

for health in the region, scientific devices which are needed but lacking at present, a communication facility which possibly could be adopted for purpose of the program.

The research group functions as a medical experiment station drawing together the talents of all university disciplines which can contribute to the definition or solution of health care problems.

Of the 21 bioengineering projects now active, I should like to mention two. One result of this research has been the development of a diagnostic chair, which simplifies the taking of a heart tracing. The chair reduces the time required for an EKG from about 20 minutes to less. Another piece of equipment developed by the engineers and the physicians working together is an electrolytic unit which has proved extremely helpful in speeding the healing of leg and body ulcers for the diabetics or patients who must be in bed for long periods, and these compact units can be taken home.

An added feature is an alarm system which reminds the patient to keep the bandage properly dampened.

Future programs could be summarized as the design of more model delivery systems in cooperation with the public and health professional involving finally the entire region, continued concentrated study of appropriate services designed to be self-supporting, the assistance to programs in providing for treatment of disease and rehabilitation of patients suffering from these categories of disease, and last, a translation of new ideas into action on behalf of the patient or the potential patient.

This is indeed an exciting, though wearing, time to be involved in health affairs. The regional medical program, to my mind, offers one of the best means for achieving optimal health for all people, who are in effect the real beneficiaries of regional medical programs.

I would certainly urge the support and the continuation of this program.

Now I have here an organization chart of the Missouri regional program which I would like to offer for the record.

Mr. ROGERS. The committee would be very pleased to have that, and it will be made a part of the record at this point.

(The document referred to follows:)

MISSOURI REGIONAL MEDICAL PROGRAM ORGANIZATION

1. GOAL SETTING

(a) Policy is set by representatives of the public and the practicing profession upon advice from:

Medical schools.

State departments related to health.

Voluntary organizations.

All health professional organizations.

(A total of more than 50 people read and comment upon each Proposal.)

(b) Planning is for a selected population of people regardless of where they may ultimately receive their care. This permits maximum use of communication mechanisms already established between the many involved groups.

(c) Planning and operations are kept administratively separate.

2. ORGANIZATIONAL PATTERN

The Project Review Committee consists of the head or his delegate from the schools of osteopathy and medicine, the Division of Health, Director of Welfare and Director of Mental Diseases. This committee serves as an advisory body to the Council on all proposals.

An Advisory Council, nominated by the Project Review Committee and appointed by the Governor, serves as the governing body. The 12 members serve staggered terms, no person's service to exceed six years. Members may not be drawn from University staff.

The Liaison Committee is composed of elected or appointed representatives sent by each state-wide voluntary or professional organization which has applied to and been accepted by the Council. The 24 members serve as a reaction panel on all projects for Council.

The University of Missouri serves as trustee for funds for the Missouri Regional Program.

3. SPECIAL URBAN ORGANIZATION

For the Kansas City area a special Metropolitan Liaison Committee has been formed. Members include five local citizens and two representatives from each of the Advisory Councils of the two regions (Kansas and Missouri) which overlap in the Kansas City area. This committee also serves in an advisory capacity to the two Regional Councils for all projects which fall within the six county urban area of Kansas City.

A special, local planning force has been assigned to Kansas City by the Missouri regional program.

No matter how a region is described, ultimately it must interact with other regions. Modifications of the Kansas City committee have been developed with three of the other adjoining regional programs and similar plans are under discussion with a number of other regions which also adjoin Missouri.

Mr. STARK. I submit for the record three separate publications of the Academy of General Practice as evidence of cooperative efforts between the practicing physician and the program.

Mr. ROGERS. We will receive those for the committee file.

Thank you very much.

Dr. Carter?

Mr. CARTER. I just want to compliment this gentleman upon the paper that he has delivered here today, and to say that I think it is a very healthy sign when men of his evident ability take part in such programs as this. Thank you.

Mr. ROGERS. I would like to second those sentiments. I think it is excellent, and we do need more and more people to involve themselves in the health field other than just the scientific community, and I wonder if you could give us an example—you say the design of more model delivery systems. What is your thinking there?

Mr. STARK. Two that I have specifically in mind: One would be the Smithville project located in a rural area about 15 miles from Kansas City where they are designing a program for the first time to give complete continuity of care from the time the patient is seen in the diagnostic stage through the treatment stage and then into the rehabilitation stage.

Another one is that taking place in Springfield, Mo., at the community hospital. A cardiovascular program is in force where they are treating the cardiac patient and also training nurses and doctors in the care, treatment, and rehabilitation of cardiac patients. This is a part of the current operational grant and is working out very well.

There are six or seven programs in operation, or being proposed now, in community hospitals.

Mr. ROGERS. Thank you very much. We appreciate your being here today.

Our next witness who has a 4 o'clock plane, I believe, is Dr. Amos Bratrude. We appreciate your presence here today. Your Congress-

man, Tom Foley, spoke to me on the floor and said he wanted to be here to personally introduce you to the committee and regrets he cannot be. He is in committee himself.

STATEMENT OF DR. AMOS BRATRUDE, WASHINGTON MEDICAL ASSOCIATION, AND ASSOCIATION OF GENERAL PRACTITIONERS

DR. BRATRUDE. I was sent here today by the Washington Medical Association, and I have the blessing of the Association of General Practitioners.

I am Dr. Amos P. Bratrude and am in general practice in Omak, Wash. I have a common failing with all people who have moved West, and that is our adopted home has become very important to us, and so you'll excuse me if I give you a few words about Omak. It is a rather typical western community of about 4,500 people. The prime industries are logging, apple orchards, and cattle. The biggest single event of the year is the Omak stampede with what we consider, a world-famous suicide race. It is a nice community and my 9 years there have been very pleasurable. I am married and have four children, and as a father am beginning to experience the rigors of a teenage daughter.

I was raised in the Middle West. My father was a general practitioner in a small town by the name of Antioch, Ill. Upon deciding where to practice, there were several things I was sure that I wanted.

I wanted a community with a hospital in it. I have always been very interested in general practice but could see no reason to choose a community that was large enough to have a well established specialist group. I wanted to choose a community that I felt had some promise of growth so that I could eventually have the type of medical practice that I was interested in. This; namely, is a group of three, four, or five doctors who are quite interested in the practice of medicine, but also want to be free to pursue academic and recreational activities. I am now the senior man of a four-man group, and the reason that I can be here today is that I have three excellent partners that are covering for me.

Those were the practical reasons for choosing Omak. The emotional ones are that the country just immediately appealed to me. I enjoy hunting and fishing and being outside, and all these things were available. We have been 15 months in a new hospital with 32 beds, and a staff of seven physicians. Of course, four of these are of our group. It is quite interesting to me to go to various meetings and seminars and hear people discuss the problems of a small hospital. Invariably these people consider anything from 100 to 150 beds to be a small hospital. Consequently, their discussions of problems that might occur there have no bearing at all on what happens in a hospital of 32 beds. I had always been quite interested in the broader problems of medicine, and when the opportunity came to me from the Washington-Alaska regional medical program I welcomed it.

I would be the first to admit that I had a rather biased viewpoint when I joined the Washington-Alaska regional medical program board. I had been raised of fairly conservative parentage and had a decidedly jaundiced opinion of the role I thought Government was playing in medicine. It is quite surprising to find out at the first advisory com-

mittee meeting that most of us had the same feeling. Then it was interesting to see the change in everyone as the meeting progressed. It seemed that most of us had very definite, but very erroneous ideas of what the regional medical program would be and how it would work. It was explained in the first session in May of 1966 that the regional medical program was not going to be a vehicle to transport the patient to "supercenters" but rather was going to be a vehicle to transport knowledge, technique, and assistance to the local level to improve patient care in places such as Omak. I, of course, was very suspicious that this was just the bait to lure us into the trap. I have now completed approximately 20 months on this committee, and I am convinced that at least the Washington-Alaska program has not altered from this ideal; that is, to attempt to improve the level of care for victims of heart disease, cancer, and stroke and related diseases in local communities. I was also prejudiced in another area as I approached the work on the regional medical program. I am in a very rural community. I think it is wonderful to have great research projects and a large amount of what we call ivory tower medicine. But I also feel there is a tremendous amount of medicine that has to be practiced on a day-to-day basis to help the people receive proper care.

I also had many preconceived ideas about physician education programs that I felt were fairly worthless. I have taken these prejudices and conveyed them into ideas for our group, and am afraid I have helped to sidetrack certain programs I felt had little practical value.

I do want to say that I feel there is a definite place for complicated research projects, and without them many of the advances we enjoy today would not be here. But I feel, as the only general practitioner on the Advisory Committee, that I have wasted very little time arguing for the aspect of medicine because many about me are. In regard to specific problems that were present in the practice of medicine in north-central Washington these are some.

There are certainly many other problems which deal with rural areas, and many of these would fall in the categorical areas of the heart, cancer, and stroke program. We are looking forward to taking advantage of the coronary care unit training programs that are currently being established by our RMP and are looking forward to many other benefits from it. I think the point that I would like to make so strongly is that the RMP has offered the first opportunity for local medical communities to feel that it is worthwhile to get involved and interested in because their opinions and problems are being sought.

There certainly has been a considerable change in stance of the average physician in regard to Government in medicine. Just a few years ago no cooperation would be offered, and if preferable no interference would be tolerated. Today we find the average physician understanding that the Government will be involved in medicine and that a cooperative venture of some kind would be most desirable. The RMP with its emphasis on regionalization has, I believe, caught the fancy of the medical communities of the United States. As I travel to various meetings with colleagues who are scattered across the country, I find that quite often they have many favorable comments concerning the aims and goals of this program. I think that if this pro-

gram were to be significantly curtailed or even dropped, you would find a considerable disillusionment in the medical profession. I think most of us feel there is a strong chance that the RMP is going to offer all of us help and cooperation, not interference, from the Government on our local medical problems. I think that if it were possible to establish a long period, such as 5 years, the RMP could then do significant future planning and the medical community would know that the program was here to stay.

I have certainly enjoyed the experience of coming to Washington, D.C., and appearing before this committee.

Thank you very much for the opportunity.

Mr. ROGERS. Thank you very much, Dr. Bratrude. Your testimony is the type I think the committee needs to hear, from a practicing physician. We are delighted that you took time to present this testimony to the committee.

Dr. Carter?

Mr. CARTER. I certainly want to congratulate the gentleman upon his presentation. He is one of the men who applies the tools which have been given him, and in addition will evaluate and use what other tools are given him by our regional groups. I am impressed by his paper, and the depth of what he says. I am happy to have such a young physician before us today.

Mr. ROGERS. Let me ask you: You say you are the only general practitioner on the Advisory Committee for your region, or is this a subregion?

Dr. BRATRUE. I am the only one for the Washington-Alaska meeting. We have six practicing specialists from various disciplines; in addition, of course, to many physicians in the universities.

Mr. ROGERS. But there are six out of 30 whom you would classify as practicing physicians?

Dr. BRATRUE. Seven, counting me.

Mr. ROGERS. How many hospital administrators do you have?

Dr. BRATRUE. Two.

Mr. ROGERS. Do you think this is a good ratio?

Dr. BRATRUE. It is difficult to put everybody there. We have six or seven lay people, we have two nurses, we have a dentist; and by the time you are done, we really aren't heavily laden with the medical school people.

Mr. ROGERS. Would it be more of a problem getting away if you were not in partnership?

Dr. BRATRUE. I would like to speak about this a bit. I think the concept of the practicing physician is changed somewhat. As we are trained today, we are totally convinced that we have to stay current; and I think, as we set ourselves into practice, many of my colleagues in our county are in independent practice, such as Bill Henry, one of the doctors there. He feels it is important enough, and has educated his patients enough that he gets away for courses. I believe that group or no group, this is the way it is going to be in the future.

Mr. ROGERS. You don't think it can be brought down to the hospital level?

Dr. BRATRUE. I don't mean that. We have hospital staff meetings, and visiting professors who come for seminars, and the gentleman

from Missouri, some of his programs sounded outstanding. When you think about help that you need—it is 3 o'clock in the morning and you have a cardiac problem; you don't need a seminar, you need someone to give you some help. It sounded like this aspect of his program was very exciting.

Mr. ROGERS. Thank you so much. We appreciate the benefit of your advice.

Our next witness will be Dr. Carl Brumback, who is appearing for the American Public Health Association.

Dr. Brumback is from my own home county of Palm Beach County, Fla. He has done an exceptional job, and really some of the pilot projects with migrant health programs, and I am particularly pleased to have you appear before the committee again, because you were helpful in our previous legislative hearings.

You may proceed.

STATEMENT OF DR. CARL L. BRUMBACK, MEMBER, EXECUTIVE BOARD, AMERICAN PUBLIC HEALTH ASSOCIATION

Dr. BRUMBACK. Thank you.

The American Public Health Association appreciates this opportunity to present our views of H.R. 15758. I am here as an executive board member of this association, which now has over 20,000 members.

I have a prepared statement which has been given to the staff, and I would like to have your permission to summarize these remarks.

Mr. ROGERS. Certainly, and your prepared statement will be made part of the record, following your remarks.

Dr. BRUMBACK. My comments refer to the migrant health portion of the bill. It is unnecessary, probably, to recall the fact that nearly one-fourth of the Nation's 3,100 counties depend upon migrant labor to harvest the crops. We all depend on this labor for much of our food. Approximately 1 million men, women, and children migrate each year in response to this need.

Although these people perform essential work, their annual income, \$1,400 average per worker in 1965, seldom allows them to rise above the poverty level.

Furthermore, the places in which they work and live are usually far removed from sources of health care, and clinics are usually held at a time when they are working, and they seldom qualify under welfare residence requirements for usual forms of assistance.

Treatment of illness becomes difficult. Actually, the migrants' need for health care is greater than that of the rest of the population. Environmental conditions predispose them to illness and injury. Lack of education and knowledge of where to turn for help compounds these problems. Statistics confirm the fact that migrants have more health problems than the rest of the population.

Infant mortality was over 30 per thousand live births in 1964 among the migrants, compared with less than 25 for the national average.

The rate from tuberculosis and other infectious diseases was 26 per thousand, compared with 10 for the Nation as a whole.

Through the Migrant Health Act, health services specifically designed to meet the migrants' needs have become available in many

parts of the Nation. Recent figures indicate 115 projects in 36 States and Puerto Rico. The number of migrants having access to these services is now estimated to be over 300,000. However, it should be pointed out that this is still less than one-third of the total migrant population.

Also those migrants now reached by existing projects receive only basic or minimal services for the most part, and these are available to them throughout the year.

Migrant progress has been essential to make a beginning to give these people resources, but it takes a long time to make up for years of neglect. We are only now beginning to see benefits from our projects in Palm Beach County, which have been underway for 12 years.

Services must be made available and acceptable. This is a strong argument for keeping this program separate. The absorption into the general program at this time would destroy the most beneficial settlements that have been achieved. The fact that only part of the migrant population is being reached in a minimal way, indicates that the program should be continued and be expanded.

Thank you.

(Dr. Brumback's prepared statement follows:)

CLARENCE L. BRUMBACK, M.D., M.P.H., MEMBER, EXECUTIVE BOARD, AMERICAN PUBLIC HEALTH ASSOCIATION

Mr. Chairman, Members of the Committee: The American Public Health Association appreciates this opportunity to present its views on H.R. 15758, a bill to extend the authority for the Regional Medical Programs, for migrant health services and to initiate a much more active program dealing with the severe problems of both alcoholism and narcotic addiction. I appear before you as spokesman of the APHA in my capacity as a member of its Executive Board. I shall spare you the details of a description of our Association—we, and I, have appeared before you sufficiently often in the past to acquaint you with both—except to tell you that our membership now totals in excess of 20,000.

MIGRANT HEALTH

The APHA has traditionally expressed a deep concern for the welfare of the nation's migratory workers. Prior to the passage of the Migrant Health Act of 1962, the APHA advocated health services for migrant laborers including: child care; pre-natal assistance; control of communicable diseases through vaccination, and dental health. In the past, the extreme mobility of the nation's migrant workers, together with their dire economic need, prevented them from enjoying adequate medical attention.

Since the passage of the Migrant Health Act, important strides have been made in providing essential health facilities for the seasonal agricultural worker. These accomplishments were made possible through joint Federal, State and local funds. During the past five years, migrant health projects have provided remedial care for workers and their dependents, immunization, family planning services, nutrition counseling and the continuing of medical care when workers move from one area to another. Additionally, during this time span, the workers' environment has improved through the joint efforts of employers and local health workers working to improve housing and sanitation facilities.

Migrant workers have slowly been educated as to the availability of health services at their disposal. So successful has this instruction been, that today the services of existent projects are deficient in relation to the demand. Despite advances made in this field, current health services fall short of their goals. One principal handicap to the migrant health program is the hardship it places on local participating hospitals, resulting from the payment, on the average, of only 60 percent of total hospital costs. Many communities find it difficult to make up this deficiency due to the rising costs of hospital care.

At present, the number of medical professionals is insufficient to adequately meet growing medical needs. In order to cope with health problems of migrant laborers, more physicians and dentists must be employed to narrow the gap between the medical and dental care received by migrant workers and those services received by the nation as a whole. In addition to the expansion of the professional ranks, it is also necessary that more aides be trained as liaisons to serve as a link between the professional health worker and the migrant laborer. These aides would assist the worker in utilizing health services created for his benefit. With this goal achieved, the migrant worker would then become more of an economic asset to his country rather than a liability. A healthy labor force will alleviate costly health emergencies, thus reducing economic drain as a consequence of unnecessary illness and disability.

In order to illustrate the need for increased funds, I would like to use an example with which I am most familiar—the health program of Palm Beach County, Florida.

The migratory health projects in my county have expanded greatly since 1962. At the outset of these projects we were faced with the same problems plaguing the rest of the nation in administering to its migrant workers' health needs. These problems were partially solved by services furnished by Federal, State and local money. These funds provided the means for developing services tailored to the specific needs of the worker. As the program progressed, more migrant laborers became aware of the facilities open to them. As a consequence of the 1962 Migratory Health Act, significant advances were achieved in environmental health. State laws and regulations have established guidelines for migrant housing and sanitation; such programs would not have been possible without the assistance of the Migrant Health Act. Migrant workers are finally learning where to turn for assistance in treating their illnesses. Yet we have only begun to teach them the value of the preventive measures and positive health. Much has been done to aid the migrant, but more must be done if his environment is to be raised to acceptable standards. Once accomplished, it will require continual effort to maintain these levels.

In the case of Florida, funds for extended hospitalization and the staffing of physicians are completely inadequate. Consequently, obtaining adequate treatment is often difficult except in the case of extreme emergency. In some instances hospitals and their physicians have provided medical care without reimbursement. Therefore, if local health facilities are to furnish satisfactory medical care for migrants in the future, more funds must be made available through amendments to the Migrant Health Act. Speaking in behalf of the APHA, I strongly urge that the increase in funds conform at a minimum with the amounts recommended in H.R. 12756, introduced by Congressman Paul Rogers of Florida.

Only when we meet the overwhelming task at hand with sufficient resources will the migrant worker then achieve the same degree of medical aid now available to the general populace.

ALCOHOLISM PROGRAMS

The interest and concern of the American Public Health Association in the promotion of alcoholism programs is well established:

1. In 1963, the Association adopted a resolution recognizing alcoholism as a major public health problem and urging all State and local health departments to initiate programs.
2. The Association has prepared a "Guide to the Community Control of Alcoholism" which will be published later this year.
3. Through its regional offices, the Association has conducted a series of training programs intended to stimulate local health workers to implement their skills in dealing with the problems of alcoholism in their communities.
4. The staff of the Association has served in advisory and consultative capacities to national agencies, voluntary organizations and state agencies in the development of programs for dealing with alcoholism.
5. The APHA previously has testified before Congress concerning alcoholism bills.

The need for a major effort to combat alcoholism is apparent. Great numbers of persons are afflicted with the condition. The toll that it takes in terms of broken homes, lost man hours, employee inefficiency and physical suffering, is unmeasurable. In addition, the Supreme Court is presently considering the case

of Powell vs. Texas which may change our courts' methods of dealing with chronic drunkenness offenders. If the Court rules in favor of Powell, it will be held unconstitutional to sentence alcoholics to correctional institutions. The resulting increased need for clinical facilities for treatment of these alcoholics will have to be met by the health care system.

The establishment of such centers as proposed in H.R. 15758 will provide a portion of the resources needed for meeting the crucial treatment needs of the alcoholics in this country. However, we respectfully submit that the present bill meets only a small portion of the total requirement. Treatment facilities also should be supported in conjunction with other health care units such as general hospitals and health departments. In addition, consideration must be given to the following, if a truly comprehensive public health approach to the problem is to be successfully initiated:

1. Research in the etiology, treatment, rehabilitation and prevention of alcoholism. Research in the cause, effect and prevention of alcohol problem. Training of appropriate professionals to apply new and existing knowledge in the control of alcoholism and alcohol-related problems.
2. Appropriate measures to direct national attention to alcoholism as an important as an important medical-social problem—measures which will encourage the utilization of existing knowledge such as that concerning the treatment of alcoholics, and techniques of education of special groups about alcohol and alcoholism.

3. Efforts to insure that consideration of community alcoholism problems be a part of every comprehensive health plan.

4. Full use of the potential resources and services of governmental agencies.

5. Of particular importance in the implementation of Federal programs to deal with alcoholism and alcohol problems is the newly organized National Center for the Prevention and Control of Alcoholism in the National Institute of Mental Health. This Center should be given authority, finances, and responsibility for the coordination, implementation and development of comprehensive programs.

Unless and until each of these important program elements are fully implemented, efforts to cope with this serious health problem will be proportionately less than adequate. Therefore, although we support these provisions, we also must emphasize that a truly comprehensive program to deal with alcoholism must include a variety of concerted approaches on a multitude of fronts.

Again, we appreciate this opportunity to present our views on this important health legislation. We respectfully request your consideration of our recommendations. Thank you.

Mr. ROGERS. Thank you.

Dr. Carter?

Mr. CARTER. No questions.

Mr. ROGERS. In the program there in Palm Beach County, could you just give me a brief summary of, for instance, the housing conditions in the camps, and what you have been able to do with this through the migrant program?

Dr. BRUMBACK. Yes, sir. We have over 100 camps. We actually have in Palm Beach County more agricultural migrants than in any other county in the United States. We have over 27,500, according to the last count. These people live in the county, all over the county, in all sorts of housing. Through the Migrant Health Act we have been able for the first time to acquire a staff through which we have actually been able to get into all of these places, inspect them and upgrade the housing.

As a result, environmental health situation for the migrants in Palm Beach County is immeasurably better now than it was. However, there is a great deal left to be done, and we have to continually provide supervision and maintenance of this program in order to keep the benefits that we have achieved.

Mr. ROGERS. What about your mobile unit? Don't you have a unit that can go to the field where the migrants are, with a doctor and nurse and so on?

Dr. BRUMBACK. Yes, we do. This clinic was acquired through this program, and we can go out in the fields and provide the services there. In the beginning even though we took the services to them, they were afraid to come and take advantage of them. They had been abused and refused service so long that they didn't know what to expect.

Now they will come long distances to reach these services, and there is much more demand than we can see. We estimate that we have provided personal health services to only about 11,000 of our 27,000 migrants.

Mr. ROGERS. Does this include the children?

Dr. BRUMBACK. Yes. To some degree. Some of these services, of course, do reach other migrants.

Mr. ROGERS. I know that you put out a report each year on your particular program, and I would be interested in having a copy of that for the committee.

Dr. BRUMBACK. We will send you a copy, Mr. Chairman.

(The document requested was not available at time of printing.)

Mr. ROGERS. Thank you for coming to let us have the benefit of your views on this legislation.

There is a call for Members to come to the floor, and so I think with your concurrence, Dr. Carter, we will recess to allow Members to answer the call, and then we will begin again as soon as we can get back from the floor.

The committee will stand in recess for 10 minutes.

(Brief recess.)

Mr. ROGERS. The committee will come to order.

Our next witness is going to be introduced by Mr. Staggers, chairman of our full committee. We are very pleased to have the chairman of our committee with us this afternoon. It is the chairman's bill that we are considering and taking testimony on, so it is a pleasure to have him recognize the gentleman now for introduction.

Mr. STAGGERS. Thank you.

We are glad to have Dr. Carter here, too.

At this time, I would like to present Mr. Louis S. Southworth. Would you come forward, sir, and take the stand.

Mr. Southworth is assistant supervisor of the Division of Alcoholism of the West Virginia Department of Mental Health, and he is presenting a statement regarding alcoholism on behalf of and for Gov. Hulett C. Smith. I know the Governor wanted to be here. He told me personally he felt this was important and he has appeared before this committee several times, but he selected the next best man to come over and present his views for him, and I guess they were prepared by you, Mr. Southworth.

I understand you also have statements by Dr. M. Mitchell-Bateman, the director of the West Virginia Department of Mental Health, and also a statement of Donald Dancy, supervisor of the Division of Alcoholism.

We are happy you are here, and we are pleased that West Virginia is taking an interest in these issues, and is going forward in this work. We are trying to complement what the States are doing. We realize it is not only a State problem, but a Federal problem all over the Nation.

So we are happy to have you. And tell the Governor we are sorry he couldn't make it.

You may proceed.

**STATEMENT OF HON. HULETT C. SMITH, GOVERNOR OF THE STATE
OF WEST VIRGINIA, PRESENTED BY LOUIS S. SOUTHWORTH,
ASSISTANT SUPERVISOR, DIVISION OF ALCOHOLISM, WEST VIR-
GINIA DEPARTMENT OF MENTAL HEALTH**

Mr. SOUTHWORTH. Thank you, Congressman Staggers, Mr. Chairman and Dr. Carter.

I would like to make a few remarks prior to presenting the Governor's statement.

It is a pleasure, a privilege and an honor to come before you today in support of title III, part A of H.R. 15758, and I appreciate this opportunity to speak in favor of sound alcoholism legislation such as you are considering today.

We support the testimony given by Mr. George Dimas, president of the North American Association of Alcoholism Programs. The interest in West Virginia in this kind of program is longstanding. Governor Hulett Smith of West Virginia and our Secretary of State, the Honorable Robert D. Bailey, Jr., previously submitted statements for the record before the full Committee on Interstate and Foreign Commerce, at the hearing in September 1965. Their statements reflect the sentiments of the entire State government of West Virginia in support of this sound legislation.

Governor Smith asked me to tell you that he deeply regretted that he could not appear here today in support of this bill. He did, however request that I read to you the following statement voicing his complete approval of this important measure.

"As throughout the Nation, alcoholism is a serious public health problem in West Virginia. During the past 4 years, our State has taken positive action. With State moneys and a small Federal grant, we have established the base for a comprehensive alcoholism program. We now have eight alcoholism information centers and three treatment facilities. Even though West Virginia has had national recognition for what it has done, the facilities we now have cannot begin to meet the need for services demanded. Each of the treatment facilities has a long waiting list and our local alcoholism information centers have a caseload far beyond their capacity to provide adequate services * * * and the caseload continues to mount.

"We are one of the States under the jurisdiction of the U.S. Fourth Circuit Court of Appeals. The decision by this court that 'we can no longer treat the alcoholic as a criminal * * * but as a medical problem,' has resulted in a very noticeable impact on the need and demand for alcoholism services. The current case now before the Supreme Court, *Powell v. Texas*, will no doubt have a still greater impact and create a still greater demand on our limited resources. This problem of alcoholism that we now face in West Virginia and the Nation is so great that State and local resources cannot cope with the problem. Federal action is essential. Money for staff and facilities is a must, and time is of the essence.

"This bill on alcoholism that we are considering here today was introduced by our own Congress, Harley O. Staggers. The State of West Virginia is proud that our Congressman had the courage and foresight to take the leadership for legislation on this most serious public health problem.

"As Governor of West Virginia, I personally urge this committee to take favorable action on title III, part A of H.R. 15758, 'The Alcoholic Rehabilitation Act of 1968.'"

Mr. ROGERS. Without objection, the statements of Dr. Mitchell-Bateman and Mr. Dancy, referred to earlier by Mr. Staggers, will be made a part of the record at this point.

(The statements referred to follow:)

STATEMENT OF M. MITCHELL-BATEMAN, M.D., DIRECTOR, WEST VIRGINIA
DEPARTMENT OF MENTAL HEALTH

During the past four years, the Department of Mental Health has endeavored to establish the base for a comprehensive alcoholism program as part of our state mental health plan. As we have progressed, our Division of Alcoholism has made every attempt possible to provide a complete range of services needed. We have used existing facilities in our state hospitals and local mental health clinics and worked with other agencies, trying to meet the ever increasing demand for alcoholism services requested by our citizenry.

We are proud of what we have accomplished but, in essence, the work we have done is just the beginning of what must be done in the future. The problem of alcoholism and the many related problems of the families of the alcoholic must not only be recognized as a joint responsibility of the federal, state and local governments, but must be cooperatively funded if we ever hope to treat alcoholism as a serious medical and public health problem.

The Alcoholic Rehabilitation Act of 1968, as introduced by Congressman Staggers, can be the breakthrough for developing comprehensive programs and services as an integral part of our Comprehensive Mental Health Centers Act. Favorable action on this alcoholism bill by the Sub-Committee on Public Health and Welfare, can lead to the eventual passage of the bill with adequate federal funding to make the "Great Breakthrough." I urge favorable committee action on this bill.

STATEMENT OF DONALD R. DANCY, M.P.H., SUPERVISOR, DIVISION OF ALCOHOLISM,
WEST VIRGINIA DEPARTMENT OF MENTAL HEALTH

The passage of the proposed "Alcoholic Rehabilitation Act of 1968" is essential. Title III, Part A of H.R. 15758 can be the beginning of a real federal, state, and local cooperative effort to meet the ever increasing demand for alcoholism facilities and service in West Virginia and the Nation.

In West Virginia, a small state of 1.8 million people, we have at least 75,000 persons with alcohol problems, plus three more persons per case (family members) indirectly involved. This makes a total of 300,000 persons adversely affected by alcoholism problems.

From sample surveys made in urban and rural areas, we found the following:

1. Between 1962 to 1966, records of one urban police department showed 52 percent of all arrests were for drunkenness; 74.4 percent of the cases appearing before Justices of the Peace were for offenses involving drunkenness, and 66.2 percent of misdemeanors appearing in the county court involved drunkenness.
2. In a current study (not yet complete) the indications are rather conclusive that at least 40 to 50 percent of all arrests in rural areas are for public drunkenness. Drunkenness arrests plus other charges that involved drunkenness show a range of 60 to 70 percent of all arrests involve a drunkenness offense.

West Virginia State Police arrest records for 1966 show 53.7 per cent of all misdemeanor arrests were for drunkenness. Arrests for moving violation showed 4.5 per cent were for drunken driving. Of all arrests made by the West Virginia State Highway Patrol, 12.63 per cent involved either drunkenness or a drinking driver.

A survey of State Mental Hospitals from January 1 through June 30, 1967, showed 35.29 per cent of admissions reported that, "excessive use of alcohol was a major factor contributing to their illness." This 35.29 per cent plus voluntary admissions to our alcoholic intensive treatment units (3.4 per cent) makes a total of 38.69 per cent of all admissions to our State Mental Hospitals who have serious problems with excessive use of alcohol.

From information and data available on prisoners in our state institutions, between 75 and 80 per cent of all prisoners are alcoholic or have a related alcohol use problem.

A survey of alcoholic patients receiving intensive treatment in one of our more advanced alcoholic treatment units shows that 66.4 per cent have responded very favorably to treatment. Of these, 38.8 per cent have refrained from drinking and made improvement in other areas of adjustment to life, and another 27.6 per cent have had less than one 24-hour drinking episode per six months during the last year and improved in other areas of social and personal adjustment.

In one study of public drunkenness offenders, the records of 140 such offenders showed an average of 23.3 arrests per each individual. From 116 of these cases referred to a local alcoholism information center for counseling, guidance and treatment, only 21 have reappeared in court over a period of one year. Although the study is not complete, these current findings definitely indicate that the old system of prosecution is outdated, outmoded and inadequate, and that proper referral, education, counseling, and treatment is effective and an economically sound investment.

A recent study by the West Virginia Division of Vocational Rehabilitation shows the average cost of service for rehabilitating an alcoholic is considerably less than any other disability category. The average cost per alcoholic was \$103. Comparatively, the next lowest disability category cost was \$217 and the highest category was \$876.

The problem of alcoholism in West Virginia is beyond our financial and human resources. We need more facilities for treatment and staff to expand the treatment facilities we have. We need more local alcoholism information centers and the staff to operate them. In short, we are only providing a token of what is needed.

I respectfully request that the Sub-Committee on Public Health and Welfare favorably consider the proposed, "Alcoholic Rehabilitation Act of 1968."

Mr. SOUTHWORTH. Mr. Chairman, West Virginia recognizes the size and extent of the problem and we take pride in the positive steps we have made in creating a division of alcoholism in the Department of Mental Health and in allocating State moneys to start our program. We have tried to make maximum use of our moneys and other existing resources. We have worked cooperatively and established inter-agency programs with the West Virginia Association of County Officials, the division of vocational rehabilitation and other related agencies. This has enhanced our progress. Still, without substantial assistance from the Federal Government, we have reached a point where further progress will be extremely limited. West Virginia is in desperate need of the kind of Federal assistance proposed by Congressman Staggers in the Alcoholic Rehabilitation Act of 1968.

Mr. ROGERS. Thank you, Mr. Southworth, for being here and for presenting these statements. They will be most helpful in the consideration of this matter by the subcommittee.

While you are still sitting there, I want to recognize the presence of one of our distinguished colleagues from West Virginia, who has come into the hearing room, the Honorable Ken Hechler. If you have anything to say, Mr. Hechler, the committee would be glad to hear you.

STATEMENT OF HON. KEN HECHLER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WEST VIRGINIA

Mr. HECHLER. Thank you.

I would like to echo the statement on the need for this legislation in the State of West Virginia that Congressman Staggers is sponsoring.

The statistics that have been presented to the committee, I think, show conclusively the need for this legislation. The fact that over

one-third of the occupants, inmates, of our mental institutions are affected by alcoholism problems I think is a point which the committee should consider. The fact, also, that such a large percentage of the inmates of our prison institutions in the State of West Virginia are affected with problems associated with alcoholism I think is also something that should be considered by this committee in favorably reporting this legislation, which I think is necessary for the Nation.

Mr. ROGERS. Thank you very much for being here and giving us the benefit of your statement.

Mr. HECHLER. Thank you.

Mr. ROGERS. Our next witness is Dr. Chambers, Medical Association of Georgia, Atlanta, Ga.

It is a pleasure to have you here, and we know of you through your good friend, Congressman Jack Flint of Georgia.

Dr. CHAMBERS. I would like to submit a copy of this journal for the record.

Mr. ROGERS. Without objection, we will accept the journal for the files.

(The publication referred to, "Journal of the Medical Association of Georgia," April 1967, was placed in the committee files.)

Mr. ROGERS. You may proceed, Dr. Chambers.

STATEMENT OF DR. J. W. CHAMBERS, REPRESENTING THE MEDICAL ASSOCIATION OF GEORGIA

Dr. CHAMBERS. Mr. Chairman and members of the committee, I am in private practice of medicine in La Grange, Ga., associated with a fee for service group practice. La Grange, Ga., is a small city of 25,000 population in a county of 50,000 population. There is one hospital in our community; it has approximately 220 beds and is an accredited hospital.

I appreciate the courtesy of this committee in hearing a voice from the "grassroots support" of H.R. 15758. It is my belief that the health professionals in our region consider the original legislation, Public Law 89-239, as important as any that has been passed by the Congress in many years, and we feel that it deserves continued support.

Our interest in this program, however, began before Public Law 89-239 was passed. This was evidenced by discussion among representatives of the Medical Association of Georgia, Emory University School of Medicine in Atlanta, the Medical College of Georgia in Augusta, the Georgia Heart Association, and the Georgia Division of the American Cancer Society. These discussions were expanded during 1966 to include the representation from the Georgia Hospital Association, Georgia Department of Public Health, Georgia Medical Association, Georgia Dental Association, Georgia Pharmaceutical Association, Georgia Division of Vocational Rehabilitation, Georgia State Nurses Association, Georgia State League for Nursing, Georgia Department of Family and Children Services, Community Council of Atlanta Area, Inc., and the Planning Council of Metropolitan Savannah.

In addition, the Georgia Nursing Home Association and knowledgeable and interested laymen were included. From such discussions,

involving these diverse groups, a plan was developed for the organization of a regional advisory group composed of approximately 125 knowledgeable and interested persons broadly representative of our region.

Evidence of the interest of the physicians of Georgia in the regional medical program has been shown by the fact that the entire April 1967 issue of the journal of the Medical Association of Georgia was devoted to the Georgia regional medical program.

This is the journal I asked to be put in the record.

Although the program had only officially begun on January 1, 1967, the responsibility for leadership by physicians was already keenly felt. In fact, the Medical Association of Georgia was unanimously elected by the regional advisory group to serve as applicant for the Georgia region.

May I quote briefly from an editorial entitled "A Unique Opportunity for Leadership," which appeared in the April journal.

The regional medical program for Georgia provides the membership of the Medical Association of Georgia a unique opportunity for leadership in "promoting the science and art of medicine and the betterment of the public health." However, the role of leadership can only be effectively assumed as physicians understand the program.

The legislation which established this program was the result of the report of the President's Commission on Heart Disease, Cancer, and Stroke, commonly called the DeBakey report. However, Congress gave thoughtful consideration to many medical leaders and organizations before passing Public Law 89-239 in October 1965. As a result, this law provides for local medical programs which can and will be developed by people in the areas involved for the people in the areas to be served. This is inherent in the legislation through the language of "cooperative arrangements," and "without interfering with the patterns, or the methods of financing, of patient care of professional practices, or administration of hospitals."

The regional medical program for Georgia has been planned carefully by Georgia people in a truly cooperative atmosphere during the past 15 months. This can best be judged by the membership of the program's Georgia advisory group. The program is practical and will provide the tools for every practitioner to improve not only his own medical capabilities but also to improve the quality of medical care provided for each and every one of his patients.

This is a challenge for each member of the Medical Association of Georgia and may well be our greatest opportunity in our time for exhibiting responsible leadership.

Another factor which we feel recommends the extension of the regional medical program is the already demonstrated marked improvement in communication and dialog, not only among teachers, medical schools, and practitioners, but also among all of the health professions in the region. In short, we have begun what we believe to be successful treatment of the "town gown" syndrome in our region. The long-range effect of this will be improved care of patients. The original program plan for the Georgia region takes into account that new knowledge from the medical centers must flow to every area of the region and equally important, the knowledge and needs of the practitioner and others in the small towns must flow to the medical centers.

Still another recommendation for the extension of this program, we believe, has been the demonstrated mechanism for developing a program of public education to stimulate lay people to want and to seek good medical care. There are many economically disadvantaged people

whom we hope to educate to want adequate medical care, but there may be just as many medically deprived people totally unrelated to economic circumstances. Included in this group are many of our most talented and capable citizens who simply do not seek medical care that could be classified as adequate.

Finally, Mr. Chairman, we believe that the key to the success of the regional medical program in Georgia is the involvement of community hospitals. This, no doubt, is true in every region in the country to a greater or lesser extent. Very early in the development of plans for the Georgia program, the regional advisory group recognized that the vast majority of physicians, nurses and others involved in the regional program relate themselves to one or more hospitals. Therefore, each hospital in the region has a vital role in the program and in the future of medicine. This includes the large hospital, the small hospital, and the hospital in the medical center, and the hospital remote to the medical center. At the present time there are about 19,500 hospital beds in Georgia distributed among 178 general and limited services hospitals of all sizes. Over 3,000 physicians serve on the staffs of these hospitals.

To emphasize the role of hospitals in the program, it is planned that each hospital will become a central focal point through which the objectives of the regional medical program will be carried out. Every hospital will become a teaching hospital. This does not imply that medical students and house staff need to be present; but, it does imply that physicians, nurses, dentists, pharmacists, administrators, members of the public, and all of the allied health professionals shall organize themselves into an educational program. Each hospital has been asked to submit the names of a group of persons to serve as a local advisory group to the regional medical program. It was suggested that a physician (as chairman), a hospital administrator, a nurse, and a member of the public be the minimum number to comprise each designated group.

This local advisory group may be as large as the local hospital or community desires, but it must be named by and through acceptable administrative mechanisms.

These groups of local hospital representatives are functioning well. Of Georgia's 178 hospitals, 121 have appointed local advisory groups. This represents approximately 90 percent of the general hospital beds in the region. It is pertinent to this presentation that the chairman of the local advisory groups met in Atlanta on Sunday, March 24, 1968, for a day of planning and discussion. According to the registration, 87 hospital representatives were present. Similar meetings, as approved in the program plans for Georgia region, will be held at least twice during each calendar year. This method of affiliating local direction at the grassroots with the overall program of health planning is, in our opinion, a sound and effective approach.

Although health planning has been going on in our region for many years, this is the first time that representatives from all interested groups have deliberated together in an attempt to coordinate their health care planning into a unified plan for progress. Both interest and participation of the practicing physicians, local hospitals, and medical schools have been excellent. Close communication with other agencies, organizations, institutions, and Government programs is

assuring complete coordination of all activities in the area of health in the Georgia region, and the purposes of Public Law 89-239 are being achieved.

Thank you again, Mr. Chairman, for this opportunity.

Mr. ROGERS. Thank you for an excellent statement.

I notice that you say 87 hospital representatives were present at your last meeting out of what? Some 178?

Dr. CHAMBERS. Potentially 178. Of that number 121 have already set up the local advisory groups. The ones who have not are primarily the extremely small hospitals, Mr. Chairman, maybe as few as 15 to 20 beds.

Mr. ROGERS. But you feel the major hospitals in the State have?

Dr. CHAMBERS. We have 90 percent of the beds covered.

Mr. ROGERS. Even though they don't attend the meeting, they have signed up for this?

Dr. CHAMBERS. Yes. These same ones are not the ones who were at previous meetings, necessarily, but this percentage is a pretty good attendance, for a region our size.

Mr. ROGERS. Is the region too large?

Dr. CHAMBERS. No, we do not think so. We are beginning to get sub-regionalization now. This is what we hope to accomplish.

Mr. ROGERS. How long have you actually had the region formed?

Dr. CHAMBERS. Our program, Mr. Chairman, actually began January 1, 1967, so we are only about 15 months old.

Mr. ROGERS. You present a very encouraging picture.

Dr. CHAMBERS. We feel we have accomplished a lot in 15 months, sir.

If the committee would be interested, sir, I would be glad to leave a copy of the operating rules and regulations of our programs.

Mr. ROGERS. I would like very much to have that for the committee files.

Thank you very much, Dr. Chambers.

Our next witness will be Thomas Carpenter, president of the National Council on Alcoholism, Inc., New York.

STATEMENT OF THOMAS P. CARPENTER, PRESIDENT, NATIONAL COUNCIL ON ALCOHOLISM, INC.; ACCOMPANIED BY WILLIAM MOORE, EXECUTIVE DIRECTOR

Mr. CARPENTER. I have with me Mr. William Moore. He comes to us after a distinguished executive career with the Heart Association.

I know the previous testimony has covered many aspects of the problem. We have a brief statement identifying ourselves and our particular interests.

Mr. ROGERS. You may proceed.

Mr. CARPENTER. The National Council on Alcoholism is the voluntary health agency concerned with alcoholism. It has 82 affiliates serving the major cities, plus 11 group members in smaller communities throughout the United States. Each affiliate has a volunteer board of directors and a citizen constituency. These boards, like the national board of directors, are representatives of the legal, medical, educational, civic, religious, business, and industrial interests which are concerned with the disease of alcoholism.

The National Council on Alcoholism directly speaks for nearly 11,000 U.S. citizens who are involved in its programs and vitally concerned about the prevention and control of alcoholism. The council represents a unique citizen response to this problem, and has been leading the attack against this disease for 23 years.

This national voluntary health organization, concerned as it is with the third largest public health problem of modern times, also seeks to change community attitudes toward alcoholism and the alcoholic. Long regarded as a personal and moral problem, alcoholism has only in recent times been recognized as a major medical and social problem affecting a broad spectrum of health, welfare and social areas of concern.

The National Council on Alcoholism, through its programs of public and professional education, attempts to bring a message of hope and help to the community regarding alcoholism. The basic points of this message are: alcoholism is a disease; it can be treated successfully; it is a public health problem and a public responsibility.

The affiliates of the National Council on Alcoholism have ongoing programs of public education which are reaching increasing numbers of citizens where they live. Affiliates also sponsor professional seminars for physicians, nurses, social workers, and other professional persons to enable them to deal more effectively with alcoholics whom they see in the course of their regular work. These activities comprise the portion of the National Council on Alcoholism's program which is intended to transform public and professional attitudes toward alcoholism, thus making it easier for the alcoholic to seek and accept treatment.

In addition, each affiliate of the National Council on Alcoholism maintains an alcoholism information center which serves as neutral ground for alcoholics and their families to obtain information concerning alcoholism, and which makes referral to treatment resources and facilities. Because our local voluntary councils on alcoholism have of necessity, in some places, had to fill the vacuum created by a lack of community facilities for the treatment and rehabilitation of alcoholics, we are particularly concerned that this legislation be approved by the Congress.

The establishment of specialized facilities for alcoholics as provided in title III, part A, H.R. 15758 is a major contribution toward creation of a comprehensive community attack on the problem of alcoholism.

As president of the National Council on Alcoholism, I commend the members of this subcommittee and the leaders of the House of Representatives for their concern for the health and social welfare of their constituents who suffer from, and are threatened by, alcoholism. I am happy to testify in favor of title III, part A, H.R. 15758, which, if passed, will insure that specialized facilities for alcoholics will be included in the Community Mental Health Centers Act. By this wise and humane gesture, facilities will be provided which will help advance the control of alcoholism in the United States of America.

I pledge to you anything that the National Council on Alcoholism can do in the way of support or the furnishing of any additional information which may be helpful to you.

Thank you very much.

Mr. ROGERS. Thank you, Mr. Carpenter and Mr. Moore, for being here.

I think it would be helpful to the committee if you could give us the number of alcoholics, the number which you have made studies of in major cities, or by State, and those areas where the problem of the homeless alcoholic is greatest, and any facts like that.

Also, I would like to have some memorandum from your organization as to how they feel these emergency rooms or facilities would operate, how the domiciliary care would work as proposed in the bill.

If you have any experience that we could go on, I think it would be helpful, because I think the committee is going to want to know more facts about this, rather than to get into the beginning of a large building program.

Can't this be integrated within the community health center, in this program we have already done, as an adjunct there? Must it be separate and apart, or how much is it supposed to be tied together?

If you could let us have your thinking on this for the record, we would appreciate it.

Mr. CARPENTER. I will be happy to supply that information.

(The following supplemental statement was subsequently submitted by Mr. Carpenter:)

SUPPLEMENTAL STATEMENT OF THE NATIONAL COUNCIL ON ALCOHOLISM, INC.

ALCOHOLISM STATISTICS

Statistics on the incidence of alcoholism are necessarily rough estimates, based on inferences derived largely from the prevalence of cirrhosis of the liver in communities. Obviously, it is not possible to use routine questionnaires and sampling techniques in determining the number of alcoholics in a given state. It has been noted that denial of the condition of alcoholism is a symptom of the disease. Because of the effects of social stigma, those who have alcoholism are not likely to state that they do.

Efron and Keller have published a state-by-state breakdown for 1960 of the number of male and female alcoholics, the rates of alcoholism and the rank order of the states by rate. It should be noted that these figures are unquestionably a conservative estimate. For example, the California Department of Public Health in March 1965 estimated 850,000 alcoholics in the State of California, while Efron and Keller estimate a total of 623,400. Similarly, Colorado's State Department of Health in October 1967 declared that there were 275,000 alcoholics in the state; Efron and Keller estimated there were 42,500. Other states have also estimated that they have many more alcoholics than the Efron and Keller study would indicate. Hence it may be said that the statistical analysis presented here probably represents the least number of alcoholics, rather than the opposite.

The viewpoint of the National Council on Alcoholism is that regardless of whether estimates of the number of alcoholics in the United States are 5 million or 8 million, the basic fact is that alcoholism is a health and social problem of immense magnitude. When it is considered that every active alcoholic affects at least four other persons, the significance of the problem is apparent. One of the principal objectives of the National Council on Alcoholism is to make community leaders and the general public aware of the very large number of Americans whose lives are blighted by alcoholism. The statistical data follows as Appendix A.

DETOXIFICATION CENTERS AND HALF-WAY HOUSES

A detoxification center is generally understood to be a short-term treatment facility for the acute symptoms of withdrawal from alcoholism, i.e., delirium tremens, alcoholic convulsions, etc. The usual duration of emergency treatment is approximately 5 days, although some have reported adequate detoxification in 72 hours.

Essentially, detoxification centers provide withdrawal from alcoholism under medical supervision and with minimum risk of death to the patient during the withdrawal period. They are designed to replace the hit or miss searching by concerned friends and relatives for a health facility which will accept alcoholics or the potentially dangerous "drunk tank" in jails, which may or may not provide any medical supervision, and invariably has minimal facilities for treatment of the physical symptoms of alcoholic withdrawal. Although a few detoxification centers in the United States and abroad have reported some effort at beginning rehabilitation of patients, their prime function is not long-term treatment of alcoholism. They are a way of returning the patient to a physical condition which allows him to be free from the dangers of withdrawal from acute alcoholism.

Half-way houses, on the other hand, are temporary residential facilities which provide a "substitute family for the person in the course of his treatment. . ." This ". . . transitional facility provides a peer group experience for the individual to learn how to live without the help of chemical crutches." See Appendix B for description of a model half-way house.

After a detoxification period, some patients with alcoholism find they are unable to benefit from treatment unless their environment is conducive to it. Since they may have failed to develop a sense of community orientation, or through their alcoholism may have lost this sense, they need the reassurance of an orderly existence among congenial persons who have the same problems.

A half-way house can serve as a bridge between the disorientation of late-stage alcoholism, and the ability to lead a normal life characteristic of the majority of Americans. A half-way house is not usually thought of as a custodial institution. Its residents are encouraged to find work as soon as they are able to do so, and they henceforth pay for their room and board. The goal of the half-way house is to enable its residents to take their place in the community as self-respecting and self-supporting individuals, free of their disease.

Half-way houses are heartily endorsed by the National Council on Alcoholism as a means of providing help to homeless alcoholics. It should be pointed out, however, that the homeless alcoholic represents no more than 10% of the total number of alcoholics in the United States. Hence the provision of half-way houses, while eminently desirable, does not in any sense deal with the entire population affected by alcoholism.

Detoxification centers also are endorsed without qualification by the National Council on Alcoholism. These facilities would provide emergency treatment for alcoholics in the acute stages of withdrawal from alcoholism regardless of economic status. They will do much to close the gap which exists between emergency facilities available to alcoholics and the number of alcoholics requiring such facilities. We would find it highly desirable for the legislation to specifically mention the construction, maintenance, staffing and operation of detoxification facilities under the provision of HR 15758 Title III, Part A.

ALCOHOLISM AND COMMUNITY MENTAL HEALTH CENTERS

The U.S. Department of Health, Education and Welfare, National Institute of Mental Health, has published an excellent pamphlet entitled "The Community Mental Health Center and Alcoholism Programs." It is felt that this pamphlet is so concise and well presented that an appropriate quotation will be adequate to cover this question of the Committee. There follows a section of the pamphlet which sketches the various ways that alcoholism programs may be meshed into the community mental health centers:

"Complete 'integration' of alcoholism services with other activities of the mental health center. Under such an arrangement all services of the center are open to problem drinkers with no special arrangements made for their care. This presupposes that staff are adequately trained and well motivated to work effectively with these patients.

"Special alcoholism services or 'units' within the mental health center. Under this arrangement services for persons with drinking problems are physically located within the center's facilities and the alcoholism staff is administratively responsible to the director of the center.

"Special alcoholism services or 'units' as an administrative part of the mental health center program but not physically located in the center's facilities. Under this plan, overall program direction is the responsibility of the center's director.

"Special alcoholism programs not administratively part of the center but closely coordinated with it. In communities where adequately staffed alcoholism services already exist, formal administrative integration with the center may be neither possible nor desirable. However, such alcoholism services should work collaboratively with the mental health program to assure continuity of care and appropriate referral and consultation.

"Specialized treatment personnel in the community mental health center, but no separate alcoholism 'units.' Staff with particular interest and training can be designated as 'alcoholism specialists,' available to work with problem drinkers, as well as other patients. They can also serve as the center's alcoholism consultants.

"Special personnel to function primarily in nonclinical roles, but no alcoholism 'units.' This type of personnel engages in little or no treatment but works primarily to ensure that problem drinkers receive appropriate attention in all the activities of the community mental health center. In this capacity they function not only as consultants and as liaison persons with other community agencies, but also as a kind of 'conscience' for both the mental health center and the total community in relation to alcohol problems. They act principally as 'catalysts' and 'change agents' rather than as therapists."

This presentation appears to cover all possible methods of including alcoholism in the community mental health center complex.

The position of the National Council on Alcoholism regarding the community mental health centers has been enunciated in an address delivered by Thomas P. Carpenter, President of the National Council on Alcoholism, in New Orleans, Louisiana February 9. The following quotation from this statement indicates the thinking of NCA in this regard:

"... assuming that community mental health centers all over the country become operative with a full range of services as outlined above—both the required and the suggested services—and assuming that alcoholism is included in the services (as I fervently hope) there still remains a critical gap with respect to alcoholism. This gap is the function that the Alcoholism Information Center was invented to perform.

"Dr. Fritz Kant in his treatise on *"The Treatment of the Alcoholic"* stated it this way:

'Discussions of treatment always assume that the patient is under the care of the therapist. To get him there is often the greatest difficulty.'

'He goes on to note that public education has made some impact and:

'More awareness and better recognition of the impending danger of alcoholism has on the whole improved the situation by bringing the patients for treatment earlier than would have been the case 10 years ago.'

"This, however, is only part of the problem. It is not just the 'increased awareness and better recognition of the impending danger of alcoholism' that removes the blocks to effective treatment and prevention. Availability for treatment implies more than the mere getting together of the patient and the therapist, as I am sure Dr. Kant would agree. The major block to effective treatment of the alcoholic and to the establishment of effective programs for such treatment, would seem to lie more in misconceptions of the nature of the problem and therefore what kind of measures are indicated...."

"I think it is apparent that the community mental health center as conceived is in this respect lacking for effective service to alcoholics. I have little doubt but that the prospectuses of many, if not most, community mental health centers will include 'services for alcoholics.' Likewise, I predict, that they will be programmed on the assumption that the patient is already there under the care of the therapist, is there by his own choice and has faith in the therapy offered.

"Obviously, the thing that throws most people off in their thinking and planning about alcoholics is that these are entirely warranted assumptions in the case of most illnesses. Most sick people in our society 'know' that their problem is illness and they 'know' what kind of help is effective and where and how to find it. Moreover, they approach the helping source—person or institution—with faith and willingness to cooperate.

"People are not born with this knowledge or these attitudes; they are taught—very carefully taught—by the society in which they live. In fact, in his respect, we might say that the alcoholic is a very good citizen—he believes implicitly about himself, the same things that his society believes. Unfortunately these beliefs prevent him from availing himself of whatever effective help there is

and he is even accepting of the barbarous methods of his society for handling his behavior.

"Remedying this situation is the function that is missing in the mental health center outline and it is the function to which the Alcoholism Information Center addresses itself. Thus the Alcoholism Information Center fits into the general plan as a necessary adjunct at least until such time as the community changes and undertakes this therapeutic function as it does in other illnesses—which I presume will be some time from now."

[APPENDIX A]

ESTIMATES OF ALCOHOLICS WITH AND WITHOUT COMPLICATIONS, UNITED STATES, BY STATES, 1960, AND RATES PER 100,000 ADULT POPULATION (AGED 20 YEARS AND OVER)¹

	Number of alcoholics	Rates of alcoholism	Rank order (by rate)
Alabama.....	32,700	1,800	48
Arizona.....	22,500	3,000	29
Arkansas.....	29,700	2,863	32
California.....	623,400	6,388	2
Colorado.....	42,500	4,088	16
Connecticut.....	76,300	4,838	9
Delaware.....	10,700	3,963	18
Florida.....	108,900	3,538	23
Georgia.....	55,300	2,513	39
Idaho.....	7,200	1,900	47
Illinois.....	315,300	5,050	6
Indiana.....	106,800	3,850	20
Iowa.....	45,700	2,763	35
Kansas.....	32,000	2,413	40
Kentucky.....	57,100	3,238	26
Louisiana.....	70,100	3,925	19
Maine.....	24,200	4,175	14
Maryland.....	73,800	4,000	17
Massachusetts.....	184,800	5,713	4
Michigan.....	200,100	4,350	11
Minnesota.....	66,500	3,313	25
Mississippi.....	26,700	2,288	41
Missouri.....	143,100	5,038	7
Montana.....	14,300	3,663	21
Nebraska.....	25,600	2,988	30
Nevada.....	11,700	6,638	1
New Hampshire.....	13,200	3,563	22
New Jersey.....	184,800	4,838	10
New Mexico.....	15,800	3,050	28
New York.....	583,100	5,463	5
North Carolina.....	51,600	2,013	45
North Dakota.....	12,500	3,463	24
Ohio.....	247,600	4,263	13
Oklahoma.....	29,600	2,088	44
Oregon.....	27,400	2,538	37
Pennsylvania.....	302,100	4,325	12
Rhode Island.....	31,600	5,913	3
South Carolina.....	34,000	2,700	36
South Dakota.....	10,100	2,525	38
Tennessee.....	59,800	2,900	31
Texas.....	153,200	2,763	34
Utah.....	9,500	1,988	46
Vermont.....	9,400	4,138	15
Virginia.....	44,600	2,275	42
Washington.....	49,000	2,788	33
West Virginia.....	33,200	3,100	27
Wisconsin.....	117,800	4,988	8
Wyoming.....	4,400	2,263	43
District of Columbia.....	27,000	5,300	

¹ Selected statistical tables on the consumption of alcohol, 1850-1962, and on alcoholism from 1930-1960. Prepared by Vera Efron and Mark Keller. Published by Rutgers Center of Alcohol Studies, New Brunswick, N.J.

Note: These estimates are derived by the original Jellinek formula; the rates (on which the numbers are based) are those of the year 1945, with R=5, applied to 1960 populations. The formula may be less reliable in units with smaller populations. These estimates should be considered as very rough approximations. Numbers are rounded to nearest hundred.

[APPENDIX B]

"MODEL" HALF-WAY HOUSE

The surveyed half-way houses give the impression that there is a good deal of variety in the operations of these houses. Nonetheless, even with these differences in approach, all of the half-way houses have had some success. We would

like to select the best features from this survey to fabricate a composite picture of what, to the writers, would be a model half-way house.

The location of the facility deserves careful consideration. It should be in a central urban area where there is low cost public transportation, and near centers of occupation, particularly unskilled and semiskilled employment. It should also be in a city near the homes, or former homes and families of the men. It should be located in a respectable residential neighborhood whose social status is neither too high nor too low, and not close to Skid Row habitats or concentrations of bars. It is also desirable to choose a central urban location so that qualified staff, including part-time, consultive, volunteer, and either unpaid personnel, may be obtained and can travel with relative ease to the treatment center. This would also enable the half-way house to use existing educational, research, and training facilities that are available in such areas.

As for physical characteristics, the half-way house should be a "family" type residence with furnishings that are adequate though simple, and furniture that has firm rather than stylish construction. There should be space for offices, meetings, recreation, a lounge for quiet reading and relaxation, dining facilities, and sleeping accommodations. Regarding sleeping accommodations, the Belmont Rehabilitation Center in Worcester, Massachusetts, has worked out an interesting and successful system. The men live closely at first in dormitory style. As self-improvement progresses, the men are advanced to accommodations for three. And finally, when a man is considerably improved he is "graduated" to a single room. Each step in this ladder-like progression provides more comfort, greater convenience, and added prestige through a concrete recognition of his progress. But whether or not some system is used for assigning different accommodations within the plant, it would seem that the model half-way house should have different types of arrangements and, above all, emphasis should be on creating a home and club-like atmosphere.

The bed capacity should be limited to 30. Admission and eligibility requirements should be decided by the administrator and staff with consideration in particular of age, sex, and sobriety. The residents must agree to abide by some general rules and regulations such as curfew, schedules, house chores, program attendance and the like, which should be designed to maximize chances for recovery. Fees should be waived initially, but when employment is obtained the resident should pay a reasonable fee of \$15 weekly.

On entering the program of the model half-way house each individual should undergo a three-day orientation phase, beginning with an initial interview and ending with a commencement of the regimen of daily activities. In this orientation period the man would receive a physical examination and would be introduced to procedures and rules, the program and methods, the philosophy and its bearers. At this time he would learn what he can expect from the staff, fellow residents, and the half-way house in general, and what is expected of him. At the same time the staff would formulate suitable plans for his future participation in the program.

The program itself should provide for participation in some kind of counseling or psychotherapy, either individually or in a group. An AA group should be formed for residents only, using their own and outside speakers, and they occasionally should attend outside meetings. The men would also participate in frequent group meetings concerned with daily problems and policies related to government and management of the center. Using principles of self-government, the men themselves would exercise responsible authority in enforcing the rules and policies which govern the behavior of residents. Each man should be helped to find employment as soon as possible after completing orientation, and should receive both casework and vocational counseling in this regard as required. Arrangements should be made for clergy of various denominations to be available for religious counseling and spiritual help at the request of the men.

The staff for carrying out the program should include a top-level professional with training in the social or behavioral sciences who would be the director. He should have some experience in administration, supervision, institutions work, treatment, and research. An assistant director with similar qualifications, although of less experience, would aid the director. There also should be a resident supervisor, perhaps a recovered alcoholic who has clearly demonstrated a capacity to assume responsibility. The latter individual is a key figure, for he must see that the affairs of the institution are run smoothly, and be available to meet the needs of the men in times of stress. The director, assistant director, and

resident supervisor would be full-time. In addition there should be on the part-time consulting staff one psychiatrist, two social workers, one psychologist, and one researcher. These part-time consultants would be diagnostic work, and would plan and conduct treatment. All personnel must be equipped with warmth, maturity, and understanding.

Emphasis in the last stages of the program should be placed on easing the member back into a less protected situation in the community. Length of stay in this program should be limited to 90 days. This is not an arbitrary figure, for pragmatic experiences indicate that 3 months is in many ways the optimum length of time: it is a suitable period for the majority; it avoids excessive dependency on the protective half-way house; and from the practical point of view it will allow for a reasonable amount of turnover. Readmission policies, however, should be flexible, depending on staff judgment of the individual case. And in any case, opportunities for the use of the recreational and physical facilities should be made available to successful "graduates" of the program, so that discharge does not come as a kind of weaning shock. For discharge, like orientation, is a critical period. It is a time of crisis and decision making. Every possible measure should be taken to avert failure. Efforts, which begin several weeks before discharge, should be directed at finding housing, re-establishing family, religious, and other non-Skid Row relationships, and strengthening all routes of reintegration into society.

CONCLUSION

These ingredients for a model half-way house are presented mainly as guide-posts. Local conditions and the relative youthfulness of the half-way house concept of rehabilitation demand that flexibility and continued self-evaluation be a guiding philosophy. Whatever the specific ingredients, however, the general goal that we commend to any half-way house program is that it attempt—through its plant, program, personnel and procedures—to combine the best features of a relaxed home and a therapeutic milieu.

A great many problem drinkers have been and will be helped by half-way house rehabilitation. Through this method they gradually gain increasing personal strength and ability to deal with inwardly and outwardly induced frustration and anxiety in ways that preclude the use of alcohol. Thereby they rebuild their self-respect and sense of dignity, restore their usefulness occupationally, recover their social relationships and eventually ease the heavy burden they had put on the community. And, this is accomplished with "unreachables!"

Mr. ROGERS. Our last witness today is Eugene Sibery.

May I say we will make your statement a part of the record, following your remarks. Now, if you would give us your comments, it would be helpful.

STATEMENT OF D. EUGENE SIBERY, EXECUTIVE DIRECTOR, GREATER DETROIT AREA HOSPITAL COUNCIL

Mr. SIBERY. I shall paraphrase the important items, so that I shall not make a 15-minute commentary on a 7-minute formal statement.

Mr. Chairman and members of the subcommittee, I am D. Eugene Sibery, executive director of the Greater Detroit Area Hospital Council. I also serve as chairman of the American Hospital Association's Council on Research and Planning, and I am the president of the Association of Health Planning Agencies. I was the acting coordinator of the Michigan regional medical program during its initial, organizational period, and now serve on that program's regional advisory group.

I am here today to speak in support of title I, H.R. 15758, to extend the authorization for regional medical programs for heart disease, cancer, and stroke.

As a health planner involved with the coordinated planning activities of a hundred hospitals in one of the Nation's most heavily

urbanized areas, I am strongly attracted by the potential of regional medical programs and impressed by their progress.

The strength of these programs stems from the spirit of voluntary cooperation which underlies them, and which was written into the law largely by your committee 3 years ago.

This voluntary, cooperative approach to problem solving isn't as swift as a more direct approach might appear to be, but I hope that you will be persuaded that it is far more sure.

Regional medical programs are becoming strong and successful forces in our society because they challenge the ingenuity of the participants. They are becoming strong and successful forces in our society because they exist to meet specific local problems, not problems that have been rendered sufficiently vague to be labeled national problems. And finally, regional medical programs are becoming strong and successful forces in our society because they are based upon plans and decisions made by those who must carry out the plans and decisions, and by those who will be affected by them.

The last point—broad-based involvement for cooperative planning and action—is the paramount reason regional medical programs will ultimately succeed in the inner cities of America. It is a program that health planners have long awaited, a program to draw together the hospitals, physicians, public health agencies, and all of the other elements necessary to provide efficient, effective, and economic health services.

It is also a program which must incorporate the opinions and thoughts of the public to be served by these health resources, and this too is a terribly difficult task. The population of our inner cities is depressed in mind and spirit, handicapped by lack of education and opportunity, and all but overwhelmed by poverty and need. This must not deter us. Without the cooperation and the support of these people, no program can succeed.

The development of regional medical programs has seemed slow in the inner cities, but there has been progress. It's not unlike the construction of a building. Until the foundation is laboriously dug and built, and the main structure begins to rise, progress is not apparent. Regional medical programs have been digging their foundations with a process of careful planning, and the structures beginning to merge—the operational programs—will be all the sounder and stronger for this every effort. Briefly stated, from the national view, the progress of regional medical programs has been dramatic. Less than 2 years ago, there were no regional medical programs; today there are 53 organized and at work.

There is one further reason why I view the period of planning as so essential. The experience gained in this program—I wish to stress this point—for heart disease, cancer, and stroke can serve as a guide to make it far easier for other health programs to meet the needs of our country's entire population, including our urban areas. Significant changes in the traditional methods of delivering health care must be effected. I believe with active and meaningful involvement of all health professionals, the regional medical programs will provide the mechanism for the health professionals to markedly improve the patterns of organization and distribution of health care.

I believe our experience in Michigan is not atypical. I do think it is important for us to understand the soundness of the program which is under way, the marshaling together of resources, the innovation which characterizes all of the planning activities in the foundation for the program which is being well laid at this point in time.

To help these programs, I would certainly hope that a great deal of emphasis will be placed on the need for the efforts under comprehensive health planning programs and the cooperative regional arrangements developed under the Regional Medical Program Act, to be compatible and in conformity.

I think they are complementary with respect to goals and activities, and I think at the local level we must do everything possible to be certain that these are not in conflict, but in fact do cooperate and support each other.

I do believe there is a real need, as the statement indicates, for limited construction funds, and I would hope that as a part of the introduction of my formal statement in the record that you would also include the appended article entitled "Hospitals and Regional Medical Programs, a Plea for Coordinated Action," which was in the December 1967 issue of Hospitals magazine. This was written by my good friend, Dr. Robert Evans, and I think amplifies eloquently on the point that I would make, that there is a real need for limited construction dollars.

Mr. Chairman, I certainly hope that this bill will be supported by your committee and will be adopted. I think the progress so far is sound, because we have gone cautiously. I believe the operational programs will speed the day that we will get to every area in Michigan, to every citizen in Michigan the benefits that this program was designed to bring.

I should be pleased to answer any questions you might have. It has been a pleasure to appear.

(Mr. Sibery's prepared statement follows:)

STATEMENT OF D. EUGENE SIBERY, EXECUTIVE DIRECTOR, GREATER DETROIT AREA HOSPITAL COUNCIL, DETROIT, MICH.

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I believe our experience in Michigan is not a typical. With the \$1,294,449 grant awarded the Michigan Regional Medical Program almost a year ago, the Federal Government has essentially bought a blueprint for the initial stages of action. Most tangibly, this initial blueprint is a 504-page document, our first operational grant request, which defines what we must do and commits us to doing it. It is not a sterile plan devised in some ivory tower. It represents a realization that previously fragmented health resources can unite to provide the best possible patient care for heart disease, cancer, and stroke, a realization held by the scores of men and women who live in the real world and who have contributed and will continue to contribute to this planning task. It represents our entire Michigan countryside.

From my point of view as a health planner concerned with the total health needs of my metropolitan area, one of the most important facets of this Michigan Regional Program is the series of linkages which have been made with a great number of groups and institutions engaged in health planning and providing health services in our Region. I hope that the staffs and Advisory Groups of all Regional Medical Programs share my zeal for coordination of activities in this regard. Specifically I believe Regional Medical Programs and Comprehensive Health Planning programs, both authorized by legislation enacted by the 89th Congress, are quite complementary and mutually supportive of their activities and goals. Every effort should be made by the staffs of these two programs, at the local levels, to ensure this cooperation and coordination exist.

To help make these Programs more effective, I urge your approval of Title I, HR 15758, with one change: Give the Regional Medical Programs limited authority for construction to meet regional needs as stated in the Surgeon General's *Report on Regional Medical Programs to the President and the Congress*, and as eloquently amplified in an article entitled, "Hospitals and Regional Medical Programs: A Plea for Coordinated Action". This article appeared in the December 16, 1967, issue of *Hospitals* magazine. It was written by my good friend, Dr. Robert L. Evans, Director of Medical Education at the York (Pennsylvania) Hospital, and immediate past president of the Association of Hospital

Directors of Medical Education. Dr. Evans assisted me in preparing my testimony for today, Mr. Chairman, and I would like to request that his article be inserted in the record of this hearing. I hope, gentlemen, that Dr. Evans' article will convince you of the need for Regional Medical Program construction authority.

Thank you; that concludes my statement.

[From the Journal of the American Hospital Association, December 1967]

HOSPITALS AND REGIONAL MEDICAL PROGRAMS: A PLEA FOR COORDINATED ACTION

(By Robert L. Evans, M.D.¹)

To say that in the last three years our medical care system has been subjected to close scrutiny, deep concern, and an incomprehensible quantity of advice is both trite and insufficient. Since early 1965, our medical care system has existed in a holocaust of suggestion, pressures for change, and internal and external examination, which has involved the President of our nation on one hand and volunteer drivers of our neighborhood ambulance clubs on the other.

Organizations representing every level of medical care and medical education in our voluntary system and virtually every executive and legislative branch of our national, state, and local governments have had their say—and are still talking. Beginning with the Coggeshall report in 1965 and progressing through the DeBakey commission, the AMA task forces on education and care, the Millis commission, the pending reports of the National Advisory Commission on Health Manpower and a similar Commission on the Cost of Medical Care, our system, its voluntary hospitals, organized medicine, medical colleges, and the role of our federal and state governments have been studied by so many groups and individuals that often there have seemed to be more bacteriologists than bacteria composing the culture. There are no indications that this trend will stop. There should be no desire for the cessation of these activities unless they are threatened with the mumps of miniscule, from which they may emerge sterile.

Good health is now a fundamental right, together with life, liberty, and the pursuit of happiness. Examination of the system that ensures this health is now in the public domain.

LEGISLATIVE ACTIVITY

Complementing the studies and investigations has been a host of bills representing the greatest activity in social legislation our nation has ever experienced. This began with the legislation encompassing hospital and medical care for the aged and indigent, followed by the various health career training acts, and more recently has included the programs for planning on a regional nonpolitical base and on a nonregional, political base (Public Law 89-239 and Public Law 89-749).

This legislative onslaught is aimed at producing better health for the citizens of our nation, although in some respects it replaces properly aimed rifle fire with poorly aimed shotgun charges. No one can predict with any degree of accuracy the eventual effect of the activities of the mid-1960s on our voluntary care system—indeed, to attempt an intelligent appraisal is a staggering and incomprehensible task. This paper is concerned with only a small and comprehensible portion of the studies—the planning legislation—that portion concerned with the Regional Medical Programs of the National Institutes of Health, continuing education in medicine, their relationships to our hospitals and medical colleges, and their governmental support system.

Beginning in the 1930s, but accelerated productively by World War II, two parallel governmental funding systems have had a vital impact on medical care and knowledge: (1) billions of dollars of federal support and additional millions of voluntary foundations support have gone into basic biomedical research, and (2) additional billions have gone into hospital and facility construction.

While expenditures for research were producing almost indigestible quantities of new knowledge designed to be productive in the prevention, diagnosis, and treatment of disease, other monies in smaller quantity were developing a voluntary system of hospitals and other community facilities that are structurally

¹ Robert L. Evans, M.D., is director of medical education, York (Pa.) Hospital, and president of the Association of Hospital Directors of Medical Education.

modern and usually competent. New medical knowledge has been produced largely in major medical college research and teaching hospital complexes, but the majority of health care has been delivered to our people through a distinctly separate system of community medical institutions.

Communication between medical education and research centers and community health care delivery centers began to deteriorate before and during World War II. It has become increasingly ineffective through the 1950s and 1960s.

Unquestionably, the federal system of research support has been productive in terms of knowledge, but it has served, through the tender trap of "soft money," to enhance greatly the difficulty in communication between the teaching and research centers and the community hospitals. Patterns of human behavior dictate that an individual infected with the virus of discovery—whether through financial or personal suasion—and whose job and family support are functions of continuing success in discovery, will lose interest at a rapid and predictable rate in the more mundane functional application of his discoveries, except as such application might further prove his theses. Understandably, as the Midas touch of research support produced more full-time faculty members who received their major support from investigation rather than teaching, less and less of their time became available to transmit and validate information from the medical college to the functional arm of the medical care system. These attitudes are both inevitable and defensible *within the system* that has produced them.

At the receiving end of this sclerotically deteriorating pipeline of communication between educational centers and care centers, other disruptive forces were at work. Most of the governmental support to our voluntary medical care system, as represented by our community hospital, is directed at bed needs. Provable demographic studies, leading to indicated increases in bed capacity, produce the highest priority of funding in hospital construction. Very little support has gone into the creation of diagnostic or treatment facilities unless they are immediately defensible by bed capacity. Almost no support has gone into nonpatient care and supportive facilities of an educational, evaluative, or analytic nature. Accrediting bodies stress in ponderous manner the necessity for smooth operation and recording of the administrative and business functions of a hospital and its medical staff, but pay almost no attention to the actual quality of the staff, or to any system of assuring the continued quality of the staff in terms of updating of knowledge and techniques.

The exceptions to this insistence on administrative and directive function have occurred in relation to two active forces: (1) incidental to approval of graduate programs (internship and residency), the American Medical Association's Council on Medical Education does insist on minimal standards of graduate education and on evidence of departmental educational activities in those departments operating approved programs; and (2) the American Academy of General Practice for some years has had an established minimum requirement in continuing education for its membership, which the academy itself recognizes as a minimal figure.

EMPHASIS ON BUSINESS FUNCTION

The predominantly lay boards and lay administrators of our voluntary hospital system frequently have contributed further emphasis upon bed capacity and direct bed support. It is a paradox that individual hospital board members, who are involved in corporate structures that place tremendous emphasis on continuing education in management techniques, psychology, and evaluation for their management personnel, neither insist upon, nor are oriented toward, the same emphasis on comparable continuing education activity in the medical staffs of the hospitals that are their community charge. The development of this orientation is again both understandable and defensible *within the system* that has produced it.

Businessmen tend to regard hospitals as businesses and to stress their business function to the administrative group. Government and accrediting bodies understandably have been reluctant to impose continuing education requirements on the medical profession. Many examples around the country show that when the necessity for continuing education and its basic purposes in relation to medical practice are explained in a clear and knowledgeable manner, most board members and administrators are quick to recognize its import, but still may assign

it a low funding priority in an overall system that directs insistent light upon bricks, mortar, systems, and machines.

ATTITUDES OF MEDICAL STAFFS

Hospital medical staffs have been both active and passive in adding plaques to the sclerotic communications pipeline. The measurable shortage of physician manpower tends to confine their immediate thought to the care tasks at hand, which are all too time consuming. Physicians have tended to regard the medical colleges, which spawned them, as sophisticated purveyors of a type of intellectual exercise that is impractical in terms of temporal, physical, and emotional pressures in the community setting. With some justification, they look on medical college faculties and functions as consuming inordinately large numbers of physicians, in both intern and resident programs and staff positions. Their plea to the medical colleges too frequently has been based on what they believe to be a clearly demonstrated need for house staff in the operation of their hospitals and for passive spoon-fed, time-consuming continuing education programs. That these pleas have fallen on deaf and unsympathetic ears is understandable in view of the content of the pleas and the nature of the institutions and individuals to whom they are directed.

Although many other factors have contributed to a lessening of effective communication between the sources of our knowledge and the institutions of its application, those discussed would seem to be the most important and relevant to the effects of federal support on the individuals and institutions at each end of the "knowledge to application" transport system.

Suddenly, into this potpourri of understanding, misunderstanding, interest, and disinterest has come a tremendous force for motivating change. After decades of providing major fund support for both medical research and medical care institutions, the federal government, *representative of the consumers of our product*, recently has discerned that much of its investment in research has been unproductive because the information, techniques, and skills produced in the research centers have not been transmitted *effectively* to the operational arm of the medical care system—the community hospital and its medical staffs.

Whether the failure of *effective* transmission is due to simple lack of information transfer is open to serious question, even though it is a convenient theorem. Campbell Moses, medical director of the American Heart Association, identifies the real problem as validation of knowledge—that is, inability of the practitioner to accept and adopt new knowledge or technique until he has had the experience of "seeing" it used and using it under direction. Perhaps the "information gap" is really a "validation gap," but probably it is both—certainly the therapy for either lies in continuing education.

Forces within government also are beginning to recognize that much of the support assigned to the construction of community medical care facilities has been less than totally effective in producing efficient and knowledgeable delivery of medical care. Funding instead has produced an overemphasis on inpatient care and medical staff direction and administration, to the detriment of a coordinated system of patient care involving logical division of inpatient and outpatient activities, and to the detriment of the continuing updating of physician knowledge, techniques, and skills.

With the recognition of its less-than-complete success in the past, the consumer group, represented by the Regional Medical Programs, the National Institutes of Health, and their parent body, the Department of Health, Education, and Welfare, have come up with a very efficient and almost certain to be effective mechanism to correct some of the past inadequacies.

A "SHOTGUN WEDDING"

Stated simply, medical care and medical education, the two ends of our sclerotic pipeline for the transmission of knowledge and understanding, are about to be subjected to one of our more common social relationships—the inevitable progression from the spurned proposition, to the proposal, to the engagement, and finally to the marriage. Considering the divisive factors above, this is certain to be a stormy junction, but it is just as certain that it will be consummated and productive, for it is a "shotgun wedding." The people of our nation are holding the shotgun. It is loaded with cash—the greatest motivator in our society. Of

a moment, the disinterested and apathetic governmental father of the research years has become the kindly, interested, but extremely firm, future father-in-law. (That he may become an overbearing tyrant is possible, depending upon the success of the courtship.)

The imminent wedding is complicated by the fact that we are not quite certain who is the bride and who is the groom. If educational ability, facility, and personnel are the measure of virility, then the medical college system must be the groom. It is doubtful that the father will listen for long to any disclaimers of ability of the groom to effectively support the bride without further prodding or promise to help with support. It also is doubtful that any disclaimers on the part of the bride (the medical care delivery system) as to her ability to assume educational or analytic duties in the household seriously will affect the future of the marriage.

Similes aside for the moment, let us consider this union between medical education and research and medical care and examine the factors necessary for its success. Three areas require close scrutiny: (1) the depth of the quality, the ability, and the personnel of our educational and research facilities; (2) the sophistication, the quality, the ability, the personnel, and the functional pattern of our medical care institutions; and (3) the question of facilities support and construction subsequent to a productive union of the educational and research institutions and the medical care institutions—perhaps recognizable as the eventual arrangements for housing the family.

The medical college system at present is rich in all three areas. Over the last four decades, it has built up a large cadre of educationally oriented individuals, in spite of research emphasis. The very nature and primary task of the medical college system provides it with adequate classroom, audio-visual, instructional, and other material aids to education. Its hospitals are equipped for the most sophisticated care—a significant portion of it on a research or research-connected basis—and are largely modern and relatively well staffed. Although the medical college certainly will need some additional support to help it in its new role as the *resource* of both content and some instructional ability for the transmission and validation of knowledge, it is relatively well equipped to cope with its role as educational breadwinner. The distaff side—the community hospital, which will consume and utilize the educational paycheck—is much less adequately prepared.

NONUNIVERSITY HOSPITALS

The nonuniversity hospitals divide into those that have graduate educational programs and those that do not. A recent survey conducted by the Association of Hospital Directors of Medical Education shows that although graduate teaching hospitals are much smaller in number, their total bed capacity and total number of staff physicians are approximately equal to the total bed capacity and total medical staff physicians of the hospitals that do not conduct teaching programs. The same survey indicates that even among those hospitals conducting graduate programs, less than 50 per cent have *minimally* adequate teaching facilities and less than 10 per cent have the services of trained educators, evaluators, or sociologists available, even by consultation.

There is little difference between the two types of nonuniversity hospitals in most of the important parameters we shall measure. The major difference seems to be that those hospitals conducting graduate programs may be a little further advanced in educational philosophy. Their staffs, however, frequently are composed largely of physicians who do not actively participate in the teaching programs, and their educational facilities, with a few notable exceptions, tend to be little different from those present in hospitals that do not conduct graduate programs. Consequently, for the purposes of this discussion, the two types of nonuniversity hospitals may be discussed as a common entity. The fact remains that the emerging strident necessity for the nonuniversity hospital is that it *assume its proper role as the center of continuing education for the physicians and allied health personnel of its area*.

Most nonuniversity hospitals are modern, quite sophisticated, and relatively well equipped to render medical care. When one compares them with the medical college hospital, the difference in the area of medical care is a difference between acceptable sophistication on the part of most nonuniversity hospitals and proper ultrasophistication on the part of the medical college hospitals. This is a tolerable and appropriate difference.

INTOLERABLE DIFFERENCE

The difference between the university and community hospitals in educational facility and ability, however, is so great as to be *intolerable*, even under present loads in continuing education in the nonuniversity hospital. These community institutions have their ultimate direction residing in the hands of boards and administrations who, in a proper and dedicated fashion, represent the voice of the community in the operation of its medical care facilities. Very few of the medical staffs and educationally oriented physicians in these hospitals have been able to impress upon their boards and administrators the overriding importance of continuing education to the competence and survival of our medical practice system and its hospitals. Some of the blame for this failure to impress directive bodies must reside in the medical staffs, who have not made a coordinated effort to educate and thus produce a change in the attitude and behavior of their boards and administrations.

Similarly, with fault resting in medical staffs as well as directive bodies, non-university teaching hospitals have tended to look upon graduate (Intern and resident) education programs as tolerable and interesting because they appear to raise the level of medical care, and because they provide additional hands with which to supply that medical care. However, even in relation to graduate education, it has been difficult to bring boards and administrators to spending patient care income on educational facilities, or to supply within the hospitals physicians whose base purpose is graduate or continuing education as opposed to the delivery of medical care. With the rapidly rising cost of hospitalization, and the clamor this rise has produced, one certainly must have sympathy with our hospital boards and administrators in their reluctance to utilize patient care funds for educational facilities and personnel, even though the dollars spent on education are the best purchase the patient might make. The concept is sufficiently abstract to make direct continuity of purpose and decision difficult to achieve.

PROPOSALS AND PRACTICALITIES

In addition to being the subject of studies and recommendations by various commissions and individuals, our medical care and education system has been exposed to many different proposals in relation to continuing education. One hears of universities with and without walls, nationwide closed circuit television, application of the national educational television network to medicine, two-way radio, television tape, and a host of other novelty approaches. When one digs beneath the veneer, he is forced to the inescapable conclusion that, in spite of all of these proposals and gimmicks, *the only practical place to educate the practicing physician in a continuing and productive manner is in the milieu in which he works, treats his patients, and earns his living—his hospital*. While it is true that in leading a horse to water, one may not force him to drink, the horse is a great deal more likely to drink if the water is under his nose constantly.

While the universities and their medical centers may be the central nervous system of continuing education and of the Regional Medical Programs, there cannot be must doubt that the nonuniversity community hospitals will be the muscle of these programs. No portion of the knowledge produced by the billions of dollars spent in basic research in the last 40 years can be productive until it is in the hands of the individuals who care for the majority of the people of our nation—the physicians of our community hospital medical staffs. The people of our nation—our consumers—in the form of Congress, have spoken in a loud and clear voice.

The basic purpose of the Regional Medical Programs is to translate knowledge into understanding and thence into medical care, in a cooperative, regional, and efficient manner. Thus, the basic and initial form of the activities of the Regional Medical Programs must be reparative education in bringing physicians and other health professionals up to date. This must be followed by continuing education to maintain their competence.

Once education is well under way, attention may be paid to providing the facilities in which the newly understood knowledge, techniques, and skills may be applied in a coordinated manner. It is senseless to build the facilities until the system of education that will assure their proper usage is established and functioning; with the explicit purpose of making the billions of dollars they have spent in research productive in the care of our people.

HOSPITALS NEED HELP

At this time, the educational muscle of the nonuniversity hospital system is so weak that it is difficult or impossible for it to handle its presently assigned tasks in education. If it is to become the cornerstone and functional arm of the Regional Medical Program, then the nonuniversity hospital needs a great deal of help. This help must be twofold: (1) an informational campaign that stresses the importance of an educational foundation to underlie all patient care activities so that the boards, administrators, and medical staffs of our hospitals assign proper recognition and importance to the educational activities of their institution; and (2) direct financial support to establish the skeletal framework of facilities and personnel necessary to support the educational functions.

The first of the requirements for help to the nonuniversity hospital in education is well under way. The publications of the Regional Medical Program division of the National Institutes of Health place constant stress on this area. Programs within other portions of the government are designed to stimulate the medical colleges and organized medicine to a more active recognition of continuing education as unquestionably the most important portion of the spectrum of undergraduate, graduate, and continuing health profession education.

Accrediting organizations and institutional groups, such as the American Hospital Association, should play a more important role in the stimulation of interest in the educational function of hospitals; they are just beginning to evidence interest in this activity. The Association of Hospital Directors of Medical Education, composed of key individuals in stimulating and directing continuing education, continues to increase its voice, competence, and activity. Continuation and expansion of these initial activities on the part of all the interested groups and organizations will assure proper emphasis to a function that will produce more good patient care in the future than any other single area of endeavor.

The second need, that of funding support, becomes increasingly important as more emphasis is placed on continuing education. The initial direction of funding in the Regional Medical Programs and in the comprehensive community planning programs properly has been toward the commitment of monies for integrated planning of an approach to the problem of opening the communications pipeline between medical education and research and medical care. Once these groups have planned to communicate effectively, we still are faced with the problem of a bride and groom who are geographically separate, and who, therefore, must be provided with the means to communicate appropriate to their desire to do so.

FACILITIES AND EQUIPMENT

Funds must be provided for educational facilities and equipment in non-university hospitals. Facilities include most importantly, auditorium and conference room space and their accoutrements, library facilities and materials, audio-visual materials and departments, and areas specifically designed for educational demonstrations in patient care. These require brick, mortar, and equipment funds, which most hospitals simply cannot supply from monies currently available in their communities, the Hill-Harris program, or as a result of their patient care efforts. These are the very basic facilities that all hospitals must have to adequately perform their task in educating their staffs and personnel. They are multiuse facilities and, thus, can serve for the continuing education of allied health professionals as well as physicians.

Design and construction of facilities may occupy a considerable period of time; thus, their funding should be of first priority. Concurrently, however, funding should be available to ensure proper and complete utilization of these educational facilities. To make these new facilities really functional will require two additional factors: (1) investigation and measurement to assure the most productive content of the programs they will house; and (2) adequate numbers of educationally competent personnel to assure the productive application of the identified curriculum content and the facilities.

Two of the greatest problems for individuals with practical experience in continuing education are curriculum design and content and the motivation of the practicing physician who is the student. These two factors are inextricably interwoven with a need to know patterns of medical care and physician func-

tion. The area where need for information and the presence of misinformation is most apparent is in the field of function—the activities of physicians in the delivery of medical care and the identification of their needs and motivation in relation to continuing education.

There is sore need for support within the nonuniversity setting for the measurement and evaluation of continuing education to assure its efficiency and pertinence. Additional need relates to the measurement and evaluation of the physician's performance, so that he can be helped to become more efficient and productive in the delivery of medical care. In short, we should be attempting now to identify *what* we should teach and *what changes in behavior* we are trying to bring about through continuing education.

ESTABLISH REGIONAL UNITS

It would seem of great importance that within each of the Regional Medical Programs there be one or more nonuniversity hospital granted funds to construct and staff units to measure and devalueate systemically patient care and its delivery, thus to assist in determining need, content, and motivation in continuing education. These units should be staffed by physicians, educational personnel, and sociologists. Because each region by definition is singular in quality, it is probable that each region will have sufficiently different needs to require difference in approach and measurement techniques. To establish just one or two national institutions or units involved in this type of research would be inefficient and insufficient. This investigative function cannot be carried on in the university setting, for we are studying a nonuniversity organism.

Once identification has been begun of need, content, and pertinence in relation to continuing education, it will be necessary to ensure that sufficient educationally oriented, able and motivated individuals are present within each community hospital (or available to it) to ensure productive usage of the information gleaned and facilities added. This assurance, in the form of trained personnel, might vary across a spectrum encompassing highly skilled, formally trained educators in the larger and more complex hospitals, to individual staff members who have had the opportunity to receive additional understanding in educational philosophy, skills, and techniques in smaller hospitals and communities. One might regard these individuals as the "marriage counselors" of our simile. They are vitally important to a marriage that has little solid foundation in previously existent love or mutual respect between its partners.

Only after the establishment and support of competent and productive continuing education programs should attention be turned to large-scale support of patient care facilities. While such devotion to competence in continuing education, orientation, and ability would somewhat delay the construction of actual physical facilities for more complex and sophisticated patient care, the delay would serve to ensure that these facilities would be properly utilized by physicians. Some programs could be coordinate and concurrent. Caring for patients is, after all, the primary purpose for the existence of our entire medical care system.

A PLEA FOR ACTION

In summary, this presentation is a plea for a cogent and logical progression of activity in relation to Regional Medical Programs, perhaps the most important portion of the socially oriented legislation that has arisen in recent years. By simile, it is a request for good, sound premarital discussion and orientation by the groom and the father-in-law to ensure that the bride of our "marriage" has the knowledge and the necessary appliances and counsel to keep house properly.

Community hospitals and their health professionals must be properly prepared to accept and use the knowledge that will pour from the perviously sclerotic communications pipeline. The medical care system must have initial funding support for identification of educational need and provision of educational space and personnel. Such funding will prepare it for the proper and productive utilization of the health care system and facilities to be established in the future as the result of coordinated regional and community planning for the delivery of medical care.

To paraphrase Winston Churchill, "We are not at the end, nor the beginning of the end, but perhaps we are at the end of the beginning." It is of vital importance that we be sure that this "beginning" represents a solid foundation for a productive and functional future.

Mr. ROGERS. Thank you. We appreciate your being here.

Are we getting enough representation from hospital administrators, from local people involved with the delivery of services in the councils?

Mr. SIBERY. From my vantage point I cannot generalize. I would say that because of my American Hospital Association responsibility, I hear some say we do not have enough hospital involvement. Others say it is fine. Hospitals are certainly welcome to participate.

Generally, I believe they are eagerly invited to participate, so I don't have much sympathy for those who say they have not had an opportunity to be an integral part.

I think that our experience in Michigan might help you to see that this is not just a continuing education program for our medical schools, but in fact is a program that was designed to develop truly cooperative regional arrangements, and it took us many months to develop a working mechanism for the three medical schools to coordinate their efforts and communicate because they had never done this in a similar way before.

I think the very fact that I as executive director of a hospital council was asked to take the initiative in trying to draw together the program and develop the grant application is a good indication that in our State at least the hospital role was well identified.

Thank you very much.

Mr. ROGERS. Thank you. Your testimony has been most helpful.

This concludes the hearing for today. The hearings for tomorrow will be held, I understand, in the main hearing room, which is on the first floor, room 2123, and so the committee will now stand adjourned until 10 o'clock tomorrow morning.

(Whereupon, at 4:15 p.m. the committee adjourned, to reconvene at 10 a.m. Thursday, March 28, 1968.)

REGIONAL MEDICAL PROGRAMS; ALCOHOLICS AND NARCOTICS ADDICTS FACILITIES; HEALTH SERV- ICES FOR DOMESTIC AGRICULTURAL MIGRATORY WORKERS

THURSDAY, MARCH 28, 1968

**HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON PUBLIC HEALTH AND WELFARE,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C.**

The subcommittee met at 10 a.m., pursuant to notice, in room 2123, Rayburn House Office Building, Hon. Paul G. Rogers presiding (Hon. John Jarman, chairman).

Mr. ROGERS. The subcommittee will come to order.

We are continuing our hearings on H.R. 15758, and our first witness this morning is Mr. Clinton M. Fair, who is the legislative representative of the AFL-CIO here in Washington, D.C.

Mr. Fair, we are pleased to see you this morning, and thank you for being present to give testimony.

STATEMENT OF CLINTON M. FAIR, LEGISLATIVE REPRESENTATIVE, AFL-CIO; ACCOMPANIED BY RICHARD SHOEMAKER, ASSISTANT DIRECTOR, SOCIAL SECURITY DEPARTMENT

Mr. FAIR. Mr. Chairman, for the record, my name is Clinton Fair. I am with the legislative department of the AFL-CIO, and with me is Mr. Richard Shoemaker, who is the assistant director of our social security department, Mr. Chairman.

Mr. ROGERS. We are delighted to have you with us, too.

If you would like to, you can make your statement a part of the record, following your remarks, and you may sum up for us.

Mr. FAIR. Thank you, Mr. Chairman.

Let me read in part from the statement, only because I can then add the emphasis that I would like to add.

Through the extension and improvement of the regional medical programs, this legislation strikes at the cause of death for seven out of 10 Americans.

In extending the migrant health program, this legislation helps bring better health to some of the Nation's 1 million migrant farmworkers and their families and brings us closer to the day when we will have corrected what has been called America's shame.

The alcoholic rehabilitation amendments in this legislation will help provide proper treatment for the 5 million persons—more than twice the population of the entire Washington, D.C., area—who with their

families suffer the physical and emotional problems which result from alcohol addiction. The narcotic addict rehabilitation amendments in H.R. 15758 will aid in carrying on and expanding what must be an aggressive effort to stem the rising number of drug addicts, especially among the Nation's young people.

I would like to make one comment, turning to page 2, with regard to the regional medical programs.

The regional medical program has within the short time it has been in operation in our opinion made remarkable strides in developing cooperative arrangements with the medical profession, our medical colleges, and our health institutions. This program holds great promise in making available to patients the latest advances in diagnosis of heart disease, cancer, stroke, and related diseases.

This coordination of effort also holds great promise of avoiding the needless cost of duplication and wasteful proliferation of diagnostic and treatment centers in our hospitals.

We realize, of course, that the evaluation of the program is quite difficult at this time. The program is new, and the great bulk of expenditures to date has been for planning activities.

But we would point out further examples, which are in our testimony, Mr. Chairman, and which we think spell great promise for the program.

The second part of our testimony deals with the migrant health program. The migratory provisions of H.R. 15758 would extend this 6-year-old migrant health program for another 2 years.

The plight of the migrant farmworker in this country has been widely publicized in recent years, but the publicity in no way cushions the shock that must be felt by every thinking American upon being reminded that people living in this country today, working amidst plenty, must endure such squalor.

I would point out on page 6 of our statement are some of the statistics in this area.

Of more than 1 million migrants, 650,000 still live and work outside the area served by existing migrant health projects. By conservative estimates, this group includes over 6,500 persons with diabetes who are without adequate medical care, over 5,000 migrants with tuberculosis, and over 3,000 children under the age of 18 who have suffered cardiac damage as a result of rheumatic fever.

Many children have untreated iron deficiency anemia, and over 250 infants will die in the first year of life as a result of congenital malformation or disease.

Over 16,000 expectant mothers will find it difficult to obtain prenatal care, and between 20,000 to 30,000 individuals have enteric or parasitic infestations, resulting in most cases from poor sanitation.

I would point out, as the testimony does, that as these people move from crop to crop, the necessity for the program is greater because they move from one area where a program is now in operation to an area in which it is now nonexistent. And if they are to get the kind of medical care we think they need, the program needs the expansion so as these people move from one area to another they have the facilities available to them.

As you know, our migratory workers today may have a community in which he lives, but on the whole he is moving for long periods of time away from that area.

The alcoholism provisions in H.R. 15758 would authorize a 2-year grant program of building, staffing, and operating facilities for treating alcoholism, using the same types of mechanisms as provided in the Mental Health Centers Act. The local centers it will provide will aid the alcoholic, replacing the neglect and abuse which in the past resulted all too often in his eventual destruction.

It will also aid the less than 10 percent of alcoholics who are the homeless men and women, hopefully putting an end to the revolving door cycle of arrest, jail, release, drunkenness, and arrest again.

The narcotic addict rehabilitation provisions extend and make the very logical placement of narcotic addict rehabilitation activities in the mental health centers authorized under the community mental health centers programs. To enable the centers to absorb their new responsibility, the new legislation, would authorize a 2-year grant program for construction, staffing, and operation and maintenance of new facilities and for training of the necessary personnel.

Drug addiction as a symptom of mental illness has been recognized in the act. As with the alcoholic the drug addict is a hazard to his family and his community as well as to himself.

Now, while the number of centers provided for treatment of addicts is small, the number of addicts is increasing. By providing this as part of the complex of mental health centers, it gets treatment to persons who need it in places where they can get it, and allows for efficient use of existing facilities.

Psychological dependence, if not addiction, is a problem for young people today, and I would add that there are other dangerous drugs in addition to narcotics, as this committee knows, which have become a problem in recent times.

We would hope that this program will be extended to them as well as to the narcotic drug addicts. We hope this committee will report favorably this program. We believe this legislation will stand as a model which the States may use in developing and modifying their own legislation, and certainly treatment of drug addicts and alcoholics and organization of medical service.

It includes incentives and assistance from which each State can benefit in assuring that the medical fields of its citizens are met.

Most certainly the Federal influence in the advance of medical knowledge and the application of that advance for the benefit of all citizens should continue.

In the past much of this influence took the form only of financial assistance to various State programs. Today this influence also assumes the form of acting as a clearinghouse, and as techniques are developed and tested by those closest to the problems.

We trust that approval of H.R. 15758 by this committee will indicate a continued willingness to maintain Federal support of health programs to the highest degree possible. And we urge your favorable consideration of the bill before you.

Mr. Chairman, we thank you kindly for the opportunity to appear in support of these various programs.

(Mr. Fair's prepared statement follows:)

STATEMENT OF CLINTON M. FAIR, LEGISLATIVE REPRESENTATIVE, AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS

Mr. Chairman, H.R. 15758, the Public Health Service Act Amendments which this committee is now considering, is a package of important extensions and improvements to existing legislation as well as extension of the Community Mental Health Centers Act to provide facilities for alcoholics and drug addicts.

Through the extension and improvement of the Regional Medical Programs, this legislation strikes at the cause of death for seven out of ten Americans. In extending the Migrant Health Program, this legislation helps bring better health to some of the nation's one million migrant farm workers and their families and brings us closer to the day when we will have corrected what has been called "America's Shame." The Alcoholic Rehabilitation Amendments in this legislation will help provide proper treatment for the five million persons—more than twice the population of the entire Washington, D.C. area—who with their families suffer the physical and emotional problems which result from alcohol addiction. The Narcotic Addict Rehabilitation Amendments in H.R. 15758 will aid in carrying on and expanding what must be an aggressive effort to stem the rising number of drug addicts, especially among the nation's young people.

REGIONAL MEDICAL PROGRAM

The President's Commission on Heart Disease, Cancer, and Stroke, described three years ago the severe toll in human suffering which these diseases inflict on the American public, each diminishes the strength of our nation. The American worker looks forward to the day when major inroads will be made against these diseases through medical research and when the fruits of such research can be made available to him at a price he can afford.

The nation's poor, whose ill health is virtually inseparable from their way of life, look forward to the day when they can share fully in the fruits of modern medical science.

Since the Report of the Committee on the Costs of Medical Care was published in 1932, the regularization of health services has been considered necessary in order to bring about a more rational allocation of our health resources, but until the passage of P.L. 89-239, very little had been accomplished to implement such goals. The Regional Medical Program has, however, within the short time it has been in operation, made remarkable strides in developing cooperative arrangements with the medical profession, our medical colleges and other health institutions. This program holds great promise of making available to patients the latest advances in the diagnosis and treatment of heart disease, cancer, stroke and related diseases. This coordination of effort also holds great promise, not only of providing the best of care for those afflicted, but also of avoiding the needless costs of a duplication and wasteful proliferation of diagnostic and treatment centers in our hospitals.

We realize, of course, that evaluation of the program is difficult at this time. The program is too new and the great bulk of expenditures, to date, have been for planning activities. A total of 53 grants have been made for such planning, and it will be some time before plans can be implemented. However, the Surgeon General's Report on Regional Medical Programs to The President And The Congress, submitted by Dr. Stewart last June, indicated some of the program's early accomplishments.

A few special examples of programs already in operation deserve mention here. In the notorious Watts section in California, too large a proportion of the population has been virtually cut off from the mainstream of modern medicine. Under the Regional Medical Program proposed there, the medical schools of the University of Southern California and the University of California at Los Angeles and the Charles R. Drew Medical Association are cooperating to devise a plan for bringing some order into the health service vacuum now existing there. A 485-bed hospital and a proposed Postgraduate Medical School are later phases of the program's bold plan.

The Albany Regional Medical Program has developed a comprehensive program of education, organization, record-keeping, and follow-up examinations in an attack on cancer of the cervix. This disease, which now kills some 14,000 women each year, could be eliminated as a major cause of death if the disease is diagnosed and acted upon at an early stage. During the first year, the cancer control program is being inaugurated in seven hospitals in New York and Massachusetts.

A symposium will be held next month (April) in New York City dedicated to educating people in health careers. Through the Regional Medical Program, planning for health careers now involves all seven universities and the community colleges of the five boroughs.

It would indeed be an unthinkable waste of public planning funds as well as a severe setback to a new spirit of cooperation that has developed among the many separate and independent professional and institutional components of the health enterprise not to extend this legislation—a program with so much promise, which is so widely accepted and on behalf of which so many public spirited professional and non-professional people have made substantial contributions of their time, needs continuing Federal support.

MIGRANT HEALTH PROGRAM

The Migratory Workers provisions of H.R. 15758 would extend the six-year old Migrant Health Program for another two years. The plight of the migrant farm worker in this country has been widely publicized in recent years, but the publicity in no way cushions the shock that must be felt by every thinking American upon being reminded that people living in this country today, working amidst plenty, must endure such squalor. The average annual income of the migrant farm worker in 1965 was \$1,400. While the average annual expenditure for personal health care is more than \$200 for all Americans, the figure is only \$12 per year for the migrant, including \$7.20 in Federal funds and \$4.80 from other sources.

At present only an estimated one-third of the total migrant population has access to Migrant Health Act project services. During the 1967 fiscal year, one-fourth of the Nation's migrants had access to project services for a brief period only. This means that of the one million men, women and children, who travel the migrant stream, only about 350,000 have access to Migrant Health Act project services.

By August 1, 1967, 115 public or private nonprofit community organizations were using migrant health grants to help them provide medical, nursing, hospital, health education and sanitation services to their seasonal migrants; but, three-fifths of the counties identified as migrant home-base or work areas are still untouched and service coverage remains weak in many of the areas where projects are now receiving grant assistance.

One or more migrant health projects operate in 36 states and Puerto Rico. Each project serves migrants in from one to 20 counties. Community-based projects offer personal health care to migrants in about two-fifths (270) of the 726 counties thus far identified as migrant work or home-base areas. They offer sanitation services in most of these and an additional 142 counties. About 40 home-base counties, reporting an estimated outmigration of 200,000 persons, are included in migrant health project areas in southern Florida, Texas, New Mexico, Arizona, southern California and the bootheel of Missouri. Continuity of care becomes more possible as project services are provided at strategic points along major migration routes. Personal health records carried by the migrants facilitate continuity and help to avoid duplication or gaps in services. Project reports indicate that from 10 to 90 percent of the migrants contacted present a personal health record upon request. A few state-level projects provide sanitation, nursing or other services throughout the state wherever a major migrant influx exists. This is most likely to be true in the case of sanitation services.

For continuity of care and protection, migrants need access to health services in every county where they live and work temporarily. Because geographic coverage by project services is still far from complete, a total of 750,000 migrants had no access to personal health care provided through projects in 1966. The remainder had ready access to personal health services for only part of the year.

Only one out of three counties with migrants offered grant-assisted personal health care geared to the special needs of migrants during 1966. Only six out of ten counties offered protection of their living and working environment through sanitation services with grant assistance. Lack of continuity of health care will remain a problem as long as many communities have no place to which a migrant can turn and expect to find needed health care. Recently, in one of the wealthiest states in the nation, a migrant with an emergency illness was refused care by 4 hospitals because he could not assure payment of the bill. At the fifth hospital where he obtained attention, doctors said that the patient would have died if he had had to shop around for hospital treatment for another two hours.

Migrant farmworkers are not commuters. They travel so far from their homes that they must establish a temporary residence in one or more other locations during each crop season. On the average, the people live and work in two or three locations annually. They may move several times from farm to farm or camp to camp at each location. At each of his temporary homes the migrant needs access to health services and a safe home and work environment; but his home base and work communities are typically rural, isolated, lacking in both economic resources and health resources. As a result the typical migrant home is small, overcrowded, and of substandard construction. It often lacks facilities for food storage and preparation. It often lacks adequate and safe water supply for drinking, dishwashing, bathing, and laundry. The area too often lacks adequate sewage and waste disposal facilities which attracts insects and rodents. There are no recreational areas or facilities. The typical places where they work are exposed to heat, cold, wind, dust, chemicals and mechanical hazards. They lack safe and accessible water for drinking or washing and they lack adequate toilet facilities. On some farms there are no facilities at all. All of us have a stake in the continuation and extension of this program.

The migrant's road to health care is beset with obstacles—as the side of the migrant is poverty, lack of health knowledge, isolation, fear of non-acceptance by the community. On the side of the community are legal restrictions against serving nonresidents, legal exclusion from protective legislation, health planning priorities that exclude migrants, inadequate health manpower, inadequate financial resources, problems of serving a mobile group and resistance to minority groups. Many of the communities where migrants live and work temporarily are themselves considered poverty areas.

Little wonder then that the accident mortality rate for migrants in 1964 was nearly three times the U.S. rate. It was 6 percent greater than the U.S. rate 30 years ago. Migrants' 1964 mortality from tuberculosis and other infectious diseases was $2\frac{1}{2}$ times the national rate, approximately the national average of over a decade ago. Their mortality from influenza and pneumonia was more than twice the national rate and slightly in excess of the U.S. rate for 1940.

The infant mortality rate reflects like an index the results of our nation's apathy toward these workers. In 1964 the infant mortality rate among migrants was at the level of the country as a whole for 1949. The maternal mortality rate in 1964 was the same as the national level of a decade ago.

Of the more than one million migrants, including workers and their dependents, 650,000 still live and work outside the areas served by existing migrant health projects. By conservative estimates, this group includes:

1. Over 6,500 persons with diabetes who are without adequate medical care.
2. Over 5,000 migrants with tuberculosis who are traveling and working with their disease undetected and untreated.
3. Over 3,000 children under the age of 18 who have suffered cardiac damage as a result of rheumatic fever. These children are not likely to receive treatment for prevention of reinfection and further cardiac damage. Such treatment is ordinarily available to most nonmigrant children in their communities.
4. Approximately 9,800 children have untreated firm deficiency anemia. This increases their susceptibility for childhood infection and interferes with their normal growth and development.
5. Over 250 infants who will die in the first year of life as a result of congenital malformation or disease. Early, adequate medical care will not be available for these infants.
6. Over 16,000 expectant mothers who will find it difficult to obtain prenatal care. Infant and maternal mortality rates can be expected to be significantly higher under such conditions.
7. Between 20,000 to 30,000 individuals who have enteric parasitic infestations—resulting in most cases from poor sanitation. Such a problem is almost nonexistent in the general public.

Before the passage of the Migrant Health Care Act in 1962 the migrant farmworker had virtually no medical care available to him and to his family. Only in grave emergencies did he get care, and even then he was frequently denied the needed medical services. Much progress has been made since 1962 but there is still a long way to go before the migrant farmworker and his family will have available even the barest minimum of medical services.

Certain facts are highlighted which show progress is being made, but there is also evidence that the progress is too slow, and only a small segment of the migrant population is the beneficiary of the migrant health program.

1. The migrant health program provides prenatal and postnatal care, obstetrics service, immunization, examinations, and treatment for ordinary ailments. Of these services only about 250,000 out of the one million men, women, and children who make up the migrant stream get this care. Also, this care is not continuous as not all communities have migrant project services facilities and as the migrant moves from camp to camp and from state to state these services become episodic, periodic or nonexistent.

2. Continuity of health care services for all migrant workers and their families is of the utmost importance for a rational nation-wide health care program. The American people today feel that health care services are a right. This concept should certainly encompass the men, women, and children who work in this country's fields and who make it possible for our people to be the best fed nation in the world.

The AFL-CIO not only urges the extension of this program, but strongly recommends the authorization of \$9,000,000 for fiscal 1969 be substantially increased.

ALCOHOLISM AND DRUG ADDICTION

The Alcohol and Narcotic Addict Rehabilitation Amendments in H.R. 15758 represent a meritorious effort to cope with two insidious and destructive behavior problems. An estimated 80 percent of the nation's five million alcoholics are living with their families, holding—or trying to hold—some kind of job, and trying to maintain a place in the community. The cost of their alcoholism to American industry is an estimated \$2 billion a year as a result of absenteeism, lowered efficiency and medical insurance expenses. The suffering which the alcoholic inflicts on his family is immeasurable. His community may spend as much as \$100,000 on an alcoholic and his family during his lifetime. The safety of the alcoholic, of his family, his coworkers and indeed of the entire community is endangered by his habit. According to Dr. Daniel P. Moynihan's recent advisory committee report on traffic safety, made to the Department of Health, Education and Welfare last February, as much as every tenth car encountered on the road may be driven by an alcoholic. Problem drinking is cited as a factor in at least 30 percent of the more than 40,000 motor vehicle deaths occurring annually.

The alcoholism provisions in H.R. 15758 would authorize a two-year grant program building, staffing and operating facilities for preventing and treating alcoholism, using the same types of mechanisms as provided in the Mental Health Center Act. The local centers which this legislation will provide will aid the working alcoholic, replacing the neglect and abuse which in the past resulted all too often in his eventual destruction. It will also aid the less than ten percent of all alcoholics who are the homeless men and women, the so-called Skid Row inhabitants, hopefully putting an end to the revolving-door cycle of arrest-jail-release-drunkenness and arrest again.

We very definitely endorse this effort to fight the disease of alcoholism with the humane and intelligent treatment that is required.

The Narcotic Addict Rehabilitation provisions of H.R. 15758 extend and make the very logical placement of narcotic addict rehabilitation activities in the mental health centers authorized under the Community Mental Health Centers Act. To enable the centers to absorb their new responsibility the new legislation would authorize a two-year grant program for construction, staffing, operation, and maintenance of new facilities and for training of the necessary personnel. Drug addiction as a symptom of mental illness has been recognized officially in the two-year-old Narcotic Addict Rehabilitation Act. As with the alcoholic, the drug addict is a hazard to his family and community as well as to himself.

The need for providing treatment and rehabilitation is apparent when we consider the 40 percent increase in the number of narcotic addicts recorded by the Bureau of Narcotics during the past ten years. Our concern over the drug addiction problem is also due in no small part to the fact that drug abuse is a behavioral illness of the nation's great labor centers. More than half the addicts recorded by the U.S. Bureau of Narcotics are residents of New York State. California, Illinois, New Jersey, and Michigan, have a larger proportion of addicts than other states.

While the number of centers providing treatment for addicts is small, the number of addicts increases. Providing this treatment in facilities which are part of the complex of the community mental health centers, gets treatment to persons

who need it in places where they can get to it, and allows for efficient use of existing facilities. Psychological dependence, if not addiction, is a problem for younger people today. There are other dangerous drugs in addition to narcotics as this committee knows.

We hope the committee will report favorably this program.

We believe this legislation will stand as a model which the States may use in developing and modifying their own legislation concerning treatment of drug addicts and alcoholics and organization of medical services. It includes incentives and assistance from which each state can benefit in assuring that the medical needs of its citizens are met.

Most certainly the Federal influence in the advancement of medical knowledge and in the application of that advancement for the benefit of all citizens should continue. In the past, much of this influence took the form only of financial assistance to various State programs. Today this influence also assumes the form of acting as a clearinghouse and disseminator of medical information and techniques developed and tested by those who are closest to the problems.

We trust that approval of H.R. 15758 by this committee will indicate a continued willingness to maintain Federal support of public health programs to the highest degree possible. We urge your favorable consideration of H.R. 15758.

Mr. ROGERS. Thank you, Mr. Fair, for an excellent statement, and I am impressed particularly with some facts you gave on migrant health problems. I am very interested in it and have been since helping to write the original legislation.

As a matter of fact, I was concerned with health, where we give block grants to the State. It was the thinking of the Bureau of the Budget that, at first, they would not continue migrant health as a separate program. But, as a result of the interest some of us have shown—I introduced a bill for continuation for 3 years of this program—we have gotten them to go along with a 2-year extension.

We appreciate your support on this. I think it is a very necessary program. And we appreciate very much your testimony.

Dr. Carter?

Mr. CARTER. I have no questions.

Mr. FAIR. Thank you, Mr. Chairman.

Mr. ROGERS. Our next witness is David J. Pittman, director, the Social Science Institute, and professor of sociology, Washington University, St. Louis, Mo.

STATEMENT OF DAVID J. PITTMAN, PH. D., DIRECTOR, THE SOCIAL SCIENCE INSTITUTE, AND PROFESSOR OF SOCIOLOGY, WASHINGTON UNIVERSITY, ST. LOUIS, MO.

Mr. PITTMAN. It is a pleasure to be here, and I have a statement that can be entered into the record.

Mr. ROGERS. Without objection, the formal statement will be made part of the record following your remarks.

Mr. PITTMAN. The part I would like to bring to the attention of the committee is in reference to the recent court decisions. I have for 10 years served as a consultant to the St. Louis Metropolitan Police Department, as well as consultant to the President's Commission on Law Enforcement and the Administration of Justice, which recommended that communities should establish detoxification centers to remove the offenders from jail, the so-called "revolving door" process.

The first detoxification center in North America was in St. Louis, Mo., and this was under the aegis of the St. Louis Metropolitan Police Department, a Catholic nursing order, and Washington University's

social science institute. The center has been in operation for 17 months and has become a model for the whole Nation. The results thus far have surpassed all expectations on the first followup studies of patients going through the center, who are from the homeless and lower income group. Twenty-one percent are abstinent at the end of 3 months.

Mr. ROGERS. Twenty-one are what?

Mr. PITTMAN. Twenty-one percent are abstinent for 3 months.

Mr. ROGERS. That is excellent.

Mr. PITTMAN. This was far beyond any expectancy that any of us had concerning that particular program.

Mr. ROGERS. How long has this been going on?

Mr. PITTMAN. For 17 months. In fact, the results were so good that in October 1967 the St. Louis Board of Aldermen unanimously passed a new statute governing public intoxication in that city, without any court pressure being needed.

The essence of the statute is that chronic alcoholism is a positive defense to the charge of public intoxication. However, very few such cases find their way to the court anymore, as they are handled in the detoxification center.

The 30-bed facility is a cooperative effort. The Department of Justice helped on this, and the Missouri State Legislature appropriated \$150,000 for this work; the St. Louis Board of Police Commissioners, with the approval of the board of apportionment in the city, has appropriated somewhere close to \$150,000 for the city of St. Louis.

The detoxification center in St. Louis handles approximately 80 percent of all "drunk on street" cases and graphically demonstrates what a community can do when it is willing to move on this major problem. I think the unique aspect is that Federal, State, and local cooperation has been brought to bear in terms of providing a facility "from scratch," so to speak, and we have been deeply appreciative of the support of press, radio, and community organizations in these efforts.

Now, I would like to indicate, in terms of the Federal Government action in alcoholism and particularly in reference to this bill, that the bill is not as specific as it should be in terms of noting that detoxification facilities or emergency care facilities, or resources, should be eligible for construction grants as well as providing for staff, operation, and maintenance grants. Unless these emergency facilities are provided to intervene rapidly into the treatment of these individuals, we will continue to see a sizable proportion of alcoholics who do not have full access to treatment.

Unfortunately, a sizable portion of general hospitals and community mental health centers do not provide, or are unwilling to provide, emergency care for chronic alcoholics. This was the case in St. Louis, as well as other cities, which have now pioneered in emergency care facilities, such as Des Moines, Washington, D.C., and so forth.

Therefore, I respectfully request that the subcommittee give consideration to making emergency detoxification facilities eligible for support under this act. The recovery rate can be much higher than was anticipated if treatment is immediately brought to bear, and this is

reflected in the case of the city of St. Louis. This is a manageable problem.

I would like to close by indicating that we who have been involved in the alcoholism movement for the last few years are deeply appreciative of the interest of the Congress of the United States in reference to this particular problem which has been ignored for so long.

Thank you.

(Mr. Pittman's prepared statement follows:)

STATEMENT OF DAVID J. PITTMAN, PH. D., EXECUTIVE VICE CHAIRMAN, GOVERNOR HEARNES' ADVISORY COMMITTEE ON ALCOHOLISM, STATE OF MISSOURI, PAST PRESIDENT, NORTH AMERICAN ASSOCIATION OF ALCOHOLISM PROGRAMS, DIRECTOR, SOCIAL SCIENCE INSTITUTE, AND PROFESSOR OF SOCIOLOGY, WASHINGTON UNIVERSITY

It is indeed a pleasure to testify in support of HR 15758, Title III, Part A, "The Alcoholism Rehabilitation Act of 1968." The introduction of this Bill by the eminent Chairman of the Committee, Mr. Harley O. Staggers of West Virginia, is indeed a forward looking and progressive step in coping with one of America's most neglected health problems. One of the most neglected areas of health care in American society today is the provision of treatment facilities for the alcoholic. The presence of around six million alcoholics in the United States makes this one of the nation's foremost medical and social problems, but an equally salient fact is that the expansion of treatment facilities and resources has lagged far behind the growth of the alcoholism problem. Title III, Part A, of this Bill would be a major step forward in providing increased resources to meeting this complex problem.

As the former president of the North American Association of Alcoholism Programs and as the Executive Vice Chairman of the Governor's Council on Alcoholism in Missouri, I am keenly aware of the desperate need for increased federal involvement in providing resources for coping with alcoholism to supplement the increasing efforts by state and local authorities, both private and public.

The United States remains one of the few countries in the Western world without an enacted legislative program of alcoholism control at the national level. National alcoholism programs now exist in both Western and Eastern European countries and have had a major impact in ameliorating this problem. Therefore, it is a heartening sign to see the Congress of the United States concerned with this major problem.

RECENT COURT DECISIONS

Recent United States Courts of Appeals decisions in Virginia and the District of Columbia have ruled that chronic alcoholism may be used as a positive defense to the charge of public intoxication. This change in legal interpretation must be placed against the backdrop of the fact that in 1966 about one-third of all arrests made by American police was for public intoxication violations.

New Medical and social approaches will have to be mounted in American communities. As the President's Commission of Law Enforcement and Administration of Justice recommended, communities should establish civil detoxification centers to remove the chronic drunkenness offenders from the status degrading process of arrest, jailing, and re-arrest, which in an earlier work I termed the "revolving door process."

It is indeed a source of pride to note that the first Detoxification Center in North America to systematically remove chronic alcoholics (whose only offense is public intoxication) from the jails is in St. Louis, Missouri. The Detoxification Center is an undertaking of the St. Louis Metropolitan Police Department, under the leadership of a most able past president, Col. Edward L. Dowd, along with the cooperation of the Sisters of St. Mary's and the Social Science Institute of Washington University. This Detoxification Center in St. Louis in the 17 months of its operation has become a model for the whole nation, and the results thus far obtained have far surpassed our expectations—approximately 21 per cent of the chronic inebriates being abstinent when interviewed in the community three months after treatment.

In October, 1967, the St. Louis Board of Aldermen unanimously passed a new statute governing public intoxication in our city without any court pressure

being needed. The essence of our new statute is that chronic alcoholism is a positive defense to a charge of public intoxication. However, very few cases of public intoxication involving chronic alcoholics find their way to the court any more as they are handled in the major medical facility or Detoxification Center. This thirty-bed facility is supported in a cooperative endeavor of federal, state, and local agencies. The federal government, through the Office of Law Enforcement Assistance in the Department of Justice, provided the original grant; the Missouri State Legislature in its recent special session just concluded this month appropriated \$150,000 for the partial support of detoxification centers in our major urban centers of St. Louis, Kansas City, and Springfield; and the St. Louis Board of Police Commissioners has appropriated municipal funds with the approval of the Board of Apportionment and Estimate. The Detoxification Center now handles approximately 80 per cent of all "drunk on street" cases in St. Louis and graphically demonstrates what a community can do when it is willing to move on this major problem. The goal of our state and municipal agencies and their personnel is the total removal of chronic alcoholics whose only offense is public intoxication from the jail cells of America. I would like to note for the Committee that the support of the press, television, radio, and community organizations has been completely behind these new actions to remove chronic alcoholics from the judicial process to the medical, rehabilitation, and social context.

On March 7, 1968, the Supreme Court of the United States heard arguments on the *Powell vs Texas* case, and the Court has been asked to rule on the constitutionality of the public intoxication statute's use in cases involving chronic alcoholics. It is expected that the Court will rule that chronic alcoholism is a positive defense to charges of public intoxication and that these individuals are not to be incarcerated but must receive medical and social treatment. Thus, there will be a crisis in treatment resources unless bold and imaginative steps are taken by local communities now.

But the tragedy is that the implementation of court decisions with new programs and facilities has been so difficult to obtain—individuals are still dying in jail cells of America from chronic alcoholism.

FEDERAL GOVERNMENT ACTION

But for local and state initiative to be successful in combatting this major health problem there must be more vigorous leadership shown at the federal level. Past efforts to cope with alcoholism on the national level have been fragmentary and do not represent a national attack on alcoholism.

Last year the Federal Government spent only eleven million dollars on alcoholism control. This miserly expenditure of funds on a national problem of great importance occurs despite the fact that over one-third of the arrests in America are for public intoxication, despite the fact that 40 to 50 per cent of all fatal traffic accidents involve chronic alcoholics or heavy drinkers, and despite the fact that hundreds of Americans die needlessly in jail cells from the effects of chronic alcoholism.

This Bill should be more specific in noting that detoxification facilities or emergency care resources should be eligible for construction grants as well as staff, operation, and maintenance grants. Unless these emergency facilities are provided, we will continue to see a sizeable proportion of alcoholics who do not have full access to medical and social care. Unfortunately, a sizeable proportion of general hospitals and community mental health centers do not provide, or are unwilling to provide, emergency detoxification care for chronic alcoholics. This was the case in St. Louis as well as in many other cities, such as Des Moines, Washington, and Denver, where new detoxification centers have been established to care for the homeless, chronic inebriate population. Therefore, I respectfully request that the Subcommittee give consideration to making emergency detoxification facilities eligible for support under this Act.

In the last four years in connection with the North American Association of Alcoholism Programs, I have traveled from coast to coast, from border to border, and I can assure the members of this Committee that there is a ground swell of support for the enactment of systematic federal legislation to aid the states and the municipalities in coping with this major medical and social problem. I am sure that the people of America are wholeheartedly in support of vigorous federal action for alcoholism rehabilitation, control, and eventual prevention of this major health problem.

Mr. ROGERS. Thank you very much, Dr. Pittman. It is a very interesting statement.

Mr. NELSEN?

Mr. NELSEN. No questions, except to comment that the success you have had is outstanding, and it would indicate the merit of the bills before us.

Mr. ROGERS. Dr. Carter?

Mr. CARTER. Certainly we realize the great problem that alcoholics present to our country, and I want to commend you on your efforts in this direction. I support the part of this bill for the treatment of chronic alcoholism.

There is one thing that interests me, of course. As you state, some of the courts have held that chronic alcoholism is a defense against arrest for intoxication.

How are you going to manage acute alcoholics who are on the streets and who are some danger to the public? How will you take care of them?

Mr. PITTMAN. The procedure we have developed in cooperation with the police and the district attorney's office, as in the case of an accident victim, or a coronary case that may collapse on the street, is taking the individual to the medical facility for treatment.

The law as it is revised does not remove the arresting process for public intoxication. The determination comes in a court hearing. But, briefly speaking, anyone brought by the police to the detoxification center has a summons left with him. If he undergoes the treatment, then the summons is canceled, and that is the end of that particular episode.

There is a volunteer program, and the ultimate sanctioning, of course, is in the statute itself. If the individual goes to court, he can plead chronic alcoholism and under the statute certain options are open to the judge, that is, a voluntary referral to a private doctor or a psychiatrist. The compulsory sentence in the workhouse is still there for the nonalcoholic.

Mr. CARTER. A compulsory sentence to the workhouse? I hardly see how that would be possible for such an offense.

But how are you going to handle the intoxicated people on the streets?

Mr. PITTMAN. We have had a training program for 10 years on how to handle the chronic alcoholic. It is not a very difficult matter. The police officers have had intensive experience in terms of handling these individuals, and in our experience it has not resulted in any violent episode.

Mr. CARTER. Describe the method of handling them.

Mr. PITTMAN. Well, actually, the officer, when he sees the intoxicated person on the street, asks him to go along with him to the center. The minimal degree of force is used.

There is no handcuffing, no use of extreme measures. The talking procedure is used first, and it has not been necessary to restrain any of the individuals. It may be necessary very rarely for two officers to take an individual to the center.

Mr. CARTER. Where are they taken, then?

Mr. PITTMAN. They are taken to the St. Mary's Infirmary, which is a 30-bed facility with 24-hour service and a hospital staff.

Mr. CARTER. You have treatment facilities there for one who has delirium tremens?

Mr. PITTMAN. Yes. There have been few cases of delirium tremens. They are brought immediately into treatment, and care is provided so that there is rapid recovery.

Mr. CARTER. Sometimes even with the best treatment we see this. If you see many alcoholics, you will see delirium tremens. There is no question about that, and it does take a great deal of care and attention, and there is the problem of how to apprehend promptly those who are in this state as a result of the ingestion of alcohol. That is a problem.

Mr. PITTMAN. I think your point is well made. It is a matter of training on the part of the police, the nurses, and so forth. This can be reduced to a minimum.

Mr. ROGERS. I am interested in how your detoxification center works. What is your budget, or do you have it here?

Mr. PITTMAN. I would be glad to send the whole exhibit to the committee for the record. But, briefly, approximately \$350,000 yearly. (The following information was received by the committee:)

U.S. DEPARTMENT OF JUSTICE, OFFICE OF LAW ENFORCEMENT ASSISTANCE
GRANT ADJUSTMENT NOTICE

Grantee: St. Louis Metropolitan Police Department (Grant No. 284-(S-093)).
Title of project: St. Louis Detoxification Diagnostic and Evaluation Center (Adjustment No. 1).

Nature of adjustment: Budget Change (Date, 2-20-68).

To grantee: Pursuant to your request of February 19, 1968, the following change, amendment, or adjustment in the above grant project is approved, subject to such conditions or limitations as may be set forth below:

DANIEL L. SKOLER,

Deputy Director, Office of Law Enforcement Assistance.

Approval of the attached revised project budget for the project, with changes as follows:

	Dec. 1, 1967, to Nov. 30, 1968		
	Original approved budget	Change	Revised budget
Personnel.....	\$79,850	-\$21,668	\$58,182
Supplies and communications.....		+3,151	3,151
Other:			
Space rental (St. Mary's Infirmary).....		+8,107	8,107
Food (patients).....		+9,635	9,635
Laundry.....		+525	525
Emergency patient fund.....		+250	250
Total award.....	79,850	0	79,850
Grantee contribution.....	263,402	+47	263,449
Total.....	343,252		343,299

Form LE-411
(Rev. 4-15-65)
**U.S. DEPARTMENT OF JUSTICE
OFFICE OF LAW ENFORCEMENT
ASSISTANCE**
**APPLICATION FOR GRANT
Page 3**
Detailed Project Budget
☐ Complete Project

 Period from December 1, 1967
☐ First Year Only (projects exceeding 16 months)

 Through November 30, 1968

A: Personnel (Employees and Consultants)	Percent of Time Devoted	Annual Salary	Requested of OLEA	Category Total
(1) Employees (list each position)				
See Continuation Sheet				
(2) Consultants (list by individual or type)		Fee		
(3) FICA, Retirement, etc. (employees only)				
See Continuation Sheet				\$ 58,182

B. Travel (Transportation and Subsistence) (Itemize)	
None	
	\$ -0-

C. Supplies, Communications and Reproduction, (Itemize)	
See Continuation Sheet	
	\$ 3,151

D. Other (Equipment, Miscellaneous and Indirect Costs) (Itemize)	
See Continuation Sheet	
	\$ 18,517

E. Total Amount Requested (Sum of Categories A through D above)	\$ 79,850
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F. Total Grants Contribution (Page 2, Item IV)	\$ 253,449
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[Continuation Sheet—p. 3, item A]

PERSONNEL (EMPLOYEES AND CONSULTANTS)										
Percent of time devoted	Annual salary	Police department contribution (Dec. 1, 1967, to Dec. 23, 1967)	Requested of OLEA (Dec. 24, 1967, to Dec. 31, 1967)	Requested of OLEA (Jan. 1, 1968, to Mar. 31, 1968)	Requested of OLEA (Apr. 1, 1968, to Nov. 30, 1968)	Police department contribution (Apr. 1, 1968, to June 30, 1968)	Police department contribution (July 1, 1968, to Nov. 30, 1968)	To be paid by State (Dec. 1, 1967, to June 30, 1968)	To be paid by State (July 1, 1968, to Nov. 30, 1968)	
(1) Employees:										
Medical director, Joseph B. Kendis, M.D.	50	\$22,000	0	0	0	0	0	\$6,419	\$4,581	
Assistant medical director, Cornelius Hogan, M.D.	50	19,200	0	0	0	0	0	5,600	4,000	
Chief social worker	100	11,700	0	0	0	0	0	6,825	4,875	
Staff social worker	100	7,700	0	0	0	0	0	3,205	3,205	
3 registered nurses (at \$7,300)	100	21,990	1,992	1,305	0	1,336,50	0	4,494	9,125	
5 licensed practical nurses (at \$5,000)	100	25,000	1,562	520	\$16,668	5,7523	6,87167	0	7,377	
11 attendants (1 half time) (at \$4,300)	100	45,150	2,820	942	\$10,033	3,328	5,544	0	0	
Medical students (at \$2 per hour)	100	13,312	852	260	3,328	1,125	1,875	0	0	
Secretary	100	4,500	282	93	1,328	875	1,456	0	0	
Housekeeper	100	3,500	219	75	875	875	1,456	0	0	
Planning and Research Division, St. Louis Police Department, person- nel:										
Division director, Capt. Frank Mateer	25	10,500	0	0	0	0	0	0	0	
Project codirector, associate, Mr. Michael Laski	100	8,392	0	0	0	0	0	0	0	
Research assistant, Mr. Larry Pattison	80	7,993	0	0	0	0	0	0	0	
Patrolman Edwin Pohl	80	8,060	0	0	0	0	0	0	0	
Patrolman Harold Schlegel	100	8,060	0	0	0	0	0	0	0	
Patrolman Delos Schaefer	100	8,060	0	0	0	0	0	0	0	
Statistical clerk, Miss Margaret Bolesina	60	5,411	0	0	0	0	0	0	0	
Chief clerk, Mr. Richard Bumann	5	5,965	0	0	0	0	0	0	0	

See footnotes at end of table.

[Continuation Sheet—p. 3, item A]—Continued

PERSONNEL (EMPLOYEES AND CONSULTANTS)—Con.											
(1) Employees—Continued St. Mary's Infirmary personnel:											
Percent of time devoted	Annual salary	Police department contribution (Dec. 1, 1967, to Dec. 23, 1967)	Requested of OLEA (Dec. 24, 1967, to Dec. 31, 1967)	Requested of OLEA (Jan. 1, 1968, to Mar. 31, 1968)	Requested of OLEA (Apr. 1, 1968, to Nov. 30, 1968)	Police department contribution (Apr. 1, 1968, to June 30, 1968)	Police department contribution (July 1, 1968, to Nov. 30, 1968)	To be paid by State (Dec. 1, 1967, to June 30, 1968)	To be paid by State (July 1, 1968, to Nov. 30, 1968)		
100	\$12,000	0	0	0	0	0	0	0	0	0	0
100	9,000	0	0	0	0	0	0	0	0	0	0
100	3,016	0	0	0	0	0	0	0	0	0	0
50	6,240	0	0	0	0	0	0	0	0	0	0
60	7,200	0	0	0	0	0	0	0	0	0	0
50	6,000	0	0	0	0	0	0	0	0	0	0
10	6,000	0	0	0	0	0	0	0	0	0	0
50	8,400	0	0	0	0	0	0	0	0	0	0
50	5,824	0	0	0	0	0	0	0	0	0	0
50	3,120	0	0	0	0	0	0	0	0	0	0
25	4,800	0	0	0	0	0	0	0	0	0	0
(2) Consultants:											
David J. Pittman, Ph. D., director, Social Science Institute, Washington University, St. Louis, and consultant to the police department											
50	3,750	0	0	0	0	0	0	0	0	0	0
Laura E. Root, M.S.W., research associate, Social Science Institute, Washington University, St. Louis, Consulting psychiatrist (at \$40 for 1 visit per week)											
10	12,000	0	0	0	0	0	0	0	0	0	0
(3) FICA:											
FICA (at 4.4 percent)											
Workman's compensation											
Total											
		7,114	2,302	27,948	27,932	18,314	17,673	28,885		32,626	

1 2 registered nurses.

2 1 registered nurse.

3 3 registered nurses.

4 3 full-time, 1 half-time attendants.

1 7 attendants.

4 4 attendants.

3 3 attendants.

Note: Total personnel cost (December 1, 1967 to November 30, 1968), \$162,794.

[Continuation sheet—p. 3, item C]

	Total annual cost	Requested of OLEA (Jan. 1, 1968– Mar. 31, 1968)	Police Department contribution (Apr. 1, 1968– Nov. 30, 1968)	Police Department contribution for December 1967
C. Supplies, communications, and reproduction:				
1. Office (pencils, paper, etc.)	\$500	\$125	\$333	\$42
2. Telephone (local and long distance), telegraph, postage	1,000	250	667	83
3. Medical supplies and medications (for patient treatment)	10,000	2,500	6,670	830
4. Replacement of sheets (6 sheets per bed, per year equals 180 at \$3.28 each)	591	148	394	49
5. Replacement of pillow cases (6 pillow cases per bed, per year equals 180 at \$0.78 each)	141	35	94	12
6. Replacement of towels (50 dozen at \$4.90 per dozen)	245	61	164	20
7. Replacement of wash cloths (50 dozen at \$1.35 per dozen)	68	17	45	6
8. Laundry soap (46 pounds per month at \$0.11 per pound)	61	15	41	5
Total	12,606	3,151	8,408	1,047

[Continuation sheet—p. 3, item D]

D. Other (equipment, miscellaneous and indirect costs):				
1. Rental for 3d and 2d floors at St. Mary's Infirmary (19,074 square feet, utilities, 30 beds and bedding, hospital furniture) at \$1.70 a square foot	\$32,462	\$8,107	\$21,617	\$2,702
2. Food for high protein meals (based upon a food cost of \$4.05 per patient, per day, and an average daily patient population of 26)	38,540	9,635	25,693	3,212
3. Laundry (a fixed flat fee to be paid on a monthly basis at \$175.16 per month)	2,102	525	1,402	175
4. Emergency patient fund ¹	1,000	250	667	83
5. Insurance—For payment of comprehensive general liability and hospital professional insurance	2,000	0	2,000	0
Total	76,068	18,517	51,379	6,172

¹ The emergency patient fund of \$1,000 is necessary to provide indigent alcoholics with bus fare for employment interviews and housing arrangements. These moneys will insure transportation of the indigent to the other agencies of referral which are part of the rehabilitation program. It also provides for temporary food and lodging while the indigent is awaiting employment and/or his first paycheck, or admission to another helping referral agency. This fund, likewise, will cover other necessary minor expenditures of the indigent.

APPLICATION FOR GRANT

BUDGET NARRATIVE

Begin below and add as many continuation pages (4a, 4b, etc.) as may be needed to complete the required justification and explanation of the project budget.

A. PERSONNEL (EMPLOYEES AND CONSULTANTS)

1. *Employees.*—The budget of this application indicates that a total of forty-seven (47) people, excluding medical students, will be involved in the operation and administration of the St. Louis Detoxification Center. During the period of December 24, 1967 through March 31, 1968, OLEA funds will provide for the employment of: two (2) Registered Nurses, five (5) Licensed Practical Nurses, eleven (11) Attendants (one on a half-time basis), the Medical Students, the Secretary, and the Housekeeper.

It is to be noted that during the period of January 26, 1968 through February 9, 1968, OLEA funds may have to be used for the salary of two Secretaries, and this revised budget includes the funds necessary to cover this situation. The Secretary is terminating employment on January 26, 1968. The replacement Secretary, if obtained, will start employment on January 26, 1968 to provide for a one day "break in" period. Thus, the payroll may include two Secretaries during the period of January 28, 1968 through February 9, 1968.

During the eight month period of April 1, 1968 through November 30, 1968, OLEA funds will provide for the employment of five (5) Licensed Practical Nurses and four (4) Attendants (one on a half-time basis).

During the seven month period of December 1, 1967 through June 30, 1968, the State of Missouri will assume the payment of salaries by placing the following positions on its payroll: Medical Director, Assistant Medical Director, Chief Social Worker, Staff Social Worker, and one (1) Registered Nurse. In addition to these positions, the State of Missouri will also assume the payment of salaries during the five month period of July 1, 1968 through November 30, 1968, for the following positions: two (2) Registered Nurses and three (3) Attendants.

The St. Louis Metropolitan Police Department assumed the Detoxification Center payroll cost as a grantee contribution for the period of December 1, 1967 through December 23, 1967.

During the three month period of April 1, 1968 through June 30, 1968, the St. Louis Metropolitan Police Department will provide funds for the employment of the following positions: two (2) Registered Nurses, seven (7) Attendants, the Medical Students, Secretary, Housekeeper, and the consulting Psychiatrist.

During the five month period of July 1, 1968, through November 30, 1968, the St. Louis Metropolitan Police Department will provide funds for the employment of the following positions: four (4) Attendants, the Medical Students, Secretary, Housekeeper, and the consulting Psychiatrist.

The St. Louis Metropolitan Police Department will contribute the services of eight (8) Planning and Research Division personnel and the services of David J. Pittman, Ph. D., Consultant. The Sisters of St. Mary will contribute the services of eleven (11) St. Mary's Infirmary personnel.

2. *Consultants.*—The Medical Director (Project Co-Director) and the Project Co-Director from the St. Louis Police Department will have available to them, on an as-needed basis, the consultation of two recognized experts in the field of alcoholism and alcoholism treatment. These experts, David J. Pittman, Ph. D., Director of the Social Science Institute of Washington University, St. Louis, and Laura E. Root, M.S.W., Director of the Alcoholism Education Program of the Social Science Institute of Washington University, St. Louis, will provide guidance to insure the proper operation and administration of the Center.

3. *FICA, Retirement, etc.* FICA costs have been calculated at 4.4% of the total salaries requested of OLEA.

Workmen's Compensation has been estimated according to the rates that currently apply to St. Mary's Infirmary, with an allowance for a rate increase. To calculate the cost at the current rate, the total salary for Professional (8833) Employees is multiplied by a rate of .28%. The total salary of the Other (9040) Employees, which includes only the housekeeper, is multiplied by a rate of 1.23%. These two products are then multiplied by an experience credit of 74% for hospitals operated by the Sisters of St. Mary.

Mr. ROGERS. This is a 30-bed facility?

Mr. PITTMAN. Yes.

Mr. ROGERS. How many people do you take care of a year?

Mr. PITTMAN. In the first 12 months of operation, about 1,400 persons were sent through the center. This is about 80 percent of the "drunk on street" cases.

Mr. ROGERS. What is the staffing of this center?

Mr. PITTMAN. It involves two physicians, one psychiatrist, and a consultant, one psychiatric resident, and a full complement of staff, approximately five nurses.

Mr. ROGERS. You operate on a 24-hour basis?

Mr. PITTMAN. Yes, full medical coverage, 24 hours a day.

Mr. ROGERS. All the patients brought in are kept in bed? In other words, do you do any, in effect, outpatient treatment?

Mr. PITTMAN. Immediately, they enter into the acute treatment phase, which Dr. Carter was mentioning, in which delirium tremens or hallucinations are treated, and then they are moved to the ambulatory part of the unit in which a group of social workers attempts to make a plan with the individual, in terms of aftercare, to utilize mental health resources in the community.

One of the major deficiencies are the transitional resources, or the halfway houses, or the facilities that are involved in the third part of H.R. 15758. But the social workers attempt to make a plan for outpatient care, referral to other agencies for more intensive care or long-term care in the State hospital, and so forth.

An emergency diagnostic center might be another way of putting it.

Mr. ROGERS. So they can then be referred from there if they need long-term care?

Mr. PITTMAN. Yes.

Mr. ROGERS. Do you have any difficulty in getting them into long-term care?

Mr. PITTMAN. Yes, sir. We have had extreme difficulty in getting long-term care for some of these patients because they are at the bottom of the economic ladder, and their conditions are extremely complex. But that has improved dramatically since the State division of mental health has become involved in this particular project. Their facilities are now available.

Mr. ROGERS. Could you give me a typical case that is brought in? How long would he stay in emergency?

Mr. PITTMAN. Approximately 24 to 48 hours in the emergency unit, approximately 4 to 6 days in the ambulatory part.

Mr. ROGERS. Did I understand you to say this is voluntary?

Mr. PITTMAN. No, it is run by the police, so it is not voluntary. It has taken the place of the drunk tank. Instead of taking people to the jail—

Mr. ROGERS. Instead of that you bring them here, so it is not really voluntary, then.

Mr. PITTMAN. No.

Mr. ROGERS. Suppose they were to leave?

Mr. PITTMAN. If they leave against medical advice, the procedure is presently no prosecution of the summons. In other words, if they leave, then we emphasize the voluntary aspect within the police procedure.

Mr. ROGERS. So there is nothing to compel them, then, but if they go through this procedure, the case is not—

Mr. PITTMAN. Not heard in court.

Mr. ROGERS. Is there any procedure where you wait until there is a clearance given by the doctor and then dismiss the case?

Mr. PITTMAN. If they remain in the center, the summons is automatically canceled.

Mr. ROGERS. Suppose they leave. Would the case be prosecuted?

Mr. PITTMAN. It could be, but it is not.

Mr. ROGERS. As a matter of fact, you don't.

Mr. PITTMAN. No; we don't.

Mr. ROGERS. Is this tied in with a community health center?

Mr. PITTMAN. Originally, it was not, and it was necessary to energize the community mental health center to become involved. It is now partially supported by the State division of mental diseases in Missouri, and this required the mobilization of community concern.

We had originally hoped these people would be treated in community mental health centers.

Mr. ROGERS. Is there any reason why community mental health centers could not undertake this treatment?

Mr. PITTMAN. There is no reason they should not if they have the desire, motivation, and willingness to do it.

Mr. ROGERS. What do you estimate the population of the alcoholics in the area served by this center to be?

Mr. PITTMAN. In the city, we carry an estimate of approximately 50,000 alcoholics, of which approximately 5,000 to 6,000 would fall into this area. Most alcoholics are not police cases.

Mr. ROGERS. Can someone come in for voluntary treatment?

Mr. PITTMAN. Not to this facility, but we have the community mental health center unit, and they are referred to them.

Mr. ROGERS. Are the 30 beds sufficient to serve the population?

Mr. PITTMAN. No, sir. We have had great financial problems in the sense of slowly but surely increasing from 24 to 30 beds, and we feel that approximately 36 to 40 beds will cover it.

Mr. ROGERS. That would be about correct for this service for this 5,000 or 6,000 patients that you feel are chronic?

Mr. PITTMAN. Yes.

Mr. ROGERS. What would that ultimate cost be?

Mr. PITTMAN. Approximately \$400,000 is the estimate.

Mr. ROGERS. What is the overall population of St. Louis?

Mr. PITTMAN. 700,000 in St. Louis City.

Mr. ROGERS. If you would let us have a complete breakdown, it would be helpful to the committee.

Mr. PITTMAN. I will be glad to do that.

(The following document was received by the committee:)

PRELIMINARY EVALUATION REPORT OF "THE ST. LOUIS DETOXIFICATION DIAGNOSTIC AND EVALUATION CENTER"

INTRODUCTION

The St. Louis Detoxification Center has been in operation since November 18, 1966 under funds provided by Grant No. 93 from the Office of Law Enforcement Assistance Act, the following is a preliminary evaluation of some of the results achieved in the initial period of this operation. The underlying philosophy of the Center is a humanitarian theme which acknowledges that the alcoholic offender is a sick individual who involuntarily displays the symptoms of his disease. It has long been recognized that the "revolving door" process of arrest, incarceration, release, and rearrest has no rehabilitative effect upon the individual. Rather than achieving rehabilitation, this process caused further harm and suffering to those individuals whom we might term the chronic police case inebriate.

The Detoxification Center is a major forward-looking step in eliminating the "revolving door" process. It effectively removes these individuals from the criminal process and places them in the context of a medical, social and psychological treatment milieu. The results reported below, although preliminary, demonstrate explicitly that the Center has been successful in both goals. In addition to these long range goals, there exists a knowledge that criminally processing these individuals is a time consuming procedure which creates a heavy burden not only on law enforcement, but upon the courts and correctional systems as well.

In terms of both the grant stipulations and the continued impact of the socio-legal reform movement in this area, a comprehensive evaluation of the Center is being carried out. The evaluation can be dichotomized into the following categories. The macro-social category deals with the impact of the Center's operation on those agencies and institutions traditionally endowed with the responsibility for dealing with this social problem. This section will consist of a simple cost accounting procedure to weigh the costs of the treatment program against the costs of the continuance of the old criminal process system. Tangible gains would be in the form of patrol time saved, reduced clerical operations, adminis-

trative efficiency and the reduction of supplies and other resources consumed in support of the criminal processing of these individuals. These savings on the part of the affected agencies and institutions, rather than reflecting budgetary excesses are in fact merely "paper economies" which show what proportion of their present resources may be reallocated to the other pressing problems in our society.

This report leaves aside the first category of the evaluation and focuses on the infra-social level of analysis. The clinical evaluation of the patient population for both before and after treatment gives the positive side of what can and has been accomplished by treating the revolving door chronic inebriate. As a demonstration project, the Center has been a pioneering effort, particularly in terms of its sponsorship under the St. Louis Metropolitan Police Department. It is not, however, a demonstration in the sense that it is an untried or untested idea. This would be tantamount to saying that we need proof that treatment measures are better than current punitive procedures under the criminal justice system. There can be no argument that rehabilitation is better than simply punitive incarceration. It is rather the job of this evaluation to show how much better and in what ways our resources can be better utilized in dealing with the chronic police case inebriate.

THE CENTER IN OPERATION

The first question which must be answered is simply, "Who are these people whom we are treating?" Since the Center opened, until July 1, 1967 there has been a total of 548 admissions. A profile of this group demonstrates that we are indeed treating the chronic police case inebriate. Some of the indices which clearly point this out are the demographic characteristics of race, sex, age, marital status, educational level, income, etc. By comparison, the similarity between the patient population and the drunkenness offender for the year of 1966 shows high congruence. If we limit ourselves to those individuals who were arrested three or more times during the year 1966, the parallels are obvious.

	Average age	Percent male	Percent female	Percent White	Percent Negro
1966 arrestees (chronic).....	49.4	91	9	71	26
Treatment group as of July 1, 1967.....	48.1	91	9	83	17

A breakdown of the marital status of the treatment group lends further support to the idea that we are reaching the target population for whom the Center was designed.

<i>Treatment group as of July 1, 1967</i>	<i>Percent</i>
Single	40
Divorced	27
Married	21
Widowed	6
Separated	6

A further analysis of the treatment group yields the statistic that per admission these individuals had an average of 1.6 arrests during the year 1966. Many individuals have extensive police records, some of whom had in excess of 100 arrests for public intoxication previous to treatment.

These personal characteristics are highly consistent with the findings of other studies of the skid row alcoholic or the chronic police case inebriate. The patients averaged less than an eighth grade education. Approximately 47 percent of those admitted had an eighth grade education, or less. Only 29 percent entered but did not finish high school, while only 24 percent have an education of high school or beyond. Less than 1 percent completed college. The average weekly income of the patients at the time of admission was \$48.75. Fully 34 percent were not gainfully employed at the time of admission. Some of these, however, are receiving income through old age pensions, disability payments, and very few are on relief rolls.

Not only can it be demonstrated that the Detoxification Center is dealing with the revolving door inebriate, but is also effectively eliminating the revolving door process in St. Louis. The Center is drawing from three out of a total of nine police districts. It serves those districts which accounted for 82 percent

of all public drunkenness charges registered in 1966. Below is a table which shows the arrests for the time the Center has been in operation and the comparable period of the previous year.

	December	January	February	March	April	May	June
Arrest totals for previous year (1965-66)	205	162	145	223	221	173	202
Arrest totals while center in operation (1966-67)	82	56	64	76	84	75	86
Decrease of (percent)	60	66	56	66	62	57	58

These figures represent the total drunkenness offenses for *the entire City*. The foregoing data leave no doubt that the Center is indeed treating the chronic police case inebriate, for whom it was intended.

EVALUATION OF TREATMENT PROGRAM

Before proceeding with the patient analysis, an over-view of the referral network and after-care program is presented. Of the 548 patients admitted as of July 1 of this year, approximately 7 percent are leaving before the end of the seven-day treatment. This is a very low percentage considering that the treatment program is administered on a purely voluntary basis. Another 8 percent of the patients were transferred to various state and city institutions to continue their physical and mental rehabilitation. Many in this latter group without the treatment and diagnostic services of the Center would have suffered serious consequences, possibly even death due to other complicating diseases.

The following dispositions can be reported for those who went directly back into the community after treatment. Approximately 43 percent were found not to need assistance in employment. Seventeen percent were offered and accepted referrals for employment. This then is 60 percent of the patient population who upon their return to the community had a productive self-supporting role to fulfill. Fully one-third or 33 percent were offered employment assistance but refused our help in this area. Many of these people stated they preferred to "make it on their own." Another 7 percent were not offered employment assistance. For the most part, this latter group was composed of retired and/or disabled persons who received some form of support or were adjudged to be unemployable.

In the area of housing it was found that 43 percent had a relatively stable residential setting to return to, another 23 percent were offered and accepted referrals for living accommodations. This means that approximately 66 percent of those returning to the community had adequate housing awaiting them. As in the case with employment, 33 percent refused referrals for housing. These were, in the main, individuals who preferred to return to the more familiar, though inadequate, accommodations they had in the skid row environment. Less than 1 percent left the Center without the benefit of the offer of adequate housing arrangements.

It was anticipated that since we admittedly are dealing with a chronic disease, a certain percentage of the patients would return for treatment more than once. In the more than eight months of operation since the Center has opened, the readmission rate is presently 28 percent. Seventy-six percent of the treatment group have been admitted only once. Another 14 percent have two admissions, while only 10 percent have been admitted more than twice since the Center opened. Although no complete statistics have been compiled to date, there do seem to be significantly fewer police contacts with the treatment group after treatment as compared to the arrest rate prior to the opening of the Center. Once one accepts the chronicity of this disease and is aware of the fact that on the average our treatment group has been unsuccessfully coping with their alcoholic problem in excess of 14 years, this readmission rate seems low, particularly in comparison with the revolving door process prevalent in some other major cities. The above results indicate the opportunities provided by the Center's treatment program and referral network.

For the most part these individuals are the chronic police case inebriates who have become "institutionalized." Their life cycle exhibits not only a dependency on alcohol but also dependency on the various agencies and institutions of our society which contribute to the maintenance of their bare existence.

PRELIMINARY CLINICAL EVALUATION

Among those subjects being treated at the Center, a detailed clinical evaluation is being conducted on a sample to determine the rehabilitative gains from this therapeutic setting. The evaluation consists of a series of before-treatment characteristics on which each individual studied is rated. Follow-up interviews are conducted after a minimum period of 90 days from the patients' first discharge. Three areas are rated by the use of scales which have been developed specifically for this treatment population. The scaled items are residential accommodations, employment and drinking patterns. The scales used are not presented in full in this report; however, a complete description of all instruments will be given in the final evaluation.

At present the evaluation is past the mid point. One hundred patients have been located and follow-up interviews conducted. As the study is not yet complete, the findings in this preliminary report are tentative; however, these trends seem to be a good approximation of the final results.

The data used for the before treatment measure are drawn from the patients' admission forms, medical records, social histories (conducted by a social worker at the Center), and the records of the St. Louis Police Department. The simple before and after design was deemed most appropriate in that each patient would set his own standard in assessing any change. This retrospective-prospective model to a great extent avoids the necessity of establishing success standards. This rationale rests on two assumptions, first, that alcoholism is a progressive disease. Deterioration in the individual is markedly uniform in the alcoholic's life, this is particularly true for the chronic police case (inebriate). Second, without some therapeutic intervention into the disease progression, the prognosis is hopeless. Success then in this study rests on the ability of the measures to demonstrate either the arresting of the disease progress or improvement where found. The decision was made to focus on the qualitative changes after treatment. It was feasible to set up categories within some of these scales so that a continuum appeared imparting the qualities or ordinal ranking between classifications. This is made possible due to the above assumptions that in the advanced stages of alcoholism, there is a pronounced downward movement in the socio-economic ranking and, the clustering of certain variables (which are actually indices of socio-economic standing) is uniform enough to allow the generalizations implicit in the classification scheme.

In dealing with the scale items, the lower the ranking the lower the socio-economic standing of the individual. For one to move into higher categories on any of these scales would represent a significant positive change in his life style since receiving treatment.

RESIDENTIAL ACCOMMODATIONS

The high mobility of this problem group has been characterized in a number of ways by the experts in the field of alcoholism. The homeless man stereotype illustrates the migratory patterns and social isolation of this group. This would seem to be of a piece with other personality and social characteristics of the indigent alcoholic all of which points to his inability to assume responsibility and/or function in a stable capacity. This scale deals with two correlated variables: first, the frequency with which the subject finds shelter and, secondly, the type of shelter or lodging to which the individual typically has access.

Ratings	1	2	3	4	5	6	7	Total
Before treatment.....	6	5	8	20	28	11	22	100
After treatment.....	6	2	6	18	31	14	23	100

Of the first 100 patients evaluated, approximately 14 percent evidenced some significant improvement in their living arrangements. Eighty-three percent remained at about the same level of housing after treatment, while only 3 percent showed a decline in the frequency of shelter or the quality of their living arrangements.

Below is a table which gives a breakdown number of individuals assigned to each category before and after treatment. On this scale a rating of four or lower would place the individual in an undesirable and/or unstable residential setting.

In the before rating of these individuals, 39 percent had what would have to be considered inadequate housing arrangements. In the after treatment rating, 32 percent were still in the categories which would have to be considered inadequate. The average rating before treatment is 4.8 while on the after measure the average is 5.0. This is not an impressive change. A rating of four could be characterized as an individual who is a regular inhabitant of the missions, shelters and transient lodgings in or surrounding the skid area. This individual will average six days a week in some type of shelter and finds himself sleeping in streets and alleys of the city less than once a week. Category five is characterized as a structured environment such as a half-way house, accommodations with friends, relatives or some form of semi-permanent address with some food arrangements within the housing situation. The after treatment ratings (categories five through seven) indicate that 68 percent were at the time of the follow-up interview, living in a more or less stable structured or home-like environment. By far, then, the majority of patients after treatment had adequate residential accommodations.

EMPLOYMENT

Even with the progression of alcoholism, many of these individuals are still capable for some varying lengths of time to maintain their present job skills, if any, and to continue at a steady job. Progressively, as the individuals move lower and lower on the scale into the skid row environment, many other factors such as declining health, emotional instability, as well as such subtle factors as one's personal appearance, all enter to negate the possibility of steady employment. The employment scale takes into consideration both the type and frequency of employment.

At the time of intake, 34 percent were totally unemployed; that is to say for a period of three months prior to admission these individuals had not been gainfully employed. A rating of four or below would have to be considered under-employment. Categories five through seven may, depending on the individual's needs, i.e., dependents, housing, etc., be adequate for some of these individuals. The average rating for the first 100 cases evaluated was 3.8. This rating in terms of our scales must be considered inadequate by any criteria. The after-treatment ratings average 4.4. Although this is a statistically significant change, it would still have to be considered inadequate employment. Twenty-five percent of those followed-up had shown some significant improvement in their work patterns. This means that they were either working with more frequency or had achieved some stability in an occupational role. Sixty-six percent evidenced no significant change either positively or negatively. The interpretation of this figure must be tempered by the fact that some of these individuals already had adequate employment. We were unable to rate four of the individuals (or 4 percent) studied due to their being institutionalized for the majority of the time since their release. Only 5 percent according to our scales showed a decline in their employment.

Rating ¹	1	2	3	4	5	6	7	Total rated
Before treatment.....	18	8	17	3	10	19	9	84
After treatment.....	14	8	13	2	8	10	25	80 ²

¹ Excluded are 10 retired patients and 6 individuals receiving disability compensation.

² 4 patients at followup were institutionalized.

This table shows 38 percent of the study group having "regular" employment as evidenced by a rating of five or higher at the time of admission. Forty-three percent had achieved this level by the time of the follow-up interview. This latter figure of 43 percent is not indicative of the complete employment picture. Ten percent of the study group were retired and 6 percent received disability benefits, hence, a total of approximately 59 percent could be reported as self-sufficient to an appreciable degree three months after receiving treatment.

INCOME

Since the modal occupation of the treatment population is casual day labor, income was best estimated on a per weekly basis. The gross average weekly income of the study group was \$48.75 at the time of admission. This figure

represents all forms of cash income including pensions, disability payments, welfare, etc. Fifteen percent reported no income in the intake rating. The same was true of only 10 percent on the after-treatment measure. At the time of the follow-up interview the average weekly income for the study group had risen to \$53.27 for a net average gain of \$4.52 per week. Sixteen of the study group are responsible for this increase. These, who showed improvement, averaged a rise in weekly income amounting to \$21.62. Seventy-two percent remained at approximately the same level with 8 percent having decreased income. The remaining 4 percent were not scored as was the case with employment.

HEALTH

At the outset it was felt that the most immediate and marked effects of treatment were to be found in the areas of health. None of the evaluation team can claim competency in the area of medicine; hence, this measure proved to be unscaleable. In an attempt to achieve some assessment, this evaluation is based on gross factors which are readily available during the interview process. In order to achieve a rating of "improved," the patient must display a significant change evidenced by such things as weight gains, increased appetite, cessation of or a decrease of polyneuritic pains, or the disappearance of other complicating symptomatology (DT's, blackouts, etc.). Fifty-six of the study group showed marked improvement in their physical well-being based on the above factors. Thirty-five percent displayed no significant improvement and 9 percent showed a decline in overall health.

For half of these individuals, the Center represented the first medical treatment they had received for alcoholism. Almost all subjects indicated during the follow-up interview that the care they received at the Center was the first sign, in a long time, that "somebody cared about me." The interviewers expressed the opinion that perhaps the therapeutic effects were even greater for the individual's mental health than upon his physical self. The mere fact that a seven-day program of nutrition, sanitation and mental hygiene would leave its effects on such large numbers of these individuals three months after the treatment period is evidence of the accomplishments which can be made with this group of "hopeless people."

DRINKING

The area of drinking is the most crucial test to be applied to the treatment program. Rehabilitative gains in any other area must be seen as temporary unless a concomitant improvement is displayed in the individual's drinking patterns. The question is not simply a matter of sobriety or insobriety so much as how well the individual copes with his problem. Primarily, this scale measures the frequency and duration of the drinking bouts in ratio to the periods of sobriety as representative of one's ability or inability to deal with his dependency on alcohol.

At the time of admission the medical rating was category I. This rating represents a prolonged drinking pattern where the individual would have to be drinking steadily (daily) for more than two months prior to rating and the quantity of alcohol consumed would have to exceed approximately two fifths of wine or one fifth of whiskey, gin, vodka, etc. per day. The average rating on intake was 2.9. On the basis of our experience with these scales it would appear that a rating of four or lower negates the maintenance of any semblance of adequate functioning in the areas of familial or employment roles or a stable residential setting over any appreciable length of time. Seventy-six percent of the patients admitted were rated four or below. The remaining 24 percent were marginal in their capacity to function with any degree of normalcy. No one achieved a rating of seven at the time of admission.

The after-treatment ratings showed 51 percent of the patients studied displaying some significant improvements in their ability to control their consumption of alcohol. Approximately 46 percent demonstrated no significant improved control, while only 3 percent actually deteriorated in their drinking pattern. The average rating achieved at the time of the follow-up interview was 4.1 for an average increase of 1.2 in the study group ratings. The frequency distribution of ratings was bi-modal being equally distributed with 21 individuals in both categories 1 and 7. For the categories of 5 through 7 which could permit some degree of stability or normalcy to prevail in the individual's life style we now find 51 percent after treatment as opposed to only 24 percent prior to treatment.

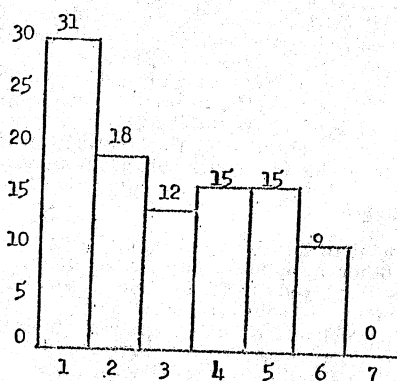
These results greatly exceeded those anticipated by all concerned. Fully 21 percent of the study group had been for all practical purposes dry since discharge until the time of the follow-up interview (see category 7). This time averaged a lapse of approximately 120 days of total sobriety. Certainly, by any standards, this 21 percent would represent unqualified success in treatment outcome. Below is a table of the ratings for the before and after treatment measures.

Ratings	1	2	3	4	5	6	7	Total
Before treatment.....	31	18	12	15	15	9	-----	100
After treatment.....	21	12	9	7	14	16	21	100

Following are two histograms which graphically illustrate the transitions in ratings achieved from the before-admission drinking patterns to the after-treatment drinking patterns displayed at the time of the follow-up interview.

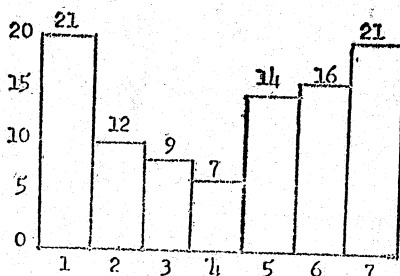
DRINKING SCALE

Before Treatment



Total Rated - 100

After Treatment



Total Rated - 100

RATINGS BASED ON DRINKING PATTERNS
DISPLAYED - 1 (most severe) to 7 (least severe)

One of the unusual findings during this study was that Negroes were disproportionately represented in this 21 percent who achieved what might be termed total success. Seventeen percent of the entire treatment population were Negroes. Eighteen percent of the study group were Negroes while 25 percent of the "drys" were Negroes. Of the possible alternative hypotheses, two are most reasonable and complementary. First, that the treatment they received initiated by a police contact was totally dissonant with all their expectations. In all cases the Negroes found themselves better clothed, better fed and more well cared for than they could ever remember. Somewhere in the treatment process their initial disorientation was turned into a positive motivational attitude. Although in retrospect the same process was noted with the white patients it was perhaps not of the same degree. Another very plausible explanation of this finding is that perhaps the Negro subculture has not imposed quite the same rigid value structure upon these individuals as one would find in the more middle class oriented whites. This would mean that the Negro offender would not experience the same degree of guilt over his drinking problem and hence, as a result, have one less problem to deal with at the time of discharge.

In all discernible characteristics the study group was representative of the total patient population, i.e., age, race, marital status, years of alcoholism, etc. One qualification exists; whereas females compose 9 percent of the patient population none was included in the follow-up study. Further, it was found that those achieving a rating of 7 after treatment on the average had slightly higher ratings in the other scales before admission. The significance of this has been demonstrated in other studies of this type, namely, that the type of treatment administered is not the determining factor for prognosis so much as the social setting the individual is taken out of and the setting into which he is placed after treatment. The implications of this finding are even more crucial in a program designed to handle the "revolving door" clientele. A strong referral network and an intensive after-care program is essential.

ARRESTS

The area of arrests has been left until this point because of the scant data available. The seasonal nature of this type of arrest rules out comparing equal time periods before and after treatment. Further, a significant percentage of the patients had been residents of this area for less than one year; hence, any measure based on a comparison of specific months for the year prior to opening the Center or since its opening could be grossly misleading due to incomplete data.

It is hoped that by the time of the final report this dilemma can be resolved satisfactorily. Earlier in the report the arrest figures for the City of St. Louis were cited showing a tremendous decrease. Even after adding the number of admissions to the current arrest rate there would still be a total decrease of 28 percent in police contacts with drunkenness offenders. The findings on our study group were an average of 1.6 arrests for 12 months prior to treatment as compared to an average of 0.4 after treatment. This latter figure is arrests plus readmissions over an average period of six months. This should be interpreted cautiously as the parameters of these figures have not been fully explored. However, it is safe to say that a significant decrease in police intervention can be noted after treatment.

The following table is presented in summary. The interpretation of these figures should be unequivocal. Where improvement is reported, it must be of a significant magnitude to the extent that the individual has, at least in some areas of his life, reversed this deterioration process. Many individuals who have received ratings of "remained the same" may well be in the process of establishing a new claim on life. It may prove to be unrealistic for this evaluation to demand significant demonstrable change in such areas as housing and employment in a three or four month period. This idea would seem to be supported by the findings in the area of drinking which would indicate more improvement than shown in the other scales. Further, improved control over one's drinking pattern is certainly a precondition to improvement in the other areas of life.

	Markedly Improved (percent)	Remained same (percent)	Deteriorated (percent)	Unable to rate
Drinking.....	51	46	3	0
Employment.....	25	66	5	4
Income.....	16	72	8	4
Health.....	56	35	9	0
Housing.....	14	83	3	0

Aside from this clinical picture one might ask the question "What has the impact of the Center been on the police?" Other than arrest figures, man-hours, and increased efficiency, this question may never be answered fully. The impact on the patrol officers has been as remarkable as in any other area under study. Many who were openly skeptical of the treatment program have expressed unqualified enthusiasm as a result of some of the Center's success cases whom they have known. Some have even gone so far as to volunteer their services both on and off duty in any way that they might further the treatment program.

St. Louis has always had a non-punitive approach to the problem of public intoxication. At the individual level officers are so sensitized to this problem that they have donated clothing and other useful articles to the Center. The acceptance of the treatment program on the part of the line officers could not help but be recognized when investigators in this research began to hear of informal shuttling procedures being conducted so that an individual would be found in one of the districts being served by the Center.

Mr. ROGERS. And any suggestion you have as to how this could best be incorporated into the community health centers that we already have authorized.

This is most helpful, and this is what we need, some specific information.

Mr. PITTMAN. Thank you, sir.

Mr. ROGERS. Thank you.

The next witness is Mr. F. Morris Lookout, industrial representative, Tulsa Council on Alcoholism.

We appreciate your presence here.

STATEMENT OF F. MORRIS LOOKOUT, INDUSTRIAL REPRESENTATIVE, TULSA COUNCIL ON ALCOHOLISM

Mr. LOOKOUT. Mr. Chairman and members of the committee, my name is F. Morris Lookout, and I represent the Tulsa Council on Alcoholism, Tulsa, Okla., for which I serve as industrial representative.

It is indeed an honor and a privilege to appear before this distinguished committee—and I thank you, Mr. Chairman, for the opportunity to testify in support of the Alcoholism Rehabilitation Act of 1968.

In my position with the Tulsa Council on Alcoholism, I am presently working with 30 business firms in the Tulsa area. Each of these firms now recognizes the significant impact of alcoholism on their company productivity. They also know by experience that it is much more profitable for them to treat their alcoholic employees and to rehabilitate them than it is to deny that the problem exists and to discharge summarily those employees with drinking problems.

This enlightened concept is now implemented by many firms of the Nation's business community. Eastman Kodak, North American Rockwell, Western Electric, Pittsburgh Plate Glass, and many other major firms across the country have recognized the economic feasibility of rehabilitating alcoholic employees who, aside from drinking problems, have proven to be productive employees.

I deal primarily in education, yet I know only too well there must be a balance between education and treatment. I know that before an alcoholism rehabilitation program can work for a company, it must have therapeutic resources to which the alcoholic employee can be referred. In Tulsa, and throughout Oklahoma, such facilities are rare and, in terms of the need, totally inadequate.

Thus, in view of the Supreme Court decision to be handed down within the next 2 months, which is likely to make it unlawful to hold alcoholics criminally liable for public drunkenness charges, the very limited number of facilities now available for treatment of company employees and others with less complicated cases of alcoholism will be overwhelmed with caseloads found by the courts to be alcoholics.

The provisions of title III, part A, of H.R. 15758 would make possible, immediately, the implementation of a much-needed alcoholism treatment program within the Tulsa Community Mental Health Center and other community mental health centers throughout Oklahoma. Without new facilities we face the same grave situation as was the case here in the Nation's Capital following the *Easter* decision.

Comprehensive programs of alcoholism care and control must become a part of the pivotal, basic institutions of our society. The provisions of title III, part A, of H.R. 15758 will provide a very constructive beginning to such needed comprehensive programs. It will provide a stimulus to legislators and to a broad spectrum of allied professional disciplines. And, as more and more of these key persons become interested and involved, more professionals will seek the training provided by title III, part A, of H.R. 15758.

That industry is vitally concerned throughout Oklahoma, not only in their own obvious stake in the problem of alcoholism but in the broader social and cultural implications, is evidenced by the fact that I am an ex officio member of the Tulsa County Bar Association, serving as technical adviser to its grievance committee, and I also serve as technical adviser to the Tulsa Division of the State Department of Corrections. These extra activities resulted from my industrial contacts.

I am a full-blooded American Indian and have a great interest in the problems of the Indians in this country, and I know that alcoholism is one of the most serious of those problems. I also know that, in those municipalities with a significant Indian population, the Indian continues to be jailed for public drunkenness on the slightest provocation. Yet the major proportion of these Indians are suffering from the illness of alcoholism. They should be treated as sick people and not as criminals.

I am therefore doubly pleased with the provisions of the alcoholism bill, title III, part A, H.R. 15758. It will serve a longstanding need from the business community standpoint, it will provide congressional intent that all alcoholics should be treated medically and not as criminals, and it will provide Federal resources to help accomplish a more humane and effective method of dealing with this tremendous problem in all communities.

Thank you, Mr. Chairman.

Mr. ROGERS. Thank you very much. We appreciate the testimony you have given.

Mr. Nelsen?

Mr. NELSEN. I have no questions. I wish to compliment the gentleman for his appearance. I wondered, are you acquainted with Congressman Reifel from South Dakota?

Mr. LOOKOUT. No, I am not.

Mr. NELSEN. He is a Sioux Indian, and he speaks the Sioux language. He is a competent Member of Congress, and he is very concerned about

the American Indian. He served with the Indian Bureau for a number of years. You should meet him while you are here.

Mr. LOOKOUT. I will do this. Thank you.

Mr. ROGERS. Dr. Carter?

Mr. CARTER. I want to compliment the gentleman on his excellent presentation.

Mr. ROGERS. Our next witness is Richard S. Cook, Chief, Division of Alcoholism, Illinois Department of Mental Health, Springfield, Ill.

STATEMENT OF DR. RICHARD S. COOK, CHIEF, DIVISION OF ALCOHOLISM, ILLINOIS DEPARTMENT OF MENTAL HEALTH; ACCOMPANIED BY WILLIAM N. BECKER, JR., ASSISTANT CHIEF, ALCOHOLISM PROGRAMS

Mr. ROGERS. The committee is delighted to have you here with us this morning. We will make your statement a part of the record following your summary. If you will, just sum it up for us.

Dr. COOK. I would like to introduce to you Mr. William N. Becker, Jr., who is assistant chief of the alcoholic programs in our State.

Mr. ROGERS. We are delighted to have you with us, Mr. Becker.

Dr. COOK. Mr. Becker has worked for many years with alcoholics in our State institutions. I have worked an equally long time with emphasis on outpatient care.

I would like to bring to you the wishes of Hon. Gov. Otto Kerner, who yesterday indicated that I should convey his request to you for the passage of this bill.

Also, the director of our department of mental health is in full support of this legislation.

I would like to read part of my statement to you.

The State of Illinois has forged ahead in providing a continuum of services on a statewide basis. We believe that bill, H.R. 15758, is a wise, timely, and urgently needed step in the right direction.

We urge its passage to provide the leverage enabling the delivery of a full range of services to alcoholics at different levels of severity and varying stages of their illness.

In endorsing this bill wholeheartedly we feel it incumbent to remind the committee that at present with the combined facilities available we treat less than 10 percent of the alcoholics in Illinois.

This bill reflects the needs of the Nation and has been hammered out of pooled experience of thousands of people in close cooperation with the legislators here in Washington, D.C. Those of us working in this difficult field believe that this pending legislation shows that you have heard us and have written down pronouncements and rules that go a long way to establish direction with us and to implement our efforts to gain control over this vast public health problem.

I would like to turn to the situation in Illinois to illustrate how well this legislation can fit with the progress in the State with regard to comprehensive community medical centers and comprehensive community mental health centers.

While it is occurring throughout the State, I would like to focus on the metropolitan area of Chicago, where the problem of alcoholism is especially acute.

In Chicago the city has been divided into many areas for medical and mental health planning. Plans are being made as rapidly as possible, translated into actual programs involving construction, assembly of staff, and offering of services.

It is most timely that we in the section on alcoholism programs be enabled to urge the appropriate authorities to include in their planning, programing, and services a complete continuum of care for the alcoholic in Chicago.

We believe that the time is now for reestablishing the alcoholic as a legitimate patient for coverage in every mental health, public health and welfare program. We believe each community throughout the State should provide the entry and some responsibility for the continuum of services for the alcoholic, and that it can be obtained through a program as provided in this bill.

We have been successful in Chicago in persuading some general hospitals to accept alcoholics for treatment during the acute phase of intoxication. We are providing a program of follow-up care designed to meet the need of each particular patient.

This comprehensive service for the alcoholic is in accordance with other welfare programs throughout the State.

To carry out this conception of establishing facilities for alcoholics in all of the newly planned and realized medical, mental health, public health, and welfare programs we need the provisions of this bill which amends the Community Mental Health Centers Act. We have plans, we have ideas for special facilities, and we are eager to carry through with research.

We urge that you make these hopes and visions attainable through enactment of this legislation.

(Dr. Cook's prepared statement follows:)

STATEMENT OF RICHARD S. COOK, M.D., CHIEF, ALCOHOLISM PROGRAMS,
STATE OF ILLINOIS DEPARTMENT OF MENTAL HEALTH

The State of Illinois has forged ahead in providing a continuum of services to alcoholics on a statewide basis. We believe that Bill HR-15758 is a wise, timely, and urgently needed step in the right direction. We urge its passage to provide the leverage enabling the delivery of a full range of services to alcoholics at different levels of severity and varying stages of their illness. In endorsing this Bill wholeheartedly we feel it incumbent to remind the Committee that at present with the combined facilities available we treat less than 10% of the alcoholics in Illinois.

This Bill reflects the needs of the Nation and has been hammered out of pooled experience of thousands of people in close cooperation with the legislators here in Washington, D.C. Those of us working in this difficult field believe that this pending legislation shows that you have heard us and have written down pronouncements and rules that go a long way to establish direction with us and to implement our efforts to gain control over this vast public health problem.

It is clear that three powerful forces are tied together by this Bill. One force is the combined effort of the 50 states to deal with alcoholism and to find ways and means of coping successfully with its many aspects. This involves highly trained specialists in increasing numbers who have reflected and expended great effort to learn about alcoholism. This force has been substantially aided by grants from such agencies as NIMH, VRA, and other Federal agencies.

The second force which exerts power by accelerating change is that of the Federal courts. The pending decisions by the Supreme Court regarding the status of the chronic alcoholic is setting in motion already many agencies, public and private, which must meet the potential thrust of new conditions. If it comes to pass that the acutely intoxicated man cannot be arrested for public intoxication if he is a chronic alcoholic, then the jail must be replaced by health agencies in

dealing with the chronic alcoholic. It is not news that available facilities are woefully inadequate to measure up to the consequences of the possible Supreme Court decision.

The third force is that of the Congress of the United States which can act to consolidate the power of the national effort thus far and the possible tumultuous consequence of the Supreme Court action. The enactment of favorable legislation could add the greatest impetus to the national effort in the management and rehabilitation of the chronic alcoholic.

Thus, we from Illinois see greatly the immediacy and necessity of the passage of this superbly conceived bill.

I would like at this moment to turn to the situation in Illinois to illustrate how well this legislation could fit with the progress in the State in regard to comprehensive community medical centers and comprehensive community mental health centers. While it is occurring throughout the State, I would like to focus on the metropolitan area of Chicago where the problem of alcoholism is especially acute.

In Chicago the city has been divided into many areas for medical and mental health planning. Plans are being made as rapidly as possible, translated into actual programs involving construction, assembling of staff, and the offering of services.

It is most timely that we in the Section on Alcoholism Programs be enabled to urge the appropriate authorities to include in their planning, programming, and services a complete continuum of care for the Chicago alcoholic.

We believe that the time is now for re-establishing the alcoholic as a legitimate patient for coverage by every new medical, mental health, public health, and welfare program. We believe sincerely that each community throughout the State should provide the entry and some responsibility for this continuum of services for the alcoholic and that it can be most effectively attained through a comprehensive alcoholism program, as provided in Bill HR-15758. We have been successful in Chicago in persuading some general hospitals to accept intoxicated alcoholics for treatment during the phase of acute intoxication. Following the medical management we are providing a program of follow-up care which will be designed to meet the particular needs of each patient. This comprehensive planning of services for the alcoholic is in accord with other health and welfare planning programs throughout the State.

To carry out this conception of establishing facilities for alcoholics in all of the newly planned and realized medical, mental health, public health, and welfare programs we need the provisions of this Bill which amends the Community Mental Health Centers Act. We have plans, we have ideas for special facilities, and we are eager to carry through with research. We urge that you make these hopes and visions attainable through enactment of this legislation.

Mr. ROGERS. Thank you very much.

Mr. Nelsen?

Mr. NELSEN. No questions.

Mr. ROGERS. Dr. Carter?

Mr. CARTER. No questions.

Mr. ROGERS. I recall the testimony received from the Bureau of Mental Health in operation in Illinois, and from the Governor, too, and the work that you had done there served as a model, somewhat, in drawing this legislation.

Do you anticipate these centers will be run in conjunction with your community mental health centers?

Dr. Cook. We are trying to provide treatment of alcoholics, but we feel we need funds through grants to enable the alcoholic to be treated.

Mr. ROGERS. Would you anticipate that perhaps a wing would be built onto the community mental health center?

Dr. Cook. Yes, it could work like that. I talked to Dr. Paul Neilsen, who is head of the Mile Square Area Community Mental Health Center, and in his plans, he envisages a building for, say, the care and treatment of alcoholics after the acute phase. He is willing to treat them in his hospital for acute intoxication and then have an after-care program in another building less expensive to operate.

Whether this is a new building or he would take over an existing building, he would include the alcoholics.

Mr. ROGERS. Would you have a detoxification center, in effect?

Dr. COOK. We don't want a separate, large detoxification center. We would like each medical center to accept and treat the alcoholic. We are providing funds for detoxification. We will pay on a contractual basis, or we could establish a unit with funds from some source in a medical or mental health center.

Mr. ROGERS. Would you let us have a rundown on how you would do the operation of this?

Mr. BECKER. We have recently submitted a proposal for a grant, and approximately \$350,000 from the State legislature for this program of buying medical care for the indigent alcoholic. Funds would also come from public aid to purchase medical coverage.

The idea is to contract for these services on a per diem basis. Particularly in the city of Chicago, we have a problem. In any one given day, we would have anywhere from 150 to 200 patients coming in. This could soon inundate a single program, so we are in the process of continuing to develop citywide programs in concurrence with the comprehensive health program services. Each of these programs will utilize the hospital in that area.

We will contract with them for their medical services in any one year.

Mr. ROGERS. What is the estimate of your population of alcoholics?

Mr. BECKER. Using the information we have, our public health statistics indicate we have in excess of 500,000 alcoholics in the State of Illinois. Over 80 percent of these reside in the Greater Chicago area.

During 1967 we admitted on a voluntary basis something like 7,000 alcoholics, and over 4,500 of these were in the Greater Chicago area. So we have been involved in the detoxification process for a long time.

We do need the opportunity for some comprehensive backup support that this comprehensive bill would supply.

Mr. ROGERS. Are you having any success with bringing about abstinence?

Dr. COOK. We are having a good deal of success in our State hospital programs, but what we are trying to do is keep the alcoholic in his local area, in his community for detoxification, and refer him there for followup care, and save our State hospitals for special treatment centers for the alcoholic who needs 30, 60, or more days of continued treatment.

Mr. ROGERS. Do you get into the treatment of narcotics?

Dr. COOK. In our State we have a council on narcotics, which is established by the legislature and appointed by the Governor.

Mr. ROGERS. Do you handle this in your program yet?

Dr. COOK. Not yet.

The pilot project is being established to try to determine what would be the best statewide program for narcotics.

Mr. ROGERS. What is your narcotics population?

Dr. COOK. About 60,000 would be an estimate.

Mr. ROGERS. Thank you very much.

If you would, let us have a breakdown on your operation.

Dr. COOK. Yes, sir.

(The following information was received by the committee:)

STATE OF ILLINOIS DEPARTMENT OF MENTAL HEALTH,
Springfield, Ill., April 1, 1968.

HON. PAUL G. ROGERS,
*Committee on Interstate and Foreign Commerce,
 U.S. House of Representatives, Washington, D.C.*

DEAR CONGRESSMAN ROGERS: First may we extend our appreciation for the privilege of appearing before your Committee. We hope that our contribution may help in some small way to assist you in reaching your decisions.

As you recall, during the Committee Hearings you requested information on our General Hospital Detoxification Program which I am enclosing.

Again, our deepest appreciation, and should you feel that we can be of assistance to you in any way, it will only be necessary for you to so advise.

Sincerely yours,

WILLIAM N. BECKER, JR.,
Assistant Chief, Division of Alcoholism.

Enclosure.

PROJECT

Section on alcoholic programs, Department of Mental Health, detoxification program

PROPOSAL

To provide emergency care for acutely intoxicated indigent persons in general hospitals. In this proposal the main emphasis is on a situation which involves the Chicago metropolitan area but it is our intention to include the entire state in our plans to offer care to acutely intoxicated patients.

RATIONALE

During the past five years it has become increasingly apparent to the Section on Alcohol Programs of a need for a program of mass management of the acutely intoxicated person at the community level. It is common knowledge in the field of alcoholism that the federal government, and the Nation as a whole, is becoming vitally aware of the need for more adequate care and treatment of the acutely intoxicated person. It is equally known that (a) the Supreme Court of the United States will issue a decision regarding compulsory care of the inebriate, the acutely intoxicated, and the chronic alcoholic; (b) that the American Bar Association and the American Medical Association are jointly sponsoring model legislation to assure the appropriate medical management of the alcoholic; (c) that the President of the United States recommended the "Alcoholic and Narcotic Addict Rehabilitation Amendments of 1968" (HR 15281) (Appendix V) to the 90th Congress.

With full knowledge of the above, the Section on Alcohol Programs strongly proposes the immediate establishment of a pilot project for the mass management of the acutely intoxicated and/or inebriated and/or the chronic alcoholic. In addition to preparing for the effect of the inevitable legislative action, this proposal will have a marked effect on the management of our present problem with acute and chronic alcoholics.

During the last nine months of the last fiscal year, 1,830 persons were assigned to the Department of Mental Health facilities through the hospital referral service for chronic alcoholics. (Appendix I) It is estimated that, as of 1967, there are in excess of 500,000 alcoholics in Illinois with the majority of them residing in Cook County. Utilizing 1967 statistics provided for us on February 13, 1968, by the Department of Mental Health Data Processing Division, there were 7,059 admissions to the Department of Mental Health for alcoholism, representing 30.3% of the total admissions to thirteen state hospitals and four zone centers. (Appendixes II and IV)

Our experience with this increasing number of alcoholic patients, particularly in the metropolitan Chicago area, indicate the following: (1) that the majority require medical management; (2) a large number of these patients do not want, will not, or cannot accept or benefit from treatment or rehabilitation in the alcoholism programs provided in our state hospitals; (3) a substantial number of this group could benefit more by being treated for the acute phase of intoxication and then referred to a variety of ancillary programs for appropriate care; (4) a reasonable number require no emergency medical or psychiatric care but do require direction for the above mentioned ancillary programs;

(5) that once these patients are inappropriately assigned to our state hospital alcoholism programs (a) they will continue to return, (b) they are inclined to leave before medically discharged or recommended discharge, (c) they tend to interfere with more effective programming for those who are more able to benefit from the programs.

OBJECTIVE

To establish a cooperative program between the Department of Mental Health, Section on Alcohol Programs, the Illinois Department of Public Aid, and the Cook County Department of Public Aid;

To provide emergency psychiatric care of indigent persons in general hospitals for acute intoxication;

To short-circuit the general flow of the alcoholic patient away from the state hospital alcoholism programs to the community agency programs.

PROGRAM

In response to this situation, we have developed a program which provides medical treatment for acutely intoxicated patients in certain acceptable general hospitals. (Appendix VII) Hospitals, where this care can be given, are available. Aside from the money requested by this grant, the cost of this care will be covered by payment from the Department of Public Aid and its county representatives in situations in which patients are eligible for coverage for medical expenses. We believe that some category of assistance will compensate for this service in a majority of cases. In other instances the cost will be paid by the patient's insurance, family, or by the patient himself. However, funds requested in this grant are vital because there will be a significant group of patients unable to pay from personal resources and yet not eligible for payment through any of the categories of assistance available through Public Aid. Funds from this grant request, also, enable us to assure each participating hospital against loss incurred through caring for our indigent patients. This program will include the entire state, depending upon where this programming is indicated and where local arrangements permit its development. The present most pressing situation is in metropolitan Chicago.

It is our expectation that this program will be a solution, or a very substantial step toward a solution, of the three conditions which we have long recognized as needing correction. This innovation of service is much more far-reaching in its implications. First, it is a step toward anticipating the tremendous demands, previously mentioned, which these changes will make on our health services. A second significant point is that this program is very much in keeping with the current decentralization of health services in general. We believe that it makes much better sense to treat the alcoholic patient in his own community and in existing health facilities or in those facilities which are being planned than to direct further effort toward establishing special installations for the care of the acutely intoxicated at this time.

The providing of medical treatment in general hospitals for acutely intoxicated people is only one phase of our plan. The question of intake is highly relevant. At the outset, patients would be admitted chiefly from the Hospital Referral Services and from the admitting service of other to be designated programs, but our chief mission is to pick up patients before they arrive at state hospitals. Since our program includes several general hospitals, we include a "clearing center" which would keep carefully compiled information regarding the movement of patients in and out of beds set aside for acutely intoxicated patients. This clearing center would serve all sources of referral, both in and out. Also, our net work of ancillary programs will be expanded to permit referral for ongoing aftercare. (Appendix VI)

At the outset, this program would not be sufficient to deal with all patients seeking hospitalization because of acute intoxication. For example, this program would have to be greatly expanded before it could accommodate the hundreds of intoxicated patients who are now jailed daily until they recover from the acute stages of intoxication.

The criteria for admission for medical treatment of the acute intoxicated would involve the following: (1) acute intoxication with or without complications; (2) indications that the patient cannot be restored to a nontoxic state in his home; (3) acceptance of hospitalization on a voluntary basis; (4) behavior compatible with admission to a general hospital.

The period of hospitalization would be brief, three to five days, in as many instances as possible. Screening and diagnosis would be done before discharge as much as practicable, but this could be completed at the clearing center. Based on the screening and diagnosis, an aftercare plan will be made on each case with appropriate referral to existing facilities in the area closest to where the patient resides. Referral could be to outpatient clinics, state hospital programs, halfway houses, missions, service centers, vocational rehabilitation, Veterans Administration, employment agencies, and public aid. Emphasis will be on follow-up from the very outset, although this is a very challenging task.

We visualize this program as a model for future expansion into both existing and planned medical services.

IMPLEMENTATION

Tentative plans have been made with three Chicago area general hospitals to initially involve themselves in this project. (Appendix VI) An attempt has been made to determine a per diem cost for each of the participating hospitals based on the latest cost analysis, as published by the Department of Public Health. Pending the approval of this grant, we have received a firm agreement with the Martha Washington Hospital (Appendix VII) tentative per diem amounts from Alexian Brothers and Grant Hospitals. As indicated in Appendix VII, the per diem rate for Martha Washington would be \$50 and it would appear that the other two hospitals would vary between that amount and \$60. The per diem amounts that we are attempting to establish with the participating hospitals include all charges excepting surgical and psychiatric services. Where it can be readily assessed that the patient requires either prolonged or intensive care for conditions other than detoxification, he would not be referred to this program.

Realizing that over 3,000 patients were admitted to Chicago area state hospitals in 1967, and that the rate of alcoholism admissions across the state rose 2,000 patients in 1967 over 1966, it would be extremely difficult to immediately meet the obvious needs, rather it is our intent to establish a pilot program with whatever funds are available and to extend the program as additional funds become available from other sources.

REQUEST

In view of the above, the Section on Alcohol Programs requests your consideration of funds in the amount of \$250,000 for the remainder of the present biennium. These funds augmented by funds from the Department of Public Aid and the cost shared by third parties, in behalf of our patients, will enable us to establish a pilot program for the management of the indigent alcoholic patient in the metropolitan Chicago area.

Recognizing that the same problems exist in other areas throughout the state, we further recommend consideration of an amount of \$100,000 to seed these programs where other funding and programs are not available.

ADMINISTERING AGENTS

That the Section on Alcohol Programs be responsible for the administration and supervision of the funds requested.

APPENDIX I

(Following paragraph extrapolated from Department of Mental Health Annual Report—July 1966–June 1967.)

The number of persons with a primary diagnosis of alcoholism continue to comprise more than one third of the non-emergency applications processed through this Unit. During the last nine months of the past fiscal year eighteen hundred and thirty (1830) persons were assigned to Department of Mental Health facilities as chronic alcoholics. Many had previous records of hospitalization. This group of patients demand services, and all too often misuse available facilities. Many are in need of medical attention, which is often denied at the only medical resource available to them. Many are undomiciled, estranged from families, and unemployed. They see in Department of Mental Health facilities

a temporary room and board situation as well as a place where medical attention is available if needed. It is felt repeated request for readmission may be due to a lack of adequate services for the alcoholic in our facilities, as well as a lack of motivation for change on the part of the patients. This writer is aware of the shortage of staff and space, however, a more concentrated effort to coordinate our present resources may prove definitive in the care and treatment of the alcoholic.

APPENDIX II

Estimated number of alcoholics in Illinois according to the Jellinek estimating formula, calendar years 1952-66

Year:	Estimated number of alcoholics
1952	308, 150
1953	333, 450
1954	322, 250
1955	303, 100
1956	331, 350
1957	358, 600
1958	341, 750
1959	360, 750
1960	371, 250
1961	372, 800
1962	392, 650
1963	404, 850
1964	413, 200
1965	403, 650
1966	¹ 460, 150
1967 (plus)	² 500, 000

¹ Subject to revision pending reporting of new facilities.

² Pending Revision.

Source: Department of Mental Health, Division of Planning and Evaluation Services, Statistical Research Section, June 30, 1967.

APPENDIX III

MALE ADMISSIONS TO ILLINOIS STATE HOSPITALS, FISCAL YEARS 1954-66

Year	Total admissions	Alcoholic admissions	Percentage
1954	8, 314	2, 955	35. 5
1955	8, 083	3, 141	38. 9
1956	9, 179	3, 860	42. 1
1957	9, 707	4, 433	45. 7
1958	9, 324	3, 918	42. 0
1959	8, 972	3, 565	39. 7
1960	9, 703	4, 142	42. 7
1961	10, 044	4, 279	42. 6
1962	10, 361	4, 120	39. 8
1963	9, 991	4, 094	41. 0
1964	10, 244	3, 955	38. 6
1965	11, 467	4, 665	40. 7
1966	12, 951	5, 263	¹ 41. 4
1967		7, 059	² 30. 3

¹ Subject to revision pending reporting of new facilities.

² Pending revision.

Source: Department of Mental Health, Division of Planning and Evaluation Services, Statistical Research Section, June 30, 1967.

APPENDIX IV

*Admission of patients to Illinois State hospitals with a diagnosis of alcoholism
fiscal year 1953-66*

Year	Number of admissions
1953	3, 233
1954	3, 287
1955	3, 470
1956	4, 247
1957	4, 861
1958	4, 283
1959	3, 937
1960	4, 487
1961	4, 695
1962	4, 556
1963	4, 499
1964	4, 346
1965	5, 140
1966	¹ 5, 906
1967	² 7, 059

¹ Subject to revision pending reporting of new facilities.

² Pending Revision.

Source: Department of Mental Health, Division of Planning and Evaluation Services, Statistical Research Section, June 30, 1967.

APPENDIX V

NORTH AMERICAN ASSOCIATION OF ALCOHOLISM PROGRAM,
Washington, D.C., February 15, 1968.

NEWS MEMORANDUM

Re: The Administration Alcoholism Bill.

To: All members.

From: A. H. Hewlett, Executive Secretary.

Following through on President Johnson's alcoholism legislative recommendations contained in his recent Crime message to Congress, Representative Harley O. Staggers (Democrat-West Virginia), chairman of the House Committee on Interstate and Foreign Commerce, has introduced the "Alcoholic and Narcotic Addict Rehabilitation Amendments of 1968." This bill (HR-15281) would amend the Community Mental Health Centers Act to include three new titles—one for Alcoholic Rehabilitation, the second for Narcotic Addiction, and the third a general title relating to the funding of both.

Title I—Alcoholism. The proposal would add "Part C—Alcoholism" to the Community Mental Health Centers Act and would provide:

A. Construction grants for facilities for the prevention and treatment of alcoholism. Such grants may be made only to public or nonprofit private agencies or organizations, the applications of which must meet the requirements for approval set forth in clauses 1) through 5) and clause (A) of Section 205(a) of the Community Mental Health Centers Act.

Applicants for such grants would be required 1) to show the need "for special facilities for the inpatient or outpatient treatment, or both, of alcoholics"; 2) to show satisfactory assurance that the services would be principally for persons residing in or near the particular community or communities in which the facility is to be located and that the facility services will provide at least those essential elements of comprehensive mental health services, and services for the prevention and treatment of alcoholism, including post institutional aftercare and rehabilitation that are prescribed by the Secretary of HEW; 3) to assure that the application has been approved and recommended by the single State agency designated by the State as being the agency primarily responsible for care and treatment of alcoholics in the State, and, in case this agency is different from the agency designated as the Mental Health authority, assurance must be shown that the application has also been approved and recommended by the Mental Health authority; 4) to show that the project is entitled to priority over

other projects for treatment of alcoholism; 5) to show that adequate provision has been made for furnishing needed services for persons unable to pay in accordance with regulations of the Secretary under Section 203(4) and for compliance with State standards for operation and maintenance; 6) the amount of any such grant may not be in excess of 66⅔ percent, as the Secretary may determine.

B. Staffing, Operation and Maintenance Grants under Section 261 of the Community Mental Health Centers Act may be made to any public or nonprofit private agencies and organizations for new facilities or for new services in existing facilities for prevention and treatment of alcoholism.

Grants under this section would be made only on applications meeting requirements under part B of the Mental Health Centers Act. In making such grants, the Secretary would consider relative need for services, population of the area to be served and financial need.

Federal matching funds would be available over a 10 year period, the first year of which the Federal percentage would not be more than 90%, 80% for the second year, 70% for the third, 60% for the fourth and 50% for the next 6 years.

C. Specialized Facilities. Grants from appropriations under Section 261 of the Mental Health Centers Act would also be made for projects for construction, operation, staffing and maintenance of specialized residential and other facilities, such as halfway houses, day care centers and hostels, for the treatment of homeless alcoholics.

Such grants would be made only for facilities which 1) are affiliated with a community mental health center meeting the essential elements of comprehensive community mental health services prescribed by the Secretary, or 2) are not so affiliated but with respect to which satisfactory provision (as determined by the Secretary) has been made for appropriate utilization of existing community resources needed for an adequate program of prevention and treatment of alcoholism.

D. Short Title. This part (everything outlined above) is to be cited as the "Alcoholic Rehabilitation Act of 1968."

Title II—Narcotic Addiction. HR-15281 would further amend the Community Mental Health Centers Act to include "Part D—Narcotic Addict Rehabilitation" which would provide:

A. Grants under Section 261 to assist in projects for constructing, operating, staffing and maintaining treatment centers and facilities (including post hospitalization treatment centers and facilities) for narcotic addicts within the states.

This grant program, as it deals with the kinds of activities authorized by parts A and B of the Mental Health Centers Act will be carried out consistently with the grant programs under that Act except to the extent that in the Secretary's judgment, special consideration would make differences appropriate.

B. Grants may be made beginning July 1, 1968 through June 30, 1970 to public or nonprofit private agencies and organizations to cover part or all of the cost in 1) developing specialized training programs or materials or in-service training or short-term or refresher courses with respect to the prevention and treatment of narcotic addiction; 2) training personnel to operate, supervise and administer such services; and 3) conducting surveys and field trials to evaluate the adequacy of the programs for prevention and treatment of narcotic addiction.

Title III—General. HR-15281 would authorize appropriations for both parts above—to begin July 1, 1968 through June 30, 1970, to provide such sums as may be necessary (to be determined by Congress) for project grants for construction, operation, staffing and maintenance of facilities described above.

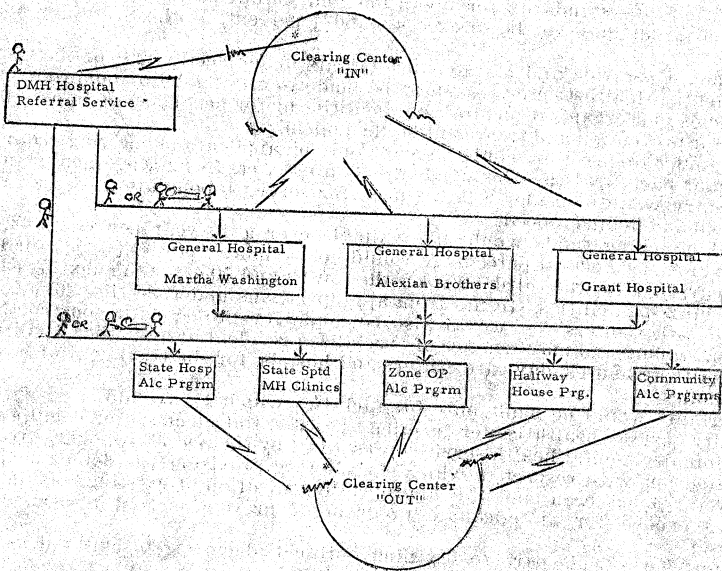
Further, appropriations beginning with the years July 1, 1970 through the next eight years would be authorized to be made for continuance of those projects begun prior to June 30, 1970.

This title would further amend Part B of the Community Mental Health Centers Act to add a new section (Sec. 225) for "Facilities Relating to Rehabilitation of Alcoholics or Narcotic Addicts." This new section would specify that alcoholism or narcotic addiction projects undertaken by community mental health centers would come under the requirements and provisions set forth in the new titles proposed for alcoholism and narcotic addiction outlined above.

Cost of Administration. This bill would also amend the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 to provide up to one half of the administration expenses annually except that not more than 2 percent of the total allotments for any one year, or \$50,000, whichever is less, shall be available.

APPENDIX VI

Patient Flow Chart



Clearing Center: Coop Program
Chicago Council/Alc

APPENDIX VII

Estimated Cost Analysis on Martha Washington Hospital

DETOXIFICATION:

Room and Board
Nursing Care
Physician

BACK-UP SUPPORT

Lab
X-Ray
Pharmacy
Surgical

	First Day	Second Day	Third Day	Fourth Day	Fifth Day
Room and Board	36.00	36.00	36.00	36.00	36.00
Nursing Care					
Physician					
Lab	21.00				
X-Ray	10.00				
Pharmacy	14.00	14.00	3.00	3.00	3.00
Surgical	Cost	Cost	Cost	Cost	Cost
	\$ 81.00	\$ 50.00	\$ 39.00	\$ 39.00	\$ 39.00
Actual Charges					\$ 248.00
	\$ 60.00	\$ 50.00	\$ 30.00	\$ 30.00	\$ 30.00
Per Diem Charges					\$ 200.00

Mr. ROGERS. Our next witness is Dr. Isadore Tuerk, commissioner of mental hygiene, State of Maryland, accompanied by Mr. Harry Schnibbee.

STATEMENT OF DR. ISADORE TUERK, REPRESENTING THE NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS; ACCOMPANIED BY HARRY C. SCHNIBBEE, EXECUTIVE DIRECTOR

Mr. ROGERS. We are delighted to have you here, gentlemen, and appreciate your presence.

Mr. TUERK. I am Isadore Tuerk, M.D., commissioner, Maryland Department of Mental Hygiene.

I am here today representing the National Association of State Mental Health Program Directors, and I am accompanied by Mr. Harry C. Schnibbee, executive director of the association.

The members of our association are responsible for the administration of the major portion of the residential and outpatient public mental health programs in the United States. We administer 1,161 treatment facilities, both residential and outpatient. We have under treatment annually 1,500,000 persons.

Last fiscal year the State mental health program directors administered programs funded at \$2.4 billion, which is $2\frac{1}{2}$ times bigger than all other State public health programs combined.

In 31 States the director of the State mental health program is also responsible for administering the treatment program for alcoholics, and virtually all major, public narcotic addict treatment programs are under the administration of our members.

It is from our experience in administering these vast public programs, and especially the alcoholism programs, that I wish to speak today.

Mr. Chairman, in general we endorse and support both the objectives and the specific approach of H.R. 15758.

Alcoholism and drug addiction are serious public health and social problems. The impact of alcoholism in terms of human suffering, physical illness and complications, financial and economic loss, disruption of family life, highway accidents, and suicides, is incalculable.

Physicians and psychiatrists and other professional personnel have only recently begun to involve themselves with the important problem, despite the fact that for some time the American Hospital Association and the American Medical Association have urged that alcoholism be considered a disease and that physicians and general hospitals provide treatment for the alcoholic.

There has been encouraging progress in the treatment of the alcoholic, but still much needs to be learned in coping with this grave disorder. Alcoholism is a chronic illness which cannot be treated exclusively in a hospital setting, and any attempt to evaluate the effectiveness of the treatment program must depend upon the availability of a wide variety of treatment facilities, programs, and resources.

Individual psychotherapy, group therapy, antabuse, Alcoholics Anonymous, tranquilizing drugs, general health management, churches, industrial counseling, family group therapy, utilization of family agencies, welfare departments, departments of education,

schools, parole and probation, courts, labor, et cetera, are all valuable and necessary elements in a comprehensive approach to the treatment of alcoholism.

A comprehensive community mental health center program should include among its elements facilities and programs for the treatment of the alcoholic. The comprehensive community mental health center is in a strategic position to integrate the many resources and programs necessary for a coordinated comprehensive approach to this problem.

The elements of a spectrum of services in a broad approach to this problem would include detoxification centers, treatment of the acute phase of alcoholism in a general hospital, inpatient treatment for such complications of alcoholism as delirium tremens or acute hallucinosis, general hospital care for such complications as cirrhosis of the liver and peripheral neuritis.

Halfway houses, diagnostic clinics, outpatient long-term treatment resources, public health nursing, long-term rehabilitation centers for the chronic alcoholic who had little or no personal resources, shelters for those who have reached the point of chronic dependency with no capacity for rehabilitation, with our current knowledge of the treatment of this illness.

Many of these programs can be related to a community mental health center. Some should begin to develop apart from community mental health centers, particularly where such centers have not yet come into existence but could then become affiliated with, and integrated with, community mental health centers as they emerge.

The following motion was unanimously adopted by the members of the National Association of State Mental Health Program Directors in meeting at the Drake Hotel, Chicago, Ill., March 14, 1968:

The proposed Federal alcoholism legislation should provide mechanisms to strengthen services to alcoholics and drug addicts and encourage the development of these services as components of programs of comprehensive community mental health services rather than as separate autonomous units.

Federal support of such developments, both in terms of concept and in terms of financing, will go far in overcoming current resistances to developing programs, and will emphasize and stimulate the urgent desirability of including programs in behalf of the alcoholic in the community mental health services now taking shape throughout the country.

Another powerful factor at work is the judicial decisions which have already occurred and which are now in the process of being formulated by the Supreme Court making it illegal to punish the chronic alcoholic for public intoxication and requiring his treatment as a sick person instead.

Drug addiction and drug abuse have become significant in recent years as challenges to psychiatric and medical knowledge and enterprise and have provoked professional leaders to develop liaison with other innovating personnel in the antipoverty programs and the war on crime.

Drug addiction and drug abuse play salient roles in the perpetuation of poverty and in the incidence of crime.

Effective treatment programs and prevention programs in the areas of drug addiction and drug abuse should have an important impact

upon the reduction of illness and human suffering, but also in the reduction of crime and the alleviation of poverty.

Treatment of drug addiction is still a very perplexing and difficult problem. It requires more than an inpatient program. The experience of hospital programs alone has been that fairly prompt relapse into drug addiction occurs upon the release of the patient back to the community.

An effective spectrum of services would require treatment of addicts in the community with such measures as methadone, counseling by cured drug addicts, vocational rehabilitation, vigilant monitoring of urine for evidences of relapses, appropriate involvement of courts and probation officials, ministers, general practitioners, public health nurses, family agencies, and Narcotics Anonymous.

Facilities should include hospital programs, clinics, self-help groups such as Syn-Anon and related residential treatment centers and half-way houses.

Many addicts who are incarcerated after having committed a crime should be prepared for return to the community by appropriate programs in the penal institutions. Many addicts have concurrent problems with alcoholism, and both problems need to be treated by professionals knowledgeable in both fields.

It is imperative that research and evaluation be an important part of the approach to the treatment and prevention of alcoholism and drug addiction.

Education of industrial leaders and management is important in enabling both addicts and alcoholics to regain effective roles as citizens through appropriate employment.

As is the case with the alcoholics, the community mental health centers would be in a strategic position to coordinate and integrate a great variety of programs and resources in behalf of the addict. However, I would want to emphasize that many such programs for the addicts may need to start prior to the development of community mental health centers and then become integrated into the total program of the community mental health center as it evolves.

It is my hope and concern that facilities and programs for the alcoholics and drug addicts, which are a part of comprehensive community mental health centers, will not compete with the amount of money available to such centers, but will attract sufficient funds from the Federal sources to add to available financing for existing comprehensive community mental health centers and community mental health centers which will come into existence in the future.

As in the case for the alcoholic, so would it be in the case of the addict, that Federal support and stimulation of programs in behalf of drug addiction will encourage professional personnel, hospitals, community mental health centers, community mental health services, to bring to bear whatever talents are available in coping with a serious threat to the health and social well-being of this Nation.

I now wish to address myself, Mr. Chairman, to a particular section of the bill, page 6, section C, starting at line 6 and ending at line 14.

This matter involves the efficient administration of the new program.

The section on page 6 says that an application for a grant for construction of alcoholism facilities may be made only if it contains satis-

factory assurance that the application has been "approved and recommended" by either:

- (1) The single State agency designated by the State as being the agency primarily responsible for care and treatment of alcoholics in the State or
- (2) The agency designated pursuant to section 204(a)(1) (of Public Law 88-164, which is the Community Mental Health Centers Construction Act of 1964).

It is the concern of the directors of mental health programs in the States that some confusion in the administration of the proposed alcoholism treatment program might result from the language on page 6 of the bill unless it is either modified or clarified.

The directors of State mental health programs have sole responsibility for administration of the alcoholism treatment programs in only 27 States. In four other States they have partial responsibility. And in an additional four States mental health is in an agency where another branch of the agency has responsibility for the treatment of alcoholics.

In 16 States the mental health agency of the State has no administrative connection at all with the State alcoholism program.

I might add that despite all the foregoing about "administrative responsibility," alcoholics are treated in virtually every State mental hospital in this country and in some cases represent as much as 40 percent of the admissions to these State hospitals.

If the language of the bill starting at line 6 is interpreted by a State as requiring it to designate the agency presently "responsible for care and treatment of alcoholics," then it is possible that in 16 States the State mental health agency will not be involved in approving and recommending the proposed facilities.

If the language starting on line 10 ("in case this agency is different * * *") is applied, then the agency designated under 204(a)(1) of Public Law 88-164 must approve or recommend the facility.

The 204(a)(1) agency is the "community mental health center construction authority."

In 20 States the 204(a)(1) designated agency is not the State agency that is responsible for the mental health program. I have a list of these States here, which I will not read at this point.

However, in 11 (out of the above 20) States the "alcoholism treatment program" is in the mental health agency. And out of the remaining nine States only four of the 204(a)(1) designees have any responsibility for an alcoholism program.

The defect in the substance of the "designated agency" paragraph on page 6 could be partially corrected by adding language to the effect that the "mental health authority" of the State will be consulted for construction and staffing of alcoholism facilities.

It is a matter of grave concern to me that there be a significant role provided the State mental health director. This is a matter of concern to the other State mental program directors, too. I hope it will be possible that the language of the bill can be modified to include this concept and that the legislative history of this proceeding call attention to my concern and the concern of other State program directors for preservation of their roles in developing effective, broadly based programs for alcoholics and drug addicts.

Mr. Chairman, I now refer to section 305 on page 14 of the bill.

This section adds language to the Community Mental Health Centers Construction Act of 1963, providing for a set-aside of 2 percent of the construction money allotted to each State. This 2 percent, when matched 50-50 by the State, is to be used by the State, for "proper and efficient" administration of the State plan for construction of mental health centers.

This is a long-overdue amendment, and it was at the specific request of our association to HEW officials that this amendment was included in the draft bill sent to Congressman Staggers, which is now H.R. 15758.

Matching Federal assistance to State central offices for administration of Federal grant programs is an integral part of many existing laws. Thus, there is broad precedent for adopting section 305 of the bill before you. Actually, this provision should have been in the original law, and this association was derelict in not forcing this issue several years ago.

A provision similar to the one we now have in the bill before you has been in the Public Health Service Act for years. Section 606(c)(2) of the PHS act provides to the State Hill-Burton agency 2 percent of the federally allotted money for administration of the State plan.

Last year your committee initiated a bill, which became Public Law 90-170, which authorized each State to use for administration purposes up to 2 percent or \$50,000, whichever is less, of the \$30 million Federal allotment for construction of facilities for the mentally retarded.

In the Elementary and Secondary Education Act there is administration money available to the States under several sections of the act:

Five percent is available to the States for administration of the school library resources program.

Five percent is available to the States for administration of the education of handicapped children program.

One percent is available to the States for administration of the Federal school aid programs for education of children of low-income families. The maximum amount of money available to a State agency under this provision is \$150,000.

Seven and one-half percent is available for administration of the supplementary educational centers and services program. The maximum amount of money available to a State agency under this provision is \$150,000.

Under the Vocational Rehabilitation Act as amended, section 2, authorizing grants to States for rehabilitation services, provides that a portion of the State allotment may be used by the State agency for administration of the program. There is no limitation on the amount of money the State agency may request for this purpose.

You will note, Mr. Chairman, that in several instances the maximum sums available to the States for administration of the various Federal programs is \$150,000. In the bill before you the sum, on line 20 of page 14, is \$50,000.

We consider this an inadequate share, and we recommend that the sum be \$100,000 per State. The Federal Government through this fiscal year will have granted about \$125 million toward development

of community mental health centers in the States. The States are administering this \$125 million with no Federal help.

In Public Law 90-170, extending the mental retardation centers program, the Congress allowed \$50,000 per State for a \$30 million annual program. The community mental health center program involves annual grants twice the size of the Public Law 90-170 program, or \$60 million. The administration proportion should be \$100,000.

PROGRAM EVALUATION MONEY

We suggest a further amendment of section 305, Mr. Chairman.

We recommend the addition of language on line 19 following the word "part." Strike the semicolon and all language through line 24 and add the following language:

... and for evaluation of the programs, by the State agency, under Part A of Title II; except that not more than 2 per centum of the total of the allotments of such State for a year, or \$100,000, whichever is less, shall be available for the purpose of administration for such year, and not more than 1 per centum of the total of the allotments of such State for a year, or \$50,000, whichever is less, shall be available for the purpose of evaluation of programs for such year. Payments of amounts due under this paragraph may be made in advance or by way of reimbursement, and in such installments, as the Secretary may determine.

Our proposed amendment would provide a small amount of money to each State central office, to be matched by the State, for purposes of evaluating the community mental health center program as it functions in each State.

Again, there is strong precedent in recent Federal legislation for provision of funds to evaluate a program to determine its efficacy and judge whether or not the congressionally authorized and appropriated money is being spent wisely.

In the Elementary and Secondary Education Act there are at least six separate sections of the law in which "program evaluation" money is made available. The Office of Education has asked the Congress for \$14 million to fund these programs, most of which will be carried out by State agencies.

In the extension of the partnership for health program, Public Law 89-749, which originated in this committee last year and passed the Congress as Public Law 90-174, you included "program evaluation" money for several parts of the law, namely: 314(d), 314(e), 314(c), 304 and 309.

Your committee made the following comments about "program evaluation" in your Report No. 538 (August 3, 1967), and we heartily concur:

As a basic tool of program implementation and development, evaluation is insurance that the health research, service, facilities, demonstrations, and related activities proposed in this bi-1 will fully accomplish their purposes.

Evaluation studies and analyses should be conducted to identify and extend the application of those program methods and approaches which show high success and to spot program weaknesses in time to permit steps to be taken to improve program performance.

Although the funds available for evaluation will be a small fraction of those available for the programs which are authorized, no more than 1 percent, the committee feels that making these funds available for evaluation will contribute substantially to the success of the programs proposed in the bill.

What we now ask is that everything you said about the need for program evaluation be applied to the community mental health centers

program, and we respectfully request that your committee adopt the amended bill language we have provided today in this testimony.

Mr. Chairman, I thank you for your courtesy in hearing the testimony of our association today, and, as always, we stand ready to assist the committee and its individual members in any way that we can.

Mr. ROGERS. Thank you very much. Your testimony is most helpful, and we have, I guess, all of your proposed amendments now.

Thank you very much.

Our next witness is Dr. Jacob Fishman, professor of psychiatry, Howard University College of Medicine, and director, Howard University Community Mental Health Center.

**STATEMENT OF DR. JACOB FISHMAN, PROFESSOR OF PSYCHIATRY,
HOWARD UNIVERSITY COLLEGE OF MEDICINE, AND DIRECTOR,
HOWARD UNIVERSITY COMMUNITY MENTAL HEALTH CENTER**

Mr. ROGERS. We are delighted to have your comments.

Dr. FISHMAN. Thank you. I appreciate the opportunity to testify as an individual here on behalf of the bill, and in particular on behalf of the alcoholism and narcotics addiction programs contained therein.

I would certainly like to lend my support for the alcoholism addiction components of these programs, particularly stress the importance of these programs in the poverty areas of our urban centers, since, as we all well know, alcoholism and addiction are a major problem in the mental health of the poor, particularly as they are related to the social, educational, employment, and psychological factors connected with poverty and the general problems of the urban ghetto.

However, I am here particularly to speak to one aspect of alcoholism and addiction programs as they relate to community health centers, and that is to urge the committee to stress consideration of the employment and use of local residents as nonprofessionals in new careers providing alcoholism and addiction services in these health centers.

In our experience in community mental health work, we have found that there are enormous advantages to the systematic recruitment, training, and employment of such persons in the delivery of services. They increase the effectiveness of services in these communities because of their unique backgrounds in connection with the community and experience. They provide an important link between the professional and the client population, with whom frequently the professional has had little real life experience.

They provide an important vehicle for helping people to help themselves in the community, and they also provide an important potential vehicle in these local health centers for meaningful employment and career development for the poor.

Now, this is true in general for community mental health programs. It is particularly true in addiction and alcoholism where we find that the use of ex-addicts and ex-alcoholics is a potential manpower resource of very significant effect.

Because of their previous personal experiences, contact with others in the community, and the knowledge of their own living situation, when they are given structured training, employment opportunities and career potential as nonprofessionals in these programs, they give

very important, extremely significant assistance to the professional in providing treatment and rehabilitative services for alcoholics and addicts.

In fact, there are some who feel that in many ways you can't run an effective program for alcoholics and addicts without the use of such subprofessionals providing a kind of treatment resource.

I would urge you to emphasize this approach for the staffing and organizational patterns for these centers. And, in fact, if it were possible to develop an amendment to the existing legislation for community mental health centers to provide for the development of systematic programs for the use of such subprofessionals in new careers, I would urge that, too.

It is especially important in developing manpower resources for these centers to recognize that today there is an extreme shortage of trained manpower for all community mental health programs, particularly for alcoholism and addiction.

This manpower shortage focuses on some of the basic problems in the philosophy of approach to treatment. We have found in our experience in Washington, and in many other communities of the country, that in reassessing the issue of manpower utilization in these centers (which I must add is an extremely urgent problem for all centers and all programs) a great deal can be gained by considering the use of local residents; employing them and providing them with subprofessional careers in these programs.

It gives the subprofessional and the people in the community a way of participating in the development and delivery of services in their own community, which has generally been denied by the typical staffing pattern in which the middle-class professional who lives in the suburbs spends the hours 9 to 5 in the ghetto and knows little else about the lives of the people there.

The use of such people adds a new dimension to these programs, and we feel it is essential to their implementation.

I would further urge that it is extremely important in the development of this model to consider the need for upward mobility possibilities so that these people do not wind up, as has been generally the pattern in health services, in dead-end jobs, doing low-level tasks, without the possibility for educational or financial advancement, or for new responsibility.

Such career ladders, when linked with more experience and training, provide additional opportunity for the poor, particularly the Negro poor in our communities, to move into responsible positions in health services which are generally denied to them because of existing educational, training, and employment barriers.

The current opportunities as nursing assistants in a variety of health service programs provide only dead-end situations for these people. Consequently, the turnover is rapid, there is a great deal of frustration, and their potential as a treatment resource and real help to the professional is generally lost.

We find enormous benefit for the center and the community as a whole.

I would urge the committee and the people who will be making operational such centers and programs to develop systematic and structures programs for subprofessionals and professionals in new careers

in alcoholism, addiction, and in all the other components of the community mental health center so that health services can be significantly improved and these people provided an opportunity for advancement.

Thank you.

Mr. ROGERS. Thank you very much.

Let me just ask you: Have you done this in your center?

Dr. FISHMAN. Yes, we have; in all fields, including alcoholism and addiction.

Mr. ROGERS. How many people have you used in this capacity?

Dr. FISHMAN. We have at this point trained and utilized 70 to 80 such people.

Mr. ROGERS. Have they been given the opportunity to advance?

Dr. FISHMAN. Yes. We have developed three levels of subprofessional advancement, beginning with the aide, on to the mental health assistant, mental health associate, and mental health technician.

Mr. ROGERS. Do you give them education along with the in-house training?

Dr. FISHMAN. We have programs to supplement the training, and are now negotiating with the Washington Technical Institute for a joint program that could lead to an associate of arts degree.

Mr. ROGERS. It might be well if you gave us your setup.

Dr. FISHMAN. I would be glad to.

(The following information was received by the committee:)

STATEMENT OF DR. JACOB FISHMAN, DIRECTOR, HOWARD UNIVERSITY COMMUNITY MENTAL HEALTH CENTER, ON CAREER DEVELOPMENT AND RELATED TRAINING AND EDUCATION FOR PERSONNEL IN THE MENTAL HEALTH PROGRAM

In the past several years of experience with job and career development and related training and education we have found the following to be critical elements in the success of any such programs:

1. JOB DEVELOPMENT

The creation of permanent subprofessional positions in community mental health facilities or other agencies which can lead to career advancement is the ultimate test of the acceptance of a new level of personnel. Without such positions, training of mental health aides can have no real effect as a vehicle for social change or delivery of services.

The initial step, therefore, should be an analysis of structure and manpower needs of the facility, the climate of acceptance or resistance to innovative approaches, and the possible ways in which the subprofessional can help fill some of the gaps in the delivery of services in the community.

Usually the mental health aide job description includes primarily community outreach functions and group leadership. It is the mental health aide who provides treatment assistance to the professional team and acts as liaison between the alcoholic or the addict and the professional staff.

2. CAREER LADDERS

The availability of opportunities and career steps that will enable a person to move toward a desired career is necessary for continued motivation. This requires a linkage of the products of job development into a series of entry level, second, third and fourth level jobs with the potential for upward mobility built in. Local educational resources can provide the necessary training programs and certification for movement from one job to the next. This is a crucial component of the model and requires the combined efforts of the employing agency, civil service and the educational institution. An example of the career ladder as used for the mental health aide in the Community Mental Health Center is:

- a. Community Mental Health Aide
- b. Community Mental Health Assistant
- c. Community Mental Health Associate
- d. Community Mental Health Technician

For each step upward on the ladder there are increased responsibilities, additional in-service training, increased salary and decreased supervision of the subprofessional by professional staff.

3. TRAINING

The most important goals of New Careers training for entry level positions are:

- a. To prepare the trainee in the shortest possible time to successfully and responsibly undertake the duties and roles of the entry-level position;
- b. To ensure that the trainee, in his on-the-job training is quickly given the responsibility of performing relevant and meaningful tasks, and
- c. To provide the trainee with a number of basic skills and attitudes that can be put into practice in the job as soon as possible. This provides him opportunity for identification with a role and for the reception of feedback on skills and performance. It allows the individual as well as others to see his competence, and is the base on which further skills can be built. This, training for role rather than simply learning a set of skills is an important and successful approach.

In order to get maximum returns from the training program, several principles should be followed. First there should be training in generic issues as well as specific entry-job training, basic training in a particular human service area, and remedial training. These training elements should be provided within the context of a small group. Secondly, there should be basic generic training in a particular area of human services such as health or mental health. There should also be specialty skill training for the specific entry position. Lastly, a supervised on-the-job work training experience is essential for each trainee.

4. EDUCATIONAL LINKAGES

The first step in career oriented training for disadvantaged and under-educated people must be directed toward enabling them to acquire high school equivalency diplomas. Some accrediting agencies, for example, the District of Columbia Board of Education and the New York State Board of Regents, have provided guidelines for high school and college accreditation of work experiences and on-the-job training.

For advancement beyond the high school level, to the associate of arts or bachelor's degree, linkages must be established between the community educational institution and the human service agency, in which the school would provide accreditation for on-the-job training and field placement, as well as assistance to the agency in job and career development.

5. TRAINING OF TRAINERS

For many of the professionals, this will be the first experience in training or supervising disadvantaged people. They will have many unspoken doubts about the ability of trainees to be of any help to other people and about their own ability to teach or supervise the trainees. Therefore, careful training and preparation of trainers and orientation of employing agency staff is a necessary component of the New Careers training model. Without this there is loss of motivation, confusion, conflict between trainees and professionals, and loss of effectiveness.

Dr. FISHMAN. We have been particularly gratified with the results, contrary to the usual expectations that these people would have only difficulties, and that the "vulnerable could not help the vulnerable."

Mr. ROGERS. We would be happy to have material on that.

Dr. FISHMAN. I will be happy to supply it.

(The following information was received by the committee:)

STATEMENT OF DR. JACOB FISHMAN, DIRECTOR, HOWARD UNIVERSITY COMMUNITY HEALTH CENTER, ON PARTICIPATION OF SUBPROFESSIONAL AIDES IN REHABILITATION TREATMENT PROGRAMS

In several years of experimentation with such training programs at the Howard University Institute for Youth Studies and in other research centers in various parts of the country, it has been found that this approach is highly successful. Two brief examples of this kind of program follow:

1. A group of 125 youths, ages 17 to 21, who were school dropouts or unemployed, with multi-problem backgrounds, were trained and employed in the human services, including mental health, education, welfare and child care. During training, students were assisted in working toward high school equivalency and increasing their general knowledge and skills. Eighty-seven percent of the trainees finished the training program and were subsequently employed. A study done from one to two years after employment began showed that 52 percent were still in the same jobs in human services and each job change had been accompanied by an increase in salary.

2. A program was developed at Cardozo High School in Washington, D.C., for similar students which combined human service training with the regular curriculum leading toward both a diploma and a certificate of training. Part of the day was spent in classroom work, part of the day in supervised on-the-job training in local human service agencies. The trainees received stipends for the latter. Students were selected from the bottom of the class. On graduation, these students filled jobs in the agencies in which they were trained. A few went on to higher education such as community college or college. Half of these students spent their on-the-job training as classroom aides in elementary schools and half as health aides in local health facilities.

There are several programs in Washington, D.C., which have demonstrated success in the use of ex-addicts and ex-alcoholics in treatment centers. The D.C. Public Health Department has a Drug Addiction Treatment and Rehabilitation Center in Northwest Washington. Over half the staff are ex-addicts who have been trained at the center to work with addicts. There are five Drug Addiction Counselors, at the GS-5 level and five Mental Health Aides at GS-4. These subprofessionals assist the other staff in such areas as determining which of the patients are sincerely motivated in the direction of breaking the habit, and which are trying to "work the system," as well as tasks such as screening, intake records, and therapeutic techniques.

At the Rehabilitation Center for Alcoholics (RCA) at Occoquan, Va., another D.C. Health Department facility, 65 subprofessionals are employed as alcoholic counselors. A large proportion of the counselors are or have been alcoholics, themselves, and are currently members of Alcoholics Anonymous. They were trained at RCA and are rated at the GS-7 level. Their duties include security, training, control and counseling. Each counselor acts as "house father" for a group of eight patients which he follows throughout their stay at Occoquan. The counselor orients the patient to the program at RCA, teaches good work habits, conducts the Alcoholics Anonymous program, refers the patient to professional staff members for medical or other services when necessary and in general observes, evaluates and advises. The close relationship developed between the counselor and the patient enhances the therapeutic aspects of rehabilitation.

The use of local community residents as subprofessionals in alcoholic and narcotic addict rehabilitation centers has been proven successful in various programs throughout the country. The subprofessional increases the effectiveness of services in these programs because his background and familiarity with the community from which he comes enables him to provide the important link between the client and professional, where it possibly would not otherwise exist. The important therapeutic effect on the subprofessional, his family and his community cannot be overlooked. Significant and lasting behavioral change has been found in these people, through training and employment for nonprofessional careers in mental health and other human services. The concept of helping oneself through helping others is an aspect of this effect. The local resident now undertakes to deliver the services of which heretofore he was only the dependent recipient.

In addition, this is a most significant answer to the critical problem of training effective manpower which is now confronting alcoholism, addiction and other mental health programs. New Careers training can provide a meaningful em-

ployment and career opportunity for the above population. I would like to urge the committee to emphasize in this legislation the use of local residents and former addicts as subprofessionals in New Careers in these programs.

Mr. ROGERS. Thank you very much.

Our next witness is Dr. Gerald L. Klerman of Yale University and director of Connecticut Mental Health Center.

STATEMENT OF DR. GERALD L. KLERMAN, ASSOCIATE PROFESSOR OF PSYCHIATRY, SCHOOL OF MEDICINE, YALE UNIVERSITY, AND DIRECTOR OF CONNECTICUT MENTAL HEALTH CENTER

Mr. ROGERS. We appreciate your presence. We will make your statement a part of the record, following your summary.

Dr. KLERMAN. We welcome the proposed legislation, and in particular I wish to support those provisions which link these new specialized facilities for alcoholic and drug-dependent and narcotic individuals to the newly developing mental health centers. I will not read the entire statement, but I would like to address myself to one question that came up earlier.

The question has come up: "Why make these centers part of the community health centers?" "Why not create separate centers for alcoholism and drug addiction?"

My belief and experience indicates that the development of separate facilities unrelated to community health centers would be a serious error, and I would like to offer a number of reasons for this judgment.

First, there is substantial evidence that alcoholic and narcotic addict patients have a high proportion of associated medical and psychiatric conditions. These require active involvement, consultation, and collaboration with neurologists, internists, and other health specialists.

Our Connecticut Mental Health Center, like many other centers, is located adjacent to a general hospital, to which it is linked architecturally, and programmatically. Thus we have available X-ray, laboratory, surgical, and other treatment resources on an immediate basis without red tape.

Second, I wish to emphasize the desirability of treating the individual in his own community. Treatment at distant resources, even such excellent ones as Lexington and Fort Worth, have unfortunately resulted in high rates of relapse when individuals are returned to their own communities.

Programs of after-care are needed, and these require the continued involvement of the patient's family, neighborhoods, clergymen, and local institutions.

This is true where the new drug techniques are being used.

Mr. ROGERS. May I interrupt there?

How is methadone used. You say you are using this?

Dr. KLERMAN. We are about to initiate a project on long-term methadone therapy.

Mr. ROGERS. Have you not yet gotten into this program?

Dr. KLERMAN. Not yet. We have used methadone in the withdrawal phase. In order to initiate such projects, you must be in continual contact with the addict, there must be facilities for special laboratory

tests, as well as for pharmacy and for other things. This can only be done in the local community and if the person in treatment has a sense of trust and rapport with the treatment team.

I feel that a community resource has a distinct advantage. Ideally the same staff treating the patient during the acute detoxification and rehabilitation phase should be involved with the patient in the followup phase.

The third reason is that cooperative linkages already exist with established community agencies such as police, social welfare, and neighborhood groups through present programs developed in many community mental health centers. The effectiveness of ongoing alcoholism and narcotic addiction programs, I believe, can be increased by strengthening existing linkages rather than having to establish new ones.

Fourth, our experience and the experience of others indicates that the families of addicts have associated emotional problems, and a more comprehensive approach is more readily facilitated.

Fifth, recruitment of qualified and experienced personnel who are scarce. Currently, the areas of alcoholism and addiction do not have made public acceptance. Integration of mental health centers with this program, particularly those linked with medical schools and hospitals will help recruitment.

I have discussed this problem with Mr. Ernest Sheppard, of our department, and with Dr. W. Bloomberg, Commissioner of Mental Health. We all agreed that one of the major obstacles to the development of quality programs in these fields has been the resistance within the health professions to assume an adequate responsibility for these important public problems.

This is evidenced by inadequate instruction upon these topics in medical schools and in training programs for psychiatrists, social workers, nurses, et cetera. Moreover, only a small fraction of mental health professionals are devoting themselves to the sub-specialties.

There is an air of pessimism and an air of pervasiveness that these are hopeless. Our society continues to attach stigma to these conditions.

While this legislation would go a long way to improving this condition, I would like to recommend amending the regulation for mental health centers so as to make the inclusion of facilities of addicts and alcoholics part of them.

The current regulations do not include these important public health areas as necessary components for community mental health centers. In my opinion, consideration should be given not only to permissive legislation, but to a future mandatory requirement, so that a community center with specialized facilities on panels for alcoholic and drug addiction must be included along with the existing five essential components of in-patient, out-patient, emergency, partial treatment and education.

I realize that this proposal may seem radical to some of my colleagues, but it is my prediction that within a decade we will come to expect that just as emergency treatment in today's hospitals is part of the mental health center, so will the treatment of alcoholism.

I also wish to offer my special enthusiasm and support for section 252, which authorizes grants for training and evaluation of programs.

We must acknowledge that our current treatments have only limited efficacy.

However, new and exciting treatments are being developed, and there is promise that they will be joined by other techniques.

The recent introduction of drugs such as methadone and cyclazocine is attracting bright young scientists and professionals into the field. However, research is needed to undertake field trials to assess the long-term efficacy of these programs.

Investigation should include followup studies to ascertain the long-term consequences of alcoholism and drug addiction.

It is my conviction that the enactment of this legislation will further strengthen these programs.

(Dr. Klerman's prepared statement follows:)

STATEMENT OF GERALD L. KLERMAN, M.D., ASSOCIATE PROFESSOR OF PSYCHIATRY,
YALE UNIVERSITY SCHOOL OF MEDICINE AND DIRECTOR, CONNECTICUT MENTAL
HEALTH CENTER

My name is Gerald L. Klerman, M.D. I am an Associate Professor of Psychiatry at Yale University School of Medicine and Director of the Connecticut Mental Health Center. The purpose of my testimony today is to support the proposed legislation to amend the Community Mental Health Centers Act to make provision for specialized facilities for alcoholics and narcotic addicts.

My support for this bill is derived from my general experience in psychiatry and mental health, and my recent experience as Director of the Connecticut Mental Health Center in New Haven.

It has long been my conviction that the problems of alcoholism and narcotic addiction are best treated as integral parts of a comprehensive mental health program rather than in isolation. As part of this comprehensive program, I recommend that adequate training be provided for mental health workers, general physicians, personnel in the police and law enforcement agencies, and other groups to enhance their understanding of the nature and effects of alcoholism and drug addiction. I also strongly support the need for further research, especially in the development of new treatments.

THE CONNECTICUT MENTAL HEALTH CENTER AND THE NEW HAVEN COMMUNITY

These convictions have been reinforced by very recent experiences in the year and a half since the opening of the Connecticut Mental Health Center in July, 1966. The Connecticut Mental Health Center is a facility of the Connecticut State Department of Mental Health, and is operated jointly by that agency and Yale University School of Medicine. Located in the center of New Haven, immediately adjacent to the Yale-New Haven Medical Center, it represents the first such facility in Connecticut. We are proud that while the center was initiated and constructed prior to the enactment of the federal program for community mental health centers, our building and program embody the essential elements called for by the federal legislation and regulations, including inpatient and outpatient treatment, day hospital, emergency treatment, and community consultation and education. Early in our operation we applied for and were awarded a National Institute of Mental Health comprehensive community mental health center staffing grant to support our activities in a catchment area composed of the Hill neighborhood of New Haven and the city of West Haven, a population of 80,000 persons. In addition to providing comprehensive mental health services for this catchment area, we are involved in less intensive ways with the remainder of greater New Haven. Furthermore, as part of our university involvement we have major teaching and research programs in concert with our patient care and community activities.

Let me say a few words about the Hill neighborhood, on whose periphery the Center is located. The Hill is a typical inner city neighborhood, with characteristic social unrest and high rates of mental illness, accompanied by pervasive unemployment, substandard housing, poor schools, and racial discrimination. This neighborhood is in the midst of marked social transition; relatively large numbers of Blacks and Puerto Ricans have moved in, following upon the exodus of

Italian, Irish, and Jewish groups to the suburbs. This neighborhood was recently selected for a Model Cities program. It was also, significantly, the neighborhood where the "riot" in New Haven broke out in August, 1967. Yale Medical School is making major community health commitments to this neighborhood and our mental health program is part of this commitment. I mention these social factors because our experience indicates that in neighborhoods like this, alcoholism and drug addiction are prevalent and are part of a destructive cycle. I shall return to this later.

In the year and a half since the Center has been in operation we have learned that the extent of alcoholism and narcotic addiction in this neighborhood and in all of New Haven is far greater than had either been expected or planned for. Moreover, facilities, staff, and skills are limited in these problem areas and we are not able to deal adequately with patients with these problems.

NARCOTIC ADDICTION AND DRUG DEPENDENCE

Before discussing the programmatic aspects of narcotic addiction, I would like to say a few words about the terminology. While it is true that narcotic addiction, particularly to heroin, is the most serious problem, there are other drug-related areas. We also recognize problems of 1) illicit experimentation such as glue sniffing and use of LSD and marihuana 2) misuse of medications in excess of recommended or prescribed dosage, and 3) abuse: the repeated excessive use of drugs short of dependence. We have also found it more useful to use the term "drug dependence" as recommended by the World Health Organization as having broader scope. Narcotic addiction thus is one form of drug dependence. I mention this because a community mental health program probably should best be designed to deal with all forms of drug abuse and drug dependence, not exclusively drug addiction.

In New Haven, as in other cities, the predominant, although not exclusive, involvement with narcotic addiction is through the use of heroin among young negro males. Members of my staff estimate that there are between four and six hundred active heroin users in the New Haven area, only a fraction of whom are known to medical or law enforcement agencies. At the Connecticut Mental Health Center we do not have specialized facilities for detoxification treatment or rehabilitation of narcotic addicts, nor do they exist anywhere else in the New Haven region. The nearest inpatient facility is at the Connecticut Valley Hospital, a state mental hospital thirty miles away to which patients must be escorted by ambulance or the police. This geographical separation creates special hardships for the family and social agencies, and limits programs for after care and rehabilitation.

Connecticut has recently enacted a far sighted and pioneering Drug Dependence Law which allows for treatment and rehabilitation as alternatives to criminal sentencing. In the past two years, admissions to public mental hospitals for drug-related problems have more than doubled, even before this law became operative in October, 1966. Judges, court officials, and probation officers tell us that existing treatment facilities are grossly inadequate. As a result, the goal embodied in this new legislation may be undermined because of inadequate facilities to care for those patients who can now be referred for treatment rather than sent to correctional institutions. As a member of the recently established Connecticut Drug Advisory Board, I have become increasingly aware of the many difficulties encountered. My experience as a psychiatrist has been supported by contracts with jurists, lawyers, and correctional officers. In Connecticut, as elsewhere, each of our communities, and particularly the urban communities, need specialized facilities where detoxification, treatment, rehabilitation, and after care can be provided. We are especially interested in initiating treatment programs with methadone and cyclazocine, new drugs which, in early studies, offer hope for interrupting the cycle of illegal narcotic dependency and thereby facilitating the narcotic addict's rehabilitation to a useful and productive life.

As I have mentioned, narcotic addiction has highest rates among underprivileged minority groups, especially young negro and Puerto Rican males. Our contact with neighborhood groups, including the black militants, indicates to us that within the inner city neighborhoods drug addiction is regarded as a problem of very high priority. Residents of the neighborhood and city officials insist that the problem is not being dealt with adequately, innovative and imaginative programs for narcotic addicts offer critical opportunities to relate mental health to the racial crisis of our urban centers. I hope that the mental health professions will not avoid this opportunity.

ALCOHOLISM

Let me turn now to the problem of alcoholism. There seems little need to document the wide prevalence of this disorder or the need for intensified action. In New Haven, we have recently become aware that a moderate sized group of homeless, white males constitute a hard core in need of rehabilitation and social adjustment. As in other cities, surveys in New Haven indicate that a significant proportion of the efforts of the police and other law enforcement agencies are tied up in arrests for drunkenness and related problems. Here, as is also the case with narcotic addicts, the police, courts, and probation officers perform medical and social welfare activities to an unrecognized extent. This involvement with problems of alcoholism prevents the use of their limited resources for their primary tasks of law enforcement and crime prevention. Of course alcoholism is not found exclusively in these areas, but also among industrial workers, professionals, and housewives. Here again, the limited specialized facilities in New Haven has restricted our activities. The efforts of the local Alcoholism Clinic, the Salvation Army, and the Yale Hope Mission have proven inadequate to meet the need. Just as for drug addicts, the only detoxification and inpatient treatment unit exists at the Connecticut Valley Hospital thirty miles away. As I will detail later, our attempts to diagnose, treat, and rehabilitate patients with these problems at our new Center with existing facilities and staff have been limited.

THE NEED FOR FACILITIES AS PART OF THE COMMUNITY MENTAL HEALTH CENTER

I have not described these circumstances in New Haven because they are unusual. On the contrary, I believe they are illustrative of what is probably the pattern in every medium and large size city in our nation: great need, damaging social consequences, inadequate resources, and over burdened efforts by clinics, police, and other agencies. The situation is made worse by a lack of integration and coordination of existing facilities.

In view of this experience, we welcome the proposed bill. In particular, I wish to support the provisions which link these new, specialized facilities for alcoholic and narcotic addiction to the newly developing community mental health centers. Why make these facilities part of the community mental health centers? Why not create separate, independent centers? My belief is that development of separate facilities unrelated to community mental health centers would be a serious error. I can offer a number of reasons why.

One, there is substantial evidence that alcoholic and narcotic addicts have a high proportion of associated medical and psychiatric conditions. These require active consultation and collaboration with neurologists, internists, psychologists, and other specialists. The Connecticut Mental Health Center, like other community mental health centers, is located adjacent to a general hospital, the Yale-New Haven Hospital, to which it is also linked architecturally, administratively, and programmatically. Through this linkage, the mental health center has available x-ray, laboratory, and other adjuncts to treatment.

Second, in addition to this need for medical, surgical, and laboratory services, I wish to emphasize the desirability of treating the alcoholic and drug dependent individual in his community. Treatment at distant facilities, such as those at Lexington and Fort Worth, results in a high rate of relapse when the individual returns to his community. Programs of rehabilitation and after care are needed, and these require involvement of the patient's family, neighbors, clergyman, and local institutions. This is particularly true where modern drug techniques, such as methadone for narcotic addicts and Antabuse in the case of alcoholism, are being tried. These often require long periods on a maintenance drug dosage, up to five years or longer, with frequent laboratory testing of urine or blood. Ideally, the same staff who treated the patient during the acute detoxification and rehabilitation phase should also be involved with him in the follow up phase while he is readjusting to the community.

Third, cooperative linkages with the police, social welfare agencies, and rehabilitation centers already exist through the network of community mental health centers. It would increase their effectiveness to incorporate alcoholic and narcotic addiction programs.

Fourth, experience indicates that the families of alcoholics often have associated emotional problems, especially their children. There can be a more comprehensive approach, involving group and individual psychotherapy and

family work, with a community mental health center than if the alcoholism facility or drug addiction center are separated administratively, geographically, and architecturally.

Fifth, recruitment of qualified and experienced personnel to separate facilities for these groups is difficult. Currently, these areas do not have the professional prestige and community acceptance they merit. Integration with community health centers, especially those linked to medical schools and general hospitals, will facilitate recruitment. It would also contribute to the needed cadre of experienced workers who can train others while also educating personnel in associated health and social welfare fields.

The question may arise as to why mental health centers and general hospitals cannot treat these patients within existing facilities and programs. We have learned that specialized facilities and equipment, properly trained staff, and an accumulated body of knowledge and experience are required. Our attempt to treat alcoholics and narcotic addicts in our regular adult programs have proven frustrating and ineffective. Experience indicates the desirability of specialized units with associated laboratory facilities and trained personnel devoted to these problems.

I have recently had discussions about this problem with Mr. Ernest Shepherd, Director of the Drug and Alcoholic Dependence Division of the Connecticut Department of Mental Health, Dr. Wilfred Bloomberg, Commissioner of Mental Health, and other leaders in the Connecticut area. We are all agreed that one of the major obstacles to the development of quality programs for treatment and prevention in the fields of alcoholism and drug dependence has been the resistance within the medical professions to assuming responsibility for these important areas. For too many decades, alcoholism and drug dependence have been stepchildren within the mental health family. This is evidenced by inadequate instruction on these topics in medical schools and in training programs for psychiatrists, psychologists, social workers, and psychiatric nurses. Moreover, only a small fraction of mental health professional have devoted themselves to these important subspecialties. Within the mental health profession there is a myth of fatalism and pessimism because of the pervasive conviction that these are hopeless conditions for which no effective treatment programs exist. While our treatments have their limitations, pessimism and fatalism are unfounded. The evidence indicates that properly integrated and supported programs can achieve substantial results in reducing mortality and morbidity, returning patients to the community, and facilitating their social and vocational readjustment.

These professional attitudes are related to the stigma which our society continues to attach to these conditions. Alcoholism and drug dependence have long been regarded as legal, rather than medical, problems. I am concerned that the current attitudes toward alcoholism and drug dependence are similar to the attitudes toward the psychoses and other mental health problems held by our society a hundred years ago. Let us remember that when Dorothea Dix began her crusade for humane treatment of the mentally ill, many were being treated as criminals, housed in jails and county poor houses, rather than in medical facilities. I think we are at a similar historical point in the social attitude toward alcoholism and drug dependence. A crucial turning point would be the transfer of these problems from purely legal and correctional approaches to medical and social welfare programs.

While this legislation will go a long way towards improving this situation, I would recommend that, ideally, consideration be given to amending the regulations for community mental health centers so as to make the inclusion of programs and facilities for alcoholics and narcotic addicts among the essential and required services of community mental health centers. The current federal regulations do not include these important areas as necessary components of community mental health center programs. In my opinion, consideration should be given not only to permissive legislation, such as is proposed here, but also to mandatory requirements so that to be truly considered a community mental health center, eligible for federal funds for construction and staffing, specialized facilities and programs for alcoholic and drug addiction must be included in the plans. I realize that these may be radical proposals for today, but it is my prediction that within a decade we will expect this, as we now expect that emergency treatment and day hospitals are parts of mental health centers along with in patient care and out patient care.

CONCLUSIONS

In conclusion, I wish to offer my special enthusiasm and support for Section 252, which authorizes grants for training and evaluation of the program. As our nation in general, and the mental health professions in particular, have come to realize the extent of the problem of alcoholism and drug addiction, we have also become aware of the inadequacy of trained personnel and the limitation of existing treatment methods. As regards training, it is increasingly apparent that because physicians, social workers, psychologists, nurses, and other professionals are poorly trained in their fields, they have insufficient knowledge about the nature of narcotic addiction and the newly developed methods for detection, treatment, and rehabilitation.

Most important, we must acknowledge that our current treatments have only limited efficacy. New and exciting treatments are being developed, and there is promise that they will be joined by other new techniques. For example, the availability of methadone and cyclazocine, drugs I have mentioned previously, has attracted bright young professionals and scientists into this field by generating new optimism. However, research is needed to undertake field trials and to assess the efficacy of these programs. This investigation should include follow up studies to ascertain the long term consequences of alcoholism and drug addiction and the success of treatment programs in promoting a healthy life of abstinence and family, social, and occupational adjustment. The National Institute of Mental Health has recently strengthened its research programs in these areas and the activities of its staff is having a beneficial effect throughout the mental health field. It is my conviction that the enactment of this legislation will further strengthen these programs.

Thank you very much.

Mr. ROGERS. Thank you very much, Dr. Klerman.

In your mental health center, could you let us have your staffing and the number of people you serve?

Dr. KLERMAN. I would be delighted to.

(The information requested was not available at time of printing.)

Mr. ROGERS. Is the number of people you serve connected with any number of alcoholics?

Dr. KLERMAN. We do not have the specialized facilities we would like. Our estimates indicate that about 10 percent of our admissions have associated problems of alcoholism and drug dependence, but we know we are turning away people with these problems. And large numbers of them still go to the State hospital at Middletown, which is 25 miles away.

One facility was originally planned for 100 beds, but because of financial difficulties, only 50 beds were finally constructed. So we do not have the specialized facilities that this legislation would allow to be included and for further construction and staffing.

Mr. ROGERS. Actually, there is a provision that psychiatric services could be provided.

Dr. KLERMAN. I realize that that was the intent. I would submit that in practice—

Mr. ROGERS. This hasn't been done.

Dr. KLERMAN. It would be like ours. We had underestimated the magnitude of the problem and also the desirability of specialized facilities.

Mr. ROGERS. Thank you.

Our next scheduled witness is Dr. Walter Barton, who is medical director of the American Psychiatric Association.

Is he present?

Dr. Barton is not present but he has submitted a statement for the record.

(Dr. Barton's prepared statement follows:)

STATEMENT OF DR. WALTER BARTON, MEDICAL DIRECTOR,
AMERICAN PSYCHIATRIC ASSOCIATION

H.R. 15281 (S. 2889) now before the Congress, would amend the Community Mental Health Centers Act by providing for specialized facilities for alcoholics and narcotic addicts.

In the view of the American Psychiatric Association the purposes of this legislation are altogether laudable and its detailed provisions are entirely satisfactory with a single possible exception noted below.

Recently, the Joint Information Service of the American Psychiatric Association and the National Association for Mental Health published a report of a comprehensive study of psychiatric treatment facilities for persons with alcohol problems. (See *The Treatment of Alcoholism* by Raymond Glasscote, Thomas F. A. Plaut, et al, American Psychiatric Association, Washington, D.C., 1967). Perhaps the most salient observation of the report is quoted as follows: "Services for alcoholics must be greatly expanded in quantity. There is no city in the United States where the amount of service begins to approach the already manifest need."

In several states alcoholism is the largest single diagnostic category for male first admissions to the state mental hospitals. In Maryland, for example, the figure reaches 40%. Some forty different states have alcoholism programs, but a number of them are limited solely to public education. Other states have some limited grant funds to assist outpatient clinics and occasionally some inpatient services. Altogether there are about 125 outpatient clinics for alcoholics in the nation as a whole, but many of these are part time only and offer very limited services. Many general hospitals in our country will not admit alcoholics as such, and when they do, the services they render tend to be brief, superficial, and inadequate. As for the community mental health centers now getting under way, it is too early to evaluate how effective they may become in treating alcohol problems, but one may confidently expect that this legislation, if passed, will further ensure the success of their efforts.

Specifically, the legislation provides for grants to suitable agencies in areas where a need for special facilities for inpatient and outpatient treatment of alcoholics is demonstrated and when the proposed plan is adjudged satisfactory according to various sensible criteria.

There is just one provision (Sec. 241(C)) which in our judgment needs some modification. It is stated "that the application (must have) been approved and recommended by the single state agency primarily responsible for care and treatment of alcoholics in the state . . ." The problem here is that in many states the "single state agency" is in fact a politically appointed commission whose responsibility is confined largely to public education programs. The members of these commissions are not representative of the expertise in the treatment of alcoholism to which this legislation primarily addresses itself. Experts in treatment problems are rather to be found in the offices of mental health authorities, departments of institutions and corrections, etc. This provision should, at the very least, in our view, eliminate reference to the "single state agency designated by the state as being the agency primarily responsible for care and treatment of alcoholics." Rather a phraseology should be substituted to the general effect that a state will appoint a single agency to administer the program and comprising the essential expertise that should be brought to bear on the execution of the entire program.

No exception is taken to the mode of financing that is proposed for construction and staffing. It is most especially praiseworthy that the legislation allows funds for a variety of treatment modalities such as specialized residential facilities, half-way houses, day care centers, hostels for homeless alcoholics, and the like. In short, the more flexibility governing the use of the grant monies the more promising and effective the program will be in our view.

Title II of H.R. 15281 provides for grants for constructing, operating and staffing treatment centers and facilities for narcotic addicts, including the development of specialized training programs for personnel involved in treating addicts and the evaluation of programs for the prevention and treatment of addiction. No exception is taken to any of the provisions of Title II.

In sum, the American Psychiatric Association strongly supports this legislation hoping that the provision about approval of grant programs by the "single state agency" may be further refined to ensure that appropriate professional expertise is brought to bear on the total program. The growing and widespread

acknowledgment of alcoholism as a disease (including the tendency of the courts to so label it) together with the appalling poverty of the nation's resources for treating it, is evidence enough of the urgency of such legislation. The same massive need exists in relation to the addiction problem.

Mr. ROGERS. Dr. Gilbert Geis, California State College in Los Angeles. Is he present?

Dr. Geis has submitted his statement for the record.

(Dr. Geis' prepared statement follows:)

STATEMENT OF GILBERT GEIS, PROFESSOR OF SOCIOLOGY, CALIFORNIA STATE COLLEGE

COMMUNITY TREATMENT OF NARCOTIC ADDICTS

Narcotic addiction, we now know, can best be controlled in community setting. It will probably remain necessary to incarcerate some addicts either in prisons or under the auspices of civil commitment programs, particularly addicts who perform criminal acts of a nature not directly associated with their addiction or of a kind that society cannot reasonably tolerate. But, for the most part, it appears not only important, but also imperative that future efforts toward controlling and reducing narcotic addiction be included as part of the work of community mental health centers.

The reasons appear compelling. For one thing, we have consistent evidence that the incarceration of addicts produces only minimal rehabilitative results. In California, we have learned that incarceration in prison of narcotic addicts plus routine parole aftercare will bring about a success rate (measured by abstinence from drugs and lack of criminal difficulty for one year subsequent to release to the community) of about thirty percent. There has been no substantial increase in this success rate when parole caseloads are reduced, nor when parolees are placed in a halfway house. Neither, for that matter, has the massive civil commitment program for narcotic addicts, pioneered in California, managed to improve upon the success rate of earlier approaches to the problem.

We believe now that the reason for the failure to increase success rates is tied rather intimately to the fact that the addicts' success and failure to remain abstinent is closely tied to their self-image. This self-image most usually is one defining addiction as an intransigent behavior and establishing the myth that "once an addict always an addict." For substantial rates of cure to be realized, it appears necessary that the addict not become immersed in prison or civil commitment cultures and not be allowed to wallow in the self-justifying rationalization that his difficulties are insurmountable.

Support for the validity of this thesis can be derived from the experience of Synanon, a self-help program originated in California, which transmits to its recruits the idea that addiction can and will be conquered. Synanon does this by putting on display its own successes, men who were addicts, but have been clean for many years and have made their way in "square" society.

The Synanon program, community-based, indicates clearly that addicts can be helped without the constraints or lessons imposed by institutional life.

The Synanon experience is further supported by data from California which show that medical doctors who become addicted to drugs are able to cease their use of such drugs in some 92 percent of the cases, though the penalty imposed on them is nothing more than the withdrawal from them for five years of their prescription-writing privileges. Allowed to remain in the community, allowed the opportunity to retain the prerogatives of their professional performance (including status and money), the medical doctors in an overwhelmingly large number of cases conform to social demands. We would argue that incarceration of the same doctors would produce a much lower rate of subsequent abstinence.

It seems apparent, therefore, that community-based programs for rehabilitative work with addicts offer the most hopeful opportunities for success. Such programs can provide counseling, can refer persons for employment, can deal with family difficulties as they arise. Equally as important, they can permit the addict to retain his self-confidence in his ability to ultimately live a drug-free existence.

I would finally call attention to the early success that we have been having with a community-based program in Los Angeles which employs 28 ex-addicts to work with practicing addicts in the Boyle Heights area, a neighborhood with the highest addiction rate in the State. Paid decent salaries, supervised with some

care, the ex-addicts have to date demonstrated a reassuring willingness to work hard and well in discovering and caring for other men currently using drugs. It is our belief that the Boyle Heights program has had an impact upon the rate of drug use in the area, and concomitantly the rate of crime, particularly crime against property. The employees of the Boyle Heights project report that meaning has been imparted to their lives, and their clients note that the object-lesson of successful former addicts, the opportunity to remain in the community while they deal with their addiction, and the clear understanding of their problem by those who once shared it, all have contributed to their own willingness and ability to refrain from drug use.

It is in terms of experiences such as that which we are having in Boyle Heights, as well as a review of previous experiences with prison programs, federal public health operations, and civil commitment that the proposed legislation to incorporate narcotic addiction within community mental health center programs seems preeminently decent and desirable.

Mr. ROGERS. Mr. H. Leonard Boche, director, Department of Social Welfare of the Board of Christian Social Concerns of the Methodist Church; and president, Association of Halfway House Alcoholism Programs of North America.

STATEMENT OF H. LEONARD BOCHE, DIRECTOR, DEPARTMENT OF SOCIAL WELFARE OF THE BOARD OF CHRISTIAN SOCIAL CONCERNS OF THE METHODIST CHURCH, AND PRESIDENT, ASSOCIATION OF HALFWAY HOUSE ALCOHOLISM PROGRAMS OF NORTH AMERICA

Mr. BOCHE. Thank you, Mr. Chairman. It is a pleasure for me to have this opportunity to meet with you.

Mr. ROGERS. We will make your prepared statement a part of the record following your remarks.

May I interrupt just a minute? I see one of our distinguished members on this committee, Congressman Stuckey, of Georgia. We are always delighted to have colleagues of this committee come in and visit.

Mr. BOCHE. I would like to highlight only a few points from my prepared statement. I come before this committee primarily out of my experience. Previous testimony has clearly indicated the value of a complete continuum of care in the treatment of alcoholism.

I would like to point out that the halfway house, or the aftercare facility has theoretically come of age, but in practical terms there is a social lag which has not included the halfway house, in fact, in the total continuum of care.

This has largely been related to the inadequate philosophy of funding that has been associated with halfway house programs. These programs have grown up out of the concern of individual citizens and have not been fully incorporated into the community plan.

Hence, I come before you in support of this bill, especially that section dealing with halfway houses and aftercare facilities.

I raise with you for your consideration that the existing halfway house alcoholism programs, be seriously considered to be included within the act as well as new and expanded facilities.

The crisis of the halfway house is that it is unable to do the task under the financial structures that presently exist. The halfway house is an economical way of protecting the public investment in detoxification and inpatient treatment.

We find, as in the testimony of Dr. Pittman, the experience of Des Moines and other inpatient treatment facilities that aftercare and halfway houses are urgently needed if we are going to be able to adequately capitalize on the amount of investment that is made in inpatient care and in detoxification itself.

And so I would like to call this to your attention, Mr. Chairman, and members of the committee, for I believe that the structure of this bill may very possibly provide the theoretical model and the means by which the halfway houses can be, in fact, integrated within the total continuum of care in the treatment of alcoholism.

The halfway house uses as its mechanism and as its dynamics primarily the community of mutual support which is generated by people who have similar afflictions and who join together out of their weaknesses and contribute to each other's recovery.

The principle that the afflicted can help others afflicted to recover has been demonstrated by Alcoholics Anonymous. This has been applied over and over again in a multitude of self-help organizations now in existence. This applies to the halfway house where a shared experience of hope can be developed and the learning experience necessary to live in a complex world without chemical assistance and chemical crutches.

I support this bill for I believe that it develops public policy which will integrate the halfway house into the total community of treatment. I urge the committee to amend the bill to cover existing halfway house programs which meet the appropriate standards and which are integrated into the total community plan.

If existing programs are not included, a premium will be placed on the development of new programs rather than using the experience of existing services. Any financial plan for halfway houses must take into account that supplementation must come from some source, either public or private, if the programs are to carry out their intended purpose.

We believe that this source, most appropriately, is through some type of public funding, which is outlined in this proposed bill.

I come supporting this bill because I believe that the halfway house makes each dollar spent on treatment of the addicted significantly more productive.

(Mr. Boche's prepared statement follows:)

STATEMENT OF H. LEONARD BOCHE, DIRECTOR, DEPARTMENT OF SOCIAL WELFARE OF THE BOARD OF CHRISTIAN SOCIAL CONCERNS OF THE METHODIST CHURCH, AND PRESIDENT, ASSOCIATION OF HALFWAY HOUSE ALCOHOLISM PROGRAMS OF NORTH AMERICA

Mr. Chairman, and members of the committee, my name is Leonard Boche, and I come in my own behalf before this committee to testify out of my experience as the director of a community alcoholism program, co-founder of a halfway house for alcoholic women, and now as president of the Association of Halfway House Alcoholism Programs of North America. The Association has 96 members in 36 states and three provinces of Canada.

I come before this committee to support H.R. 15758, especially that portion (Sec. 243 (b)) dealing with halfway houses and after care facilities. For reasons which shall be given, I urge the committee to give consideration to provisions for supplementing existing halfway house programs and programs developed under this act.

The concept of the halfway house as a transitional facility in the treatment of a variety of conditions is rapidly coming into its own. As one listens to comprehensive health plans, or tunes oneself to the care and need of the retarded, the mentally ill, and to the field of corrections, the common ground uniting them all

is their interest in the use of transitional facilities. On a theoretical basis, a discussion of the continuum of care in any one of these fields, as well as in addiction, has integrated within it the concept of the halfway house as a means by which the afflicted is introduced into the complexities of modern society. The theoretical model has come of age, but there is a sizable lag between the concept and its application in the affairs of people in need.

The one overriding consideration which seems to unite the many and diverse programs under the label of halfway house is their lack of consistent financing. It seems that it is the lack of financial security which unites, as much as the program services which are provided. When talking to administrators of halfway house alcoholism programs, the common problem which all face is funding. Few consistent patterns have emerged so that each program looks almost unique in terms of its fiscal structure. What I believe is needed is the development of a philosophy of halfway houses and funding. Halfway house alcoholism programs may be able to exist on the basis of getting funds where they can, but it will not be until consistent funding is worked out will the halfway house be able to relate effectively to the total community structure.

The halfway house can best be thought of as a bridge. A means by which the individual moves from one point of his addiction to another point which represents successful treatment. In most instances we are relating to in-patient intensive care on one hand, to out-patient supportive care within the halfway house, and then, finally, to independent living within society. I am well aware that halfway houses have at times been seemingly forced into the situation of being a treatment facility, but it is my firm conviction that the primary in-patient role is not the proper area of the halfway house and every effort should be used to divest the program of that element of responsibility. The reason for this is that the halfway house is simply not equipped by either its facilities or staff to carry on the intensive in-patient care that is often needed in the treatment of alcoholism.

The halfway house makes its main contribution in providing a substitute family for the person in the course of his treatment and is not a substitute for the primary treatment of alcoholism. The transitional facility provides a peer group experience where the individual can learn how to live without the help of chemical crutches. It is a transference of dependency from chemical means to interpersonal relationships that are characteristic of the family setting. Many individual who find their ways into the cycles of addiction have never learned how to live so the process of socializing is very difficult for persons with addictive histories. This can be most effectively accomplished within the living situation in which there is a common identity and supportive staff.

The dynamics of the halfway house are in the community of mutual support which is generated by people who have similar afflictions, who join together not out of their strengths, but out of their weaknesses and contribute to each other's recovery by providing support, identification, and hope. The principle that the afflicted can help others who are afflicted recover has been dramatically demonstrated within the program of Alcoholics Anonymous, and this principle has been accepted and re-applied over and over again in the multitude of self-help organizations which are now in existence. The same principles apply to the halfway house where out of a common experience of misery, there can develop a shared experience of hope and the learning experience necessary to live a new life.

In that the community of mutual support is the basic therapeutic ingredient of the halfway house, therefore I believe that halfway houses will invariably, of necessity, be specialized facilities. The individuals entering the halfway house are often by definition incapable of accepting the broad spectrum of community maladies and are so preoccupied with their own state of misery that they are able only to identify with people of similar experience. I can foresee that there will be those who are interested in comprehensive planning who will want to seriously consider multi-purpose types of halfway houses, but I cannot see practical application. I defend as a practical consideration that the specialization of halfway house facility is necessary and there is need to provide specialized facilities and to adequately fund them.

The claim that halfway houses can be self-supporting outside of capital investment has often been made in a well-intentioned way to insure the private donors that there would be a limitation on the appeals made in behalf of halfway house facilities. Time has been the teacher and we have come to learn

that good halfway houses must be supplemented on an annual basis. Halfway houses which have become financially self-supporting do so invariably at the cost of staff, and they degenerate too often into boarding house situations rather than adequate halfway houses where people learn how to live.

The present dilemma in which we find ourselves is that all of the elements of sound halfway house program development are present but are not coordinated or blended in a harmonious way. The private halfway house is having its effectiveness curtailed by the demands which are made on the staff and the board of directors in fund-raising activities. Its effective resources are being devoured in the struggle with survival, curtailing its essential functions of "bridge building" in the lives of the afflicted. Program budgets are being starved in the face of economic necessity.

In an attempt to go beyond the mere definition of the problem, let me attempt to create a model program which could blend the many constructive elements in a harmonious and creative way. It will of necessity be a joint venture between the voluntary agency and public responsibility in funding. The private voluntary halfway house has the tools to do the job if it can be given financial security and the means to provide sound programming. The basis of this joint venture is the familiar phrase that has become a byword to the people working in the field of alcoholism, but nevertheless profound in its ramifications, "Alcoholism is a public health problem and hence a public responsibility." The establishment of this public responsibility has been developed on a voluntary basis as well as through the coercive activity of the court as in the Driver and Easter cases, and hence it is a real factor today.

It is necessary to affirm again the valid contribution that the halfway house makes in the care and treatment of the alcoholic. It is a legitimate and necessary element in the continuum of care if alcoholics are in fact to be successfully rehabilitated. The detoxication units in Des Moines and St. Louis, as well as inpatient facilities across the country, have clearly seen the need of after care facilities if the money the public spends on detoxication and treatment is to be a sound investment. Detoxication and returning the alcoholic back on the street can be a new revolving door somewhat more humane but nevertheless just as revolving. The halfway house provides the vehicle which can make the detoxication center a worthwhile investment.

The voluntary private halfway house makes its contribution to the whole field of alcohol treatment in its ability to mobilize the needed multi-disciplinary community of interest necessary to develop a sound recovery program. It is able to involve people within the whole process which can give content and substance to program.

The partnership which emerges is the volunteer program supplemented by public funds. The private volunteer halfway house has its financial crises in the area between income received from the residence and the cost of the program needs. This is the area mentioned before in terms of the need of supplementation. This is the area where historically the private halfway houses have struggled to scratch up dollars and pennies to keep the programs alive. But if the halfway house is really going to be integrated within the total health program, it is going to have to be underwritten by public policy and public money.

I support this bill for I believe that it develops public policy which will integrate the halfway house into the total community of treatment. I urge the committee to amend the bill to cover existing halfway house programs which meet the appropriate standards and which are integrated into the total community plan. If existing programs are not included, a premium will be placed on the development of new programs rather than using the experience of existing services. Any financial plan for halfway houses must take into account that supplementation must come from some source, either public or private, if the programs are to carry out their intended purpose.

The halfway house makes each dollar spent on treatment of the addicted significantly more productive.

Mr. ROGERS. Thank you very much, Doctor, for your testimony.

Dr. Carter?

Mr. CARTER. No question.

Mr. ROGERS. Let me ask you this: Who would run the halfway houses?

Mr. BOCHE. Halfway houses have been staffed for the most part by recovered addicts who have been especially trained. Now, this is not—

Mr. ROGERS. I mean, would it be a staff that runs the community mental health center, or would it be private groups? Or who would establish it, in other words?

Mr. BOCHE. I think a strong point can be made for the private non-profit, community-oriented group working on a voluntary basis in cooperation with the community mental health clinic.

I think the big value of this is that you provide in this kind of organization, an army of volunteers which can help in the resocialization process.

Mr. ROGERS. Could you let us have a rundown of examples of halfway houses, the costs of maintaining them, the services provided, maybe some examples of success, or problems?

Mr. BOCHE. Yes. I could deliver for you outlines of some of the more successful and ideal programs.

(The information requested by Mr. Rogers and submitted by Mr. Boche may be found in the committee files.)

Mr. ROGERS. If it is going to be voluntary—that is, you don't envision that the people running the halfway house would all be voluntary?

Mr. BOCHE. Oh, no. I am saying that in terms of its organization and board of directors, that we are dealing with a voluntary agency which hires a staff and then is able to enroll and bring in an army of volunteers.

Mr. ROGERS. Yes. This would provide shelter, I presume.

Mr. BOCHE. Yes; we find the halfway house is providing a substitute home, with all the productive possibilities that a substitute home can provide.

Mr. ROGERS. This is what would be covered, I assume, in the legislation by residential—

Mr. BOCHE. Yes, sir; or after-care facilities on a live-in basis; yes.

Mr. ROGERS. Do you estimate how much would be needed?

Mr. BOCHE. This is very difficult. Out of the experience of St. Louis, for instance, they could probably use, without any difficulty, six or eight facilities of 30 beds each.

The big advantage that the halfway house has is that it is able to operate at significantly less cost, and that approximately—in facilities for men—about half of the cost of running the house comes from their own contribution. With women, this runs approximately a third.

Mr. ROGERS. While they are in the halfway house, is it essential that they take treatment?

Mr. BOCHE. We believe that before a person comes to a halfway house that they should be involved in significant inpatient treatment, and that such after-care as indicated by the professional community be carried on when the resident is living in the halfway house, so that when he leaves the halfway house he basically takes with him all of his therapeutic relationships.

Hence, we do not believe that these kinds of supportive therapeutic relationships should be contained within the house, but rather within the community, so that this continuum of care can be continued beyond this living-in situation.

Mr. ROGERS. Is there any compulsion, or is this all voluntary?

Mr. BOCHE. Well, there is, of course, a question always raised, Is alcoholism ever voluntarily treated? Working in a community program, I have known of many instances where a man went voluntarily to get help because if he didn't his wife was going to divorce him.

So there are many forms of coercion.

Mr. ROGERS I mean in a legal sense.

Mr. BOCHE. In a legal sense, no. The halfway houses in operation do not use legal means to keep a man in residence. At the present time we have had no experience in that area.

Mr. ROGERS. Thank you very much. We appreciate your help to the committee.

The record may stay open for 5 days for anyone to make a statement, if they desire.

There are no other witnesses. This concludes the hearings.

The committee is adjourned.

(The following material was submitted for the record:)

STATEMENT OF JUDITH G. WHITAKER, EXECUTIVE DIRECTOR, AMERICAN NURSES' ASSOCIATION, INC.

The American Nurses' Association wishes to record its support of the provisions of H.R. 15758 which will extend and improve the provisions of the Regional Medical Program, extend the special grants for health of migratory workers, and provide for specialized facilities for alcoholics and narcotic addicts.

We believe that the Regional Medical Programs, P.L. 89-239 is one of the very significant programs enacted by the Congress in the last few years. It is demonstrating that it has great potential for making more readily available to the people of this country the results of the latest advances in the treatment of heart disease, cancer and stroke and related diseases. Physicians, nurses and other health personnel have the opportunity through the programs to become familiar with these advances and to update their skills in caring for patients. The programs have further stimulated cooperation between members of the health professions as they prepare to give the highest quality of service to people.

The legislation was devised as a means of reducing the gap between care possible in a medical center and that available to persons remote from the centers. To achieve this end we have encouraged active participation of the registered nurse as a member of the health team in both the planning and the implementation of the law.

Title II of H.R. 15758 proposes the extension of the special grants for health of migratory workers. We urge that this extension of the special grants for health proposed in the bill.

Migrant workers have always faced difficulties in obtaining adequate preventive and therapeutic health services. Studies show the disease rate for farm workers to be three times that of industrial workers. Forty percent of these diseases result in permanent disability for regular work as compared with twenty-seven percent among industrial workers. Women in farm worker families receive no prenatal care or late care in 33% of cases as compared with 6% in skilled worker families. Special means have to be taken to correct these serious deficiencies in the provision of health and preventive care services. Assistance from the federal government is essential. Many states alone are unable to provide such services because of insufficient resources. Also, eligibility to receive medical and health care services is often governed by the residence requirements of a state. Since migrant farm workers move from state to state, establishing residency is frequently not possible.

The Association also supports Title III of H.R. 15758 which proposes construction grants and staffing, operation and maintenance grants for centers for the treatment and rehabilitation of alcoholic and narcotic addicts.

We urge the Committee to act favorably on H.R. 15758.

STATEMENT OF MYRON KOWALS, ASSISTANT DIRECTOR, SEATTLE MENTAL
HEALTH INSTITUTE

Alcoholism in particular has long been a critical problem in the Seattle area. Facilities such as the Pioneer Fellowship House, the Women's Studio Club, the Lewis Martin Home, and the Alcoholism Treatment Clinic, have been struggling to devote services to alcoholics in an effort to promote their rehabilitation. However, the financing of these projects is a constant struggle. We recognize alcoholism as a mental health problem which is properly the province of the community mental health center and therefore these facilities dealing with the problem of alcoholism should be funded under community mental health centers legislation. Due to the immense problem of lining up state and local support in order to permanently fund these facilities, it is felt that a declining federal support over a period of ten years would give the facilities the best chance for permanent success.

Because the Seattle Mental Health Institute feels so strongly about the problem of alcoholism a great effort was made to establish working agreements with the alcoholic facilities as part of the grant application for community mental health centers staffing funds. Even though SMHI felt that alcoholism was a mental health problem and therefore should be included in the service centers, it is still important that the legislation puts clearly into writing the eligibility of the alcoholic rehabilitation facilities.

However, to allow a period of ten years of federal support alcoholic facilities and at the same time to limit community mental health centers in general to a period of support of 51 months seems to me to be putting the cart before the horse. Every effort should be made to amend the bill to lengthen the period of support for community mental health centers in general to a period longer than 51 months. It is my personal belief that community mental health centers can be supported by state and local sources without any permanent federal support, but achieving this will definitely be a challenging task. State legislation is going to play an important part in establishing the permanent sources of non-federal support. County funds can also be expected to play an important part in local support. However, promoting state legislation to provide the support funds would take considerable work in more than one session of the legislature. Under the present federal law the level of support by the fourth year of funding of a community mental health center is at a critical low level. If two sessions of the legislature were sufficient to provide legislation for the funds needed by the time the laws became effective the centers would have already experienced considerable financial difficulty.

If community mental health centers are unsuccessful within the 51 month period in lining up sources of support to supplant federal funds it is inevitable that these centers will gravitate towards the serving of the paying patients. This will result in a drastic cut-back of service to citizens who are unable to pay or capable of paying only a portion of the cost. Naturally this would defeat the purpose of the federal community mental health legislation.

I strongly urge the committee to consider amending the bill in such a fashion as to provide longer period of support than 51 months. To wait for community mental health centers to begin failing before doing so would be indeed short-sighted. I believe there is enough evidence to this date to show that the entire burden of the community mental health centers cannot be shouldered by state and local sources in such a short period of time.

STATEMENT OF THE NATIONAL CONSUMERS LEAGUE

The National Consumers League has for over half a century concerned itself with the problems of the migratory agricultural workers, the most neglected segment of our working population, and in their behalf wishes to go on record in support of extension of the Migrant Health Act of 1962, as amended in 1965, provided for in the Health Services Act of 1968, H.R. 15758.

It is estimated that there are about one million Americans—migrant farm workers and their families—who suffer from inadequate health care. Until the Migrant Health Act was passed in 1962, health care for migrants was practically nonexistent. Since that time, some real progress has been achieved, but the "health gap" among this group is still shockingly large. Only about one-third of the migrants have received health services under the program, and almost 40% of the counties where seasonal migrants work still have no grant-assisted project

services. Six out of ten of the counties serving as "home base" for migrant workers have no personal health care for farm workers. Among this group of workers deaths from influenza, pneumonia, tuberculosis, infant diseases and accidents are from one and a half to four times the national average. National per capita health expenditures are almost twenty times greater than the per capita health expenditures for migrants.

Until this gap is significantly narrowed, the need to continue the special program of Migrant Health Services is urgent. Not only should present projects be continued, but new ones must be established in those communities which now have none.

The National Consumers League therefore strongly urges that you extend the Migrant Health Program for at least two years, and that at least \$10 million be authorized for each of the fiscal years ending June 30, 1969 and 1970.

[Telegram]

CARMEL, CALIF., March 27, 1968.

Hon. JOHN JARMAN,
Chairman, Subcommittee on Public Health and Welfare,
House of Representatives, Rayburn Building, Washington, D.C.:

The Board of Directors of the National Council on Alcoholism, Monterey Peninsula Area, Monterey County, California, composed of physicians, clergymen, judges, lawyers, educators, and businessmen, voted unanimously today to convey to the Subcommittee on Public Health and Welfare concerns for the vast unmet need of alcoholics in this area and throughout the Nation. We heartily approve the purposes of H.R. 15758, especially its provision for facilities for alcoholics. With very limited facilities to date our community has demonstrated the unlimited potential for conservation of human resources through alcoholic rehabilitation. The need for more facilities is crucial to prevent needless waste. We urge favorable action on H.R. 15758.

GEORGE E. RIDGWAY, *President.*

[Telegram]

SAN RAFAEL, CALIF., March 25, 1968.

Subject: Hearings on H.R. 15758.

Hon. JOHN JARMAN,
Chairman, Subcommittee on Public Health and Welfare,
Rayburn Building, Washington, D.C.:

Legislation pertaining to recognition and treatment of alcoholics is long overdue. Presently only small fraction of alcoholics are being reached by public and private agencies. Features in this bill represent important steps toward meeting imminent tremendously increased demand for expansion in all areas of field.

ALLEN SKINNER,

Chairman, Alcoholic Recovery Homes Association, San Francisco, Calif.

HOUSE OF REPRESENTATIVES,
Washington, D.C., March 26, 1968.

Hon. JOHN JARMAN,
Chairman, Subcommittee on Public Health and Welfare of the Committee on
Interstate and Foreign Commerce, U.S. House of Representatives, Wash-
ington, D.C.

DEAR MR. CHAIRMAN: Hearings are currently being held by your Subcommittee on H.R. 15758, a bill to amend the Public Health Service Act so as to extend and improve the provisions relating to regional medical programs, to extend the authorization of grants for health of migratory agricultural workers and to provide for specialized facilities for alcoholics and narcotic addicts, which was introduced by the distinguished Chairman of the Committee on Interstate and Foreign Commerce, the Honorable Harley O. Staggers. Because of the increasing involvement in medical programs in the Pacific by the relatively young University of Hawaii School of Medicine, I would like to take this opportunity to comment specifically on Section 103 of the bill, under the subtitle "Inclusion of Territories."

This section apparently is designed to extend the regional medical programs to Guam, American Samoa, and the Trust Territory of the Pacific Islands, as well as to other areas. The extension of such programs would promote the acquisition and dissemination of medical knowledge and skills throughout U.S. territories in the Pacific. Medical research and training in which the University of Hawaii School of Medicine is presently engaged in several cooperative ventures in these Pacific areas, would be strengthened and improved. The result of all this is that the people in these areas would receive the full benefits and assistance of American medical science and technology.

For the foregoing reasons, I strongly urge that Section 103 be retained in the measure that is reported out by your Subcommittee.

It is requested that this letter be included in the record of hearings on H.R. 15758.

Aloha and best wishes.

Sincerely,

SPARK M. MATSUNAGA,
Member of Congress.

AMERICAN HOSPITAL ASSOCIATION,
Washington, D.C., March 26, 1968.

HON. HARLEY O. STAGGERS,
*Chairman, Interstate and Foreign Commerce Committee,
House of Representatives, Washington, D.C.*

DEAR CONGRESSMAN STAGGERS: This statement expresses the views of the American Hospital Association on H.R. 15758 which amends the Public Health Service Act so as to extend and improve the provisions relating to regional medical programs, to extend the authorization of grants for health of migratory agricultural workers, to provide for specialized facilities for alcoholics and narcotic addicts, and for other purposes.

REGIONAL MEDICAL PROGRAMS

This Association strongly supported the development of the legislation which resulted in P.L. 89-239. We were pleased that certain recommendations, which we felt were essential to the most effective development of the program, were incorporated in the law. We have continued to follow carefully and with great interest the progress of the program. The past two years appear to have been spent in the main in the establishment of regional programs and in their planning. The operating stage of the program is really only just beginning with a limited number of projects having been approved to date. Though good planning is highly essential it is to be hoped that the program will move forward rapidly in its application. We have always believed the purpose of the bill is to establish a bridge between the science of medicine and its full application to the care and treatment of patients. In the coming months, therefore, it is to be hoped that the programs developed will be felt by the public in terms of a broadened application of knowledge in the treatment of these diseases covered under the program. We urge the Committee to authorize the full amount requested for the program for the fiscal year ending June 30, 1969.

The Association has continued to feel that implementation of the intent of the law would necessitate a full involvement on the part of hospitals and their medical staffs. This will necessitate not only the participation of the medical schools and the larger teaching and community hospitals but the smaller hospitals spread throughout the nation which provide a focal point for medical care and treatment in smaller communities. We have been disappointed at the extent of involvement of hospitals and particularly the minimal participation of these smaller community hospitals which is so essential if the program is to have meaning to the public at large. Therefore, the American Hospital Association will undertake a number of steps which it is hoped will result in a much wider involvement of hospitals. We have also noted that very little emphasis has been given thus far to preventive care and long-term patient care and we intend to stimulate leadership on the part of the hospital field in fostering such a broad approach to the regional medical programs. We will continue to work closely with the administrators of the program and to work for the fullest participation of the hospital field.

We recognize fully the merit of thorough planning as a basis for the development of regional medical programs. Such plans, of course, must involve the facilities, personnel and services pertaining to the illnesses covered under the program. However, the Congress under P.L. 89-749 initiated comprehensive health planning thereby establishing planning mechanisms throughout the nation to be involved in over-all health care and to specifically include health facilities, services and personnel. It is obvious therefore, that rather complete duplication of planning now exists between the two programs and from reports which we receive we are just beginning to witness the confusion resulting from this conflict and overlapping. If health planning, which we strongly approve, is to be developed in an orderly manner, any overlapping and conflict must be resolved. At present the existing provisions go far towards encouraging competitive activities for domination of the field.

We recommend, therefore, the Congress take action to eliminate the existing overlapping and confusion by requiring that the cooperative regional medical programs developed under P.L. 89-239, and the results of the planning developed under P.L. 89-749 be in conformity.

H.R. 15758 proposes to increase the membership of the advisory council from twelve to sixteen members. In order to facilitate further the closest possible coordination between this program and the comprehensive health planning program, we would urge that additional representation of council members be required to include individuals directly engaged in area and state wide planning activities.

We are pleased to note that the bill, as in the original Act, does not propose to authorize funds to be appropriated for construction purposes. The program is of such magnitude that we believe the funds should be expended for the operational phases of the bill. Further, we feel it would be unwise to duplicate the construction authority now provided for in other acts.

The bill requests clarification so that grants may be made to agencies and institutions for services which will be useful to two or more regional medical programs. There are various services which can be developed most efficiently and effectively for larger areas than would be encompassed in a single region. We believe, therefore, that the authority to make grants as suggested here is desirable.

MIGRATORY AGRICULTURAL WORKERS

The bill proposes to extend the program of grants providing for health services to migratory agricultural workers for an additional two years. We strongly supported the original legislation and later urged an increase in the program so as to permit payment to hospitals for care provided migratory workers and their families. Our recommendations were made after a study of the problem of migratory workers in considerable depth. We found that hospitals in various parts of the country were providing care under emergency circumstances and with very sizable costs for services and for which no reimbursement was available. We were, therefore, very pleased that the Congress provided funds which could be paid to hospitals for inpatient care.

The major portion of the funds which have been made available go for the provision of public health services and preventive medicine with a very modest amount being made available to pay for inpatient hospital care. We urge, therefore, that the funds to be provided under the bill be increased to at least \$15,000,000, with \$5,000,000 of this amount being allocated for reimbursement of hospitals providing inpatient care.

Because of limited funds, the administrators of the program have necessarily restricted payments to hospitals under the program to areas which had an over-all public health program for migrants. Therefore, no provision has been made for assistance to migratory workers in transit or in areas of the country which had no over-all public health program for migrants. The increased authorization which we have recommended should enable the administrators of the program to provide inpatient hospital care to migrants wherever it is needed. Further, we recommend that the program be authorized for a period of four years instead of the two years called for in the bill.

We have no comment at this time on other provisions of the bill.

We would appreciate your making this statement a part of the record of these hearings.

Sincerely,

KENNETH WILLIAMSON,
Associate Director.

NATIONAL TUBERCULOSIS AND RESPIRATORY
DISEASE ASSOCIATION,
New York, N.Y., March 20, 1968.

HON. HARLEY O. STAGGERS,
*Chairman, Interstate and Foreign Commerce Committee,
House of Representatives, Washington, D.C.*

DEAR MR. STAGGERS: The National Tuberculosis and Respiratory Disease Association wishes to express its support for continuation of Regional Medical Programs as provided for in H.R. 15758. Although Programs have been largely developmental, reports of progress throughout the country indicate that the majority will shortly be initiating operational activities. Reports indicate an earnest desire on the part of persons concerned with this Federal program to fulfill the purposes of the legislation; namely, that the American public receive improved medical services through coordinated and more efficient delivery of medical and paramedical skills and talents.

Authorization for funds must be adequate to meet the growing needs of the Programs in the next few years if they are to achieve their goal. The momentum of this Federal program, which involves relationships with many agencies and groups, is accelerating as operational activities are due to begin. Readiness to perform will be affected by the amount of Federal funds available. Therefore the Committee should consider whether or not the authorization of \$65 million for fiscal 1969 is large enough to permit implementation of the extensive plans developed over the past few years.

The NTRDA is particularly eager that Regional Medical Programs be successfully launched into operational activities because of the great need to improve services for chronic pulmonary disease patients. At time of appropriating funds for fiscal 1968, Congress specified that between one and two million dollars of the RMP appropriation for that year be devoted to chronic respiratory disease programs.

The NTRDA had requested such action by Congress because of the critical situation in diagnosis and treatment of these diseases, particularly emphysema. Incidence of emphysema has so accelerated that it has become the second most frequent disease for which benefits are granted to workers who are retired for disability prior to age 65, at an annual cost of about \$90,000,000. Other diseases of pulmonary insufficiency, such as chronic bronchitis, are widespread and responsible for much illness and restricted activity. Deaths from emphysema have been doubling approximately every five years in the recent past and along with asthma and chronic bronchitis now represent the tenth cause of death in the United States.

The seriousness of the chronic respiratory disease situation impelled the Public Health Service and the National Tuberculosis and Respiratory Disease Association to convene a Task Force in the Fall of 1966 to discuss how the control of these diseases could be improved. The critical needs in medical services for patients became a focus for much of the discussion and led to one of the Task Force's major recommendations; namely, that provision be made for pulmonary function laboratories, respiratory-care units, home-care, and rehabilitation programs.

Data indicate that the lack of such resources is widespread. Many community hospitals are even without the necessary apparatus to take care of seriously ill respiratory disease patients. Organized home-care programs exist in only a small percentage of our general hospitals, while outpatient clinics which can play a full role in rehabilitation and counseling of respiratory disease patients are virtually non-existent.

The community practitioner is particularly at a loss to help patients with chronic respiratory disease except for recommending hospitalization when the illness becomes critical. The average general practitioner is the victim of inadequate education because of the recency in the rise of these diseases. Thus, the type of supervision needed to protect patients from acute infections and to maintain their physical condition at as optimal a level as possible cannot be provided in most communities under existing conditions.

It is obvious that direction and supervision of high quality chronic respiratory disease programs must be provided by medical schools and medical centers. Demonstrations of patient diagnosis and treatment must be brought to the community practitioner through continuing education courses offered by these institutions and facilities. The Regional Medical Programs offer the most

expeditious way to achieve this goal. Interest in improving programs for chronic respiratory disease patients exist in many areas and it is our belief that this interest will generate development of such programs.

TB-RD associations will help stimulate interest in such programs, utilizing their background of experience in promoting better patient services. In the past, many associations have supported medical education in pulmonary disease, and have demonstrated the need for screening surveys and diagnostic and treatment services.

TB-RD associations were influential forces in communities for many years in promoting more adequate services for tuberculosis patients. In the same way, associations have been in a position to witness the dearth of help for emphysema and chronic bronchitis patients today and because of this, they will be good community partners to the RMP in seeing that the urgent needs of respiratory disease patients are met.

The American Thoracic Society, the medical section of the National Tuberculosis and Respiratory Disease Association, has provided leadership in medical standards and research in tuberculosis and other respiratory diseases. Staff of our organization will continue to work closely with the Division of Regional Medical Programs to promote high standards of diagnosis and care for chronic respiratory disease.

The NTRDA is pleased with the proposal in H.R. 15758 to expand the number of Advisory Council members from twelve to sixteen. At the time Congress specified that attention be paid in Regional Medical Programs to chronic respiratory disease, it also requested that one of the members of the National Advisory Council have competence in this particular medical field. Expansion of Council membership will provide more scope for ensuring representation of the various areas of medicine which are of necessity involved in the many activities of Regional Medical Programs.

We question if evaluation of Programs, as provided in Section 102 of the bill, should be performed solely by the Secretary. It would seem more satisfactory for both the Department of HEW and the public, to require that such evaluation be done by outside groups.

We are certainly in support of extension of grants for health services for migratory workers and our only reservation is that these seem very minimal amounts considering the high rate of disease in this segment of our population. Tuberculosis rates are high in these people because of their low economic status and because their living conditions favor spread of the disease.

We support provision of funds for construction of special facilities for inpatient and outpatient treatment of alcoholism. Alcoholics have a high rate of tuberculosis, and extensive difficulties have arisen in recent years in hospitalizing many of these persons in community hospitals, including tuberculosis hospitals. Some of these difficulties would seem to be obviated by the provisions suggested. However, recognition of the high rate of tuberculosis in alcoholics is essential in planning adequately for treatment facilities.

It gives us great pleasure to record our support for extension of Regional Medical Programs.

Sincerely yours,

JAMES E. PERKINS, M.D.,
Managing Director.

AMERICAN DENTAL ASSOCIATION,
Washington, D.C., March 27, 1968.

HON. JOHN JARMAN,
Chairman, Subcommittee on Public Health and Welfare, Committee on Interstate and Foreign Commerce, House of Representatives, Washington, D.C.

DEAR MR. JARMAN: Pursuant to the announcement of March 18, 1968, the American Dental Association wishes to submit its views on H.R. 15758, the Health Services Act of 1968. The Association's brief comments will be limited to those provisions of the bill which would extend and improve the Heart Disease, Cancer and Stroke Amendments of 1965 and the Migrant Health Act of 1962, as amended.

As part of its commitment to improving the total health of our people, the American Dental Association is sympathetic to the goals of H.R. 15758.

The dental profession has particular and long-standing concern with respect to oral cancer and some forms of heart disease. Additional research into the pre-

vention and treatment of these disease manifestations is needed and can and should be included in the regional medical programs authorized in H.R. 15758. When the Heart Disease, Cancer and Stroke legislation was under consideration in 1965, the Association submitted to this Committee details regarding the incidence of oral cancer and the low survival rate of victims of the disease. At that time, attention was directed to the need for more research into the specific causes of oral cancer and the methods of treatment and rehabilitation of patients who suffer from it.

The Association is pleased to note that considerable progress is being made in this field and that members of the dental profession and several dental schools are participating in the programs that are being developed.

The Association also is pleased with and supports fully the amendment included in H.R. 15758 which makes it clear that a practicing dentist as well as a physician may refer a patient to a facility engaged in research, training or demonstration activities which are supported by regional medical program funds.

With respect to the provisions of the bill extending the migrant health program, the American Dental Association recognizes the need for increasing the availability of dental care for migrant workers and their children. The Association supports the extension of the program but agrees that as soon as feasible, this activity should be included in the regular public health programs of states and communities.

The American Dental Association appreciates the opportunity to present its views on this legislation and respectfully requests that this letter be included in the record of hearings.

Sincerely yours,

JOHN B. WILSON, D.D.S.,
Chairman, Council on Legislation.

UNIVERSITY OF HAWAII,
SCHOOL OF MEDICINE,
Honolulu, Hawaii, March 13, 1968.

Re H.R. 15758.

HON. HARLEY O. STAGGERS,
*Interstate and Foreign Commerce Committee,
House of Representatives, Washington, D.C.*

DEAR REPRESENTATIVE STAGGERS: House Resolution 15758 includes a paragraph on "inclusion of territories" which would bring Guam, American Samoa, and the Trust Territory of the Pacific Islands within the scope of the Regional Medical Program.

The Medical School of the University of Hawaii is involved in medical research and teaching in many areas of the Pacific. We have been asked by the health administrators in American Samoa to develop an affiliation between the new Lyndon B. Johnson Tropical Medicine Center and the University of Hawaii School of Medicine. The same applies, but at a somewhat more preliminary stage, with the health administrators of the Trust Territories, with special regard to the hospital that will be built on Ponape. These programs will be mutually advantageous as we will provide continuation education for the medical and nursing staffs, and they will provide facilities for research and certain aspects of education for our faculty and students.

I would urge your support of the paragraph in question because this would facilitate the cooperative ventures described.

Sincerely yours,

WINDSOR C. CUTTING, M.D., *Dean.*

THE CHRISTOPHER D. SMITHERS FOUNDATION, INC.,
New York, N.Y., March 21, 1968.

HON. HARLEY O. STAGGERS,
*Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington, D.C.*

DEAR CONGRESSMAN STAGGERS: I am pleased to learn that you have scheduled hearings on HR-15758. If it is appropriate, I request that this letter be made a part of the record for those hearings.

As you know, this Foundation participates primarily in activity associated with alcoholism. We support the activities of all the major organizations at work in this field.

I have read with much interest the provisions of Title III, Part A of HR-15758, to be known as the Alcoholic Rehabilitation Act of 1968. In my judgment, it is an excellent piece of legislation which, when passed and adequately funded, will provide much needed Federal assistance to the states and communities. Because of the humane and progressive decisions of the courts in recent years to the effect that late stage alcoholics should be treated as sick people and not as criminals, the states and municipalities must now prepare to meet the needs in treating large numbers of persons found by the courts to be suffering from alcoholism. The size of this problem and the urgency for new facilities and trained personnel make it impossible for the states and cities to meet their needs adequately without significant Federal assistance. The enactment of Title III, Part A of HR-15758 will provide the kind of Federal assistance necessary in a most commendable way.

Sincerely yours,

R. BRINKLEY SMITHERS, *President.*

ALCOHOLISM COUNCIL OF PALM BEACH COUNTY,
Lantana, Fla., March 22, 1968.

Congressman PAUL G. ROGERS,
*Harvey Building,
West Palm Beach, Fla.*

DEAR CONGRESSMAN ROGERS: Your endorsement of Bill U.S. H.R. #15758, Title 3, Part A would be greatly appreciated.

It is our feeling that this legislation would be extremely helpful in rehabilitating the 12,000 alcoholics in Palm Beach County.

Sincerely,

RICHARD A. CONLIN, *Chairman.*

TAMPA, FLA., *March 20, 1968.*

Congressman PAUL G. ROGERS,
*House of Representatives,
Washington, D.C.*

DEAR CONGRESSMAN ROGERS: We have just started our Florida Regional Medical Program and not too many physicians are yet aware of its great potential for improving the quality and efficiency of medical care through improvements in communications and in continuing medical education.

The Regional Medical Programs must develop into ongoing operational projects and therefore the administrations bill to extend and slightly modify Regional Medical Programs is highly desirable. This is the type of congressional legislation the physician in practice and in education will favor.

Cordially yours,

H. PHILLIP HAMPTON, M.D.

GATEWAY COUNCIL ON ALCOHOLISM,
Ketchikan, Alaska, April 24, 1968.

The CHAIRMAN,
Subcommittee on Public Health and Welfare, Committee on Interstate and Foreign Commerce, House of Representatives, Washington, D.C.

DEAR SIR: I have recently received a publication from the North American Association of Alcoholism Program outlining the hearings of March 26-28 on HR-15758. I was not present to represent the Ketchikan Gateway Council on Alcoholism during those hearings, but would nevertheless wish to voice our opinion of that bill; especially the section Title III Part A, known as the "Alcoholic Rehabilitation Act of 1968".

Under the Alcoholic Rehabilitation Act of 1968 we understand that alcoholic facilities and programs will be tied directly with the existing mental health centers of each state. And that provisions for receiving aid for construction, staffing, and specialized facilities will be requisited by this direct tie with the mental health centers.

We realize that there does need to be close coordination with the mental health offices so that an integrated state program can be as effective as possible. However the situation within each state varies so widely that in our opinion such a tie should be left at the discretion of each individual state. That the states that do not wish to tie their alcoholic programs with the mental health centers should not be discriminated against for enacting said tie provisions.

It is our opinion that states like Alaska which have very limited mental health centers and even fewer alcoholic rehabilitation programs would be adversely affected although they would be the ones in need of the services as outlined in H.R. 15758. The testimony before the Committee as related by this letter therefore is spoken against the alcoholic propositions of the said bill. We propose instead that some individual state discretion should be allowed so that an alcoholic rehabilitation program can be as flexible as our varied conditions demand and able to serve the best interests of the people.

Sincerely,

STEVE CLARK, *Chairman.*

(Whereupon, at 12 noon the subcommittee was adjourned.)

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