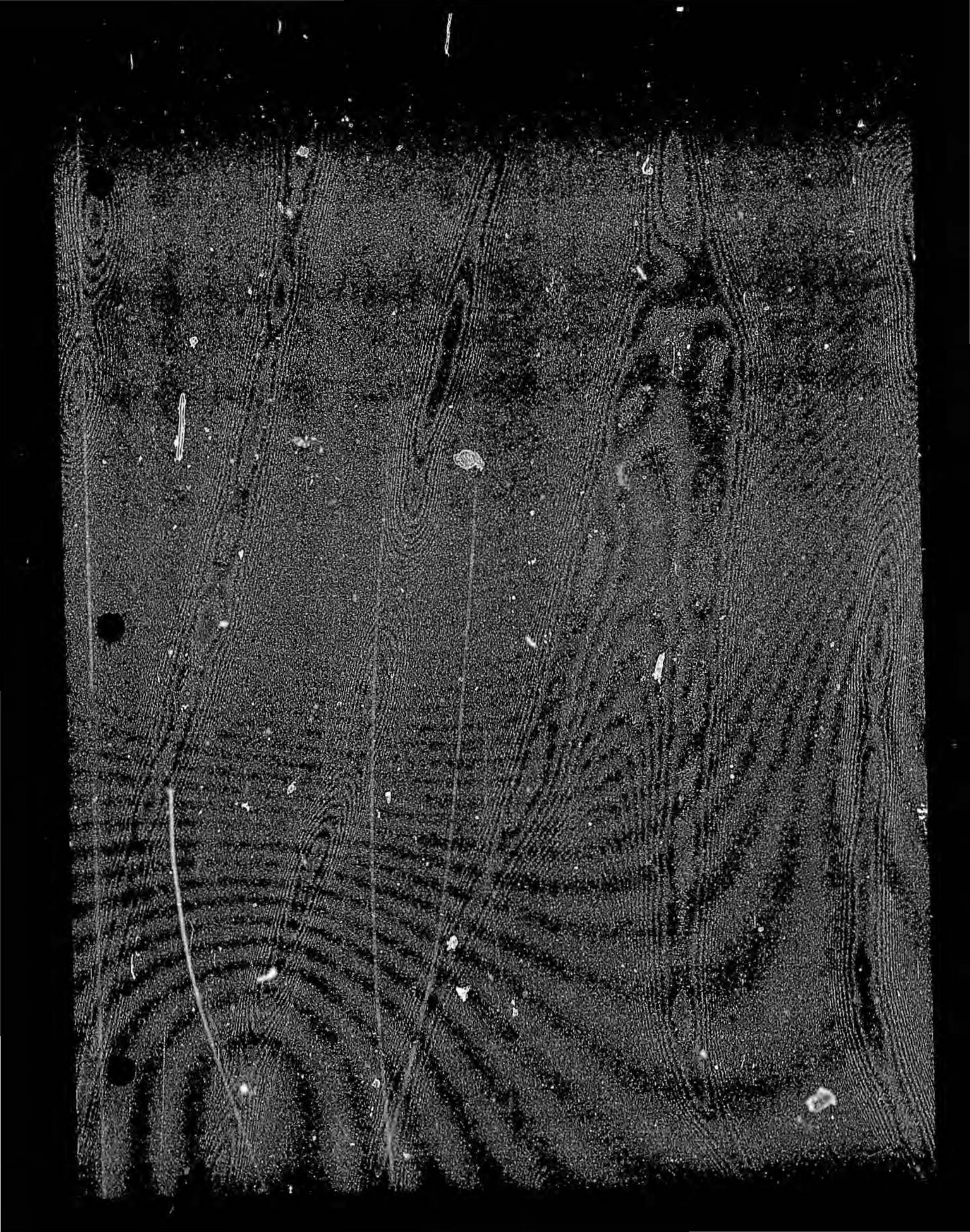
Considering the multiple factors involved, several should be of the greatest importance in dealing with alcohol-related behavior. First are the attitudes toward taking alcohol. Second come the actual sets of behaviors that people engage in, which are of course not always necessarily the same as their attitudes. A third major factor includes the laws and customs that contribute so much to our patchwork quilt of inconsistent drinking-related practices. The patterns of drinking, including the economics of the availability of beverages and the availability of money to buy them, are certainly involved. The environments in which people live and work and drink, discussed earlier in this *Report*, are also critical in providing clues about the extent to which their behavior deviates from generally accepted norms.

Attitudes Toward Alcoholism

There is reason to believe that attitudes toward alcohol are changing. A small experimental Government prevention campaign has yielded a multiplied growth in free public exposure of some four to five times the dollar investment in radio, television, magazine, newspaper, and outdoor advertising about alcoholism. One reason for this enormous public involvement is the fact that techniques of public communication have been used effectively to catch and sustain attention. The effectiveness of this campaign has been measured independently by a public-opinion research organization by means of standard population polls *(12)*. The data in table 1 address the questions whether the public is aware of the campaign, and whether attitudes toward the use of alcohol have changed. As can be expected from a limited experiment, the results are modest, but they are clear.

It may reasonably be concluded that Americans' attitudes toward alcohol have changed over the last few years. Moreover, since public information campaigns by voluntary organizations are continuing and growing in volume, it is likely that heightened public awareness of alcoholism as a major social problem will also be sustained.

The problem now becomes one of taking constructive steps to capitalize on the increased sensitivity of the public. Studies of public attitudes and practices, including house-to-house surveys, are continuing *(5)*, but in the meantime the information currently at hand must be used appropriately. Not only is it inimical to our democratic ideals to impose any sort of behavioral practices upon people, but it is unlikely that compulsion will lead to sustained behavior in a given direction. Indeed, there is evidence that even people living under authoritarian governments manage to ignore official anti-alcohol propaganda which goes against long-ingrained popular practices *(16)*. On the other hand, there is great potential value in stimulating open public discussion about the values and practices related to drinking that characterize various groups of Americans. In this way tacit assumptions can be scrutinized and mutual understanding achieved.



National Institute on Alcohol Abuse and Alcoholism

Third Special Report to the U.S. Congress on Alcohol and Health, June 1978

From the Secretary of Health, Education and Welfare

The First Special Report to the Congress on Alcohol and Health (1971) broadly described historical and contemporary alcohol uses and abuses, the causes of alcoholism, and treatment methods. Effects of alcohol on the nervous system, and the legal status of intoxication and alcoholism were discussed in detail.

The Second Special Report on Alcohol and Health (1974) focused on the advances in knowledge gained in the interim between the two reports and supplemented the first volume with discussions of health consequences and of alcohol use among adults, young people, and the elderly.

This Third Special Report on Alcohol and Health incorporates the most significant findings of recent research in the field of alcoholism. The findings are described in extensive detail in the Technical Report in Support of the Third Special Report on Alcohol and Health. The latter, to be published separately by the National Institute on Alcohol Abuse and Alcoholism, will be appropriate for those seeking references, as well as for additional data and discussion.

INTRODUCTION

Beyond the obvious role of the Federal Government in translating public moral judgments about alcohol and alcoholism into law during the past 200 years, the history of active Federal involvement in the alcoholism field has been a short one indeed. As late as 1965, there was but one identifiable alcoholism specialist among the entire staff of the National Institute of Mental Health. In 1967, a small National Center for the Prevention and Control of Alcoholism was established within the National Institute of Mental Health, but its budget of less than $3 million was a very small sum to combat an illness that afflicted millions of Americans. It remained for landmark legislation at the end of 1970 to initiate a new era of significant Federal leadership and commitment to the problem of alcohol abuse and alcoholism.

When the National Institute on Alcohol Abuse and Alcoholism was established 7 years ago, the field of alcoholism was fragmented, and many aspects of the subject were virtually unexplored. It was essential to develop a substantial body of research and information on which to base program and policy development. In 1971, the First Special Report to the Congress on Alcohol and Health represented the first effort in the history of the Federal Government to collect and transmit to the American people a substantial portion of the current knowledge about alcohol and its effect on health. The Second Special Report, published 2-1/2 years later, covered the new knowledge gained in the field since the initial report was issued. As the Institute has matured, along with the alcoholism field, our knowledge base has grown tremendously, as reflected in this Third Special Report to the Congress on Alcohol and Health.

This Third Special Report stands as important testimony to the continuing progress we have made in the alcoholism field. But its negative aspects cannot be ignored. We now know that the problems are far more extensive than we realized at the time of the First Special Report. We currently estimate that there are 10 million problem drinkers (including alcoholic people) in the United States, and each of them directly affects the lives of many others--family members, coworkers, employers, friends, innocent bystanders--so that literally tens of millions of Americans face some form of negative consequences due to alcohol misuse. In purely economic terms, the alcohol-related cost to our society in 1975 is estimated at nearly $43 billion in lost production, medical expenses, motor vehicle accidents, violent crime, fire losses, and the maintenance of social mechanisms to deal with the problems--and that figure covers only the losses we can measure. Alcoholism shortens life expectancy by an estimated 10 to 15 years. It also contributes significantly to such serious conditions as heart disease, cancer, and diseases of the liver. Patients with alcohol-related problems occupy an unwarranted proportion of the Nation's hospital beds. Alcohol may be involved in as many as one-third of all suicides, half of all homicides, half of all traffic fatalities, and one-quarter of all nontraffic accidental deaths. Furthermore, alcohol is now suspected to be a major factor in child abuse and marital violence. In total, more than 200,000 premature deaths each year may be associated with alcohol misuse and hundreds of thousands more people suffer alcohol-related illnesses or injuries.

Table 1. Apparent Consumption,[1] of Alcoholic Beverages in U.S. Gallons per Capita of the Drinking-Age Population,[3] U.S.A. by States, 1976

State	Distilled Spirits		Wine		Beer		Total Ethanol Volume	Rank Order
	Beverage Volume	Ethanol Volume	Beverage Volume	Ethanol Volume	Beverage Volume	Ethanol Volume		
Alabama	1.99	0.86	1.04	0.15	19.64	0.88	1.89	48
Alaska	5.08	2.18	3.58	0.52	34.83	1.57	4.27	4
Arizona	2.56	1.10	2.64	0.38	36.60	1.65	3.13	12
Arkansas	1.56	0.67	0.86	0.12	19.26	0.87	1.66	51
California	3.11	1.33	4.84	0.70	29.47	1.33	3.36	7
Colorado	3.20	1.37	3.16	0.45	32.48	1.46	3.29	9
Connecticut	2.93	1.26	2.51	0.36	22.72	1.02	2.64	28
Delaware	3.32	1.43	1.72	0.25	27.69	1.25	2.93	18
Florida	3.37	1.45	2.45	0.36	29.65	1.33	3.14	11
Georgia	2.85	1.22	1.16[2]	0.17[2]	21.89	0.98	2.37	35
Hawaii	3.01	1.29	2.95	0.43	33.16	1.49	3.21	10
Idaho	1.86	0.80	1.87	0.27	33.94	1.53	2.60	30
Illinois	3.01	1.29	2.31	0.33	29.12	1.31	2.93	19
Indiana	1.75	0.75	1.00	0.14	24.21	1.09	1.98	43
Iowa	1.81	0.78	0.72	0.10	28.63	1.29	2.17	40
Kansas	1.60	0.69	0.77	0.11	25.04	1.18	1.93	44
Kentucky	1.84	0.79	0.69	0.10	22.60	1.02	1.91	47
Louisiana	2.47	1.06	1.98	0.29	28.53	1.28	2.63	29
Maine	2.50	1.07	1.76	0.25	31.46	1.42	2.74	24
Maryland	3.37	1.45	2.24	0.32	29.50	1.33	2.10	14
Massachusetts	3.04	1.31	2.62	0.38	29.09	1.31	3.00	16
Michigan	2.47	1.06	2.06	0.30	31.81	1.43	2.79	22
Minnesota	2.79	1.20	1.45	0.21	28.92	1.30	2.71	25
Mississippi	2.02	0.87	0.87	0.13	22.75	1.02	2.02	42
Missouri	1.89	0.81	1.37	0.20	26.65	1.20	2.21	38
Montana	2.62	1.13	1.40	0.20	39.75	1.79	3.12	13
Nebraska	2.26	0.97	1.18	0.17	31.01	1.39	2.53	32
Nevada	9.31	4.00	5.89	0.85	45.54	2.05	6.90	1
New Hampshire	7.04	3.03	3.66	0.53	42.43	1.91	5.47	3
New Jersey	2.77	1.19	2.88	0.42	24.09	1.08	2.69	26
New Mexico	2.28	0.98	2.32	0.34	34.84	1.57	2.89	20
New York	2.89	1.24	3.05	0.44	24.84	1.12	2.80	21
North Carolina	2.02	0.87	1.61[2]	0.23[2]	22.07	0.99	2.09	41
North Dakota	2.80	1.20	1.10	0.16	29.35	1.32	2.68	27
Ohio	1.78	0.76	1.41	0.20	27.55	1.24	2.20	39
Oklahoma	1.81	0.78	0.95	0.14	22.26	1.00	1.92	45
Oregon	2.22	0.95	3.46	0.50	28.84	1.30	2.75	23
Pennsylvania	1.83	0.79	1.54[2]	0.22[2]	29.26	1.32	2.33	36
Rhode Island	2.84	1.22	3.27	0.47	30.83	1.39	3.08	15
South Carolina	2.76	1.19	1.39	0.20	24.30	1.12	2.51	33
South Dakota	2.48	1.07	1.19	0.17	25.16	1.13	2.37	34
Tennessee	1.72	0.74	0.77	0.11	23.77	1.07	1.92	46
Texas	1.90	0.82	1.39	0.20	34.89	1.57	2.59	31
Utah	1.41	0.61	1.04	0.15	20.81	0.94	1.70	50
Vermont	4.11	1.77	3.42	0.50	31.79	1.43	3.70	5
Virginia	2.22	0.95	1.65	0.24	25.13	1.13	2.32	37
Washington	2.59	1.13	3.33	0.48	30.20	1.36	2.97	17
West Virginia	1.91	0.82	0.69	0.10	20.91	0.94	1.86	49
Wisconsin	3.05	1.31	1.87	0.27	40.00	1.80	3.38	6
Wyoming	3.07	1.32	1.45	0.21	40.53	1.82	3.35	8
District of Columbia	8.24	3.54	6.46	0.94	29.01	1.33	5.81	2
Average	2.54	1.09	2.26	0.33	28.09	1.26	2.68	

SOURCE: Data updated from Mark Keller and Carol Gurioli, *Statistics on Consumption of Alcohol and on Alcoholism*. New Brunswick, N.J.: Rutgers Center of Alcohol Studies, 1976.

[1]For comparative purposes only. Amounts calculated according to tax paid withdrawals.

[2]Data are from 1975; 1976 data were not available.

[3]Data are based on a drinking-age population 14 years and over.

Table 2. Apparent per Capita Consumption,[1] in Gallons, of Alcoholic Beverages by Persons 15 Years Old and Older in 26 Countries[2]

Rank	Country	Year Of Latest Data	Distilled Spirits		Wine		Beer		Total	
			Beverage Volume	Ethanol Volume	Beverage Volume	Ethanol Volume	Beverage Volume	Ethanol Volume	Persons 15 Yrs. and Older	Entire Population
1.	Portugal	1974	1.20[3]	0.46	43.91	5.27	10.87	0.54	6.27	4.60
2.	France	1972	2.34	0.80	37.40	4.07	20.11[6]	0.99	5.87	4.43
3.	Italy	1973	1.32	0.66	37.91	3.79	4.74	0.24	4.69	3.55
4.	Switzerland	1971-73	1.88	0.75	15.41	1.70	28.72[3,6]	1.39	3.85	2.95
5.	Spain	1971	2.67	1.07	19.83	2.18	1.34	0.53	3.78	2.85
6.	W. Germany	1974	2.39[3]	0.91	7.78	0.82	50.50	2.02	3.75	2.88
7.	Austria	1972	2.10	0.84	11.87	1.25	36.30	1.63	3.72	2.79
8.	Belgium	1973	1.21	0.61	5.96	0.63	48.90[6]	2.15	3.39	2.61
9.	Australia	1972-73	0.82[3]	0.47	3.71	0.45	48.08	2.40	3.32	2.36
10.	Hungary	1972	2.00[3]	1.00	13.36	1.54	19.70	0.69	3.23	2.51
11.	New Zealand	1972	0.85[3]	0.49	2.94	0.35	46.85	2.34	3.18	2.17
12.	Czechoslovakia	1973	2.29	0.92	4.66	0.57	49.69	1.49	2.98	2.30
13.	Canada	1974	2.54[3]	1.01	2.00	0.32	30.27	1.51	2.84	2.07
14.	Denmark	1973	1.25	0.53	3.69	[illegible]	38.85	1.71	2.79	2.14
15.	U.S.A.[2]	1976	2.65	1.14	2.34	0.34	29.03	1.31	2.78	2.08
16.	United Kingdom	1974	0.93[3]	0.53	2.32	0.28	38.92	1.94	2.76	2.11
17.	Netherlands	1974	1.94[3]	0.97	3.66	0.44	26.74	1.34	2.75	2.04
18.	Ireland[2]	1975	1.36[3]	0.78	1.31	0.14	32.43	1.56	2.47	1.70
19.	Soviet Union[7]	1972	3.30[3]	1.22	6.05[3]	0.91	6.93[3]	0.21	2.34[7]	1.69
20.	Poland	1974	2.87	1.43	2.40	0.29	12.94	0.49	2.21	1.63
21.	Finland[2]	1976	2.81	1.07	1.60	0.24	17.58	0.82	2.14	1.61
22.	Sweden	1973	2.23	0.87	2.42	0.30	15.17	0.67	1.84	1.46
23.	Japan[2]	1974	1.33[3,4]	0.44	5.60[3,5]	0.86	11.63	0.46	1.77	1.34
24.	Norway	1974	1.47	0.63	1.11	0.15	15.24	0.69	1.47	1.11
25.	Iceland	1973	2.30	0.94	0.85	0.10	6.01	0.12	1.16	0.76
26.	Israel	1974	0.97	0.48	1.47	0.18	3.96	0.20	0.86	0.58

SOURCE: Data updated from Mark Keller and Carol Gurioli, *Statistics on Consumption of Alcohol and on Alcoholism*. New Brunswick, N.J.: Rutgers Center of Alcohol Studies, 1976.

NOTE: Only per capita consumption by actual drinkers produces a satisfactory comparison among countries. For the same years as shown in the table, consumption of ethanol per drinker has been calculated for the following countries: Canada, 3.56 gallons, U.S., 3.92 gallons, Ireland, 4.35 gallons; Finland, 3.38 gallons.

[1]For comparative purposes only.
[2]A drinking age population other than 15 years and older seems more accurate in at least these countries: U.S., 14 years and older, total consumption in this group – 2.69 gallons; Ireland, 18 years and older, total consumption in this group – 2.68 gallons; and Japan, 20 years and older, total consumption in this group – 1.90 gallons.
[3]Values converted from ethanol.
[4]Includes shochu.
[5]Includes saki.
[6]Includes cider.
[7]Illegally produced samogon is estimated to increase total consumption to about 2.97 gallons per capita.

Table 3. Apparent Consumption,[1] of Alcoholic Beverages in U.S. Gallons per Capita of the Drinking-Age Population,[2] U.S.A., 1850-1976

Year	Distilled Spirits		Wine		Beer		Total
	Beverage Volume	Ethanol Volume	Beverage Volume	Ethanol Volume	Beverage Volume	Ethanol Volume	
1850	4.17	1.88	0.46	0.03	2.70	0.14	2.10
1860	4.79	2.16	0.57	0.10	5.39	0.27	2.53
1870	3.40	1.53	0.53	0.10	8.73	0.44	2.07
1871-80	2.27	1.02	0.77	0.14	11.26	0.56	1.72
1881-90	2.12	0.95	0.76	0.14	17.94	0.90	1.99
1891-95	2.12	0.95	0.60	0.11	23.42	1.17	2.23
1896-1900	1.72	0.77	0.55	0.10	23.72	1.19	2.06
1901-05	2.11	0.95	0.71	0.13	26.20	1.31	2.39
1906-10	2.14	0.96	0.92	0.17	29.27	1.47	2.60
1911-15	2.09	0.94	0.79	0.14	29.53	1.48	2.56
1916-19	1.68	0.76	0.69	0.12	21.63	1.08	1.96
			— PROHIBITION —				
1934	0.64	0.29	0.36	0.07	13.58	0.61	0.97
1935	0.96	0.43	0.50	0.09	15.13	0.68	1.20
1936	1.20	0.59	0.64	0.12	17.53	0.79	1.50
1937	1.43	0.64	0.71	0.13	18.21	0.82	1.59
1938	1.32	0.59	0.70	0.13	16.58	0.75	1.47
1939	1.38	0.62	0.79	0.14	16.77	0.75	1.51
1940	1.43	0.67	0.01	0.16	16.29	0.73	1.56
1941	1.58	0.71	1.02	0.18	17.97	0.81	1.70
1942	1.89	0.85	1.11	0.20	20.00	0.90	1.95
1943	1.46	0.66	0.94	0.17	22.26	1.00	1.83
1944	1.00	0.76	0.02	0.17	25.22	1.13	2.06
1945	1.95	0.88	1.13	0.20	25.97	1.17	2.25
1946	2.20	0.99	1.34	0.24	23.75	1.07	2.30
1947	1.65	0.76	0.90	0.16	24.56	1.11	2.03
1948	1.56	0.70	1.11	0.20	23.77	1.07	1.97
1949	1.55	0.70	1.21	0.22	23.48	1.06	1.98
1950	1.72	0.77	1.27	0.23	23.21	1.04	2.04
1951	1.73	0.78	1.13	0.20	22.92	1.03	2.01
1952	1.63	0.73	1.22	0.21	23.20	1.04	1.98
1953	1.70	0.77	1.19	0.20	23.04	1.04	2.01
1954	1.66	0.74	1.21	0.21	22.41	1.01	1.96
1955	1.71	0.77	1.25	0.22	22.37	1.01	2.00
1956	1.31	0.81	1.27	0.22	22.18	1.00	2.03
1957	1.77	0.80	1.26	0.22	21.44	0.97	1.99
1958	1.77	0.80	1.27	0.22	21.35	0.96	1.98
1959	1.86	0.84	1.28	0.22	22.15	1.00	2.06
1960	1.90	0.86	1.32	0.22	21.95	0.99	2.07
1961	1.91	0.86	1.36	0.23	21.47	0.97	2.06
1962	1.99	0.90	1.32	0.22	21.98	0.99	2.11
1963	2.02	0.91	1.37	0.23	22.51	1.01	2.15
1964	2.01	0.95	1.41	0.24	23.08	1.04	2.23
1965	2.21	0.99	1.42	0.24	23.07	1.04	2.27
1966	2.26	1.02	1.40	0.24	23.52	1.06	2.32
1967	2.34	1.05	1.46	0.25	23.81	1.07	2.37
1968	2.44	1.10	1.51	0.26	24.33	1.09	2.45
1969	2.51	1.13	1.62	0.28	24.90	1.12	2.51
1970	2.56	1.15	1.84	0.29	26.95	1.17	2.61
1971	2.62	1.18	2.08	0.33	25.90	1.17	2.68
1972	2.60	1.12	2.16	0.31	26.62	1.20	2.63
1973	2.61	1.12	2.25	0.33	27.49	1.24	2.69
1974	2.57	1.10	2.13	0.31	27.76	1.25	2.66
1975	2.58	1.11	2.24	0.32	28.08	1.26	2.69
1976	2.54	1.09	2.26	0.33	28.09	1.26	2.68

SOURCE: Data updated from Mark Keller and Carol Gurioli, *Statistics on Consumption of Alcohol and on Alcoholism*, New Brunswick, NJ: Rutgers Center of Alcohol Studies, 1976.

[1] For comparative purposes only. Amounts calculated according to tax-paid withdrawals.

[2] Data through 1973 are based on a drinking-age population 15 years and over; data since 1973 are based on a drinking-age population 14 years and over.

Figure 1. Trends in per Capita Ethanol Consumption in U.S. Gallons, Based on Beverage Sales in Each Major Beverage Class in the United States, 1946-1976

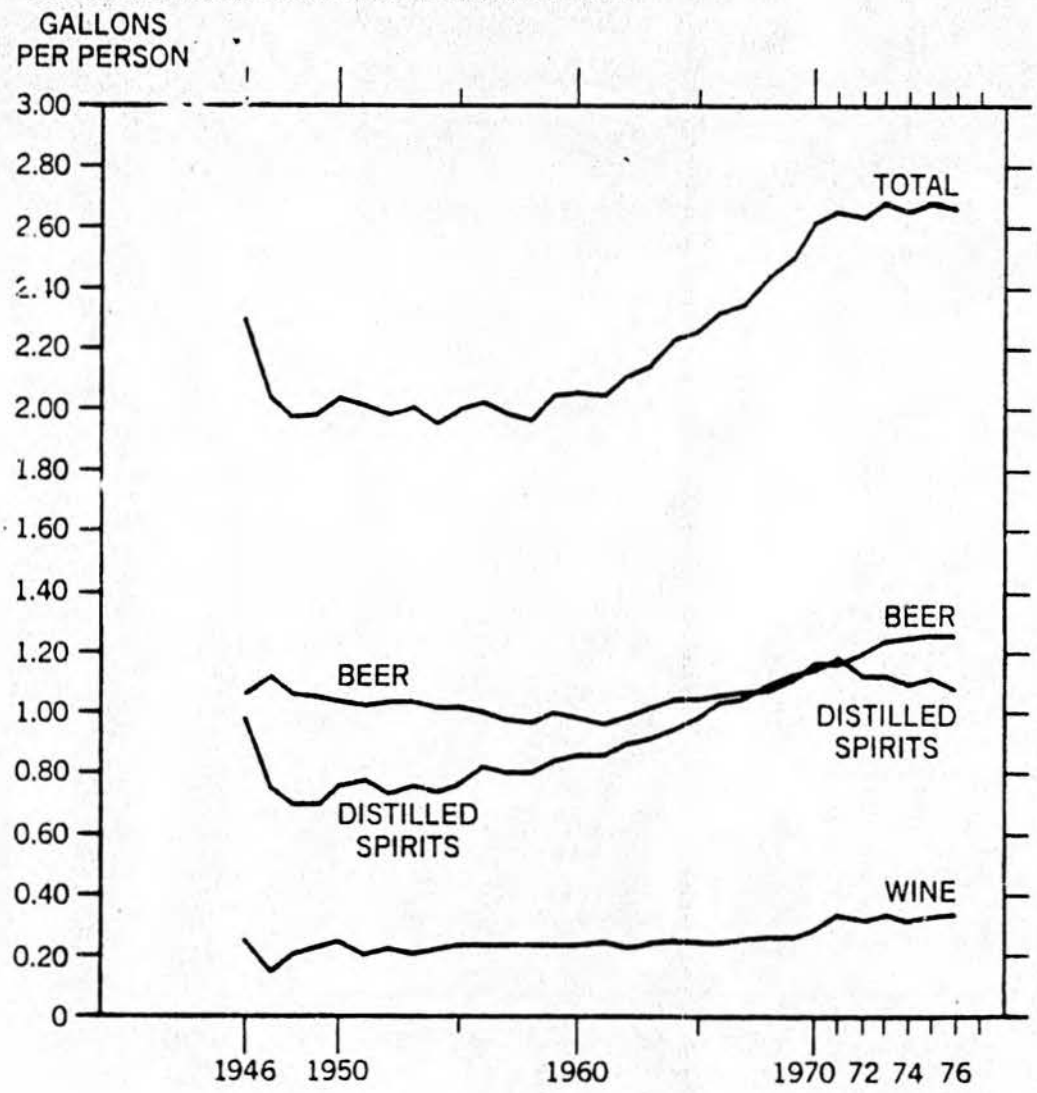


Table 4. Trends in Alcohol Consumption, 1971-1976

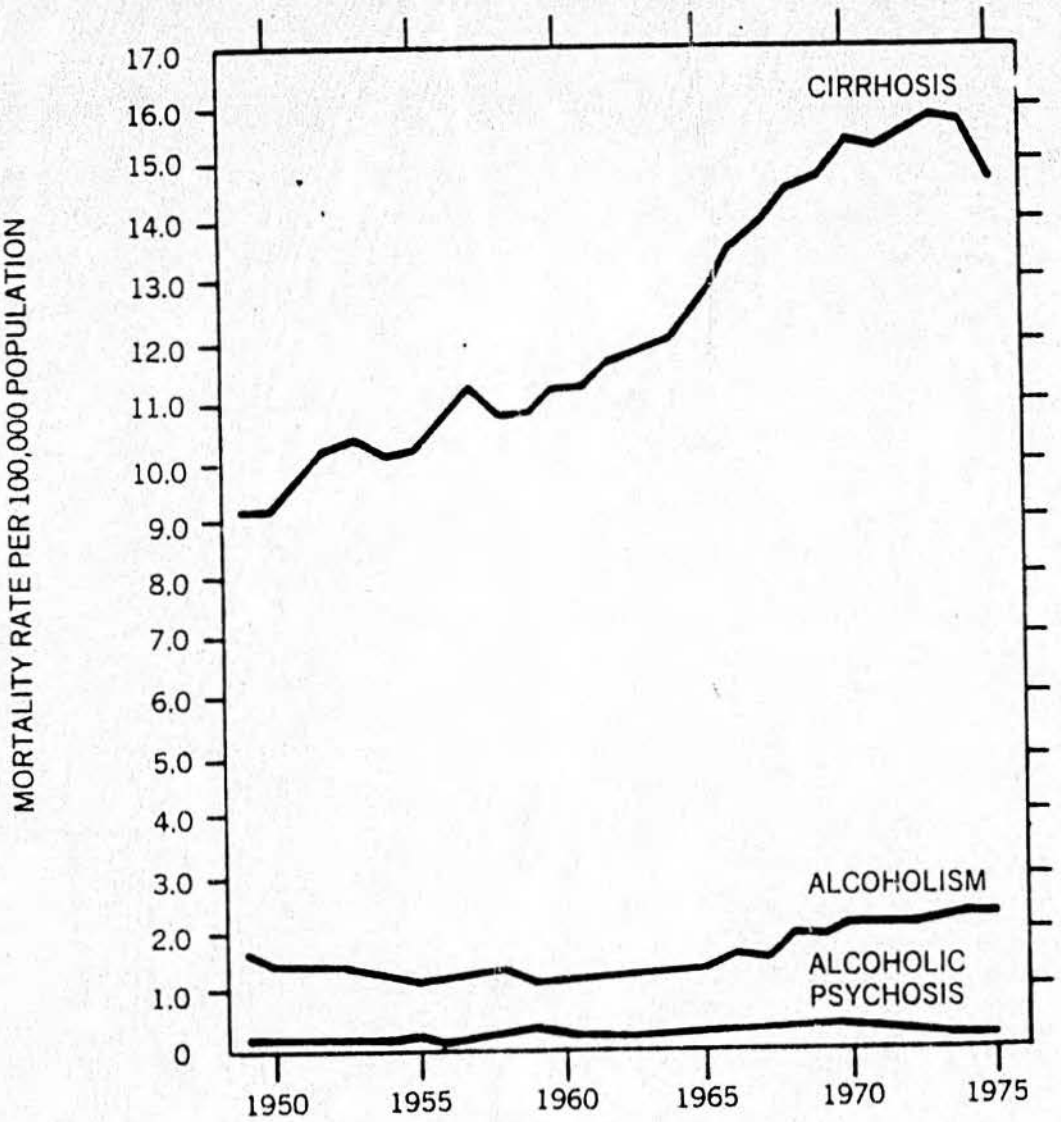
Type of Drinker	Percentage in Each Drinking Category							6 Yr. Average	Ounces of Ethanol Consumed in 1 Day[1]	Amount Consumed[2]
	1971	1972	1973, Spring	1973, Fall	1974	1975	1976			
Abstainer	36	36	34	37	33	36	33	35	0	Drinks less than once a year or never
Lighter	34	32	29	30	28	31	38	32	0.01-0.21	One drink a year up to 3 drinks/week or 12 drinks/month
Moderate	20	23	23	21	28	21	19	22	0.22-0.99	4 to 13 drinks/week or 13 to 58 drinks/month
Heavier	10	10	14	11	11	12	10	11	1.0 or more	2 or more drinks/day or 14 or more drinks/week
(N)	(2,195)	(1,544)	(1,588)	(1,603)	(1,578)	(1,071)	(2,510)	(12,090)		

SOURCE: Paula Johnson, David Armor, Susan Polich, and Harriet Stambul, U.S. adult drinking practices: Time trends, social correlates, and sex roles. Draft report prepared for National Institute on Alcohol Abuse and Alcoholism under Contract No. ADM 281-76-0020 July, 1977

[1] The measure is derived from the frequency of drinking each type of beverage (beer, wine, and distilled spirits) expressed in number of occasions per day, multiplied by the amount of ethanol consumed on a typical drinking day (assuming ethanol proportions of 0.04 for beer, 0.15 for wine, and 0.45 for distilled spirits).

[2] A drink is the equivalent of one 12-oz. can of beer, one 4-oz. glass of wine, or one 1-oz. shot of distilled spirits, each of which contains approximately ½ oz. of ethanol.

Figure 2. Trends in Selected Mortality Rates in the U.S., 1949-1975



SOURCE: Data from National Center for Health Statistics, *Vital Statistics of the United States, 1949-75.* Washington, D.C.: U.S. Government Printing Office, 1975.

Table 5. Estimated Deaths Related to Alcohol in the United States, 1975

Cause of Death	Number of Deaths, 1975	Percent Related to Alcohol	Estimated Number Related to Alcohol
Alcohol as a direct cause			
Alcoholism	4,897	100	4,897
Alcoholic psychosis	356	100	356
Cirrhosis	31,623	41-95	12,965-30,042
Total	36,876		18,218-35,295
Alcohol as an indirect cause			
Accidents			
Motor vehicle	45,853	30-50	13,756-22,926
Falls	14,896	44.4	6,614
Fires	6,071	25.9	1,572
Other*	33,026	11.1	3,666
Homicides	21,310	49-70	10,442-14,917
Suicides	27,063	25-37	6,766-10,013
Total	148,219	29-40	42,816-59,708
Overall Total	185,095		61,034-95,003

SOURCE: Data from Nancy Day, *Alcohol and mortality*. Paper prepared for National Institute on Alcohol Abuse and Alcoholism under Contract No. NIA-76-10(P). January, 1977; and National Center for Health Statistics, *Vital Statistics of the United States, 1972, Vol. II*: Washington, D.C.: U.S. Government Printing Office. 1975.

*Includes all accidents not listed above; but excludes accidents incurred in medical and surgical procedures.

Table 6. Rates of Problem Drinking Among U.S. Drinkers, by Drinking Population, 1973-1975

Drinking Population	Percentages for Each Survey			
	Mar. 1973	Jan. 1974	Jan. 1975	June 1975
All Drinkers				
No problems	64	70	65	63
Potential problems[1]	26	24	24	26
Problem drinkers[2]	11	6	10	10
Males				
No problems	57	66	62	57
Potential problems[1]	29	27	23	31
Problem drinkers[2]	14	8	15	13
Females				
No problems	74	77	70	73
Potential problems[1]	21	19	27	21
Problem drinkers[2]	5	4	3	6

SOURCE: Paula Johnson, David Armor, Susan Polich, and Harriet Stambul, U.S. adult drinking practices: Time trends, social correlates, and sex roles. Draft report prepared for National Institute on Alcohol Abuse and Alcoholism under Contract No. ADM 281-76-0020. July, 1977.

[1]A potential problem drinker experienced two or three of sixteen problem drinking symptoms frequently or four to seven symptoms sometimes.

[2]A problem drinker experienced four or more of sixteen problem drinking symptoms frequently or eight or more symptoms sometimes.

Table 7. Economic Costs of Alcohol Misuse and Alcoholism in the United States, 1975

Item	Cost (billion $)
Lost production	19.64
Health and medical	12.74
Motor vehicle accidents	5.14
Violent crime	2.86
Social responses	1.94
Fire losses	0.43
Total	$42.75

SOURCE: Ralph Berry, James Boland, Charles Smart, and James Kanak, *The Economic Costs of Alcohol Abuse and Alcoholism—1975.* Report prepared for National Institute on Alcohol Abuse and Alcoholism under Contract No. ADM 281-76-0016. 1977.

Table 8. Estimated U.S. National Health Expenditures for Alcohol-Related Problems in 1975, According to Type of Expenditures

Type of Expenditure	Total Adult Population Health Expenditures (billion $)	Expenditures Resulting from Alcohol Abuse (billion $)	Expenditures Resulting from Alcohol Abuse as a Percentage of Total Expenditures (%)
Health service and supplies			
Hospital care	42.3	8.40	19.9
Physician's services	17.9	1.30	7.3
Dentist's services	6.2		
Other professional services	1.7	0.12	7.3
Drugs and drug sundries	8.9	0.28	3.2
Eyeglasses and appliances	2.0		
Nursing home care	8.8	0.19	2.2
Expenses for prepayment and administration	3.9	0.78	19.9
Government public health activities	3.0	0.33	13.1
Other health services	2.5	0.39	13.1
Research and medical facilities construction	6.1	0.78	13.1
Training and education	2.3	0.17	7.3
Total	$105.6	$12.74	12.1%

SOURCE: Data from Ralph Berry, James Boland, Charles Smart, and James Kanas, *The Economic Costs of Alcohol Abuse and Alcoholism—1975* Report prepared for National Institute on Alcohol Abuse and Alcoholism under Contract No. ADM 281-76-0016. 1977

Fires

The net cost of alcohol-related fires in 1975 was $434.1 million. Problem drinking may contribute to the cause of a fire and may intensify the consequences. There is evidence that alcohol misuse contributes to a number of fire fatalities and burn injuries. This estimate is tentative and reflects only a best approximation based on limited data.

Social Response Systems

The cost of social response systems for alcohol abuse and alcoholism in 1975 was estimated at nearly $1.94 billion. There are two general kinds of government-financed social response programs for alcohol misuse--direct and indirect. Direct programs are established specifically to combat alcoholism and are directed toward detection, prevention, treatment, rehabilitation, research, and education. Indirect programs such as social welfare systems are directed toward alleviating various social problems that may be partly a consequence of alcohol misuse.

The total economic cost of alcohol abuse and alcoholism may well have been lower because of the social responses to it. To the extent that these programs succeed, the economic costs of alcohol-related problems will decrease.

SUMMARY

- Drinking practices are influenced by population characteristics, availability of alcoholic beverages, drinking contexts, and geographical location.

- Increased availability of alcoholic beverages has occurred as a result of the lowering of the drinking age in several States, a trend to longer hours of sale, and an increase in the number of retail outlets.

- Americans generally drink in their own and their friends' homes, although drinking in bars, taverns, and restaurants is most common among 18- to 29-year-olds.

- Since 1971, per capita alcohol consumption in the United States has been the highest since 1850, ranging from 2.63 to 2.69 gallons of absolute ethanol per person 14 years and older. During the 1970's, there has been little change in total per capita alcohol consumption.

- There are an estimated 9.3 to 10 million problem drinkers (including alcoholics) in the adult population--7 percent of the 145 million adults (18 years and older).

- Of adults who drink, 36 percent can be classified as either being problem drinkers or having potential problems with alcohol (10 percent and 26 percent, respectively). Similar to consumption patterns, combined rates of problem drinkers and those having potential alcohol problems are substantially less for women (27 percent) than for men (44 percent).

- In addition to adult problem drinkers, there are an estimated 3.3 million problem drinkers among youth in the 14 to 17 age range--19 percent of the 17 million persons in this age group. (Youth problem drinking is defined differently than for adults, because youth problems tend to be acute rather than chronic.)

- The concern over increased alcohol consumption in youth is heightened by the observation that early drinking behavior predicts drinking habits in later life. Specifically, a recent study showed that those who were problem drinkers in college were most likely to be problem drinkers and least likely to be abstainers 25 years later.

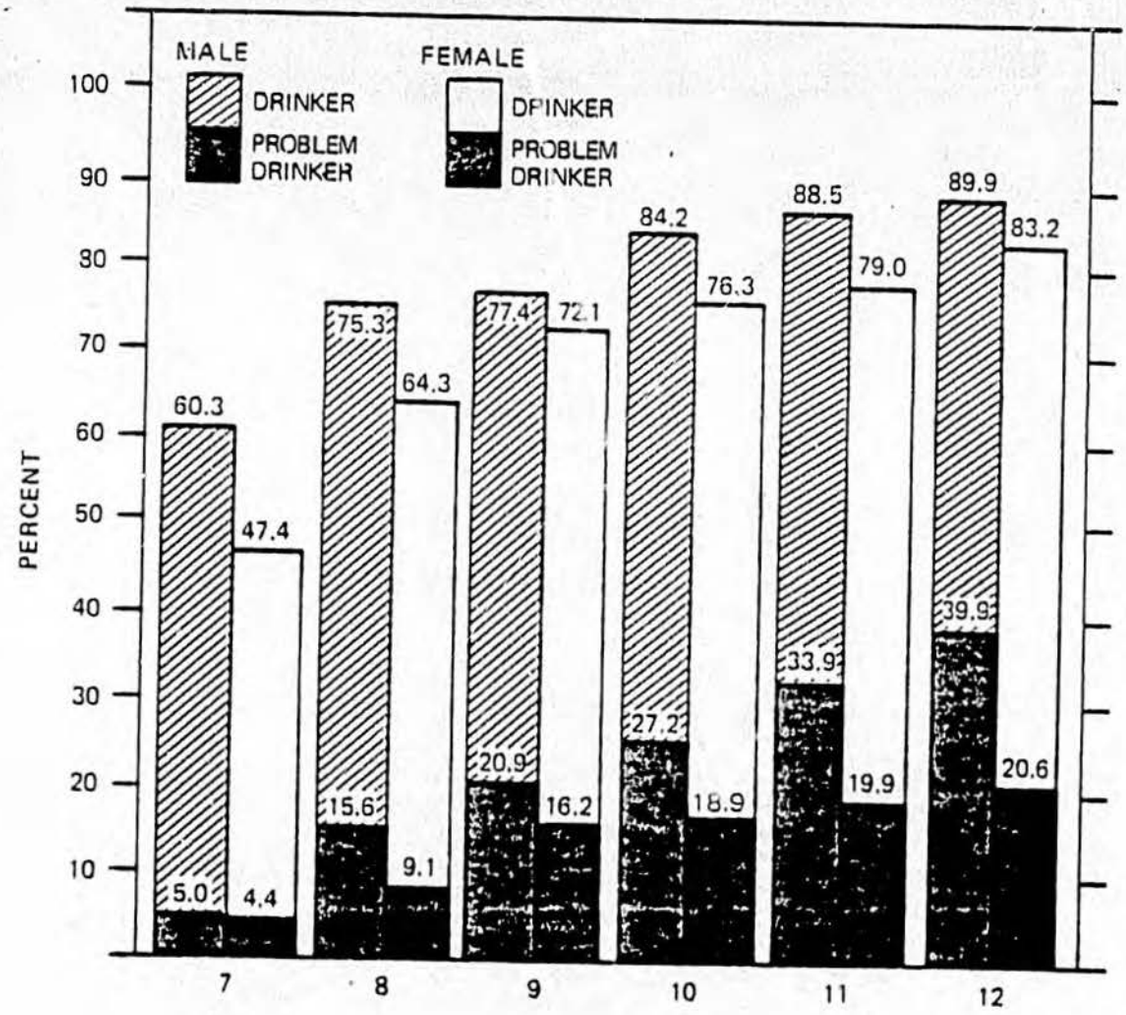
- The rate of total cirrhosis deaths increased by 36.6 percent from 1960 to 1970, followed by a gradual leveling during the early 1970's and a decrease of 6.3 percent from 1974 to 1975. Even though this decrease is encouraging, liver cirrhosis still ranked as the sixth most common cause of death in the United States in 1975, with up to 95 percent of those cases estimated to be alcohol related.

- It is estimated that alcohol-related deaths may run as high as 205,000 per year (11 percent of the 1.9 million deaths in 1975). In fact, clinical studies consistently show that various types of alcohol problems in males are associated with mortality rates two to six times higher than rates in the general population.

- Studies of international alcoholic statistics demonstrate a high correlation between the per capita level of consumption and the rate of cirrhosis deaths. Preliminary results from a recent study also show that alcohol taxes and prices are related negatively to alcohol consumption.

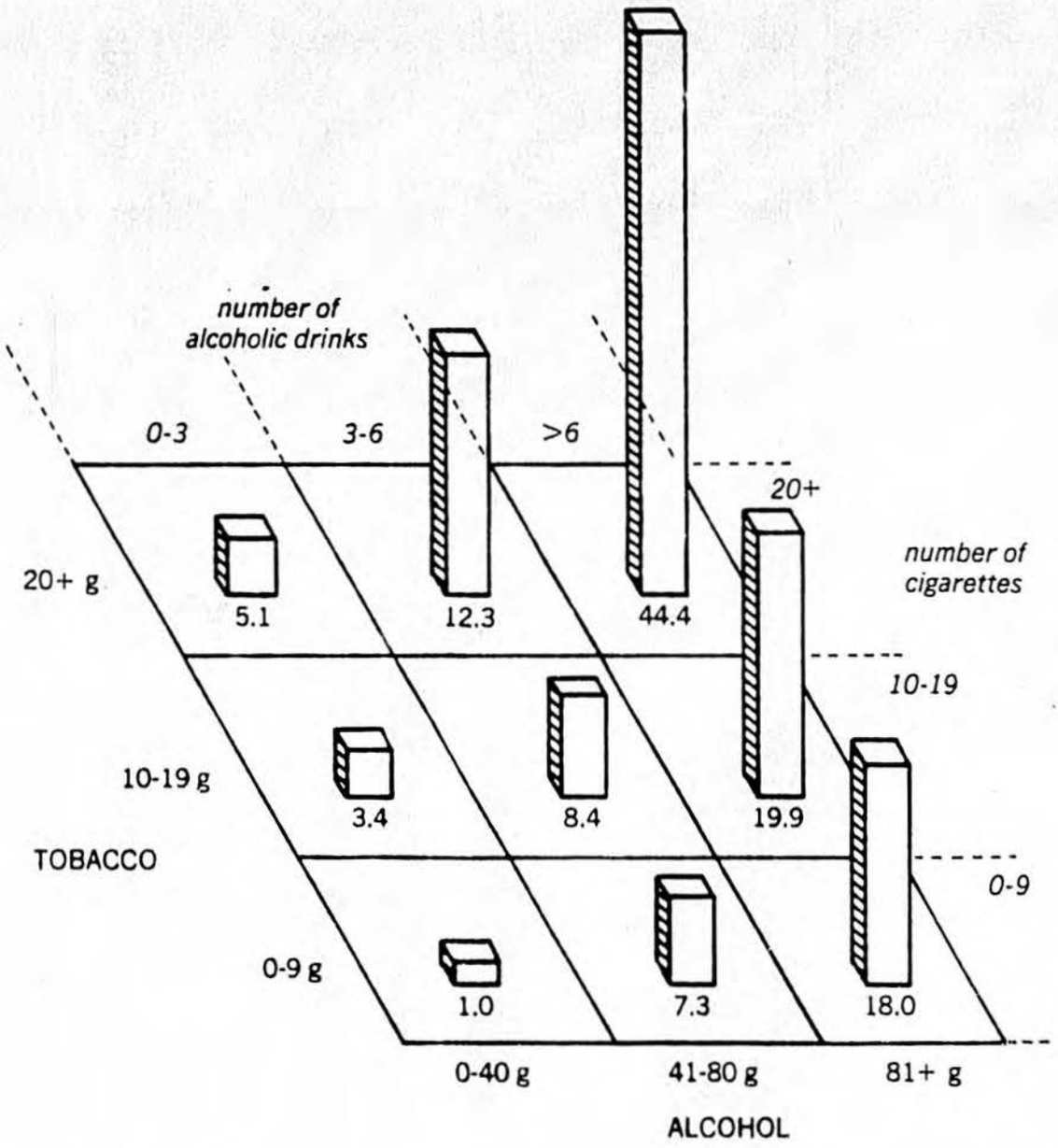
- Alcohol abuse and alcoholism cost the United States nearly $43 billion in 1975--including $19.64 billion in lost production, $12.74 billion in health and medical costs, $5.14 billion in motor vehicle accidents, $2.86 billion in violent crimes, $1.94 billion in social responses, and $0.43 billion in fire losses.

Figure 1. Drinking and Problem Drinking by Sex and Grade in School



SOURCE: Data from John E. Donovan and Richard Jessor, Adolescent problem drinking: Psychosocial correlates in a national sample study. *Quarterly Journal of Studies on Alcohol*. In press.

Figure 2. Relative Risks of Esophageal Cancer in Relation to the Daily Consumption of Alcohol and Tobacco



SOURCE: Data from A. J. Tuyns, G. Pequignot, and O. M. Jenson, Le cancer de l'oesophage en Ille et Vilaine en fonction des niveaux de consommation d'alcool et de tabac: Des risques qui se multiplient. *Bulletin du Cancer*, 65(1):45-60. 1977.

Note: The risk is 44.4 times greater for individuals consuming 20 g or more of tobacco and 80 g or more of alcohol per day (upper right block) than for individuals consuming little or none of either drug (lower left block). One ounce of ethyl alcohol is approximately 23.4 grams, thus 40 grams is 1.7 oz. or approximately equivalent to 3 drinks.

CHAPTER IV. THE FETAL ALCOHOL SYNDROME AND OTHER EFFECTS ON OFFSPRING

In February 1977 NIAAA sponsored a workshop to assess the state of knowledge gained from research on the intrauterine effects of alcohol. Reports were presented from human epidemiologic investigations, animal studies, behavioral assessments in animals and infants, and mechanistic studies exploring the biochemical consequences of maternal alcohol ingestion on metabolic function of fetal tissue. The evidence gathered from these studies clearly indicates that alcohol is a substance that can cause birth defects and behavioral impairment in offspring of mothers who consume it while pregnant. In particular, a unique pattern of dysmorphology with mental impairment occurs in some offspring of women who consume alcohol heavily; this condition has been termed the fetal alcohol syndrome (FAS) (see table 1).

When moderate levels of alcohol are involved, it is not easy to implicate alcohol as a unique factor in the development of birth defects and mental impairment. Furthermore, with human subjects, it is difficult to separate alcohol's effects from those of substances such as caffeine and nicotine. As a result, animal studies have become increasingly important as a means of studying the dangers of alcohol use during pregnancy and evaluating threshold limits.

Based upon the evidence presented and discussed at the workshop, the participants recommended that NIAAA issue a cautionary statement on alcohol use during pregnancy. On June 1, 1977, the following statement was released:

> Recent research reports indicate that heavy use of alcohol by women during pregnancy may result in a pattern of abnormalities in the offspring, termed the Fetal Alcohol Syndrome, which consists of specific congenital and behavioral abnormalities. Studies undertaken in animals corroborate the initial observations in humans and indicate as well an increased incidence of stillbirths, resorptions, and spontaneous abortions. Both the risk and the extent of abnormalities appear to be dose-related, increasing with higher alcohol intake during the pregnancy period. In human studies, alcohol is an unequivocal factor when the full pattern of the Fetal Alcohol Syndrome is present. In cases where all of the characteristics are not present, the correlation between alcohol and the adverse effects is complicated by such factors as nutrition, smoking, caffeine, and other drug consumption.
>
> Given the total evidence available at this time, pregnant women should be particularly conscious of the extent of their drinking. While safe levels of drinking are unknown, it appears that a risk is established with ingestion above 3 ounces of absolute alcohol or six drinks per day. Between 1 ounce and 3 ounces, there is still uncertainty but caution is advised. Therefore, pregnant women and those likely to become pregnant should discuss their drinking habits and the potential dangers with their physicians.

A version of this statement appeared in the June 3, 1977 (vol. 26, no. 22) Morbidity and Mortality Weekly Report, circulated by the Center for Disease

Table 1. Most Consistent Features of the Fetal Alcohol Syndrome

Growth and Performance

- Prenatal onset growth deficiency, more pronounced in length than in weight
- Concomitant microcephaly (small head circumference) even when corrected for small body weight and length
- Postnatal growth deficiency in weight and length, usually below 3rd percentile
- Delay of intellectual development and/or mental deficiency (mean IQ from Seattle study = 64, range 16-92)
- Fine motor dysfunction (poor coordination)

Head and Face

- Microcephaly
- Short palpebral fissures (narrow eye slits)
- Midfacial (maxillary) hypoplasia (underdevelopment of midfacial region)
- Flattened, elongated philtrum (middle of upper lip) associated with thin, narrow vermilion lip borders (highly specific to FAS)
- Minor ear anomalies including low set ears

Limbs

- Abnormal creases in the palm of the hand
- Minor joint anomalies
  - —syndactyly (fingers or toes joined together)
  - —clinodactyly (abnormal bending of fingers or toes)
  - —camptodactyly (one or more fingers constantly flexed at one or more phalangeal joints)

Heart

- Ventricular and atrial septal defect (valve defects)

Brain

- Absence of corpus callosum
- Hydrocephalus (excess fluid in cranium)
- Brain cell migratory abnormalities

Other

- Minor genital anomalies
- Hemangiomas (benign tumors made up of blood vessels) in infancy

SOURCE: Data from Kenneth L. Jones and David W. Smith, The fetal alcohol syndrome. *Teratology*, 12(1):1-10, 1975.

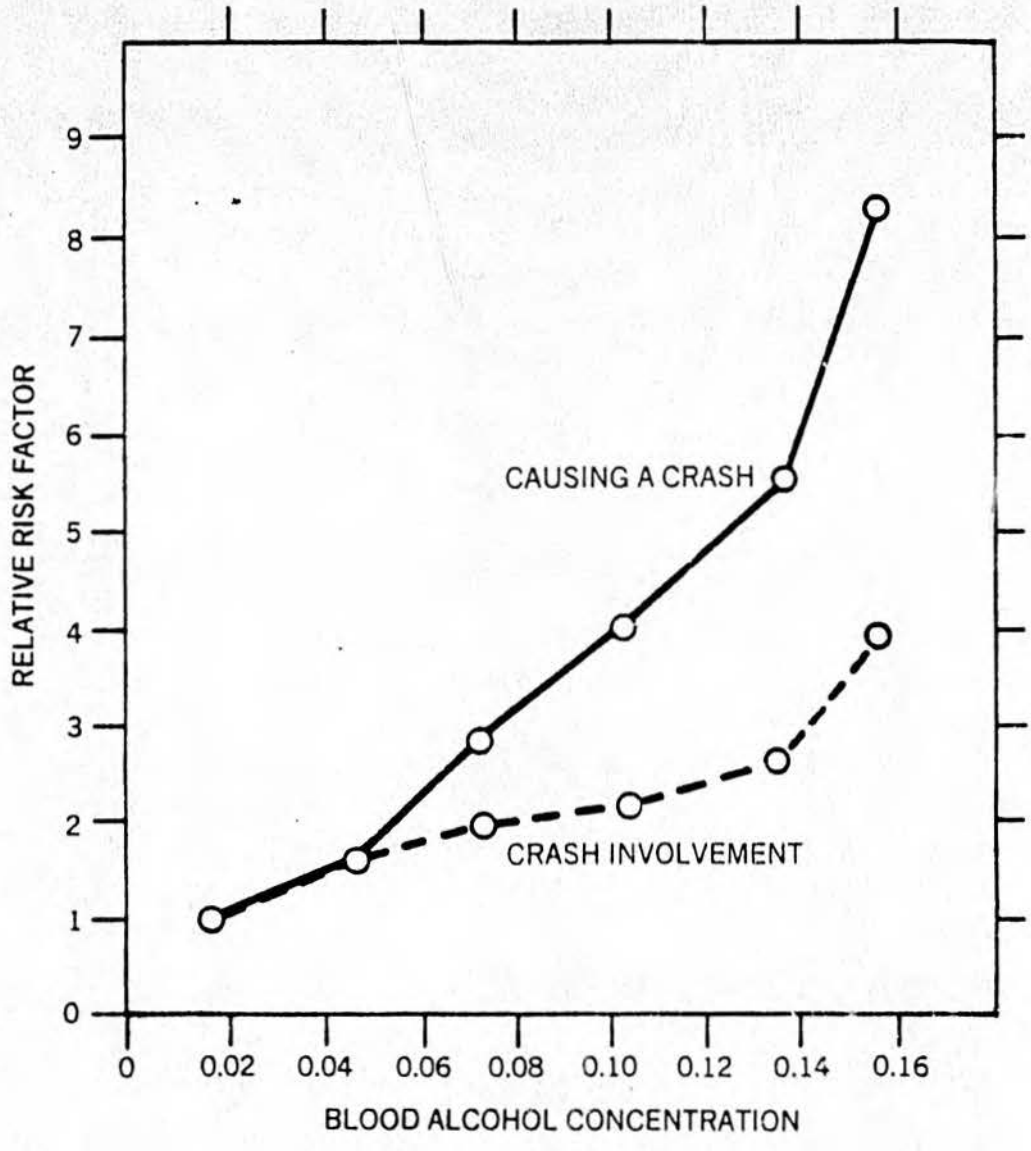
Table 1. Use of Other Drugs Among Current Drinkers and Those Who Are Not Current Drinkers*

Use of Other Drugs	Percentage of Youth: Ages 12 to 17 Years		Percentage of Adults: Ages 18+ Years	
	Current Drinkers	Not Current Drinkers	Current Drinkers	Not Current Drinkers
Size of sample (unweighted base)	302	684	1622	968
Nonmedical psychotherapeutic pill user				
Yes	18.8	6.5	18.9	9.4
No	81.2	93.5	81.1	90.6
Ever used marihuana				
Yes	44.3	11.8	31.4	6.9
No	55.7	88.2	68.6	93.1
Ever used other illicit drugs				
Yes	36.7	10.2	19.7	4.7
No	63.3	89.8	80.2	94.6

SOURCE: H. I. Abelson and P. M. Fishburne, *Nonmedical Use of Psychoactive Substances*. Princeton, NJ: Response Analysis Co., 1976.

*Those who report drinking alcoholic beverages within the past month.

Figure 1. Relative Probability* that a Driver Causes and Is Involved in a Crash as a Function of BAC Level



SOURCE: Marc Aarens, Tracy Cameron, Judy Roizen, Ron Roizen, Robin Room, Dan Schneberk, and Deborah Wingard, *Alcohol Casualties and Crime*. Special report prepared for National Institute on Alcohol Abuse and Alcoholism under Contract No. ADM 281-76-0027. Berkeley, CA: Social Research Group, University of California, 1977.

*Relative to the probability that a driver with a BAC of less than 0.03% is in or causes a crash.

Table 1. Changes in Alcohol Consumption in Four NIAAA-Funded Programs During 1976*

Program	Drinking behavior during past 30 days:						Number of Cases
	Percent Abstaining		Average Ethanol Consumed per Day (oz)		Average Number of Drinking Days		
	At Outset	6 Months Later	At Outset	6 Months Later	At Outset	6 Months Later	
Comprehensive alcoholism treatment program (ATC)	12	53	5.8	1.6	15	6	4280
Drinking driver program	8	44	2.5	0.8	12	5	1551
Occupational program	11	64	2.8	0.6	16	4	254
Public inebriate program	9	58	10.8	3.4	18	6	384
Average across programs	10	55	4.4	1.6	15	5	

SOURCE: Harriet Stambul, *Treatment outcomes*. Paper prepared for National Institute on Alcohol Abuse and Alcoholism under Contract No. NIA-77-10(P). April, 1977.

*All changes are statistically significant at or better than $p < 0.05$.

Table 2. Changes in Alcohol Consumption for Participants in NIAAA ATC Programs at 18-Month Followup

Group	Abstained Last Month (%)		Abstained Last 6 Months (%)	Ethanol Consumed per Day (oz)		Number of Cases
	At Outset	18 Months	18 Months	At Outset	18 Months	
Male non-DWI[1]	8	46[2]	24	8.3	2.5[2]	600
Female non-DWI[1]	13	56[2]	39	4.5	1.3[2]	158
Male DWI[1]	22	29	18	1.7	0.9	162

SOURCE: Harriet Stambul, *Treatment outcomes*. Paper prepared for National Institute on Alcohol Abuse and Alcoholism under Contract No. NIA-77-10(P), April 1977

[1] DWI denotes enrollment in connection with a driving-while-intoxicated incident.
[2] Changes are statistically at or better than $p < 0.05$.

the other facilities offered outpatient care as well as other services ranging from consultation to education. An assessment of nongovernment agencies indicated that Alcoholics Anonymous was most often cited as a treatment resource, followed by voluntary and private hospitals and clinics, councils on alcoholism, and private alcoholism residential programs. Although councils on alcoholism ranked third, they offered the broadest range of services--education, consultation, management and support, outreach, aftercare, and outpatient care.

Data compiled by NIAAA indicated that there were at least 1.1 million admissions for alcoholism treatment in 1976. The number of admissions by treatment sources is shown below.

NIAAA Funded Projects	337,000
Private Physicians	305,000
Mental Health Facilities	260,000
Veterans' Administration Hospitals	97,000
Department of Defense Facilities	40,000
Halfway Houses	36,000
Department of Transportation (Driving-While-Intoxicated) Programs	28,000
	1.1 million

In addition, it was estimated that in 1976 there were 320,000 admissions to Alcoholics Anonymous programs and 481,000 to short-stay hospitals.

The growth of treatment resources over the past decade is illustrated dramatically in the increase in occupational or industrial rehabilitation programs (see Chapter X, Occupational Alcoholism Programing), halfway houses, and programs funded by NIAAA. National surveys have shown that the number of halfway houses has grown from 40 in 1963 to more than 750 in 1976. In addition to providing transitional support to the alcoholic moving from inpatient care back to the community, halfway houses provide more cost-effective care than institutions. Since 1971 NIAAA has provided direct funding assistance to more than 850 treatment programs that have served more than 1 million clients. By 1976, 330,000 clients had been served in 554 treatment programs, representing a wide variety of treatment settings and modalities.

Although substantial numbers of treatment resources exist, several problems must be resolved. Most people with alcohol-related problems do not receive treatment for them. Various aspects of the barriers to treatment are discussed in this chapter, as well as in chapter II; issues surrounding the financing of treatment are presented in chapter XI. Greater understanding is needed of the mixture of services necessary to provide the most effective and efficient treatment to the largest number of people.

BARRIERS TO TREATMENT

There may be several major reasons why only a small proportion--approximately 10 percent--of the Nation's 10 million problem drinkers (including alcoholics) receive treatment each year. A number of psychological, sociological, and economic factors interfere with the utilization of treatment

CHAPTER XI. FINANCING ALCOHOLISM TREATMENT SERVICES

The magnitude of the alcohol problem in this country and the economic costs to society of alcohol-related problems have been discussed in chapter I of this report. It has been noted that health care costs directly attributable to alcohol-related problems are an estimated 12.1 percent of U.S. national health expenditures. There is a significant opportunity for reducing health care expenditures if effective alcoholism treatment services are supported. Recognition of this opportunity has led to funding by Federal, State, and local governments, as well as to modifying health insurance policies to cover alcoholism services. This chapter discusses these and other funding sources that currently are being used to finance alcoholism treatment services.

GOVERNMENTAL SUPPORT

Since its inception in 1970, the National Institute on Alcohol Abuse and Alcoholism has been helping to establish alcoholism programs by funding service projects directly and by making Federal formula grants available to States. An added source of Federal moneys became available from NIAAA in 1974 when incentive grants to the States were authorized to encourage the adoption of the Uniform Alcoholism Treatment and Intoxication Act. In addition, Federal support from other agencies (table 1) totaled approximately $207 million in 1976.

The financial base at the local level has expanded as States and other local governments either matched Federal funds or appropriated other sources of support. Federal, State, and local administrators consequently have sought to determine what resources are available for alcoholism programs and to identify what services these moneys are buying. This information is compiled in NIAAA's State Alcoholism Profile Information System (SAPIS), developed to discover the impact of formula grants within the States. According to a 1977 SAPIS report of 43 States providing information, average financial sources were formula grants, 13 percent; other NIAAA funds, 17 percent; local sources, 17 percent; and State and other Federal funds, 53 percent. An average of $7,322,000 per State was available to the States in FY 1976.

Information about resources undoubtedly will be improved by the SAPIS program, the impact of 1976 legislation requiring an accounting of States' public and private alcoholism service facilities in formula grant applications, and a recent NIAAA initiative to compile an annual report on all Federal activities related to alcohol problems.

Whatever the precise level of public funding of treatment services may be, nonpublic support clearly is required if adequate treatment resources are to be made available. Therefore, the extent of health insurance coverage for alcoholism treatment is of great concern. To illustrate the situation, table 2 shows the amount of insurance coverage of clients of selected NIAAA programs in 1976. The proportion of individuals with health insurance at all and with alcoholism coverage in particular varies

Table 1. Federal Agency Alcoholism Obligations for Treatment Services

Treatment and Rehabilitation	1976 Actual (Thousands of Dollars)
DHEW:	
ADAMHA (NIAAA)	$ 93,616
Human Development	32,414
Subtotal	$126,030
HUD	$ 2,693
Department of Defense	14,109
Veterans Administration	62,286
Department of Transportation	253
Department of Justice	291
Other	925
Total Treatment and Rehabilitation	$206,587

Table 2. Health Insurance Reports by Clients of Selected NIAAA Programs (1976)

	Alcoholism Treatment Programs (%)	Public Inebriate Programs (%)	Occupational Programs (%)	Problem Drinking Driver Programs (%)	Cross Population Programs (%)
Clients with Health Insurance	48.0	21.0	85.0	56.0	48.0
Health Insurance Covers Alcoholism	18.0	10.0	45.0	10.0	18.0
Medicare	2.3	1.6	0.2	0.5	1.6
Medicaid	3.9	4.5	1.5	0.7	5.3
Blue Cross/Blue Shield	4.8	1.8	22.8	3.7	5.6
Private Insurance	3.7	1.3	11.6	2.2	3.1
Other	3.6	1.2	9.2	2.8	3.0
No. of Projects Reporting	39	20	14	19	47

SOURCE: Data from D. C. Jones, D. T. Kay, and B. B. Silber, *Implementation of the State Alcoholism Profile Information System (SAPIS)*. Final report prepared for National Institute for Alcohol Abuse and Alcoholism under Contract No. ADM 281-76-0003. 1977.

widely with the type of program. Health insurance coverage varies from 21 to 85 percent and alcoholism coverage from 10 to 45 percent. The proportion of individuals with health insurance who also have alcoholism coverage ranges from 18 percent to 53 percent.

HEALTH INSURANCE

Health insurance has been made available specifically for alcoholism only within the last decade. In the past, alcoholism was a hidden illness, and treatment usually took place in a State-supported institution because care in the private sector was either unavailable or prohibitively expensive. Little is known about the nature or extent of insurance coverage for alcoholism before the mid-1960's. However, it is safe to assume that many alcoholics received treatment under the mental health benefits of their insurance policies.

By the late 1960's it became clear that insurance carriers and providers were applying obvious sanctions to the treatment of alcoholics. Hospitals frequently blocked the admission of alcoholics, and health insurance policies limited coverage in many ways. With the dramatic surge of health care costs in this era and the increased recognition of the extent of alcoholism and alcohol abuse, the need to establish effective private third-party payment mechanisms was clear. NIAAA worked with representatives of health agencies and insurance carriers to study the status of alcoholism insurance coverage, to identify barriers to improved coverage, and to develop model benefit provisions.

PRIVATE SECTOR PLANS

The private sector has three major components: Blue Cross-Blue Shield plans, commercial insurance companies, and independent plans. Blue Cross-Blue Shield is a confederation of two private nonprofit corporations. Commercial companies include life and casualty insurance companies as well as other companies that provide health coverage. Finally, independent plans include employer- or employee-sponsored programs, health maintenance organizations, private group clinics, and dental service corporations.

Blue Cross-Blue Shield

An estimated 84 million subscribers are covered by the approximately 70 Blue Cross and Blue Shield associations operating in the United States and Puerto Rico. In 1976, the Blue Cross Association (BCA) and NIAAA initiated a nationwide study to determine the feasibility of offering comprehensive benefits for alcoholism treatment throughout the Blue Cross health insurance system. The study has produced a series of technical assistance documents designed to address the essential components needed in comprehensive alcoholism coverage. They were (1) a marketing package, including the benefit structure, a defined target population, rates, and a subscriber education program; (2) an administrative segment covering contracts with health care providers, legal constraints, and control of benefit utilization; (3) a guideline for test-site selection; and (4) a program for evaluating test-site results.

Some individual Blue Cross plans are offering increasingly comprehensive alcoholism benefits. In 1974, for instance, Capital Blue Cross in Pennsylvania introduced an alcoholism benefit that provided rehabilitation treatment immediately following detoxification in institutions specializing in alcoholism treatment. Premiums were not increased for this benefit because the plan's administrators realized that alcoholism treatment previously had been paid for under other diagnoses. Current data indicate that the benefit will reduce the number of claims and the total costs incurred by the carrier.

Blue Cross of Maryland provides alcoholism treatment benefits through one program in residential nonhospital settings and through another in outpatient care. Substance-abuse benefits--including alcohol and other drugs--were made available to the approximately 1 million members of the United Auto Workers Union, their spouses, and dependent children by Blue Cross and Blue Shield of Michigan.

Commercial Carriers

The trend among major commercial carriers is toward offering coverage for alcoholism treatment. The percentage of policies specifying exclusions or limitations on alcoholism coverage dropped from 16.5 percent in 1972 to 13 percent in 1975, according to one survey.

Independent Plans

Health Maintenance Organizations (HMO's). HMO's provide basic and supplemental health care on a prepaid basis to their membership. To qualify for Federal subsidies, an HMO must offer medical treatment and referral services for alcohol or other drug abuse. The Group Health Association of America, a national voluntary organization of group health plans, initiated an alcoholism treatment feasibility project to test the potential of comprehensive alcoholism treatment services in prepaid group practice plans. Although the data are too limited to be conclusive, indications are that there is a reduction in total health care use when alcoholism is identified and treated appropriately.

The Harvard Community Health Plan. This plan in Cambridge, Mass., which includes both inpatient and outpatient alcoholism benefits, reported a monthly cost for alcoholism treatment of only $0.05 per member. During the first year, no client used the inpatient treatment beyond the benefits provided.

Employee Benefit Plans. The industries sponsoring occupational alcoholism programs usually have policies that cover inpatient services, according to one survey. Considerably less coverage was provided for outpatient treatment.

Unions and Health Insurance Plans. The Nation's labor unions have participated actively in encouraging health insurance coverage for treating alcoholism and other drug abuse. Unions affiliated with the AFL-CIO and major independent unions such as the United Auto Workers, the United Mine Workers, and the Teamsters are implementing and expanding alcoholism treatment benefits.

PUBLIC SECTOR PROGRAMS

Several health insurance assistance programs are provided by law under Federal or State auspices and are financed through taxes. Benefits, fixed by law, are available to those who qualify under the plan. These publicly supported programs include medicare, medicaid, CHAMPUS (Civilian Health and Medical Care Program for the Uniformed Services), the Veterans' Administration program, and State temporary workers' compensation systems.

Medicare

Primarily, medicare pays medical expenses to individuals aged 65 or older who are entitled to retirement benefits under title II of the Social Security Act or under the Railroad Retirement System. Administered by the Social Security Administration, medicare's benefits and eligibility requirements are uniform for all participants and include hospital insurance and supplementary medical insurance for the aged and disabled. Medicare categorizes alcoholism and drug abuse treatment under psychiatric or mental health services, and the coverage is less than that available for physical illness.

Medicaid

Medicaid provides medical assistance to low-income individuals. Treatment cost is shared by the States and the Federal Government. A major limitation is that persons aged 21 to 64 cannot receive care in a psychiatric hospital under medicaid. In several States, however, medicaid plans provide reimbursement for treatment of problems associated with drug or alcohol abuse. Because services for alcohol or drug abuse problems are not mentioned in the medicaid statutes, the States determine whether treatment should be excluded or included.

A 1976 telephone survey revealed a wide range of practices. Most States reimburse for inpatient treatment of organic illnesses caused by or related to alcoholism, and 85 percent of the States reimburse for outpatient care for these illnesses. The proportion of States that reimburse for direct treatment of alcoholism is substantially lower. Approximately two-thirds reimburse for treatment at a community health center; nearly one-third pay for care at an alcoholism treatment center or from an alcoholism counselor; and about one-tenth absorb treatment costs at a halfway house or similar facility.

Title XVI

Under title XVI of the 1973 Social Security Act, supplemental security income (SSI) is granted by the Federal Government to those eligible for Aid to Families with Dependent Children, to the blind, to persons who are otherwise disabled, and to needy persons over the age of 65. The present social security law requires an alcoholic SSI recipient to designate a third party to receive his or her supplementary income. Often, this procedure undermines the self-confidence of recovering alcoholics. Pending legislation would enable the attending physician of the facility where an individual is undergoing treatment to certify that direct payment of SSI benefits

to the patient would be beneficial. The costs of alcoholism treatment generally are not covered by the SSI program.

Title XX

Title XX, a 1975 amendment to the Social Security Act, currently contributes $2.7 billion annually to the States for social services. The required State comprehensive plans may include alcoholism treatment services if they are defined explicitly. A 1976 analysis of services available for treatment of alcoholism and drug abuse under State title XX plans revealed that 10 States provide services specifically concerned with treatment of alcohol abuse; 11 pay for services related to both alcohol and drug abuse, and 16 reimburse for specific mental health services.

CHAMPUS and CHAMP-VA

This insurance program for dependents of military personnel covers inpatient and outpatient care for alcoholism. However, inpatient rehabilitative care beyond detoxification is limited to a lifetime maximum of three admissions, and outpatient treatment is limited to psychiatric services. A similar program, CHAMP-VA, is available to the dependents and survivors of some disabled veterans.

Disability Insurance

Public disability programs involving workers' compensation are available in all 50 States. Compensation is limited by 27 States if alcoholism or problem drinking is the cause of injury resulting in a claim.

OTHER FEDERAL INVOLVEMENT

National Health Insurance

In view of the tremendous health, social, and economic costs related to alcoholism, benefits for alcoholism and related health problems should be considered in the development of health insurance coverage. These should include a range of service components to assure a minimum level of continuity of care for alcoholism treatment.

A recent cost-benefit study of alcoholism treatment centers reinforces the argument for including coverage for alcoholism care in any health insurance package. The study found that the national economy will realize 10 years of benefits, estimated at close to $22 million, from the operation of 41 alcoholism treatment centers during the last half of 1974. However, half of the 20 legislative proposals for national health insurance introduced in the 94th Congress did not mention alcoholism specifically.

Civil Service Plans

The Federal Government offers 55 health insurance plans to its employees. Most of these include some benefits for alcoholism, although the extent

of the coverage varies widely. Some plans have a specific alcoholism benefit, but most alcoholism treatment is part of the mental health benefits or some other benefit category.

NIAAA Activities

NIAAA has sponsored a range of studies to plan increased health insurance coverage for alcoholism treatment and has developed experimental projects to demonstrate the feasibility of this type of insurance. The agency helped to develop standards for treatment facilities that, when implemented, lead to accreditation. When a facility is accredited by the Joint Commission on Accreditation of Hospitals (JCAH), more carriers are willing to insure the care provided there. More than 200 alcoholism programs nationwide have been accredited by JCAH.

One of the agency's feasibility studies resulted in a model alcoholism treatment package designed to provide insurance companies with a basis for projecting a range of costs in various alcoholism treatment settings. The model benefit package recommends 6 days of inpatient emergency care, 14 days of inpatient care, 30 days of outpatient care, 30 days of short-term intermediate care, and 60 to 90 days of long-term intermediate care. This package was tested for 2 years in the California State Employees' Insurance Alcoholism Program.

NIAAA is concerned with State and local service programs in several administrative areas, including training, cost accounting systems, and policy procedures, and is working with others in the field to develop certification standards for alcoholism counselors.

STATE INVOLVEMENT

State Regulatory Agencies

Since State insurance departments are empowered by statute to regulate the extent and cost of insurance contracts and the conduct of insurance carriers, State legislative actions have become important in setting minimum standards for alcoholism treatment. A mid-1976 survey of State legislative activities showed that insurance coverage for alcoholism treatment had increased considerably since 1974. Unfortunately, the enacted legislation often emphasizes inpatient care and limits outpatient treatment, although recently some States have mandated more extensive outpatient benefits. By mid-1977, 20 States had enacted legislation into law, and 11 other States had introduced legislation related to health insurance coverage for alcoholism (figure 1).

California State Employees' Insurance Alcoholism Program

This 2-year pilot alcoholism program was based on the model benefit package described briefly above and more extensively in the Second Special Report on Alcohol and Health. It offered benefits for 158,000 State employees and more than 300,000 family members, through nine insurance carriers. The program involved no risk for the various moneys paid for both alcoholism treatment claims and carrier administrative expenses.

Figure 1. State Legislative Activities Relating to Health Insurance Coverage for Alcoholism, 1971-77

SOURCE: Data from Jerome Hallan and Becky Hayward, Health insurance coverage for alcoholism: Current status. Unpublished report prepared for National Institute on Alcohol Abuse and Alcoholism under Contract No. ADM 281-76-0023. Raleigh: H-2, Inc. 1977.

The alcoholism benefit package provided

- inpatient care in a hospital or other licensed facility, including up to 6 days of detoxification services and 21 days of treatment a year;
- day or night residential care in a licensed recovery home for a maximum of 30 days annually; and
- outpatient care limited to 45 visits a year to a physician or to a licensed or certified professional or paraprofessional mental health worker.

For each of the 766 persons participating in the program, the average expenditure was approximately $600. Some 422 inpatient admissions were recorded at an average cost of $1,392. An estimated 540 persons each attended an average of nine outpatient sessions at an average cost of $17 a session. Outpatient care benefits represented approximately 16 percent of the total benefits paid. Recovery-home care was the least used service.

For one evaluation, data were collected on nonalcoholism health care for 2 years before treatment began and continued during treatment. Preliminary findings indicate that average monthly nonalcoholism treatment costs were reduced by approximately 25 percent after a person began treatment for alcoholism.

If the State of California had not paid for all costs of the pilot program, the additional average premium for each family enrolled in the State and public employees' program would have been only $2.05 a year, or $0.17 per month, to cover the cost of alcoholism treatment. However, these estimates are based on a relatively low utilization rate for the available services.

SUMMARY

- Federal, State, and local government funds constitute a significant proportion of the resources for alcoholism treatment. If adequate treatment coverage is to be provided to alcoholics, a major increase in the share of this support must be provided by health insurance.
- Lack of third-party reimbursement has limited the number of service providers. Until recently, insurance carriers were reluctant to cover treatment of alcoholism, but the trend is changing. For example, in 1972 approximately 25 percent of all Blue Cross plans specifically excluded alcoholism. By 1976, only 4 of 60 plans responding to a survey excluded alcoholism treatment.
- Although some private insurance carriers still exclude or limit alcoholism treatment, increasing numbers are providing coverage.
- Increasingly comprehensive alcoholism benefits are being offered by individual Blue Cross plans. Some offer alcoholism treatment in special inpatient centers and others provide innovative outpatient

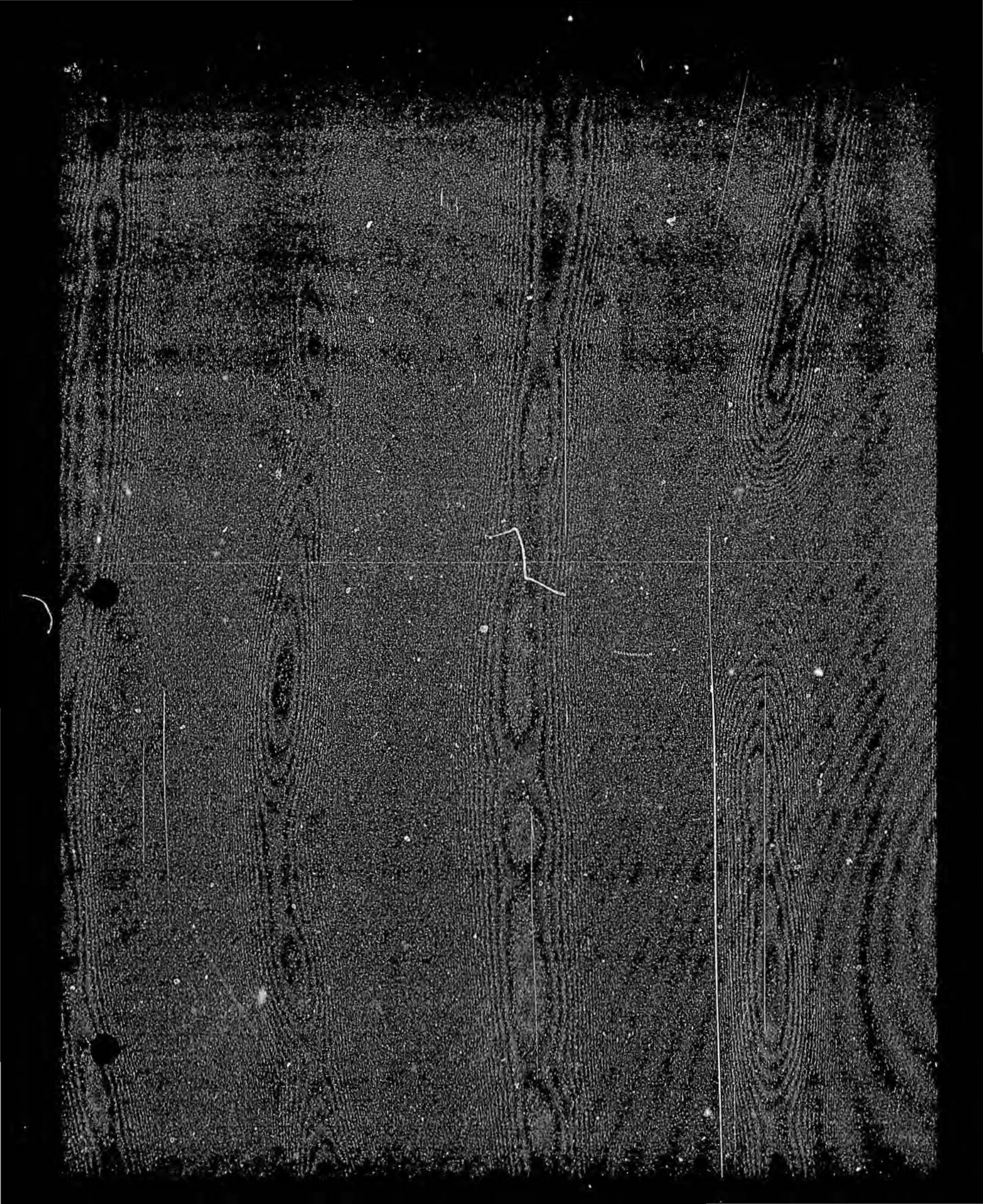
care. The United Auto Workers union Blue Cross coverage includes both residential and outpatient treatment.

- Many employee health insurance plans specifically include inpatient alcoholism treatment; far fewer cover outpatient treatment.

- State legislatures are concerned about the availability of insurance for alcoholism treatment. Twenty States have enacted legislation either mandating that alcoholism coverage be provided or requiring that it be available as an option.

- Preliminary findings from a California experimental project indicate that the average monthly nonalcoholism health care costs for both the alcoholic and the immediate family were reduced by 25 percent after the individual began treatment for alcoholism.

- Varied benefits are offered in the public sector. Current medicare provisions for alcoholism treatment to the aged and disabled are restrictive compared to benefits available for physical disease. Medicaid programs often ignore treatment for alcoholism. The Supplemental Security Income Program (title XVI of the Social Security Act) employs sanctions against the alcoholic who fails to stay in treatment. Alcoholism treatment is specifically provided for under the Social Services for Individuals and Families Program (title XX of the Social Security Act) in 10 States, and specific alcoholism services are reimbursed by 11 States.



Alcoholic Person's Right to Disability Aid Stressed

Disabled alcoholic persons have the same right as other disabled persons to receive social security disability payments if they meet the eligibility requirements, according to John A. Noble, deputy director of NIAAA's Division of Special Treatment and Rehabilitation.

However, says Mr. Noble, greater awareness of this right must be acquired both by disabled alcoholics and treatment personnel to ensure that eligible alcoholics receive their fair share of such payments.

The Institute is concerned over whether eligible alcoholics are receiving disability benefits—both for "humanitarian interest" and because "we would like to see as many funding sources as available made accessible to alcoholic people," Mr. Noble said at a recent meeting of the National Advisory Council on Alcohol Abuse and Alcoholism.

He noted that alcoholic persons who qualify for disability payments can receive fully paid treatment if selected as candidates for vocational rehabilitation. The Social Security Administration (SSA) pays all costs of rehabilitation for disabled persons when it can be shown that this will help remove such persons from the disability rolls.

Alcoholic persons who might be eligible to receive social security disability funds often fail to apply for this aid due to a widespread misunderstanding of the facts, Mr. Noble said. This probably stems from lack of knowledge by the public about changes in SSA regulations that have in recent years improved the prospect that an alcoholic person will qualify for the disability program, he suggested.

Under a 1956 criterion, alcoholism and drug abuse were viewed as personality disorders. There was some evidence that, as a result, a diagnosis of alcoholism or drug abuse "may have discouraged some examiners from giving further consideration" to a disability case, Social Security Administration officials said in discussing the subject in a top-level HEW conference in 1973. (They added at the time that "such cursory treatment of claims on the basis of diagnosis was not intended.")

Between 1968 and 1974, evidence of "irreversible organ damage" was used in disability determinations to demonstrate the presence of chronic alcoholism. Again, according to Social Security officials, the absence of such damage "was not infrequently a cause for rejection despite the presence of significant function psychopathology or organic pathology," Mr. Noble noted.

In 1974, Social Security dropped the language about irreversible organ damage and reemphasized that alcohol or drug abuse should be evaluated as a disability based on the symptoms, signs, and laboratory findings in each case, and not on the "diagnostic label" of alcoholism or drug addiction.

How does one qualify for disability payments?

Under SSA regulations, an individual is deemed to have a disability if unable to engage in substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted, or can be expected to last, for a continuous period of at least 12 months.

It is not known how many disabled alcoholics are receiving social security disability payments. As a possible indication of the number, 2 percent of a sample of applicants for disability had reference to severe alcohol problems in their records. Though this sounds like a small figure, 2 percent of the several million receiving these payments would amount to a significant total, Mr. Noble said.

Receiving payments under

(Mutual) INS Bulletin

the social security disability program are approximately 2.5 million disabled persons, plus 1.9 million dependents. An additional 2 million are receiving disability benefits under the newer Supplementary Security Income (SSI) program of the Social Security Administration. An estimated $12.4 billion is being paid out annually in the two programs.

The SSI program has complicated the picture since it was introduced in 1974, Mr. Noble said. Under this program, alcohol- and drug-dependent persons "are treated differently from other disabled persons" in that they must be in treatment for their disorder in order to be eligible for payments and, in addition, the payments are not sent directly to them but to a person designated as their payee.

SSA officials note that no special funds or facilities have been provided to treat such persons under the SSI program.

The Treatment and Rehabilitation Working Group of the Interagency Committee on Federal Activities for Alcohol Abuse and Alcoholism has taken a special interest in the SSI program, which falls under Title XVI. A resolution on the program initiated by the Working Group and sent by the Interagency Committee to SSA Commissioner James B. Cardwell requested that the SSA:

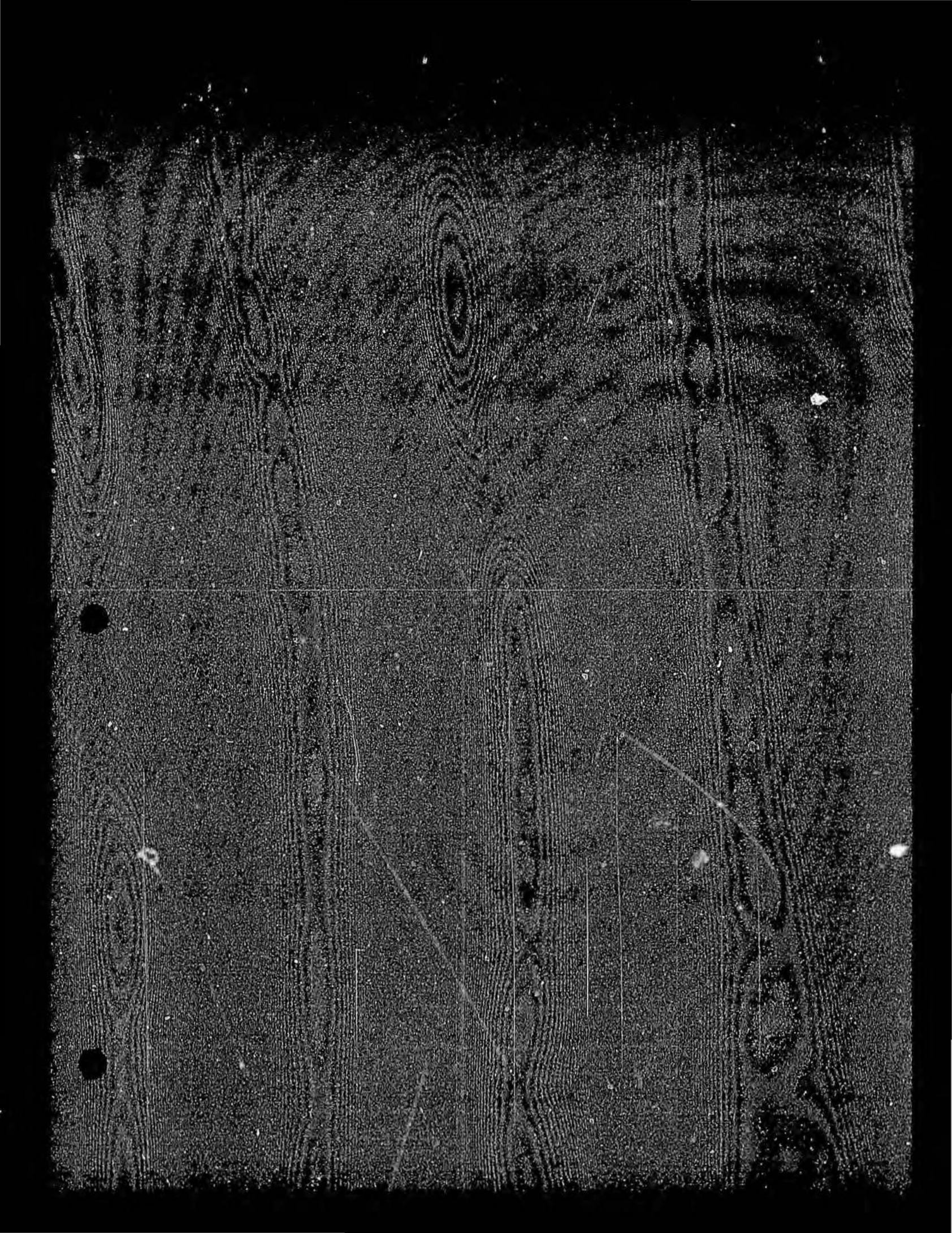
"1. Take the necessary steps to assure that disabled alcoholic persons receive the same consideration as any other applicant in the disability determination process in Title XVI, and that any indication of alcohol abuse or alcoholism manifested by an applicant be fully developed.

"2. Place greater emphasis in the Title XVI program on assuring that the maximum number of disabled alcoholic persons enter treatment services."

In reply, Elmer Smith, Associate Commissioner for Program Policy and Planning, SSA, wrote Dr. Ernest P. Noble, NIAAA Director expressing concern that applicants with alcohol addiction receive the same consideration as other applicants under SSI. He noted that the change in SSA regulations deleting reference to "irreversible organ damage" as a sign of alcoholism was made to aid in fully developing indications of alcoholism in disability applicants.

Mr. Smith also indicated that SSA's program goals are consistent with the Interagency Committee's resolution, and expressed an interest in receiving the Committee's suggestions on specific aspects of the SSI program. However, he stated that SSA was not prepared "to offer specific program changes at this time."

Persons interested in disability payments for alcoholic persons under either of the two SSA programs should contact their local Social Security office.



LIQUOR LINKED TO ROAD DEATHS

About half the drivers killed in multiple fatality traffic accidents in Wisconsin in the latter part of 1977 had been drinking, Acting Gov. Martin Schreiber said.

Schreiber released the results of a study he commissioned after 27 persons died on Wisconsin's highways last Aug. 19-21, the highest non-holiday weekend traffic toll in state's history.

Of the 32 drivers killed in multiple fatality accidents in the next four months, 14 were legally drunk when they died, two had some alcohol in their blood, 15 tested negative and one was not tested, Schreiber said.

Twenty-five of the 66 drivers involved in the accidents had from one to five speeding convictions on their records, and four had been convicted of drunken driving, the study added.

It said only seven of the 118 drivers and passengers involved in the multiple fatal auto accidents were wearing seat belts. Three of the seven died. Schreiber's safety advisers estimated that another 10 of the victims would have survived had they been wearing safety belts.

The four persons killed on motorcycles in the accidents surveyed all were wearing helmets.

The team that conducted the study said three-fourths of the drivers of the motorcycles, compacts and subcompacts involved in the accidents were killed, but only two-fifths of the drivers of the intermediate and full-sized cars and trucks involved in the accidents were killed.

DRIVE-A-DRUNK

Is Wisconsin Next?

One of the fascinating things about life is people's ingenuity. Let a need arise — any need — and someone will start a business to fill it.

In California, in 1971, a need arose. That was the year the courts ruled that a bar owner is liable to civil suit if he serves a person who is obviously drunk. It took a while, but now an organization has been created to serve it. Drive-a-Drunk, it's called.

It is a simple, and ingenious, idea. If you are out drinking someplace, and you think you have had too much

(continued on page 16)

SOCIAL DEMANDS TOO COSTLY

Americans, in their "headlong rush for social and economic progress," may be in danger of stifling the institutions that make progress possible, William B. Spann, Jr., president of the American Bar Association, said.

"Not only the disadvantaged but the entire population demand a wide variety of social benefits unknown and inconceivable a generation ago," he said.

This adds up to a psychology of entitlement, a belief that "what we want is what we have a right to," said Mr. Spann, and it gives him concern, he added, because "the world does not have unlimited resources to satisfy our every whim."

Mr. Spann said he believed government should draw up "balance sheets" for each new proposed program so that its social and economic costs "can be as easily perceived as its economic gains."

For their parts, business and the professions must make "critical choices," he said.

"How much justice can we afford? As lawyers we must participate in the answering of that question and then seek vigorously for solutions that will give us the fastest and fairest adjudication of disputes within those limits," he said.

"Can your industry insure against every risk? Can society afford the premiums? If not, rational boundaries must be established so that individuals will bear more responsibility for their own actions."

He said the time has come for the legal profession and the insurance business "to help society define the limits of the attainable and to exercise vigorous leadership in delivery within those limits."

Life Insurance Paid $4 Billion Tax to federal, state and local governments in 1977.

When change is successful we look back and call it growth.

(**Drive-A-Drunk** continued from page 7)

to be able to drive safely, you call Drive-a-Drunk. You tell them where you are, and where you want to go. They will quote you a fee ranging from $15 upward, depending on how far it is. If you go for it, they send out two people in a car. One drives you home in your car, and the other follows in their vehicle. They deposit you on your doorstep, and leave you to negotiate your way to your bedroom all by yourself.

The advantage to all this is that, unlike calling a taxi for safe transportation home, you don't have to face the hassle of getting your car the next day. And the service really doesn't cost much more than a cab anyway, depending on the distance involved.

(**Twenty Commandments** continued from page 12)

gets out of hand, advise the company why you referred it to an adjuster. If you "goofed" (and who doesn't) so advise the company.

8. Don't try to get your adjuster to color the facts to the company. If you want a favor in settlement, contact the production department of the company.
9. Remember that no one can sell everyone. If a serious difference of opinion exists between the insured and adjuster contact the adjuster. Get his story. If he is right, help him sell the insured.
10. Get well acquainted with your adjuster. Make him want to do a good job for you.

TEENAGE DRINKING

Lowering the legal drinking age to 18 has had no effect on highway crashes in the state, but has resulted in more arrests of 13-17 year olds for liquor law violations, according to a report by the Wisconsin Council on Alcohol and Other Drug Abuse.

Although not yet formally released, the report said that while the number of liquor law violation arrests dropped by more than 60 percent for the 18-20 year olds, it increased by 120 percent for 13-17 year olds.

"It means that more kids are drinking younger, more liquor and more frequently, but those facts do not represent a significant difference in overall trends that have been going on since Prohibition," said one Department of Health and Social Services employee.

ALCOHOL AND AUTO DEATHS

About 70 percent of all drivers killed in Wisconsin highway crashes from 1968-77 were alcohol-involved (above the .05 percent legal evidence of intoxication level), yet just 65 percent — or five percent fewer — 18-20 year old driver deaths involved alcohol.

While nearly seven percent of all Wisconsin highway accidents involved drivers who "had been drinking," the 18-20 age group was no more represented than any other.

Other alcohol-related facts are:

• Wisconsin residents consumed 12 million gallons of absolute alcohol in 1975 — enough to give every resident, age 15 and older, 962 drinks per year.

• Nine percent of all high school students — nationwide — smoke marijuana daily while six percent say they daily consume alcohol.

• Approximately 80 percent of all 12th graders say they drink alcohol; 72 percent of all seventh graders say the same.

• An estimated 185,743 Wisconsin kids between 13-19 could be considered "problem drinkers" while 13,936 are considered "alcoholics."

Although about 92 percent of the 42,500-mile Interstate Highway System is open to traffic, more than 28,000 miles require safety and other improvements, according to the Department of Transportation.

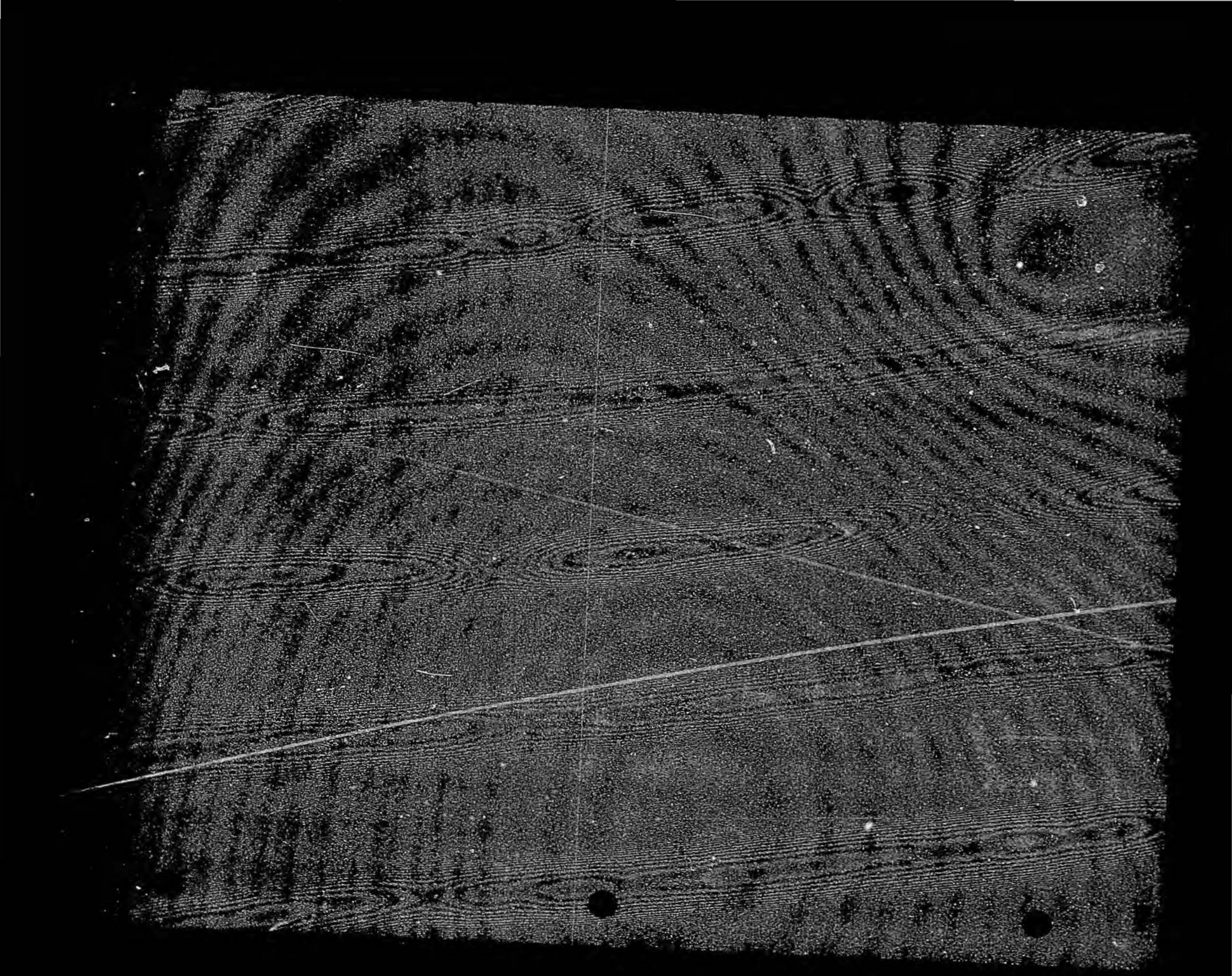


TABLE 1—MORTALITY FROM ALCOHOLIC DISORDERS

United States, 1963-64 and 1973-74

Sex and Age	Average Annual Death Rate per 100,000				Percent Increase† 1963-64 to 1973-74	
	1963-64		1973-74			
	White	Nonwhite	White	Nonwhite	White	Nonwhite
Male						
Ages 20 and over*	11.5	20.6	16.8	42.6	46	107
20-29	.6	4.9	1.1	7.3	83	49
30-39	4.9	23.1	7.0	39.7	43	72
40-49	15.2	33.4	22.9	70.6	51	111
50-59	25.1	29.2	34.9	76.0	39	160
60-69	25.9	24.3	40.0	48.7	54	100
70 and over	13.7	10.4	18.5	22.3	35	114
Female						
Ages 20 and over*	4.2	9.5	5.7	16.2	36	71
20-29	.2	2.6	.2	2.5	—	−4
30-39	2.4	12.9	2.3	15.2	−4	18
40-49	7.5	16.0	9.2	30.5	23	91
50-59	9.2	12.5	13.4	27.7	46	122
60-69	6.0	7.0	10.4	15.5	73	121
70 and over	2.5	‡	3.3	4.8	32	‡

*Adjusted on basis of age distribution of the United States total population, 1940.

†Minus sign (−) denotes decrease.

‡Fewer than 20 deaths.

Note: Disorders include Alcoholic psychosis (International Classification of Diseases, Adapted, 291), Alcoholism (ICDA 303), and Cirrhosis of liver, alcoholic (ICDA 571.0).

Source of basic data: Reports of the Division of Vital Statistics, National Center for Health Statistics.

Mortality from Alcoholism

Rising death rates from alcoholic disorders *(alcoholic psychosis, alcoholism,* and *alcoholic cirrhosis of the liver)* indicate that mortality from alcoholism in the United States is substantial. The true impact of the disease is hard to measure, however, because of considerable underreporting of alcoholism as a cause of death. The present system of tabulating mortality statistics by selecting the underlying cause of death excludes deaths in those cases where alcoholism is mentioned only as a contributory cause on the death certificate. In addition, many reporting physicians are reluctant to specify alcoholism as the underlying cause of death—when it is possible to assign another cause or complication—and may even omit mention of alcoholism as a contributory cause of death. Investigation of the causes of death indicates, however, that alcoholics are subject to excess mortality from all of the major diseases, as well as from accidents, suicide, and homicide.

Mortality from alcoholism rose alarmingly between 1963-64 and 1973-74, with a much steeper rise for nonwhites than for whites. As shown in Table 1, the death rate from alcoholic disorders doubled for nonwhite males at ages 20 and over, while the rate among white males rose by 46 percent. The disparity among females was not quite so great; nonwhite women experienced an increase of 71 percent, compared with a 36-percent increase among white women. The most substantial increase in mortality from alcoholism among nonwhite males (160 percent) occurred in their fifties, while the increase in mortality among nonwhite females reached about 120 percent at ages 50-69. Among whites, the increases were greatest for males at ages 20-29 (about 85 percent) and for females at ages 60-69 (about 75 percent).

The mortality rates from alcoholic disorders varied considerably by age. Death rates among white males in 1973-74 rose from 1.1 per 100,000 at ages 20-29 to 40.0 per 100,000 at ages 60-69, then dropped to 18.5 at ages 70 and over. Among nonwhite males death rates rose from 7.3 per 100,000 at ages 20-29 to a high of 76.0 at ages 50-59, before declining to 48.7 at ages 60-69 and to 22.3 at ages 70 and over. The rates among white females followed much the same pattern on a considerably lower scale, with a peak of 13.4 per 100,000 at ages 50-59. The mortality among nonwhite females reached its highest point at ages 40-49, with a rate of 30.5 per 100,000. Women of each race had uniformly lower death rates than did men in the same age group.

To determine the extent of alcoholism involvement in recently reported deaths, a special study of death claims has been conducted by the Statistical Bureau of the Metropolitan Life Insurance Company. All death claims paid during the 12-month period from June 1975 to June 1976 on Standard Ordinary policies issued by the Metropolitan were reviewed. Whenever an alcoholic disorder *(alcoholic psychosis, alcoholism,* or *alcoholic cirrhosis of the liver)* was mentioned anywhere on the death certificate, the available records were examined in detail. The 692 claims so selected were analyzed by age and sex and as to whether the alcoholic disorder had been reported as the underlying or contributory cause of death. (See Table 2.) Four out of five of these alcohol-related deaths occurred among males. Almost three-fifths of the deaths among men and about two-thirds of the deaths among women occurred in the age range 45-64. The proportion of alcohol-related deaths was also quite high among men aged 65 and over (about 30 percent) and among women at ages 25-44 (about 25 percent).

Of the 692 claims, alcoholic disorders were reported as the underlying cause of death in 536 cases; 462 of these deaths were assigned to *alcoholic cirrhosis of the liver,* 65 to *alcoholism,* and 9 to *alcoholic psychosis.* In the remaining 156 claims, alcoholic disorders were considered a contributory cause of death. It appears, there-

TABLE 2—MORTALITY FROM ALCOHOLIC DISORDERS*

Underlying and Contributory Causes

Metropolitan Life Insurance Company
Standard Ordinary Policyholders
Death Claims Paid June 1975-June 1976

Sex and Age	Number of Deaths		
	Total	Underlying Cause	Contributory Cause
Both Sexes	692	536	156
Male			
All Ages	553	415	138
Under 25	7	3	4
25-34	26	18	8
35-44	53	44	9
45-54	136	107	29
55-64	177	127	50
65-74	137	105	32
75 and over	17	11	6
Female			
All Ages	139	121	18
Under 25	—	—	—
25-34	8	7	1
35-44	25	23	2
45-54	51	44	7
55-64	38	34	4
65-74	13	10	3
75 and over	4	3	1

*Disorders include Alcoholic psychosis (International Classification of Diseases, Adapted, 291), Alcoholism (ICDA 303), and Cirrhosis of liver, alcoholic (ICDA 571.0).

fore, that underreporting of alcoholism as a cause of death could be as high as 25 percent.

The same death claims were then analyzed to determine which other causes of death were associated with alcoholism when it was either the underlying or the contributory cause; the results are presented in Table 3. In 319 claims alcoholism was considered the underlying cause of death, and one or more contributory causes were also mentioned on the death certificate. Diseases of the digestive system (gastrointestinal bleeding, ulcers, pancreatitis) were the most frequently reported contributory cause, occurring in 27 percent of the cases. Certain vascular diseases (mostly bleeding esophageal varices) accounted for 24 percent of the deaths, and diseases of the urinary system (renal failure, urinary infection) for 22 percent. Diseases of the respiratory system (bronchopneumonia, pulmonary edema, emphysema) and heart disease were reported somewhat less frequently (19 percent and 16 percent, respectively).

The second column in Table 3 gives the distribution of the underlying causes of death for the

TABLE 3—MORTALITY FROM ALCOHOLIC DISORDERS* ASSOCIATED WITH OTHER CONDITIONS

Metropolitan Life Insurance Company
Standard Ordinary Policyholders
Death Claims Paid June 1975–June 1976

Associated Cause of Death	Alcoholic Disorders as Underlying Cause Where Associated Cause is Contributory	Alcoholic Disorders as Contributory Cause Where Associated Cause is: Underlying	Contributory
	Number of Claims		
All Causes	319	156	68
	Percent Distribution of Claims		
Infective diseases (septicemia, etc.)	4	—	4
Malignant neoplasms	4	3	—
Diabetes mellitus	3	2	12
Anemia and malnutrition	7	—	4
Heart disease	16	30	22
Cerebrovascular diseases	3	9	1
Other vascular diseases	24	1	9
Diseases of respiratory system	19	8	29
Diseases of digestive system	27	8	9
Diseases of urinary system	22	—	12
Accidents	2	30	1
Suicide	—	6	—
All other causes	15	3	25

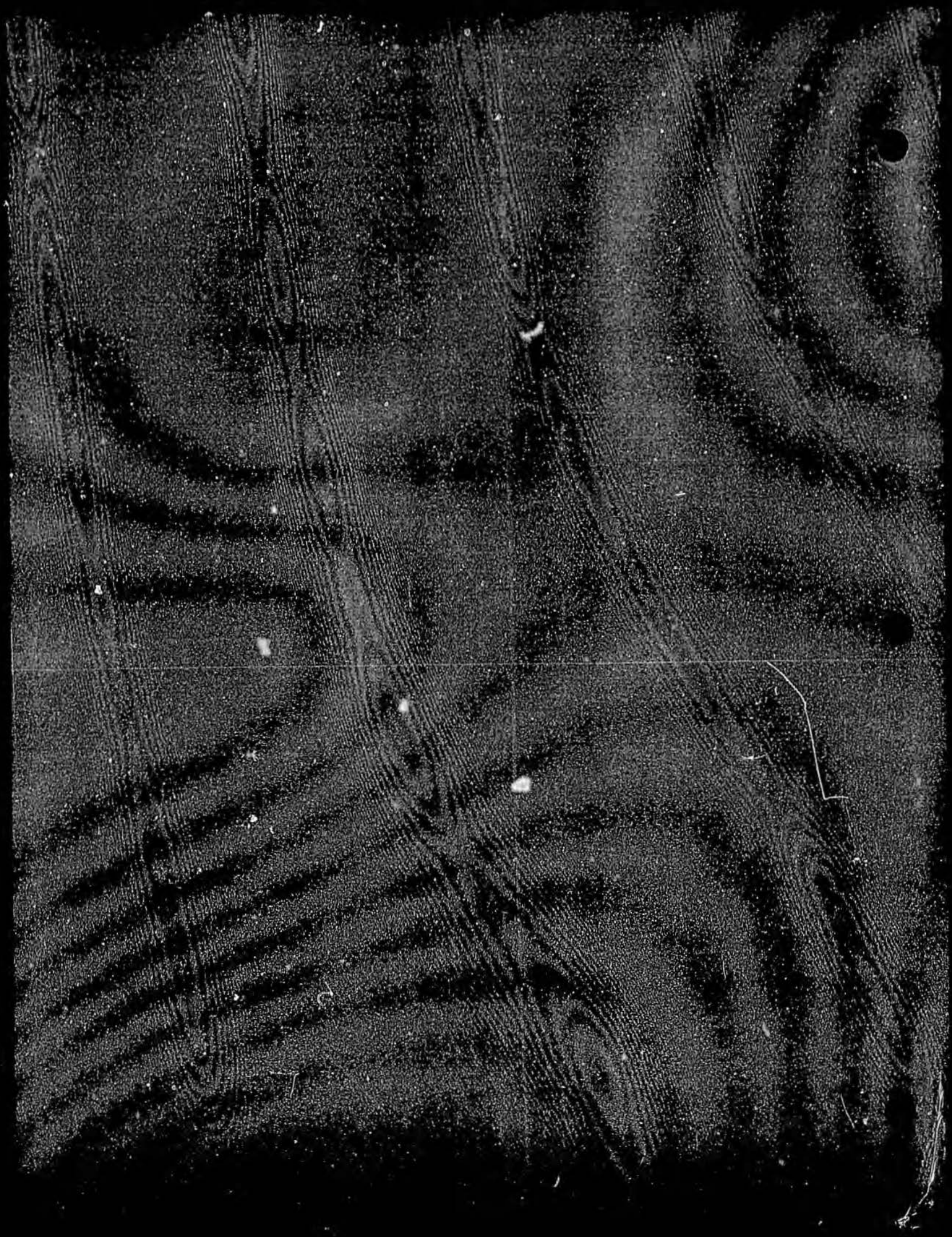
*Disorders include Alcoholic psychosis (International Classification of Diseases, Adapted, 291), Alcoholism (ICDA 303), and Cirrhosis of liver, alcoholic (ICDA 571.0).

Note: First and third columns total more than 100 percent due to recording of multiple contributory causes.

156 deaths in which alcoholism was considered a contributory cause. Thirty percent of these claims show heart disease as the underlying cause of death, while another 30 percent specify accidents. Respiratory, digestive, and cerebrovascular diseases each accounted for 8 or 9 percent of the total.

The third column in Table 3 relates to 68 claims in which other causes were reported as contributory to death in addition to alcoholism. In these cases, respiratory diseases were the most frequently mentioned, with heart disease a close second; both diabetes mellitus and disorders of the urinary system were reported to a lesser degree.

Additional research is needed to clarify the relationship between alcoholism and the increased risk of mortality. It is also important that, when applicable, alcoholism be mentioned on the death certificate along with other associated medical conditions. As the coding of multiple causes of death becomes more widespread, a more precise measure of the role of alcoholism in mortality will be obtained.



PUBLIC POLICY REPORT

NEW JERSEY ALCOHOLISM ASSOCIATION
212 West State St.
Trenton, N.J. 08618
(609) 392-0808

HEALTH INSURANCE COVERAGE FOR ALCOHOLISM

The New Jersey Alcoholism Association supports the enactment of A-1718, A-1719, A-1720 and A-1722 which provide for the inclusion of treatment of the disease of alcoholism in health insurance policies in the State of New Jersey.

Alcoholism is a Distinct Primary Illness.

Alcoholism is a disease that can be as fatal as heart disease and cancer. This year 86,000 people will die as a result of acute alcoholism. Last year alcoholism and alcohol abuse was responsible for the arrest of two million public intoxicants that cost the judical system, the police and the corrections system one half billion dollars. An estimated 28,500 of the 50,000 motor vehicle fatalities were a direct result of alcohol abuse. The estimated impact on our economy is $25 billion in lost productivity and absenteeism.

Alcoholism is recognized as a distinct primary illness by the U.S. Department of HEW, State of New Jersey, ABA, AMA, and the industrial sector:

American Medical Association, 1956.

> "Alcoholic symptomatology and complications come within the scope of medical practice. Acute alcoholic intoxication can be and often is a medical emergency."

American Hospital Association, 1967.

> "Alcoholism is a serious health problem. It falls within the scope of medical practice and it is often a medical emergency. The alcoholic should not be denied the advantage of a thorough study of the cause or causes of his condition and should not be denied the advantage of the best possible management of his case."

American Psychiatric Association, 1965.

> "All prepayment plans for defraying the cost of medical care through insurance should cover the person presenting symptoms of alcohol problems who seeks treatment on the same basis as for other illnesses."

State of New Jersey.

> The New Jersey Alcoholism Treatment and Rehabilitation Act, recently enacted by the legislature, declares that "it is the policy of the State of New Jersey to afford alcoholics a continuum of treatment in order that

they may lead normal lives as productive members of society." P.L. 1975, Chapter 305.

New Jersey AFL-CIO.

"The disease of alcoholism has been recognized as a treatable illness and the third most serious health problem for the nation and the American worker... the New Jersey AFL-CIO encourages its affiliates to negotiate provisions in their contracts covering expenses incurred for the treatment of alcoholism whether the services are administered by a hospital or a non-hospital extended care facility." Res. #24, AFL-CIO.

The recognition of alcoholism as a chronic disease makes it as incumbent to provide quality care for the alcoholic as it is to provide care for the diabetic, the coronary patient, or any other sick person at the lowest appropriate cost setting consistent with patient needs and high quality care.

Alcoholism Coverage is Cost Effective.

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) recently released the results of a cost benefit study on 41 Alcoholism Treatment Centers (ATC's) funded by NIAAA in 1971. The study demonstrates that 70% of clients show a significant reduction in alcohol consumption rates, unemployment, and health impairment. Approximately three dollars will be returned to the economy for every treatment dollar expended in the next 10 years. The benefits realized from the operation of 41 ATC's will exceed $33 million primarily a result of reduction in health care cost, and increases in productivity, taxable earnings.

Experience in other states demonstrates that concerns of increased costs and over utilization of benefits by alcoholics are unfounded. In Washington, the legislature mandated alcoholism coverage in approved residential care facilities to the normal limits of the policy. Connecticut has mandated the inclusion of alcoholism with no premium increase.

In California, only $172,801 in benefits were paid in a one year period. The average annual premium required for the four major carriers amount to 26¢ per member. In Pennsylvania, Capital Blue Cross covered alcoholism in licensed residential care facilities with no premium increase. Pennsylvania found the increase in utilization to be gradual--the natural maturation of a new program. By virtue of receiving treatment, an alcoholic recovers from the disease, achieves better health and utilizes fewer or less costly medical services, permitting Capital Blue Cross to adopt a three day to one day per diem tradeoff.

Insurance providers that cover alcoholism such as Prudential, Kemper, Hartford and Employees Insurance of WAUSAU, recognized that they were already "paying" for alcoholism indirectly through claims paid to general hospitals for alcoholism related admissions under other diagnosis such as musculoskeletal disorders and cirrosis. Licensed residential care facilities demonstrate an average recovery rate of 70% and cost one-third the average hospital per diem.

Basic Element V. Optional Coverage

The experience of other states, insurance carriers, and industry document that concern of increased costs and over-utilization of benefits are unfounded. Alcoholism coverage as a basic element of an insurance policy is consistent with the basic principal of insurance to distribute the risks among a large number of subscribers, thereby minimizing the cost to individual subscribers.

Alcoholism is a stigmatized illness, basic denial is a part of the illness, and an alcoholic rarely recognizes the symptoms of the disease. Alcoholism is a primary illness and the recognition of alcoholism as a deadly and chronic disease makes it as incumbent to provide quality care for the alcoholic as a basic element of coverage as it is for the cancer or coronary patient.

Current methods of coverage restricted to a hospital setting encourage hospitalization under an inappropriate diagnosis, and contribute to increased health care costs due to late diagnosis and serious medical complications such as cirrosis and muscoskeletal disorders. The bulk of the alcoholic patient population is adequately insured and currently treated for complications in the later stages of chronic alcoholism at a hospital per diem rate three times the cost of a comprehensive treatment program.

The attached addenda outline the experience of major industries that have an alcoholism benefit. The experience of major insurance carriers document the cost effectiveness of alcoholism coverage. The experience of the following major insurance providers is outlined: Prudential, Kemper, Hartford, Employees Insurance of WAUSAU, Blue Cross of Michigan, Blue Cross of Maryland, and Capital Blue Cross of Pennsylvania. The actual experience of states that have adopted similar legislation, insurance carriers, and the industrial experience strongly support the conclusion that alcoholism should be a basic element of coverage in health insurance polices in New Jersey. It is for these reasons that the New Jersey Alcoholism Association strongly support the adoption of A-1718, A-1719, A-1720 and A-1722.

addendum I

EXPERIENCE OF MAJOR INSURANCE CARRIERS

Insurance carriers have instituted coverage in recognition that traditional limitations are actually counterproductive. Educators Mutual Life recognized that a benefit restricted to hospital treatment, tends to encourage repeated treatment and increased costs. According to Mr. A. W. Adee, Vice President of Educators Mutual Life:

> "it makes good economic sense from an insurance standpoint. We were already paying...for...detoxification in general hospitals and found that the situation tended to repeat itself and we were paying for more than one incident of detoxification. Why not take the claim money of the second incident...and spend it on rehabilitation and try to prevent the repetition? We think we can and that in the long run we will be making no more payments for alcoholism than we were already making."

Prudential Insurance Company.

October 1972, deleted from new policies their standard exclusion of treatment for alcoholism in "a facility for the care of alcoholics."

The Kemper Insurance Companies.

Medical and hospital expenses incurred in the treatment of alcoholism are covered, including income protection, in the same way as any other illness. There are benefits for hospital out-patient care as well as in-patient and out-patient services at licensed non-hospital alcoholism treatment centers. Kemper included these services effective June, 1973, without premium increase.

Hartford Insurance Company.

June 1974, offered coverage for alcoholism "on the same basis as any other disease" in group policies, coverage extended to alcoholism treatment facilities and out-patient programs.

Employees Insurance of WAUSAU.

September 1973, included benefits for both in-patient and out-patient treatment of alcoholism at treatment centers.

Blue Cross of Michigan.

The United Auto Workers has 2.5 million members enrolled in the plan. The cost for coverage of alcoholism treatment in residential care facilities is 36¢ per subscriber per year.

Blue Cross of Maryland.

January 1974, extended benefits to approved non-hospital residential facilities, in 1975, out-patient coverage was included.

Capital Blue Cross of Pennsylvania.

Effective August, 1974, Capital provided alcoholism coverage for alcoholism treatment in residential care facilities to their seven million subscribers as a basic benefit.

Capital Blue Cross cited major reasons for providing coverage for residential care facilities with no rate increase:

1. "Recognition of alcoholism as a chronic disease makes it incumbent on the third-party payor to provide appropriate benefits...obligation to provide care for the diabetic, coronary patient, or any other sick person. If the revolving door syndrome is to be avoided, the alcoholic patient cannot be deserted after (hospital) treatment for his acute illness..."

2. "...treat alcoholism as a distinct disease entity for purposes of third-party reimbursement consistent with policy to provide benefits...in the lowest appropriate cost setting consistent with patient needs and high quality care."

3. Capital Blue Cross recognized it has been "paying" for alcoholism indirectly, through claims paid in the general hospital for alcoholism or alcoholism-related admissions under other diagnosis such as muscoskeletal disorders or cirrosis. Limitation of benefits encourages admission under a disguised diagnosis contributing to the "revolving door"--the alcoholic is treated at a hospital and released without referral to appropriate treatment, only to return to drinking and ultimately the hospital.

4. Utilization: First year experience indicated a low volume of utilization, alcoholics did not "come out of the woodwork" at the availability of covered care, any increase should be gradual--the natural maturation of a new program.

5. Cost: Capital Blue Cross projected their cost in 1974 to be $600,000; it was $200,000. Capital estimates a savings to the plan from those subscribers who, by virtue of receiving treatment, maintain sobriety and thus better general health and utilize fewer or less costly medical services. Coverage is provided on a three-day to one-day tradeoff from regular hospital benefit days because the per diem cost for licensed alcoholism providers is significantly less than an in-patient hospital per diem. A recent report indicates that after a two year period, the cost of the benefit was $345,000 or 18¢ per subscriber per year. This does not take into account any savings as a result of reduced medical expenses.

addendum II

THE INDUSTRIAL EXPERIENCE

Problem drinkers use a disproportionately high portion of health benefits, contributing to high insurance cost. Statistics document that the mortality ratio for alcoholics is 3.22 times greater than non-alcoholics. The problem drinkers' overall accident rate is 3.6 times that of other persons. The benefit utilization rate of alcoholics is 3 times that of others for digestive and muscoskeletal disorders, and 2 times greater for respiratory infection. In industry, the average and total benefits paid to alcoholics cost employers three times that of other employees and absenteeism is 2½ times greater.

The actual findings of major industrial companies clearly document a high treatment success rate, a marked decrease in utilization of health benefits and an insurance cost savings due to an adequate alcoholism health benefit:

The Philadelphia Fire Department.

Established a referral program for its 3,410 employees in 1972. For those problem drinkers referred to out-patient care, sick leave was reduced by 55%. Injuries were reduced by 67%; both of these factors indicating a significant decrease in health insurance utilization.

Scovill Manufacturing Company in Waterbury, Connecticut.

Employs 6,500 employees. The Scovill program processed 180 employees over a three year period. They estimate their annual savings at $186,550. Importantly, 78% of those problem drinking employees referred for treatment arrested the disease.

Economics Laboratory, Inc. of St. Paul, Minnesota.

Has an employee population of 3,500 in the United States. They have a rehabilitation success rate of 80% for employees and 50% for dependents of the employees. In addition, the Company reduced treatment cost 60 to 65 percent by utilizing non-hospital facilities such as alcoholism treatment centers.

General Motors.

General Motors has saved millions of dollars in lost productivity, on-the-job accidents and sickness and accident benefits through alcoholism coverage. Over 8,000 employees have been referred and health insurance benefits declined 42% in a two year period.

The De Paul Industrial Alcoholism Project of Milwaukee, Wisconsin.

Receives referrals from 23 companies in the Milwaukee area. This population is composed primarily of blue-collar skilled and unskilled factory workers. In conducting a nine month follow-up study of problem drinkers treated, 46% reported total abstinence and 25% essential abstinence, for a total of 71% significantly improved.

Illinois Bell Telephone Company.

Studied 402 employees for five years prior to referral and for five years after. The job rehabilitation rate was 72%. In addition, these 402 employees had 602 cases of sickness disability before rehabilitation and 356 cases after rehabilitation. This is a reduction of 46% in sickness disability, indicating a tremendous decrease in utilization of insurance plans.

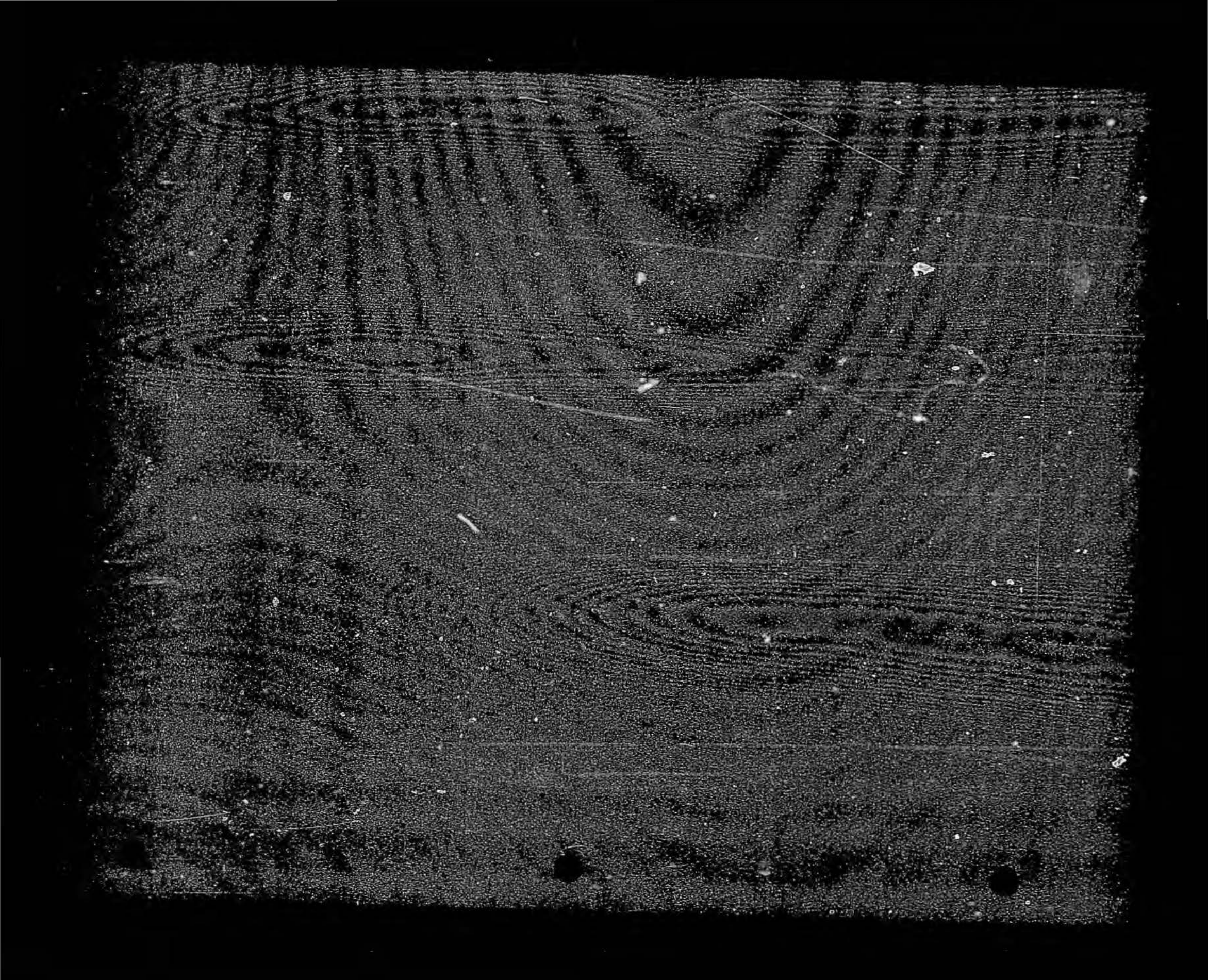
Kennecott Copper Company.

Found sickness and accident cost ratio for alcoholics compared with the non-alcoholic employee to be more than 5 to 1; hospital, medical and surgical costs were more than 3 to 1. Yet, after a 12½ month involvement in a treatment program, hospital, medical and surgical costs decreased 55.35%.

Problem drinkers utilize three dollars in health benefits to one dollar for the average person. In-patient treatment programs average a 70% success rate. If the recovery rate were only 20%, the impact on insurance would still effect a 2% cost savings in claims paid.

To cite specific examples, the following table represents cost savings in the industrial experience previously presented:

COMPANY	EMPLOYEE REHABILITATION SUCCESS RATE	PROBLEM DRINKERS REDUCTION IN CLAIMS PAYMENTS
SCOVILL	78%	-
ECONOMICS LAB, INC.	80%	65%
COMPANIES IN MILWAUKEE	71%	-
ILLINOIS BELL TELEPHONE CO.	72%	46%
PHILA.FIRE DEPARTMENT	-	55%
KENNECOTT COPPER COMPANY	-	55%



JANUARY 1976

THE STATE BAR OF CALIFORNIA

Reports:

IN THIS ISSUE...

- Alcohol Abuse Program
- Letterhead Rule Interpretation
- Conference Call

Signing for WAPAC were Ms. Mary Rogers (top, left), and Arnold Townsend (below, left). John S. Malone (top, watching Ms. Rogers and Board member Richard C. Dinkelspiel (below) signed for the State Bar. In background (top) are John N. Doggett, III, and Kenneth B. Gillis.

BAR AND COMMUNITY REACH UNDERSTANDING

The State Bar and the Western Addition Project Area Committee signed a compact governing minority hiring by the Bar. The agreement may be the first of its kind. See story, p. 4.

Board Seeks Comment On Proposed Attorney Advertising Experiment

The Board of Governors is anxious to receive comments from all Bar members and other interested persons regarding the proposed pilot program of lawyer advertising approved for publication in December.

If the Board decides to proceed with the plan after reviewing those comments, it will ask the State Supreme Court to approve certain amendments to the Rules of Professional Conduct.

Those amendments would relax the present ban on advertising—at least with respect to yellow pages and legal directory listings—in order to provide the public with useful information on which to base the choice of an attorney.

As stated in December *Reports*, the Board stresses that in approving publication of the program for comment, no present relaxation of the Rules of Professional Conduct is implied.

The deadline for receiving comment is March 1, 1976.

In a December 12 letter to local bar association presidents, Bar President David S. Casey urged "active consideration, discussion and debate on the local bar level between now and that date."

He suggested that workshops, general meetings and plebiscites be conducted on the subject of lawyer advertising, and offered to send members of the Bar Board or staff to speak locally. Any comments or requests for speakers should be addressed to the Board Committee on Professional Responsi-

(Continued on page 4)

11th Annual Conference of Bar Presidents Will Focus On Advertising, Other Major Issues Facing Lawyers

Panels on attorney advertising and maintenance of professional competence will be among the highlights of the Eleventh Annual Conference of Bar Presidents, to be held February 27-29 at the Harbor Island Sheraton Inn in San Diego.

Additional presentations on major issues confronting the legal profession in 1976 will cover specialization, various types of legal services, legal malpractice insurance, public affairs and legislative advocacy, unauthorized practice of law and changes in disciplinary procedure.

All members of the Board of Governors will be present to answer questions and bring the conferees up to date on the work of the Board.

The Conference of Bar Presidents is not restricted to "bar presidents," Robert D. Raven, chairman of the Conference of Delegates, wrote the presidents of 102 local bar associations suggesting that not only they attend but also presidents-elect or vice-presidents, persons in charge of public affairs for the local bars, and executive directors and executive secretaries as well.

Bar President David S. Casey will speak at a luncheon Saturday, February 28, honoring local bar presidents and presidents-elect.

SPECIAL ELECTION RESULTS

Members of District II have elected Melvyn J. CoBen of Sacramento to represent them on the Bar's Board of Governors. Results of the balloting were announced Jan. 6. More information on the election and CoBen will appear in February Reports.

Bar Committee Opens New Front in War Against Alcoholism

While thousands of Americans make annual New Year resolutions, the Bar's Committee on Alcohol Abuse operates year-round to encourage troubled attorneys and judges to make one of the toughest resolutions of them all: the decision to confront and deal with the illness called alcoholism.

The committee's program, underway for barely a year, has already helped at least 40 attorneys and judges, and an estimated 85 are currently participating.

The committee's success may be partly due to the fact that a number of its members have been through the alcoholism mill and back.

One of them is Ted Cohen, a Los Angeles attorney. He did not request anonymity, saying instead, "Most of us were never anonymous when we were out there stumbling around, or getting in trouble with the law. I'm not ashamed of having straightened out."

Cohen works hard for the committee. "My profession gave me another chance. This is my way of repaying it."

Two aspects of Ted Cohen's case are typical of the estimated 4,000-7,500 California lawyers and judges who suffer from problem drinking.

"Difficult to Reach Attorneys . . ."

First, Cohen was unable to admit to himself that alcohol was a problem. He started drinking heavily after a personal tragedy in 1963 and, at the time, did not recognize drinking as a problem.

This is characteristic, according to Jack L. Sanow (occupational program consultant of the Alcoholism Council of Greater Los Angeles and consultant to the Bar committee). Sanow says it's extremely difficult to reach attorneys and doctors:

"Both professions are always giving advice to other people but resist taking it themselves. Generally, the more intelligent individuals are, the harder it is to work with them.

"When you're with attorneys, you're in court. Their alibi structure is strong. They can offer a thousand excuses why they drink. And people cover up for them in a way they would not for truck drivers or salesmen.

"The secretary will tell clients that the lawyer is studying a case, when in fact he passed out at lunch. Other lawyers in a firm will take over in court rather than admit that the senior partner blacks out during cross examination."

Alcohol & Discipline Problems

The second aspect of Cohen's case typifying the problem of the alcoholic attorney is that it led to commission of offenses resulting in disciplinary action by both the State Bar and the State Supreme Court. Judge Leon Emerson of Downey Municipal Court, chairman of the Committee on Alcohol Abuse, says alcoholism is responsible for "probably two-thirds of the disciplinary actions against California lawyers."

Lily Barry, assistant secretary in charge of the Bar's Los Angeles office, reports, "Often in the course of disciplinary proceedings we discover that the respondent attorney is a problem drinker.

"Whether drinking caused his problems or his problems caused the drinking, the fact remains that to become rehabilitated the attorney should first control his drinking. We tell him about the Committee on Alcohol Abuse and the consultants available, and suggest that he call and make an appointment and see if they can help."

While suffering from alcoholism, Cohen committed offenses in 1964 and 1965 which led to his conviction in 1968 of grand theft and conspiracy to commit grand theft and forgery.

"At the time of the offenses," Cohen says today, "I wasn't aware of my alcohol problem. It was the jolt of being sentenced to prison that did it.

"Actually that sentence was the best thing that ever happened to me. It woke me up to the fact that something was seriously wrong."

Again, Sanow says, the pattern is typical. "Most of the time, the full-blown alcoholic becomes a thief. He needs money for booze but can't function to earn it. Alcohol will take away wives, children, homes, law practices. Sometimes the alcoholic *must* hit bottom and lose all those things before he or she will admit there is a problem."

Cohen adds, "I don't want anyone to have to go through what I did. We want to reach people before they hit rock bottom."

Why a Bar Program?

Since organizations to help alcoholics already existed, why did the Bar feel it necessary to create a program of its own to help problem drinkers in the legal profession?

Bruce Bartlett, vice chairman of the committee, says "The advantage of working with other attorneys is the identification factor. Most attorneys and judges with the alcohol problem think they are unique, that no other attorney or judge has ever had that affliction. By talking with fellow-lawyers who have successfully corrected their drinking problems, the identification opens new vistas of motivation."

Cohen adds to this theory:

"Lawyers are independent souls—they feel more educated, more intelligent. We started a committee on alcohol abuse within the Bar so the attorneys and judges can share experiences with fellow lawyers. They relate better. I know of several lawyers and judges currently in the program who, if it weren't for this Bar-sponsored program, wouldn't be getting help anywhere."

There are exceptions. Vice chairman Bartlett points out, "Another type of attorney is very fearful of having his or her problem known. He or she can work best with the committee's consultant non-attorneys rather than with other attorneys."

(Continued on page 3)

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Legal Specialization Board Announces Time and Places Of Annual Examination for Certification of Specialists

The California Board of Legal Specialization has announced that the fourth annual written examination for attorneys seeking certification as legal specialists will be held August 29, 1976, 8:30 a.m.-5 p.m. at these locations:

Hastings College of the Law, 198 McAllister Street, San Francisco;

University of California, Los Angeles School of Law, 405 Hilgard Avenue, Los Angeles.

The filing deadline for applicants wishing to take the examination is July 15, 1976. Specialty experience and educational requirements must be completed before the filing deadline.

The specialization program includes criminal law, worker's compensation law and taxation law, and is open to active State Bar members who will have 5 years of law practice on or before November 1, 1976.

For applications and information, write: California Board of Legal Specialization, 633 Battery Street, Suite 510, San Francisco, CA 94111. (Indicate area of interest—criminal, worker's compensation or taxation field—and include State Bar membership number.)

The application packet costs $5. Please include a check or money order with written request. If an application is filed, the $5 will be credited against the application fee of $100.

FOR THE RECORD: The deadline for submitting counter-arguments to conference resolutions is May 15, 1976—not 1975 as printed in the December issue of Reports.

Alcohol Program

(Continued from page 2)

The Word Is Confidential

What can the troubled attorney or judge expect, after contacting the committee for help?

First of all, he or she can expect total confidentiality. The Committee on Alcohol Abuse is wholly separate from the profession's disciplinary arms—i.e., the Commission on Judicial Qualifications and the State Bar disciplinary committees. Bartlett explains: "We each pursue our separate but interrelated objectives. The Bar disciplinary agencies are bound to strict confidentiality under Rule 8. A similar rule applies to judges. They cannot reveal the identity of a person under disciplinary proceedings. We, in turn, don't divulge the identity of persons who seek our assistance.

"In those situations where our participants already face disciplinary proceedings, individual participants invariably request that we forward the results of our documentation and monitoring efforts to the involved disciplinary agency.

"Correction of the drinking problem is often a factor tending to mitigate the otherwise harsh consequences that would attach to the professional conduct violation. These are the *only instances* in which we reveal the identities and program involvements of our participants."

Ted Cohen's experience illustrates this point. After his conviction, and following hearings held before a Bar committee, the Bar's Disciplinary Board recommended disbarment. The State Supreme Court ordered continuation of suspension for five years, but stayed execution of that order and placed Cohen on probation for five years on specified conditions, including that he abstain from the use of alcoholic beverages.

Specifically concerning Cohen's problem drinking, the Court pointed out that although doubt existed that alcohol caused his problem it may have been a contributing factor.

The Court said it found mitigating circumstances, including the testimony of witnesses demonstrating Cohen's rehabilitation and expressing their belief in his present fitness.

Help: What Kind & Where?

Today, Cohen stresses, "Help exists. There is a number to call, a place to go. There are a number of fellow attorneys who've been there and want to help."

When a lawyer or judge contacts the committee, its members introduce him or her to several fellow attorneys who have fought the alcohol battle and won. These people are available to call whenever their colleague is tempted to take a drink or just wants to talk, and meet regularly with him or her. Professional alcoholism counselors such as Sanow also work with the attorneys and judges, and help steer them to whatever other sources of assistance might be appropriate for the individual case.

(Continued on page 8)

Board Announces Official Interpretation Of Letterheads Rule

LETTERHEADS. Rule 2-103(A)(4) of the Rules of Professional Conduct permits a lawyer to use a letterhead which sets forth the lawyer's name, his address(es) and telephone number(s), the name of his law firm, the names of his associates and, if he is a patent or trademark lawyer, such fact pursuant to Rule 2-106(1) of the Rules of Professional Conduct. The names of, and dates relating to, deceased and retired members of the law firm may also be listed on the letterhead. Rule 2-103(A)(4) further allows (and defines) "Of Counsel" designation on a letterhead, and the listing of predecessor law firms.

If a member of the State Bar devotes a substantial amount of time in the representation of a client, such client's letterhead may designate him as "General Counsel," provided such letterhead is used only for correspondence relating to the professional representation of that client. Readers are referred to the text of Rule 2-103(A)(4) for complete information and are cautioned to read Section (A) with subparagraph (4) to determine the scope of information permissible on a lawyer's letterhead.

In Rule 5-103, the word "associate" is defined to mean "an employee or fellow employee who is a member of the State Bar." "Associate" as used in Rule 2-103 is intended by the Board of Governors to refer only to members of the State Bar; the word is not intended to include employees or affiliates who are not members of the State Bar. It should also be noted that Rule 2-103(A)(4) specifies what may appear on a lawyer's letterhead and that which is not included in the Rule is deemed to be proscribed by the specific language of Section (A).

The above is intended to serve as notice to all members of the State Bar of the Board's official interpretation of Rule 2-103(A)(4). A willful breach of this Rule constitutes cause for discipline pursuant to Business and Professions Code § 6077.

COMMENTS INVITED

Members of the bar who are of the view that Rule 2-103(A)(4) should be revised to permit additional information on letterheads are requested to send their written comments to the State Bar of California, 601 McAllister Street, San Francisco, CA 94102, c/o Ronald W. Stovitz, by Feb. 10 for consideration by the Board of Governors.

Bar Office Expansion in Redevelopment Area Leads to Unique Minority Hiring Agreement

Cooperation rather than confrontation was the key to the Dec. 17 "Memo of Understanding" between the State Bar and San Francisco's Western Addition Project Area Committee (WAPAC).

Basically, this contract — perhaps the first of its kind in the country— provides that the State Bar call on WAPAC when newly-created jobs are to be filled or vacancies occur, when these fall under the Bar's affirmative action program. Preference will be given to the minority applicants who possess the necessary skills to fill the positions in question.

The History

The agreement is the result of protracted negotiations between the Bar and WAPAC, which began when the Bar staff and functions outgrew its present headquarters. A three-story building will be constructed just southeast of the Bar's existing structure on Franklin and McAllister Streets. The property is part of the Western Addition Area. WAPAC is the official community organization authorized under the Redevelopment Act of 1949 to advise the San Francisco Redevelopment Agency.

The Goal

The eventual goal is to have 47% of the Bar's staff be minority persons, reflecting the ethnic composition of San Francisco. The 47% includes persons already employed. Of the 123 people currently employed by the Bar's San Francisco headquarters, 23 are minority—about 19%.

Job openings eligible for WAPAC consideration will be determined by the composition of the employee classification level—i.e., professional, paraprofessional or clerical—in which the opening occurs.

Kenneth B. Gillis, director of the Bar's financial affairs, estimated that in the next several years, 100-125 jobs will be available due to Bar expansion and natural attrition.

The Significance

At the signing ceremony, John N. Doggett, III, the Bar's assistant director of the Office of Legal Services, noted that "To our knowledge this is the first agreement between a community organization authorized under the Redevelopment Act of 1949 and a corporation like the State Bar."

This agreement, Doggett says, "represents recognition by the State Bar that residents in the Western Addition community have the right to determine what's going to happen to their community."

Participating in the ceremony was Brent M. Abel, immediate past president of the State Bar. Abel stated that from the Bar's standpoint, "One of the major pluses of this agreement is that it enables the State Bar to stand tall for affirmative action, as an example to the 50,000 lawyers in the state.

"It shows that the organized bar stands for an open profession, for advancement of society, and I hope it will have a substantial inspirational effect on lawyers throughout the state—both in their own lives and in representing their clients."

Board members Richard C. Dinkelspiel and Kurt W. Melchior were instrumental in completing final negotiations with WAPAC. Dinkelspiel said that ". . . the exciting thing about this is the emergence of the Western Addition as a vital part of San Francisco.

"I hope this is the beginning and not the end of a great movement of government agencies and business out into this area.

"This could be a vital movement that would rehabilitate San Francisco, which has been suffering from all the ills that plague urban areas in the United States, and I see, out there, the city of the future. I'm very pleased to be part of that, pleased that the State Bar can contribute something to that important development."

The agreement was signed by John S. Malone (secretary, State Bar), Richard C. Dinkelspiel (Bar Board member), and, representing WAPAC, Ms. Mary Rogers (chairperson, WAPAC Board of Directors) and Arnold Townsend (WAPAC executive director).

Cooperation—Not Confrontation

Both Townsend and Rogers said it was important that the decision was made through discussion rather than forced by activism.

Ms. Rogers said that "three or four years ago, I would have been sitting here with a group of people fighting with the State Bar.

I'm happy that we've grown enough to sit down and negotiate this first step to bridge the gap that existed between the community and institutions for so many years."

(Continued on page 7)

Proposed Rule to be Reconsidered

The Bar's Board of Governors will reconsider a rule previously sent to the State Supreme Court for approval. The proposed rule would govern the conduct of lawyers running for judicial office.

Proposed Rule 9-101 (Rules of Professional Conduct: Bar Misc. 3849), now pending before the Court for approval, has been calendared for reconsideration by the Board of Governors at its January 22-24, 1976 meeting.

Board Approves Support For Determinate Sentence Bill

At their December meeting, the Bar's Board of Governors approved a report submitted by the Committee on Corrections recommending support of S.B. 42.

The bill would establish a determinate (fixed term) system of sentencing for all except capital crimes.

"Proof of Damages" Institute Set by ABA Litigation Section

The American Bar Association's Section of Litigation is presenting an institute on "Proof of Damages," Jan. 22-23, at the Fairmont Hotel in San Francisco.

Section chairman Robert F. Hanley, of Chicago, says the program will give litigators "practical insights and information in an area which is often overlooked."

For further information, call ABA National Institutes, 312-947-3950.

Advertising

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bility, Suite 502, 633 Battery Street, San Francisco, CA 94111.

With his letter, President Casey enclosed a copy of the committee's report containing a description of the proposed pilot program, and two other attachments:

(1) A memo on lawyer advertising prepared by the ABA Young Lawyers Section, which analyzes developing case law and pertinent policy issues. The memo concludes in favor of a controlled advertising program similar to that being considered by the Bar's Board of Governors.

(2) A Discussion Draft of proposed amendments to the Ethical Considerations and Disciplinary Rules of Canon 2 of the Code of Professional Respon-

(Continued on page 5)

Board Seeks Local Bar Comment on Creating More Sections

The Board of Governors is studying the advisability of creating "sections" in various areas of the law.

The purposes would include: (1) permitting greater participation of individual members and local bars in State Bar activities; (2) giving Board members broader input on matters affecting certain areas of law; (3) keeping section members up to date in those areas of law of special interest to them; (4) giving broader-based support for Bar-sponsored legislation, insuring that Bar legislative activities represent the thinking of the Bar in general; and (5) permitting the Conference of Delegates to focus on the more important aspects of proposed legislative change.

A Taxation Section was created in 1974 on a pilot basis, and the Board has approved a Legal Services Section.

In a December 15 letter to all local bar presidents, however, Bar President David S. Casey wrote that the Board "does not want to create additional sections until assured the bar generally and the local bar associations in particular approve the concepts."

Included in Casey's letter were four questions, which he asked the local bar presidents to answer and return to the State Bar headquarters no later than January 26, 1976.

Briefly, the questions asked what local bar presidents thought about the concept of State Bar sections; whether creating such sections would adversely affect their local associations; whether those whose local bars had sections would favor or oppose State Bar sections in the same field; and specifically, whether the bar presidents favored State Bar sections on Patent, Trademark and Copyright Law, and on Family Law.

Advertising

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sibility prepared by the ABA Standing Committee on Ethics and Professional Responsibility. This draft, which would permit advertising except for "a false, fraudulent, misleading, deceptive, or unfair statement or claim," will be discussed by the ABA House of Delegates at its midwinter meeting.

Earlier this month, Casey also sent out sample lay-outs of the type of advertisements envisioned in the pilot program, with an extensive bibliography of relevant cases and articles for those interested in acquiring a thorough understanding of the issues.

All of the above-mentioned material has been distributed to local law libraries and law schools so that it is accessible to concerned Bar members. Additional copies are available at cost from the State Bar.

In a very summarized form, the pilot program would permit the following for an experimental period of 18 months:

(1) Each law firm or sole practitioner could take out a Yellow Pages display ad in the local telephone directory. No ad could be larger than 1/16 of the page on which it's printed, and no artwork or photography would be allowed. (Phone company regulations prohibit listing fees, but the ad could contain a statement that a fee schedule is available on request.) The display could also contain, in addition to normal name-address-telephone data, the following information: number of attorneys and paralegals in the office—fields of law in which the lawyer practices—office hours—whether credit cards are accepted—languages other than English spoken by attorney—whether the attorney interviews clients away from the office—State Bar-approved specialties—whether the attorney would submit to binding arbitration in a fee dispute.

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DISCIPLINE IMPOSED

December 31, 1975

Addresses appearing below are last addresses as shown by State Bar membership records.

Only certain matters which have become effective are shown.

The reader is referred to articles which will be appearing in the State Bar Journal for a summary of the facts found with respect to the following cases:

Discipline ordered by the Supreme Court following State Bar proceedings.

RICHARD B. BLYTHE, also known as Richard Barclay Blythe, 1250 Wilshire Boulevard, Suite 501, Los Angeles, California 90017, suspended from the practice of law for a period of one year and until he makes restitution and returns client's documents, November 20, 1975, effective December 19, 1975.

ROBERT H. McCOY, also known as Robert Hughes McCoy, 19730 Ventura Boulevard, Woodland Hills, California 91364, suspended from the practice of law for a period of three years and until he makes restitution, suspension to commence upon the reinstatement from his present suspension, November 20, 1975, effective December 21, 1975.

RICHARD R. MURPHY, 106 North McPherson Road, Orange, California 92668, suspended from the practice of law for a period of three years, execution stayed, placed on probation for said three year period upon condition that he be actually suspended for one year and that he comply with the conditions recommended by the Disciplinary Board, November 18, 1975, effective December 19, 1975.

ALEXANDER G. SHIROKOW-WALTERS, P.O. Box 1841, Monterey, California 93940, order of June 26, 1974, suspending Mr. Shirokow-Walters from the practice of law until further order of the Court terminated forthwith. (The Disciplinary Board had recommended that the period of suspension already served was sufficient discipline) November 25, 1975.

AVERY SEYMOURE WAISBREN, 4210 Bellingham, Studio City, California 91604, suspended from the practice of law for a period of four years, commencing on September 29, 1972, November 26, 1975, effective December 27, 1975.

FRED KEE WONG, 940 Mei Ling Way, Los Angeles, California 90012, disbarred, November 18, 1975, effective December 19, 1975.

In addition to the foregoing, the Court has entered an interim suspension order pursuant to Section 6101-6102 of the Business and Professions Code with respect to the following member of the Bar who has been convicted of a crime. The effective date of the order is shown.

RICHARD DOLWIG, also known as Richard Joseph Dolwig, 535 Wilhaggin Drive, Sacramento, California 95825, effective December 21, 1975.

RESIGNATION ACCEPTED WHILE DISCIPLINARY MATTER PENDING

December 31, 1975

Addresses appearing below are last addresses as shown by State Bar membership records. The Supreme Court has accepted the voluntary resignations of the following members of the State Bar without prejudice to further proceedings in any disciplinary matters pending against them should they thereafter seek reinstatement.

The dates of acceptance are shown.

JAMES H. BANKS, 16200 Ventura Boulevard, Encino, California 91316, accepted November 25, 1975.

ROBERT M. DERITIS, 14045 Milbank Street, Sherman Oaks, California 91403, accepted November 20, 1975.

Conference Call

JANUARY 1976

Vol. 76 No. 1

Co-editors Judith E. Ciani and Thomas W. Eres

President's Report—by Edward W. Poll

Our bicentennial year promises to be the dawning of a new era for the California Barristers Association. Barristers all over the State are preparing to enter the twenty-first century, both as individuals and as members of a professional association. To do this, we must master change.

Paraphrasing one recent writer, to master change, we shall need both a clarification of important long range goals *and* a democratization of the way in which we arrive at these goals.

The California Barristers Association has recently made large strides toward achieving greater participation of young lawyers in their professional destiny. The California Barristers Association is a changed organization because of this new involvement. The following is a brief list of some of the changes in your organization: (1) *Conference Call* is being forwarded to *every* Barrister in California. We now have the opportunity for frequent and direct communication with our constituency. (2) We have direct and frequent communication with the Board of Governors of the State Bar. Two CBA representatives sit with the Board of Governors at each of their meetings. Thus, the Barristers' voice is heard on every issue of our concern. If you need to say something on any given subject which may properly be brought before the Board of Governors, please contact me or the CBA director in your district. (3) A Barrister will sit as liaison to each of five committees of the Board of Governors. This most recent development will permit early consideration of Barristers' opinions. Barristers, for the first time, will have the opportunity to make important contributions in the beginning stages of a program's development rather than merely react to an accomplished fact. The five committees are: Unauthorized Practice of Law, Delivery of Legal Services, Professional Responsibility, Budget and Efficiency and Long Range Planning. We look forward in 1976 to continuing our good relations with the Board of Governors and improving the effectiveness of the communication of your wishes to the Board. (4) Creation of task forces on Employment Opportunities, Law Office Management and Ethics.

In the coming year, we will turn our attention to the "clarification of long-range goals". Our task forces will help in their respective areas; we anticipate the task forces will submit reports and/or have completed their tasks by September, 1976. In each of the three areas mentioned, exciting programs are planned. The response to these task forces has been fantastic!

However, for those to whom these areas have insufficient interest to have become involved, I ask you to let me know of your particular interests. We will move into any area where the CBA believes we can make a contribution and where Barristers have expressed a desire to become involved. We look forward to your comments and to your becoming participants in your organization.

One area in which your Board of Directors has become involved and which is of concern to all attorneys is that of advertising. Each president of a local barristers' organization has received a packet of materials discussing the various issues and arguments pertaining to advertising. Please be sure your organization discusses this very important topic. Send your comments to me at 9777 Wilshire Boulevard (Suite 718), Beverly Hills, California 90212 by February. The CBA wishes to reflect and report your attitudes to the Board of Governors. We need your support and responses to be able to do this.

In February, 1976, the State Bar will hold its annual mid-year meeting in San Diego. On Saturday afternoon of this meeting, the CBA will conduct its mid-year Conference of Barristers. All Barristers in attendance are urged

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Barristers: Interested In Placement Service?

To determine barrister interest in establishing a placement service for California lawyers, the Employment Opportunity Task Force has prepared the following brief questionnaire. Please take a moment to complete the questionnaire and mail it to Toliver Besson, Paul, Hastings & Janofsky, 22nd floor, 555 South Flower Street, Los Angeles, CA 90071.

1. Are you in favor of establishing a lawyer placement service in California which would match lawyer applicants with job openings in California?
   yes_____ no_____
2. Would you use such a service if it were established?
   yes_____ no_____
3. Is there a 50-50 chance or better that you would need to use such a service within the next five years?
   yes_____ no_____
4. Would you use the service if there were a $25.00 application fee?
   yes_____ no_____
5. Please provide the following information:
   a) age: _____
   b) number of years in practice: _____
   c) type of practice: (check as appropriate)
      individual practitioner ____
      associate ____
      partner ____
      government service ____
      employed by private concern ____
   d) county in which you practice _____
6. Additional comments: _____

Barristers Attend ABA Young Lawyers' Regional Meeting

by Noel W. Nellis

California Barristers Clubs affiliated with the ABA Young Lawyers Section were recently invited to send representatives to attend a regional meeting of affiliated young lawyer organizations sponsored by the ABA Young Lawyers Section and held on December 6 at the Stanford Court Hotel in San Francisco. Invitations to the meeting were sent to affiliated organizations in eight western states. Attending from California were representatives of barristers clubs in Beverly Hills, Fresno, Long Beach, Los Angeles, Sacramento, San Francisco, Santa Barbara, Santa Clara County, and Shasta-Trinity Counties, as well as representatives of the California Barristers Association Board of Directors.

The main purpose of the meeting was to give the ABA Young Lawyers Section an opportunity to discuss with affiliated organizations various current projects and activities which the Young Lawyers Section has underway. The Young Lawyers Section distributed background materials dealing with such subjects as Mental Health Law Reform and Youth Education. In addition, the conference also served as a forum for an exchange of ideas among local young lawyer organizations concerning their activities and concerns. Among the subjects discussed was the pending proposal by the California State Bar Board of Governors and the American Bar Association for allowing limited advertising by lawyers.

President's Report

(Continued from page 6)

to attend this meeting. Further details will be mailed directly to the presidents of the local barristers' organizations.

The future of our profession can be very bright. However, the will of large members of hitherto unconsulted attorneys must be ascertained. To some, this appeal for a form of neo-populism may seem naive. Yet, nothing is more naive than the notion that the Bar Association can shape the destiny of the legal profession without the input and support of its members.

BIOSKETCH: Edward W. Poll, CBA President

(Editor's Note: Beginning with this issue, we will prepare a brief biographical sketch of Board members for the Conference Call in an effort to give Barristers more information on their representatives.)

Ed is a long-time Southern California resident now in private practice in Beverly Hills. He obtained his BS, cum laude and JD from UCLA. In 1973 he received an MBA from the University of Southern California.

Ed began his professional career in 1965 as a trial attorney for the City of Los Angeles. In 1966 he left public service to become vice president and general counsel for the Fairfax Food Corporation.

He remained in business practice until 1970 when he began his private practice with emphasis in general corporate matters, real estate, civil litigation, and tax and estate planning.

Ed is a former editor of *Conference Call* and is currently a member of the Board of Governors of both the Beverly Hills Bar Association and Beverly Hills Barristers. He is a member of the American Arbitration Association, American Bar Association, Los Angeles Bar Association and Association of Business Trial Lawyers. He is an associate editor of the "Journal of the Beverly Hills Bar Association" and is a Judge Pro Tempore of the Beverly Hills Municipal Court, Small Claims.

Community activities include liaison with the Department of Consumer Affairs, City of L.A. for the food industry, member of Palms Jr. High School Advisory Council, and vice president, Canfield-Crescent Heights Community School.

CBA Board to Confer with Presidents Of Local Barrister Associations

Members of the Board of Directors of the California Barristers Association will meet with presidents of barrister associations throughout the state on Saturday, Feb. 28, 1976, in San Diego.

The meeting will be held in conjunction with the Conference of Bar Presidents scheduled Feb. 27-29, also in San Diego.

On the agenda will be discussion of the new CBA Task Force concept, better ways of communicating barrister activities, concerns and problems on a statewide basis, and additionally, major current topics such as legal advertising, recertification, legal specialization, and the organization of the State Bar.

* Formal invitations and materials are now being sent to barrister presidents, and if you have topics of concern you would like voiced at this meeting you should contact your local association president.

WAPAC

(Continued from page 4)

Townsend said that while the agreement was not expected to solve the employment problems of the Western Addition area, it was nonetheless significant:

"A positive step has been made by two organizations to sit down and rationally work out an agreement—rather than having the State Bar say 'because this area in which our headquarters is located is going through some redevelopment and some problems, we're going to pack up and move down to Los Angeles.'

"The Bar has done what I think is the proper thing, in saying instead 'this is the situation at home; now what can we contribute?' "

Program Discusses Opening & Managing Small Law Offices

The ins and outs of "Opening and Managing a Small Law Office" will be covered in a program sponsored by the Barristers of Los Angeles County Bar Association. The program will be held Saturday, Feb. 7, in Department 1 of the Los Angeles Superior Court. The fee is $15. For more information, phone the Los Angeles County Bar Association: 213-624-8571.

Advertising

(Continued from page 5)

(2) Law lists and legal directories, now published under existing rules, would be permitted to contain additional information of interest to consumers of legal services. This might include any of the items listed above, as well as the cost of an initial half-hour or one-hour consultation fee.

In addition to comment on the basic program, the Board is especially interested in responses to these specific possibilities: experiment with placing law list information in the classified sections of newspapers once a week (or month) — limit experimentation with Yellow Page display advertising to specified geographic regions (perhaps only two or three counties)—increase efforts to assist local bars in engaging in institutional forms of advertising.

The Board would also like members' thoughts on whether any of the proposed forms of advertising should include information about paralegals.

To aid in consideration of this issue, Bar members are urged to examine the specific, proposed changes in the Rules of Professional Conduct. The proposed changes are printed in their entirety on pps. 20-27 of the Board committee's report describing the proposed pilot program. (Again, that report was sent, with other material mentioned above, to all local bar presidents by President Casey; it has been distributed to local law libraries and law schools; and it is available at cost from the State Bar.)

The deadline for receiving comment is March 1, 1976. Comments should be addressed to the Board Committee on Professional Responsibility, Suite 502, 633 Battery Street, San Francisco, CA 94111.

Alcohol Program

(Continued from page 3)

Any attorney or judge who wonders if he or she might benefit from contacting the committee can look in the November-December 1975 issue of the *California State Bar Journal*. On page 489, the Journal printed 20 questions prepared by the committee specifically geared to lawyers. A "yes" answer to any one of the questions indicates that alcohol might be a problem.

Vice chairman Bartlett says, "If you need a Bloody Mary, Screwdriver or similar concoction in order to make it to the office this morning, maybe you should give us a call."

In Northern California: Bruce Bartlett (vice chairman, Committee on Alcohol Abuse), 415-851-7248; Ed Spanier (consultant), 415-467-6688; Hal Cook (consultant), 408-293-4848.

In Southern California: Judge Leon Emerson (chairman, Committee on Alcohol Abuse), 213-923-1271; Jack L. Sanow (consultant), 213-413-4800.

February Brings 2 New CEB Programs Plus Repeat of Discovery Presentation

The CEB February line-up includes Remedies for Breach of Contract, the Law of Politics, and Repeat Discovery programs.

Remedies for Breach of Contract in California—a three-hour intermediate level program exploring techniques available to attorneys who handle contractual disputes. Experienced litigators discuss what contract remedies to pursue and how best to solve problems likely to be encountered. Topics covered: understanding statutory remedies; drafting and interpreting clauses providing specific remedies; avoiding litigation when a breach occurs or is threatened; deciding whether to seek declaratory relief; measuring and proving various types of damages; pleading and recovering punitive damages; handling materials shortages. The $35 fee includes an outline of statutes, cases and other authorities, and sample clauses.

The Law of Politics—a CEB conference on lobbying, corporate/union political activity, and campaign regulations, pertaining to both state and federal level activity. Conferees should be familiar with the basics of political campaign and lobbying regulations. Speakers will discuss: tax consequences to contributors and recipients; disclosure obligations; limitations on expenditures and contributions; lobbying and its restrictions; misrepresentation and defamation in campaigns; and current trends in regulation of political activity. Daniel H. Lowenstein (chairman, Fair Political Practices Commission) will give an insider's view of coping with the FPPC, speaking at a luncheon. The $90 fee includes the luncheon and two 75-page syllabi of excerpts from the coming CEB book on the law of elections and political activity.

Creating and Implementing Discovery Plans in California—a three-hour program (repeat of a June '75 presentation) for attorneys who need to learn the basics of discovery. Using hypothetical case situations, experienced trial attorneys and law and motion judges will discuss tactics and procedures of designing and implementing discovery plans: use of depositions; written interrogatories; requests for admissions, for production and inspection of documents, for inspection of land, and for physical examination; impact of amendments to the California Civil Discovery Act; use of objections; motions for protective orders; motions to compel discovery, and for sanctions. The $30 fee includes a chart analyzing California's civil discovery practices.

For program dates and locations, contact CEB, 2150 Shattuck Ave., Berkeley, CA 94704; 415-642-0223; in Los Angeles, 213-825-5301.

PLAN AHEAD FOR THESE CEB PROGRAMS

March—Organizing California Partnerships

March/April—Income Tax Consequences in Real Property Transactions • Problems in Criminal Law Practice: Search Warrants and Eye Witness Identification

April—2nd CEB Consumer Law Conference • California Federal Civil Practice Seminar

May—Probate Problems Seminar • Problems and Pitfalls of Attorneys' Opinion Letters and Recommendations • Dissolving California Businesses.

Reports: PUBLISHED MONTHLY BY THE STATE BAR OF CALIFORNIA
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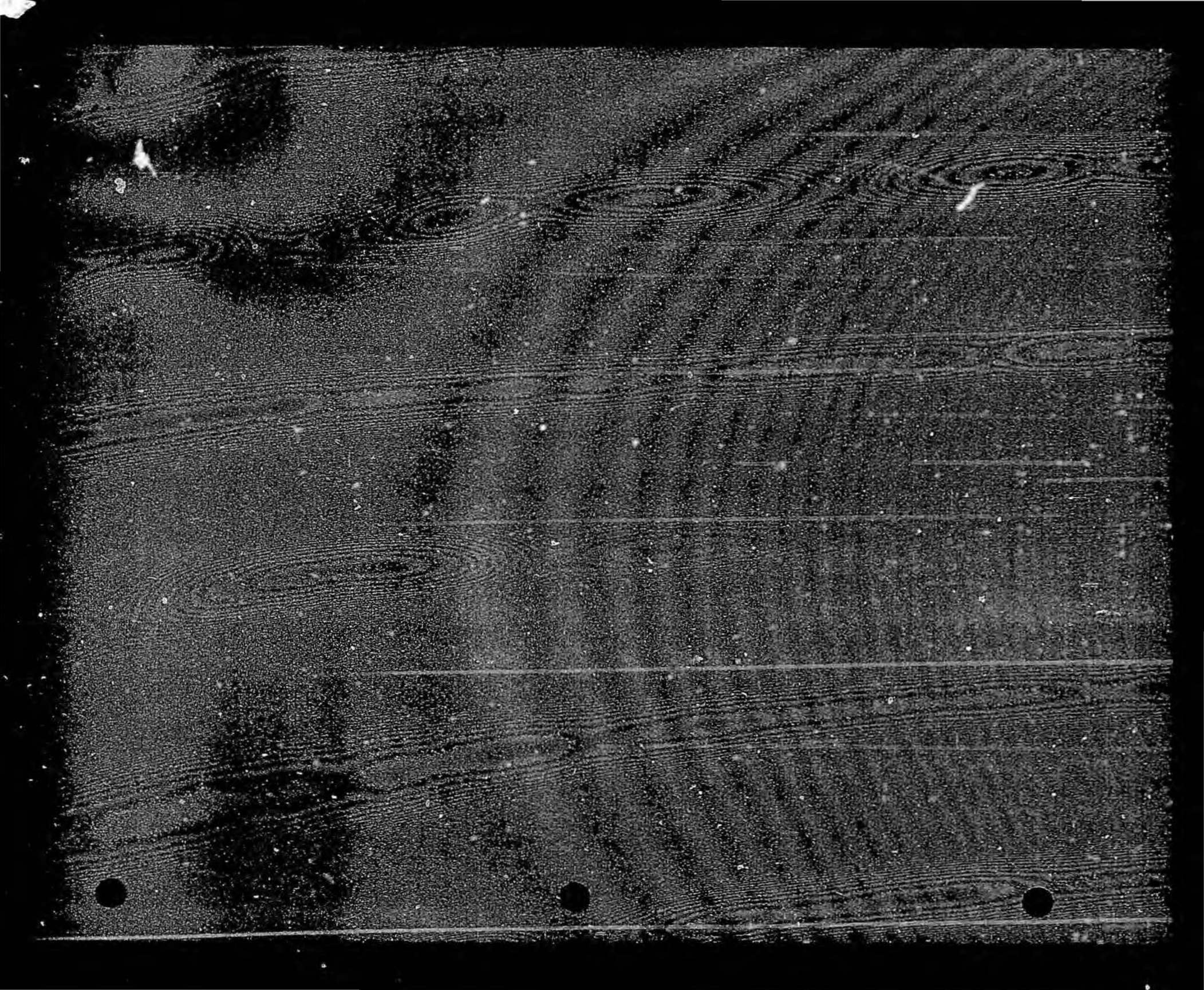

INFORMATION FOR HEALTH CARE PROVIDERS CONCERNING MANDATED BENEFITS FOR THE TREATMENT OF ALCOHOLISM, DRUG ABUSE AND MENTAL AND NERVOUS DISORDERS

STATE OF WISCONSIN
OFFICE OF THE
COMMISSIONER OF INSURANCE
123 WEST WASHINGTON AVENUE
MADISON, WISCONSIN 53702

This guide has been prepared by the Office of the Commissioner of Insurance of the State of Wisconsin to assist health care providers (and insurers) in understanding and applying Wisconsin's mandated health care benefits law, as it relates to treatment of alcoholism, drug abuse and mental and nervous disorders.

The guide is not as easy reading as we would have liked, because it is addressing a complicated law, which presents many complex problems of administration. It is hoped that the guide will alleviate needless confusion and misunderstanding concerning this innovative law; but it should be kept in mind that in any particular fact situation, it will be that fact situation, and the law, which will determine the outcome. For that reason, whenever possible, footnotes have been used to tie statements in the guide to specific statutory provisions.

Revisions of the guide will be made in the future as necessary.

INFORMATION FOR HEALTH CARE PROVIDERS CONCERNING MANDATED BENEFITS FOR THE TREATMENT OF ALCOHOLISM, DRUG ABUSE AND MENTAL AND NERVOUS DISORDERS

Providers of health care services have asked the Department of Health and Social Services and the Office of the Commissioner of Insurance many questions about the provisions of section 632.89, Wisconsin Statutes, which mandates coverage in some circumstances for inpatient and outpatient hospital treatment of alcoholism, drug abuse and mental and nervous disorders.

The following questions and answers prepared by the Office of the Commissioner of Insurance should provide a better understanding of this legislation. All of the questions and answers should be read carefully as a guide to the interpretation of this statute and the insurance contracts to which it applies. The provisions of health insurance contracts vary greatly from one policy to another so that it is unlikely that all of the possible questions which can arise have been answered, but it is hoped that the most important ones have been included. Further questions can be referred to the Bureau of Alcohol and Other Drug Abuse, Department of Health and Social Services, 1 West Wilson Street, Room 523, Madison, WI 53702, (608) 266-0907, or the Office of the Commissioner of Insurance, 123 West Washington Avenue, Madison, WI 53702, (608) 266-3585.

Q. *Wisconsin insurance law (section 632.89, Wisconsin Statutes) requires that certain inpatient and outpatient benefits be paid by insurers for the treatment of: 1) alcoholism; 2) drug abuse; and 3) nervous and mental disorders.*

To what policies or plans does the law apply?

A. This law generally applies only to group insurance policies and contracts issued in Wisconsin which provide hospital treatment coverage, and to comparable policies issued to a group based in another state if more than 25% of the insured persons are Wisconsin residents.

These mandated benefits are not required (but may be included) in:

- individual insurance policies;[1]
- federal employee group plans (e.g. postal carriers' plans);[2]
- self-insured employer group plans falling within the terms of the Federal Employee Retirement Income Security Act of 1974 (ERISA limits or precludes state regulation of properly constituted plans, even when they are administered by an insurance company);
- most policies issued to a group based in another state in which fewer than 25% of the insured persons are Wisconsin residents.[2]

Q. *Must all plans and policies to which the law otherwise applies provide both in.tient and outpatient treatment?*

A. No. Inpatient hospital treatment benefits are required only under group plans which provide hospital treatment coverage.[3]

Generally outpatient treatment benefits are required only under group policies which provide both hospital treatment coverage and outpatient treatment coverage.[4] An exception to this is the requirement that "Blue Plans" (e.g. Blue Cross, Surgical Care, WPS) must provide outpatient hospital treatment benefits for alcoholism under any group contract or plan which provides either hospital or outpatient treatment.[5]

Q. *What types of coverage must be provided for in those plans subject to the law?*

A. Required coverages are as follows:

1) Alcoholism

-- a minimum of 30 days' confinement in any calendar year for inpatient hospital treatment.[6]
-- the first $500 in any calendar year for outpatient treatment services, including but not limited to partial hospitalization services, prescribed drugs and collateral interviews with patients' families.[4]

2) Drug Abuse

-- Coverages provided are identical to those provided for alcoholism.[4, 6]

3) Mental and Nervous Disorders

— a minimum of 30 days' confinement in any calendar year for inpatient hospital treatment.[6]
-- The first $500 in any calendar year for outpatient treatment services provided by or under contract for a board established under section 51.42 of the state statutes. (These are the county mental health boards.)[4]
— $500 in any calendar year for any other outpatient services for mental and nervous disorders.[4]

Q. *Do coinsurance requirements and deductibles apply to these mandated benefits?*

A. Section 632.89 (2) (b) specifies that exclusions and limitations which are generally applicable to other conditions covered in a policy may be applied to:

— inpatient hospital treatment for alcoholism, drug abuse and mental and nervous disorders.

— outpatient treatment for nervous and mental disorders — other than by or for a 51.42 board — as long as $500 per year in benefits are provided.

Deductibles and coinsurance may not be applied to coverage required for outpatient treatment of alcoholism and drug abuse, or outpatient treatment provided by or for a 51.42 board for nervous and mental disorders until the first $500 has been paid by the insurer.

Q. *What is an "outpatient treatment facility?"*

A. An outpatient treatment facility is a facility licensed or approved by the Wisconsin Department of Health and Social Services whose outpatient services meet the standards established in section 51.42 (12), Wis. Stats., and which provide those services, except inpatient services, enumerated in section 51.42 (5) (b) to (d), Wis. Stats., for the prevention and amelioration of mental disabilities, including but not limited to mental and nervous disorders, alcoholism and drug abuse.[7]

Q. What are "outpatient services"?

A. "Outpatient services" mean services, medications, equipment and supplies performed or furnished by or under the supervision of or on referral from a physician at a hospital or outpatient treatment facility to a patient who is not a bed patient of the hospital or outpatient treatment facility.[8]

Q. Are psychologists' or social worker's charges for outpatient treatment required to be covered?

A. This depends upon whether such services are provided under the supervision of or on referral from a physician. The definition of outpatient services in section 632.89 (1) (d) which insurers are required to provide does not include those of non-physicians unless furnished under the supervision of or on referral from a physician.

Referral and supervision are not further defined. Comparable psychotherapy programs seem to require that, at a minimum, initial referral will include written authorization from a physician and that any subsequent visits will involve periodic reporting to that physician.

Q. Some group policies set waiting periods for "pre existing conditions." How is the date of onset of the alcoholism or drug abuse condition to be determined, in order to judge whether the condition is a "pre-existing condition" for insurance purposes?

A. The applicable standards for judging pre-existing conditions are contained in Wisconsin Administrative Code section Ins 3.31 and read as follows:

> A claim shall not be reduced or denied on the grounds that the disease or physical condition resulting in the loss had existed prior to the effective date of coverage, under coverage providing such a defense, unless the insurer has evidence that such disease or physical condition, as distinguished from the cause of such disease or physical condition, had manifested itself prior to such date. Such manifestation may be established by evidence of medical diagnosis or treatment of such disease or physical condition prior to the effective date, or the existence of symptoms of such disease or physical conditions prior to the effective date which would cause an ordinarily prudent person to seek diagnosis, care or treatment. (Emphasis added)

The insurer must use these standards in determining if a condition is pre-existing. Health care providers can assist in proper settlement of claims involving questions of a pre-existing condition by providing complete information about medical diagnosis or treatment, including recorded symptoms, of the condition.

Q. *What if benefits could be paid under more than one plan?*

A. Benefits can be paid under more than one plan. However, most group plans contain a coordination (or non-duplication) of benefits provision which is intended to limit the payment of benefits under all coverage to the amount of the total expenses incurred.

Q. *Does the requirement of section 632.89 (2) (d) that coverage for the first $500 of outpatient treatment in a calendar year be provided prohibit any limitation on the amount of a charge to be co... for services of a provider, e.g., application of a "usual and customary fees" limitation that would be generally applicable to other covered conditions?*

A. No, if the basis an insurer uses to establish fee reimbursement ...els is reasonable, and equitably ...lied to all providers.

Q. *What level of coverage for outpatient treatment must a contract include in order for the coverage for outpatient services mandated by section 632.89 (2) (d) to be required?*

A. Coverage which provides any kind of benefit for health care service other than for a hospital inpatient is "coverage for outpatient treatment" even if this coverage is very limited. This means that a policy which provides any outpatient treatment must include the mandated benefits.

Q. *When did this law become effective? Does it apply to policies and contracts then in force or only to those issued after that date?*

A. The legislative chapters that included these mandated coverages became effective May 5, 1976. All group policies and contracts issued after that date or renewed or otherwise changed after that date must include these coverages. Thus, all group contracts presently in force in Wisconsin which are subject to the law in other respects must now include these coverages and benefits. Moreover, most of them should have been including some of the mandated benefits for a number of years.