

Chapter X
ALCOHOL AND DRUG ABUSE SERVICES

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INTRODUCTION AND CHAPTER SCOPE

The misuse and abuse of alcohol and psychoactive substances by citizens is a widespread behavior pattern which has adverse social and personal consequences. In California's highly mobile, fast paced, youth oriented and often hedonistic environment, the level of abuse of these substances exceeds the State's ten percent share of the nation's population, according to national prevalence estimates.

Ours is a drug taking culture. Society condones, even encourages, the use of prescription and over-the-counter drugs as well as alcohol, tobacco and other substances. Tension, stress, sleeplessness, overweight, mild pain or discomfort -- all can be alleviated with a pill or a drink, according to television, radio or other news media. Instead of eating properly, getting adequate rest, dealing with problems, using good judgment and modifying nonproductive behaviors, people are encouraged to seek a quick solution to problems. In addition, people are taught that enthusiastic participation with others in the social use of substances will enhance popularity, happiness and acceptance.

Government takes an affirmative role to alleviate problems related to inappropriate use or misuse of alcohol and other drugs, particularly where such problems are likely to cause harm to individuals, families, and the communities. Publicly funded assistance is available. Information is available and warnings are made regarding the potential for harm from the inappropriate use or misuse of alcohol and other drugs; there is intervention when the risks appear high; and there is the provision of treatment, recovery, and other related services to those needing help. However, in the final analysis, as it is with so many health issues, what the individual consumes, and what effect it has on the individual, depends upon many complex social, psychological and physiological factors.

ALCOHOL ABUSE

DEFINITIONS AND SCOPE OF SERVICES

During 1979, each Californian over 14 years is expected to consume an average of 30 and one-half gallons of beer, five and one-quarter gallons of wine and three and one-quarter gallons of distilled spirits. This will be about three and one-half gallons of absolute alcohol for each person, which will be about 20 percent greater than the national average.

The perceived pleasure and satisfaction as well as the economic benefits of drinking are accompanied by a variety of serious undesirable effects, namely, premature death and disability, plus the pain, suffering, financial burden and indignities of alcohol related problems. These include traffic accidents, deaths, injuries and property loss; children born with alcohol caused birth defects; poor job performance, accidents and time lost from work; spouse and child beatings along with other domestic discord; violent acts such as murder, assault and rape, plus other crimes; and other conditions which place a large burden on welfare, medical, protection, judicial, and health services. Not only do problem drinkers and their victims suffer, but all Californians share in paying for the extra health, social welfare and law enforcement protection services required.

Alcohol is the most commonly used drug in the U.S. In addition, alcohol is inappropriately used by more people than all other drugs combined. As a result, alcohol problems are among the nation's most serious health problems. In the same way, alcohol problems are major health and social problems in California and have a detrimental impact on our lives -- so much so that the California Legislature declared that alcoholism is the most serious drug problem in California.

The following types of services are offered in California to reduce the effects of alcohol problems and its resultant suffering, social damage and economic costs:

- Prevention, early identification, treatment/recovery and intervention services and local community planning are provided at the county level, assisted by federal and state funding allocated from the Division of Alcohol Abuse and Alcoholism to county programs.
- These same services are also provided by the private sector. Some of the privately operated services are publicly funded while others use only private funds. (However, all alcohol services in the county are encouraged to be part of a county alcoholism service system.)

- Prevention services are delivered both locally and through state and national organizations. Much of the prevention effort is accomplished through mass media efforts to influence policies and legislation.
- There are two large self-help organizations concerned with alcoholism, Alcoholics Anonymous and Al-Anon Family Groups:
 - Alcoholics Anonymous (AA): a fellowship of men and women who share their experience, strength and hope with each other, that they may solve their common problem and help others recover from alcoholism.
 - Al-Anon Family Groups: a fellowship that tries to meet the needs of those who live with the alcoholic.

BACKGROUND

Relationship to Health Status

Alcohol use affects health status in two broad ways. First, it acts within the individual's body, often causing or increasing vulnerability to physical disorders. Second, it affects individual behavior, frequently involving violent acts — accidental or intentional.

The development and progression of these alcohol related medical disorders and other alcohol exacerbated disorders have been clinically charted and show identifiable physical damage to organs and the nervous system. Alcoholism is California's sixth largest fatal illness — over 3,400 deaths directly attributable to it.

There is a strong relationship between excessive alcohol use and certain cancers, heart disease, pancreatitis, stillbirths, the fetal alcohol syndrome and other problems. Sound morbidity and mortality statistics are severely limited; nevertheless, there is adequate indication that among problem drinkers, especially alcoholics, shortened life expectancy and susceptibility to major health disorders are to be expected.

When an individual stops drinking, these alcohol related health problems either improve or at least the rate of deterioration is slowed. For these disorders, abstinence is the most appropriate treatment goal for continued recovery and the only assurance against relapse. The individual who has stopped drinking must cope with the social pressures that influence his or her drinking behavior. In addition, that person must cope with the emotional, economic and social problems of life by finding productive, nondrinking ways to deal with such problems.

Alcohol is the drug most often associated with violent behavior. Violence, accidental or intentional, constitutes a substantial part of all mortality, illness and impairment in California. Violence plays an especially prominent role in death and injury among younger

age groups. For example, the National Safety Council reports in 1976 that accidents are the leading general cause of death for all ages from 1 to 38. Research shows that alcohol often plays a major role in such violent events as motor vehicle accidents; home, industrial and recreational accidents; crime; suicide; and family abuse.

National Trends and Policy

Trends in the use of alcohol, and planning and development of programs can be characterized as follows:

- there has been little change in total per capita alcohol consumption during the 1970s; since 1971, per capita alcohol consumption has ranged from 2.63 to 2.69 gallons of ethanol per person 14 years and older
- there is active interest in local HSAs planning to address the unique needs of alcoholic people and their families; in state plans for alcoholism services, there appears to be more emphasis on alcohol-related problem reduction and less on the morality of drinking and drinkers
- there is an increasing number of alcohol programs for employed people, especially Employee Assistance Programs sponsored by industry and/or labor organizations
- there is more basic and applied research information available on such topics as the causes and treatment of alcoholism, the biological effects of alcohol and drinking practices
- there are a variety of government funding mechanisms under consideration, such as special health revenue sharing funds, the expansion of formula and block grants and national health insurance; there is some activity in the public and private sector for third party reimbursement for alcoholism services as part of standard health coverage packages -- organized labor and private industry are especially active in this area
- there is continuing controversy surrounding the certification of alcoholism personnel; development of service standards for programs continues, and some programs are being certified, however, there is much disagreement over the process and content of such efforts.

National policy as stated by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) is:

"As the focal point for Federal activities in the alcoholism field, NIAAA is working with the field to develop a national plan designed to end

alcoholism's outcast status and incorporate the illness into the mainstream of the social and health care delivery system. During the next five years, NIAAA will:

- Work to make treatment resources more available, accessible, and effective;
- Work to obtain the same level of health coverage for alcoholism that other diseases now have;
- Emphasize and promote prevention as a major strategy for reducing the incidence of alcohol abuse and alcoholism; and
- Seek a major increase in the Nation's investment in research on alcohol-related problems."

On the federal level, the National Institute on Alcohol Abuse and Alcoholism makes direct funding grants to selected service providers, research projects and American Indian programs, and does some mass media advertising. The Veterans Administration also directs some of its efforts towards alcohol problems.

California Trends and Policy

In 1979, between 11 and 12 million Californians will drink alcoholic beverages. Their per capita consumption is about 20 percent greater than the national average and continues to increase about two to five percent per year while the national average has changed little during the 1970s. Alcohol consumption by women and youth is increasing.

Privately funded services have increased both in number and variety. There is extensive use of social model recovery services. Self-help groups, such as Alcoholics Anonymous, have experienced substantial increase in the number of members and groups — especially in those local communities that have increased other services to alcoholics and their families.

There is an increased awareness of, and demand for, services to specific target populations such as — employees, women, youth, Blacks, Hispanics, American Indians, elderly, disabled and gay persons.

There is an increased awareness of the complex socioeconomic factors associated with public inebriety, especially in skidrow areas, with accompanying efforts to distinguish alcohol services from other needed health, social and economic services.

There are continued efforts to improve alcoholism services and staff. These efforts include: establishing service specific guidelines or standards, upgrading skills of

practitioners and increasing the number and variety of formal training programs — especially for those without degrees or professional licenses.

The California Legislature declared in 1979, when establishing the Department of Alcohol and Drug Programs, that problems related to the inappropriate use of alcoholic beverages are the most serious drug problem in California.

- substantial fatalities, permanent disability and property damage which result from driving under the influence of alcoholic beverages and a drain on law enforcement, the courts and penal system which result from crimes involving inappropriate alcohol use
- alcohol in the individual, which is an addiction to the drug alcohol, with its attendant deterioration of physical and emotional health and social well-being
- alcoholism in the family with its attendant deterioration of all relationships and the well-being of family members
- a risk of increased susceptibility of serious illnesses and other major health problems which ultimately create a burden on both public and private health facilities and resources
- a risk of fetal alcohol syndrome
- losses in production and tax revenues due to absenteeism, unemployment and industrial accidents.

California Health and Safety Code, Division 10.5, establishes the Department of Alcohol and Drug Programs (ADP). That Department, as part of the Health and Welfare Agency, bears part of the responsibility to enhance the quality of life in California. The Division of Alcohol Programs (DAP) seeks to accomplish this goal by reducing alcohol problems and the resultant personal suffering, social damage and economic costs and by providing and promoting public and private programs of prevention, early identification and intervention and treatment recovery services. DAP responsibility includes mobilizing public resources (federal, state and local) and coordinating both public and private resources to effectively and economically provide for alcoholism research, prevention, treatment and recovery of those disabled by excess use of alcohol -- this includes alcohol disabled persons, their victims and their families. Other agencies -- most notably Alcoholic Beverage Control, the California Highway Patrol and the Department of Education -- also provide numerous other aspects of alcohol programs.

For the most part in California, however, programs and services to address alcoholism and other alcohol related problems are administered locally. Each county establishes an alcoholism service system administered by a County Alcoholism Program (CAPA). The CAPA coordinates planning of services according to the needs and priorities of the local community. The CAPA attempts to coordinate all alcoholism services irrespective of

whether the service is government operated and funded, privately operated and funded or a combination of both. While the services are planned, administered and operated locally, the ADP allocates the bulk of public funds to counties. Approximately \$35 million was allocated to 57 diverse county alcohol programs in FY 1978-79.

The California alcoholism program, as stated by the Department of Alcohol and Drug Programs (policy) includes:

- continuing refinement of an alcoholism service system within each California county which is responsive to local needs and priorities (currently, local alcoholism service systems are not able to increase services or are unable to maintain pre-Proposition 13 levels of services because of reductions in local funding; in addition, the inflation rate of recent years has exceeded increases in state allocated resources)
- maximizing services to specific target populations, such as women, youth, Blacks, Hispanics, American Indians and elderly, disabled and gay persons
- mainstreaming — bringing an end to alcoholism's outcast status and including the basic and unique needs of the alcoholic and the alcoholic's family into the mainstream of the social and health care delivery systems
- maximizing the quality of alcoholism programs and services so that alcoholics are assured of safe and appropriate care and that the services themselves fulfill the requirements of health insurers or other third party payors
- maximizing the availability of appropriate and effective alcoholism services, through public health employee's benefit programs, as well as private and group health insurance programs.

ANALYSIS OF DEMAND AND SUPPLY

Analysis of Demand

The National Institute on Alcohol Abuse and Alcoholism estimated that during 1975 the cost of alcohol related problems to the United States was \$42.8 billion. This total is broken down into lost production — \$19.6 billion; health and medical costs — \$12.7 billion; motor vehicle accidents — \$5.1 billion; violent crime — \$2.9 billion; social responses — \$1.9 billion; and fire losses — \$0.4 billion. The burden to Californians is roughly 10 percent of the above, or about \$4.28 billion a year. As a point of comparison, the entire budget for the State of California in 1975 was \$10.2 billion.

Estimates of the alcohol problem in California include the following:

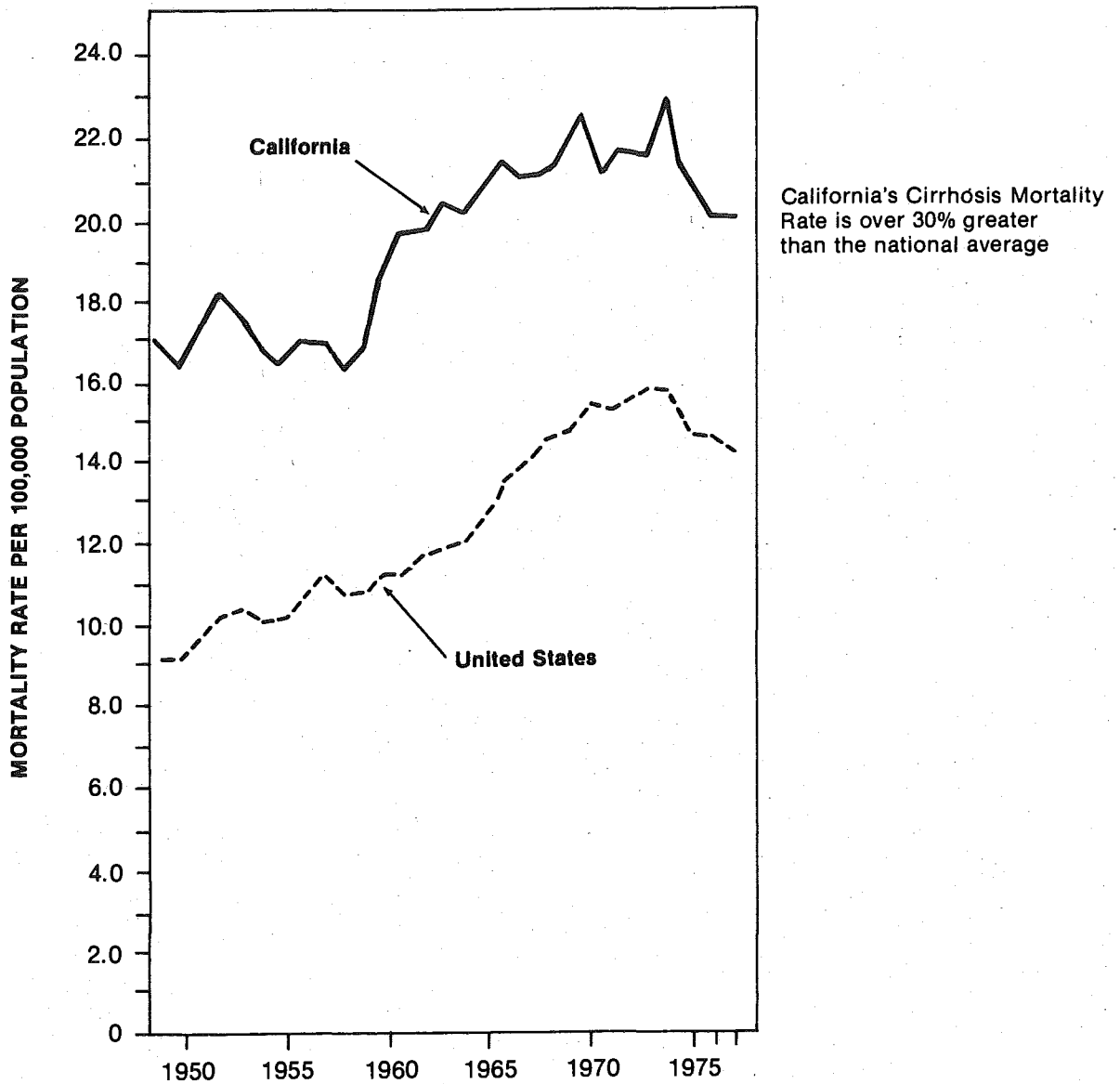
- In 1979 there were at least 1.4 million problem drinkers, including alcoholics. This is based on an estimating method described in Alcohol and Health, the Third Special Report to the Congress which estimates the number of problem drinkers for the U.S. The estimate for California is conservative as other indicators of alcohol problems support a conclusion that the prevalence of alcohol problems is higher in California when compared to the Nation as a whole. Only a small portion of the problem drinkers are "skid row" types. The vast majority of people experiencing alcohol problems are employed and live with their families.

About 5.6 million additional people are adversely affected by these problem drinkers. The National Council on Alcoholism estimates that each adult problem drinker affects, on the average, four other people.

In addition to adult problem drinkers, there are about 296,000 problem drinkers among youth in the 14 to 17 age range using the estimating method from Alcohol and Health.

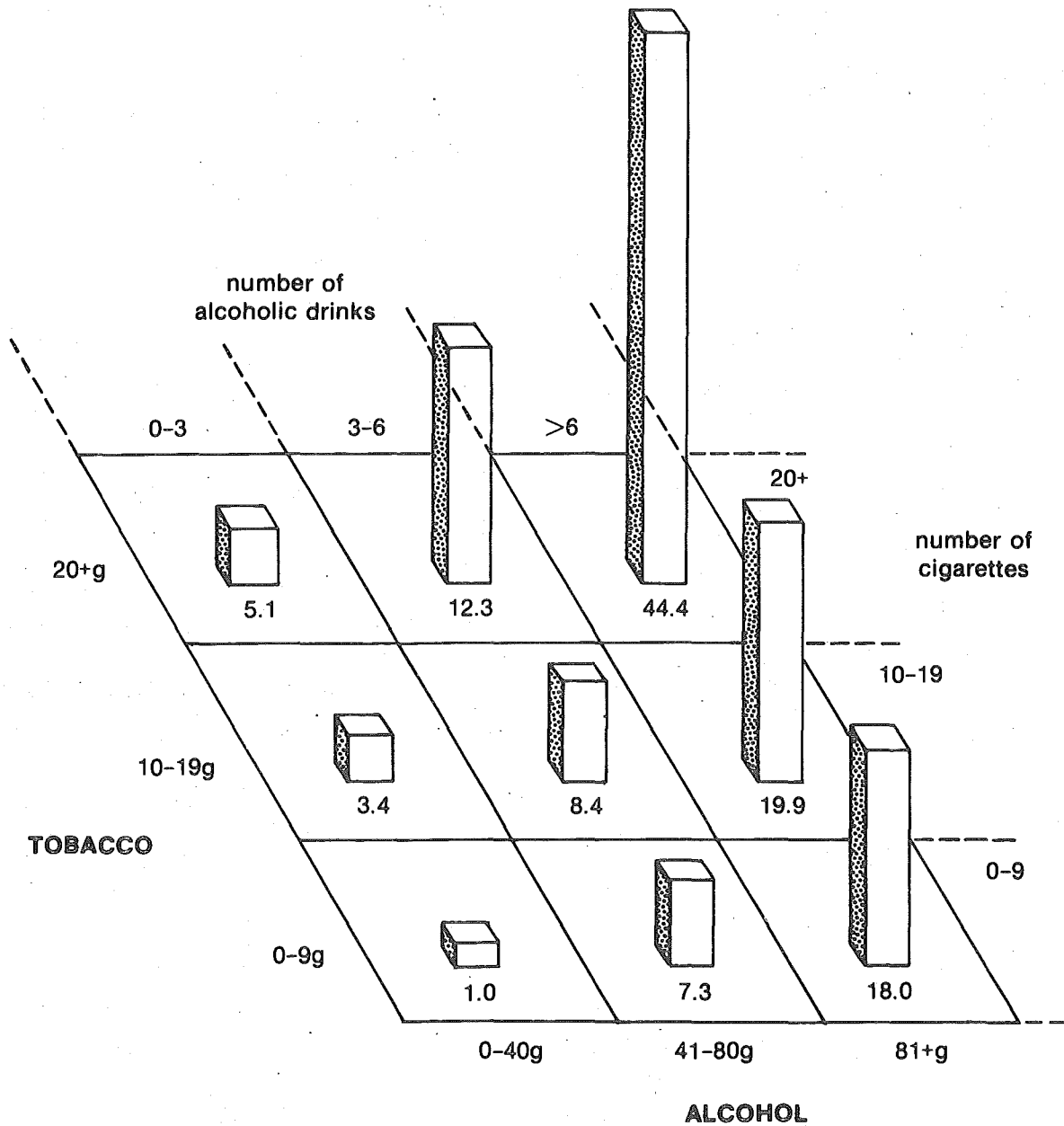
- Alcoholism is California's sixth largest fatal illness. In 1980, approximately 3,400 deaths in California will be attributed directly to alcoholism: deaths diagnosed as cirrhosis due to alcoholism, alcohol addiction or alcohol psychosis. California's cirrhosis mortality rate exceeds the national average by more than 30 percent. (See Figure X-1.) In addition, research has shown that there is a strong relationship between excessive alcohol use and certain cancers, heart disease, pancreatitis, stillbirths, the fetal alcohol syndrome and other problems. Sound morbidity and mortality statistics are severely limited, nevertheless, there is adequate indication that among problem drinkers, especially alcoholics, shortened life expectancy and susceptibility to major health disorders are to be expected. Figure X-2, at the end of this section, shows the relationship between alcohol consumption and esophageal cancer.
- Alcohol and traffic is another serious problem. In 1980, California can expect over 2,500 alcohol related traffic deaths out of a total of 5,000 traffic fatalities. There will also be more than 74,000 alcohol related traffic injuries. These will occur despite approximately 280,000 arrests of persons for driving while intoxicated.
- Alcohol is the drug most often associated with violent behavior. Alcohol often triggers aggressive acts; there is a high correlation between drinking and violent or destructive acts. Many murderers and their victims have significantly high alcohol blood levels at the time of the crime. Drinking also accompanies other assaultive behavior such as spouse and child beatings, rape, felonious assaults and sexual crimes against children. In addition, alcohol use

Figure X-1
Comparison of Cirrhosis Mortality Rates
United States and California
1949 through 1977



Source: Data from National Center for Health Statistics. Vital Statistics of the U.S., 1949-75. Washington, D.C.: U.S. Govt. Printing Office, 1975; California Center for Health Statistics.

FIGURE X-2
RELATIVE RISKS OF ESOPHAGEAL CANCER IN RELATION
TO THE DAILY CONSUMPTION OF ALCOHOL AND TOBACCO



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

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

accompanies many other types of crimes such as robbery and burglary. The research into the relationship of alcohol involvement with violent behavior and criminal activity shows a wide variation in the estimates of such involvement. Therefore, it is difficult at this time to precisely state for California the number of alcohol-related incidents and casualties of violent behavior or crime. However, in order to give some indication of the scope and magnitude of the problem, two tables are presented. One displays the estimated number of deaths related to alcohol use in the U.S. and in California. The other estimates the number of crimes related to alcohol use in California. (See Tables.)

- The fetal alcohol syndrome will affect a portion of California's approximately 300,000 live births. The fetal alcohol syndrome is the third leading cause of birth defects following only Down's syndrome and spina bifida and the only one of these three that is preventable. (Alcohol and Health--Third Report to the Congress.) Furthermore, there is an increase in per capita consumption of alcohol by women, which means that the incidence of fetal alcohol syndrome may be expected to increase.

Some other consequences of problem drinking include the following:

- Fire deaths: A primary cause of fire deaths of persons aged 16 to 60 is alcohol impairment of sensory, judgmental and physical functions. A large factor in fire deaths of children, particularly small children, is the failure by alcohol impaired parents to perceive and respond to a fire emergency.
- Accidental injuries: A national survey found that 36 percent of moderate drinkers reported two or more accidental injuries in one year compared to eight percent of nondrinkers. There are other alcohol related accidents where the numbers affected are unknown but suspected to be large. These accidents occur in the home, on the job and at recreation.
- Others: Some other consequences include: loss of custody of children, divorce, truancy and school dropout attributable to alcoholism in the home.

ANALYSIS OF ISSUES

The following is a brief analysis of major issues in alcoholism. A more detailed description of current programs; their objectives and activities can be found in the annual California State Plan for Alcoholism and Report to the Legislature prepared by the DADA.

Table X-1

**ESTIMATED NUMBER OF DEATHS RELATED TO ALCOHOL
IN THE UNITED STATES AND CALIFORNIA**

USA Data for 1975

California Data for 1975 and 1980

Cause of Death	USA 1975 Estimate			California 1975 Estimate			California 1980 Estimate		
	Number of Deaths, 1975	Percent Related to Alcohol	Estimated Number Related to Alcohol	Number of Deaths, 1975	Percent Related to Alcohol	Estimated Number Related to Alcohol	Projected ^b Number of Deaths	Percent Related to Alcohol	Estimated Number Related to Alcohol
Alcohol as a direct cause									
Alcoholism	4,897	100	4,897	443	100*	443	650	100	650
Alcoholic psychosis	356	100	356	20	100*	20	20	100	20
Cirrhosis	31,623	41-95	12,965 to 30,042	4,567	57	2,588	4,530	50	2,730
TOTAL—direct cause	36,876		18,218 to 35,295	5,030		3,051	5,200	65	3,400
Alcohol as an indirect cause									
Accidents									
Motor vehicle	45,853	30-50	13,756 to	4,451	51*	2,226	5,000	50*	2,500
Falls	14,896	44.4	6,614	1,333	44.4	592	1,100	44.4	500
Fires	6,071	25.9	1,572	485	25.9	426	400	25.9	100
Other ^a	33,026	11.1	3,666	4,121	11.1	457	2,900	11.1	300
Homicides	21,310	49-70	10,442 to 14,917	2,373	49-70	1,145 to 1,661	3,000	49-70	1,500 to 2,100
Suicides	27,063	25-37	6,766 to 10,013	3,887	25-37	972 to 1,438	3,800	25-37	900 to 1,400
TOTAL—indirect cause	148,219	29-40	42,816 to 59,708	16,650	33-39	5,518 to 6,500	16,200	35-42	5,800 to 6,900
OVERALL TOTAL	185,095	32-51	61,034 to 95,003	21,680	39-44	8,569 to 9,551	21,400	43-48	9,200 to 10,300

* California collects alcohol-related information for this category.

^a Includes all accidents not listed above, but excludes accidents incurred in medical and surgical procedures.^b Projections based on actual data thru 1978.

US Data

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

TABLE X-2
ESTIMATED NUMBER OF CRIMES RELATED TO ALCOHOL USE
CALIFORNIA 1980

Crime	Total Number of Incidents (Projected) ^a	Percentage of Incidents Alcohol-Related (Estimated) ^b	Number of Incidents Alcohol-Related (Estimated) ^d
<u>THE SEVEN MAJOR OFFENSES</u>			
<u>Crimes Against People</u>			
Willful Homicide	3,000	50%	1,500
Forcible Rape	13,000	30	3,900
Robbery	77,000	40 ^c	30,000
Aggravated Assault	94,000	48	45,000
<u>Crimes Against Property</u>			
Burglary	500,000	40 ^c	200,000
Theft (\$200 and over)	189,000	40 ^c	75,000
Motor Vehicle Theft	170,000	(^d)	—
<u>OTHER CRIMES</u>			
Assault—not aggravated	105,000	48	50,000
Driving While Intoxicated	280,000	100	280,000
Public Drunkenness	245,000	100	245,000

^a Projections of incidents based on data through 1978

^b The estimates for each crime category are the average of the range of values reported in *Alcohol and Health—Third Special Report to the Congress*. These estimates represent a “best guess” and as such are reasonable estimates upon which to base broad public policy.

^c In the “Third Special Report”, the categories Robbery, Burglary, and Theft were combined.

^d Insufficient evidence to determine relationship at this time.

Issue #1: Reduction in Public Funding Despite Increasing Demand for Services

All levels of government are reducing their support of alcoholism services. While demand for services has increased within California, inflation has made State and local governments unable to keep up with rising costs for these services. The net effect is that while the alcoholism budget may be larger today than it was three years ago, the purchasing power of that budget is less — the loss being about \$6.04 million or 17 percent of the current budgeted amount. Public funding at the local level has been reduced by a third (\$3.4 million), largely as a result of Proposition 13.

At the same time that funding is decreasing, the demand for services is increasing. The increased demand is a result of several factors:

- increased awareness of the problem and of available services
- many services appear to be effective, thereby increasing people's confidence in using them more
- early identification and intervention services have increased substantially over the years
- specialized populations, which formerly received few services, are now organizing and demanding more and better services.

Issue #2: Necessary Resource Allocation Decisions

As a result of decreased public funding, there will be increased competition among alcohol service providers, public and private, for limited resources. This situation means that increased importance is placed on evaluation of the relative efficiency and effectiveness of existing publicly funded programs. Such efforts will have to go beyond the current cost control guidelines which have focused primarily on efficiency within specific alcohol services. Troubling policy implications are generated by consistently reported research findings stating that the kind or amount of treatment for alcoholism has little relationship to success rates. On the other hand, many people, clients and potential clients perceive many alcohol services as beneficial and have indicated the need for more of these alcohol services. The public policy decision makers are interested in the intended and actual outcomes of programs and services, the cost of these efforts and the efficiency of the programs. Since alcohol programs are fairly new and still going through developmental stages, the ADP is still in the process of establishing operational procedures. This includes establishing standards, guidelines and evaluative procedures for program, service, service system and fiscal concerns. There is need to improve the application of current knowledge (and to systematically improve such knowledge) to alcohol programs and services at the local level and to integrate it into a State overview of the California Alcohol Program.

Issue #3: Public Inebriate Problem

Many people consider the "skid row" problem to be entirely a public inebriate problem despite the fact that only about 25 percent of those on skid row are directly affected by alcohol problems, including alcoholism. Such a viewpoint makes inordinate and inappropriate demands on local alcohol services resources and impedes problem reduction. The State's recently completed 30 month Public Inebriate Demonstration Project demonstrates that when the problems are studied from a socioeconomic point of view, many problems are found, only one of which is alcohol. These problems, in addition to alcohol, include unemployment, low income, poor health and inadequate housing. A December 1979 report on alcohol services for public inebriates revealed that in Fiscal Year 1979-80 over one-third of all public funding for locally operated and administered alcohol services went to the public inebriate. Often these funds were used to provide basic necessities of living in addition to alcohol services.

While some of the alcohol services funding may appropriately be used to cope with the alcohol related problems of skid row, involvement of other health and social agencies is needed. The underlying socioeconomic and other medical problems are so pervasive that nothing less than an extensive holistic effort will prove effective in the long run. In July, 1980, the Department of Alcohol and Drug Programs will hold a meeting of experts in this field to develop policy for a more comprehensive approach to resolving the problems of alcohol misuse within this targeted poverty population.

Issue #4: Negative Concepts of Alcoholics and Alcoholism

Alcoholics and alcoholism treatment still carry a stigma. Treatment for alcoholism, even though it is considered a disease, is all too often considered peripheral to the health care system. Alcohol related problems are not covered adequately in most public and private health insurance plans. Individuals often avoid treatment or are not encouraged to seek treatment in nonalcoholism service specific health or social facilities. Furthermore, alcoholics are often discouraged or rejected in their attempts to obtain needed treatment or referral to the appropriate services.

Issue #5: Accessibility

There are some population groups for which alcoholism services are not accessible, acceptable or available. Physical barriers prevent some handicapped persons from entering alcoholism services. For some sociocultural groups, the alcoholism services offered are not compatible with the unique needs of those groups.

Issue #6: Government Coordination

There are several alcohol related problems that Californians have expressed increased concern about through the Legislature and public opinion polls. These include alcohol involvement in (a) automobile traffic safety, (b) the work place (c) the public inebriate problem, and (d) particularly assaultive behavior.

These alcohol related problems cross traditional governmental program, service and administrative jurisdictions. This impedes coordinated planning, financing and service implementation. The amount of resources available is unknown but thought to be considerable. The different jurisdictions view the alcohol problem differently and deal with it accordingly, often at cross purposes. Usually only one aspect of the problem is handled and the remainder is assumed to be another agency's responsibility, resulting in both unnecessary program duplication as well as serious gaps in service delivery.

Issue #7: Fetal Alcohol Syndrome

Conservative figures suggest an incidence of fetal alcohol syndrome greater than 1 in 5,000 pregnancies, perhaps on the order of 1 in 2,000. One fully developed case of fetal alcohol syndrome per 100 women occurs among those who consume an average of more than one ounce of alcohol per day during early pregnancy. On this basis, fetal alcohol syndrome would be the third leading cause of birth defects with associated mental retardation, following only Down's syndrome (1/1600) and spina bifida (1/1000). Most important, unlike Down's or spina bifida, fetal alcohol syndrome is preventable.

The recognition of the fetal alcohol syndrome as a consequence of excessive alcohol use during pregnancy plus the fact that women are drinking more, requires prevention efforts by health care professionals and health information disseminators. While there is some evidence that offspring of heavy drinking women who decreased their alcohol consumption after they learned they were pregnant may not have a higher incidence of congenital abnormalities than light drinkers. It is still questionable, however, whether reduction of alcohol consumption in the second or third trimesters will prevent all or even part of the fetal alcohol syndrome. In addition, recent data suggest that heavy alcohol ingestion prior to recognition of pregnancy may be sufficient to produce either full or partial manifestations of the fetal alcohol syndrome in a statistically significant number of cases. Further analysis of associated variables is still needed in this area.

Given the total evidence available at this time, women of childbearing age need to be particularly conscious of the extent of their drinking. While safe levels of drinking are unknown, it appears that a risk is established with drinking above three ounces of absolute alcohol, or six drinks per day. Between one ounce and three ounces, there is still uncertainty, but caution is advised.

Some implications are clear. Prudence dictates that women of childbearing potential must be alerted to the dangers of misuse of alcohol before they become pregnant. Once women are pregnant, they must be alerted to the risk involved if they continue to drink during their pregnancy

Issue #8: Effective Prevention

In spite of overwhelming evidence that, "too much drinking can be harmful to your health and happiness" and that "winners quit while they're ahead,"* some Californians consume alcohol excessively. For many of these people, continued excessive consumption continues because of "denial" — the continued refusal to admit that alcohol use is detrimental to health or well-being despite overwhelming evidence. Overcoming that denial both in the individual and the community is essential before productive recovery from alcoholism may occur. Therefore, it is necessary to affect the attitudes and behavior of society as well as of individuals to minimize the adverse affects of alcohol on the individual, their families and the society.

Efforts to reduce community denial are included in the state alcoholism prevention program. The objective of the prevention program is to reduce the number of new cases of alcohol problems — to reduce the incidence rate of alcohol problems — by establishing and supporting policies and programs leading to the continued nonuse or moderate use of alcoholic drinks. The nonuser is encouraged to continue that nonuse and the drinkers are encouraged not to incur an alcohol related disability or inflict others with the adverse affects of their problem drinking.

Closely associated with alcoholism prevention services are early identification and intervention services. These services are designed to reduce the severity and frequency of those who are already problem drinkers or suffering from the effects of problem drinking - to reduce the prevalence rate of alcohol problems - by identifying alcohol problem drinkers and their victims as early as possible and promptly initiating constructive intervention measures.

The California Alcoholism Program makes a programmatic distinction between these two kinds of programs and services - one is aimed at preventing alcohol problems from occurring in the first place (to reduce the number of new cases) while the other intervenes as early as possible with those who are already experiencing alcohol problems. This distinction is made to help each of the programs focus more sharply on those intended good effects they can produce. In no way is the importance and necessity of the early identification and intervention programs and services lessened. Both these programs and the prevention programs are vital, but different efforts are used to combat alcohol misuse.

* ADP Alcoholism Prevention Program themes.

Until recently, the identification/intervention type efforts predominated over prevention services. The early identification and intervention programs and services are community based, i.e., operated and administered at the local level. Many are publicly funded but many others are staffed largely by volunteers, usually by recovering alcoholics. One type of identification program, the occupational alcoholism program, has enjoyed success in industry and labor, reducing the cost of poor job performance and absenteeism associated with drinking. Within the private sector, there are numerous self-help programs which assist recovering alcoholics to maintain their sobriety. Alcoholics Anonymous is the largest of these organizations and is impressively successful with respect to those persons to whom its methods and philosophy appeal.

Prevention programs, on the other hand, include mass media advertising, legislative and regulatory controls and general alcohol education. Since the service delivery mechanisms of most prevention services transcend local community boundaries, these services frequently emanate from state or national organizations. Recent years have seen a substantial increase in mass media efforts aimed at the general public. Voluntary organizations have a long history of involvement in alcoholism prevention programs. The National Safety Council's "If you drink, don't drive; if you drive, don't drink" campaign has been going on for over 30 years. Other organizations which have mounted public alcoholism prevention campaigns include the Alcoholism Councils of California, National Council on Alcoholism, National Congress of Parents and Teachers, Parents Without Partners and Boys Clubs of America. Most of these prevention projects include a cooperative working arrangement with local volunteer groups to actively influence individual attitudes about drinking behaviors and are the vanguard of local identification/intervention services.

The ADP is conducting a three year prevention demonstration project aimed at changing people's knowledge and attitudes about alcohol and changing their drinking behavior. That project has completed its first phase and is being evaluated. Upon completion of the first phase evaluation, the ADA will make a policy determination as to the most effective methods to pursue. Prevention programs are necessary to combat alcoholism. It is futile to address alcohol problems solely by treating the casualties as there are insufficient resources. Prevention methods are needed not only to increase resource utilization effectiveness but, more importantly, to eliminate unnecessary suffering from occurring in the first place. In addition, there is a governmental responsibility to inform the public of the risks involved in drinking so they may make an informed choice. Furthermore, the development of such information must be done to ensure that the materials are sensitive to local customs and practices so as to avoid having a different effect than intended.

POLICY RECOMMENDATIONS FOR ALCOHOL ABUSE

Alcohol-1: THE EXISTING BUDGETING AND COST REPORTING METHODS TO IDENTIFY ALCOHOL SERVICE COSTS SHOULD BECOME MORE ACCURATE AND EFFICIENT IN ORDER TO IMPROVE FISCAL AND SERVICE ACCOUNTABILITY.

Alcohol-2: THE INFORMATION COLLECTING CAPACITY OF THE ADP SHOULD BE INCREASED. THIS EFFORT SHOULD BE DIRECTED TOWARD COLLECTING, ARRANGING AND DISTRIBUTING TO ALL PLANNING BODIES INFORMATION REGARDING ALL TREATMENT RECOVERY, IDENTIFICATION AND INTERVENTION SERVICES IN THE STATE.

Alcohol-3: THE ADP SHOULD COOPERATE FULLY WITH THE EFFORTS OF THE DEPARTMENT OF FINANCE AND OTHER PLANNING AGENCIES TO DEVELOP A PROGRAM BUDGETING SYSTEM.

Alcohol-4: THE ADP SHOULD UPDATE AND IMPROVE EXISTING ALCOHOL SERVICES, INCLUDING DEVELOPMENT OF COST GUIDELINES THAT WOULD REFLECT CURRENT AND FUTURE PROGRAM CONDITIONS. THIS WILL REQUIRE REEXAMINATION AND REVISION OF EXISTING STANDARDS AND PROGRAM BUDGETING PROCEDURES.

Alcohol-5: THE ADP SHOULD ESTABLISH A SOCIAL RESEARCH ADVISORY GROUP TO ADVISE ON RESEARCH TOPICS. IN THE MEANTIME THE ADP SHOULD CONTINUE TO DEVELOP ALCOHOL SPECIFIC SOCIAL RESEARCH IN THE AREAS OF:

- THE RELATIVE NEED FOR SERVICES, THE INCIDENCE AND PREVALENCE OF ALCOHOLIC AND PROBLEM DRINKERS IN CALIFORNIA AND THEIR UTILIZATION OF TREATMENT SERVICES.
- THE CAUSAL RELATIONSHIP BETWEEN CONSUMPTION AND THE AVAILABILITY OF ALCOHOL BEVERAGES, INCLUDING THE EFFECTS OF REGULATORY POLICIES SUCH AS PRICING, LOCATION, ALCOHOLIC CONTENT, ETC.
- THE RELATIONSHIP OF DEVELOPMENTAL LEARNING PATTERNS AMONG YOUTH WHO USE AND MISUSE ALCOHOL.

Alcohol-6:

THE STATE SHOULD ASSIST IN THE REMOVAL OF THE STIGMA OF ALCOHOLISM AND SHOULD ASSIST PERSONS WITH ALCOHOL PROBLEMS IN GETTING APPROPRIATE HEALTH SERVICES FOR BOTH THEIR ALCOHOL RELATED NEEDS AND THEIR OTHER HEALTH PROBLEMS IN THE FOLLOWING WAYS:

- THE PRIMARY MECHANISM BY WHICH THE STATE ASSISTS PERSONS AFFECTED BY ALCOHOL PROBLEMS IS THROUGH COUNTY ALCOHOL PROGRAMS. THE ADP WILL CONTINUE TO WORK THROUGH THEM, AS WELL AS WITH STATE AND REGIONAL HSAS TO ENSURE THE FULL RANGE OF HEALTH SERVICES FOR ALCOHOL DISABLED PEOPLE. IN ADDITION, THE ADP WILL ENCOURAGE THOSE CITIZENS AND GROUPS THAT ARE CONCERNED ABOUT ALCOHOL PROBLEMS INCLUDING ALCOHOL PARTICULARLY COUNTY ALCOHOLISM PROGRAMS, TO PARTICIPATE TO THE FULLEST EXTENT IN HEALTH PLANNING WITHIN THEIR RESPECTIVE HSAS.
- THE ADP WILL CONTINUE TO REVIEW CURRENT KNOWLEDGE CONCERNING THE AVAILABILITY, UTILIZATION AND EFFECTIVENESS OF PUBLIC AND PRIVATE HEALTH INSURANCE COVERAGE FOR ALCOHOLISM.

Alcohol-7:

THE ADP SHOULD ENSURE THAT ALCOHOLISM SERVICES ARE AVAILABLE TO ALL CALIFORNIANS:

- THE ADP WILL CONTINUE TO MONITOR AND PROVIDE TECHNICAL ASSISTANCE TO ENSURE THAT FACILITIES PROVIDING ALCOHOL SERVICES MEET THE FEDERAL ACCESSIBILITY REQUIREMENTS FOR HANDICAPPED PERSONS.
- THE ADP WILL ENSURE THAT SPECIFIC ALCOHOL SERVICE NEEDS OF SPECIAL POPULATIONS ARE ADDRESSED IN THE STATE ALCOHOL PLAN AND IN COUNTY ALCOHOL PLANS BY NOTING SPECIAL POPULATION DESCRIPTIONS, THEIR PARTICULAR PROBLEMS AND SERVICE NEEDS, AND THE EXTENT TO WHICH THEIR NEEDS AND THE NEEDS OF THE GENERAL POPULATION ARE BEING MET.

Alcohol-8:

THE ADP, THROUGH THE ALCOHOL RESEARCH CENTER AND ADP RESEARCH ACTIVITIES, SHOULD FURTHER IDENTIFY THE ALCOHOL PROBLEMS, SERVICE NEEDS, AND SERVICE UTILIZATION OF SPECIFIC POPULATIONS, SUCH AS THE ELDERLY, AMERICAN INDIANS, BLACKS, HISPANICS, DISABLED, GAYS, PUBLIC INEBRIATES, WOMEN AND YOUTH.

Alcohol-9: THE ADP SHOULD INCREASE EMPHASIS ON PRIMARY PREVENTION SERVICES THROUGH:

- DEVELOPMENT OF EFFECTIVE LANGUAGE AND CULTURALLY ACCEPTABLE MASS MEDIA TOOLS TO INFORM THE PUBLIC OF THE RISKS INVOLVED IN DRINKING AND TO AFFECT ATTITUDES REGARDING NONDRINKING.
- IMPLEMENTATION OF A FETAL ALCOHOL SYNDROME CAMPAIGN TO REDUCE BIRTH DEFECTS.

Alcohol-10: THE ADP SHOULD ASSUME A LEADERSHIP ROLE AND INITIATE AND FUND PLANNING AND TREATMENT EFFORTS FOR EACH OF THE ABOVE MENTIONED CONCERNS ON A PRIORITY BASIS.

Alcohol-11: THE STATE SHOULD ENCOURAGE THIRD PARTY REIMBURSEMENT FOR THE ALCOHOL TREATMENT SERVICES WHICH MEET STATE AND FEDERAL STANDARDS.

DRUG ABUSE

DEFINITIONS AND SCOPE OF SERVICES

Drug abuse, or "dysfunctional drug use," can be defined as "drug use that results in physical, psychological, economic, legal and/or social harm to the individual drug user or to others affected by the drug user's behavior." It can be conservatively estimated that such drug abuse costs Californians more than two billion dollars a year in crime, enforcement, medical treatment, unemployment, public support and other quantifiable resources, as calculated in a 1976 National Institute on Drug Abuse study.

The specific drug being abused, the setting and the manner in which it is ingested (orally, injected, etc.) and the amount and frequency of use are all factors in diagnosing and treating an individual's drug abuse problem. Drug dependency includes physical addiction to such drugs as heroin, barbiturates or tranquilizers and psychological habituation to such drugs as cocaine, marijuana or phencyclidine (PCP). In the past, the drug problem was "heroin addicts." In the late 1970s, however, the increased use of a variety of psychoactive substances for nonmedical purposes, from aerosols and paints to hallucinogens to marijuana, has also increased the numbers of those who fit into the "dysfunctional drug user" definition. Additionally, the "drug problem," as recognized by the federal government and by professionals in the field, includes the inappropriate use of prescription and over-the-counter drugs and alcohol, often in combination.

Drug abuse prevention can be defined as an ongoing process of promoting an individual's full personal growth and potential in order to reduce the probability of drug misuse or abuse. Prevention includes intervention services to reduce the incidence of dependence or dysfunction requiring treatment; informational services to persuade people to avoid misuse of drugs; and educational services to teach self awareness, values clarification and personal decision making techniques and to suggest alternative behaviors and life styles.

The State Department of Alcohol and Drug Programs, through the Division of Drug Programs, has the primary responsibility for fiscal and programmatic management of the statewide drug abuse prevention effort. This includes development of generic prevention strategies responsive to diverse target populations. Efforts in the area of prevention also include coordination with the State Department of Education's school health program, since school curricula requirements include instruction about drugs, alcohol and tobacco. Because of the interdisciplinary nature of the primary prevention field, coordination with other State agencies is an ongoing activity. Prevention services are delivered at the

community level - in schools, community based programs, hotlines, youth service bureaus, information centers and related programs. Promoting improved cooperation among these prevention services and molding them into community networks will require coordinated planning.

BACKGROUND

Relationship to Health Status

Through the first half of this century, drug abuser meant drug addict or junkie, a criminal of the inner city streets. With the exception of some institutional programs, until the late 1960s and 1970s, the primary social response to such behavior was punishment. But lack of success in either reducing the problem or "curing people" encouraged other responses, including redefining drug abuse. If drug addiction were considered a health problem rather than a criminal problem, it was reasoned that medical treatment would successfully rehabilitate or at least contain the consequences of addiction.

At the end of the 1970s, the easy answers have disappeared, to be replaced by a broader view of drug abuse as a sociobehavioral health problem requiring a variety of approaches. No longer confined to the ghetto or barrio, the delinquent, criminal, special or underground culture, we now see drug abuse among our own children, family and friends. Drug treatment programs seek to individualize services based upon the needs of their clients and the environment in which drug abuse occurs. Yet knowing that drug abuse becomes a chronic problem, increased attention is being focused on prevention and early intervention.

Few disagree that preventing a problem, disorder, or disease is preferable to having to treat it, but because prevention presents an intangible and often unmeasurable effect, there exists a high philosophical - but low financial commitment to drug abuse prevention. This is the case for all levels of government - federal, State and local - and in other health fields as well. During the past few years, there has been increasing interest in prevention. Too often, health education/prevention programs are an adjunct to departmental programming; thus when budget cuts occur, prevention programs/funds are highly vulnerable. Currently, over 90 percent of drug abuse funding focuses on treatment, particularly on treating those individuals who are the most severely disabled and who cause the greatest societal disruption. Only a small percentage of drug abuse resources are allocated for prevention.

Attempting to diminish drug abuse through positive prevention programs which address individual needs is a relatively recent strategy. In the first half of this century, the primary emphasis was upon supply reduction, enforcement of harsh laws as a deterrent and scare tactics designed to induce fear of drugs and drug addicts. In the last two decades, legislation and administrative policies recognize the greater complexity of human behavior and the need to promote good health and positive physical and mental

development as the best deterrent to self-destructive behavior such as drug abuse. However, where treatment is needed and utilized by clients, there are benefits derived.

A two year followup evaluation study of 1,000 ex-clients conducted for the Department of Alcohol and Drug Programs confirms national studies which provide evidence that drug abuse services are, on the whole, cost effective to society and beneficial to clients. When an opiate dependent person stays in a detoxification program only a few days to reduce a habit, at a cost of about six dollars per day, there are savings to the community in income producing property crime. It costs about five dollars per day to maintain a methadone client, or fifteen dollars a day to treat someone in a therapeutic community and since most clients have significant drug addiction and criminal histories, treatment services have been determined to be cost beneficial.

Drug Use: Over 80 percent of the respondents report reduced drug use — measured by reduced quantity per occasion, use on fewer occasions and reduced expenditures on drugs.

Average expenditures for all drugs in the year preceding treatment were about \$5,900 and fell to about \$3,500 in the post-treatment year — a drop of \$2,400 per client. Costs in both periods were largely attributable to heroin purchase.

Average days of use per year were reduced as follows:

	<u>Pre-treatment</u>	<u>Post-treatment</u>
Heroin	160	58
Marijuana	115	85
Alcohol	109	87

Patterns of use shifted from heroin, amphetamines, barbiturates and hallucinogens toward marijuana, alcohol or abstinence.

Heroin was the most frequent primary drug of abuse both before and after treatment, but was reported as the most heavily used drug by 60 percent of the sample before treatment and by 40 percent after treatment.

Analysis of voluntarily provided urine samples indicated recent opiate use among 15 percent of the respondents; but 24 percent had actually self-reported recent use. Among those who provided specimens, opiates were detected in only three cases per hundred of those who denied use. Less than 5 percent of respondents reported increased drug use after treatment and 10 percent had become totally abstinent.

Illegal Activity: One-third of the respondents claimed that illegal activity, ordinarily drug dealing or property theft, had been their major source of income prior to treatment; less than one-fifth made this claim for the post-treatment period.

