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Before discussing the programs necessary to control alcoholism, a definition of the problem will be provided. As is the case in so many behavioral-social-psychological areas, definitions are primarily descriptive rather than causal. Nowhere is this more true than in the field of alcoholism.

The literature is replete with alternative definitions. In 1955, the World Health Organization suggested that alcoholism "is a collective term for a 'family of problems' related to alcohol," with symptoms described as " 'craving' . . . ; 'withdrawal' . . . ; 'loss of control.' " Jellinek, in i960, defined alcoholism as "any use of alcoholic beverages that causes any damage to the individual or society or both." Keller, in 1962, in meeting the criteria for public health purposes (that is, identification of alcoholic populations for epidemiological study and control) defined alcoholism as "a chronic disease manifested by repeated implicative drinking so as to cause injury to the drinker's health or to his social or economic functioning." Chafetz and Demone, in 1962, offered both a descriptive and etiological definition:

We define alcoholism as a chronic behavioral disorder which is manifested by undue preoccupation with alcohol to the detriment of physical and mental health, by a loss of control when drinking has begun (although it may not be carried to the point of intoxication) and by a self-destructive

attitude in dealing with personal relationships and life situations. Alcoholism, we believe, is the result of disturbance and deprivation in early infantile experience and the related alterations in basic physiochemical responsiveness; the identification by the alcoholic with significant figures who deal with life problems through the excessive use of alcohol; and a sociocultural milieu which causes ambivalence, conflict, and guilt in the use of alcohol.

With the uncertainty of definition, it logically follows that epidemiological data will have wide variance. Based on the Jellinek formula, for many years the estimated alcoholic population of the United States was considered to be 4.5 million. More recently, estimates based on a national interview sample suggest an "alcoholic population" in excess of 9 million. Of this population only 5 percent fall into the highly visible skid-row derelict model; the remainder are employed or employable, mostly family-centered individuals.

Whatever the number and definition, it is clear that the population directly involved is substantial, and as a nation, we are ill prepared to cope with the problem. Collectively, the effects are staggering.

Extent and Distribution of Alcoholism and Alcohol Problems

It has been estimated that more than 40 percent of all arrests, either in a

public place or while driving, are for drunkenness. Out of 5 million arrests made in our nation during 1964, it is reported that more than 1,535,000 were for public drunkenness, 250,000 were for driving while intoxicated, and 500,000 involved alcohol-related offenses.

The 1968 *Alcohol and Highway Safety Report* concluded that "alcohol contributes to about 25,000 of the approximately 53,000 fatal highway injuries in the United States annually (1966 and 1967)." The National Safety Council estimated that alcohol plays a role in 6 percent of the 14 million run of the mill crashes that occur in the country each year and that cause disabling injuries.

Alcoholism as a cause of death (including cirrhosis of liver with alcoholism, alcoholic psychosis, and so on) annually appears on more than 13,000 death certificates.

For 1968, out of 140,000 total male admissions diagnosed as alcoholic to psychiatric inpatient services, 59,000 were admitted to state and county mental hospitals, 40,000 to general hospitals and 29,000 to Veterans Administration hospitals, and 6,000 to private mental hospitals and federally funded community mental health centers.

The cost to the nation may be as high as $15 billion each year: $10 billion in lost work time, considering only the employed alcoholics; $2 billion

in health and welfare costs, incurred by alcoholics and their families; and $3 billion in property damage, wage losses, and the like associated with traffic accidents. In addition, based on a conservative national estimate, there are such costs as $100 million plus for police, court, and penal costs for the drunkenness arrests; health and welfare expenditures on behalf of alcohol abuse come to $300 million plus, of which only $85.5 million is directly programmed for rehabilitative care for the alcoholic population.

To these must be added the human cost of broken homes, deserted families, and the countless psychological problems common in children of alcoholic parents. It has been estimated that the life expectancy of alcoholics is about ten to twelve years less than the average. And, through the alcoholic's impact on his family, the tragedy of death and disability related to alcohol abuse affects, at a minimum, one of every six Americans.

Self-Help Movements

In any examination of programs aimed at controlling alcoholism, Alcoholics Anonymous must head the list. The Alcoholics Anonymous movement was created in a cauldron of despair, neglect, and desperation manifested in the persons of an alcoholic physician and an alcoholic stockbroker during a chance meeting in Akron, Ohio, in 1935. The prevailing influence of the Oxford and Washingtonian group movements is

acknowledged and documented in all the historical descriptions of Alcoholics Anonymous. But Alcoholics Anonymous determination to succeed was evidenced by the founders' determination to focus only on alcoholism rather than the broader social goals espoused by the two older organizations. The movement's drive for anonymity, to preclude the development of personality cults, and its single-minded focus on alcoholic persons, have made it a powerful and effective program. It does not allow for diffusion of energy into political or social causes. A.A. is almost a non-organization; the program is the organization. In a sense, therefore, the banding together of alcoholics under the A.A. banner is a living example of a participant democratic procedure. It is the model for all self-help groups. There exists a general service board, consisting mainly of non-alcoholics, plus members. The board functions to sustain integrity and services of the general service headquarters. The headquarters is the common linkage to Alcoholics Anonymous groups all over the world. Although there is a general service conference charter, the conference is unincorporated; the charter is not a legal instrument.

If Alcoholics Anonymous has a single voice, it is through its publications, especially the monthly *Grapevine,* that the tone is set.

Since Alcoholics Anonymous is a loosely knit body, the exact number attending group meetings is unknown. In 1938, there were only three A.A. groups with approximately 100 members in all. In 1944, it is estimated that

the figure rose to 10,000 members in approximately 300 groups in North America. By 1965, this figure was about 300,000 members in approximately 10,000 groups in the United States. Today, in the Washington, D.C. metropolitan area alone, it is estimated that there are about 125 groups. There are perhaps to 500,000 alcoholics participating in A.A. all over the world: Africa, Asia, Australia, central and southern Europe, Canada, and areas not covered in the world directory.

Structurally independent of Alcoholics Anonymous but direct outgrowths of that organization are Al-Ateen, and Al-Anon. Al-Ateen is an organization of teenage children of alcoholics, and Al-Anon an organization of spouses and relatives of alcoholics. There are now more than 4,000 groups comprising Al-Anon in the United States, Canada, and thirty-five foreign countries. The Al-Anon Family Groups, as the organization is called today, has published a number of books, such as A *Guide for the Families of Problem Drinkers, Living with An Alcoholic with the Help of Al-Anon, The Dilemma of the Alcoholic Marriage,* and *One Day at a Time in Al-Anon.* About 50 percent or more of Al-Anon members are relatives of still drinking alcoholics who have not yet joined Alcoholics Anonymous.

Voluntary and Other Alcoholism Organizations

The National Council on Alcoholism (NCA) is one of the nineteen

member agencies of the National Health Council. It is a national voluntary health organization with fifty-five affiliates throughout the United States. It was organized in 1944 to "combat alcoholism through a national program of education, research and community services," and unlike Alcoholics Anonymous, has often engaged in public policy activities in support of enlarged governmental efforts. Similarly, it has provided important leadership in programs of public information and consultation to the many interested groups. Of particular emphasis during recent years has been an extensive industrial consultation program. Expenditures in 1970 of the NCA and its affiliates amounted to $2.7 million.

On the local level, the number of affiliated members of NCA has remained relatively stable over the last decade, the principal growth having occurred between 1950-1960. When contrasted to the substantial growth of voluntary associations in mental retardation and mental health, public ambivalence about alcoholism is underlined.

The North American Association of Alcoholism Programs (NAAAP), developed by administrators of government-supported programs for treatment, education, and research in alcoholism, was organized in 1949 and has served as a forum for the exchange of ideas and information among publicly and privately sponsored treatment, research, and education organizations.

The Center of Alcohol Studies at Rutgers (formerly at Yale), in addition to its continuing research, documentation, and publication activities, developed the Summer School of Alcohol Studies, which has served as a model for the development of many other schools and summer institutes throughout the United States and Canada. The center has been instrumental in the organization of many state alcoholism programs and publishes the *Quarterly Journal of Studies on Alcohol,* the world's leading journal in its field.

Counselors on Alcoholism and Related Disorders (CARD), a nonprofit organization incorporated in California in 1968, offers a three-unit training course in alcoholism, in cooperation with the University of California extension division, to "train those interested in working with the alcoholic as their vocation." In addition, CARD regional summer schools have become quite popular.

The Licensed Beverage Industries, Inc., and foundations such as the Christopher D. Smithers Foundation carry on research and education activities in the field of alcoholism.

Industrial Programs

The following definition of "alcoholism" was included in the National Industrial Conference Board's report published in March 1970: "Alcoholism: 'A highly complex illness.' It is a chronic disease characterized by repeated

excessive drinking which interferes with the individual's health, interpersonal relations or economic functioning."

Business and industry in the United States have, during the past decade, become much more responsive to their employees who have alcohol problems. Since some 3 to 8 percent of the employees of a typical company are likely to be alcoholics, estimates of the annual dollar cost can be substantial as noted earlier. Nor is the executive immune; it has been estimated that perhaps 10 percent of the American executives are alcohol dependent.

In 1947, recognizing the problem of the alcoholic employees, Consolidated Edison of New York began a company rehabilitation program. Gradually, programs by such major companies as Allis-Chalmers, Equitable Life, Kemper Insurance, Du Pont, and Raytheon, to name only a few, were initiated.

An industrial consultant of the NCA reported an increase of 357 percent in the number of companies developing new alcoholism programs from 1959 to 1965 (counting fifty companies with "formal programs in full operation" in the base year of 1959). In a government report (1967), it is stated that "more than 200 American firms maintain their own company programs."

From a 1968 National Industrial Conference Board survey, it appears

that there has been a shift from a disciplinary approach toward more positive programs of rehabilitation. The majority of companies in the study also feel that control programs more than pay for themselves.

The NCA estimated that, as of January 1968, there were about 3.1 million alcoholics in the nation's work force of 58.3 million (in business, industry, and civilian government), or 5.3 percent of that work force.

From the "Report to the Special Subcommittee on Alcoholism and Narcotics Committee on Labor and Public Welfare" it is estimated that the prevalence of alcoholism among federal civilian employees ranges from 4 to 8 percent of the work force and costs the federal government from $275 to $550 million annually.

In the military, one of the earliest attempts to treat alcoholics in the armed forces was at the Fitzsimmons Army Hospital in 1950. In 1966, the air force initiated its Wright-Patterson Program for alcoholics. In a paper by A. N. Papas, alcoholism is deemed "a threat to the well-being of the individual and the Air Force in peacetime as well as in wartime." In this treatment program it was reported that seventeen men out of thirty-four eligible for a six-month follow up remained sober, an abstinence rate somewhat higher than the results of most treatment programs, which usually give one year follow-up figures of one-third abstinent, but lower than that reported by industry,

which reports success rates of up to 70 percent.

Today, many companies have effective alcoholism control programs. In a study of fifty companies, the number willing to rehire a recovered alcoholic (in 1968 as compared to 1958) rose from fourteen to eighteen, and the number that "probably would rehire" rose from eighteen to twenty-four.

Government-Sponsored Alcoholism Programs

The federal program under the division of alcohol abuse and alcoholism within the National Institute of Mental Health (NIMH) had a total fiscal 1971 budget of $14 million: $6 million in grant support for research; $330,000 in intramural research; $1 million in grant support for training; $6 million in federal matching grants for construction and staffing of community-based services for the treatment of alcoholics, and $330,000 for a national information and education program.

On December 31, 1970, President Nixon signed into law the "Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970," which established a National Institute on Alcohol Abuse and Alcoholism within NIMH and authorized $300 million for alcoholism programs over the period of fiscal years 1971-1973. If any substantial portion of these authorized moneys is appropriated for use, the programs of the NIMH in support of alcoholism activities at the state and local

level, and through the awarding of grants and contracts, will be dramatically increased.

An additional federal program under the Department of Health, Education and Welfare's social and rehabilitation service made $25 million in rehabilitation grants, which could include services to alcoholics, available during fiscal year 1971. The Department of Transportation had an alcohol-related program of approximately $18 million and the Office of Economic Opportunity's program was approximately $10 million for fiscal year i97i-

The Veterans Administration has the largest alcoholism research program in the country, since it also has the world's largest sample of alcoholic patients accessible for long-term study, treatment, and follow up. During 1965, 55,581 patients with principal or associated alcoholic diagnosis were treated in Veterans Administration hospitals. During 1968, this figure rose to 92,231. During fiscal 1969, Veterans Administration hospitals operated twenty-seven pilot alcoholism treatment units in participating hospitals, without special funding. During 1970, alcoholism research was funded at approximately $2.5 million.

As of July 1, 1970, only two states (Idaho and Illinois) lacked state alcoholism authorities as designated by their governors. Of course, the quality and quantity of state programs vary considerably. In fact, the province of

Ontario, in Canada, has clearly developed North America's outstanding government-sponsored program. Referring only to actual medical, psychiatric, social, and rehabilitation services for alcoholics, the state alcoholism agencies expended more than $40 million during fiscal year 1970.

Generic, Noncategorical Service Systems

Many alcoholics, though they do not acknowledge their alcoholism, are already in contact with one or more major helping agencies, such as general hospitals; mental hospitals; community mental health centers; and welfare, rehabilitation, and family service agencies. Estimates indicated that alcoholism is involved in 10 to 25 percent of welfare cases. Studies of patients admitted to hospitals after attempted suicide indicated 11 to 23 percent were alcoholics; in a study of completed suicides, 31 percent were found to be alcoholics. A study in Maryland found that 25.4 percent of males admitted to psychiatric outpatient facilities were excessive drinkers, though more than half of these persons received diagnoses of other than alcoholism.

In addition, state mental hospitals during fiscal 1970 received $174 million for treatment of alcoholism; state support for psychiatric wards of tax-supported general hospitals, community mental health clinics, psychiatric clinics, and vocational rehabilitation agencies was between $14 and $20 million.

The general hospital has had a mixed record in alcoholism. Early in 1958, recognizing the alcohol problem, the Morristown Memorial Hospital (in a New Jersey community of established an alcoholic service, among the first of such specialized hospital services in North America. The service included a follow-up care unit in the alcoholic clinic. Since then, an increasing number of hospitals have opened their facilities to alcoholics, following the leadership of the American Hospital Association, but only a few other communities have established services similar to those of the Morristown Memorial Hospital.

Since hospitals are not always ready or willing to admit alcoholics, or are overcrowded, the jail still remains the major single source of immediate care for the individual who is drunk in the streets. During recent years, a major movement has been under way to remove the offense of public intoxication from the criminal statutes. Both through state legislatures and the courts, this “crime” is under attack. Some success has occurred. The underlying issue is the ability of the health and social welfare system to accommodate this substantial influx of patients ordinarily described as unreachable.

The alcoholic has often also found refuge with the Salvation Army when few other social agencies were willing to work with him.

Recognizing the need for the care and study of alcoholism, in 1953

Massachusetts established an alcohol clinic at the Massachusetts General Hospital in Boston, a university-affiliated hospital. A pilot study to engage the alcoholic to enter into treatment was initiated. It was known that many alcoholics who make their first contact with a hospital through the emergency service do not follow through on treatment by seeking outpatient care. In a study of 200 male alcoholics admitted to the emergency service of the hospital, 100 were assigned to an experimental group for treatment, and 100 to a control group receiving no special treatment. Follow up of the 200 cases at the end of the one-year experimental period attested to the fact that the alcoholic can form a therapeutic attachment. Prior to the study no alcoholic came to the alcohol clinic as a consequence of emergency service admission; the study showed that 65 percent of experimental cases made initial visits in contrast to 5 percent of the control cases; that 42 percent of the experimental cases made five or more visits in contrast to 1 percent of the controls. Additional findings showed that the usual clinical approaches to difficult treatment groups must be reexamined and revised, that, in fact, the establishment of treatment relations can be highly effective.

At Memorial Hospital in North Conway, N.H., "a federally supported demonstration project designed to offer comprehensive services to persons with alcohol problems in a rural area" was begun in an effort to provide emergency psychiatric services in a nonteaching general hospital loosely linked for consultative and teaching purposes to members of the psychiatric

and social service departments of Massachusetts General Hospital.

In fifteen years, from 1944 to 1958, the incidence of alcoholism in New Hampshire more than doubled, and the estimated number rose from 17,000 in 1953 to 30,000 a few years later. The Alcohol Rehabilitation Unit was conceived for a rural village of 12,500 where there were no professionally trained mental health personnel; where the one hospital with university affiliation is 100 miles away; where a state-operated two day a month clinic for diagnostic evaluation problems in young persons is seventy miles in a different direction; where the few private practicing psychiatrists were some sixty to eighty-five miles away; where the state hospital is ninety miles away; and where not a single inpatient facility for persons with emotional problems exists within the county.

Therefore, custodial care for alcoholism (in addition to that provided by general hospitals to patients admitted for delirium tremens, gastritis, and other acute medical manifestations of the illness) had to come from nursing homes, jails, houses of correction, and country infirmaries.

A case in point, which suggests the therapeutic potential of the unit, concerned an alcoholic of long standing (twenty years). Treatment attempts such as several admissions to the state hospital, commitment to the county farm, a live-in occupational arrangement in a neighboring state with

attendance at A.A. seven nights a week, disulfiram therapy as an outpatient without other treatment, and confinement in the local "drunk tank" had all proved fruitless. After sixteen months of treatment, which included "direct involvement in the community and . . . consequent ability to be very active on behalf of the client, to be able to respond immediately and flexibly to any crisis with hospitalization, medication, or a quick home visit, to shore up wavering motivation and hope, and to enlist the aid of many people in the person's life," the patient's drinking was reduced to only one-tenth of what it had been during the past several years, and the patient's absenteeism at work decreased correspondingly. The patient was reunited with his wife, and his functioning, both as head of the household and as employee, improved substantially.

Because of the effectiveness of the facility, we feel this approach to providing alcoholism services in rural areas is worthy of development for the future.

One of the more successful efforts at establishing an effective alcoholism program at a state hospital was at Mendocino State Hospital. Here, 100 miles north of San Francisco, in the state having the second highest rate of alcoholism in the United States, Mendocino State Hospital serves San Francisco County, which has the highest alcoholism rate within California. In the first half of 1966, nearly patients, men and women, were admitted to the

alcoholism service. Patients are accepted by the alcohol service either by court commitment (about 17 percent) or by voluntary admission (83 percent). Mendocino is the only California state hospital that routinely accepts alcoholics on a voluntary basis.

A greatly enlarged staff, needed to cope with the high ratio of patients and to coordinate the new unified program that came into effect in 1965, was filled mostly by employees who had volunteered for the alcoholism program. Use was made of a variety of staff members, not assigned to the alcohol service, as group leaders for the alcoholic patients.

Between the end of 1965 and the middle of June 1967 admissions to the alcohol program rose to more than 2,600 each year, more than 96 percent voluntary, and comprised more than two-thirds of all of the hospital's admissions. Some of the reasons for the success of the program can be attributed to the exceptional leadership, the well-trained, well-qualified, and highly motivated staff, and the treatment of the alcoholic patient, allowing and encouraging him to take on responsibilities. Some senior patients' involvement in the program were in counseling all new admissions, acting as group leaders, presenting panel discussions on alcoholism in communities, and managing a non-staffed residence. The program's effort toward the control and prevention of alcoholism by integrating many and varied resources resulted in its being designated as the California Department of

Mental Hygiene's demonstration alcoholism service.

A Future View

A look at potential positive results if programs are accelerated suggests that aggressive, carefully planned programmed efforts could produce impressive cost benefits.

It is estimated that the cost to the average industry would be $5 a year for each employee, or $300 million a year for the entire work force, to cover the costs of an educational campaign, training program, and the identification and referral of the alcoholic employee.[1] (The actual treatment would occur in community settings.) The benefits of such a program could mean a substantial reduction of the $10 billion annual loss of productivity (25 percent of the salary of each alcoholic). Three and one-third million employed rehabilitated alcoholics (based on 50 percent rehabilitation success) X 25 percent of their average annual salaries equals $5 billion, minus the $300 million program cost, or an annual saving of about $4.7 billion a year, or roughly $15 saved for each $1 spent.

There are approximately 200,000 federal civilian employees who suffer from alcoholism. Based on a minimum of 50 percent of the employed alcoholics who can be rehabilitated, and a cost of approximately $15 million annually for such a program (without paying for treatment services), the

benefit figures for the federal program are higher than the private sector (due to higher average salary) and would result in a savings of $250 million, or $17 saved for $1 spent.

To the governmental and industrial programs for education, identification, and referral must be added treatment costs, of course. It is impossible to estimate the precise treatment cost to industry and government since cost to a large degree is dependent on health services that are locally available. Where local health services are adequate, industry need only refer alcoholics and may not have to assume any financial burden. However, where there are inadequate health services, the question of who will pay costs varies with the health insurance benefits available, the industry's contribution, and the public's participation through governmental programs.

Based on a 50 percent chance of rehabilitating alcoholics who come into contact with health and care-giving agencies, 2.5 million alcoholics would be rehabilitated at a savings of approximately $4 billion at a cost of $400 million, or a cost benefit ratio of 1 to 10.

More than $100 million per year is currently spent in arrest and incarceration of public drunkenness offenders, and a large amount also is spent in health and welfare services for this population. Treatment of these individuals in the health system has a 20-25 percent chance of success while

"treatment" in the criminal system has proven largely unsuccessful. In addition, a saving in police and court time would be achieved.

The reduction of automobile accidents and the annual death toll of 28,000 and 500,000 disability injuries (and several hundred thousand traffic arrests) and more than $1 billion in property damage, insurance costs, and medical services through treatment by identification, education, and environmental manipulations and instrumentation might roughly be set at 40 percent.

Federal programs for alcohol abuse among Indians would cost $7.5 million with cost benefits inestimable at this time but commensurate with cost benefits for the general alcoholic population of the nation.

Because of the long-term neglect and unique inherent stigma associated with alcoholism and drinking problems and the more than 9 million problem drinkers in the United States (as compared with 250,000 heroin users), the need for broad-based comprehensive programs is paramount.

A Note on Prevention

No examination of alcoholism programs can be complete without consideration of prevention. In alcoholism, the parameters for possible action are considerably enlarged when the traditional public health model of

primary, secondary, and tertiary targets for prevention is used and the host, agent and environment continuum is visualized.

Typical of most alcoholism endeavors to date, which focus on the late stages of the alcoholic process, the bulk of this discussion focuses on tertiary prevention, that is, on programs developed to treat the severe casualties of the alcoholic illness. In some quarters, the identification in industrial programs of the alcoholic employee is labeled early intervention and does possess some features consistent with secondary prevention. There are other possible opportunities in secondary prevention outside of industrial programs. A focus on early case finding in youth-oriented settings, such as schools, colleges, YMCAs, religious organizations, and so forth could be productive. Once the stigma of alcohol-related problems is removed from the moralistic and punitive arena, these formal organizations are in a unique position to identify those whose dependence on and behavior with alcohol is beyond the social norm. As in early case findings, secondary prevention is highlighted.

Primary prevention, most desirable of all, remains challenging and nonspecific. Without the single fact or etiological agent of the infectious model, specific “vaccination” as a primary preventative is inhibited. The amorphous inputs to better health and living, such as resilient coping mechanisms, improved mental health, less poverty, and a lessening of a

myriad of social health problems could of course contribute to changing the milieu of alcohol problems and thereby lower the incidence of alcoholic conditions.

Some specific alcoholic preventive methods, to date unproven, are possible. These include measures designed to make available and desirable alcoholic beverages of lower, rather than higher, alcoholic content; measures designed to promote a style of integrative drinking (alcohol with meals, sporting activity, religious and family feasts), instead of alcohol use in, by, and for itself. Certainly no preventive approach could hope to succeed without some public campaign to identify drunken behavior as unacceptable.

Whenever educational thrusts are introduced, school programs are suggested. The use of school systems in alcoholism education is not a new phenomenon, since the fervor of the prohibition experiment resulted in all mainland state legislatures enacting legislation requiring the schools to educate the young to the dangers of drink (most were written about the turn of the century). Although the “fear teaching” exemplified by the old alcohol laws is not much of an example, it illustrates the continuing dilemma and debate about whether or not the school system ought to have the goal of social problem prevention. On one hand, some contend that the degree of support for school programs of prevention merely reflects the state of knowledge: When specific preventive measures are unclear or unavailable

(when we do not know what to do), we turn to the school system and ask it to assume the task. Those persons of such persuasion contend that we attempt to prevent sexual problems by sex education, mental illness by mental health education, and drug and alcohol abuse by drug and alcohol education. Others, who make a strong distinction between information and education, contend that the educational system reneges on its highest calling when it abdicates its implicit mandate to awaken and develop mechanisms of social responsibility among its young charges. The pros and cons of this important debate are beyond the scope of this chapter, but bear noting in any discussion of prevention.

Conclusion

The examination of alcoholism programs illustrates that the significant function of a specialized alcoholism network is to demonstrate, stimulate, and train. The needs, implications, and extent of alcohol problems are such that it is unrealistic to expect a specialized system to cope with the immensity of the total alcoholic population and their families. They will and must become part of the total health care system. But the alcohol programs must demonstrate and, hopefully, thereby change the negative attitudes and improve the healing competence of the generic system. The advent of the new alcoholism legislation of the federal government is a major thrust in this direction. By its broad mandate of increased federal support to states with its formula grant

provisions, by the removal of civil service barriers to employment of persons with prior alcoholism histories, by the strength of its confidentiality provisions, by the demand that all state health programs include planning for alcoholism, and by the creation of a National Institute on Alcohol Abuse and Alcoholism, the potential and initiative are at hand. What psychiatry and the other allied helping professions do with this significant achievement is up to them.

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Notes

1 Based on estimates available in 1970.