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**MANUAL FOR
REGIONAL EDUCATION ON SUBSTANCE ABUSE ISSUES
TO ENABLE THE COURTS TO MAKE MORE
USE OF COMMUNITY RESOURCES**

**SPONSORED BY
STATE JUSTICE INSTITUTE
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AND

**SALT LAKE COUNTY
CRIMINAL JUSTICE SERVICES**

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WORKSHOPS FOR COORDINATION BETWEEN
COURTS AND SUBSTANCE ABUSE TREATMENT AGENCIES

BY
THE STATE JUSTICE INSTITUTE
(SJI)
AND
THE DIVISION OF CRIMINAL JUSTICE SERVICES

The SJI is a federally sponsored agency in Alexandria, Virginia, which is charged with distributing federal funds to promote the orderly functioning of state and local courts throughout the United States. The Salt Lake County Division of Criminal Justice Services consists of Pre-Trial Services (preadjudication) and the Alcohol Counseling and Education Center (postadjudication). The Division of Criminal Justice Services has been awarded a grant from the State Justice Institute with the gracious approval of the State Office of the Court Administrator. Below is a summary of the grant and some of its requirements.

GOALS OF THE GRANT

The goals of the grant are (1) to enable Judges to take full advantage of community resources in dealing with substance abuse cases which come before them and (2) to reduce the time and resources of Courts and substance abuse treatment agencies in dealing with cases involving substance abuse by coordinating efforts between them and (3) coordinate treatment programs and courts.

METHODS OF THE GRANT

The methods of the grant are (1) to set up a workshop in each of the eight judicial districts to provide education about substance abuse and to provide opportunities for networking between the courts and the substance abuse treatment programs, (2) to set up a district coordinating committee in each of the eight judicial districts to provide continuing opportunities for networking, and (3) to set up a State Oversight Council to provide suggestions and resources to the eight district coordinating committees.

Workshop agenda: The ultimate purpose of the workshops is to improve the working relationship between the courts and the substance abuse treatment programs. The agenda will consist of participatory presentations and exercises designed to expose the barriers between treatment programs and courts and to build bridges between these two societal institutions for the benefit of both. For example, judges sometimes perceive that sentencing a defendant to a treatment program is the equivalent of allowing the defendant to walk free with no consequences for illegal behavior because treatment may not work. On the other hand, treatment personnel sometimes believe that the courts are using their programs for

minimum security jails.

The heart of the agenda will be to inform courts what treatment programs require to improve the success rate of clients in treatment and to inform the treatment programs what the courts require to make sure that a referral to treatment is in the interest of justice.

District coordinating committees: It is anticipated that eight coordinating committees will be established. Each coordinating committee will be set up at the workshop in each district and then will meet regularly afterwards. It is the intention of the grant approved by the State Justice Institute that the coordinating committees will consist of judges, other court personnel, and administrators of substance abuse treatment programs with the power to break down barriers and to set up channels of communication in order that persons with substance abuse problems can be treated without creating a further burden to the criminal justice system. Emphasis will be placed on a minimum of staff time being used for this activity.

The State Oversight Council: The purpose of the State Oversight Council is to provide direction to the administration of the grant and to provide suggestions and resources to the district coordinating committees. The State Oversight Council has already met once and will be meeting again shortly to refine the agenda for the workshops to be held in each district. The State Oversight Council is comprised of two judges, the state judicial education officer, a well-known and experienced prosecutor, and top officials of state and local authorities for providing substance abuse treatment. The staff to the State Oversight Council are employees of the Salt Lake County Division of Criminal Justice Services, the grant recipients. (Please see attachment one for members and staff.)

OTHER INFORMATION

The workshops will be one day in length and will be held throughout the state in the judicial districts.

Generally, there will be no cost to the participants of the workshops. The grant includes the cost of the workshops. Local presenters will not be reimbursed. Since the workshops will be held locally, transportation and per diem will generally not be an issue. In geographically large districts, some participants may elect to stay overnight, but it is expected that the courts and treatment agencies will bear that cost.

The first workshop has been scheduled on June 4, 1992, for the Third District Juvenile Court. It is expected that the State Oversight Council will meet immediately after that workshop to refine the agenda and that the second workshop for the combined Third District Court, Third Circuit Court, and Justice Courts will be held in the middle of July 1992. Note that only in the Third

Judicial District will there be two workshops. The other seven judicial districts will have one workshop apiece for all the courts in the district. The time frame of the remaining workshops requires them to be held from July 1992 and to completed by September 30, 1993.

The workshops will be coordinated by Dr. Michael D. DeCaria, PhD, Clinical Psychologist with Pre-Trial Services and Errol S. Remington, MSW, Treatment Coordinator with the Alcohol Counseling and Education Center (see resumes, attachment two). Local presenters will be requested as assistants to ensure local relevance of the workshops. They will be marketed to agencies selected by local players and the State Oversight Council. Attachment three is a preliminary draft of a brochure used in this marketing.



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CHAPTER 1

PHARMACOLOGY

PSYCHOPHARMACOLOGY OF COMMONLY ABUSED SUBSTANCES

INTRODUCTION

Understanding the action of mood altering drugs on humans is part of the study of psychopharmacology. Pharmacology and psychopharmacology overlap a great deal, and psychopharmacology emphasizes the behavioral aspects of substance use and abuse. A basic knowledge of psychopharmacology enhances one's understanding of and ability to work with persons who abuse substances. However, psychopharmacology is only a fraction of the knowledge necessary to become familiar with the etiology of substance abuse. (Please see the chapter, Etiology of Substance Abuse).

The purpose of this chapter is convey basic facts and hypotheses of psychopharmacology to make the behavior of persons who abuse substances more understandable. This chapter is not meant to be a comprehensive text of psychopharmacology. The facts and hypotheses enumerated below are meant to have direct relevance for persons whose positions require them to interact with individuals who have substance abuse problems.

For the purposes of this chapter, the drugs of abuse are divided into five categories: (1) the central nervous system depressants, (2) the opioids, (3) the stimulants, (4) the hallucinogens, and (5) cannabis (marijuana). Because there are other valid ways of categorizing drugs of abuse, the reader should not be put off when encountering this or other classification systems.

DEFINITIONS

Acetylcholine (ACh) is the primary neurotransmitter in the central nervous system and the only neurotransmitter in the peripheral nervous system. Nicotine substitutes for acetylcholine in the nervous system.

Central nervous system (CNS) is the brain and the spinal cord.

Cross-tolerance is tolerance which develops to drugs with similar pharmacological action. Cross-tolerance makes it possible to become tolerant to drugs which one has never used if the user is taking a similar drug. Cross-tolerance is a property of some drug categories but not of others. Cross-tolerance makes it possible to substitute one drug for another to ease the pain of drug withdrawal in certain cases.

Dopamine is a neurotransmitter in the central nervous system, and its presence may be necessary to experience pleasure. Cocaine acts on it to prevent its reuptake.

DSM-III-R is the abbreviation for the *Diagnostic and Statistical Manual*, third edition, revised. The DSM-III-R is published by the American Psychiatric Association and is considered by most professionals as the official list and criteria of behaviors considered as mental disorders.

Effects are the actions the drug has on the organism including behavior. Undesired effects are called side effects (q.v.). It is important to know that effects vary with dose, route of administration, social setting, and expectations of the user.

Half-life is the amount of time required for the body to eliminate one-half of the drug present in the body. Most drugs are eliminated according to this geometric progression, that is, with the ratio of one-half eliminated in a fixed amount of time. Drugs which are eliminated according to this geometric progression are virtually eliminated after four half lives have elapsed. At the end of the first half-life, 50% of the drug remains; at the end of the second half-life, 25% of the drug remains; and the end of the third half-life, 12.5% of the drug remains; and at the end of the fourth half-life, 6.25% of the drug remains. Alcohol is an exception to this rule because alcohol is eliminated according to an arithmetic progression with a fixed amount, rather than a fixed ratio, eliminated in a fixed amount of time.

Neuron is the basic nerve cell in the central nervous system and the peripheral nervous system. In the brain the term brain cell could be a synonym, although there are brain cells other than neurons.

Neurotransmitter is a chemical in the nervous system which allows one neuron to excite or inhibit the activity of another neuron. There may be upwards of 100 neurotransmitters. The primary neurotransmitter in the central nervous system and the only neurotransmitter in the peripheral nervous system is acetylcholine (ACh). Two other neurotransmitters are dopamine (DA) and norepinephrine (NA).

Norepinephrine is a neurotransmitter in the central nervous system, and its presence may be necessary to experience pleasure. Cocaine acts on it to prevent its reuptake.

Peripheral nervous system is the portion of the nervous system which lies outside the brain and spinal cord.

Physical addiction is the physiological craving for a drug which will temporarily end the withdrawal syndrome. Physical addiction is a physical illness caused by the withdrawal of certain drugs. Because certain drugs are capable of inducing physical addiction and some are not, physical addiction can be seen as a property of some drugs. While the connection between physical

addiction and continued abuse of a drug seems obvious, the fact is that physical addiction does not explain substance abuse. Some drugs which do not cause physical addiction are abused, and some drugs which do cause physical addiction are not abused. For example, tricyclic antidepressants are physically addicting, but persons who use them give them up readily.

Potentiation is the multiplying effect from consuming two different drugs at the same time so that the combined effects are greater than two doses of the same drug.

Psychological addiction is a person's subjective craving to use a drug. Psychological addiction is an unfortunate concept for two reasons. The first is that it implies that certain drugs cause substance abuse by having the property of psychological addiction. The fact is that the majority of persons exposed to mood altering drugs do not abuse them. For example, only 10% of persons who use alcohol or heroin abuse it. The second reason is that the concept of psychological addiction describes a craving; the concept has no explanatory power, only descriptive power. Psychological addiction is really a property of a person and not of a drug, and the roots of the concept are in biology, psychology and sociology. (Please see chapter on Etiology of Substance Abuse.)

Reverse tolerance is the capacity to experience the effects of a drug as more intense with repeated use of the same dose.

Side effects are the undesired effects of a drug.

Substance abuse is behavior characterized by continued use of psychoactive substances in spite of social, occupational, psychological, or physical problems or continuing use in situations which are physically hazardous (DSM-III-R).

Substance dependence is behavior which is characterized by at least three of the following behaviors: (1) using larger amounts of substance than intended, (2) unsuccessful efforts to quit or cut down, (3) inordinate time devoted to obtaining substances, (4) frequent intoxication or withdrawal which interferes with one's obligations, (5) forgoing important activities in favor of substance use, (6) using substances in spite of problems caused or exacerbated by substances, (7) tolerance, (8) withdrawal symptoms, (9) using substances to manage the signs and symptoms of the withdrawal syndrome (DSM-III-R).

Synapse is the space between two neurons, sometimes called the synaptic cleft.

Therapeutic ratio or index is a relative measure of how dangerous a drug is in terms of potential for a lethal overdose. The more times the usual dose required for a lethal overdose, the

safer a drug is thought to be. Therapeutic ratio can be calculated by the following formula: $TR = \frac{LD}{ED}$

where TR is therapeutic ratio, ED is effective or usual dose and LD is lethal dose.

Tolerance is the capacity to experience the effects of a drug as less intense with repeated use of the same dose. Increasing the dose may or may not lead to increased effects if tolerance is operating. Tolerance may exist for some effects and not for other effects of the same drug. Tolerance may develop at different rates for the different effects of the same drug. Tolerance can be demonstrated for some drugs and not for other drugs so that tolerance can be said to be the property of a drug. Although in some sense tolerance can be said to be the property of a drug, the rates of tolerance vary from individual to individual.

Withdrawal syndrome is the signs (externally demonstrable) and symptoms (reported by the sufferer) experienced by the person who has become physically addicted to a drug and has ceased taking the drug. The signs and symptoms are opposite the effects of the drug.

CENTRAL NERVOUS SYSTEM DEPRESSANTS

Definitions

The central nervous systems can be defined in two ways, by an analysis of the words and by listing some included drugs. An analysis of the words leads to two parts: "central nervous system" and "depressants." Central nervous system simply refers to the brain and the spinal cord. Depressant does not mean causing emotional depression. Instead, depressant means reducing physiological functioning and arousal. Therefore, central nervous system (CNS) depressants are drugs which reduce the physiological capability of the brain and spinal cord.

A list of CNS depressants includes beverage alcohol (ethanol), barbiturates, meprobamate, benzodiazepines, and some other substances. Most but not all drugs referred to colloquially as tranquilizers or sedative/hypnotics are CNS depressants.

Effects and Properties

With small doses the CNS depressants affect higher order behaviors such as judgment, behavior in social settings, and reasoning. With increasingly larger doses, lower order physiological functions are impaired. CNS depressants are lethal when doses large enough impair the most basic physiological processes such as breathing. Lethal doses of CNS depressants cause death by depressing the respiratory center in the medulla of the brain to the point where the individual does not breathe

sufficiently to support life. In other words, the CNS depressants cause death through respiratory depression.

Other properties which the CNS depressants have in common include tolerance, cross-tolerance, the ability to potentiate each other, and the potential for physical addiction. The cross-tolerance exists within the category of CNS depressants and does not extend beyond it with few exceptions. Cross-tolerance allows persons to have controlled withdrawal from one CNS depressant by substituting another.

When persons consume more than one kind of CNS depressant at a time, potentiation exists which may be more powerful than the combined doses of the two substances. Substances which have the property of depressing the CNS but are not categorized as CNS depressants also potentiate CNS depressants. Examples include opioid drugs and some antihistamines found in cold and allergy medications.

There are six possible signs and symptoms of withdrawal syndrome from the CNS depressants. A person experiencing withdrawal may or may not have all signs and symptoms or experience them a set order. Some CNS depressants are more likely to cause certain withdrawal signs and symptoms than are other CNS depressants. All of the signs and symptoms of CNS depressants withdrawal are explained by CNS stimulation or the opposite of CNS depression. The following is list of the possible signs and symptoms of CNS depressant withdrawal syndrome:

1. Hangover. The primary symptoms of hangover are inability to sleep restfully and gastrointestinal (GI) upset. It is easy to hypothesize that the portions of the CNS responsible for sleep and digestion of food are aroused rather than sedated or regulated. Hangover can happen with just one episode of CNS depressant use. Unlike the remaining symptoms, hangover is not a medical emergency, although some of those who have experienced it may say otherwise.

2. Tremors of the extremities. These are sometimes known as the "shakes." Portions of the brain and spinal cord which control muscle movement may be aroused which may account for the involuntary muscle movement. Sometimes person who are experiencing tremors of the extremities also complain of "inner shakes" inside their bodies. Tremors demand medical attention because they are often the precursor of the next sign, grand mal seizures.

3. Grand mal seizures. These seizures are identical to the grand mal seizures seen in persons with epilepsy. While persons are under the influence of CNS depressants, the seizure threshold is raised and the possibility of seizures is decreased. During the withdrawal syndrome, the seizure threshold rebounds, not to normal, but below normal which increases the probability of seizures. As a point of interest, the medications such as phenytoin (Dilantin)

and phenobarbital commonly used to control seizures in persons who have epilepsy are CNS depressants.

Withdrawal seizures may begin 24 hours to several days after the last dose of the CNS depressant. The persons who experience these seizures usually remain unconscious after each seizure for several hours. People who are alone and have seizures are not aware of them. They often explain their bruises and other injuries sustained during the seizures by saying that people are breaking into their residences and beating them. Each seizure usually lasts as long as there is oxygen in the brain. When the oxygen supply is depleted, the seizure ends and the person's breathing restores the proper oxygen level before there is risk of brain damage from oxygen deprivation. Normally, the susceptibility to seizures without treatment dissipates with time, perhaps as long as six weeks, if the person avoids CNS depressants. Withdrawal syndrome grand mal seizures do not cause epilepsy, although it is possible for someone to have head trauma during a seizure which could cause scar tissue on the brain and epilepsy later on.

4. Auditory hallucinations. During the withdrawal syndrome, persons often hear voices which are not really present. Generally, people find these voices annoying but not frightening. Auditory hallucinations are common during withdrawal from alcohol. Because adolescents often experience them after one episode of alcohol intoxication, one should not be quick to diagnose schizophrenia in adolescents with auditory hallucinations. Adults experience auditory hallucinations more commonly after several days of alcohol consumption.

5. Delirium tremens (DT's). The symptoms of DT's include vivid, visual and frightening hallucinations such as the proverbial pink cockroaches, elephants, worms, and snakes. People in DT's often feel the creatures crawling on their bodies, a symptom called tactile hallucinations. DT's is dangerous because it is accompanied by precipitous fall in blood pressure, which medical professionals call cardiovascular collapse or shock.

6. Death. Untreated DT's can result in death from cardiovascular collapse because the vital tissues of the body may not be adequately perfused with blood to support life. The vital tissues include the brain, the heart, the lungs, the liver, and the kidneys. As can be seen, the CNS depressants are dangerous both in overdose as well as during withdrawal.

Alcohol

Beverage alcohol (ethanol) is the prototype drug of the CNS depressant category. Unlike most other CNS depressants, alcohol not only sedates tissue but also irritates tissue. Hence, alcohol used often or in heavier amounts can cause many inflammations including pancreatitis and esophagitis. Alcohol may be the only

commonly abused substance which causes visible brain damage. Persons who use alcohol heavily have less brain mass on autopsy than do those persons who abstained or used moderately. The evidence is that alcohol enlarges the ventricles, the four fluid filled hollow cavities in the brain. Alcohol use deposits fat in the liver, and alcohol abuse is the leading cause of cirrhosis of the liver.

A legitimate question is whether it is possible for persons to use alcohol in a manner which does not compromise their health. The answer is a yes for most people. The common consumption pattern of Americans is to use alcohol rarely and moderately. The majority of Americans use alcohol less often than once a week and then consume only one to three drinks when they do. However, persons who have demonstrated alcohol abuse disorder virtually never become so-called "social drinkers." It seems that approximately 85% of Americans who describe themselves as consumers of alcohol drink only about 25% of all the alcoholic beverages manufactured. Therefore, a small percentage, 15% of Americans who describe themselves as consumers of alcohol, drink 75% of all the alcoholic beverages manufactured. There are suggestive data available which shows that persons who consume two or more alcoholic beverages a day are on the borderline between moderate and heavy drinking. However, the etiology of substance abuse is so complicated that alcohol abuse disorder cannot be defined by the number of alcoholic beverages consumed in a given period.

Small amounts of alcohol, much less than required for intoxication, can reduce a person's inhibition to violence. A body of credible research now exists which says that consuming even one or two alcoholic beverages increases the risk of violence. More frightening is the finding that persons who have not consumed alcohol but believe they have are at increased risk to perpetrate violence. The greatest probability for violence is when both the perpetrator and victim have been consuming alcohol. The other situations with potential for violence in descending order of probability are only the victim consuming alcohol but not the perpetrator, the perpetrator consuming but not the victim, and neither the perpetrator nor victim consuming. Note that violence is more likely when only the victim has been consuming than when only the perpetrator has been consuming.

A common occurrence with alcohol abuse disorder is alcohol-induced amnesia, sometimes called an alcohol amnesic episode but better known as alcohol blackout. People in alcohol blackout appear to behave normally and often do not look intoxicated to the casual observer. The key feature is that persons have no memory for their activities during the blackouts. Nevertheless, persons often commit crimes ranging from shoplifting to DUI to rape and homicide during blackouts. It is difficult for many people to understand this phenomenon because they believe that blackouts

could only occur when a person is obviously intoxicated as indicated by staggering gait and slurred speech.

Blackouts often occur when blood alcohol content (BAC) is decreasing. People often have more tolerance and do not appear intoxicated when their BAC's are declining rather than rising. For example, a person may go to a party and consume many alcoholic beverages during the first few hours and then switch to soft drinks later. If the BAC is measured early in the party at 0.14%, that person would likely appear to be under the influence. Several hours later when the BAC is declining and at 0.14% again, many observers would say that the person was not intoxicated because there would be no staggering gait or slurred speech. Alcohol blackout is a frequently overlooked phenomenon behind DUI and felony crimes committed under the influence of alcohol. Just because people are responding to others, appropriately or inappropriately, does not mean that they are going to remember it later on.

BAC's are interesting in relation to arrests for DUI. Most lay persons believe that the average BAC in a DUI arrest is 0.08%, the legal limit. However, the average is about 0.16% which is fascinating since many persons who are not tolerant to alcohol would be too intoxicated to even start a vehicle at ranges from 0.10 to 0.15%. The conclusion is that persons arrested for DUI at levels from about 0.12 to 0.30% and higher are persons who have a demonstrated tolerance to alcohol which comes from frequent and heavy consumption of alcohol. Indeed, 0.30% is lethal for persons not tolerant to alcohol, but many persons have been arrested for DUI with BAC's 0.30% and higher. People who consume alcohol often enough in heavy enough amounts frequently report that they did not even feel impaired or "drunk" even with high BAC's at the time of a DUI arrest.

Alcohol can act to relieve physically perceived pain but is only effective at doses which cause someone to lose consciousness.

Barbiturates

Barbiturates were introduced into medicine at the beginning of the 20th century. Until then alcohol was the primary CNS depressant available to physicians to prescribe for their patients, although other CNS depressants, such as chloral hydrate, were available. Barbiturates are commonly classified according to the length of their actions as ultrashort acting, short acting, intermediate acting, and long acting. Ultrashort acting barbiturates, such as Sodium Pentothal, are not commonly abused because they have a low therapeutic ratio (see definitions) and result in deep unconsciousness. Short acting and intermediate acting barbiturates are commonly abused because the onset of the effects is rapid and intense. Knowledgeable people who abuse

barbiturates do not readily choose long acting barbiturates, such as phenobarbital, because the onset of effects after an oral dose can take hours and not be intense. Amobarbital and secobarbital are two short to intermediate acting barbiturates often abused. They are available in the brand name preparations of Seconal and Tuinal, sometimes referred to as "reds" and "rainbows."

Barbiturates began to lose popularity in medicine by the early 1970's due to newer medications (See "Minor Tranquilizers" below). Barbiturate abuse is still a problem but not as much as it was two decades ago. The individuals who would have abused barbiturates in the past are now abusing alcohol and the newer pharmaceutical CNS depressants. Barbiturates are probably the drugs of abuse which present the greatest acute physical danger to users for the following reasons:

Barbiturates have the ability to produce fairly rapid tolerance to the effective doses but not to the lethal doses. For persons not tolerant to barbiturates, the lethal dose is generally 10 to 20 times the effective dose. With use the effective dose rises, but the lethal dose remains about the same. Therefore, the therapeutic ratio (please refer to definitions above) can begin at 10 to 20 but lower to 1. At the therapeutic ratio of 1, the effective dose is the same amount as the lethal dose. Therefore, accidental lethal overdoses can occur. Some overdoses are probably mistaken for suicides.

Barbiturates increase perception of pain. Instead of numbing pain as an analgesic, barbiturates increase pain. Because people who experience pain have difficulty sleeping or relaxing, they often end up taking barbiturates, which make the pain worse. As a result the individuals increase the dose and compound the problem. Without intervention, death may occur.

Another problem with barbiturates is the possibility of accidental arterial injections. If barbiturates are injected into an artery rather than a vein, the artery immediately closes up. The tissues which depend on that artery and its branches are deprived of blood which results in gangrene and the possible need for amputation.

Still another problem with barbiturates is the probability of withdrawal seizures. If a person becomes physically addicted to barbiturates, the probability of withdrawal seizures is higher than for persons withdrawing from alcohol.

"Minor Tranquilizers"

The term "minor tranquilizers" has fortunately long been abandoned, but it is useful in understanding some of the history of CNS depressants. For more than half of the 20th century, researchers were looking for drugs to replace the barbiturates.

Meprobamate (Miltown) was introduced in about 1960 as a nonaddicting substitute for barbiturates. It did not take long to learn that meprobamate was as addicting as barbiturates and in many ways it was not an improvement. Nevertheless, it was given the name minor tranquilizer to distinguish it from the recently introduced phenothiazine drugs (e.g. Thorazine) used to provide symptomatic relief of schizophrenic symptoms. The phenothiazines were called "major tranquilizers." There were two ironies. The first was that the major tranquilizers are not addicting and do not produce euphoria. Therefore, the major tranquilizers should have been called the minor tranquilizers. The second irony was that there is nothing minor about the "minor tranquilizers."

The term "minor tranquilizer" was also applied to the benzodiazepines, such as Valium which was the second most commonly prescribed drug in the western world in the last half of the 1970's. There can be no doubt that the term "minor tranquilizers" played a role in promoting drug abuse. Some readers may even remember the late Allen Sherman song entitled *Miltown* which was a parody of Petula Clark's song *Downtown*.

Today the terms "minor tranquilizers" and "major tranquilizers" have been laid to rest. The "minor tranquilizers" are the benzodiazepines and the "major tranquilizers" are called neuroleptics.

Benzodiazepines

Some proprietary names of benzodiazepines include Valium, Librium, Halcion, Dalmane, and Ativan. They remain popular drugs, and some are prescribed for anxiety and others for sleep. They provide short periods of symptomatic relief at best, and they are associated with drug abuse at worst. The symptom called anxiety has numerous causes and is almost always better treated with psychological therapies and/or some newer medications which do not have the potential for abuse. Most authorities agree that benzodiazepines and other CNS depressants should not be used to treat anxiety for more than two weeks, and then only in severe situations where the source of stress is simply and easily identified. Sleep disorders also have a variety of causes and almost never are the benzodiazepines appropriate. Medications do not promote natural sleep cycles, and the CNS is going to be aroused rather than normal after each dose of benzodiazepine wears off. Insomnia will be worse rather than better after the medication is stopped.

There is one area where the benzodiazepines were a marked improvement over the barbiturates, and that area is the potential for lethal overdose. The therapeutic ratio for the benzodiazepines is high, probably in the hundreds. Therefore, a person would have to take many times the usual dose to run the risk of lethal

overdose. However, the benzodiazepines are potentiated by other CNS depressants consumed concurrently, most notably alcohol. Therefore, benzodiazepines should not be considered safe drugs.

A problem with benzodiazepines is their long half-life. With half-lives of even 100 hours of some benzodiazepines and of their active metabolites, regular doses taken as prescribed by a physician can build up in the body over time. An analogy is pouring water into a sink with a very small drain. More water comes in than goes out so that the level of the water reaches a higher level than intended. The result is that persons who take benzodiazepines in prescribed doses can become physically dependent and suffer withdrawal syndrome if they stop taking the benzodiazepines. It is also possible that they can become intoxicated with the buildup in the body.

Other CNS depressants

There are other many CNS depressants other than the ones listed above. However, they are not often abused, although they have same potential for abuse as the ones listed above. The fact that they are not often abused has more to do with lack of availability and publicity rather than with their pharmacology.

Atypical CNS depressants

Other substances have many of the properties of the CNS depressants, but it has not been demonstrated that they induce physical addiction. These other substances include the volatile solvents and phencyclidine.

Phencyclidine, better known as PCP or angel dust, was popular in the late 1960's through the 1970's. It is little used now. Phencyclidine was introduced as an anesthesia for surgery in the early 1950's. Unfortunately, patients often exhibited delirium under its influence, and its use was restricted to veterinary medicine early on. In the 1960's illicit use of phencyclidine began, and supplies were diverted from veterinary channels, or it was manufactured in clandestine laboratories. In low doses phencyclidine causes effects similar to any CNS depressant. In higher doses it acts like an hallucinogen much like LSD, In very high doses or in sensitive individuals it causes an intense but temporary syndrome similar to schizophrenia along with a propensity for violence. Phencyclidine has often been sold to unsuspecting users as LSD, mescaline, or other hallucinogenic chemicals which have much less potential for harm than does phencyclidine.

The volatile solvents include toluene, an industrial solvent and the ingredient in model glue; gasoline; aerosol propellants; paint; and paint thinner. There are scores of volatile solvents which could be used for the purposes of intoxication. Use of these chemicals for intoxication can lead to death through cardiac

arrhythmia and/or suffocation. The primary users of these chemicals are immature adolescent boys and young adult men who prefer to be alone. The use of volatile solvents no longer appears to be a major drug problem, and the few chronic users are usually well known to law enforcement and treatment programs. When volatile solvents were more commonly abused, the consumers were young people who had difficulty obtaining alcohol or other preferred drugs. Now it seems that persons who were once inclined to use volatile solvents now find it easier to obtain alcohol and other drugs including cocaine and crack cocaine.

OPIOIDS (OPIATES, NARCOTICS)

Definitions

The opioid drugs are derived from the dried exudate of the opium poppy, or they are synthesized chemicals with similar properties. A partial list of opioid drugs includes: opium, morphine, codeine, heroin, oxycodone, meperidine, hydrocodone, propoxyphene, hydromorphone, and methadone.

Effects and Properties

Three effects are especially prominent with the opioid drugs: (1) they suppress cough, (2) they control the symptoms of diarrhea, and (3) they are powerful pain killers. The cough suppression and the control of diarrhea can be achieved with small doses which do not induce euphoria or cause a person to feel high. Doses to control pain have to be high enough to induce euphoria. One of the quests of pharmaceutical science is to find a substance which will reduce pain without the euphoria, but that quest continues today.

Properties which the opioids share include tolerance, cross-tolerance, and the potential for physical addiction. The cross-tolerance exists within the opioid category and probably does not extend to other drugs including the CNS depressants. CNS depression is a feature of opioid drugs, but enough similarities exist that opioids are not classified with the CNS depressants. However, the mechanism of death in opioid overdoses is respiratory depression, the same as CNS depressants overdoses. Constipation is a common side effect of the opioids, a reasonable expectation given the antidiarrheal action of the opioids.

About 30% of persons who first use an opioid drug experience dysphoria rather than euphoria. Many find themselves vomiting. Tolerance sometimes but not always develops for the dysphoria and vomiting.

The theory of the action of opioid drugs is relatively simple. The body produces its own chemicals called endorphins. These endorphins reduce or eliminate pain and mediate feelings of

pleasure by occupying certain receptor sites in the central nervous system. The opioids are so shaped that they can occupy the same receptor sites and reduce pain and cause intense pleasure. If a person uses opioid drugs frequently, the body reduces its own production of endorphins and becomes dependent on opioid drugs to fill the void. There are suggestive data that many persons who abuse opioids may permanently damage their ability to produce endorphins. Tolerance is the result of reduced endorphins requiring the user to take more opioid. Physical withdrawal is explained by the lack of endorphins or opioids to occupy the receptor sites.

Physical addiction to opioids does not occur after a single use or even several consecutive administrations of opioid drugs. Although the processes which result in physical addiction are set up with the first dose of an opioid, physical withdrawal signs and symptoms do not develop until a person has used several times a day for three or four weeks. As with any drug which is physically addicting, the signs and symptoms of withdrawal are opposite the effects of the drug. There is a long list of signs and symptoms for withdrawal from opioid drugs, but the six most prominent are: runny nose, diarrhea, stomach cramps, muscle aches, insomnia, and rapid heart rate. The withdrawal syndrome can be likened to a severe case of the flu and is not life threatening to person in reasonable good health. However, it is horribly painful because the body's own system for handling pain, the endorphin system, is not functioning. Depending on the drug, the withdrawal syndrome may last from 24 hours to several weeks.

Opium

Opium is the dried exudate of the slashed seed pod of the opium poppy. Although percentages vary, opium is comprised of 10% morphine, 2-1/2% codeine and 87-1/2% inert ingredients. Some of the inert ingredients can be taken into a laboratory and transformed into drugs a thousand times more potent than morphine. Americans are familiar with opium in the form of paregoric, which is an old and needlessly complicated recipe for camphorated tincture of opium. A teaspoon (5 ml) of paregoric contains only 2 mg of morphine, and morphine is not effective when taken orally. Paregoric is meant to be used in small doses for control of diarrhea primarily in infants and young children. Many states, Utah not included, allow paregoric to be sold over the counter. While some persons addicted to opioids may try to concentrate paregoric if they cannot obtain other opioids, their use of paregoric is a desperate measure and may not justify removing it from over-the-counter sales. Their use of paregoric is akin to a person with an alcohol problem consuming Listerine mouth wash if the liquor stores are closed.

Morphine

Morphine is one of the two active ingredients in opium. Morphine is not effective orally; it is estimated that perhaps one-sixteenth of morphine consumed orally actually makes it to the blood stream. The standard pain relieving dose of morphine for comparison purposes is 10 mg of morphine subcutaneously. (Please note that persons who use needles generally inject the drugs intravenously not subcutaneously. The references to standard doses is given subcutaneously to be consistent with laboratory and clinical settings.) Morphine overdoses are relatively common for persons who abuse morphine.

Heroin

Heroin is compounded from morphine and is also called diacetylmorphine. When heroin is taken into the body, the acetyl parts of the morphine molecule split off and leave the morphine. Therefore, taking heroin is actually another way of taking morphine. Because the standard comparison dose of heroin is only 3.5 mg subcutaneously, heroin is about three times more potent milligram for milligram than morphine. This has important ramifications for smuggling drugs. (For a history of heroin, please see the Chapter entitled Treatment v. Incarceration.)

Codeine

Codeine is the other active ingredient in opium. Codeine is prized because it is effective orally, unlike morphine. Much of the world's supply of morphine is actually changed to codeine to meet the demand. The pain-killing action of codeine can be potentiated by combining it with non-opioid pain killers, such as aspirin or acetaminophen (e.g. Tylenol). One dose of codeine and one dose of aspirin or acetaminophen combined together is more effective than two doses of codeine or two doses of aspirin or acetaminophen. Persons who abuse codeine preparations may have worse consequences from the aspirin or the acetaminophen than from the codeine. Aspirin may cause gastrointestinal bleeding and make the problem worse by making it more difficult for the blood to clot. A single overdose of acetaminophen may cause permanent kidney damage, and chronic use of acetaminophen may cause permanent kidney and liver damage even without an overdose.

Oxycodone

Oxycodone is a synthetic opioid which is effective orally. Like codeine its efficacy is enhanced by combining it with aspirin (e.g. Percodan) or acetaminophen (e.g. Percocet, Tylox). Persons who abuse oxycodone preparations may experience chronic problems from the aspirin and acetaminophen as described in the section on codeine. Oxycodone itself has a difficult withdrawal syndrome. Persons who have developed a physical addiction to oxycodone may

require as long as three months for the withdrawal syndrome to run its course. There are pharmacological interventions available to reduce this time to ten days, but they are not commonly used.

Methadone

Almost everyone knows that methadone was developed by Nazi chemists during World War II as a solution to the shortage of morphine. One of its trade names, Dolophine, is a tribute to Adolf Hitler. Methadone is effective orally and a single dose lasts for 24 hours. There are variants of methadone available with effective periods of action as long as 72 hours.

The primary use of methadone is to treat persons with problems with opioid drugs usually heroin. Methadone stops the craving for other opioid drugs including heroin in order that the persons can get the other aspects of their lives under control. The use of heroin consumes one's entire life because there are only three ways to afford a heroin habit: stealing, dealing, or prostitution. Methadone allows the persons with opioid problems to stop dealing, stealing, and prostituting and to stabilize their lives.

Like oxycodone, cold turkey withdrawal from methadone is a painful and drawn out affair that can last three months. Clients in well-run methadone programs are withdrawn slowly over several weeks time to avoid the discomfort.

Hydrocodone

Hydrocodone is combined with other ingredients in the preparation with the trade name, Hycodan. Hycodan is frequently abused in large quantities by middle class, upwardly mobile and ambitious, young adults who view Hycodan as cough syrup rather than a drug. They often come to the attention of the criminal justice system for uttering forged prescriptions and driving under the influence.

Meperidine

One trade name for meperidine is Demerol. The standard analgesic dose is 100 mg subcutaneously, but meperidine is also effective orally. It is often the drug of choice for medical professionals to abuse because it is available and has an old reputation for not being as "serious" a drug as morphine.

Propoxyphene

Most persons are familiar with propoxyphene under the trade name of Darvon. As with codeine and oxycodone, propoxyphene is often compounded with aspirin or acetaminophen. The pain killing properties of propoxyphene are weak when compared to other opiates.

Hydromorphone

The trade name for hydromorphone is Dilaudid. Hydromorphone is abused most often when heroin is temporarily unavailable usually due to a disruption in supply. The usual analgesic dose is only 1.5 mg subcutaneously.

STIMULANT DRUGS

Definition

Stimulant drugs arouse the central nervous system. Because they work in a variety of ways, they are not a cohesive class of drugs as are the CNS depressants and the opioids. The stimulant drugs are grouped together because of their final action, not because they operate in the same way. A partial list of stimulant drugs includes nicotine, methylxanthine derivatives (e.g. caffeine), amphetamine, and cocaine.

Effects and Properties

Stimulant drugs give the user a feeling of alertness, competence, well-being, and boundless energy. Overdoses can exaggerate these feelings into hypervigilance, paranoia, extreme restlessness, anxiety and an inability to concentrate on thoughts and tasks. Overdoses often end in periods of amnesia similar to alcohol blackouts and/or in grand mal seizures. Death directly caused by acute overdose is rare except with cocaine. Withdrawal syndromes are marked by depression, suicidal ideation, suicide attempts, paranoia, and irritability. The paranoia and irritability often lead to violence with family and friends, but occasionally with strangers. The properties of tolerance and cross-tolerance are present with some of the drugs but not others. There is no cross-tolerance in this category.

Nicotine

Nicotine whether from cigarettes, pipes, cigars, chewing tobacco, or gum enters into the body and substitutes directly for acetylcholine (ACh), the most abundant neurotransmitter in the central nervous system and the only neurotransmitter in the peripheral nervous system. Nicotine probably stimulates centers in the brain which reduce feelings of anger and other unpleasant emotions. In the peripheral nervous system, nicotine at first stimulates the nerve bundles which join nerves from the spinal cord to nerves which innervate the voluntary muscles of the body. The nerve bundles are called ganglia (sing. is ganglion) and are located up and down the exterior of the spinal cord. After the nicotine stimulates the nerves to the voluntary muscles, the nerves become fatigued and stop functioning fully. The result is that the voluntary muscles of the body become partially paralyzed in a

flaccid, or limp, paralysis. Users of nicotine interpret this partial paralysis as relaxation, well-being, and the absence of anger.

Nicotine can cause death in an overdose by totally paralyzing all the voluntary muscles of the body including the ones which control breathing. Nicotine is tightly bound in tobacco and lethal overdoses are not known from tobacco use. Pure nicotine is lethal to humans and virtually all other animals because acetylcholine is the main neurotransmitter among animals including insects.

Methylxanthine derivatives

Three methylxanthine derivatives are caffeine, theophylline, and theobromine. The effective dose of the methylxanthine derivatives is about 100 to 150 mg orally. A six-ounce cup of coffee contains 75 to 150 mg depending on the coffee and the brewing method. A six ounce cup of tea contains about 50 mg of caffeine and 1 mg of theophylline. A cup of chocolate beverage contains about 250 mg, mostly theobromine but some caffeine. Chocolate candy contains about 25 mg of theobromine per ounce. The federal government limits the caffeine in soft drinks to 55 mg per 12 ounces. Most caffeinated soft drinks have 35 to 50 mg of caffeine per 12 ounces.

The average American uses 200 mg of methylxanthine derivatives, 90% from coffee, for their stimulant effects each day, although the average American is not aware of it. Overdoses are rare except for sensitive individuals. There are no reliable scientific data to say that a few doses of methylxanthine derivatives are harmful or healthful to humans. However, the methylxanthines have effects on virtually every organ system of the body. Theobromine has little effect on stimulating the central nervous system. Although it is not strictly related to psychopharmacology, decaffeinated coffee may raise levels of low density lipoprotein (LDL), the so-called bad cholesterol.

Amphetamine

Amphetamine is a powerful stimulant of the central nervous system. Agents similar to amphetamine in its effects are dextroamphetamine, methamphetamine, phenmetrazine (Preludin), and methylphenidate (Ritalin). Amphetamine suppresses appetite and was once widely prescribed for weight loss. However, amphetamine induced loss of appetite cause loss not only of fat tissue but muscle and bone tissue. Because muscle tissue is responsible for burning fat tissue, the loss of muscle tissue means that more fat tissue will accumulate after the amphetamines lose their appetite suppressant effect. Therefore, the net result of using amphetamines to lose weight is the eventual gaining of more weight with a higher percentage of body fat. Physicians have virtually

stopped prescribing amphetamines for weight loss or any other reasons.

Speed refers to injecting amphetamine or methamphetamine. Amphetamine can be dissolved and injected or crystal methamphetamine manufactured in clandestine laboratories can be dissolved and injected. Methamphetamine is often referred to as "meth" or "crystal." Runs on speed usually last several days but not indefinitely. During runs, the users typically do not sleep except for occasional catnaps. They do not eat and often lose 30 pounds or more of body weight. Without intervention, most users of speed eventually stop the use once and for all because they recognize that they cannot afford the physical toll. However, they do not give up substance abuse because they usually return to abuse of alcohol.

Ice refers to a smokable form of methamphetamine. It is rumored to be popular in Hawaii and somewhat in southern California. In spite of much discussion, ice has not proven to be popular in Utah.

Amphetamine and the related agents often result in a disorder which is indistinguishable from paranoid schizophrenia. This disorder can last for several weeks after the last use of amphetamine. After recovery, individuals look back at their behavior and marvel at their distorted thinking. During these episodes of drug induced schizophrenia, strangers are often the target of assaults and homicides because the drug user believes that the stranger wants to attack.

Cocaine

Cocaine is most often sold in its salt form known as cocaine hydrochloride, cocaine HCl. The final user receives cocaine which has been greatly cut, usually with mannitol which is a sugar which humans cannot digest. Cocaine may be 0% to as high as 40% pure in the hands of the user. Of all the people who use cocaine, about 80% experiment with it a few times and stop. About 20% rapidly increase use so that they have periods of daily use from time to time. Individuals who use cocaine regularly know that cocaine can cause problems, but they believe that they will recognize the problems and stop in time. When cocaine causes problems, users promise themselves that each use will be the last use by saying "Just one more time."

Cocaine causes subjective feelings of competence, energy, alertness, and well-being. Because cocaine has the property of tolerance, it loses its effectiveness over time; and some people keep using more and more without achieving the subjective effects they experienced at first. When cocaine wears off the person become irritable, easily angered, and obsessed with using again. If no cocaine is available, the person becomes obsessed with

obtaining more even at great monetary expense, providing sexual favors, or committing violent crimes. Chronic use leads to depression, suicidal ideation, suicide attempts, and paranoia.

The lethal dose of cocaine taken at one time is about one gram. However, people are capable of using several grams a day as long as one gram is not consumed all at once. There are probably two separate mechanisms of death from cocaine overdose. One is respiratory depression. Although cocaine originally stimulates respiration as expected with any stimulant drug, an overdose somehow leads to ultimate respiratory depression. Another mechanism of death is cardiac arrhythmia which means that the walls of the heart quiver but do not compress rhythmically. The result is that blood is not pumped and death results. The arrhythmia may be caused by cocaine inhibiting the vagus nerve. One of the many functions of the vagus nerve is to lower heart rate when blood pressure rises. If the vagus nerve is not operating properly, cocaine will raise blood pressure and heart rate. The result then is that the heart cannot compress sufficiently to pump blood. Acute overdoses of cocaine sometimes lead to grand mal seizures.

The usual way of ingesting cocaine is to snort it through a short straw. Often three lines of cocaine are laid out with about 25 mg of cocaine material in each line for a total dose of 75 mg of material. The actual amount of cocaine depends on the purity. The pleasurable effects of snorted cocaine may last 20 to 40 minutes. The pleasurable effects can be intensified by dissolving and injecting the cocaine intravenously (IV).

The most intense way to experience cocaine is to inhale cocaine gas. Cocaine HCl can be turned into a gas by heating it, but the temperature is so high that it burns the tissues of the mouth and respiratory system. The solution is to strip away the hydrochloride ion from the cocaine ion. When this is done the cocaine ion by itself is called the "free base." It is free of the encumbering HCl ion, and it is the most basic form in which cocaine can exist and still be psychoactive. Hence, the term "free base" is derived. Free base turns into a gas at a temperature low enough to be tolerated without burning the tissues of the mouth and the respiratory system.

The free base can be extracted by using sodium hydroxide (highly caustic) and ether (highly flammable). The free base is an oily substance which can be placed on aluminum foil, a flame applied underneath, and the fumes inhaled through a cardboard toilet paper roll. Crack is a variant of the free base. Crack is made by combining cocaine HCl and baking soda and water. When the water is evaporated off, crystals remain which trap the oily free base within the lattice work of the crystals. The crystals can be smoked using the crude but effective aluminum foil and toilet paper tube paraphernalia, or the crystals can be placed in a special smoking pipe with gradations of screens in the bowl.

Smoking the free base allows blood plasma levels six times higher than can be achieved through snorting. The effects of smoking the free base are much more intense but do not last as long, maybe 10 to 20 minutes. Using free base cocaine for several hours is likely to end with irritability, paranoia, depression, and suicidal ideation which can last for as long as 10 days after the last dose.

The basic unit of commerce in cocaine is the gram which goes for an average price of \$100. Discounts are available for quantity. An ounce contains 28.35 grams, and an ounce of cocaine can be purchased for \$1,800 to \$2,200 instead of \$2,835. An eight ball of cocaine which is one-eighth of an ounce or 3.5 grams can be purchased for \$200 to \$250 instead of \$350.

Cocaine works by keeping two neurotransmitters in the synapses between neurons. Dopamine (DA) and norepinephrine (NE) are two of the neurotransmitters present in the pleasure centers of the brain. They must be present for persons to feel good and to experience pleasure. Normally dopamine and norepinephrine are held inside of neurons. Only when the neurotransmitters leave the neurons and touch other neurons is pleasure experienced. Dopamine and norepinephrine usually stay in the synapse for a fraction of a second and then are reabsorbed into the neurons from which they came. When this process is repeated with thousands of neurons, pleasure can be experienced. Cocaine works by keeping dopamine and norepinephrine in the synapses and preventing the reabsorption or reuptake of the two neurotransmitters back into their home neurons. The effect is that the pleasure experience is intensified.

The problem is that the brain has another chemical called monamine oxidase (MAO) whose job it is to break down dopamine and norepinephrine if they stay out in the open too long. Therefore, if a person uses cocaine frequently, the brain becomes depleted of dopamine and norepinephrine; and the person cannot experience pleasure. Because cocaine can work only through dopamine and norepinephrine, cocaine eventually becomes ineffective until the brain is given the opportunity to manufacture new stores of the two neurotransmitters. This mechanism can explain some of the tolerance associated with cocaine abuse and also the reason for the withdrawal syndrome.

HALLUCINOGENS

Definition

The hallucinogens are a group of drugs which reliably alter and distort the perception of one's surroundings. The hallucinogens include LSD, mescaline, peyote, psilocybin, and psilocin.

Effects and Properties

The hallucinogens are sometimes called the psychedelic drugs because their effects go beyond causing visual hallucinations. The overwhelming majority of people who have experienced the effects of these drugs find them amusing and interesting. They often believe that their sense of perception of the surreal is heightened and that they feel one with the universe. The use of these drugs appears to be like a trip to a surreal amusement park. People have fun with them but do not compulsively use them. The people who have used them typically have used them only a few times. Even the most dedicated users go for weeks at a time between uses. These drugs have much tolerance. There are no known deaths directly attributed to the use of these drugs.

From the standpoint of physical health including alleged genetic damage, these drugs are not the threat they have been made out to be. However, they pose a risk for emotional and mental consequences in terms of panic and flashbacks. It has been estimated that one in every five hundred "trips" is a "bad trip," and that 15% of users experience flashbacks.

LSD is the most powerful of the drugs listed above. Mescaline is the active ingredient of the peyote cactus. Psilocybin and psilocin are active ingredients of the psilocybe mushroom, referred to as the "magic mushroom."

There is a story that surfaces every few years that LSD has been impregnated into sheets of stamps with Disney characters on them and the stamps are distributed free to grade school children. Of course, the intent of the stamp giveaway is to have the children lick the stamps and "trip out." The story is an urban legend.

CANNABIS

Cannabis refers to the marijuana plant. The marijuana plant contains at least 68 alkaloids, or base chemicals. Some are psychoactive, some are not, and some have not been adequately researched. The most abundant psychoactive substance is called Δ^9 -THC, and it has been researched extensively. Nevertheless, cannabis remains a drug about which more is unknown than known.

The highest concentration of Δ^9 -THC is in the flowering tops of the female plants. In years past this concentration was typically in the 1 to 2% range. In the past decade selective breeding as brought this concentration to 8 to 12%. Because the concentration of Δ^9 -THC is higher than ever and because cannabis has only been abused for the past 60 years, many questions remain unanswered.

Cannabis does adversely affect human performance in operating vehicles and machinery. In social settings users of marijuana become excited and laugh easily. In solitary settings the user often becomes drowsy and falls asleep. Cannabis is not associated with an increased probability of violent behavior. In spite of the fact that cannabis smoke reportedly contains more carcinogens than tobacco smoke, there is no evidence yet of cancer caused by cannabis. More research will be needed to determine whether there is a link between cannabis smoke and cancer.

If drugs are rank ordered from barbiturates and alcohol being the most physically dangerous and the methylxanthine derivatives being the least physically dangerous, cannabis would be near the bottom as one of the least physically dangerous drugs.

The real damage of compulsive cannabis use appears to be a lack of feedback in relationships with a resulting immaturity. Compulsive cannabis use is most often seen in men who begin in their early teenage years and quit spontaneously sometime between 25 and 35 years of age. The motivation for quitting is usually the realization that their acquaintances and coworkers are farther along in life than they are. Although the data represent a correlation rather than cause and effect, marijuana use is associated with low rates of productivity among teenagers and young adult males.

CHAPTER 2

ETIOLOGY OF SUBSTANCE ABUSE

ETIOLOGY OF SUBSTANCE ABUSE

WHY STUDY THE ETIOLOGY OF SUBSTANCE ABUSE?

A rational understanding of the etiology of substance abuse is critical in reducing the prevalence and incidence of substance abuse. Unfortunately, our nation's response to the problem of substance abuse in our communities is largely guided by fuzzy, poorly thought out, and simplistic notions of etiology. The result is that our response as a society to substance abuse is fuzzy, poorly thought out, simplistic, and, most important of all, not effective. Evidence of this national failure is seen in the criminal-justice system to which the government has assigned the task of reducing substance abuse. A disproportionate share of the police and prosecutorial resources are devoted to drug crimes and the violent crimes which accompany drug trafficking. The federal and state governments cannot build prisons fast enough; and, in fact, the United States has incarcerated its citizens at a higher rate than any other nation in the world, including the former Soviet Union, South Africa, and any so-called Third World countries. The problem is so severe that it causes confusion and frustration among the highly educated and caring persons some of whom sit on the bench of justice and some of whom run the substance abuse treatment programs.

MAYBE WE'RE STARTING WITH THE WRONG QUESTION

Often people believe that having the right answers is the real meaning of knowledge. For example, we often refer to people whom we perceive as smart as being "walking encyclopedias." However, all the answers in the world are meaningless unless we ask the right questions in the first place. In some sense correct questions are more important than correct answers because wrong questions lead to solutions that just do not work. All too often people take it for granted that all questions are valid questions. One such question is "What causes substance abuse?" This one innocent-sounding question is fraught with difficulties because it assumes the fact that human behavior is caused.

René Descartes (1596-1650) brought together the ideas of human behavior with the then newly developed technology of hydraulics to posit that the nerves were hollow channels through which hydraulic fluid from the brain caused muscles to move. This is a mechanistic idea of human behavior. Mechanistic explanations of behavior have changed during the last three centuries to keep up with the latest technological marvels. For example, humans are now thought to be computers. What has remained constant for the past three centuries is that human behavior is explained as the output of a machine, and the machine mirrors the technology which is dominant at the time. Implicit in this mechanistic view is that human behavior is caused and that simple changes in input will determine the output (behavior.)

To the casual observer it, indeed, appears that human behavior is caused, but some philosophers, who have been willing to look beyond the narrowly focused obvious, have argued that human behavior is not caused. Instead, they have taught that humans are *spontaneous animals* whose behavior is based on choices, whether the persons acting see the choices or not. Therefore, it may be more productive to deal with substance abuse if we abandon the question, "What causes substance abuse" and start from a new question, "What are the factors and influences on persons who choose to use or not use substances?" This fresh perspective takes into account that people are beings who choose behaviors rather than machines or computers whose output is perfectly predictable from the input.

ENORMOUS COMPLEXITY

There is no simple factor or even simple list of factors which influence individuals to abuse substances. The risk factors for substance abuse are biological, psychological, and sociological. Each of these three areas is exceedingly complex in itself, and each contains a myriad of factors either not fully explored or not yet discovered. The controlled observations of scientist/practitioners and of research scientists continually lay bare new insights regarding substance abuse. If the insights are likened to bones from a dinosaur quarry, someday we will have the complete skeleton; but that day is in the future because an understanding of substance abuse is made from thousands of bones, not the few hundred in a dinosaur. We may take delight in each new discovery, but we must remain patient until the complete picture forms.

THE FOLLY OF MORALISTIC AND SIMPLISTIC THINKING

Morality and its exaggerated cousin, moralism, have to do with attitudes of right and wrong. Reasonable people agree on the right and wrong of issues of certain issues like cold-blooded murder and child abuse. However, the continuum opens up in controversy on the other end of the spectrum with issues like Sunday-closing laws and state-operated lotteries which have more to do with religious ideology and less with the public good. The United States is unique among the democracies of the Western World for basing governmental (federal, state, and local) policy regarding substances on moralistic thinking instead of on facts garnered by clinicians and scientists. The result is that persons with substance abuse problems are viewed as "bad," morally-defective persons who lack will power. There are two unfortunate corollaries to this commonly propounded thesis.

The first corollary is that persons with substance abuse problems are fundamentally different, inferior, and of questionable

value to the community. This thinking justifies incarcerating and otherwise ostracizing persons with substance abuse problems rather than facilitating their recovery and return to productivity.

The second corollary is that the moralistic concept of will power means that the etiology of substance abuse lies solely within the person who abuses substances. The fact is that the risk and protective factors for substance abuse are bedded in the environment (sociology) and in the person's physical functioning (biology) as well as in the person's emotional functioning (psychology). The ultimate deception of the moralistic view of substance abuse is that it reduces substance abuse to a simplistic notion, will power, with a simplistic solution, "Just say no!" As pointed out above, the etiology of substance abuse is complex, and it is exceedingly difficult for one person to see clearly all the factors and their uncountable interactions.

BAFFLING BIOLOGY

There has been inadequate scientific research to draw any firmly held conclusions about the role of the biology in the etiology of substance abuse. The little research has been intriguing with prospects of exciting discoveries in the future. Studies of identical twins, fraternal twins, and regular siblings separated at birth reveal a higher concordance rate of alcohol abuse among identical twins. Therefore, we know that biology is having some kind of influence. However, there are sets of identical twins in which one member is an alcoholic and one member is not.

Another interesting finding is that there seems to be a higher rate of alcohol abuse among men descended from the people of northern Germany and Scandinavia than among men descended from the inhabitants of other parts of Europe. (For a discussion of alcohol abuse among native Americans, please see below under "Sociology: Special Populations.")

There are little data regarding the biological susceptibility to substance abuse in women. It may be that biological predispositions to substance abuse may be sex linked to the Y chromosome which puts males at greater biological risk. (Males have an X chromosome and a Y chromosome and females have two X chromosomes.) However, it is a biological fact that women do metabolize alcohol slower than men and can become intoxicated with about half the amount required for men.

Some people have drawn the conclusion that drugs which are physically addicting in themselves cause compulsive substance abuse because individuals will continue to take the drugs to avoid the pain of withdrawal. There are many difficulties with this hypothesis. One is that persons will abuse substances which do not

cause withdrawal symptoms or will abuse the drugs before withdrawal is a problem. Another difficulty with this hypothesis is that persons will stop using drugs in spite of withdrawal discomfort. For example, most heroin addicts have episodes of compulsive use separated by periods of cold turkey withdrawal and abstinence. Yet another problem with this hypothesis is that virtually no one compulsively uses tricyclic antidepressants, commonly prescribed by psychiatrists and other physicians, in spite of the fact that these antidepressants do cause a withdrawal syndrome. The fact appears to be that compulsive users of alcohol and other drugs will sometimes temporarily prolong an episode of intoxication to avoid withdrawal pain, but withdrawal pain by itself does not explain compulsive substance abuse.

Because of only tentative findings, no real picture has yet emerged regarding the biological basis of substance abuse if any. However, it does make sense that some individuals may process substances differently from others or have more receptors in the brain and, hence, experience substances as more intense or more pleasurable than do other persons. However, even differences in the perception of levels of pleasure may be related to the amount of physical/emotional pain which a person is experiencing.

SOCIOLOGY: THE INSTITUTIONS

Sociology is the science which studies society and the institutions and groups of people who make up society. The five institutions of society are family, school, the economy, government, and religion. The following is a summary of how these five institutions may contribute to the etiology of substance abuse. The following narrative on institutions is negative in tone because the subject matter is causes of substance abuse. The reader is cautioned that the five institutions have also played healthy roles with regard to the substance abuse problem, but such is not the focus of this chapter.

Family. The connection between parenting styles and substance abuse by offspring has been widely studied. A growing body of research findings is suggesting that the seeds of substance abuse are actually sown in the preschool years, although substance abuse usually does not appear until adolescence.

Parenting factors which seem to offer protection for offspring from substance abuse include:

- consistent firm discipline before age 12 followed by more freedom during the teen years
- parents explicitly communicating their values and beliefs by word and action to offspring before the offspring are 12 years old
- simultaneous attitudes of warm support for offspring and expectation of future independent functioning

- engaging in work projects with offspring to teach them that worthwhile objectives are obtained through discipline, hard work, and patience

- never doing for offspring what they can do for themselves

- mothers as sources of advice on all subjects for sons as well as daughters

- fathers as approachable companions for both daughters and sons

- rules about home work and watching television

- no corporal punishment

- authoritative approach to discipline which allows the offspring to have input and discussion, although the parents have the last word.

Parenting factors associated with substance abuse include:

- expecting children before age 12 to acquire values on their own

- withholding either warm support and/or the expectation of future independent functioning

- never engaging in work projects with offspring

- expecting recreational activities with children to stand alone in providing good parenting

- frequently performing tasks for offspring which they themselves are capable of, such as waking the in the morning and cleaning their rooms

- parents not being part of the lives of their offspring

- neglecting to make rules or not enforcing rules about homework and television

- inflicting corporal punishment

- an authoritarian approach to discipline which precludes the offspring from having any involvement or discussion.

The goal of parenting is to raise the offspring to live eventually without the parents. It means engendering in the offspring an ability to see the future and have an influence on it. It means teaching them a delayed gratification pattern. It requires protecting children from physical abuse, neglect, and sexual exploitation.

School. Sixty percent of Utahns who are 18 years old view their schooling as a partial or complete failure. The reasons include having dropped out, one or more teachers who ridiculed them, not fitting in socially because they are near or below the poverty level, and academic failure because no support existed in the home. Although it is not possible for the school system to be all things to all people, 60% of Utahns at age 18 believe that the school system has let them down. Neither the problem nor the solution is the quality of teachers. The overwhelming majority of teachers in Utah are of high quality. Much of the problem is that Utah does not devote enough resources to education in spite of the great percentage of the population who are of school age. Utahns

ease their collective conscience about the school system by pointing out the students who do well and by boasting that Utah has the second highest percentage of high school graduates who attend college. These apologies do not compensate for the tragedy of the people left behind.

The Economy. Although at the present moment (1992) Utah has escaped the nationwide recession, the fact is that thousands of Utahns are not able to find work at all or which is commensurate with their skills. While there are jobs available at in the minimum-wage service sector of the economy, the holders of these jobs are either students or the working poor. The students usually have other means of support such as family, but the working poor do not.

Government. As pointed out above, the government is a major factor with regard to substance abuse. Utah state government and local governments are not exceptions to having public policies based on moralistic factors, that is, arbitrary distinctions between good human beings and bad human beings. It is public policy that substance abuse is not only a health and safety issue, but also an issue of good and evil with religious overtones. Governmental policy dictates that good citizens despise substance abuse without question and that all good citizens attempt to extirpate it without regard to cost. Most citizens do not have such strong emotions about violating traffic laws although they are a safety issue also.

The result is that the war on drugs is really a civil war on drugs. It is citizen against citizen. Routinely police officers exercise no-knock warrants on small-time substance abusers. In doing so, mattresses are slashed open, furniture destroyed, and people including children as young as nine years old are held at gunpoint while the police search the premises.

As a whole, the government is both ineffective in dealing with substance abuse and promotes substance abuse. The government is ineffective because it blows the problem of substance abuse out of proportion and relies on the expensive and cumbersome criminal-justice system to fight a war which need not always be engaged in the first place. The government promotes substance abuse by going overboard in two ways. The first is playing fast and loose with the protections afforded to the citizens in the Bill of Rights. The second way is exaggerating the dangers of substance abuse. Substance abuse is damaging more in interpersonal relationships including the family than it is to the infrastructure of society. The government's exaggeration and misinterpretation of dangers as well as its willingness to erode the Bill of Rights has led many citizens to lose respect for the government.

The government would make far more progress with regard to substance abuse if it recognized that substance abuse is a

behavioral disorder with a complicated etiology involving factors not only within the individual but also in society. Substance abuse is a chronic, relapsing disorder which is amenable to treatment as well as education and prevention. Treatment, education and prevention have to be aimed at individuals, groups of people, and societal institutions in order to be effective. If the government had the attitude of helping its citizens who had a disorder rather than segregating and punishing them, more progress would be made in reducing the health and safety risks which all individuals in the society face.

Religion. The role of religion in the etiology of substance abuse has not been well researched. Scientific studies going back to the 1920's agree that membership in a religion has no bearing on behaviors which people commonly define as moral. Membership or lack of membership in a religion does not seem to play a role in determining whether people obey laws, rules, or moral dictates.

Utah, with its high percentage of membership in the Church of Jesus Christ of the Latter Day Saints (LDS) (Mormons) and its ban on the use of alcoholic beverages, has the lowest rate of alcohol consumption of the fifty states. The picture is clouded by an above average rate of use of some prescription mood-altering drugs. Because abuse of prescription medications does not generally come to the attention of the authorities, there is as yet no reliable data to say where Utah stands in the total picture of substance abuse.

There are some interesting data regarding alcohol use among teenagers of various religious backgrounds. A higher percentage of teenagers who are liberal protestant, Catholic, or Jewish consume alcohol than do teenagers who are strict Protestant or LDS. This finding surprises no one. However, strict Protestant or LDS teenagers who do consume alcohol are much more likely to display alcohol abuse disorder than are liberal Protestant, Catholic, or Jewish teenagers. This finding can be explained that liberal Protestant, Catholic, and Jewish teenagers are exposed to the "rules" of consuming alcohol, that is, consumption of one or two drinks with family on an occasional basis. On the other hand, strict Protestant and LDS teenagers have no example of restrained consumption and consume alcohol away from home with the express purpose of consuming to the point of intoxication.

SOCIOLOGY: SOME SELECTED POPULATIONS

The Poor. There are strong ties between poverty and substance abuse. It is not the purpose of this manual to discuss the etiology of poverty in detail, but some thoughts on the etiology of poverty and the mythology of poverty are worth noting. Just as substance abuse itself is highly complex, so also is the subject of poverty. There is no single cause of poverty. Poverty is not the

result of personal laziness, and the solution to poverty decidedly is not to exhort persons in poverty simply to work. Poverty is a condition with an apparent life of its own which sustains itself. The majority of people who are in poverty are children, persons with disabilities, and persons raised in poverty with no realistic opportunities to escape.

One of every five children (20%) in Utah lives in poverty. This figure is the same as the national average. The effect of poverty on children is devastating. It means that they often do not have enough to eat and that they wear unfashionable clothes to school. Wearing clothes from a thrift store marks the children of poverty in school. Fellow students avoid them, and teachers often ignore them as hopeless and not worthy of learning. Children of poverty do not make friends with middle-class children because they are afraid of being embarrassed by such things as not having the money to buy birthdays presents or go on outings. Meanwhile, children of poverty see the disparity between their own standard of living and middle-class existence not only in contrast with their schoolmates but also on television and in the movies. Incidentally, if the quality of life is often exaggerated in the media, the children of poverty do not know it.

Some children live a middle class existence and then are plunged into poverty when their parents divorce. After divorce most children live with their mothers and their mothers' income decreases by an average of 23%. One-half of mothers and fathers who owe child support do not pay it or are behind in payments.

In the United States poverty is a culture of its own. In many countries of the world including those in Europe, poverty is viewed as an unfortunate condition, but the persons who live in poverty are not viewed as second-class citizens. In the United States, people are embarrassed by poverty. Middle and upper class people generally ignore poverty and consider persons in poverty as unworthy, lazy, and not fully human. Even most people in poverty believe themselves to be less than human and, therefore, have tenuous ties to society. People in poverty attempt to hide their condition. Whether they escape poverty or not, they are most unlikely to ever talk about it because it stigmatizes them. People who have experienced poverty in their past are not usually sympathetic to people who now live in poverty. For example, first and second generation immigrants who have lived in poverty are prone to say, "I worked my way out of it, why can't they?"

There are four overlapping populations of adults in poverty in the United States and in Utah. The children of poverty live with all four populations. The first are people who are disabled by virtue of mental disorders, physical diseases, and borderline mental retardation as well as mental retardation. Often people are disabled including by mental retardation and borderline mental retardation do not look different from anybody else. Only when

they are challenged, especially in the work place, does their disability become apparent. It is easy to judge persons with disabilities who dress neatly and have good personal hygiene and who do not engage in such behaviors as drooling and spastic movements as being "lazy" rather than being disabled.

A second population of persons in poverty are single parents, usually women. These are often females who were physically abused and /or sexually exploited and who married or otherwise ran away in their teenage years to avoid further abuse. Instead of mastering the periods of childhood and adolescence, they barely survive and then become parents without the knowledge of resources or the personal power to use resources.

A third population of persons in poverty are the working poor. These are people who do not receive public assistance but work at minimum wage in unskilled or semiskilled occupations. They earn enough to eat and have some shelter, but they have no discretionary income, health insurance, or retirement.

A fourth population of persons in poverty are the homeless. The homeless account for only the proverbial tip of the iceberg of poverty in Utah and the United States.

Poverty is a powerful force in influencing persons to abuse substances. Persons who are influenced by poverty to choose substance abuse as a way of coping with life are not going to talk about poverty with people who are not poor. The poor know that the poor are treated by disdain by society at large. Political conservatives of both major political parties depersonalize people in poverty by using code phrases such as "welfare cheats," "war on drugs," and "law and order."

Native Americans. Some persons believe that native Americans may be prone to alcohol abuse due to biology. However, that finding has not been scientifically determined. An alternate explanation for the apparent higher rate of alcohol abuse among native Americans is that the memories of genocide have been handed down from the survivors of the massacres, forced marches, sieges, and restrictions to barren reservations to the present generations of native Americans. Perhaps, many native Americans are manifesting post-traumatic stress disorder (PTSD) for traumas inflicted on their recent ancestors. The federal government carried on an active policy of genocide from 1860 to 1890, and the number of native Americans continued to decline until 1920.

All of the native peoples of Utah felt the scourge of genocide in the last century and the early years of this century. Two particular examples are the Utes and the Navahos. The Utes were massacred in Colorado on more than one occasion and the few survivors forced to flee to eastern Utah Territory when Colorado was in the process of becoming a state. The Navahos were decimated

in a forced march from their native areas and forced confinement in a wretched reservation on the Rio Grande River before they were allowed to return home. The aftermath of surviving genocide endures for several generations especially when it has been reinforced by the present problems of grinding poverty and of disgusting myths dished out by the media and often uncritically swallowed by the mainstream culture.

African-Americans. Many African-Americans may show the effects of generational post-traumatic stress disorder (PTSD), not from genocide but from slavery. Even the youngest African-Americans are only four and five generations removed from slavery. Further, the abolition of slavery did not end the notion among most Americans that African-Americans are less than human. From the big issues of segregated housing and schools to the relatively small issues of segregated water fountains and entrances to public buildings, African-Americans have received constant reminders that they were not meant to have political power in any level of government or any real control over their lives. As late as the late 1950's, African-Americans were not permitted in the swimming pool of the Lagoon resort in Farmington. In the 1970's there were many neighborhoods along the Wasatch Front where African-Americans were not permitted to live.

While many of these forms of discrimination have been made illegal, African-Americans are constantly aware of being "black." Most people who are ethnically Caucasian including many who are hispanic surnamed think of themselves as being "persons." African-Americans universally say that they always think of themselves first of all as being "black." Most African-Americans resent and are often emotionally exhausted by having to represent something that comes before their own personhood. In other words, it is debilitating to be judged by skin color rather than as individual human beings. Native Africans and persons of African descent from the Caribbean who come to the United States are often frustrated that they suddenly become faceless persons of an second-class group rather than individuals in their own right.

Those sexually exploited as children. Although estimates vary, it is likely that slightly more than half of all women and about one-fifth of men were sexually exploited as children. It is almost a universal trait that persons sexually exploited as children believe that they caused it and they were responsible for not stopping it. Being the target of sexual abuse engenders a life time supply of shame and guilt, and persons thus exploited rarely talk about their experiences when they are children or adults. The single act of momentarily touching a child for sexual gratification damages a child for life. Almost all women with substance abuse problems were sexually exploited on at least one occasion when they were children. The same cannot be said for men with substance abuse problems, but then not as high a percentage of men were sexually exploited as children. It may be that women sexually

exploited as children are more likely to turn to substances as a way of coping, whereas men may turn to substances and/or sexual or other addictions. Nevertheless, women and men exploited as children are at high risk for substance abuse.

Gangs. The motivation to form gangs is that Asian, Polynesian, hispanic, African-American, and poor white youth perceive that their entry to middle-class America is closed. They respond by forming their own subculture which offers them opportunities for success. Gangs use substances as one way of achieving instant gratification. Members of gangs live for today because they see no hope for themselves tomorrow. Gang members see "dope" as a substitute for hope.

PSYCHOLOGY: THE ROLE OF THE INDIVIDUAL

Moral development. One task for individuals to learn is what society regards as right and wrong. Psychologists call this task moral development, but the term should not be confused with religious training. Successful moral development leads individuals to the belief that they are part of society and that their best interests lie with a healthy society. Sometimes this is referred to as "buying into society" or having a stake or ownership in society. Moral development does not happen automatically nor is it a mystical process. Psychologists, led by the work of Jean Piaget, have studied moral development and have a good understanding how the process works.

Normally children go through three stages of moral development. The first stage extends from birth to about seven or eight years of age. During this stage children define right and wrong as whatever physically present adult authority says it is. During this stage there is no independent sense of right and wrong, and children will sway with whatever the authority of the moment desires. During the first seven or eight years of life, the conscience is a fragile and delicate structure which is not to be trusted if important consequences are at stake.

The second stage extends from age 8 to about 12 or 13 years of age. This is a time of transition when sometimes children acquiesce to the adult authority and sometimes have flashes of a sense of right and wrong independent of adult authority. However, as in the first stage children are not to be trusted if important consequences are at stake. This explains why it is important for parents, teachers and other adults to closely supervise children and to take frequent opportunities to explicitly tell them of moral values.

The third stage of normal moral development begins at age 12 or 13. This final stage is having a sense of right and wrong largely independent of adult authority. In other words, most

teenagers who are properly reared have an adult moral development which needs to be solidified during the teenage years. Jokes aside, most teenagers are reliable.

The great question in moral development is what influences children to pass through the first two stages into the third. Some hardcore traditionalists believe that physical punishment provides the motivation. Physical punishment only controls behavior when the punishing stimulus is present and has the undesired side effect of conditioned emotional responses which affect targets of physical abuse for the rest of their lives. Consequences include depression, suicidal ideation, and post-traumatic stress disorder which can lead persons to choose substance abuse and other temporary measures to relieve the emotional pain. Physical punishment has no place in moral development. Physical punishment is an expression of anger; it is not an effective means of teaching.

The greatest motivator for children to develop an independent sense of right and wrong, i.e. a conscience, is fear of parental rejection. The motivator is not parental rejection. The motivator is not fear of the parents. The motivator is the *fear of parental rejection*. This fear works only if there is a solid parent-child relationship to begin with. If the parents overindulge the children or treat the children with benign neglect, the children will have no fear of parental rejection. If the parents are abusive, the children will behave properly only when the parents are present. The solution is for parents to treat the children with warm support and with simultaneous expectations of future independent functioning. Then the fear of parental rejection can be induced with the imposition of natural consequences for inappropriate behavior. Natural consequences can include grounding, putting a favored toy out of reach, not allowing the viewing of television or videos, etc. When natural consequences are employed for acting out, parents are not withdrawing their love but they are engendering the thought in their children that their parents are displeased and could potentially reject them.

Two other motivators of less power but still effective exist in allowing children to develop a sense of right and wrong. The first is positive reinforcement or reward for desired behaviors. Some people object to this method and call it bribery. The fact is that, because children up to the age of 12 or 13 are not going to have a consistent conscience, parents and other authorities can expect to be involved in shaping behavior most of the time. It simply is not reality that children up to age 12 or 13 can be trusted to consistently do what is right or desirable if left to themselves. Positive reinforcement or bribery does not harm children. The most important point to remember is to administer the positive reinforcement only after the desired behavior has taken place. For example, if the desired behavior is to be quiet

in church and the reward is candy, the candy should be given only after church and only if the child was quiet. It would be futile to give the candy to the child just before church or during church on the basis of a promise. Children cannot be trusted to keep promises.

The second motivator is the desire of children to be like their parents. Therefore, it is important for parents to model the desired behaviors for their children.

The trap psychology has set for itself. The fundamental definition of psychology is the study of behavior of animals and humans. That definition by itself is satisfactory from the viewpoint that it includes how individuals as well as groups behave. However, a more narrow definition of psychology has come into existence as a way for psychology to distinguish itself from other disciplines like sociology and biology. A psychology divorced from sociology and biology is limited because it studies the individual in a vacuum. Individuals behave differently in different environments and if their biological states have been altered. The trap is that a study of individuals outside of their environments is not powerful or enlightening. The way out of the trap is for psychology to study the behaviors of individuals and groups in the context of internal environments (biology) and external environments (sociology).

Shame and guilt. All persons who abuse substances suffer shame and guilt, which are the two faces of embarrassment. Shame is the embarrassment which comes from believing that others disapprove of us. Guilt is the embarrassment which comes internally from our own consciences. Embarrassment in both forms runs so deeply in persons with substance abuse problems that it is painful for them to talk about. Most persons who abuse substances would rather abuse more substances, pay the consequences levied by courts, destroy their personal relationships, live without the conveniences of life, etc. rather than talk about the events which caused their shame and guilt.

Persons with substance abuse problems universally use anger as a way to deal with the guilt and shame. The anger directed towards others often brings persons with substance abuse problems into the criminal-justice system. The anger is often directed inward, and this condition is called depression. Common precursors of shame and guilt are poverty, uneven parenting, abuse, sexual exploitation, and failure in school. Many other precursors exist and the common factor is that interpersonal problems have been transformed into intrapersonal problems, i.e. shame, guilt, and depression.

IDEOLOGY AND POLITICS

Individual responsibility and societal responsibility. There is a longstanding political and ideological debate between those who argue individual responsibility v. societal responsibility. Generally, those who are identified as conservatives are thought to believe that individuals should be held strictly accountable for their behaviors in spite of the opportunities which may not have been afforded to the individual. Many conservatives will concede that individuals have different opportunities but a determined individual will succeed anyway. Generally, those who are identified as liberals believe that society should take a stronger role in affording opportunities for those who do not have them and that individual responsibility can be mitigated with the realization that society has failed to provide opportunities for all of its citizens.

This debate has real implications for viewing the role of the individual in the etiology of substance abuse. Ideological conservatives say that individuals are responsible for their own behavior and favor a psychology that studies individuals. Ideological liberals say that society has a role in the etiology of substance abuse by not affording equal opportunities for all members of the community.

Politics v. science in the United States. Mainstream American culture is European derived with the added emphasis of the individual against society. As such it is difficult to make conclusions about the etiology of substance abuse which are palatable to all. The European cultural influence is that a privileged class exists in the United States. The privileged class has the dominant influence in community affairs and government, and its viewpoints, whether healthy and effective or not, are often accepted without question. The privileged class views itself as the mainstream society and is antagonistic to those who do not fit into the mainstream society. The privileged class is concerned with its own well-being and views insularity, or ignorance of the living conditions of others, as a virtue. For example, it was an insular jury that acquitted the L.A.P.D. officers of assaulting Rodney King on the grounds that King directed the action. Insularity or social isolation is an act of omission with grave consequences for every citizen including those who isolate themselves.

The fact remains that the dominant political force in the United States is conservative. Conservative politicians get themselves elected by pandering to the myth that substance abuse is much more than a health and safety issue. The conservative politicians fan the people's fear of substance abuse by perpetuating the myth that it is a moral issue requiring extraordinary measures including a "war" on drugs along with suspension or severe weakening of constitutional rights fought for

in the Revolutionary War. Any findings from science regarding substance abuse which contradict prevailing politically favored moralistic views are ridiculed with sad consequences for all citizens.

What America can learn from other cultures. Some other cultures, notably native American culture, has the ideal, if not always practiced perfectly, that all human beings are part of society and that the individual responsibility is equal to the community responsibility for affording opportunities for all citizens. Other cultures, including modern European culture, view substance abuse as a health and safety issue and are no more emotionally alarmed by it than by measles or traffic fatalities. The etiology and the treatment of substance abuse is guided by principles that it is a community problem and increasing societal protective factors and reducing societal risk factors is a legitimate approach in dealing with substance abuse.

SUMMARY AND CONCLUSION

Substance abuse is a chronic, relapsing disorder which often requires three to five times through treatment. The etiology of substance abuse is not easily understood. An understanding of substance abuse is not possible by just studying persons with substance abuse problems, that is, substance abuse is not a only psychological phenomenon. To have a working knowledge of substance abuse requires familiarity not only with psychology but also with biology, sociology, history, current events, criminology and political science. An understanding of substance abuse which will lead to more effective strategies of education, prevention and treatment is not likely to emerge from public hysteria fanned by media sensationalism and by the rhetoric of uninformed politicians vulgarly scrounging for votes. Substance abuse is as much or more a societal phenomenon as it is a psychological or biological phenomenon. Substance abuse can be understood with only with willingness to ponder its complexity, with scholarship to persevere in studying all its aspects, with ignoring the demands of those who believe in simplistic explanations, with compassion for all members of the community, and with scientific curiosity for finding the truth.

CHAPTER 3

DIRECTORY OF SUBSTANCE ABUSE PROGRAMS

***Utah Directory of
Agencies and Services***
Substance Abuse Prevention and Treatment

Distributed by the Utah State Division of Substance Abuse
Salt Lake City, Utah January 1991

STATEWIDE AGENCIES

SEE ALSO TOLL-FREE AND STATEWIDE
NUMBERS AT BACK OF DIRECTORY

Agency													Other Information
	Alcoholism Treatment Only	Alcoholism & Drug Abuse Treatment	Detoxification (Medical)	Classes for Court-Referred DUI Defendants	Prevention Services	Licensed by H.S.O.L. **	Men Only (M) or Women Only (W)	Outpatient Treatment	Residential Services	State Funded†	Special Treatment (Live In)	24-Hour Emergency Coverage	
Adult Children of Alcoholics (ACoA) Groups 3823 Villa Drive Salt Lake City, UT 84109 278-8305													Groups for adults and children, 7-12
Alcohol, Tobacco & Firearms (Federal) 125 South State Street, #3239 Salt Lake City, UT 84138 524-5854, 8am-4:30pm													Regulatory - federal laws. Investigates breweries, wineries regarding taxation laws, conformance with brewery procedures.
Alcoholic Beverage Control Commission P. O. Box 30408 Salt Lake City, UT 84130-0408 973-7770, 8am-5pm													Administers State alcoholic laws; Beverage & licensing enforcement; issues licenses to restaurants, private clubs & beer outlets) on premise consumption).
Alcoholics Anonymous 2480 South Main, Room 112 Salt Lake City, UT 84115 484-7871, 9am-5pm, Mon-Fri	■										■		
Al-Anon/Alateen 5056 South 300 West Salt Lake City, UT 84107 262-9587 10am-4pm, Mon-Sat													
Asian Association of Utah 28 East 2100 South, Suite 102 Salt Lake City, UT 84115 486-5987													Prevention programs for Asian & Pacific Islanders; Case management for treatment & court referrals.
The Cottage Program International 736 South 500 East Salt Lake City, UT 84102 532-6185, 8am-5pm, Mon-Fri	■	■		■	■		■		■	■	■		Outside Salt Lake metro area, call toll-free 1-800-752-6100
Drug Enforcement Administration (Department of Justice) Federal #303-837-3951 125 South State Street, Room 8416 Salt Lake City, UT 84138 524-4156, 8:30am-5pm													Enforces federal controlled substances laws and regulations, investigates and prepares for prosecution of major violators, especially regarding interstate trafficking.

**Human Services Office of Licensing

†Through contract with Division of Substance Abuse (provisions for low-income clients)

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Agency													Other Information
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Families in Focus 736 South 500 East Salt Lake City, UT 84102 1-800-752-6100	■	■	■				■		■	■	■		Services: trains volunteers to work with families who are at risk for substance abuse.
Food and Drug Administration (Federal) Federal #303-236-3000 1745 West 1700 South Salt Lake City, UT 84104 524-5285 7am-4pm													Services: Testing and approval of all prescription and nonprescription drugs. Inspection of manufacture, distribution and advertisement of drugs. Investigation of complaints against drugs and drug companies.
Health Promotion Coalition for Older Utahns Salt Lake County Aging Services 2001 South State #S1500 Salt Lake City, UT 84190-2300 488-5964, 8am-5pm													Health promotion education only
Intermountain Health Care (administrative offices) 36 South State, 21st Floor Salt Lake City, UT 84111 530-3345, 8am-5pm, Mon-Fri													
Life Course P.O. Box 1414 Salt Lake City, UT 84110 266-8483 8am-6pm													Services: corporate and education leadership seminars, motivational programs, conventions, meetings, seminars, workshops & school assemblies, self-esteem enhancement for youth/adults.
Mothers Against Drugs (MAD) 4883 South 3040 West Taylorsville, UT 84118 966-3813													
M.A.D.D. (Mothers Against Drunk Driving) 3120 Metropolitan Way Salt Lake City, UT 84109-2240 484-7007													

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Agency

Alcoholism Treatment Only
Alcoholism & Drug Abuse Treatment
Detoxification (Medical)
Classes for Court-Referred DUI Defendants
Prevention Services
Licensed by H.S.O.L. **
Men Only (M) or Women Only (W)
Methadone Treatment
Outpatient Services
Residential Services
State Funded†
Special Services (Live In)
24-Hour Emergency Coverage

Other Information

Narcotics Anonymous
P. O. Box 6157
Salt Lake City, UT 84152-6157
488-2141

A non-profit, anonymous
fellowship of addicts
helping addicts recover
from addiction

**Parents Against Drunk Driving
(PADD)**

8121 Scandia Court
Sandy, UT 84092
943-2010
Answering service - 488-2124

Services: public speaking

Parents Helping Parents (Toughlove)

3353 South Main, Suite 254
Salt Lake City, UT 84115
278-9526

Self-help group providing
support for families with
substance-abusing
members.

**Pharmacists Against Drug Abuse
(PADA), Utah Pharmaceutical
Association, Inc.**

1062 East 2100 South, #212
Salt Lake City, UT 84106
484-9141

Services: Speakers,
slides, posters, handouts.

Poison Control Center

50 North Medical Drive
Salt Lake City, UT 84132
581-2151, 7 days/wk 24 hrs/day

Outside Salt Lake Metro
Area, call toll-free
1-800-466-7707

Salt Lake AIDS Foundation

3450 South Highland Drive,
Suite 102
Salt Lake City, UT 84106
466-9976
Mon-Fri

Referral service for
sexually-active, non-
monogamous individuals,
intravenous drug users,
hemophiliacs, or others
who want to be tested for
AIDS or request further
information. Hotline also
provides information to
families who are facing
the problem of sending
their children to school
with AIDS children.

**Salvation Army Alcohol
Rehabilitation Program**

54 West 700 South
P. O. Box 11626
Salt Lake City, Utah 84147
322-1253

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STATEWIDE AGENCIES

SEE ALSO TOLL-FREE AND STATEWIDE
NUMBERS AT BACK OF DIRECTORY

Agency	Alcoholism Treatment Only	Alcoholism & Drug Abuse Treatment	Detoxification (Medical)	Classes for Court-Referred DUI Defendants	Prevention Services	Licensed by H.S.O.L. **	Men Only (M) or Women Only (W)	Outpatient Treatment	Residential Services	State Funded†	Special Services (Live In)	24-Hour Emergency Coverage	Other Information
S.A.V.E., Inc. (Substance Abuse Volunteer Efforts) Central Office 2568 Washington Boulevard, Suite 101 Ogden, UT 84401 621-SAVE, 8am-5pm, Mon-Fri													Support group designed to help LDS families with substance abuse problems using AA's program but modified for LDS church members. Anyone welcome.
Southwest Regional Center for Drug-Free Schools and Communities 120 North 200 West Salt Lake City, UT 84103 538-3954													Provides support and expertise for program planning & group facilitation. Sponsors trainings & conferences. Establishes linkages & pin-points resources for information dissemination.
Utah Congress of Parents and Teachers -PTA 1037 East South Temple Salt Lake City, UT 84102 359-3875													Services: issuing competency level credentials
Utah Division of Substance Abuse 120 North 200 West, 4th Floor Salt Lake City, UT 84103-1594 P.O. Box 45500 (zip 84145-0500) 538-3939 8am-5pm, Mon-Fri													Services: offers parenting classes, prevention services for parents, related videos, and brochures.
Utah State Office of Education Prevention Dimensions/ Pre K - 12 Curriculum 250 East 500 South Salt Lake City, UT 84111 538-7713 8am-5pm Weekdays													Services: Pre-K through 12 alcohol and drug prevention curriculum; Drug-Free schools information and assistance. Film Library 538-4233

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NUMBERS AT BACK OF DIRECTORY

Agency	Alcoholism Treatment Only	Alcoholism & Drug Abuse Treatment	Detoxification (Medical)	Classes for Court-Referred DUI Defendants	Prevention Services	Licensed by H.S.O.L. **	Men Only (M) or Women Only (W)	Methadone Treatment	Outpatient Services	Residential Treatment	State Funded†	Special Services for Youth	24-Hour Emergency Coverage	Other Information
U. of U. Graduate School of Social Work Certificate Training Program in Alcohol/Drug Abuse Treatment University of Utah Salt Lake City, UT 84112 581-5738, Mon-Fri														
U. of U. School on Alcoholism & Other Drug Dependencies 230 West 200 South, Suite 2612 Salt Lake City, UT 84101 P. O. Box 2604 (84110) 575-2181 9:00am-4:00pm, Mon-Fri														
Utah Alcoholism Foundation:														
Administrative Offices 2880 South Main Street, Suite 210 Salt Lake City, UT 84115 487-3276 8am-5pm, Mon-Fri										■				
Alcoholism Treatment Center 667 East South Temple Salt Lake City, UT 84102 355-8536, 7am-11pm, 7 days/wk	■				■	M		■	■	■		■		
Family Alcoholism Counseling Services 2880 South Main Street, Suite 210 Salt Lake City, UT 84115 467-3725, 9am-7pm, Mon-Fri	■				■			■		■	■	■		
House of Hope 1006 East 100 South Salt Lake City, UT 84102 359-8374, 8am-5pm, Mon-Fri	■				■	W		■	■	■		■		
Progress Home 209 South Douglas St. Salt Lake City, UT 84102 582-1335, 7am-11pm, 7 days/wk	■				■	M		■	■			■		

**Human Services Office of Licensing

†Through contract with Division of Substance Abuse (provisions for low-income clients)

STATEWIDE AGENCIES

SEE ALSO TOLL-FREE AND STATEWIDE
NUMBERS AT BACK OF DIRECTORY

Agency													Other Information
	Alcoholism Treatment Only	Alcoholism & Drug Abuse Treatment	Detoxification (Medical)	Classes for Court-Referral Treatment	Prevention Services	Licensed by H.S.O.L. **	Men Only (M) or Women Only (W)	Outpatient Treatment	Residential Services	State Funded†	Special Services (Live In)	24-Hour Emergency Coverage	
Utah Association of Alcohol and Drug Abuse Counselors 1800 S.W. Temple Suite 108 Salt Lake City, UT 84115 487-4478													Credentialing for Alcohol and Drug Abuse Counselors for the State of Utah
Utah Association of Alcohol and Drug Program Providers 100 East Center Street, Suite 3200 Provo, UT 84606 370-8427 Bruce Burdick, Chairman													Organization of public/private alcohol & drug service providers for the purpose of providing a collective voice for the expression of the needs, attitudes & interests of alcohol & drug programs.
Utah Association of Employee Assistance Programs P. O. Box 899 Salt Lake City, UT 84110 535-4126, 8am-5pm, Mon-Fri													
Utah Boys Ranch 3809 West 6200 South Kearns, UT 84118 969-3252	■							■	■		■	■	Early intervention in-patient, outpatient treatment for boys; Individual, outpatient therapy for girls; Weekly family group & individual therapy. Sliding scale fee.
Utah Federation for Drug-Free Youth 120 North 200 West, 4th floor Salt Lake City, UT 84103 538-3949, 9am-4:30pm, Mon-Fri													
Utah Division of Investigations P. O. Box 18654 Kearns, UT 84118 533-6227, 8am-5pm													Enforcement agency w/ statewide jurisdiction; directs efforts at major drug dealers; enforcement of liquor laws pertaining to private clubs, minibottle restaurants, lounges, pharmaceutical investigations, gambling allegations, problems encountered at State borders w/ 21-drinking-age states. Investigates other cases as requested by Governor's Office.

**Human Services Office of Licensing

†Through contract with Division of Substance Abuse (provisions for low-income clients)

STATEWIDE AGENCIES

SEE ALSO TOLL-FREE AND STATEWIDE
NUMBERS AT BACK OF DIRECTORY

Agency

Alcoholism Treatment Only
Alcoholism & Drug Abuse Treatment
Detoxification (Medical)
Classes for Court-Referred DUI Defendants
Prevention Services
Licensed by H.S.O.L. **
Men Only (M) or Women Only (W)
Outpatient Treatment
Residential Services
State Funded†
Special Services (Live In)
24-Hour Emergency Coverage

Other Information

Utah State Voluntary Alcoholism Health Association

P. O. Box 25152
Salt Lake City, UT 84125
800-752-6100

No treatment services
provided. Organization of
volunteers involved in
advocacy on behalf of
alcoholics/recovered
alcoholics.

Veterans Medical Center Substance Abuse Treatment Units

500 Foothill Boulevard
Salt Lake City, UT 84148
582-1565, ex. 1860
7 days/wk 24 hrs/day

Veterans Medical Center Outpatient Substance Abuse Clinic

352 Denver Street, 2nd Floor
Salt Lake City, UT 84111
531-9315
8am-9pm, Mon-Thur, 8am-4:30, Fri

Veterans Medical Center Inpatient Substance Abuse

500 Foothill Blvd., Ward 4B
Salt Lake City, UT 84148
363-6101, 7 days/wk 24 hrs/day

Veterans Medical Center Detoxification Unit

500 Foothill Blvd., Ward 2AD
Salt Lake City, UT 84148
363-6101, 7 days/wk 24 hrs/day

**Human Services Office of Licensing

†Through contract with Division of Substance Abuse (provisions for low-income clients)

UTAH RESOURCES FOR DRUG TESTING

STATE FORENSIC LABORATORIES.
PROVIDE CONSULTATION ON PROGRAM
DESIGN, CONFIRMATION TESTING.

Agency	Alcoholism Treatment Only	Alcoholism & Drug Abuse Treatment	Detoxification (Medical)	Classes for Court-Referred	Prevention Services	Licensed by H.S.O.L. **	Men Only (M) or Women Only (W)	Outpatient Treatment	Residential Services	State Funded†	Special Treatment (Live In)	24-Hour Emergency Coverage	Other Information
Allied Clinical Laboratories 3338 Pioneer Parkway West Valley City, UT 84119 966-5252													
Associated Regional and University Pathologists, Inc. (ARUP) 500 Chipeta Way Salt Lake City, UT 84108 583-2787 / 1-800-242-2787													Certified: National Institute on Drug Abuse (NIDA) Accredited: College of American Pathology (CAP) for forensic drug testing.
Center for Human Toxicology 417 Wakara Way, Room 290 University of Utah Salt Lake City, UT 84108 581-5117													
Northwest Toxicology 1141 East 3900 South Salt Lake City, UT 84124 801-268-2431													
State Health Laboratory Contact Bruce Beck 44 Medical Drive Salt Lake City, UT 84113 801-533-6131													
Salt Lake City-County Health Dept. Laboratory 610 South 200 East Salt Lake City, UT 84111 534-4565													
Logan Regional Hospital - Dayspring 1400 North 500 East Logan, UT 84321 752-0948													

** Human Services Office of Licensing

† Through contract with Division of Substance Abuse (provisions for low-income clients)

AGENCIES BY DISTRICT DISTRICT I

CACHE, RICH AND BOX ELDER COUNTIES

Agency

Alcoholism Treatment Only
Alcoholism & Drug Abuse Treatment
Detoxification (Medical)
Classes for Court-Referred DUI Defendants
Prevention Services
Licensed by H.S.O.L. **
Men Only (M) or Women Only (W)
Outpatient Treatment
Residential Services
State Funded†
Special Services (Live In)
24-Hour Emergency Coverage

Other Information

Bear River Association of Governments

1050 South 500 West
Brigham City, UT 84302
734-9511

Services: Parenting Program

Bear River Human Services New Choices Program: Alcohol and Drug Counseling

1050 South 500 West
P. O. Box 1000
Brigham City, UT 84302
723-8591, 8am-5pm, Mon-Fri

Bear River Human Services New Choices Program: Alcohol and Drug Counseling

95 West 100 South
Logan, UT 84321
752-1799
8am-6pm, Mon, Wed, Fri
8am-9pm Tues; 8am-7pm Thur

Bear River Human Services New Choices Program: Alcohol and Drug Counseling

P. O. Box 417
Randolph, UT 84064
793-2015

Bear River Human Services New Choices Program: Alcohol and Drug Counseling

125 South 100 West
Tremonton, UT 84337

Logan Regional Hospital - Dayspring

1400 North 500 East
Logan, UT 84321
752-2050

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AGENCIES BY DISTRICT DISTRICT I

CACHE, RICH AND BOX ELDER COUNTIES

DISTRICT IIA

WEBER AND MORGAN COUNTIES

Agency	Alcoholism Treatment Only	Alcoholism & Drug Abuse Treatment	Detoxification (Medical)	Classes for Court-Referred	Prevention Services	Licensed by H.S.O.L. **	Men Only (M) or Women Only (W)	Outpatient Treatment	Residential Services	State Funded†	Special Services (Live In)	24-Hour Emergency Coverage	Other Information
DISTRICT I CACHE, RICH AND BOX ELDER COUNTIES													
DISTRICT IIA WEBER AND MORGAN COUNTIES													
Dayspring Chemical Dependency Unit McKay-Dee Hospital 5030 Harrison Boulevard Ogden, UT 84403 467-5600, 24 hrs/day		■	■	■	■		■	■		■	■		
Institute of Human Resource Development (IHRD) Proyecto La Familia - Weber County 2775 Madison Avenue, #2 Ogden, UT 84001 621-6849, 8am-5pm							■		■	■	■		Services: Bi-lingual, home-based family oriented prevention services, HIV/AIDS education services.
Northern Utah ATC 529 25h Street Ogden, UT 84401 621-3624		■		■	■		■	■				■	
Professional Services Corporation 533 26th Street, Suite 100 Ogden, UT 84401 392-5971 8:00 am-10:00pm, 7 days/wk		■		■	■		■			■	■		
Salvation Army - Ogden Center 2615 Grant Avenue Ogden, UT 84402 621-3580, 7 days/wk 24 hrs/day		■			■		■	■				■	
S.A.V.E., Inc. (Substance Abuse Volunteer Efforts) Central Office 2568 Washington Boulevard, Suite 101 Ogden, UT 84401 621-SAVE, 8am-5pm, Mon-Fri													Support group designed to help LDS families with substance abuse problems using AA's program but modified for LDS church members. Anyone welcome.

** Human Services Office of Licensing

† Through contract with Division of Substance Abuse (provisions for low-income clients)

AGENCIES BY DISTRICT **DISTRICT IIA** WEBER AND MORGAN COUNTIES

Agency

Alcoholism Treatment Only
 Alcoholism & Drug Abuse Treatment
 Detoxification (Medical)
 Classes for Court-Referred DUI Defendants
 Prevention Services
 Licensed by H.S.O.L. **
 Men Only (M) or Women Only (W)
 Outpatient Treatment
 Residential Services
 State Funded†
 Special Services for Youth
 24-Hour Emergency Coverage

Other Information

St. Benedict's ACT

St. Benedict's Hospital
 5475 South 500 East
 Ogden, UT 84405-6978
 479-2250

■ ■ ■ ■ ■ ■ ■ ■ ■ ■

Utah Alcoholism Foundation

Northern Division
 529 - 25th Street
 Ogden, UT 84401
 392-5971, 7 days/wk 24 hrs/day

■ ■ ■ ■ ■ ■ ■ ■

Weber/Morgan County Department of Substance Abuse

2650 Lincoln Avenue
 Ogden, UT 84401
 625-3650
 (SL# 532-1841 - ask for
 Alcohol & Drug Division)
 6:30am-5pm, Mon-Fri

■ ■ ■ ■ ■ ■ ■ ■

Problems Anonymous Action Group (PAAG)

2522 Wall Avenue
 Ogden, UT 84401
 621-2215, 625-3686

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AGENCIES BY DISTRICT **DISTRICT IIB** **SALT LAKE COUNTY**

Agency	Alcoholism Treatment Only	Alcoholism & Drug Abuse Treatment	Detoxification (Medical)	Classes for Court-Referred DUI Defendants	Prevention Services	Licensed by H.S.O.L. **	Men Only (M) or Women Only (W)	Outpatient Treatment	Residential Services	State Funded†	Special Services (Live In)	24-Hour Emergency Coverage	Other Information
Adult Children of Alcoholics (ACoA) Groups 3823 Villa Drive Salt Lake City, UT 84109 278-8305													Have groups for adults and children, 7-12
Alcoholics Anonymous (and Alateen) 2520 South State, Room 154 Salt Lake City, UT 84115 484-7871, 9am-5pm, Mon-Fri													
Al-Anon (and ACA) 5056 South 300 West Salt Lake City, UT 84107 262-9587, 10am-4pm, Mon-Sat													
Assessment & Psychotherapy Associates, Inc. 5770 South 250 East #435 Murray, UT 84107 269-1111													
Charter Summit Hospital 175 West 7200 South Midvale, UT 84047 561-8181		■	■	■	■	■		■		■	■		Indefinite aftercare, recovery enhancement tracked at 1 year.
Charter Counseling Center 195 West 7200 South Midvale, UT 84047 562-9440, 8am-5pm, Mon-Fri		■		■	■			■		■			Eight week intensive outpatient program for chemical dependency (adults).
Community Counseling Center 660 South 200 East, Suite 308 Salt Lake City, UT 84111 355-2846 9am-5pm, Mon-Thurs 9am-4pm, Fri		■			■			■		■	■		
The Cottage Program (refer to page 1)													
Dayspring, LDS Hospital 8th Avenue & C Street Salt Lake City, UT 84143 321-5580, 7 days/wk 24 hrs/day		■	■		■	■		■	■		■	■	

** Human Services Office of Licensing

† Through contract with Division of Substance Abuse (provisions for low-income clients)

AGENCIES BY DISTRICT
DISTRICT IIB
SALT LAKE COUNTY

Agency	Alcoholism Treatment Only	Alcoholism & Drug Abuse Treatment	Detoxification (Medical)	Classes for Court-Referred DUI Defendants	Prevention Services	Licensed by H.S.O.L. **	Men Only (M) or Women Only (W)	Methadone Treatment	Outpatient Services	Residential Services	State Funded†	Special Services (Live In)	24-Hour Emergency Coverage	Other Information
Dayspring at Wasatch Canyons Hospital 5770 South 1500 West Salt Lake City, UT 84123 265-3100, 7 days/wk 24 hrs/day	■	■		■	■			■	■		■	■		
First Step House Alcoholism Treatment & Recovery 750 West 400 North Salt Lake City, UT 84116 359-8862, 5 days/wk, 8am-5pm	■				■	■			■	■		■		
The Haven (Helping Hand Association) 974 East South Temple Salt Lake City, UT 84102 533-0070, 10am-6pm, Mon-Fri	■				■				■	■		■		
Highland Ridge Hospital 4578 Highland Drive Salt Lake City, UT 84117 272-9851, 7days/wk 24hrs/day	■	■	■	■	■			■				■		
Indian Alcoholism Counseling & Recovery House Program 375 South 300 West Salt Lake City, UT 84101 328-8515, 8am-5pm, Mon-Fri	■			■					■	■	■	■		
Indian Alcoholism Counseling & Recovery House Program Healthcare Clinic 146 East 600 South Salt Lake City, UT 84111 359-6906, 8am-5pm, Mon-Fri														Services: medical care for Indians
Individualized Learning Center Utah Teen Institute and Marmalade High School 1838 South 1500 East Salt Lake City, UT 84105 484-4792, 8am-5pm, Mon-Fri											■			

** Human Services Office of Licensing

†Through contract with Division of Substance Abuse (provisions for low-income clients)

AGENCIES BY DISTRICT
DISTRICT IIB
SALT LAKE COUNTY

Agency	Alcoholism Treatment Only	Alcoholism & Drug Abuse Treatment	Detoxification (Medical)	Classes for Court-Referred DUI Defendants	Prevention Services	Licensed by H.S.O.L. **	Men Only (M) or Women Only (W)	Methadone Treatment	Outpatient Services	Residential Services	State Funded†	Special Treatment (Live In)	24-Hour Emergency Coverage	Other Information
Information & Referral Center 212 West 1300 South Salt Lake City, UT 84115 487-4716 8:30am-5pm, Mon-Fri														
Institute of Human Resource Development (IHRD) Proyecto LaFamilia (Family Project) 431 South 300 East, #110 Salt Lake City, UT 84111 521-4473, 8am-5pm							■		■	■	■			Services, Bi-lingual, home-based family oriented prevention services, HIV/AIDS education services.
M.A.D.D. (Mothers Against Drunk Driving) (refer to page 2)														
Methadone Clinic 1847 West 9000 South West Jordan, UT 84084 566-7701	■					■								
Mothers Against Drugs (MAD) (refer to page 2)														
Narcotics Anonymous P. O. Box 6157 Salt Lake City, UT 84106-0157 488-2141														
Neighborhood Housing "Westside Youth Project" 1385 Indiana Ave Salt Lake City, UT 84104 539-1590 8:30am-5:30pm, Mon-Fri									■	■				
Neo Genesis 2480 South Main Street, #108 Salt Lake City, UT 84115 485-8139, 8:30am-5:30pm, Mon-Fri	■	■	■			■						■		

** Human Services Office of Licensing

† Through contract with Division of Substance Abuse (provisions for low-income clients)

AGENCIES BY DISTRICT

DISTRICT IIB

SALT LAKE COUNTY

AGENCIES BY DISTRICT DISTRICT IIB SALT LAKE COUNTY		Alcoholism Treatment Only	Alcoholism & Drug Abuse Treatment	Detoxification (Medical)	Classes for Court-Referred DUI Defendants	Prevention Services	Licensed by H.S.O.L. **	Men Only (M) or Women Only (W)	Outpatient Treatment	Residential Services	State Funded†	Special Treatment (Live In)	24-Hour Emergency Coverage	Other Information
Northwest Passage, Inc. (outpatient) 24 M Street, Suite 4 Salt Lake City, UT 84103 364-1507, 8am-5pm, Mon-Fri	■					■	M		■	■		■		
Northwest Passage, Inc. (residential) 432 North 3rd West Salt Lake City, UT 84103 364-3138, 7 days/week 24 hrs/day	■						M			■		■		
Northwest Passage, Inc. (residential) Self-pay court-referred DUI program (alternative to jail) 438 North 3rd West Salt Lake City, UT 84103 364-3138, 7 days/week 24 hrs/day	■			■		■	M					■		
Odyssey House, Inc. Juvenile Treatment Program 68 South 600 East Salt Lake City, UT 84102 322-1001, 7 days/wk 24hrs/day		■				■			■	■	■	■	■	
Odyssey House, Inc. Juvenile Treatment Program 68 South 600 East Salt Lake City, UT 84111 363-0203, 9am-5pm, Mon-Fri (24 hrs/day service)		■							■		■	■		
Olympus View Hospital Counterpoint Center (CPC) 1430 East 4500 South Salt Lake City, UT 84109 272-8000		■	■		■	■			■	■		■	■	
Parents Against Drunk Driving (PADD) (refer to page 3)														
Pioneer Valley Hospital Chemical Dependency Program 3460 South Pioneer Parkway West Valley City, UT 84120 964-3540 24 hrs/day		■	■		■	■			■	■		■		Two year aftercare treatment, couples/co-dependent counseling interventions

" Human Services Office of Licensing

†Through contract with Division of Substance Abuse (provisions for low-income clients)

AGENCIES BY DISTRICT
DISTRICT IIB
SALT LAKE COUNTY

Agency	Alcoholism Treatment Only	Alcoholism & Drug Abuse Treatment	Detoxification (Medical)	Classes for Court-Referral DUI Defendants	Prevention Services	Licensed by H.S.O.L. **	Men Only (M) or Women Only (W)	Methadone Treatment	Outpatient Services	Residential Services	State Funded†	Special Treatment (Live In)	24-Hour Emergency Coverage	Other Information
Poison Control Center (refer to page 3)														
Professional Services Corporation 4525 South 2300 East, Suite 201B Salt Lake City, UT 84117 272-9994, 277-8025 9am-5pm Mon-Fri		■	■	■				■			■	■		Saturday and evening appointments available.
Project Reality 225 East 600 South Salt Lake City, UT 84111 364-8080 7 days/wk 24 hrs/day			■		■		■		■	■		■		Saturday and evening appointments available.
Project Reality 1416 South State Salt Lake City, UT 84115 467-1517, 24 hrs/day, Mon-Fri		■	■				■	■	■	■		■		
Psychological Associates 77 South 700 East, Suite 250 Salt Lake City, UT 84102 532-5675		■		■				■	■		■	■		
Rescue Mission 463 South 400 West P. O. Box 1431 Salt Lake City, UT 84110 355-1302 7 days/wk 6am-9pm														
Rocky Mountain Consultants 5278 Pinemont Drive, Suite A120 Murray, UT 84123 265-2325	■	■		■	■			■				■		Day, evening and weekend appointments and groups available.
St. Benedict's Holy Cross ACT 1255 East 3900 South, Fourth Floor Salt Lake City, UT 84124-1332 262-0093, 7 days/wk 24 hrs/day		■	■		■	■		■	■			■		
St. Mary's Home 1206 West 200 South P.O. Box 941 - zip 84110 Salt Lake City, UT 84104 328-1894, 532-9808 7 days/wk 8am-4:30pm					■	M				■		■		

**Human Services Office of Licensing

†Through contract with Division of Substance Abuse (provisions for low-income clients)

AGENCIES BY DISTRICT
DISTRICT IIB
SALT LAKE COUNTY

Agency	Alcoholism Treatment Only	Alcoholism & Drug Abuse Treatment	Detoxification (Medical)	Classes for Court-Referred DUI Defendants	Prevention Services	Licensed by H.S.O.L. **	Men Only (M) or Women Only (W)	Outpatient Treatment	Residential Services	State Funded†	Special Treatment (Live In)	24-Hour Emergency Coverage	Other Information
St. Vincent DePaul Center 437 West 200 South Salt Lake City, UT 84101 534-1500, 9am-5pm, Mon-Fri	■						■						
Salt Lake County Human Services Department, Alcoholism & Drug Abuse Services Division:													
Administration Office 2001 South State, Suite S2300 Salt Lake City, UT 84190-2250 468-2009, Crisis Line: 262-8416 (emergency calls only) 8am-5pm, Mon-Fri					■								Services: Screening & referral, subcontracted prevention and treatment services.
Alcohol Counseling and Education Center 231 East 400 South Salt Lake City, UT 84111 538-2279 8am-5pm, Mon-Fri, evenings and Saturdays by appointment	■		■		■		■						
Outreach Services 2001 South State, Suite S2300 Salt Lake City, UT 84190-2250 468-2009 Crisis Line: 262-8416 (emergency calls only) 8am-5pm, Mon-Fri													Services: screening and referral.
Education & Prevention Services 2001 South State, Suite S2300 Salt Lake City, UT 84190-2250 468-2009 8am-5pm, Mon-Fri													Services: speakers' bureau, reference library, planning and technical assistance.
Healthy Aging Salt Lake County Aging Services Prevention/Education Services for Salt Lake County 2001 South State #S1500 Salt Lake City, UT 84190-2300 468-2764, 8am-5pm, Mon-Fri													Education/prevention, screening services for older persons.

**Human Services Office of Licensing

†Through contract with Division of Substance Abuse (provisions for low-income clients)

AGENCIES BY DISTRICT
DISTRICT IIB
SALT LAKE COUNTY

Agency	Alcoholism Treatment Only	Alcoholism & Drug Abuse Treatment	Detoxification (Medical)	Classes for Court-Referred DUI Defendants	Prevention Services	Licensed by H.S.O.L. **	Men Only (M) or Women Only (W)	Outpatient Treatment	Residential Services	State Funded†	Special Services (Live In)	24-Hour Emergency Coverage	Other Information
Salt Lake County Human Services Department, Alcoholism & Drug Abuse Services Division:													
Employee Resource Program Employee Assistance Unit, Salt Lake County 2001 South State, Suite S2300 Salt Lake City, UT 84190-2250 468-2009, 8am-5pm, Mon-Fri													
Valley Mental Health Alcohol & Drug Treatment Unit 404 East 45th South, Suite 22A, 22B Murray, UT 84107 262-8416, 8am-5pm, Mon-Fri	■				■			■	■	■	■		Extended hours by arrangement
Salvation Army Alcohol Rehabilitation Program 54 West 700 South P.O. Box 11626 Salt Lake City, UT 84147 322-1253	■			■	M			■	■		■		
The Sobriety Corporation 150 West 7500 South, #40 Midvale, UT 84047 566-9185, 8am-6pm, Mon-Fri			■										
University of Utah Alcohol & Drug Abuse Clinic 50 North Medical Drive Salt Lake City, UT 84132 581-6228 8am-5pm, Mon-Fri	■			■	■			■	■				
U. of U. School on Alcoholism & Other Drug Dependencies (refer to page 5)													
Utah Department of Corrections Institutional Substance Abuse Treatment Program P.O. Box 250 Draper, UT 84020 571-2300, ex 155/156 8am-5pm, Mon-Fri	■				■			■	■				For inmates & their families.

**Human Services Office of Licensing

†Through contract with Division of Substance Abuse (provisions for low-income clients)

AGENCIES BY DISTRICT
DISTRICT IIB
SALT LAKE COUNTY

Agency

Alcoholism Treatment Only
Alcoholism & Drug Abuse Treatment
Detoxification (Medical)
Classes for Court-Referred DUI Defendants
Prevention Services
Licensed by H.S.O.L. **
Men Only (M) or Women Only (W)
Outpatient Treatment
Residential Services
State Funded†
Special Services (Live In)
24-Hour Emergency Coverage

Other Information

**Veterans Medical Center
Substance Abuse Treatment Units**
(refer to page 7)

**Veterans Medical Center
Outpatient Substance Abuse Clinic**
(refer to page 7)

**Veterans Medical Center
Inpatient Substance Abuse**
(refer to page 7)

**Veterans Medical Center
Detoxification Unit**
(refer to page 7)

**Volunteers of America Receiving/
Detoxification Center**
252 West Brooklyn Avenue
Salt Lake City, UT 84101
363-9400, 24-hour monitoring

Non-medical
detoxification.

Wasatch Youth Support Systems
3545 South 3200 West
West Valley City, UT 84119
969-8841, weekdays

**Western Institute of Neuropsychiatry
Recovery Center**
501 Chipeta Way
Salt Lake City, UT 84108
584-2098, 7 days/wk 24 hrs/day

** Human Services Office of Licensing

† Through contract with Division of Substance Abuse (provisions for low-income clients)

AGENCIES BY DISTRICT
DISTRICT IIC
DAVIS COUNTY

Agency	Alcoholism Treatment Only	Alcoholism & Drug Abuse Treatment	Detoxification (Medical)	Classes for Court-Referred DUI Defendants	Prevention Services	Licensed by H.S.O.L. **	Men Only (M) or Women Only (W)	Outpatient Treatment	Residential Services	State Funded†	Special Treatment (Live In)	24-Hour Emergency Coverage	Other Information
Benchmark Regional Hospital 592 West 1350 South Woods Cross, UT 84087 299-5300 7 days/wk 24 hrs/day	■	■		■	■			■		■	■		Utah toll-free: 1-800-433-1472 Outside Utah: 1-800-233-1472
Davis County Mental Health Alcohol & Drug Services 7 days/wk 24 hrs/day 2250 North 1700 West Layton, UT 84041 773-7060	■		■		■			■	■	■	■		
Davis County Mental Health Alcohol & Drug Services 470 East Medical Drive Bountiful, UT 84010 298-3446 8:30am-9pm, Mon-Thurs 8:30am-5pm, Fri	■				■			■	■	■	■		
Davis County Mental Health Alcohol & Drug Services 85 South 185 East P. O. Box 689 Farmington, UT 84025 451-7799, 8am-5pm, Mon-Fri			■						■	■			
Davis County Mental Health Addictions Treatment and Recovery Facilities 860 South State Clearfield, UT 84015 776-4188, 7 days/wk/24 hrs/day	■				■			■	■	■	■	■	
Davis County Mental Health Addictions Treatment and Recovery Facilities 904 South State Clearfield, UT 84015 776-1724 7 days/wk/24 hrs/day	■				■			■	■	■	■	■	
Hill Air Force Base, Drug/Alcohol Section Building 396, 8th Street Hill Air Force Base, UT 84056 777-3516, 777-3407 7:30am-4pm, Mon-Fri	■		■					■					

**Human Services Office of Licensing

†Through contract with Division of Substance Abuse (provisions for low-income clients)

AGENCIES BY DISTRICT
DISTRICT IIC
DAVIS COUNTY

Agency

Alcoholism Treatment Only
Alcoholism & Drug Abuse Treatment
Detoxification (Medical)
Classes for Court-Referred DUI Defendants
Prevention Services
Licensed by H.S.O.L.
Men Only (M) or Women Only (W)
Methadone Treatment
Outpatient Services
Residential Services
State Funded†
Special Services for Youth
24-Hour Emergency Coverage

Other Information

Step One
(Lakeview Hospital Substance
Abuse Specialty Program)
630 East Medical Drive
Bountiful, UT 84010-4938
299-2186, 7 days/wk 24 hrs/day

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AGENCIES BY DISTRICT
DISTRICT IIT
TOOELE COUNTY

Agency	Alcoholism Treatment Only	Alcoholism & Drug Abuse Treatment	Detoxification (Medical)	Classes for Court-Referred DUI Defendants	Prevention Services	Licensed by H.S.O.L. **	Men Only (M) or Women Only (W)	Outpatient Treatment	Residential Services	State Funded†	Special Services (Live In)	24-Hour Emergency Coverage	Other Information
Dugway Community Counseling Center Building 5236 Dugway, UT 84022 831-2298, (SL# 522-2298) 6:50am-5:40pm, Mon-Thurs		■						■			■		
Tooele Army Depot Community Counseling Program Commander, SDSTE-PCCF-A Tooele, UT 84074-5008 833-2584, 7:30am-4pm, Mon-Fri		■			■			■			■		
Tooele County Human Services Mental Health/ Alcohol & Drugs Counseling Center 305 North Main Street Tooele, UT 84074 833-7370, (SL# 965-4979) 8am-5pm, Mon-Fri		■	■	■				■	■	■	■		
Human Services / Wendover Office Wendover, UT 84083 665-2231, Mon-Fri								■					

** Human Services Office of Licensing

†Through contract with Division of Substance Abuse (provisions for low-income clients)

AGENCIES BY DISTRICT

DISTRICT IIIA

WASATCH COUNTY

DISTRICT IIIB

UTAH COUNTY

Agency	Alcoholism Treatment Only	Alcoholism & Drug Abuse Treatment	Detoxification (Medical)	Classes for Court-Referral DUI Defendants	Prevention Services	Licensed by H.S.O.L. **	Men Only (M) or Women Only (W)	Outpatient Treatment	Residential Services	State Funded†	Special Services (Live In)	24-Hour Emergency Coverage	Other Information
DISTRICT IIIA WASATCH COUNTY													
Wasatch County Prevention Services 805 West 100 South, P.O. Box 126 Heber City, UT 84032 654-3003, 9am-2pm, Mon-Thur	■	■	■				■		■				
DISTRICT IIIB UTAH COUNTY													
Assessment & Psychotherapy Associates, Inc. 1875 South State, Suite 3200 Orem, UT 84058 224-1010	■	■					■						
Central Utah ATC 1726 South Dakota Lane P.O. Box 252 Provo, UT 84603 375-9222 / 373-6562 24 hours/day, 7 days/wk	■	■		■			■	■			■		Social detoxification services.
Central Utah Medical Clinic, Inc. 1055 North 500 West Provo, UT 84604 374-2362						■							
Charter Canyon Hospital Psychiatric and Chemical Dependency Treatment Program 1350 East 750 North Orem, UT 84057 225-2800, 800-365-9555	■	■		■	■		■	■		■	■		
Charter Counseling Center of Provo 2474 North University Avenue, Suite 100 County Club Court Provo, UT 84604 374-2820	■			■	■		■			■	■		
DUI Educational Associates P. O. Box 1306 Orem, UT 84057 373-7578	■	■		■			■			■			

**Human Services Office of Licensing

†Through contract with Division of Substance Abuse (provisions for low-income clients)

AGENCIES BY DISTRICT **DISTRICT IIIB** UTAH COUNTY

Agency	Alcoholism Treatment Only	Alcoholism & Drug Abuse Treatment	Detoxification (Medical)	Classes for Court-Referral Treatment	Prevention Services	Licensed by H.S.O.L. **	Men Only (M) or Women Only (W)	Outpatient Treatment	Residential Services	State Funded†	Special Treatment (Live In)	24-Hour Emergency Coverage	Other Information
The Heritage Schools 1426 East 800 North P. O. Box 105 Orem, UT 84057 225-5552 7 days/wk 24 hrs/day		■			■			■		■	■		Sub-acute psychiatric treatment facility for adolescents.
Mountain View Hospital Alcohol & Substance Abuse Treatment Program 1000 East U.S. Highway 6 Payson, UT 84651 465-9201, ext. 332		■	■	■	■			■	■		■	■	
Provo Canyon School 4501 North University Avenue P. O. Box 1441 Provo, Utah 84603 227-2000, 7 days/wk 24 hrs/day		■			■	■		■			■	■	
The Gathering Place Utah County Council on Drug Abuse Rehabilitation (UCCODAR) 555 South State Suite 203 Orem, UT 84058 226-2255, 7 days/wk 24 hrs/day		■				■		■		■	■	■	
Utah Alcoholism Foundation Central Division (Inpatient) 1726 South Dakota Lane P. O. Box 252 Provo, UT 84601 373-6562, 7 days/wk 24 hrs/day	■	■		■				■	■		■	■	Social detoxification.
Utah Alcoholism Foundation, Central Division (Outpatient) 585 East 300 South, Suite A Provo, UT 84603 374-6720, 8am-5pm, Mon-Fri		■			■			■					
Utah County Department of Substance Abuse 100 East Center Street, Suite 3300 Provo, UT 84601 370-8427, (SL# 532-1272, ex. 520) 8am-5pm, Mon-Fri				■		■				■			Referral services to contracted agencies.

** Human Services Office of Licensing

† Through contract with Division of Substance Abuse (provisions for low-income clients)

AGENCIES BY DISTRICT

DISTRICT IIIB

UTAH COUNTY

DISTRICT IIIC

SUMMIT COUNTY

Agency	Alcoholism Treatment Only	Alcoholism & Drug Abuse Treatment	Detoxification (Medical)	Classes for Court-Referred DUI Defendants	Prevention Services	Licensed by H.S.O.L. **	Men Only (M) or Women Only (W)	Outpatient Treatment	Residential Services	State Funded†	Special Services (Live In)	24-Hour Emergency Coverage	Other Information
Utah County Jail Alcohol & Drug Program 1776 Buckley Lane Provo, UT 84606 370-8850		■			■		■		■		■		
Utah Valley Regional Medical Center - Dayspring Chemical Dependency Unit 1034 North 500 West Provo, UT 84601 373-7850, ex 2823 7 days/wk 24 hrs/day		■	■	■	■			■			■		Services: 24 emergency number 375-HELP
DISTRICT IIIC - Summit County													
Valley Mental Health 1753 Sidewinder Drive P. O. Box 680308 Park City, UT 84068 649-8347 9am-5pm, Mon-Fri		■		■	■		■		■	■	■		

**Human Services Office of Licensing

†Through contract with Division of Substance Abuse (provisions for low-income clients)

AGENCIES BY DISTRICT DISTRICT IV

JUAB, MILLARD, PIUTE, SANPETE,
SEVIER, AND WAYNE COUNTIES

Agency	Alcoholism Treatment Only	Alcoholism & Drug Abuse Treatment	Detoxification (Medical)	Classes for Court-Referred DUI Defendants	Prevention Services	Licensed by H.S.O.L. **	Men Only (M) or Women Only (W)	Methadone Treatment	Outpatient Services	Residential Services	State Funded†	Special Services (Live In)	24-Hour Emergency Coverage	Other Information
Central Utah Mental Health - Alcohol & Drugs 96 South Main, 5-12 Ephraim, UT 84627 283-4065, 8:30am-5pm, Mon-Fri		■				■		■		■	■	■		
Central Utah Mental Health - Alcohol & Drugs P.O. Box 766 / 61 South Main Fillmore, UT 84631 743-5121, 8:30am-5pm, Mon-Fri		■				■		■		■		■		
Central Utah Mental Health - Alcohol & Drugs 255 West Main Mt. Pleasant, UT 84647 462-2416, 8:30am-5pm, Mon-Fri		■	■		■			■	■	■	■	■		
Central Utah Mental Health - Alcohol & Drugs 180 North 100 East Richfield, UT 84701 896-8236, After hours: 896-8236 8:30am-5pm, Mon-Fri		■				■		■		■	■	■		
Central Utah Mental Health - Alcohol & Drugs P.O. Box 101 656 North Main Street Nephi, UT 84648 623-1456, 623-1456		■	■		■			■		■	■	■		
Central Utah Mental Health - Alcohol & Drugs 51 North Center P.O. Box 357 Delta, UT 84624 864-3073, 8:30am-5pm, Mon-Fri		■	■		■			■		■	■	■		
Sevier County Alcohol & Drug Program 250 North Main Street Richfield, UT 84701 896-6433, 7 days/wk 24 hrs/day		■	■	■		■		■		■		■		
Sorenson's Ranch School, Inc. P.O. Box 179 Koosharem, UT 84744 638-7318 7 days/wk 24 hrs/day	■					■		■			■	■		Services: Youth only.

** Human Services Office of Licensing

† Through contract with Division of Substance Abuse (provisions for low-income clients)

AGENCIES BY DISTRICT **DISTRICT V**

BEAVER, GARFIELD, IRON, KANE AND
WASHINGTON COUNTIES

Agency	Alcoholism Treatment Only	Alcoholism & Drug Abuse Treatment	Detoxification (Medical)	Classes for Court-Referred DUI Defendants	Prevention Services	Licensed by H.S.O.L. **	Men Only (M) or Women Only (W)	Methadone Treatment	Outpatient Services	Residential Services	State Funded†	Special Services (Live In)	24-Hour Emergency Coverage	Other Information
Brightway at St. George 115 West 1470 South St. George, UT 84770 1-800-345-4828, 24 hrs/day, 7 days/wk		■	■		■	■		■	■			■		
Charter Counseling Center of Southwestern Utah 150 North 200 East, Suite 103 St. George, UT 84770 673-8700		■			■	■		■			■			
Horizon House Substance Abuse Treatment Center 54 North 200 East Cedar City, UT 84720 586-2515 (24 hr hotline) 7 days/wk 24 hrs/day		■	■			■		■	■	■		■		
Paute Indian Tribe of Utah Social Services 600 North 100 East Cedar City, UT 84720 586-5914, 8am-4:30pm, Mon-Fri								■			■			Services: BIA funded and evaluated. Services five bands. Substance abuse treatment is only one of many services provided.
Southwest Utah Mental Health/Alcohol & Drug Center 190 North 100 East P.O. Box 72 Beaver, UT 84713 438-5537, 438-2443 8am-5pm, Mon-Fri		■		■		■		■		■	■	■		
Southwest Utah Mental Health/Alcohol & Drug Center P.O. Box 837 91 North 1850 West Cedar City, UT 84720 586-8226, 8am-5pm, Mon-Fri		■		■		■		■		■	■	■		
Southwest Utah Mental Health/Alcohol & Drug Center 115 West Center Street Kanab, UT 84741 644-5885 8am-5pm, Mon-Fri		■		■		■		■		■	■	■		

** Human Services Office of Licensing

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AGENCIES BY DISTRICT DISTRICT V

BEAVER, GARFIELD, IRON, KANE AND
WASHINGTON COUNTIES

Agency	Alcoholism Treatment Only	Alcoholism & Drug Abuse Treatment	Detoxification (Medical)	Classes for Court-Referred DUI Defendants	Prevention Services	Licensed by H.S.O.L. **	Men Only (M) or Women Only (W)	Outpatient Treatment	Residential Services	State Funded†	Special Treatment (Live In)	24-Hour Emergency Coverage	Other Information
Southwest Utah Mental Health/Alcohol & Drug Center 565 North Main P. O. Box 395 Panquitch, UT 84759 676-8866, 8am-5pm, Mon-Fri		■		■		■		■	■	■			
Southwest Utah Mental Health/Alcohol & Drug Center 354 East 600 South, Suite 202 St. George, UT 84770 628-0426, 8am-5pm, Mon-Fri		■		■		■		■	■	■			Administration offices also located here.

**Human Services Office of Licensing

†Through contract with Division of Substance Abuse (provisions for low-income clients)

AGENCIES BY DISTRICT DISTRICT VI

DAGGETT, DUCHESNE AND UINTAH COUNTIES

Agency

Alcoholism Treatment Only
Alcoholism & Drug Abuse Treatment
Detoxification (Medical)
Classes for Court-Referred DUI Defendants
Prevention Services
Licensed by H.S.O.L. **
Men Only (M) or Women Only (W)
Outpatient Treatment
Residential Services
State Funded†
Special Services (Live In)
24-Hour Emergency Coverage

Other Information

Ashley Valley Medical Center

Life Balance Unit
151 West 200 North
Vernal, UT 84078
789-3342

IHS-Indian Health Services Alcohol and Drug and Social Services

722-2241
P.O. Box 160
Fort Duchesene, UT 84026

Services: aftercare and
education, early
intervention, inpatient
referral and aftercare;
also provides social
services.

Red Pine Treatment Center Ute Indian Tribe

P.O. Box 190
Duchesne, UT 84026
722-5141, ext. 202

Uintah Basin Alcohol Education Program

64 East Main Street, #1
Vernal, UT 84078
789-4926

Uintah Basin Counseling, Inc.

559 North 1700 West
Vernal, UT 84078
781-0743, 8am-5pm, Mon-Fri

Uintah Basin Counseling, Inc.

27 South 100 West
Duchesne, UT 84021
722-4625, Wednesdays only

Uintah Basin Counseling, Inc.

Alternative House
251 West Main Street
Vernal, UT 84078
Refer inquiries to: 781-0743
24 hrs/day

Uintah Basin Counseling, Inc.

510 West 200 North
P.O. Box 1524
Roosevelt, UT 84066
722-4625
8am-5pm, Mon-Fri

** Human Services Office of Licensing

† Through contract with Division of Substance Abuse (provisions for low-income clients)

AGENCIES BY DISTRICT **DISTRICT VI**

DAGGETT, DUCHESNE AND UINTAH COUNTIES

Agency	Alcoholism Treatment Only	Alcoholism & Drug Abuse Treatment	Detoxification (Medical)	Classes for Court-Referred DUI Defendants	Prevention Services	Licensed by H.S.O.L. **	Men Only (M) or Women Only (W)	Outpatient Treatment	Residential Services	State Funded†	Special Services (Live In)	24-Hour Emergency Coverage	Other Information
Ute Indian Tribe Alcohol & Drug Program P. O. Box 190 Ft. Duchesne, UT 84026 722-5141 ex. 202 722-3941 ex. 361/362 8am-5pm, Mon-Fri		■	■	■						■	■		
Ute Indian Tribe, Substance Abuse Prevention and Education P.O. Box 190 Duchesne, UT 84026 722-5141, ext. 156									■				Activities targeted toward parents.
Ute Indian Tribe, Social Services P.O. Box 190 Duchesne, UT 84026 722-5141, ext. 126			■					■		■			

**Human Services Office of Licensing

†Through contract with Division of Substance Abuse (provisions for low-income clients)

AGENCIES BY DISTRICT

DISTRICT VIIIA

CARBON, EMERY AND GRAND COUNTIES

Agency	Alcoholism Treatment Only	Alcoholism & Drug Abuse Treatment	Detoxification (Medical)	Classes for Court-Referred	Prevention Services	Licensed by H.S.O.L. **	Men Only (M) or Women Only (W)	Outpatient Treatment	Residential Services	State Funded†	Special Treatment (Live In)	24-Hour Emergency Coverage	Other Information
Eastern Utah ATC 221 South 7th East Price, UT 84501 637-3769 8am-10pm, 7 days/wk		■		■				■	■			■	
Four Corners Mental Health Alcohol and Drugs 662 East Main Street P.O. Box 387 Castle Dale, UT 84513 381-2432, 8am-5pm, Mon-Fri		■			■			■		■	■	■	
Four Corners Mental Health Alcohol and Drugs 198 East Center Moab, UT 84532 259-6131 8am-5pm, Mon-Fri		■		■	■			■		■	■	■	
Four Corners Mental Health Alcohol and Drugs 575 East 100 South P.O. Box 867 Price, UT 84501 637-2358, 8am-5pm, Mon-Fri		■		■	■			■		■	■	■	Services: provides day care
Utah Alcoholism Foundation, Eastern Division 221 South 700 East Price, UT 84501 637-3769 8am-5pm, Mon-Fri		■		■				■	■	■	■		

** Human Services Office of Licensing

† Through contract with Division of Substance Abuse (provisions for low-income clients)

AGENCIES BY DISTRICT
DISTRICT VIIB
 SAN JUAN COUNTY

Agency	Alcoholism Treatment Only	Alcoholism & Drug Abuse Treatment	Detoxification (Medical)	Classes for Court-Referred DUI Defendants	Prevention Services	Licensed by H.S.O.L. **	Men Only (M) or Women Only (W)	Outpatient Treatment	Residential Services	State Funded†	Special Treatment (Live In)	24-Hour Emergency Coverage	Other Information
San Juan Mental Health and Substance Abuse 522 North 100 East Blanding, UT 84511 678-2274	■	■	■				■	■	■	■			
San Juan Mental Health and Substance Abuse Community Operations Montezuma Montezuma Creek, UT 84534 651-3294 8am-5pm, Mon-Fri	■						■	■	■	■			
San Juan Mental Health and Substance Abuse P. O. Box 127 Monticello, UT 84535 587-2016 or 582-2015 8am-5pm, Mon-Fri	■						■	■	■	■			

**Human Services Office of Licensing

†Through contract with Division of Substance Abuse (provisions for low-income clients)

AFFILIATED AGENCIES OUTSIDE UTAH

Action/PRIDE.....1-800-241-7946
 Parent Resource Institute for Drug Education
Must have touchtone.

Adult Children of Alcoholics Central213-534-1815
 Service Board & Interim World Service Organization
 2522 West Sepulveda Boulevard, Suite 200
 (P.O. Box 3216)
 Torrance, CA 90505
National advocacy group for children of alcoholics of all ages.

Alliance Against Intoxicated Motorists (AAIM)
 P.O. Box 10716
 Chicago, IL 60610
Ask about the Extra Eyes citizen patrols to help police identify and catch drunk drivers - enclose SASE. No phone number available.

American Council for1-301-984-5700
 Drug Education

The American Medical Society on212-206-6770
 Alcoholism & Other Drug Dependencies, Inc.
 12 West 21st Street
 New York, New York 10010

Blacks Against Drunk Driving (BADD)
 Eddie Young
 125 East Elm Street
 Greensboro, NC 27401

California Society for the415-428-9091
 Treatment of Alcoholism & Other Drug Dependencies
 3803 Broadway, Suite #2
 Oakland, CA 94611
Has members from all over the country.

International Pharmacists(201)730-9072
 Anonymous **(201)735-2789**
recording

National Association of Alcoholism714-975-0104
 Treatment Programs

National Association of State606-252-2291
 Controlled Substances Authorities608-266-7586
Services: Provides a continuing means for states and federal government to communicate on controlled substances issues.

National Clearinghouse for Alcohol.....301-468-2600
 and Drug Information
 P. O. Box 2345
 Rockville, MD 20852
Provides a variety of bibliographic and other alcohol information services.

National Commission Against Drunk Driving
 1140 Connecticut Avenue, N.W.
 Suite 804
 Washington, D.C. 20036

National Congress of Parents & Teachers - PTA
 700 North Rush Street
 Chicago, IL 60611-2571

National Council on Alcoholism.....1-800-622-2255

National Federation of Parents1-800-554 KIDS
 for Drug-Free Youth

National Institute on Drug Abuse1-301-443-0353
prevention number

National Institute on Alcoholism301-443-3860
 and Alcohol Abuse *information number*

Office for Substance Abuse.....301-443-0365
 Prevention (OSAP)
 Alcohol, Drug Abuse, and Mental Health
 Administration
 Room 9A-54 Parklawn Building
 5600 Fishers Lane
 Rockville, MD 20857

Remove Intoxicated Drivers (RID)
 1013 Nott Street
 Schenectady, NY 12308

Students Against Driving Drunk (SADD)
 P. O. Box 800
 Marlboro, MA 01752
Ask for a free information kit or a lifetime contract.

HUMAN SERVICES/SUBSTANCE ABUSE TOLL-FREE NUMBERS

National Adolescent1-800-621-4000
Suicide Hotline

Legal Action Center1-800-223-4044

*Organization in New York City providing legal assistance and counsel for alcohol/drug treatment programs and client groups nationwide in such areas as confidentiality laws, legal rights of former abusers to employment, licenses, government benefits, and program community relationships.
Call between 7am and 4pm, Utah time*

Just Say No.....1-800-847-6555

Clubs for 7-12 year-olds; provide support and anti-drug activities and information.

National Institute on Drug Abuse1-800-638-2045

Prevention programming, technical assistance and networking.

Mothers Against Drunk Drivers.....1-800-GET-MADD

Callers can also call the Salt Lake Office at 966-7087.

The Cottage Program1-800-752-6100

The State toll-free number, operative 24 hours a day, provides after-hours access to all prevention and treatment programs as well as information, referral and hot-line services.

Psychiatric Institutes of America1-800-COCAINE

Provides information, advice and referrals for any kind of drug problem. 24 hours, 7 days/week. (New Jersey)

Adcare Hospital1-800-ALCOHOL

*Information/referral/advice for alcohol and/or drug problems. 24 hours, 7 days/week crisis line.
(Worcester, MA)*

National Federation of Parents1-800-554-KIDS
for Drug-Free Youth

PRIDE1-800-241-9746
(Parents' Resource Institute for Drug Education)

*Call between 6:30am and 3pm, Utah time.
Hotline for parents concerned about drug use by youth. Resource, information, conference and training organization. Provides on-site consultant services to parent groups in communities nationwide.*

Pregnancy Risk Line.1-800-822-BABY

Sponsored by the University of Utah School of Medicine and the Department of Health, Family Health Services. Answers questions for mothers-to-be regarding pregnancy and alcohol and drugs. Clients in Salt Lake City can call 583-BABY or the toll-free number, Monday thru Friday, 8:00-5:00. An answering machine will take messages during non-business hours.

AIDS recorded message.....1-800-342-2437

U.S. Department of Health and Human Services provides a 24-hour recorded message which offers updated information on the disease for AIDS carriers or those who believe they may have been exposed. AIDS victims are provided with suggestions on how to avoid spreading the disease. Information is provided on where to go for confidential testing. Callers who want to speak personally with health officials are referred to the toll-free number1-800-447-AIDS

National AIDS help line1-800-447-AIDS

For AIDS victims or those who believe they may have been exposed to the virus.

Nurse on Call56-NURSE

Salt Lake City number

This is a new consumer service for people who have non-emergency questions about health. Offered through Alta View Hospital, the service was initiated to provide information and guidance on general health care and to help callers decide when medical help is needed.

Helpline for information on272-HELP
cocaine addiction

Salt Lake City number

Cocaine Hotline1-800-662-HELP

Provided by the National Institute on Drug Abuse. Directs users to treatment facilities in their communities.

Dial-A-Sober-Thought.1-800-45-SOBER

Free, two-minute message about staying sober. Instituted by Dr. Abraham J. Twerski, M.D., founder and medical director of Gateway Rehabilitation Center in Pennsylvania.

Crisis line1-800-821-HELP

Operating 7 days a week, 24 hours per day, providing information, advice and referrals for any alcohol or drug problem. Operated by Highland Ridge Hospital.

Cocaine Self-Help Groups

*For information on groups in your area, contact "The Connection"
P.O. Box 1367
Culver City, CA 90239.
No phone number presently available.*

Narcotics Anonymous.....773-2295

May have information on this group since cocaine is presently classified as a narcotic.

NIDA Workplace Helpline1-800-843-4971
(National Institute for Drug Abuse)

For employers regarding employee assistance programs, drug testing, employee education.

SMOKING CESSATION PROGRAMS

SALT LAKE COUNTY

CLASSES

American Cancer Society332-0431
"Fresh Start" Two 1 hour sessions a week for 2 weeks - \$20. Free literature on smoking

Cottonwood Hospital262-3461
*Respiratory Therapy Department. (Gary Freck).
 Every 2 months, 7 sessions, 7 weeks. Handouts and tapes - \$35*

Holy Cross Hospital350-4539
(Victoria) No current classes. Call for information.

LDS Hospital321-1004
3-4 hours of individual counseling - \$25

Salt Lake Community Health Centers328-5761
(Agnes) Five 1-1/2 hour weekly sessions, \$12 rebate for attending all five sessions.

Seventh Day Adventist program.....484-4331
*Held at Wastch Hills Church, 2139 Foothill Dr. (SLC)
 Five 1-1/2 hour sessions in 5 consecutive days
 (Fri- Thurs), \$40*

Utah Lung Association.....484-4456
*"Freedom From Smoking" program. Held at St. Mark's Hospital 268-7422 (SLC) Katie Hedberg and St. Benedict's Hospital 479-2016 (Ogden) Rick Knowlton
 Eight 2 hour weekly sessions \$40*

DO IT YOURSELF

American Cancer Society322-0431
Free pamphlet

Cancer Information Service of Utah .1-800-4 CANCER
Free cessation kit & free counseling

Utah Heart Association322-5601
Free pamphlet

Utah Lung Association.....484-4456
*"Freedom From Smoking in 20 Days"with manual - \$7
 "In Control" home video with workbook - \$60*

Salt Lake County Aging.....468-2754
(David Turner) "Taking Control of Your Smoking," 6 week cessation curriculum

Nicorette gum
 (prescription drug) + Physician counseling

HYPNOSIS

Utah Lung Association.....484-4456
*One 2 hour session teaches self-hypnosis
 (tapes included) \$35*

Private therapistsee Yellow Pages-Hypnotists
Initial 2 hour session approx. - \$45 Follow-up 1 hour session approx. - \$25

SUPPORT GROUPS

St. Mark's Hospital.....268-7480
 1200 E. 3900 So.
Conducts meetings on the second Tuesday of each month at 7:00 p.m. for anyone who has attempted to quit "cold turkey" or through ANY established program.

Smokers Anonymous261-5433
 4500 S. 1430 E.
Conducts meetings every Thursday at 7:00 p.m. at Olympus View Hospital

OUTSIDE SALT LAKE COUNTY

Brigham City Community Hospital734-9471
"Fresh Start" (American Cancer Society)

Davis Cont Health Dept.451-3340
*"Fresh Start" (American Cancer Society Program)
 4 weeks \$20*

Humana Hospital Davis North774-7060
*Smoking Management Clinic
 90 day clinic, follow-up session at 9 mo., & 1 yr. - \$165*

Logan Regional Hospital752-2020 Ext. 119

McKay-Dee Hospital Center627-2800
 Ogden (Women's Center)
6 week program sponsored by American Cancer Society. Women only - \$30

Southeastern Utah627-4800
District Health Department
Price, will offer elsewhere in health district.

Southwestern Utah:
 Dixie Medical Center
 Fillmore Community Medical Center
 Sevier Valley Hospital
 Valley View Medical Center
 Wasatch County Hospital
No programs currently, call for information.

St. Benedict's Hospital479-2016
 Ogden
"Freedom From Smoking" - 8 week program, Built-in maintenance/\$40

Smith Clinic379-7077
 Provo
*5 Day Stop Smoking Plan -- \$30 rebate offered.
 Classes held at Utah Valley Hospital and 7th Day Adventist Church.*

CHAPTER 4

**SYNOPSIS OF THE LAWS THAT PUT CONSTRAINTS
ON THE COURTS**

WHAT THE JUVENILE COURT CAN DO

A. GENERALLY

The Juvenile Court has the authority to deal with cases involving persons 17 years of age or younger, or persons 18 and over who are under the continued jurisdiction of the Court or who committed the offense prior to their 18th birthday.

The penalties for "children" (males or females under 18) who violate federal, state, or municipal laws are not the same as the penalties for "adults" (males or females 18 or older) who violate the same law. However, the Juvenile Court has broad discretionary powers that courts dealing with adult offenders don't have, and can order virtually anything considered to be reasonable for the best interest of the child or for the protection of the public.

B. POSSIBLE COURT ACTION - The types of actions that the Juvenile Court might take include:

1. Placing a child on probation or under protective supervision at home.
2. Placing a child in legal custody of a relative or other suitable person.
3. Placing a child in the legal custody of the State Division of Social Services or other public agency.
4. Committing a child to the custody of the State Division of Youth Corrections for secure confinement or supervision, i.e., to the Decker Lake facility, for placement in a residential and/or community-based program for treatment, or for short-term observation and assessment.
5. Ordering the child to replace, repair, or otherwise make restitution for damage or loss caused by the child.
6. Ordering the child to pay a fine, or impose a work order.
7. Ordering parents and child to attend rehabilitation classes on drugs or shoplifting and/or pay a fine.
8. Ordering parents and child to attend truancy schools and/or pay a fine.
9. Terminating ALL parental rights.
10. Certification of a minor to be tried as an adult.
11. Commitment to detention for not more than ten day and a fine not to exceed \$200 - if found in contempt of court for refusing to obey an Order of the Court.
12. Commitment to detention not to exceed 30 days when convicted of an act which, if committed by an adult, would be a criminal offense.

C. UNPAID FINES OR RESTITUTION ORDERS

1. A 1983 law added to the Operator's and Chauffeurs License Act allows for the suspension of the driver's license of any person who has an unpaid fine or restitution order from the Juvenile Court. Also be advised that your Utah State income tax refund can be collected to pay for delinquent fines and restitution.
2. The Juvenile Court retains jurisdiction concerning a person over 21 years of age who has failed to comply with an order to the Juvenile Court to pay a fine or restitution if the order was imposed prior to the person's 21st birthday.

WHEN YOU TURN EIGHTEEN

A. GENERALLY

The moment you turn 18 you may be tried within the adult court system, and you may receive the penalties that adult offenders receive for violation of federal, state, or municipal laws.

B. FELONIES - For violations classified as felonies (which include some drug and shoplifting offenses), the penalties include:

1. Probation - usually for first-time offenders.
2. Fine - at the Court's discretion: First or second degree felony up to \$10,000; third degree felony up to \$5,000.
3. Imprisonment - 1 year to life.
4. Death - for capital offenses.

C. MISDEMEANORS - For violations classified as misdemeanors (which include some drug and most shoplifting offenses), the penalties include:

1. Class A - 1 year in jail or imprisonment and/or up to \$2,500 fine.
2. Class B - 6 months in jail and/or up to \$1,000 fine.
3. Class C - 90 days in jail and/or up to \$500 fine.
4. Infraction - anything which is not listed as a misdemeanor is an infraction - up to \$500 fine.

D. Any offenses committed before your 18th birthday will be handled by Juvenile Court even though you may have turned 18.

EXPUNGEMENT (SEALING) OF A JUVENILE COURT RECORD

You may ask the Juvenile Court to seal (expunge) your Juvenile Court record if you are 18 and at least one year has passed since:

1. completion of probation, and/or
2. expiration of Juvenile Court authority, and/or
3. unconditional release from the jurisdiction of the State Division of Youth Corrections

To seal (expunge) your record you must:

Petition the Court for an expungement hearing by contacting the records division of the Juvenile Court. Depending on the offense, expungement may or may not require legal assistance. If, upon a hearing, the Court finds that you have been law-biding since your last appearance before it, the Court may order the records sealed. Once sealed, only you or persons named by you may inspect the records. If you have an adult criminal record, your Juvenile Court record will not be expunged.

TOBACCO VIOLATIONS

- A. If you are under the age 19 and buy, accept, or have in your possession tobacco in any form, you are guilty of a Class C misdemeanor.
- B. Anyone selling, giving, or furnishing tobacco to someone under 19 is guilty of a Class C misdemeanor on the 1st offense, a Class B on the 2nd and a Class A on subsequent offenses.
- C. Anyone who operates a business who knowingly allows a person under 19 to use any form of tobacco on the premises is guilty of a Class C misdemeanor.

Penalties:

If you are under 18, the Juvenile Court has jurisdiction. (See page 1.)

If you are 18 or over, you are liable for a penalty which could be up to a \$500 fine, 90 days in jail or both for possession, for selling, giving, or furnishing to someone under 19. (See "When you Turn 18", page 2.)

Current violators are issued citations by police or school officials. The Third District Juvenile Court handles all citations by bail forfeitures of \$25.00 each incident.

INHALING FUMES

PSYCHOTOXIC CHEMICAL VIOLATIONS (misusing glue, gasoline, and similar intoxicants)

- A. Anyone who smells or inhales the fumes of a psychotoxic chemical or possesses or purchases one for the purpose of getting high is guilty of a Class B misdemeanor.
- B. Anyone who provides another person with a psychotoxic chemical for the purpose of "getting high" is also guilty of a Class B misdemeanor.

Penalties:

If you are under 18, the Juvenile Court has jurisdiction. (See page 1.)

- C. If you are 18 or over, you are liable for a penalty which could be six months in jail, up to a \$1,000 fine or both.

ALCOHOL VIOLATIONS

- A. Anyone who sells or gives an alcoholic beverage to someone under 21 is guilty of a Class A misdemeanor.
- B. If you are under 21 and purchase, drink, or have in your possession any alcoholic beverage, you are guilty of a Class A misdemeanor. This includes in your car, at a party, etc.
- C. If you are under the influence of alcohol to a degree that you may endanger yourself or others in a public place or you unreasonably disturb others in a private place, you may be guilty of a Class C misdemeanor.
- D. If you are under 21 and misrepresent your age or knowingly misrepresent the age of another under 21, for the purpose of obtaining an alcoholic beverage, you are guilty of a Class A misdemeanor.
- E. The "Open Container Law" states that no open container of any alcoholic drink shall be in a motor vehicle when the vehicle is on any highway.

Penalties:

If you are under 18, the Juvenile Court has jurisdiction, except for violations of the "Open Container Law", in which case the Juvenile Court only has jurisdiction on minors under age 16.

- 1. Possession/consumption: First referral - bailable \$50. Subsequent referrals - appearance in court required; fine up to \$50 and on 1st conviction the Court may order suspension of driver's license, may notify Driver's License Division, may impose 20-100 hours of community service; on 2nd conviction, the Court shall notify Driver's License Division of suspension, shall order 20-100 hours of community service.
- 2. Selling/supplying: Appearance in court required; fine up to \$250, and on 1st conviction, the Court may order suspension of driver's license, may notify Driver's License Division, may impose 20-100 hours of community service; on 2nd conviction, the Court shall notify Driver's License Division of suspension, shall order 20-100 hours of community service.
- 3. Open container: Appearance in court required; fine up to \$62.
- 4. Under the influence: Appearance in court required; fine up to \$62.
- 5. Misrepresentation of age: Appearance in court required; fine up to \$125, and on 1st conviction, the Court may order suspension of driver's license, may notify Driver's License Division, may impose 20-100 hours of community service; on 2nd conviction, the Court shall notify Driver's License Division of suspension, shall order 20-100 hours of community service.

Any case appearing in court may result in any imposition of possible court actions (see page 1) in addition to any fine ordered.

If you are over 18, the penalty for violation of the corresponding paragraphs above could be:

- 1. Class A misdemeanor = 1 year in jail or imprisonment and/or up to \$2,500 fine and for violations of A, B, and D above, there is a minimum mandatory fine of \$500.

CONTROLLED SUBSTANCE (DRUG/ALCOHOL) VIOLATIONS

A. A drug offense consists of the possession, use, or distribution (giving away or selling) of any controlled substance (including marijuana, cocaine, steroids, or other drugs listed in the law); or any imitation controlled substance (something that looks like a controlled substance, even though it isn't); or any drug paraphernalia (things like hypodermic needles, bongs, roach clips, hash pipes, etc. which may be used to produce, package, distribute, or use drugs).

1. Possession, selling, or purchasing paraphernalia that could be related to drug use is a Class B misdemeanor offense.
2. A violation involving the production or processing with intent to produce a controlled or counterfeit substance; or to distribute or agree, consent, offer or arrange to distribute a controlled or counterfeit substance; or to possess a controlled or counterfeit substance with intent to distribute, can run from a Class A misdemeanor up through a first degree felony.
3. Possession or use of a controlled substance; knowingly and intentionally permitting others to occupy your building, boat, etc., for the purpose of possessing, using or distributing a controlled substance in any of these locations; to knowingly and intentionally be present where controlled substances are being used or possessed; and possessing an altered or forged prescription or written order for a controlled substance, runs from a Class B misdemeanor up to a first degree felony.
4. Violations involving the use of imitation controlled (look-a-likes) substances, including the manufacturing, distributing, and possession with intent to distribute, use or possess may result in a Class B or Class C Misdemeanor. The 1986 Legislature eliminated any difference between distributing for value and no value. Whether a controlled substance is given away or sold for a price, the penalty is the same. If the offense takes place in a public or a private elementary or secondary school or on the grounds of such, or within any structure or grounds of such structure that is used for any school activity by any public or private elementary or secondary school, or within 1,000 feet of any such school, structure or grounds, the severity of penalty increase.

B. An alcohol offense consists of the possession, use, or distribution (giving away or selling) or any alcoholic beverage (including beer).

C. Mandatory fee or fine, community service hours, and driver license suspension.

1. 1st Conviction of Any Drug Offense:
 - Court must order \$150 drug fee (applies to juvenile and adults);
 - Court must assess 20 to 100 hours of community service;
 - Community service hours may be credited for attending an approved substance abuse program.
 - Court must order suspension of driver license;
 - All of the above are in addition to any other penalties imposed.
2. 1st Conviction of Alcohol Offense:
 - Court may order suspension of driver license;
 - Court may notify the Driver License Division;
 - Court may impose 20-100 hours of community service;
 - Community service hours may be credited for attending an approved substance abuse program.
 - Court may impose other sanctions.
3. 2nd Conviction of Alcohol Offense
 - Court must order suspension of driver license;
 - Court must notify the Driver License Division;
 - Court must order from 20-100 hours of community service;
 - Community service hours may be credited for attending an approved substance abuse program.

Effective date for fee on fine and community service hours: April 24, 1989

Effective date for Driver License Suspension: July 1, 1989

Note: If a juvenile does not yet have a driver license, and is convicted of a drug or alcohol offense, the issuance of the driver license may be delayed for at least six months from the time the juvenile would otherwise have been eligible to receive his/her license.

CHAPTER 5

**LAWS, REGULATIONS AND CONTRACTS WHICH
PUT CONSTRAINTS ON TREATMENT PROGRAMS**

CHAPTER FIVE

Laws, Regulations and Contract Elements Which Put Constraints on Substance Abuse Providers

The goal of this chapter is not to inform you of all limitations a provider may experience. Legal and regulatory limitations vary between districts and change from year to year. The goal here is more to give you an informed general picture of the limitations, their fluidity, and the bases for continual change. With that knowledge, courts will be more able to understand when a provider cannot deliver a service they need - or, at least, cannot deliver the service in the form courts anticipate. Courts may also be able to anticipate changes and so minimize interruption of services they need. They may also be able to work more closely with treatment providers to develop programs which serve both systems more effectively. Control over substance abuse service delivery comes from three primary areas: regulations, contracts and laws. This chapter deals briefly with each of these in the context of limitations, fluidity and planning. Bear in mind that what may be considered a limitation in service by the courts may be considered an extension of services by providers.

REGULATIONS

Regulations are usually passed down through contracts by the funders and consequently tend to sneak up on you due to low profile. For example, a contract may say, "Contractor agrees to abide by Confidentiality Regulations 42 CFR, Part 2". Confidentiality has a rather high profile now but that has not always been the case. Many justice readers have probably experienced refusal from providers in recent years to give certain information previously given routinely. The full meaning of these regulation are being learned even now and more changes will probably occur as providers continue to understand them more fully. Full discussion of 42 CFR, Part 2 is in Chapter 6.

Some regulations have hidden invisibly in contracts for years. Because of changing times, they may rear their unfamiliar head in the future. One example of such a regulation is, "Contractor agrees to comply with all applicable standards, orders, or regulations pursuant to the Clean Air Act as ammended (42 WSC 1857 et seq.) and the Federal Water Pollution Control Act as ammended (33 USC 1251 et seq.). (Applicable only to contracts over \$100,000.)" Every district has had this regulation in their contract since the beginning of time but there is probably someone in the State who has signed the contract without reading the acts and having a thorough understanding of them before signing. You may ask how these acts could limit services, to which we answer, "We don't know. We havn't read them." With the growing

concern about protecting our environment, however, it is not out of the realm of possibility that an unfamiliar federal inspector will someday drop down from on high and find that a provider is not in compliance. The cost of achieving compliance may reduce funds for services promised the courts. The courts will find that, due to the \$100,000 minimum, some providers can deliver full services while others can't. This may seem farfetched but it is more accurately simply far in the future. Hopefully.

Other innocuous regulations lurk silently in the fine print of contracts. Some will surface as concerns change just as confidentiality has in recent years. Others will remain hidden as the Clean Air Act has. New ones will be added as political expediency dictates. It is important to know, however, that when compliance to a regulation becomes an issue, providers have no alternative but to comply. If that effects services to the court, it cannot be helped.

CONTRACTS

With the exception of Confidentiality Regulations, contracts and subcontracts place the most visible limitations on services. Local Authorities receive the majority of substance abuse treatment funds from the State who in turn receive a good share of their funds from the Federal Block Grant. When the Local Authority signs the contract with the State which funds many of the services delivered to the courts, they accept limitations imposed on those funds by both higher government entities. A certain percentage of funds must be used for different populations and uses. For example, a minimum of 35% must be used for prevention. A minimum of 40% of treatment funds must be used to treat drug abuse other than alcohol. This guideline may hurt some rural areas where other drugs are not as prevalent. A certain percentage must be devoted to AIDS, youth, women, etc.

It is important to remember the subcontract with providers is the tool Local Authorities use to shape services to meet local needs. In a district which does not contract for services but delivers them directly, this same flexibility is achieved through local policy. "Contract" is used here to mean both of these. Each district, because of its uniqueness, has different treatment needs. Districts periodically conduct needs assessments to determine how substance use patterns have changed. They are assisted by the State Division of Substance Abuse in this process. New treatment priorities will arise to meet these changing needs. Providers are guided by these changing priorities and the services they deliver are guided by changing contracts or internal policies.

Needs assessments are made according to demographics suggested by block grant requirements, for example; sex (certain % must be used to treat women), age (certain % must be used to treat youth), substance of abuse (certain % must be used to treat drugs other than alcohol), AIDS (certain % must be used for treatment and prevention of AIDS). Such assessments are also made according to demographics which reflect changing needs and differences between districts, for example; income, public intoxication, DUI, race and ethnicity. Some demographics which are included in assessments but do not have funding attached to them as a category are; legal involvement, employment (except as reflected in income), and, to some extent, marital status.

As the Local Authority in your District identifies new or growing needs, it will reshape services through contracts to meet those needs. A district may choose to identify funds for internally

induced addictions if that becomes a growing problem. It may choose to reduce public intoxication funds. As cocaine use falls and heroine increases, it may change specialised services in funding schemes. All of these adjustments effect services available to the courts. One district required for a number of years that 75% of PI residential referrals come from a specific detoxification center. While that served the treatment system well, it may have reduced the ability of the system to be a resource to the courts. Another district used the jail to house PIs with no other charge (the cell was unlocked). It served this rural community well but the courts of a metropolitan area would be leary of making that a general practice. Some districts have funds identified for DUI services but this is not mandated by federal or state contract. If those funds become available for general treatment, this may very well impact the courts. While court resources may suffer, such a change might very well be consistent with changing treatment needs in the district.

Judicial Districts and Alcohol and Drug Districts do not always correspond, so some Judicial Districts include counties from two Local Authorities. When this occurs, courts may discover services they want are more available in some counties than in others. This is simply a product of each Local Authority having the power to determine services for their own district. Perhaps some jawboning may bring availability of services more in line from both districts.

LAWS

The courts are certainly more capable of teaching the law to treatment providers than the other way around. Providers can, though, explain to the courts how some laws have effected the services Local Authorities are able to make available. At the end of this chapter are synopses of most laws which have an impact on treatment services. A few are discussed here.

SB 106, 1979, Creation of the Division of Alcoholism and Drugs. This Bill received a great deal of impetus and support from the substance abuse treatment field. The need was seen to coordinate the use of federal block grant funds and to have a central authority acting on behalf of the State. It has had a tremendous impact on treatment in Utah. The Division was a primary force in the writing and passing of laws identifying certain services and generating funds to deliver them. Some pivotal legislative acts were:

HB 222, 1979, Drinking Driver Intervention and Treatment Act. This provided for interventions with those convicted of DUI and fees on fines to fund rehabilitative treatment. This statute has been ammended a number of times, the latest being

SB 74, 1991, DUI Technical Ammendments. This tightens sanctions a judge may impose for first and susequent violations and, like similar legislation before it, caused treatment providers serving the court to make adjustments in the services they delivered.

HB 183, 1982, Public Intoxication Treatment Act. This provided for law enforcement officers taking PIs to a detoxification facility as an alternative to incarceration. Funding was provided for through increased revenues from alcoholic beverages. This act reduced pressure on the courts, the jails, and the PIs. While funds and population were defined for a number of years, that has been muddled over time. Funds are no longer identified in State contracts, leaving Local Authorities more flexibility in the use of these funds.

SB 109, 1983, Liquor Law Enforcement Ammendments. This provided for the first major State funding of prevention efforts and marked a new demension to tackling substance abuse problems in Utah. The effects of prevention are snowing themselves in

decreased usage today and keeps some out of the court system who otherwise would have been there.

HB 286, 1985, Local Alcohol and Drug Authority. This moved much of the authority for treatment service delivery back to the Alcohol and Drug Districts. Much of this authority had been held by them prior to SB 106, 1971. They now operate with some autonomy but within parameters of State and Federal contractual requirements and regulations. This allows more independence in order to meet unique needs of each district.

This is a skeletal description of laws effecting courts and treatment providers and their relationship. The next few pages offer a comprehensive synopsis of most laws touching on this relationship. Anyone desiring a full copy of specific statutes may obtain one by contacting staff identified in Chapter One of this Manual.

1. UCA 32A-14-1 - Dram Shop Liability, 1986

Liability for injuries resulting from illegal sale or other distribution of alcoholic beverages; Injured person's cause of action against persons who provided alcoholic beverage; Survival of action; Limitation on damages; Statute of Limitations.

2. SB 109 - Liquor Law Enforcement Amendments, 1983

An act relating to intoxicating liquors and drugs; Providing an increase in the mark-up on intoxicating liquor; Providing for distribution of liquor profits to cities, towns, and counties and establishing limitations on the use of those profits; Providing for a formula for distribution; Increasing the tax on beer; Appropriating \$2,000,000 to the Division of Alcoholism and Drugs for alcohol and drug abuse prevention; and providing and effective date.

3. HB 142 - Driving While Intoxicated, 1983

An act relating to driving while intoxicated; establishing standards relating to, penalties for, and procedures to deal with, driving while intoxicated; repealing the section which formerly set the absolute minimum blood-alcohol content required to convict for driving while intoxicated; and providing and effective date.

4. HB 45 - Drinking Driver Fee Account, 1982

An act relating to persons convicted of driving while under the influence of intoxicating liquor; allowing certain fees imposed after conviction to be maintained in a non-lapsing County account.

5. HB 92 - Circuit Court Amendments, 1983

An act relating to the Circuit Court; Providing for an increase in civil jurisdiction; Establishing West Valley City as a primary location; Providing for an increase in circuit judges; Providing for appointment of associate district court judges; Providing for the State assumption of Circuit court expenses and amendment of distribution of fines, fees, and forfeitures; Providing for the appointment of trial court executives and clerks of the court; and Providing and effective date.

6. HB 183 - Intoxicating Liquors, 1982

An act relating to Public intoxication; providing that an arresting officer, upon arresting a person for public intoxication, may take the person to a detoxification facility or related service as an alternative to incarceration; providing for funding by increasing excise tax on beer and

minimum mark-up percentages on wine and distilled spirits; and providing an effective date.

7. HB 30 - Intoxicated Drivers' Fines, 1980

An act relating to persons convicted of driving while under the influence of intoxicating liquor; providing that persons convicted under statutes or local ordinances may be assessed up to \$150 above any fine imposed.

8. PL 96 181 - The Drug Abuse Prevention, Treatment, and Rehabilitation Amendments of 1979, 1980

An act to amend the Drug Abuse Office and Treatment Act of 1972, and for other purposes.

9. PL 96 180 - Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act Amendments of 1979, 1980

An act to revise and extend the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970.

10. SB 115 - Teen Drug/Alcohol Intervention and Prevention Act, 1979

An act enabling sections 63-43-8, 63-43-8.1, 63-43-8.2, and 63-43-8.3, Utah Code annotated 1953; Relating to alcoholism and drugs; Providing for an educational service for juvenile drug/alcohol offenders and their parents; Providing for the establishment of teen drug/alcohol schools; Providing that the responsibility for funding of this educational service be borne in part by the juvenile drug/alcohol offender, through the assessment of a fee not to exceed \$40; and providing that the assessment be collected and forwarded to the State Treasurer for credit to a special account established within the general fund to be used by the Division of Alcoholism and Drugs for purposes of operating teen drug/alcohol programs in each juvenile court district.

11. HB 222 - Drinking Driver Intervention and Treatment Act, 1979

An act relating to persons convicted of driving while under the influence of intoxicating liquor; Providing that persons convicted may be assessed up to \$150 above any fine imposed; Providing that the assessment be collected and forwarded to the State Treasurer for credit to a special account; Establishing a special account within the general fund to be used by the Division of Alcoholism and Drugs for purposes related to rehabilitation of drivers convicted of driving under the influence of intoxicating liquor.

12. SB 106 - Creation of the Division of Alcoholism and Drugs, 1971.

An act amending Sections 63-35-3, Utah Code annotated 1953, as enacted by Chapter 174, Laws of Utah 1967, as amended by Chapter 197, Laws of Utah 1969, as amended by Chapter 22, Laws of Utah 1970, and sections 3, 4, 5, and 6, as enacted by Chapter 22, Laws of Utah 1970, relating to drug abuse; Providing for the creation and composition of a Board and a Division of Alcoholism and Drugs within the Department of Social Services; Providing for the powers and duties of the Board and the Division of Alcoholism and Drugs; and repealing section 55-13-1, Utah Code annotated 1953, as enacted by Chapter 174, Laws of Utah 1967, sections 55-13-2 and 55-13-3, Utah Code annotated 1953, as enacted by Chapter 112, Laws of Utah 1957, and Sections 55-13-4, 55-13-5, 55-13-6, and 55-13-7, Utah Code annotated 1953, as enacted by Chapter 112, Laws of Utah 1957, as amended by chapter 174, Laws of Utah 1967.

13. Block Grant - Alcohol, Drug Abuse, and Mental Health Services

14. HB 286 - Local Alcohol and Drug Authority, 1985

An act relating to alcohol and drugs; authorizing the Division for Alcohol and Drugs to designate County Commissioners as local alcohol and drug authority upon County's request; Providing for powers and duties of local authority; and Providing an effective date.

15. SB 45 - Administrative Subpoenas Act, 1989

An act relating to criminal law; providing the Attorney General and County Attorneys authority in issuing administrative subpoenas in controlled substances investigations.

16. SB 7 - Reporting of AIDS and HIV Positivity, 1989

An act relating to acquired immunodeficiency syndrome; requiring reporting of AIDS and HIV positivity; and requiring partner notification.

17. HB 87 - Brewery Licensee Amendments, 1990

An act relating to alcoholic beverages; making technical changes regarding breweries that allow consumption of beer on their premises; and providing an effective date.

18. HB 109 - Amendments to Controlled Substances Act, 1990

An act relating to controlled substances; adding substances that are in Federal Law to the Controlled Substances Act.

19. HB 119 - Licensure of Youth Services Programs, 1990

An act relating to social service licensing; providing for licensure of nonresidential youth programs designed to provide behavioral, substance abuse, or mental health services; and providing an effective date.

20. SB 4 - DUI Penalty Amendment, 1990

An act relating to criminal law; amending provisions of the DUI law regarding the fine and penalty for repeat offenses and the period of time applied to calculate repeat offenses; and expanding City prosecutor authority.

21. HB 101 - Utah Substance Abuse Council, 1990

An act relating to State affairs; creating the Utah Substance Abuse Coordinating Council and subcommittees to coordinate State efforts to curb substance abuse; and providing an effective date.

22. SB 141 - Alcoholic Beverage Laws Revisions, 1990

An act relating to alcoholic beverages; completely revising the alcoholic beverage control laws of Utah; appropriating \$300,000 from the general fund for liquor law implementation and enforcement; and providing an effective date.

23. HB 23 - Liability Protection for Volunteers, 1990

An act relating to liability; defining liability limits for volunteers and the organizations that they serve.

24. HB 388 - Private Probation Provider Licensing Act, 1990

An act relating to occupations and professions; establishing the private probation provider licensing act; providing definitions, board duties and responsibilities, licensing responsibilities, and private probation provider qualifications, duties, and responsibilities; and providing penalties.

25. SB 74 - DUI Technical Amendments, 1991.

An act relating to criminal law; making amendments to clarify sentencing provisions of DUI law.

26. HB 23 - Human Services Licensing Amendments, 1991.

An act relating to the Department of Human Services; providing for the licensing of Human Services programs and facilities; providing definitions; clarifying the responsibilities of the Human Services Licensing Committee and Office of Licensing; and making technical amendments.

27. HB 436 - Trial Court Organization and Jurisdiction, 1991.

An act relating to the judicial code; consolidating District and Circuit Courts; phasing out all Circuit Courts; granting exclusive jurisdiction to Justice Courts over Class C misdemeanors, traffic violations, infractions, and ordinance violations; amending court fees and surcharges; repealing separate fees and consolidating fees into the victim reparation surcharge and increasing the surcharge proportionately; providing for a split in Circuit Court fines between State and Local government; increasing authority of City Prosecutors; authorizing Judicial Council to recommend reallocation of judgeships when a vacancy occurs; providing a limited retirement option; defining the role of magistrates; clarifying the the organization and staffing of courts; raising Small Claims and Circuit Court jurisdiction amounts; and providing an effective date.

CHAPTER 6

CONFIDENTIALITY

CHAPTER SIX

CONFIDENTIALITY 42 CFR PART 2

Confidentiality regulations are more stringent for substance abuse treatment than any other type of treatment services. This fact causes frequent conflicts between law enforcement and the judiciary on one hand and substance abuse treatment personnel on the other. But 42 CFR Part 2 (the regs) is very clear on the does and don'ts of information-sharing concerning substance abusers in treatment.

There are perhaps two major contributors to the seeming allusiveness of these regulations. First, most confidentiality guidelines are laws passed by Congress or Legislatures and are passed down statutorily. The net result is that judges and attorneys read them in books, participate in revising them, read legislative summaries concerning them, and try cases involving them. They are aware of them and well versed in them. But the regs are passed down through grants and contracts and so remain invisible unless we run headon into them. You'll never find them in a law book but they have the force of law. Further, since much of confidentiality is state statutes, judges and attorneys promulgate and defend their content. The regs have no such people assigned as their champions but, being federal law, they generally override state law when the two conflict.

The second contributor is simply the fact that these regulations are not well known. Well informed legal professionals often know little about the regs unless they have personally had experience with them in their own practice. So, when they hear "confidentiality" they understandably lump it all into the statutes with which they are familiar. As the foregoing demonstrates, lumping 42 CFR Part 2 with other

confidentiality law grossly distorts its impact and intent.

The general rule prohibiting disclosure under these regs states that any agency receiving federal funds directly or indirectly may not disclose any information concerning a substance abuse client including the fact that they are a substance abuser. This is so even if the request is made by someone who:

1. already has the information
2. has other means of obtaining it
3. has official status
4. has a subpoena or warrant
5. is authorized by state law

Law enforcement officers, attorneys and judges are not used to meeting the formidable obstacle in getting information as this general rule presents. That experience can be exasperating for the inquirer and frustrating for the withholder. Not uncommonly, the treatment person or agency withholding the information is viewed as uncooperative. They are not; their hands are tied.

The regs, however, list ten ways to untie those hands so information can be legally passed. Exceptions to the general rule are:

1. SIGNED CONSENT FORM WITH PROPER FORMAT. Six specific conditions must be met in the release of information. A sample on the following page identifies those conditions.
2. INTERNAL PROGRAM COMMUNICATIONS. One counselor in an agency may discuss a client with another counselor of the same agency.
3. COMMUNICATIONS WHICH DO NOT DISCLOSE PATIENT-IDENTIFYING INFORMATION. A counselor in one agency may seek consultation from a counselor in another agency concerning a certain client's circumstances as long as the first counselor does not give information which would identify that client.
4. MEDICAL EMERGENCIES. A client may be identified if that client is suffering what appears to be a medical crisis and identification will assist in giving appropriate treatment.
5. COURT-ORDERED DISCLOSURES FOLLOWING A SPECIAL

HEARING. The specific issue addressed in this hearing is "the good of the client vs. the good of THE PUBLIC". In the absence of more definition, a rough rule of thumb for the treatment agency might be that one of their staff will be called to testify if the good of the client is part of the consideration.

6. CLIENT CRIMES ON PROGRAM PREMISES. A client may be identified in order to stop or rectify a crime committed by that client on the premises of the treatment agency.
7. RESEARCH, AUDIT OR EVALUATION. Authorized agents of research, funding or licensing organizations may collect data which may have client-identifying information such as social security numbers. Such agents, however, are held to the regs and no information made public may contain client-identifying information.
8. CHILD ABUSE AND NEGLECT REPORTING. Substance abuse treatment personnel must report such cases in compliance with federal reporting laws. 42 CFR Part 2 does not protect the client under these circumstances.
9. QUALIFIED SERVICE ORGANIZATION AGREEMENT (QSOA). These are agreements between agencies which allow them to share client-identifying information. Many restrictions apply, however. For example, such an agreement can only be signed with an agency which performs a service for the first agency for a form of compensation. This appears to create the awkward situation where a treatment agency may sign a QSOA with a collection agency but not with another treatment agency or law enforcement agency with which they work closely.
10. HOT PURSUIT. This is not clearly defined but if a police officer were to run into a treatment facility on the heels of a client with gun or nightstick drawn, it may not be wise to scream, "Remember 42 CFR Part 2!" On the other hand, if an officer walks in and wants to "look around" for someone or "check things out" allowing him to do so would probably be a breach.

This discussion is a common sense approach to staying within the parameters of the regs while not being a technocrat. Actual interpretation of the law is the work of judges and attorneys and, in fact, quite an amount of that has gone on resulting in some rather complex and ethereal situations. The Legal Action Center publishes an excellent book guiding one through all the intricacies of compliance. Readers wanting more information may acquire it by writing to them at 153 Waverly place, New York, N.Y., 10014. For you real diehards, a copy of 42 CFR Part 2, June, 1987 follow this synopsis.

**Tuesday
June 9, 1987**

PLEASE NOTE** JUDITH T. GALLOWAY
RM. 12C-26 (301) 443-4640
CORRECT NUMBER
ERRATA SHEET TO COVER PRINTING ERRORS
WILL BE AVAILABLE

Part II

Department of Health and Human Services

Public Health Service

42 CFR Part 2

Confidentiality of Alcohol and Drug Abuse Patient Records; Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Public Health Service

42 CFR Part 2

Confidentiality of Alcohol and Drug Abuse Patient Records

AGENCY: Alcohol, Drug Abuse, and Mental Health Administration, PHS, HHS.

ACTION: Final rule.

SUMMARY: This rule makes editorial and substantive changes in the "Confidentiality of Alcohol and Drug Abuse Patient Records" regulations. These changes are an outgrowth of the Department's commitment to make its regulations more understandable and less burdensome. The Final Rule clarifies and shortens the regulations and eases the burden of compliance.

EFFECTIVE DATE: August 10, 1987.

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SUPPLEMENTARY INFORMATION: The "Confidentiality of Alcohol and Drug Abuse Patient Records" regulations, 42 CFR Part 2, implement two Federal statutory provisions applicable to alcohol abuse patient records (42 U.S.C. 290dd-3) and drug abuse patient records (42 U.S.C. 290ee-3).

The regulations were originally promulgated in 1975 (40 FR 27802). In 1980 the Department invited public comment on 15 substantive issues arising out of its experience interpreting and implementing the regulations (45 FR 53). More than 450 public responses to that invitation were received and taken into consideration in the preparation of a 1983 Notice of Proposed Rulemaking (48 FR 38758). Approximately 150 comments were received in response to the Notice of Proposed Rulemaking and were taken into consideration in the preparation of this Final Rule.

The proposed rule made both editorial and substantive changes in the regulations and shortened them by half. This Final Rule adopts most of those changes, with some significant substantive modifications and relatively few editorial and clarifying alterations.

Synopsis of Substantive Provisions

The Confidentiality of Alcohol and Drug Abuse Patient Record regulations (42 CFR Part 2) cover any program that is specialized to the extent that it holds itself out as providing and provides alcohol or drug abuse diagnosis, treatment, or referral for treatment and which is federally assisted, directly or indirectly (§ 2.12 (a) and (b)).

The regulations prohibit disclosure or use of patient records ("records" meaning any information whether recorded or not) unless permitted by the regulations (§ 2.13). They do not prohibit giving a patient access to his or her own records (§ 2.23). However, the regulations alone do not compel disclosure in any case (§ 2.3(b)).

The prohibition on disclosure applies to information obtained by the program which would identify a patient as an alcohol or drug abuser (§ 2.12(a)(1)). The restriction on use of information to investigate or to bring criminal charges against a patient applies to any alcohol or drug abuse information obtained by the program (§ 2.12(a)(2)).

Any disclosure permitted under the regulations must be limited to that information which is necessary to carry out the purpose of the disclosure (§ 2.13).

The regulations permit disclosure of information if the patient consents in writing in accordance with § 2.31. Any information disclosed with the patient's consent must be accompanied by a statement which prohibits further disclosure unless the consent expressly permits further disclosures or the redisclosure is otherwise permitted by the regulations (§ 2.32). Special rules govern disclosures with the patient's consent for the purpose of preventing multiple enrollments (§ 2.34) and for criminal justice referrals (§ 2.35).

The regulations permit disclosure without patient consent if the disclosure is to medical personnel to meet any individual's bona fide medical emergency (§ 2.51) or to qualified personnel for research (§ 2.52), audit, or program evaluation (§ 2.53). Qualified personnel may not include patient identifying information in any report or otherwise disclose patient identities except back to the program which was the source of the information (§§ 2.52(b) and 2.53(d)).

The regulations permit disclosure pursuant to a court order after the court has made a finding that "good cause" exists. A court order may authorize disclosure for noncriminal purposes (§ 2.64); for the purpose of investigating or prosecuting a patient if the crime involved is extremely serious (§ 2.65); for the purpose of investigating or prosecuting a program or a person holding the records (§ 2.66); and for the purpose of placing an undercover agent or informant to criminally investigate employees or agents of the program (§ 2.67).

A court order may not authorize disclosure of confidential communications unless disclosure is necessary to protect against an existing

threat to life or serious bodily injury of another person; to investigate or prosecute an extremely serious crime; or if the patient brings the matter up in any legal proceedings (§ 2.63).

A court order may not authorize qualified personnel who received information without patient consent for the purpose of conducting research, audit, or program evaluation, to disclose that information or to use it to conduct any criminal investigation or prosecution of a patient (§ 2.62). Information obtained under a court order to investigate or prosecute a program or other person holding the records or to place an undercover agent or informant may not be used to conduct any investigation or prosecution of a patient or as the basis for a court order to criminally investigate or prosecute a patient (§ 2.66(d)(2) and § 2.67(e)).

These regulations do not apply to the Veteran's Administration, to exchanges within the Armed Forces or between the Armed Forces and the Veterans' Administration; to the reporting under State law of incidents of suspected child abuse and neglect to appropriate State or local authorities; to communications within a program or between a program and an entity having direct administrative control over the program; to communications between a program and a qualified service organization; and to disclosures to law enforcement officers concerning a patient's commission of (or threat to commit) a crime at the program or against personnel of the program (§ 2.12(c)).

If a person is not now and never has been a patient, there is no patient record and the regulations do not apply (§ 2.13(c)(2)).

Any answer to a request for a disclosure of patient records which is not permitted must not affirmatively reveal that an identified individual has been or is an alcohol or drug patient. One way to make such an answer is to give a copy of the confidentiality regulations to the person who asked for the information along with general advice that the regulations restrict the disclosure of alcohol or drug abuse patient records and without identifying any person as an alcohol or drug abuse patient (§ 2.13(c)).

Each patient must be told about these confidentiality provisions and furnished a summary in writing (§ 2.22).

There is a criminal penalty for violating the regulations: not more than \$500 for a first offense and not more than \$5,000 for each subsequent offense (§ 2.4).

COMPARISON WITH PROPOSED RULE

Subpart A—Introduction

Reports of Violations

Both the existing and proposed rules provide for the reporting of any violations of the regulations to the United States Attorney for the judicial district in which the violations occur, for reporting of violations on the part of methadone programs to the Regional Offices of the Food and Drug Administration, and for reporting violations by a Federal grantee or contractor to the Federal agency monitoring the grant or contract. (See §§ 2.7 and 2.5, respectively.)

Inasmuch as it is the Department of Justice which has ultimate and sole responsibility for prosecuting violations of these regulations, the Final Rule continues to provide for the reference of reports of any violations to the United States Attorney for the judicial district in which the violations occur.

It also continues to provide for the reference to the Regional Offices of the Food and Drug Administration of any reports of violations by a methadone program. As a regulatory agency, the Food and Drug Administration has both the organization and authority to respond to alleged violations.

The Final Rule no longer directs reports of violations by a Federal grantee or contractor to the Federal agency monitoring the grant or contract or, as in the proposed revision of the rules, violations by a Federal agency to the Federal agency responsible for the program. This change is made in recognition of the lack of investigative tools available to granting and contracting agencies and of the ultimate referral which must be made to the Department of Justice. Of course, if alleged violations come to the attention of the Department of Health and Human Services, they will be forwarded to an appropriate representative of the Department of Justice.

Subpart B—General Provisions

Specialized Programs

Like the proposed rule at § 2.12, the Final Rule is applicable to any alcohol and drug abuse information obtained by a federally assisted alcohol or drug abuse program. "Program" is defined in § 2.11 as a person which says it provides and which actually provides alcohol or drug abuse diagnosis, treatment, or referral for treatment. A program may provide other services in addition to alcohol and drug abuse services, for example mental health or psychiatric services, and nevertheless be an alcohol

or drug abuse program within the meaning of these regulations so long as the entity is specialized by holding itself out to the community as providing diagnosis, treatment, or referral for treatment for alcohol and/or drug abuse.

If a facility is a provider of general medical care, it will not be viewed in whole or in part as a program unless it has either (1) an identified unit, i.e., a location that is set aside for the provision of alcohol or drug abuse diagnosis, treatment, or referral for treatment, or (2) it has personnel who are identified as providers of diagnosis, treatment, or referral for treatment and whose primary function is the provision of those alcohol or drug abuse services.

Regardless of whether an entire legal entity is a program or if a part of the entity is a program, the confidentiality protections cover alcohol or drug abuse patient records within any federally assisted program, as "program" is defined in these regulations.

Those comments opposed to limiting applicability of the regulations to "specialized" programs focused on the desirability of full and uniform applicability of confidentiality standards to any alcohol or drug abuse patient record irrespective of the type of facility delivering the services.

The Department takes the position that limiting applicability to specialized programs, i.e., to those programs that hold themselves out as providing and which actually provide alcohol or drug abuse diagnosis, treatment, and referral for treatment, will simplify administration of the regulations without significantly affecting the incentive to seek treatment provided by the confidentiality protections.

Applicability to specialized programs will lessen the adverse economic impact of the current regulations on a substantial number of facilities which provide alcohol and drug abuse care only as an incident to the provision of general medical care. We do not foresee that elimination of hospital emergency rooms and general medical or surgical wards from coverage will act as a significant deterrent to patients seeking assistance for alcohol and drug abuse.

While some commenters suggested that there will be an increased administrative burden for organizations operating both a specialized alcohol and/or drug abuse program and providing other health services, we view this as the same burden facing all general medical care facilities under the existing rule.

In many instances it is questionable whether applicability to general medical care facilities addresses the intent of

Congress to enhance treatment incentives for alcohol and drug abuse inasmuch as many alcohol and/or drug abuse patients are treated in a general medical care facility not because they have made a decision to seek alcohol and drug abuse treatment but because they have suffered a trauma or have an acute condition with a primary diagnosis of other than alcohol or drug abuse.

In sum, we are not persuaded that the existing burden on general medical care facilities is warranted by the benefit to patients in that setting. Therefore, the Final Rule retains the language of the proposed rule at § 2.11 defining "program" and making the regulations applicable at § 2.12 to any information about alcohol and/or drug abuse patients which is obtained by a federally assisted alcohol or drug abuse program for the purpose of treating, making a diagnosis for treatment, or making a referral for treatment of alcohol or drug abuse.

Communications between a Program and an Entity Having Direct Administrative Control

The existing regulations at § 2.11(p)(1) and the proposed rule at § 2.12(c)(3) exempt from the restrictions on disclosure communications of information within a program between or among personnel in connection with their duties or in connection with provision of patient care, respectively. The Department has previously interpreted the existing provision to mean that communications within a program may include communications to an administrative entity having direct control over the program.

The Final Rule has incorporated that legal opinion into the text by amending § 2.12(C)(3) to exempt from restrictions on disclosure "communications of information between or among personnel having a need for the information in connection with their duties that arise out of the provision of diagnosis treatment, or referral for treatment of alcohol or drug abuse" if the communications are within a program or between a program and an entity that has direct administrative control over the program. Paragraph (d) of that same section is accordingly amended to restrict any further disclosure by an administrative entity which receives information under § 2.12(c)(3).

Explanation of Applicability

The existing regulations are applicable to patient records maintained in connection with the performance of

any alcohol abuse or drug abuse prevention function which is federally assisted. Applicability is determined by the nature and purpose of the records, not the status or primary functional capacity of the recordkeeper. The definition of "alcohol abuse or drug abuse prevention function" includes specified activities "even when performed by an organization whose primary mission is in the field of law enforcement or is unrelated to alcohol or drugs."

The proposed regulations and the Final Rule at § 2.12 make the regulations applicable to any information about alcohol and drug abuse patients which is obtained by a federally assisted alcohol or drug abuse program. A program is defined to be those persons or legal entities which hold themselves out as providing and which actually provide diagnosis, treatment, or referral for treatment for alcohol and/or drug abuse. Thus, there is a fundamental shift toward determining applicability on the basis of the function of the recordkeeper and away from making that decision based solely on the nature and purpose of the records.

No alcohol and drug abuse patient records, whether identified by the nature and purpose of the records or the function of the recordkeeper, are covered by these regulations unless the diagnosis, treatment, or referral for treatment with which the records are connected is federally assisted.

Several commenters pointed out that while the regulatory language of the proposed rule on its face applies the rule to information about alcohol and drug abuse patients in federally assisted programs, the explanation of the applicability provision at § 2.12(e)(2) obscures the otherwise forthright statement by an additional standard based on the type of Federal assistance going to the program, i.e., some patient records in a federally assisted program would be covered and others would not. Those who commented on this section urged that coverage distinctions under the explanation in § 2.12(e)(2) be omitted because they result in disparate treatment of patient records within an alcohol and/or drug abuse program based on the type of Federal assistance going to the program. Other commenters asserted that basing coverage on the type of assistance is inconsistent with the clear meaning of the applicability provision in the proposed and Final Rule.

The Final Rule revises the proposed explanatory material at § 2.12(e)(2) to show that all alcohol and drug abuse patient records within a covered program are protected by the

confidentiality provisions and that the record of an individual patient in an uncovered program, whose cure is federally supported in some way which does not constitute Federal assistance to the program under § 2.12(b), is not afforded confidentiality protections. Thus, where a Federal payment is made to a program on behalf of an individual patient and that program is not otherwise federally assisted under § 2.12(b), the record of that individual will not be covered by the regulations. Although the Department expects them to be rare, it would be possible for such instances to occur. For example, if a Federal court places an individual in a for-profit program that is not certified under the Medicare program, that is not authorized to conduct methadone treatment, and is not otherwise federally assisted in any manner provided in § 2.12(b), the patient record of that individual would not be covered by the regulations even though the Federal court paid for the individual's treatment.

Comments to the proposed rule were persuasive that the type of assistance should not affect the scope of records covered within a covered program. When the determination of covered records was based on the purpose and nature of each record, it was consistent to view Federal assistance from the perspective of each individual record. However, when the determination of which records are covered is based on who is keeping the records, as in the proposed and Final Rule, it is consistent with the approach to view Federal assistance from the program level as applying to all alcohol and drug abuse patient records within the program.

Determining coverage based on Federal assistance to the program rather than to an individual represents a change in policy from the current regulations under which the Department views a Federal payment made on behalf of an individual as sufficient to cover that individual's record. However, any disadvantage in not covering individual records in those rare cases which may occur is outweighed by the advantages of consistency and efficiency in management of the program as a result of all alcohol and drug abuse patient records in the program being subject to the same confidentiality provisions.

The Final Rule includes new material at § 2.12(e)(3) which briefly explains the types of information to which the restrictions are applicable, depending on whether a restriction is on disclosure or on use. A restriction on disclosure applies to any information which would identify a patient as an alcohol or drug abuser. The restriction on use of

information to bring criminal charges or investigate a patient for a crime applies to any information obtained by the program for the purpose of diagnosis, treatment, or referral for treatment of alcohol or drug abuse.

Several commenters strongly urged the explicit inclusion of school-based education and prevention programs in the applicability of the regulations. School-based education and prevention activities may fall within the definition of a program if they provide alcohol or drug abuse diagnosis, treatment, or referral for treatment and if they hold themselves out as so doing. That is reflected in the Final Rule at § 2.12(e)(1) with the inclusion of "school-based programs" in the list of entities which may come under the regulations.

An example of how diagnosis affects coverage has been omitted at § 2.12(e)(3)(ii). It is omitted not because the example could never occur under the Final Rule, but because it is very unlikely that a "specialized" program, as program is defined under these regulations, would be treating a patient for a condition which is not related to alcohol or drug abuse such that the reference to a patient's alcohol or drug abuse history would not be related to the condition for which treatment is rendered. Inasmuch as the regulations only apply to programs, this example is more likely to confuse than provide guidance and for that reason has been taken out.

Notifying a Parent or Guardian of a Minor's Application for Treatment

The proposed rule at § 2.14 reorganized and revised but did not substantively amend the existing § 2.15 dealing with the subject of minor patients. Under both the existing and proposed rules, a minor patient's consent is generally required prior to notifying the minor's parent or guardian of his or her application for treatment. This is true even though without notification it is impossible to obtain parental consent in those cases where State law requires a parent, guardian, or other person to consent to alcohol or drug abuse treatment of a minor.

While this issue was not raised in the proposed rule, the Department has received several inquiries on it from the public since the proposed rule was published suggesting that in those States, where the parent's or guardian's consent is needed for the minor's treatment, the program should be free to notify the parent or guardian of the minor's application for treatment without constraint. The Department has considered this issue and decided to

make no substantive changes in the existing section dealing with minor patients.

Although both the current rule and the proposed rule generally prohibit parental notification without the minor's consent, they also provide for an exception. Under this exception such notification would be permitted when, in the program director's judgment, the minor lacks the capacity to make a rational decision on the issue of notification, the situation poses a substantial threat to the physical well-being of the minor or any other person, and this threat may be alleviated by notifying the parent or guardian. Under this provision, the program director is vested with the authority to determine when the circumstances permitting parental notification arise. In discussing the Department's philosophy behind this provision, § 2.15-1(e) of the existing rule states: "It [this provision] is based upon the theory that where a person is actually as well as legally incapable of acting in his own interest, disclosures to a person who is legally responsible for him may be made to the extent that the best interests of the patient clearly so require."

While this exception would not permit parental notification without constraint whenever the program director feels it is appropriate, the Department believes it does provide the program director with significant discretion and does permit parental notification in the most egregious cases where the "best interests of the patient clearly so require." Accordingly, the Department has determined not to make any substantive changes in the manner in which the existing rule handles the issue of parental notification. However, proposed § 2.14 has been revised to clarify that no change in meaning is intended from the current rule.

Finally, it should be noted that this rule in no way compels a program to provide services to a minor without parental consent.

Separation of Clinical from Financial/Administrative Records

The current rules governing research, audit, or evaluation functions by a governmental agency at § 2.53 state that "programs should organize their records so that financial and administrative matters can be reviewed without disclosing clinical information and without disclosing patient identifying information except where necessary for audit verification." The proposed rule transformed this hortatory provision for maintenance of financial/administrative records apart from clinical records into

a requirement in § 2.16 dealing with security for written records.

Several commenters predicted that such a requirement will pose an extremely cumbersome burden on programs, perhaps tantamount to requiring maintenance of two systems of files. The Final Rule has adopted the recommendation of those commenters to drop this requirement, primarily on the basis of the potential administrative and recordkeeping problems it poses in the varied treatment settings to which these regulations are applicable.

While it is desirable to withhold clinical information from any research, audit, or program evaluation function for which that clinical information is not absolutely essential, the Final Rule does not require recordkeeping practices designed to guarantee that outcome. The Final Rule does, of course, implement the statutory provisions which prohibits those who receive patient identifying information for the purpose of research, audits, or program evaluation from identifying, directly or indirectly, any individual patient in any report of such research, audit, or evaluation or otherwise disclosing patient identities in any manner (see §§ 2.52(b) and 2.53(d)).

Subpart C—Disclosures with Patient's Consent

Notice to Patients

Like the proposed rule, the Final Rule at § 2.22 requires that notice be given to patients that Federal law and regulations protect the confidentiality of alcohol and drug abuse patient records. The response to this provision in the proposed rule reflects strong support for notifying patients of confidentiality protections, although many stressed that the notice should be simplified in order to be useful rather than confusing to the patient. Some of those who recommended against adoption of a notice provision did so on grounds that the notice as proposed is too complex. Therefore, in response to many who supported the notice provision and those who opposed it on grounds that it is too complex, the Final Rule substantially revises the elements which must be included in the written notice to each patient and accordingly rewrites the sample notice which a program may adopt at its option in fulfillment of the notice requirement.

Form of Written Consent

The proposed rule retains the requirements in § 2.31 of the existing regulations for written consent to disclosure of information which would identify an individual as an alcohol or drug abuser. There was a great deal of

support among those who commented on this provision for the retention of the existing elements of written consent on grounds that the present system is working well and that the elements which go to make up written consent are sufficiently detailed to assure an opportunity for a patient to make an informed consent to disclose patient identifying information. Others recommended a more generalized consent form.

The Final Rule retains all elements previously required for written consent, though in one instance it will permit a more general description of the required information. The first of the required elements of written consent in both the existing and proposed rule (§ 2.31 (a)(1)) asks for the name of the program which is to make the disclosure. The Final Rule will amend that element by calling for "(1) The specific name or general designation of the program or person permitted to make the disclosure." This change will permit a patient to consent to disclosure from a category of facilities or from a single specified program. For example, a patient who chooses to authorize disclosure of all his or her records without the necessity of completing multiple consent forms or individually designating each program on a single consent form would consent to disclosure from all programs in which the patient has been enrolled as an alcohol or drug abuse patient. Or, a patient might narrow the scope of his or her consent to disclosure by permitting disclosure from all programs located in a specified city, from all programs operated by a named organization, or as now, the patient might limit consent to disclosure from a single named facility. (In this connection, the Department interprets the existing written consent requirements to permit consent to disclosure of information from many programs in one consent form by listing specifically each of those programs on the form.)

This change generalizes the consent form with respect to only one element without diminishing the potential for a patient's making an informed consent to disclose patient identifying information. The patient is in position to be informed of any programs in which he or she was previously enrolled and from which he or she is willing to have information disclosed.

With regard to deficient written consents, the Final Rule at § 2.31(c) reverts to language from the existing regulations rather than using the language of the proposed rule to express the idea that a disclosure may not be made on the basis of a written consent

which does not contain all required elements in compliance with paragraph (a) of § 2.31. There was no intention in drafting the proposed rule to establish a different or more stringent standard than currently exists prohibiting disclosures without a conforming written consent. Because that was misunderstood by some, the Final Rule will not permit disclosures on the basis of a written consent which, "On its face substantially fails to conform to any of the requirements set forth in paragraph (a) of this section..."

Express Consent to Redisclosure Permitted

Both the existing and proposed rules at § 2.32 prohibit redisclosure by a person who receives information from patient records pursuant to the written consent of the patient and who has been notified that the information is protected by Federal rules precluding redisclosure except as permitted by those Federal rules. However, the statement of the prohibition on redisclosure at § 2.32 does not make evident the Department's interpretation that it is possible for a patient, at the same time consent to disclosure is given, to consent to redisclosure in accordance with the Federal rules. The Final Rule rewords the statement of prohibition on redisclosure and adds the phrase shown in quotes below to the second sentence as follows:

The Federal rules prohibit you from making any further disclosure of this information "unless further disclosure is expressly permitted by the" written consent of the person to whom it pertains or is otherwise permitted by 42 CFR Part 2.

The purpose of the added phrase is to acknowledge that redisclosure of information may be expressly permitted in the patient's written consent to disclosure. For example, a patient may consent to disclose pertinent information to an employment agency and at the same time permit the employment agency to redisclose this information to potential employers, thus making unnecessary additional consent forms for redisclosures to individual employers. Similarly, a patient may consent to disclose pertinent information to an insurance company for the purpose of claiming benefits, and at the same time consent to redisclosure by that insurance company to another organization or company for the purpose of administering the contract under which benefits are claimed by or on behalf of the patient.

Patient Consent to Unrestricted Communications for the Purpose of Criminal Justice System Referrals

Most of those who commented on the revision of § 2.35 generally supported the proposed changes. However, two State commenters encouraged retention of language in the existing regulations which explicitly permits a patient to consent to "unrestricted communications." Otherwise, those commenters say, the revision will act as a deterrent to criminal justice system referrals.

Both the proposed and Final Rule omit most limitations on disclosures to which a patient may consent. The criteria for permitting release of information with patient consent under the Final Rule are: (1) A valid consent under § 2.31 and (2) a determination that the information disclosed is necessary to carry out the purpose for which the consent was given (§ 2.13(a)). Although special rules for disclosures in connection with criminal justice system referrals were retained, they do not restrict "how much and what kind of information" a patient may consent to have disclosed under § 2.31. Section 2.31(a)(5) places no restrictions on how much or what kind of information a patient may consent to have disclosed. That section simply requires that each written consent describe how much and what kind of information the patient consents to have disclosed. A patient may consent to disclosure of any information concerning his or her participation in a program. In the case of a consent for the purpose of a criminal justice system referral, consent to disclose "any information concerning my participation in the program" pursuant to § 2.31(a)(5) would permit "unrestricted communications" from the program to appropriate persons within the criminal justice system to the same extent permitted by the existing rule. Therefore, the Final Rule does not substantively alter § 2.35 as proposed. (Paragraph (c) has been reworded for clarity.)

Subpart D—Disclosures Without Patient's Consent

Elimination of the Requirement to Verify Medical Personnel Status

The proposed regulations at § 2.51 implement the statutory provision which permits a disclosure "to medical personnel to the extent necessary to meet a bona fide medical emergency." The proposed rule added a requirement not contained in the existing § 2.51 that the program make a reasonable effort to verify that the recipient of the information is indeed medical personnel.

The Final Rule deletes the proposed verification requirement in response to comments from several sources that such a requirement is unnecessary, will cause delay, and could possibly impede emergency treatment. In view of those comments and our interest in easing the burden of compliance where possible, the Final Rule does not require verification of the "medical personnel" status of the recipient of information in the face of a medical emergency.

However, the statute permits disclosures only to medical personnel to meet a medical emergency and elimination of the verification requirement does not in any way expand upon the category of persons to whom a disclosure may be made to meet a medical emergency. Neither does elimination of the verification requirement affect the provision in the Final Rule at § 2.51(c) that a program document in the patient's records any disclosure which is made in the face of a medical emergency.

Assessment of Research Risks

The proposed regulations at § 2.52 modified and streamlined existing provisions in §§ 2.52 and 2.53 governing disclosures for scientific research. The proposal clarified that the determination of whether an individual is qualified to conduct scientific research would be left to the program director, and required that such qualified personnel have a research protocol which includes safeguards for storing patient identifying information and prohibits redisclosures except as allowed by these regulations.

The Final Rule adds an additional condition: The program director must ensure that a written statement is furnished by the researcher that the research protocol has been reviewed by an independent group of three or more individuals who found that the rights of patients would be adequately protected and that the potential benefits of the research outweigh any potential risks to patient confidentiality posed by the disclosure of records.

This revision was prompted by comment from both the public and private sectors that review of the research protocol for the purpose of ensuring the protection of human subjects participating in the research (in this case, the patients whose records are proposed for use in research) is imperative prior to permitting disclosure of patient identifying information for the conduct of scientific research. The requirement that researchers state in writing that the protocol has been reviewed for the protection of human subjects will provide an additional point

of reference for the program director in determining whether to release patient identifying information for research purposes.

Researchers who receive support from the Department and many other Federal agencies are required under regulations for the protection of human subjects to obtain review of their protocol from an "institutional review board (IRB)." Such boards generally are set up by the institution employing the researcher. Regulations require that IRBs be composed of persons with professional competence to review research, as well as persons who can judge sensitivity to community attitudes and ethical concerns. Documentation of review and approval by an IRB or by another group of at least three individuals, appropriately constituted to make judgements on issues concerning the protection of human subjects, would meet the new requirement in § 2.52(a)(3).

Audit and Evaluation Activities by Nongovernmental Entities

The proposed regulations at § 2.53 simplify and shorten the provisions on audit and evaluation activities and divide them into two categories: (1) Those activities that do not require copying or removal of patient records, and (2) those that require copying or removal of patient records. The proposed rule permits governmental agencies to conduct audit and evaluation activities in both categories. In addition, if no copying or removal of the records is involved, the program director may determine that other persons are "qualified personnel" for the purpose of conducting audit and evaluation activities. There is no provision for nongovernmental entities to perform any audit or evaluation activity if copying or removal of records is involved.

In response to the proposed rule the Department received comment that third party payers should be permitted to copy or remove records containing patient identifying information as is permitted by governmental agencies that finance or regulate alcohol or drug abuse programs.

Recognizing that private organizations, like governmental agencies, have a stake in the financial and programmatic integrity of treatment programs arising out of their financing of alcohol and drug abuse programs directly, out of peer review responsibilities, and as third party payers, the Final Rule permits access to patient identifying information for audit and evaluation activities by private organizations in circumstances identical to the access afforded governmental

agencies. Specifically, if a private organization provides financial assistance to a program, is a third party payer covering patients in the program, or is a peer review organization performing a utilization or quality control review, the Final Rule permits the private organization to have access to patient identifying information for the purpose of participating in audit and evaluation activities to the same extent and under the same conditions as a governmental agency.

Audit and Evaluation of Medicare or Medicaid Programs

In response to specific questions which have come to the Department's attention and in recognition of the continued importance of the integrity of the Medicare and Medicaid programs to the delivery of alcohol and drug abuse services, the Final Rule includes a new paragraph (c) in § 2.53 which clarifies the audit and evaluation provisions as they pertain to Medicare or Medicaid.

Specifically, the new paragraph clarifies that the audit and evaluation function includes investigation for the purpose of administrative enforcement of any remedy imposed by law by any Federal, State, or local agency which has responsibility for oversight of the Medicare or Medicaid programs. The new paragraph makes explicit that the term "program" includes employees of or providers of medical services under an alcohol or drug abuse program. Finally, it clarifies that a peer review organization may communicate patient identifying information for the purpose of a Medicare or Medicaid audit or evaluation to the agency responsible for oversight of the Medicare or Medicaid program being evaluated or audited.

Subpart E—Court Orders Authorizing Disclosure and Use

Court-Ordered Disclosure of Confidential Communications

The existing regulations at § 2.63 limit a court order to "objective" data and prohibit court-ordered disclosure of "communications by a patient to personnel of the program." The proposed regulations delete the provision restricting a court order to objective data and precluding an order from reaching "communications by a patient to personnel of the program." Deletion of that provision provoked considerable discussion and concern on the part of a large number of persons, 85% of whom opposed allowing court-ordered disclosure of nonobjective data.

The Final Rule at § 2.63 restores protection for many "communications by a patient to personnel of the

program" and information which is of a nonobjective nature, but it does not protect that information from court order in the face of an existing threat to a third party or in connection with an investigation or prosecution of an extremely serious crime.

Because the existing regulations seem to be dealing uniformly with two related but not necessarily identical types of information, i.e., "objective" data and "communications by a patient to personnel of the program," the Final Rule drops those terms in favor of the term "confidential communications," a term in use since 1975 in existing § 2.63-1. "Confidential communications" are the essence of those matters to be afforded protection and are as readily identified as "objective" data. Furthermore, protection of "confidential communications" is more relevant to maintaining patient trust in a program than is protection of "communications by a patient to personnel of the program," a term which does not distinguish between the innocuous and the highly sensitive communication.

Most comments in opposition to relaxing the court order limitations on confidential communications said that the potential for court-ordered disclosure of confidential communications will compromise the therapeutic environment, may deter some alcohol and drug abusers from entering treatment, and will yield information which may be readily misinterpreted or abused.

While freedom to be absolutely candid in communicating with an alcohol or drug abuse program may have therapeutic benefits and may be an incentive to treatment, it is the position of the Department that those therapeutic benefits cannot take precedence over two circumstances which merit court-ordered disclosure of confidential communications.

The first of these is a circumstance in which the patient poses a threat to any third party. Existing rules do not permit a court to authorize disclosure of any communication by a patient to a program; for example, that the patient is abusing a child or has expressed an intention to kill or seriously harm another person. The balance between patient confidentiality and an existing threat posed by the patient to life or of serious bodily injury to another person must be weighted in favor of permitting a court to order disclosure of confidential communications which are necessary to protect against such an existing threat.

The second of these circumstances is one in which a patient's confidential

communications to a program are necessary in connection with investigation or prosecution of an extremely serious crime, such as a crime which directly threatens loss of life or serious bodily injury. The Department takes the position that it is consistent with the intent of Congress and in the best interest of the Nation to permit the exercise of discretion by a court, within the context of the confidentiality law and regulations, to determine whether to authorize disclosure or use of confidential communications from a patient's treatment record in connection with such an investigation or prosecution.

Our aim is to strike a balance between absolute confidentiality for "confidential communications" on one side and on the other, to protect against any existing threat to life or serious bodily harm to others and to bring to justice those being investigated or prosecuted for an extremely serious crime who may have inflicted such harm in the past. While many confidential communications will remain beyond the reach of a court order, revised § 2.63 of the Final Rule will permit a court to authorize disclosure of confidential communications if the disclosure is necessary to protect against an existing threat to life or serious bodily injury. If disclosure is necessary in connection with investigation or prosecution of an extremely serious crime, or, as in the existing rule, if disclosure is in connection with a legal proceeding in which the patient himself/herself offers testimony or evidence concerning the confidential communications.

Open Hearing on Patient Request In Connection with a Court Order

Courts authorizing disclosure for noncriminal purposes are required at § 2.64(c) of the Final Rule to conduct any oral argument, review of evidence, or hearing in the judge's chambers or in some manner that ensures patient identifying information is not disclosed to anyone who is not a party to the proceeding, to a party holding the record, or to the patient. The existing rules provide that a patient may request an open hearing. The proposed rule did not provide for the patient to request an open hearing.

The existing and proposed rule provides that a patient may consent to use of his or her name rather than a fictitious name in any application for an order authorizing disclosure for noncriminal purposes. The existing rule requires "voluntary and intelligent" consent. The proposed rule ensures the quality of the consent by requiring that

it be in writing and in compliance with § 2.31.

Upon reconsideration, the Department has reinstated the provision permitting a patient to consent to an open hearing in a noncriminal proceeding but with the same formality as is required by the proposed rule for a consent by the patient to use his or her name in an application for an order. Therefore, the Final Rule at § 2.64(c) requires that any hearing be held in such a way as to maintain the patient's confidentiality "unless the patient requests an open hearing in a manner which meets the written consent requirements of these regulations."

Content of Court Order—Sealing of Record as an Example

The content of a court order authorizing disclosure for noncriminal purposes and any order for disclosure and use to investigate or prosecute a program or the person holding the records is limited at § 2.64(e) to essential information and limits disclosure to those persons who have a need for the information. In addition, the court is required to take such other measures as are necessary to limit disclosure to protect the patient, the physician-patient relationship, and the treatment services. We have included at § 2.64(e)(3) an example of one such measure which may be necessary: sealing the record of any proceeding for which disclosure of a patient's records has been ordered. It is the Department's experience that heightened awareness of this possibility by members of the treatment community and legal profession can limit dissemination of patient identifying information to those for whom the court determined "good cause" exists without turning all or a part of a patient's treatment record into public information. The Final Rule adds as an example of a measure which the court might take to protect the patient, the physician-patient relationship and the treatment service "sealing from public scrutiny the record of any proceeding for which disclosure of a patient's record has been ordered." A similar change has also been made in § 2.67(d)(4).

Extremely Serious Crime as a Criterion for a Court Order to Investigate or Prosecute a Patient

The proposed rule at § 2.64 purported to retain the existing standard with regard to court orders which may be issued for the purpose of investigating or prosecuting a patient; i.e., the standard that no court order may authorize disclosure and use of patient records for investigation or prosecution of

nonserious crimes. In an effort to clarify the nature of those crimes for which a court may order disclosure and use of patient records to investigate or prosecute the patient, the proposed rule dropped the term "extremely serious" crime in favor of a more specific functional definition of a crime which "causes or directly threatens loss of life or serious bodily injury." While the proposed rule purported to retain the existing standard, comments received from law enforcement agencies have contested that outcome, asserting that the criterion as proposed would be significantly narrowed. Arguing in favor of a broader standard, law enforcement interests advocated a more flexible criterion which would permit courts to weigh relevant factors on a case-by-case basis.

Inasmuch as the change in the proposed rule was intended to clarify—not to further limit—those crimes for which a court may authorize use of a patient's record to investigate or prosecute the patient, the Final Rule reinstates the existing language, "extremely serious." This broader criterion will permit more flexibility and discretion by the courts in deciding whether a crime is of a caliber which merits use of a patient's treatment record to investigate or prosecute the patient.

The Final Rule names as examples of "extremely serious" crimes homicide, rape, kidnapping, armed robbery, assault with a deadly weapon, and child abuse and neglect. Deleted from the list of proposed examples is "sale of illicit drugs."

Based on the view that most patients in drug abuse treatment are vulnerable to a charge of sale of illicit drugs, many commenters asked that "sale of illicit drugs" not be categorically named as an extremely serious crime. To do so, they asserted, would make almost all patients in drug rehabilitation or treatment programs vulnerable to investigation or prosecution by means of court-ordered use of their own treatment records.

While the Final Rule eliminates "sale of illicit drugs" as an example of an extremely serious crime, it does not alter the authority of a court to find that under appropriate circumstances sale of an illicit drug is, in fact, an extremely serious crime, and it reflects a decision to leave any such determination up to a court of competent jurisdiction which is called upon to order the use of a patient's treatment records to prosecute the patient in view of any circumstances known to the court.

New Law To Permit Reporting of Child Abuse and Neglect

Section 106 of Pub. L. 99-401, the Children's Justice and Assistance Act of 1986, amends sections 523(e) and 527(e) of the Public Health Service Act (42 U.S.C. 290dd-3(e) and 42 U.S.C. 290ee-3(e)) to permit the reporting of suspected child abuse and neglect to appropriate State or local authorities in accordance with State law. The amended sections of the Public Health Service Act provide:

The prohibitions of this section do not apply to the reporting under State law of incidents of suspected child abuse and neglect to the appropriate State or local authorities.

This newly enacted statutory exception to the restrictions on disclosure of information which would identify an alcohol or drug abuse patient provides a straightforward avenue for making reports of incidents of suspected child abuse and neglect in accordance with State law without resort to devices explained in the preamble to the proposed rule, i.e., obtaining a court order, reporting without identifying the patient as an alcohol or drug abuser, getting the patient's written consent, entering into a qualified service organization agreement, or reporting a medical emergency to medical personnel. While the potential still exists for using the devices described in the proposed rule, there is no foreseeable reason to use them to report suspected child abuse and neglect in view of the amendment.

Although the new law excepts reports of suspected child abuse and neglect from the statutory restrictions on disclosure and use, it does not affect the applicability of the restrictions to the original alcohol and drug abuse patient record maintained by the program. Accordingly, if, following a report of suspected child abuse or neglect, the appropriate State authorities wish to subpoena patient records (or program personnel to testify about patient records) for civil or criminal proceedings relating to the child abuse or neglect, appropriate authorization would be required under the statutes and regulations. While written patient consent would suffice for a civil proceeding, it would be necessary to obtain an authorizing court order under paragraph (b)(2)(C) of the confidentiality statutes and § 2.65 of the regulations for use of the record to criminally investigate or prosecute a patient.

Editorial Changes

The Final Rule makes very few editorial or clarifying changes to the regulations as proposed.

Number, tense, punctuation, and sequential numbering are changed where appropriate. Definitions applicable only to prevention of multiple enrollments in detoxification and maintenance treatment programs are moved from the definitions section to § 2.34. Section 2.35(c) has been rewritten for clarity. A clarifying phrase or word is added to the definition of "patient identifying information" at § 2.11, to § 2.19 (a)(1) and (b)(1) and to § 2.31(a)(8). The phrase "or other" has been added to § 2.53(c) because a court order under § 2.66 may be issued to investigate a program for criminal or administrative purposes. At § 2.65(d)(3) alternative language is adopted consistent with language used elsewhere to express a similar thought. At § 2.65 (d)(4) the term "program" is used in lieu of "person holding the records" inasmuch as none but a program will be providing services to patients.

Regulatory Procedures

Executive Order 12291

This is not a major rule under Executive Order 12291. Overall costs to general medical care facilities will be reduced as a result of the decision to apply the regulations only to specialized alcohol and drug abuse treatment programs. Cost to covered programs will be reduced somewhat by simplification of the rules. The amendments do not have an annual effect on the economy of \$100 million or more or otherwise meet the criteria for a major rule under the Executive Order. Thus, no regulatory analysis is required.

Regulatory Flexibility Act

As a result of the decision to apply the regulations only to specialized alcohol and drug abuse treatment programs, the Final Rule will not have a significant economic impact on a substantial number of small entities. The regulations will no longer apply to general medical care providers which render alcohol or drug abuse services incident to their general medical care functions; thus, the number of small entities affected will be less than substantial. The economic impact will be less than significant because much of that impact arises from the cost of determining that the records of a general medical care patient are subject to the regulations and thereafter treating those records differently than all others in the general medical care facility. It is anticipated that programs covered by these rules will realize a small savings as a result of the simplification of the rules.

Information Collection Requirements

Information collection requirements in this Final Rule are:

- (1) Obtaining written patient consent (§ 2.31(a)).
- (2) Notifying each patient of confidentiality provisions (§ 2.22), and
- (3) Documenting any disclosure to meet a medical emergency (§ 2.51).

The information collection requirements contained in these final regulations have been approved by the Office of Management and Budget under section 3504(h) of the Paperwork Reduction Act of 1980 and have been assigned control number 0930-0099, approved for use through April 30, 1989.

List of Subjects in 42 CFR Part 2

Alcohol abuse, Alcoholism, Confidentiality, Drug abuse, Health records, Privacy.

Dated: July 3, 1986.

Robert E. Windom,

Assistant Secretary for Health.

Approved: April 9, 1987.

Otis R. Bowen,

Secretary.

The amendments to 42 CFR Part 2 are hereby adopted as revised and set forth below:

PART 2—CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS

Subpart A—Introduction

Sec.

- 2.1 Statutory authority for confidentiality of drug abuse patient records.
- 2.2 Statutory authority for confidentiality of alcohol abuse patient records.
- 2.3 Purpose and effect.
- 2.4 Criminal penalty for violation.
- 2.5 Reports of violations.

Subpart B—General Provisions

- 2.11 Definitions.
- 2.12 Applicability.
- 2.13 Confidentiality restrictions.
- 2.14 Minor patients.
- 2.15 Incompetent and deceased patients.
- 2.16 Security for written records.
- 2.17 Undercover agents and informants.
- 2.18 Restrictions on the use of identification cards.
- 2.19 Disposition of records by discontinued programs.
- 2.20 Relationship to State laws.
- 2.21 Relationship to Federal statutes protecting research subjects against compulsory disclosure of their identity.
- 2.22 Notice to patients of Federal confidentiality requirements.
- 2.23 Patient access and restriction on use.

Subpart C—Disclosures With Patient's Consent

- Sec.
- 2.31 Form of written consent.
- 2.32 Prohibition on redisclosure.
- 2.33 Disclosures permitted with written consent.
- 2.34 Disclosures to prevent multiple enrollments in detoxification and maintenance treatment programs.
- 2.35 Disclosures to elements of the criminal justice system which have referred patients.

Subpart D—Disclosures Without Patient Consent

- 2.51 Medical emergencies.
- 2.52 Research activities.
- 2.53 Audit and evaluation activities.

Subpart E—Court Orders Authorizing Disclosures and Use

- 2.61 Legal effect of order.
- 2.62 Order not applicable to records disclosed without consent to researchers, auditors and evaluators.
- 2.63 Confidential communications.
- 2.64 Procedures and criteria for orders authorizing disclosures for noncriminal purposes.
- 2.65 Procedures and criteria for orders authorizing disclosure and use of records to criminally investigate or prosecute patients.
- 2.66 Procedures and criteria for orders authorizing disclosure and use of records to investigate or prosecute a program or the person holding the records.
- 2.67 Orders authorizing the use of undercover agents and informants to criminally investigate employees or agents of a program.

Authority: Sec. 408 of Pub. L. 92-255, 88 Stat. 74, as amended by sec. 303 (a), (b) of Pub. L. 93-282, 83 Stat. 137, 138; sec. 4(c)(5)(A) of Pub. L. 94-237, 90 Stat. 244; sec. 111(c)(3) of Pub. L. 94-581, 90 Stat. 2852; sec. 509 of Pub. L. 96-88, 93 Stat. 695; sec. 973(d) of Pub. L. 97-35, 95 Stat. 598; and transferred to sec. 527 of the Public Health Service Act by sec. 2(b)(16)(B) of Pub. L. 98-24, 97 Stat. 182 and as amended by sec. 108 of Pub. L. 99-401, 100 Stat. 907 (42 U.S.C. 290ee-3) and sec. 333 of Pub. L. 91-816, 84 Stat. 1853, as amended by sec. 122(a) of Pub. L. 93-282, 88 Stat. 131; and sec. 111(c)(4) of Pub. L. 94-581, 90 Stat. 2852 and transferred to sec. 523 of the Public Health Service Act by sec. 2(b)(13) of Pub. L. 98-24, 97 Stat. 181 and as amended by sec. 108 of Pub. L. 99-401, 100 Stat. 907 (42 U.S.C. 290dd-3).

Subpart A—Introduction**§ 2.1 Statutory authority for confidentiality of drug abuse patient records.**

The restrictions of these regulations upon the disclosure and use of drug abuse patient records were initially authorized by section 408 of the Drug Abuse Prevention, Treatment, and Rehabilitation Act (21 U.S.C. 1175). That section as amended was transferred by Pub. L. 98-24 to section 527 of the Public

Health Service Act which is codified at 42 U.S.C. 290ee-3. The amended statutory authority is set forth below:

Section 290ee-3. Confidentiality of patient records.**(a) Disclosure authorization**

Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance of any drug abuse prevention function conducted, regulated, or directly or indirectly assisted by any department or agency of the United States shall, except as provided in subsection (e) of this section, be confidential and be disclosed only for the purposes and under the circumstances expressly authorized under subsection (b) of this section.

(b) Purposes and circumstances of disclosure affecting consenting patient and patient regardless of consent

(1) The content of any record referred to in subsection (a) of this section may be disclosed in accordance with the prior written consent of the patient with respect to whom such record is maintained, but only to such extent, under such circumstances, and for such purposes as may be allowed under regulations prescribed pursuant to subsection (g) of this section.

(2) Whether or not the patient, with respect to whom any given record referred to in subsection (a) of this section is maintained, gives his written consent, the content of such record may be disclosed as follows:

(A) To medical personnel to the extent necessary to meet a bona fide medical emergency.

(B) To qualified personnel for the purpose of conducting scientific research, management audits, financial audits, or program evaluation, but such personnel may not identify, directly or indirectly, any individual patient in any report of such research, audit, or evaluation, or otherwise disclose patient identities in any manner.

(C) If authorized by an appropriate order of a court of competent jurisdiction granted after application showing good cause therefor. In assessing good cause the court shall weigh the public interest and the need for disclosure against the injury to the patient, to the physician-patient relationship, and to the treatment services. Upon the granting of such order, the court, in determining the extent to which any disclosure of all or any part of any record is necessary, shall impose appropriate safeguards against unauthorized disclosure.

(c) Prohibition against use of record in making criminal charges or investigation of patient

Except as authorized by a court order granted under subsection (b)(2)(C) of this section, no record referred to in subsection (a) of this section may be used to initiate or substantiate any criminal charges against a patient or to conduct any investigation of a patient.

(d) Continuing prohibition against disclosure irrespective of status as patient

The prohibitions of this section continue to apply to records concerning any individual who has been a patient, irrespective of whether or when he ceases to be a patient.

(e) Armed Forces and Veterans' Administration; interchange of records; report of suspected child abuse and neglect to State or local authorities

The prohibitions of this section do not apply to any interchange of records—

(1) within the Armed Forces or within those components of the Veterans' Administration furnishing health care to veterans, or

(2) between such components and the Armed Forces.

The prohibitions of this section do not apply to the reporting under State law of incidents of suspected child abuse and neglect to the appropriate State or local authorities.

(f) Penalty for first and subsequent offenses

Any person who violates any provision of this section or any regulation issued pursuant to this section shall be fined not more than \$500 in the case of a first offense, and not more than \$5,000 in the case of each subsequent offense.

(g) Regulations; interagency consultations; definitions, safeguards, and procedures, including procedures and criteria for issuance and scope of orders

Except as provided in subsection (h) of this section, the Secretary, after consultation with the Administrator of Veterans' Affairs and the heads of other Federal departments and agencies substantially affected thereby, shall prescribe regulations to carry out the purposes of this section. These regulations may contain such definitions, and may provide for such safeguards and procedures, including procedures and criteria for the issuance and scope of orders under subsection (b)(2)(C) of this section, as in the judgment of the Secretary are necessary or proper to effectuate the purposes of this section, to prevent circumvention or evasion thereof, or to facilitate compliance therewith. (Subsection (h) was superseded by section 111(c)(3) of Pub. L. 94-581. The responsibility of the Administrator of Veterans' Affairs to write regulations to provide for confidentiality of drug abuse patient records under Title 38 was moved from 21 U.S.C. 1175 to 38 U.S.C. 4134.)

§ 2.2 Statutory authority for confidentiality of alcohol abuse patient records.

The restrictions of these regulations upon the disclosure and use of alcohol abuse patient records were initially authorized by section 333 of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (42 U.S.C. 4582). The section as amended was transferred by Pub. L. 98-24 to section 523 of the Public Health Service Act

which is codified at 42 U.S.C. 290dd-3. The amended statutory authority is set forth below:

Section 290dd-3. Confidentiality of patient records

(a) Disclosure authorization

Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance of any program or activity relating to alcoholism or alcohol abuse education, training, treatment, rehabilitation, or research, which is conducted, regulated, or directly or indirectly assisted by any department or agency of the United States shall, except as provided in subsection (e) of this section, be confidential and be disclosed only for the purposes and under the circumstances expressly authorized under subsection (b) of this section.

(b) Purposes and circumstances of disclosure affecting consenting patient and patient regardless of consent

(1) The content of any record referred to in subsection (a) of this section may be disclosed in accordance with the prior written consent of the patient with respect to whom such record is maintained, but only to such extent, under such circumstances, and for such purposes as may be allowed under regulations prescribed pursuant to subsection (g) of this section.

(2) Whether or not the patient, with respect to whom any given record referred to in subsection (a) of this section is maintained, gives his written consent, the content of such record may be disclosed as follows:

(A) To medical personnel to the extent necessary to meet a bona fide medical emergency.

(B) To qualified personnel for the purpose of conducting scientific research, management audits, financial audits, or program evaluation, but such personnel may not identify, directly or indirectly, any individual patient in any report of such research, audit, or evaluation, or otherwise disclose patient identities in any manner.

(C) If authorized by an appropriate order of a court of competent jurisdiction granted after application showing good cause therefor. In assessing good cause the court shall weigh the public interest and the need for disclosure against the injury to the patient, to the physician-patient relationship, and to the treatment services. Upon the granting of such order, the court, in determining the extent to which any disclosure of all or any part of any record is necessary, shall impose appropriate safeguards against unauthorized disclosure.

(c) Prohibition against use of record in making criminal charges or investigation of patient

Except as authorized by a court order granted under subsection (b)(2)(C) of this section, no record referred to in subsection (a) of this section may be used to initiate or substantiate any criminal charges against a patient or to conduct any investigation of a patient.

(d) Continuing prohibition against disclosure irrespective of status as patient

The prohibitions of this section continue to apply to records concerning any individual who has been a patient, irrespective of whether or when he ceases to be a patient.

(e) Armed Forces and Veterans' Administration; interchange of record of suspected child abuse and neglect to State or local authorities

The prohibitions of this section do not apply to any interchange of records—

(1) within the Armed Forces or within those components of the Veterans' Administration furnishing health care to veterans, or

(2) between such components and the Armed Forces.

The prohibitions of this section do not apply to the reporting under State law of incidents of suspected child abuse and neglect to the appropriate State or local authorities.

(f) Penalty for first and subsequent offenses

Any person who violates any provision of this section or any regulation issued pursuant to this section shall be fined not more than \$500 in the case of a first offense, and not more than \$5,000 in the case of each subsequent offense.

(g) Regulations of Secretary; definitions, safeguards, and procedures, including procedures and criteria for issuance and scope of orders

Except as provided in subsection (h) of this section, the Secretary shall prescribe regulations to carry out the purposes of this section. These regulations may contain such definitions, and may provide for such safeguards and procedures, including procedures and criteria for the issuance and scope of orders under subsection (b)(2)(C) of this section, as in the judgment of the Secretary are necessary or proper to effectuate the purposes of this section, to prevent circumvention or evasion thereof, or to facilitate compliance therewith.

(Subsection (h) was superseded by section 111(c)(4) of Pub. L. 94-581. The responsibility of the Administrator of Veterans' Affairs to write regulations to provide for confidentiality of alcohol abuse patient records under Title 38 was moved from 42 U.S.C. 4582 to 38 U.S.C. 4134.)

§ 2.3 Purpose and effect.

(a) **Purpose.** Under the statutory provisions quoted in §§ 2.1 and 2.2, these regulations impose restrictions upon the disclosure and use of alcohol and drug abuse patient records which are maintained in connection with the performance of any federally assisted alcohol and drug abuse program. The regulations specify:

(1) Definitions, applicability, and general restrictions in Subpart B (definitions applicable to § 2.34 only appear in that section);

(2) Disclosures which may be made with written patient consent and the form of the written consent in Subpart C;

(3) Disclosures which may be made without written patient consent or an authorizing court order in Subpart D; and

(4) Disclosures and uses of patient records which may be made with an authorizing court order and the procedures and criteria for the entry and scope of those orders in Subpart E.

(b) **Effect.** (1) These regulations prohibit the disclosure and use of patient records unless certain circumstances exist. If any circumstance exists under which disclosure is permitted, that circumstance acts to remove the prohibition on disclosure but it does not compel disclosure. Thus, the regulations do not require disclosure under any circumstances.

(2) These regulations are not intended to direct the manner in which substantive functions such as research, treatment, and evaluation are carried out. They are intended to insure that an alcohol or drug abuse patient in a federally assisted alcohol or drug abuse program is not made more vulnerable by reason of the availability of his or her patient record than an individual who has an alcohol or drug problem and who does not seek treatment.

(3) Because there is a criminal penalty (a fine—see 42 U.S.C. 290ee-3(f); 42 U.S.C. 290dd-3(f) and 42 CFR § 2.4) for violating the regulations, they are to be construed strictly in favor of the potential violator in the same manner as a criminal statute (see *M. Kraus & Brothers v. United States*, 377 U.S. 614, 621-22, 68 S. Ct. 705, 707-08 (1964)).

§ 2.4 Criminal penalty for violation.

Under 42 U.S.C. 290ee-3(f) and 42 U.S.C. 290dd-3(f), any person who violates any provision of those statutes or these regulations shall be fined not more than \$500 in the case of a first offense, and not more than \$5,000 in the case of each subsequent offense.

§ 2.5 Reports of violations.

(a) The report of any violation of these regulations may be directed to the United States Attorney for the judicial district in which the violation occurs.

(b) The report of any violation of these regulations by a methadone program may be directed to the Regional Offices of the Food and Drug Administration.

Subpart B—General Provisions

§ 2.11 Definitions.

For purposes of these regulations:
Alcohol abuse means the use of an alcoholic beverage which impairs the

physical, mental, emotional, or social well-being of the user.

Drug abuse means the use of a psychoactive substance for other than medicinal purposes which impairs the physical, mental, emotional, or social well-being of the user.

Diagnosis means any reference to an individual's alcohol or drug abuse or to a condition which is identified as having been caused by that abuse which is made for the purpose of treatment or referral for treatment.

Disclose or disclosure means a communication of patient identifying information, the affirmative verification of another person's communication of patient identifying information, or the communication of any information from the record of a patient who has been identified.

Informant means an individual:

(a) Who is a patient or employee of a program or who becomes a patient or employee of a program at the request of a law enforcement agency or official; and

(b) Who at the request of a law enforcement agency or official observes one or more patients or employees of the program for the purpose of reporting the information obtained to the law enforcement agency or official.

Patient means any individual who has applied for or been given diagnosis or treatment for alcohol or drug abuse at a federally assisted program and includes any individual who, after arrest on a criminal charge, is identified as an alcohol or drug abuser in order to determine that individual's eligibility to participate in a program.

Patient identifying information means the name, address, social security number, fingerprints, photograph, or similar information by which the identity of a patient can be determined with reasonable accuracy and speed either directly or by reference to other publicly available information. The term does not include a number assigned to a patient by a program, if that number does not consist of, or contain numbers (such as a social security, or driver's license number) which could be used to identify a patient with reasonable accuracy and speed from sources external to the program.

Person means an individual, partnership, corporation, Federal, State or local government agency, or any other legal entity.

Program means a person which in whole or in part holds itself out as providing, and provides, alcohol or drug abuse diagnosis, treatment, or referral for treatment. For a general medical care facility or any part thereof to be a program, it must have:

(a) An identified unit which provides alcohol or drug abuse diagnosis, treatment, or referral for treatment or

(b) Medical personnel or other staff whose primary function is the provision of alcohol or drug abuse diagnosis, treatment, or referral for treatment and who are identified as such providers.

Program director means:

(a) In the case of a program which is an individual, that individual;

(b) In the case of a program which is an organization, the individual designated as director, managing director, or otherwise vested with authority to act as chief executive of the organization.

Qualified service organization means a person which:

(a) Provides services to a program, such as data processing, bill collecting, dosage preparation, laboratory analyses, or legal, medical, accounting, or other professional services, or services to prevent or treat child abuse or neglect, including training on nutrition and child care and individual and group therapy, and

(b) Has entered into a written agreement with a program under which that person:

(1) Acknowledges that in receiving, storing, processing or otherwise dealing with any patient records from the programs, it is fully bound by these regulations; and

(2) If necessary, will resist in judicial proceedings any efforts to obtain access to patient records except as permitted by these regulations.

Records means any information, whether recorded or not, relating to a patient received or acquired by a federally assisted alcohol or drug program.

Third party payer means a person who pays, or agrees to pay, for diagnosis or treatment furnished to a patient on the basis of a contractual relationship with the patient or a member of his family or on the basis of the patient's eligibility for Federal, State, or local governmental benefits.

Treatment means the management and care of a patient suffering from alcohol or drug abuse, a condition which is identified as having been caused by that abuse, or both, in order to reduce or eliminate the adverse effects upon the patient.

Undercover agent means an officer of any Federal, State, or local law enforcement agency who enrolls in or becomes an employee of a program for the purpose of investigating a suspected violation of law or who pursues that purpose after enrolling or becoming employed for other purposes.

§ 2.12 Applicability.

(a) **General**—(1) **Restrictions on disclosure.** The restrictions on disclosure in these regulations apply to any information, whether or not recorded, which:

(i) Would identify a patient as an alcohol or drug abuser either directly, by reference to other publicly available information, or through verification of such an identification by another person; and

(ii) Is drug abuse information obtained by a federally assisted drug abuse program after March 20, 1972, or is alcohol abuse information obtained by a federally assisted alcohol abuse program after May 13, 1974 (or if obtained before the pertinent date, is maintained by a federally assisted alcohol or drug abuse program after that date as part of an ongoing treatment episode which extends past that date) for the purpose of treating alcohol or drug abuse, making a diagnosis for that treatment, or making a referral for that treatment.

(2) **Restriction on use.** The restriction on use of information to initiate or substantiate any criminal charges against a patient or to conduct any criminal investigation of a patient (42 U.S.C. 290ee-3(c), 42 U.S.C. 290dd-3(c)) applies to any information, whether or not recorded which is drug abuse information obtained by a federally assisted drug abuse program after March 20, 1972, or is alcohol abuse information obtained by a federally assisted alcohol abuse program after May 13, 1974 (or if obtained before the pertinent date, is maintained by a federally assisted alcohol or drug abuse program after that date as part of an ongoing treatment episode which extends past that date), for the purpose of treating alcohol or drug abuse, making a diagnosis for the treatment, or making a referral for the treatment.

(b) **Federal assistance.** An alcohol abuse or drug abuse program is considered to be federally assisted if:

(1) It is conducted in whole or in part, whether directly or by contract or otherwise by any department or agency of the United States (but see paragraphs (c)(1) and (c)(2) of this section relating to the Veterans' Administration and the Armed Forces);

(2) It is being carried out under a license, certification, registration, or other authorization granted by any department or agency of the United States including but not limited to:

(i) Certification of provider status under the Medicare program;

(ii) Authorization to conduct methadone maintenance treatment (see 21 CFR 291.505); or

(iii) Registration to dispense a substance under the Controlled Substances Act to the extent the controlled substance is used in the treatment of alcohol or drug abuse;

(3) It is supported by funds provided by any department or agency of the United States by being:

(i) A recipient of Federal financial assistance in any form, including financial assistance which does not directly pay for the alcohol or drug abuse diagnosis, treatment, or referral activities; or

(ii) Conducted by a State or local government until which, through general or special revenue sharing or other forms of assistance, receives Federal funds which could be (but are not necessarily) spent for the alcohol or drug abuse program; or

(4) It is assisted by the Internal Revenue Service of the Department of the Treasury through the allowance of income tax deductions for contributions to the program or through the granting of tax exempt status to the program.

(c) *Exceptions*—(1) *Veterans' Administration*. These regulations do not apply to information on alcohol and drug abuse patients maintained in connection with the Veterans' Administration provisions of hospital care, nursing home care, domiciliary care, and medical services under Title 38, United States Code. Those records are governed by 38 U.S.C. 4132 and regulations issued under that authority by the Administrator of Veterans' Affairs.

(2) *Armed Forces*. These regulations apply to any information described in paragraph (a) of this section which was obtained by any component of the Armed Forces during a period when the patient was subject to the Uniform Code of Military Justice except:

(i) Any interchange of that information within the Armed Forces; and

(ii) Any interchange of that information between the Armed Forces and those components of the Veterans Administration furnishing health care to veterans.

(3) *Communication within a program or between a program and an entity having direct administrative control over that program*. The restrictions on disclosure in these regulations do not apply to communications of information between or among personnel having a need for the information in connection with their duties that arise out of the provision of diagnosis, treatment, or

referral for treatment of alcohol or drug abuse if the communications are

(i) within a program or

(ii) between a program and an entity that has direct administrative control over the program.

(4) *Qualified Service Organizations*. The restrictions on disclosure in these regulations do not apply to communications between a program and a qualified service organization of information needed by the organization to provide services to the program.

(5) *Crimes on program premises or against program personnel*. The restrictions on disclosure and use in these regulations do not apply to communications from program personnel to law enforcement officers which—

(i) Are directly related to a patient's commission of a crime on the premises of the program or against program personnel or to a threat to commit such a crime; and

(ii) Are limited to the circumstances of the incident, including the patient status of the individual committing or threatening to commit the crime, that individual's name and address, and that individual's last known whereabouts.

(6) *Reports of suspected child abuse and neglect*. The restrictions on disclosure and use in these regulations do not apply to the reporting under State law of incidents of suspected child abuse and neglect to the appropriate State or local authorities. However, the restrictions continue to apply to the original alcohol or drug abuse patient records maintained by the program including their disclosure and use for civil or criminal proceedings which may arise out of the report of suspected child abuse and neglect.

(d) *Applicability to recipients of information*—(1) *Restriction on use of information*. The restriction on the use of any information subject to these regulations to initiate or substantiate any criminal charges against a patient or to conduct any criminal investigation of a patient applies to any person who obtains that information from a federally assisted alcohol or drug abuse program, regardless of the status of the person obtaining the information or of whether the information was obtained in accordance with these regulations. This restriction on use bars, among other things, the introduction of that information as evidence in a criminal proceeding and any other use of the information to investigate or prosecute a patient with respect to a suspected crime. Information obtained by undercover agents or informants (see § 2.17) or through patient access (see

§ 2.23) is subject to the restriction on use.

(2) *Restrictions on disclosures*—*Third party payers, administrative entities, and others*. The restrictions on disclosure in these regulations apply to:

(i) Third party payers with regard to records disclosed to them by federally assisted alcohol or drug abuse programs;

(ii) Entities having direct administrative control over programs with regard to information communicated to them by the program under § 2.12(c)(3); and

(iii) Persons who receive patient records directly from a federally assisted alcohol or drug abuse program and who are notified of the restrictions on redisclosure of the records in accordance with § 2.32 of these regulations.

(e) *Explanation of applicability*—(1) *Coverage*. These regulations cover any information (including information on referral and intake) about alcohol and drug abuse patients obtained by a program (as the terms "patient" and "program" are defined in § 2.11) if the program is federally assisted in any manner described in § 2.12(b). Coverage includes, but is not limited to, those treatment or rehabilitation programs, employee assistance programs, programs within general hospitals, school-based programs, and private practitioners who hold themselves out as providing, and provide alcohol or drug abuse diagnosis, treatment, or referral for treatment.

(2) *Federal assistance to program required*. If a patient's alcohol or drug abuse diagnosis, treatment, or referral for treatment is not provided by a program which is federally conducted, regulated or supported in a manner which constitutes Federal assistance under § 2.12(b), that patient's record is not covered by these regulations. Thus, it is possible for an individual patient to benefit from Federal support and not be covered by the confidentiality regulations because the program in which the patient is enrolled is not federally assisted as defined in § 2.12(b). For example, if a Federal court placed an individual in a private for-profit program and made a payment to the program on behalf of that individual, that patient's record would not be covered by these regulations unless the program itself received Federal assistance as defined by § 2.12(b).

(3) *Information to which restrictions are applicable*. Whether a restriction is on use or disclosure affects the type of information which may be available. The restrictions on disclosure apply to any information which would identify a

patient as an alcohol or drug abuser. The restriction on use of information to bring criminal charges against a patient for a crime applies to any information obtained by the program for the purpose of diagnosis, treatment, or referral for treatment of alcohol or drug abuse. (Note that restrictions on use and disclosure apply to recipients of information under § 2.12(d).)

(4) *How type of diagnosis affects coverage.* These regulations cover any record of a diagnosis identifying a patient as an alcohol or drug abuser which is prepared in connection with the treatment or referral for treatment of alcohol or drug abuse. A diagnosis prepared for the purpose of treatment or referral for treatment but which is not so used is covered by these regulations. The following are not covered by these regulations:

- (i) diagnosis which is made solely for the purpose of providing evidence for use by law enforcement authorities; or
- (ii) A diagnosis of drug overdose or alcohol intoxication which clearly shows that the individual involved is not an alcohol or drug abuser (e.g., involuntary ingestion of alcohol or drugs or reaction to a prescribed dosage of one or more drugs).

§ 2.13 Confidentiality restrictions.

(a) *General.* The patient records to which these regulations apply may be disclosed or used only as permitted by these regulations and may not otherwise be disclosed or used in any civil, criminal, administrative, or legislative proceedings conducted by any Federal, State, or local authority. Any disclosure made under these regulations must be limited to that information which is necessary to carry out the purpose of the disclosure.

(b) *Unconditional compliance required.* The restrictions on disclosure and use in these regulations apply whether the holder of the information believes that the person seeking the information already has it, has other means of obtaining it, is a law enforcement or other official, has obtained a subpoena, or asserts any other justification for a disclosure or use which is not permitted by these regulations.

(c) *Acknowledging the presence of patients: Responding to requests.* (1) The presence of an identified patient in a facility or component of a facility which is publicly identified as a place where only alcohol or drug abuse diagnosis, treatment, or referral is provided may be acknowledged only if the patient's written consent is obtained in accordance with subpart C of these regulations or if an authorizing court

order is entered in accordance with Subpart E of these regulations. The regulations permit acknowledgement of the presence of an identified patient in a facility or part of a facility if the facility is not publicly identified as only an alcohol or drug abuse diagnosis, treatment or referral facility, and if the acknowledgement does not reveal that the patient is an alcohol or drug abuser.

(2) Any answer to a request for a disclosure of patient records which is not permissible under these regulations must be made in a way that will not affirmatively reveal that an identified individual has been, or is being diagnosed or treated for alcohol or drug abuse. An inquiring party may be given a copy of these regulations and advised that they restrict the disclosure of alcohol or drug abuse patient records, but may not be told affirmatively that the regulations restrict the disclosure of the records of an identified patient. The regulations do not restrict a disclosure that an identified individual is not and never has been a patient.

§ 2.14 Minor patients.

(a) *Definition of minor.* As used in these regulations the term "minor" means a person who has not attained the age of majority specified in the applicable State law, or if no age of majority is specified in the applicable State law, the age of eighteen years.

(b) *State law not requiring parental consent to treatment.* If a minor patient acting alone has the legal capacity under the applicable State law to apply for and obtain alcohol or drug abuse treatment, any written consent for disclosure authorized under Subpart C of these regulations may be given only by the minor patient. This restriction includes, but is not limited to, any disclosure of patient identifying information to the parent or guardian of a minor patient for the purpose of obtaining financial reimbursement. These regulations do not prohibit a program from refusing to provide treatment until the minor patient consents to the disclosure necessary to obtain reimbursement, but refusal to provide treatment may be prohibited under a State or local law requiring the program to furnish the service irrespective of ability to pay.

(c) *State law requiring parental consent to treatment.* (1) Where State law requires consent of a parent, guardian, or other person for a minor to obtain alcohol or drug abuse treatment, any written consent for disclosure authorized under Subpart C of these regulations must be given by both the minor and his or her parent, guardian, or

other person authorized under State law to act in the minor's behalf.

(2) Where State law requires parental consent to treatment the fact of a minor's application for treatment may be communicated to the minor's parent, guardian, or other person authorized under State law to act in the minor's behalf only if:

(i) The minor has given written consent to the disclosure in accordance with Subpart C of these regulations or

(ii) The minor lacks the capacity to make a rational choice regarding such consent as judged by the program director under paragraph (d) of this section.

(d) *Minor applicant for services lacks capacity for rational choice.* Facts relevant to reducing a threat to the life or physical well being of the applicant or any other individual may be disclosed to the parent, guardian, or other person authorized under State law to act in the minor's behalf if the program director judges that:

(1) A minor applicant for services lacks capacity because of extreme youth or mental or physical condition to make a rational decision on whether to consent to a disclosure under Subpart C of these regulations to his or her parent, guardian, or other person authorized under State law to act in the minor's behalf, and

(2) The applicant's situation poses a substantial threat to the life or physical well being of the applicant or any other individual which may be reduced by communicating relevant facts to the minor's parent, guardian, or other person authorized under State law to act in the minor's behalf.

§ 2.15 Incompetent and deceased patients.

(a) *Incompetent patients other than minors—(1) Adjudication of incompetence.* In the case of a patient who has been adjudicated as lacking the capacity, for any reason other than insufficient age, to manage his or her own affairs, any consent which is required under these regulations may be given by the guardian or other person authorized under State law to act in the patient's behalf.

(2) *No adjudication of incompetency.* For any period for which the program director determines that a patient, other than a minor or one who has been adjudicated incompetent, suffers from a medical condition that prevents knowing or effective action on his or her own behalf, the program director may exercise the right of the patient to consent to a disclosure under Subpart C of these regulations for the sole purpose

of obtaining payment for services from a third party payer.

(b) *Deceased patients*—(1) *Vital statistics*. These regulations do not restrict the disclosure of patient identifying information relating to the cause of death of a patient under laws requiring the collection of death or other vital statistics or permitting inquiry into the cause of death.

(2) *Consent by personal representative*. Any other disclosure of information identifying a deceased patient as an alcohol or drug abuser is subject to these regulations. If a written consent to the disclosure is required, that consent may be given by an executor, administrator, or other personal representative appointed under applicable State law. If there is no such appointment the consent may be given by the patient's spouse or, if none, by any responsible member of the patient's family.

§ 2.16 Security for written records.

(a) Written records which are subject to these regulations must be maintained in a secure room, locked file cabinet, safe or other similar container when not in use; and

(b) Each program shall adopt in writing procedures which regulate and control access to and use of written records which are subject to these regulations.

§ 2.17 Undercover agents and informants.

(a) *Restrictions on placement*. Except as specifically authorized by a court order granted under § 2.6 of these regulations, no program may knowingly employ, or enroll as a patient, any undercover agent or informant.

(b) *Restriction on use of information*. No information obtained by an undercover agent or informant, whether or not that undercover agent or informant is placed in a program pursuant to an authorizing court order, may be used to criminally investigate or prosecute any patient.

§ 2.18 Restrictions on the use of identification cards.

No person may require any patient to carry on his or her person while away from the program premises any card or other object which would identify the patient as an alcohol or drug abuser. This section does not prohibit a person from requiring patients to use or carry cards or other identification objects on the premises of a program.

§ 2.19 Disposition of records by discontinued programs.

(a) *General*. If a program discontinues operations or is taken over or acquired by another program, it must purge

patient identifying information from its records or destroy the records unless—

(1) The patient who is the subject of the records gives written consent (meeting the requirements of § 2.31) to a transfer of the records to the acquiring program or to any other program designated in the consent (the manner of obtaining this consent must minimize the likelihood of a disclosure of patient identifying information to a third party); or

(2) There is a legal requirement that the records be kept for a period specified by law which does not expire until after the discontinuation or acquisition of the program.

(b) *Procedure where retention period required by law*. If paragraph (a)(2) of this section applies, the records must be:

(1) Sealed in envelopes or other containers labeled as follows: "Records of [insert name of program] required to be maintained under [insert citation to statute, regulation, court order or other legal authority requiring that records be kept] until a date not later than [insert appropriate date]"; and

(2) Held under the restrictions of these regulations by a responsible person who must, as soon as practicable after the end of the retention period specified on the label, destroy the records.

§ 2.20 Relationship to State laws.

The statutes authorizing these regulations (42 U.S.C. 290ee-3 and 42 U.S.C. 290dd-3) do not preempt the field of law which they cover to the exclusion of all State laws in that field. If a disclosure permitted under these regulations is prohibited under State law, neither these regulations nor the authorizing statutes may be construed to authorize any violation of that State law. However, no State law may either authorize or compel any disclosure prohibited by these regulations.

§ 2.21 Relationship to Federal statutes protecting research subjects against compulsory disclosure of their identity.

(a) *Research privilege description*. There may be concurrent coverage of patient identifying information by these regulations and by administrative action taken under: Section 303(a) of the Public Health Service Act (42 U.S.C. 242a(a) and the implementing regulations at 42 CFR Part 2a); or section 502(c) of the Controlled Substances Act (21 U.S.C. 872(c) and the implementing regulations at 21 CFR 1316.21). These "research privilege" statutes confer on the Secretary of Health and Human Services and on the Attorney General, respectively, the power to authorize researchers conducting certain types of research to withhold from all persons

not connected with the research the names and other identifying information concerning individuals who are the subjects of the research.

(b) *Effect of concurrent coverage*. These regulations restrict the disclosure and use of information about patients, while administrative action taken under the research privilege statutes and implementing regulations protects a person engaged in applicable research from being compelled to disclose any identifying characteristics of the individuals who are the subjects of that research. The issuance under Subpart E of these regulations of a court order authorizing a disclosure of information about a patient does not affect an exercise of authority under these research privilege statutes. However, the research privilege granted under 21 CFR 291.505(g) to treatment programs using methadone for maintenance treatment does not protect from compulsory disclosure any information which is permitted to be disclosed under those regulations. Thus, if a court order entered in accordance with Subpart E of these regulations authorizes a methadone maintenance treatment program to disclose certain information about its patients, that program may not invoke the research privilege under 21 CFR 291.505(g) as a defense to a subpoena for that information.

§ 2.22 Notice to patients of Federal confidentiality requirements.

(a) *Notice required*. At the time of admission or as soon thereafter as the patient is capable of rational communication, each program shall:

(1) Communicate to the patient that Federal law and regulations protect the confidentiality of alcohol and drug abuse patient records; and

(2) Give to the patient a summary in writing of the Federal law and regulations.

(b) *Required elements of written summary*. The written summary of the Federal law and regulations must include:

(1) A general description of the limited circumstances under which a program may acknowledge that an individual is present at a facility or disclose outside the program information identifying a patient as an alcohol or drug abuser.

(2) A statement that violation of the Federal law and regulations by a program is a crime and that suspected violations may be reported to appropriate authorities in accordance with these regulations.

(3) A statement that information related to a patient's commission of a crime on the premises of the program or

against personnel of the program is not protected.

(4) A statement that reports of suspected child abuse and neglect made under State law to appropriate State or local authorities are not protected.

(5) A citation to the Federal law and regulations.

(c) *Program options.* The program may devise its own notice or may use the sample notice in paragraph (d) to comply with the requirement to provide the patient with a summary in writing of the Federal law and regulations. In addition, the program may include in the written summary information concerning State law and any program policy not inconsistent with State and Federal law on the subject of confidentiality of alcohol and drug abuse patient records.

(d) *Sample notice.*

Confidentiality of Alcohol and Drug Abuse Patient Records

The confidentiality of alcohol and drug abuse patient records maintained by this program is protected by Federal law and regulations. Generally, the program may not say to a person outside the program that a patient attends the program, or disclose any information identifying a patient as an alcohol or drug abuser *Unless:*

- (1) The patient consents in writing;
- (2) The disclosure is allowed by a court order; or
- (3) The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

Violation of the Federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations.

Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities. (See 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 for Federal laws and 42 CFR Part 2 for Federal regulations.)

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§ 2.23 Patient access and restrictions on use.

(a) *Patient access not prohibited.* These regulations do not prohibit a program from giving a patient access to his or her own records, including the opportunity to inspect and copy any records that the program maintains about the patient. The program is not required to obtain a patient's written consent or other authorization under

these regulations in order to provide such access to the patient.

(b) *Restriction on use of information.* Information obtained by patient access to his or her patient record is subject to the restriction on use of his information to initiate or substantiate any criminal charges against the patient or to conduct any criminal investigation of the patient as provided for under § 2.12(d)(1).

Subpart C—Disclosures With Patient's Consent

§ 2.31 Form of written consent.

(a) *Required elements.* A written consent to a disclosure under these regulations must include:

- (1) The specific name or general designation of the program or person permitted to make the disclosure.
- (2) The name or title of the individual or the name of the organization to which disclosure is to be made.
- (3) The name of the patient.
- (4) The purpose of the disclosure.
- (5) How much and what kind of information is to be disclosed.
- (6) The signature of the patient and, when required for a patient who is a minor, the signature of a person authorized to give consent under § 2.14; or, when required for a patient who is incompetent or deceased, the signature of a person authorized to sign under § 2.15 in lieu of the patient.
- (7) The date on which the consent is signed.

(8) A statement that the consent is subject to revocation at any time except to the extent that the program or person which is to make the disclosure has already acted in reliance on it. Acting in reliance includes the provision of treatment services in reliance on a valid consent to disclose information to a third party payer.

(9) The date, event, or condition upon which the consent will expire if not revoked before. This date, event, or condition must insure that the consent will last no longer than reasonably necessary to serve the purpose for which it is given.

(b) *Sample consent form.* The following form complies with paragraph (a) of this section, but other elements may be added.

1. I (name of patient) ☐ Request ☐ Authorize:
2. (name or general designation of program which is to make the disclosure)

3. To disclose: (kind and amount of information to be disclosed)

4. To: (name or title of the person or organization to which disclosure is to be made)

5. For (purpose of the disclosure)

6. Date (on which this consent is signed)

7. Signature of patient

8. Signature of parent or guardian (where required)

9. Signature of person authorized to sign in lieu of the patient (where required)

10. This consent is subject to revocation at any time except to the extent that the program which is to make the disclosure has already taken action in reliance on it. If not previously revoked, this consent will terminate upon: (specific date, event, or condition)

(c) *Expired, deficient, or false consent.* A disclosure may not be made on the basis of a consent which:

- (1) Has expired;
- (2) On its face substantially fails to conform to any of the requirements set forth in paragraph (a) of this section;
- (3) Is known to have been revoked; or
- (4) Is known, or through a reasonable effort could be known, by the person holding the records to be materially false.

(Approved by the Office of Management and Budget under Control No. 0930-0099.)

§ 2.32 Prohibition on redisclosure.

(a) *Notice to accompany disclosure.* Each disclosure made with the patient's written consent must be accompanied by the following written statement:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

§ 2.33 Disclosures permitted with written consent.

If a patient consents to a disclosure of his or her records under § 2.31, a program may disclose those records in accordance with that consent to any individual or organization named in the consent, except that disclosures to central registries and in connection with criminal justice referrals must meet the requirements of § 2.34 and 2.35, respectively.

§ 2.34 Disclosures to prevent multiple enrollments in detoxification and maintenance treatment programs.

(a) *Definitions.* For purposes of this section:

Central registry means an organization which obtains from two or more member programs patient identifying information about individuals applying for maintenance treatment or detoxification treatment for the purpose of avoiding an individual's concurrent enrollment in more than one program.

Detoxification treatment means the dispensing of a narcotic drug in decreasing doses to an individual in order to reduce or eliminate adverse physiological or psychological effects incident to withdrawal from the sustained use of a narcotic drug.

Maintenance treatment means the dispensing of a narcotic drug in the treatment of an individual for dependence upon heroin or other morphine-like drugs.

Member program means a detoxification treatment or maintenance treatment program which reports patient identifying information to a central registry and which is in the same State as that central registry or is not more than 125 miles from any border of the State in which the central registry is located.

(b) *Restrictions on disclosure.* A program may disclose patient records to a central registry or to any detoxification or maintenance treatment program not more than 200 miles away for the purpose of preventing the multiple enrollment of a patient only if:

- (1) The disclosure is made when:
 - (i) The patient is accepted for treatment;
 - (ii) The type or dosage of the drug is changed; or
 - (iii) The treatment is interrupted, resumed or terminated.
- (2) The disclosure is limited to:
 - (i) Patient identifying information;
 - (ii) Type and dosage of the drug; and
 - (iii) Relevant dates

(3) The disclosure is made with the patient's written consent meeting the requirements of § 2.31, except that:

- (i) The consent must list the name and address of each central registry and each known detoxification or maintenance treatment program to which a disclosure will be made; and
- (ii) The consent may authorize a disclosure to any detoxification or maintenance treatment program established within 200 miles of the program after the consent is given without naming any such program.

(c) *Use of information limited to prevention of multiple enrollments.* A

central registry and any detoxification or maintenance treatment program to which information is disclosed to prevent multiple enrollments may not redisclose or use patient identifying information for any purpose other than the prevention of multiple enrollments unless authorized by a court order under Subpart E of these regulations.

(d) *Permitted disclosure by a central registry to prevent a multiple enrollment.* When a member program asks a central registry if an identified patient is enrolled in another member program and the registry determines that the patient is so enrolled, the registry may disclose—

- (1) The name, address, and telephone number of the member program(s) in which the patient is already enrolled to the inquiring member program; and
- (2) The name, address, and telephone number of the inquiring member program to the member program(s) in which the patient is already enrolled. The member programs may communicate as necessary to verify that no error has been made and to prevent or eliminate any multiple enrollment.

(e) *Permitted disclosure by a detoxification or maintenance treatment program to prevent a multiple enrollment.* A detoxification or maintenance treatment program which has received a disclosure under this section and has determined that the patient is already enrolled may communicate as necessary with the program making the disclosure to verify that no error has been made and to prevent or eliminate any multiple enrollment.

§ 2.35 Disclosures to elements of the criminal justice system which have referred patients.

(a) A program may disclose information about a patient to those persons within the criminal justice system which have made participation in the program a condition of the disposition of any criminal proceedings against the patient or of the patient's parole or other release from custody if:

- (1) The disclosure is made only to those individuals within the criminal justice system who have a need for the information in connection with their duty to monitor the patient's progress (e.g., a prosecuting attorney who is withholding charges against the patient, a court granting pretrial or posttrial release, probation or parole officers responsible for supervision of the patient); and
- (2) The patient has signed a written consent meeting the requirements of § 2.31 (except paragraph (a)(8) which is inconsistent with the revocation

provisions of paragraph (c) of this section) and the requirements of paragraphs (b) and (c) of this section.

(b) *Duration of consent.* The written consent must state the period during which it remains in effect. This period must be reasonable, taking into account:

- (1) The anticipated length of the treatment;
- (2) The type of criminal proceeding involved, the need for the information in connection with the final disposition of that proceeding, and when the final disposition will occur; and
- (3) Such other factors as the program, the patient, and the person(s) who will receive the disclosure consider pertinent.

(c) *Revocation of consent.* The written consent must state that it is revocable upon the passage of a specified amount of time or the occurrence of a specified, ascertainable event. The time or occurrence upon which consent becomes revocable may be no later than the final disposition of the conditional release or other action in connection with which consent was given.

(d) *Restrictions on redisclosure and use.* A person who receives patient information under this section may redisclose and use it only to carry out that person's official duties with regard to the patient's conditional release or other action in connection with which the consent was given.

Subpart D—Disclosures Without Patient Consent

§ 2.51 Medical emergencies.

(a) *General Rule.* Under the procedures required by paragraph (c) of this section, patient identifying information may be disclosed to medical personnel who have a need for information about a patient for the purpose of treating a condition which poses an immediate threat to the health of any individual and which requires immediate medical intervention.

(b) *Special Rule.* Patient identifying information may be disclosed to medical personnel of the Food and Drug Administration (FDA) who assert a reason to believe that the health of any individual may be threatened by an error in the manufacture, labeling, or sale of a product under FDA jurisdiction, and that the information will be used for the exclusive purpose of notifying patients or their physicians of potential dangers.

(c) *Procedures.* Immediately following disclosure, the program shall document the disclosure in the patient's records, setting forth in writing:

(1) The name of the medical personnel to whom disclosure was made and their affiliation with any health care facility;

(2) The name of the individual making the disclosure;

(3) The date and time of the disclosure; and

(4) The nature of the emergency (or error, if the report was to FDA).

(Approved by the Office of Management and Budget under Control No. 0930-0099.)

§ 2.52 Research activities.

(a) Patient identifying information may be disclosed for the purpose of conducting scientific research if the program director makes a determination that the recipient of the patient identifying information:

(1) Is qualified to conduct the research; and

(2) Has a research protocol under which the patient identifying information:

(i) Will be maintained in accordance with the security requirements of § 2.18 of these regulations (or more stringent requirements); and

(ii) Will not be redisclosed except as permitted under paragraph (b) of this section.

(b) A person conducting research may disclose patient identifying information obtained under paragraph (a) of this section only back to the program from which that information was obtained and may not identify any individual patient in any report of that research or otherwise disclose patient identities.

§ 2.53 Audit and evaluation activities.

(a) *Records not copied or removed.* If patient records are not copied or removed, patient identifying information may be disclosed in the course of a review of records on program premises to any person who agrees in writing to comply with the limitations on redisclosure and use in paragraph (d) of this section and who:

(1) Performs the audit or evaluation activity on behalf of:

(i) Any Federal, State, or local governmental agency which provides financial assistance to the program or is authorized by law to regulate its activities; or

(ii) Any private person which provides financial assistance to the program, which is a third party payer covering patients in the program, or which is a peer review organization performing a utilization or quality control review; or

(2) Is determined by the program director to be qualified to conduct the audit or evaluation activities.

(b) *Copying or removal of records.* Records containing patient identifying information may be copied or removed

from program premises by any person who:

(1) Agrees in writing to:

(i) Maintain the patient identifying information in accordance with the security requirements provided in § 2.18 of these regulations (or more stringent requirements);

(ii) Destroy all the patient identifying information upon completion of the audit or evaluation; and

(iii) Comply with the limitations on disclosure and use in paragraph (d) of this section; and

(2) Performs the audit or evaluation activity on behalf of:

(i) Any Federal, State, or local governmental agency which provides financial assistance to the program or is authorized by law to regulate its activities; or

(ii) Any private person which provides financial assistance to the program, which is a third party payer covering patients in the program, or which is a peer review organization performing a utilization or quality control review.

(c) *Medicare or Medicaid audit or evaluation.* (1) For purposes of Medicare or Medicaid audit or evaluation under this section, audit or evaluation includes a civil or administrative investigation of the program by any Federal, State, or local agency responsible for oversight of the Medicare or Medicaid program and includes administrative enforcement, against the program by the agency, of any remedy authorized by law to be imposed as a result of the findings of the investigation.

(2) Consistent with the definition of program in § 2.11, program includes an employee of, or provider of medical services under, the program when the employee or provider is the subject of a civil investigation or administrative remedy, as those terms are used in paragraph (c)(1) of this section.

(3) If a disclosure to a person is authorized under this section for a Medicare or Medicaid audit or evaluation, including a civil investigation or administrative remedy, as those terms are used in paragraph (c)(1) of this section, then a peer review organization which obtains the information under paragraph (a) or (b) may disclose the information to that person but only for purposes of Medicare or Medicaid audit or evaluation.

(4) The provisions of this paragraph do not authorize the agency, the program, or any other person to disclose or use patient identifying information obtained during the audit or evaluation for any purposes other than those necessary to complete the Medicare or

Medicaid audit or evaluation activity as specified in this paragraph.

(d) *Limitations on disclosure and use.* Except as provided in paragraph (c) of this section, patient identifying information disclosed under this section may be disclosed only back to the program from which it was obtained and used only to carry out an audit or evaluation purpose or to investigate or prosecute criminal or other activities, as authorized by a court order entered under § 2.66 of these regulations.

Subpart E—Court Orders Authorizing Disclosure And Use

§ 2.61 Legal effect of order.

(a) *Effect.* An order of a court of competent jurisdiction entered under this subpart is a unique kind of court order. Its only purpose is to authorize a disclosure or use of patient information which would otherwise be prohibited by 42 U.S.C. 290ee-3, 42 U.S.C. 290dd-3 and these regulations. Such an order does not compel disclosure. A subpoena or a similar legal mandate must be issued in order to compel disclosure. This mandate may be entered at the same time as and accompany an authorizing court order entered under these regulations.

(b) *Examples.* (1) A person holding records subject to these regulations receives a subpoena for those records: a response to the subpoena is not permitted under the regulations unless an authorizing court order is entered. The person may not disclose the records in response to the subpoena unless a court of competent jurisdiction enters an authorizing order under these regulations.

(2) An authorizing court order is entered under these regulations, but the person authorized does not want to make the disclosure. If there is no subpoena or other compulsory process or a subpoena for the records has expired or been quashed, that person may refuse to make the disclosure. Upon the entry of a valid subpoena or other compulsory process the person authorized to disclose must disclose, unless there is a valid legal defense to the process other than the confidentiality restrictions of these regulations.

§ 2.62 Order not applicable to records disclosed without consent to researchers, auditors and evaluators.

A court order under these regulations may not authorize qualified personnel, who have received patient identifying information without consent for the purpose of conducting research, audit or evaluation, to disclose that information

or use it to conduct any criminal investigation or prosecution of a patient. However, a court order under § 2.66 may authorize disclosure and use of records to investigate or prosecute qualified personnel holding the records.

§ 2.63 Confidential communications.

(a) A court order under these regulations may authorize disclosure of confidential communications made by a patient to a program in the course of diagnosis, treatment, or referral for treatment only if:

(1) The disclosure is necessary to protect against an existing threat to life or of serious bodily injury, including circumstances which constitute suspected child abuse and neglect and verbal threats against third parties;

(2) The disclosure is necessary in connection with investigation or prosecution of an extremely serious crime, such as one which directly threatens loss of life or serious bodily injury, including homicide, rape, kidnapping, armed robbery, assault with a deadly weapon, or child abuse and neglect; or

(3) The disclosure is in connection with litigation or an administrative proceeding in which the patient offers testimony or other evidence pertaining to the content of the confidential communications.

§ 2.64 Procedures and criteria for orders authorizing disclosures for noncriminal purposes.

(a) *Application.* An order authorizing the disclosure of patient records for purposes other than criminal investigation or prosecution may be applied for by any person having a legally recognized interest in the disclosure which is sought. The application may be filed separately or as part of a pending civil action in which it appears that the patient records are needed to provide evidence. An application must use a fictitious name, such as John Doe, to refer to any patient and may not contain or otherwise disclose any patient identifying information unless the patient is the applicant or has given a written consent (meeting the requirements of these regulations) to disclosure or the court has ordered the record of the proceeding sealed from public scrutiny.

(b) *Notice.* The patient and the person holding the records from whom disclosure is sought must be given:

(1) Adequate notice in a manner which will not disclose patient identifying information to other persons; and

(2) An opportunity to file a written response to the application, or to appear

in person, for the limited purpose of providing evidence on the statutory and regulatory criteria for the issuance of the court order.

(c) *Review of evidence: Conduct of hearing.* Any oral argument, review of evidence, or hearing on the application must be held in the judge's chambers or in some manner which ensures that patient identifying information is not disclosed to anyone other than a party to the proceeding, the patient, or the person holding the record, unless the patient requests an open hearing in a manner which meets the written consent requirements of these regulations. The proceeding may include an examination by the judge of the patient records referred to in the application.

(d) *Criteria for entry of order.* An order under this section may be entered only if the court determines that good cause exists. To make this determination the court must find that:

(1) Other ways of obtaining the information are not available or would not be effective; and

(2) The public interest and need for the disclosure outweigh the potential injury to the patient, the physician-patient relationship and the treatment services.

(e) *Content of order.* An order authorizing a disclosure must:

(1) Limit disclosure to those parts of the patient's record which are essential to fulfill the objective of the order.

(2) Limit disclosure to those persons whose need for information is the basis for the order; and

(3) Include such other measures as are necessary to limit disclosure for the protection of the patient, the physician-patient relationship and the treatment services; for example, sealing from public scrutiny the record of any proceeding for which disclosure of a patient's record has been ordered.

§ 2.65 Procedures and criteria for orders authorizing disclosure and use of records to criminally investigate or prosecute patients.

(a) *Application.* An order authorizing the disclosure or use of patient records to criminally investigate or prosecute a patient may be applied for by the person holding the records or by any person conducting investigative or prosecutorial activities with respect to the enforcement of criminal laws. The application may be filed separately, as part of an application for a subpoena or other compulsory process, or in a pending criminal action. An application must use a fictitious name such as John Doe, to refer to any patient and may not contain or otherwise disclose patient identifying information unless the court

has ordered the record of the proceeding sealed from public scrutiny.

(b) *Notice and hearing.* Unless an order under § 2.66 is sought with an order under this section, the person holding the records must be given:

(1) Adequate notice (in a manner which will not disclose patient identifying information to third parties) of an application by a person performing a law enforcement function;

(2) An opportunity to appear and be heard for the limited purpose of providing evidence on the statutory and regulatory criteria for the issuance of the court order; and

(3) An opportunity to be represented by counsel independent of counsel for an applicant who is a person performing a law enforcement function.

(c) *Review of evidence: Conduct of hearings.* Any oral argument, review of evidence, or hearing on the application shall be held in the judge's chambers or in some other manner which ensures that patient identifying information is not disclosed to anyone other than a party to the proceedings, the patient, or the person holding the records. The proceeding may include an examination by the judge of the patient records referred to in the application.

(d) *Criteria.* A court may authorize the disclosure and use of patient records for the purpose of conducting a criminal investigation or prosecution of a patient only if the court finds that all of the following criteria are met:

(1) The crime involved is extremely serious, such as one which causes or directly threatens loss of life or serious bodily injury including homicide, rape, kidnapping, armed robbery, assault with a deadly weapon, and child abuse and neglect.

(2) There is a reasonable likelihood that the records will disclose information of substantial value in the investigation or prosecution.

(3) Other ways of obtaining the information are not available or would not be effective.

(4) The potential injury to the patient, to the physician-patient relationship and to the ability of the program to provide services to other patients is outweighed by the public interest and the need for the disclosure.

(5) If the applicant is a person performing a law enforcement function that:

(i) The person holding the records has been afforded the opportunity to be represented by independent counsel; and

(ii) Any person holding the records which is an entity within Federal, State, or local government has in fact been

represented by counsel independent of the applicant.

(e) *Content of order.* Any order authorizing a disclosure or use of patient records under this section must:

(1) Limit disclosure and use to those parts of the patient's record which are essential to fulfill the objective of the order;

(2) Limit disclosure to those law enforcement and prosecutorial officials who are responsible for, or are conducting, the investigation or prosecution, and limit their use of the records to investigation and prosecution of extremely serious crime or suspected crime specified in the application; and

(3) Include such other measures as are necessary to limit disclosure and use to the fulfillment on only that public interest and need found by the court.

§ 2.66 Procedures and criteria for orders authorizing disclosure and use of records to investigate or prosecute a program or the person holding the records.

(a) *Application.* (1) An order authorizing the disclosure or use of patient records to criminally or administratively investigate or prosecute a program or the person holding the records (or employees or agents of that program or person) may be applied for by any administrative, regulatory, supervisory, investigative, law enforcement, or prosecutorial agency having jurisdiction over the program's or person's activities.

(2) The application may be filed separately or as part of a pending civil or criminal action against a program or the person holding the records (or agents or employees of the program or person) in which it appears that the patient records are needed to provide material evidence. The application must use a fictitious name, such as John Doe, to refer to any patient and may not contain or otherwise disclose any patient identifying information unless the court has ordered the record of the proceeding sealed from public scrutiny or the patient has given a written consent (meeting the requirements of § 2.31 of these regulations) to that disclosure.

(b) *Notice not required.* An application under this section may, in

the discretion of the court, be granted without notice. Although no express notice is required to the program, to the person holding the records, or to any patient whose records are to be disclosed, upon implementation of an order so granted any of the above persons must be afforded an opportunity to seek revocation or amendment of that order, limited to the presentation of evidence on the statutory and regulatory criteria for the issuance of the court order.

(c) *Requirements for order.* An order under this section must be entered in accordance with, and comply with the requirements of, paragraphs (d) and (e) of § 2.64 of these regulations.

(d) *Limitations on disclosure and use of patient identifying information:* (1) An order entered under this section must require the deletion of patient identifying information from any documents made available to the public.

(2) No information obtained under this section may be used to conduct any investigation or prosecution of a patient, or be used as the basis for an application for an order under § 2.65 of these regulations.

§ 2.67 Orders authorizing the use of undercover agents and informants to criminally investigate employees or agents of a program.

(a) *Application.* A court order authorizing the placement of an undercover agent or informant in a program as an employee or patient may be applied for by any law enforcement or prosecutorial agency which has reason to believe that employees or agents of the program are engaged in criminal misconduct.

(b) *Notice.* The program director must be given adequate notice of the application and an opportunity to appear and be heard (for the limited purpose of providing evidence on the statutory and regulatory criteria for the issuance of the court order), unless the application asserts a belief that:

(1) The program director is involved in the criminal activities to be investigated by the undercover agent or informant; or

(2) The program director will intentionally or unintentionally disclose the proposed placement of an

undercover agent or informant to the employees or agents who are suspected of criminal activities.

(c) *Criteria.* An order under this section may be entered only if the court determines that good cause exists. To make this determination the court must find:

(1) There is reason to believe that an employee or agent of the program is engaged in criminal activity;

(2) Other ways of obtaining evidence of this criminal activity are not available or would not be effective; and

(3) The public interest and need for the placement of an undercover agent or informant in the program outweigh the potential injury to patients of the program, physician-patient relationships and the treatment services.

(d) *Content of order.* An order authorizing the placement of an undercover agent or informant in a program must:

(1) Specifically authorize the placement of an undercover agent or an informant;

(2) Limit the total period of the placement to six months;

(3) Prohibit the undercover agent or informant from disclosing any patient identifying information obtained from the placement except as necessary to criminally investigate or prosecute employees or agents of the program; and

(4) Include any other measures which are appropriate to limit any potential disruption of the program by the placement and any potential for a real or apparent breach of patient confidentiality; for example, sealing from public scrutiny the record of any proceeding for which disclosure of a patient's record has been ordered.

(e) *Limitation on use of information.* No information obtained by an undercover agent or informant placed under this section may be used to criminally investigate or prosecute any patient or as the basis for an application for an order under § 2.65 of these regulations.

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CHAPTER 7

**TREATMENT: DOES IT WORK AND WHAT IS IT?
ABSTINENCE AS A GOAL**

CHAPTER SEVEN

TREATMENT: DOES IT WORK AND WHAT IS IT?

There are several approaches to saying what treatment is. We can give a definition of substance abuse treatment. The U.S. Department of HHS states that alcoholism treatment is intervention after the development and manifestation of alcohol abuse and alcoholism in order to arrest or reverse their progress. Understand that there are as many definitions as there are published theorists. This definition is not the "best" but it gives you the idea. Since treatment is a planned intervention, let's talk briefly about varying "plans" or treatment approaches. Again, there is a plethora of approaches discussed in the literature. Salt Lake County treatment providers, however, identified ten in the order of their perceived effectiveness (1989 survey). These approaches will probably represent general agreement across the state with, of course, some differences. Those approaches in order of perceived effectiveness are:

- | | |
|----------------------|------------------------|
| 1. abstinence goal | 6. medical model |
| 2. cognitive therapy | 7. psychotherapy |
| 3. behavioral model | 8. disease model |
| 4. peer model | 9. controlled drinking |
| 5. community model | 10. aversion therapy |

While these are not defined here, the names give a basic idea of the approach it represents. Greater definition is only needed by the treatment expert.

Another method of describing different treatments refers to the setting. The six settings commonly referred to are: (1) medical detox, (2) social detox, (3) inpatient, (4) residential, (5) daycare and, (6) outpatient. All can have varying degrees of medication involvement but generally #2, 4 and 6 are drug free.

In an attempt to answer the questions "does treatment work"

and "which treatment is the most effective", these few pages are a synopsis of a half dozen articles which have individual summaries following. Behind these summaries are copies of each entire article. Most of the articles are themselves synopses of many controlled studies and include bibliographies. This allows the reader to pursue these questions in any depth they wish.

SUMMARY

Generally speaking, YES, treatment works if the correct treatment is assessed. In most cases, outpatient is equally as effective as inpatient or residential. The exceptions are, inpatient or residential is more effective when:

1. heavy intoxication, addiction or chronic use, psychiatric problems
2. client is unstable or has minimal social contact
3. generally, women and adolescents

For some examples; one summary of 22 studies showed that every succesful outpatient client (6 & 12 month followup) had a place to live, all succesful gamma alcoholics [long-term addiction] had been in intensive treatment.

Approximately 15% of clients are appropriate for controlled drinking as a treatment goal. This is particularly true when client is younger, cannot accept abstinence, or is motivated to persist in a treatment program. Most people who succesfully control drinking ultimately abstain.

Many studies have compared the cost as well as the effectiveness of various treatment settings. Day treatment is considerably less costly than inpatient and outpatient is less than day treatment. Most studies which compare cost of outpatient to inpatient, however, compare against hospital based inpatient; the most costly treatment. This type of comparison greatly distorts the actual difference. It can cost \$15,000 and more per month in some cases for inpatient but some non-medical residential treatment programs are available for a very small fraction of that cost each month. Insurance

usually requires a medical setting which increases the cost dramatically. Outcome research, however, generally does not support improved success rates if the populations served are the same. Matching client to setting is a common practice in the field and increases effectiveness of treatment.

There are a number of other matches made, however, which require increasingly greater skill to accomplish. The social context of alcohol problems and alcoholism for example, have a tremendous influence on the approach to treatment which may be the most effective. This carries important implications for specialized treatment for youth, women and minorities and requires a whole body of specialized knowledge for treatment.

Indications exist that treatment approaches matched to individual clients and the drugs they use will result in improved outcomes. For example when cocaine first became a big item, users were often high achievers. This is not true as often now but still exemplifies this type of matching. Knowledge in this type of matching, however, is currently limited. Research to validate such matching is only just begun and there is much to learn yet in this area.

This brief summary serves mainly to confirm that, while treatment is more effective than no treatment, research is not always conclusive and outcome differences are not as pronounced as we would like. Significant progress has been made in matching treatment to client which has improved outcomes but the treatment community is on the brink of great strides in the ability to match treatment to client which will increase outcomes dramatically. Determination of the most appropriate and effective approach is a complex process requiring an informed understanding of substances and their effects, treatment, and the individual.

Coerced clients seem to do as well in treatment as voluntary except that Alcoholics Anonymous does not work as well under coercion.

Inpatient Alcoholism Treatment

(1986)

Miller and Hester

Inpatient medical detox is seldom necessary. 8% require referral to hospital emergency wards. Treatment setting affected no post-treatment alcohol abuse ratings. Clients in less staff-intensive programs showed greater improvement in drinking behaviors. Less cost intensive treatment setting showed the lowest relapse rate.

Inpatient versus outpatient, 6 and 12 month follow-up revealed no significant difference in drinking or social adjustment measures. This followed in a number of studies.

Exceptions are:

1. Clients with stable marriages and fewer years of problem drinking had better results with less cost intensive treatment outpatient. Socially unstable clients did better with inpatient.
2. In outpatient; every successful case had a place to live, 80% of unimproved cases had no fixed place of abode.
3. All gamma alcoholics with good outcomes had been in intensive treatment.

Ironically, EAP's tend to send people more suited for successful outpatient treatment to inpatient where these outcomes are less desirable.

Inpatient Rehabilitation

Effectiveness Vs. Cost

(1986)

Helen M. Annis, Ph.D.

The overall outcome results in the treatment field of alcoholism have been disappointing. Relapse rates typically run over 60% by three months post-treatment discharge. The evidence supports the following conclusions:

1. Inhospital alcoholism programs of a few weeks to a few months in duration show about the same success rates as periods of briefer hospitalization of just a few days
2. A majority of alcoholics seeking treatment for alcohol withdrawal can be safely and effectively detoxed without drugs at non-hospital based locations at one-tenth of the cost of inpatient hospitalization
3. Day treatment programs have been found to have equal or superior results to inpatient hospitalization at one-half to one-third the cost
4. Well controlled trials have demonstrated outpatient programs produce comparable results to inpatient programs at a saving of \$3700 per patient

There is a growing body of evidence which suggests that if patients could be matched to a range of suitable treatment alternatives, much higher overall improvement rates in alcoholism treatment would be observed.

Alcoholism Outpatient Treatment

(Most Recent Bib. 1980)

Brandsma and Welsh

A review of over 70 studies show that outpatient is equally as effective as inpatient, with a statistically insignificant trend toward outpatient being better. There are a number of exceptions to this:

1. Severe manifestations of intense or chronic alcohol abuse, i.e.; heavy intoxication, addiction, medical or psychiatric problems. Then inpatient is more effective.
2. People who are unstable or have less social contact. Inpatient is better.
3. Generally, women and adolescents do not do well in outpatient.

Studies also revealed that length of treatment, intensity of treatment and after care do not improve the prognosis. Presumably, this is also for the population left after exceptions. Five to 15 percent are appropriate for controlled drinking as a treatment goal. This is desirable if:

1. Client is a younger person
2. Client cannot accept abstinence goal
3. Client is motivated to persist in a program of treatment

Abstinence is desirable if:

1. Physical damage is occurring or likely to
2. There are previous failures to learn controlled drinking
3. A belief in abstinence exists from experience or philosophy

Coerced clients seem to do as well in treatment as voluntary, except AA does not work as well when coerced into it.

Drinker's Choice

Retha Cable
(1988)

This article advocates reduced drinking goals. Early intervention is the best time for this. The first step is for the client to determine if they are an alcoholic or a problem drinker.

Alcoholic: serious medical problems; frequent withdrawal symptoms;
drinking goal is intoxication. Abstinence

Problem Drinker: no serious medical problems; minor withdrawal symptoms;
little previous treatment. Reduced drinking

People with reduced drinking goal obtain it faster with less resistance and cheating. Abstinence clients required more treatment but both eventually reached their goals. Most reduced drinking clients eventually abstain.

Five steps to maintain a specified drinking level:

1. identify high risk situations
2. abstain for at least two weeks while setting goals
3. develop coping skills to meet urges and social pressures
4. determine long term goal for drinking
5. learn how to regulate and maintain these goals

Reduced drinking goals are successful with EAP's because it finds people early who tend to be problem drinkers.

This article is written in Canada and says, "In the U. S., alcoholism is an industry because money is made by labeling people alcoholics."

The Cultural Context of Psychological Approaches to Alcoholism

by Stanton Peele, 1984

Controlled drinking as a treatment goal has been held in disdain in this country even though:

1. The disease theory is generally in conflict with findings of social scientific research.
2. the disease model and its emphasis on abstinence has been found often to coexist with high levels of drinking problems.
3. Moderate drinking is found in ethnic or cultural groups such as Chinese and Italians (also Jews) where such drinking is modeled for the young and maintained by social custom and peer groups.
4. In 1700 we had a higher per capita consumption of alcohol (5 gallons) than today (2.4 gallons) and it was not a social problem
5. With the repeal of prohibition in 1933, the abstinence goal took a sharp turn from universal abstinence to abstinence by a small group with an inbred susceptibility to alcoholism.

Much of 20th century research has been misinterpreted or ignored because it refutes the disease concept and the need for abstinence as a goal.

1. "Alcoholics drinking behavior is subject to the same kind of laws which...describe normal drinking behavior, or...goal-directed behavior of any kind."
2. ...youth, socio-economic status, minority status (black) or Hispanic), and other conventional categories (Irish vs. Jewish and Italian), are predictors of drinking problems.
3. The most powerful predictor of drinking problems is current social environment.

4. Biologically related groups which should, according to the disease model, parallel in risk factors, do not. For example, Oriental groups vary widely, i.e., Chinese are low risk while American Indians are high risk. (current social environment varies considerably, however).
5. Rand Report (the second one) showed that close to 40% of the subjects free of drinking problems 4 years after intervention still drank. This included a substantial minority of those who were most dependant on alcohol.
6. 21 of 22 studies showed substantial benefits from controlled drinking therapies. This was greatest for those with moderate drinking problems.

Perhaps therapy for alcoholism is best conceived as the effort to minimize relapse. This takes the form of:

1. Preparing drinkers to avoid high risk situations for relapse
2. Avoid drinking when exposed to situations
3. Avoid binge drinking after having taken one drink

Relapse prevention is also most effective with "early stage" drinkers and youth. The abstinence model focuses on the long term alcoholic, overlooking the vast majority of problem drinkers who seldom seek treatment (often because of the abstinence model), and have the best prognosis. A scale measuring the alcoholic's belief about alcoholism is a better predictor of relapse than is an objective measure of alcohol dependence.

Drinking patterns and behaviors are determined by the cultural context. Alcoholism viewed as an uncontrollable urge is after all, part of a larger trend in which premenstrual tension, drug use and drug withdrawal, eating junk food, and love sickness are presented as defenses for murder. The disease concept prevails in this country because it is congruent with our ideas about self and personal responsibility.

Inpatient Alcoholism Treatment

Who Benefits?

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ABSTRACT: *Although uncontrolled studies have yielded mixed findings, 26 controlled comparisons have consistently shown no overall advantage for residential over nonresidential settings, for longer over shorter inpatient programs, or for more intensive over less intensive interventions in treating alcohol abuse. Predictor data suggest that intensive treatment may be differentially beneficial for more severely deteriorated and less socially stable individuals. The outcome of alcoholism treatment is more likely to be influenced by the content of interventions than by the settings in which they are offered. Third-party reimbursement policy should discourage the use of intensive residential models for addressing alcohol abuse when more cost-effective alternatives are available and should reinforce the use of research-supported treatment methods regardless of setting. Such policy priorities run directly counter to the current practices and financial interests of many for-profit providers.*

The treatment of alcoholism in the United States has become a major health care cost. In 1977, expenditures for the treatment of alcohol abuse and related illnesses approximated six billion dollars (*Alcohol and Health*, 1983). By 1980, these costs had climbed to an estimated \$9.5 billion, of which \$4.5 billion was spent specifically treating alcohol abuse (R. Harwood, personal communication, May 13, 1985). Recent projections indicate that by 1983 the overall costs of health services for alcohol abuse and related illnesses had risen to \$14.9 billion (Niven, 1985). Given this rate of growth, it is likely that in 1986 the specific treatment of alcohol abuse is approximating a \$10-billion enterprise. Although there has been a slight trend away from hospitalization, the inpatient setting continues to be a popular context for treating adolescent and adult alcohol abuse, and inpatient treatment programs capture a major proportion of the total dollars spent on clinical services to alcoholics (Knowles, 1983).

Yet the relative merits of residential treatment are less than clear. Kiesler (1982) reviewed controlled studies of psychiatric care delivered in inpatient or alternative settings and found no evidence for superior efficacy of inpatient treatment. If indeed alternatives to residential care yield at least equally beneficial outcomes, they afford substantial benefits in cost effectiveness. In light of present concerns about increasing health care costs and their containment, it is important to ask whether inpatient care

is justified over less costly alternatives in treating alcohol abuse.

We will first review findings from uncontrolled and controlled experimental studies of the relative effectiveness of alcoholism treatment in more versus less intensive settings. Next, we will consider predictor data addressing the question of whether certain subpopulations may benefit differentially from inpatient care. Finally, we will discuss the implications of current research findings for social policy and future treatment practices.

Uncontrolled Research

Numerous uncontrolled studies of alcoholism treatment have included ancillary analyses to examine relationships between duration of treatment and outcome variables. The typical procedure has been to determine length of stay in treatment and its correlation with short-term remission. Some studies have reported more favorable outcomes among patients receiving longer treatment in either inpatient or outpatient settings (Armor, Polich, & Stambul, 1978; Finney, Moos, & Chan, 1981; McLellan, Luborsky, O'Brien, Woody, & Druley, 1982; Smart, 1978). Others have found no relationship (Ogborne & Clare, 1979; Orford & Hawker, 1974) or a negative correlation (Gunderson & Schuckit, 1978) between length of treatment and remission. In an uncontrolled comparison of treatment settings, Ritson (1968) found no differences in outcomes following inpatient or outpatient alcoholism treatment.

A host of confounding factors in such uncontrolled studies render their data inconclusive. Length of stay in treatment is likely to be influenced by a variety of motivational variables, problem severity, socioeconomic stability, coercion, and appropriateness of client-treatment match (Miller, 1985; Miller & Hester, in press-a). Differential staff practices also bias treatment duration. Clients judged by staff to be unmotivated may be terminated earlier from treatment (e.g., Holser, 1979). Sheehan, Wieman, and Bechtel (1981) selected clients judged to be most likely to benefit from additional treatment and referred them for more lengthy care, whereas patients judged to have poorer prognoses were not so referred. On finding, then, that length of treatment was correlated with successful outcome (in the total population), they interpreted their data as questioning the conclusion that there is no benefit in longer term treatment. In fact, no reliable conclusions could be drawn from such data because differential outcomes may have been influenced by

many confounding and biasing variables not controlled in correlational designs. Given these methodological weaknesses and the inconsistency of findings, uncontrolled studies do not provide reliable support for assertions regarding the relative effectiveness of longer versus shorter or more versus less intensive treatment.

Controlled Research

Studies that control for confounding variables yield more interpretable results. We were able to identify 26 studies that used either random assignment (22) or matching (4) to equate groups receiving longer versus shorter or more versus less intensive treatment.

Treatment Setting

Fifteen of the controlled studies address the relative efficacy of treatment settings varying in intensity. We hasten to note that our use of the term *intensity* here refers primarily to cost intensity. The number of hours of treatment received (not including ward milieu) is seldom specified and may not vary substantially between inpatient and less costly settings. An individual, for example, who receives day treatment or who attends two outpatient treatment sessions per week and daily Alcoholics Anonymous (AA) meetings may be spending as many hours in therapeutic contacts as an individual hospitalized in an inpatient program. The studies reviewed in this section compare alternative settings within which treatment can be delivered. First, however, we will briefly consider research on detoxification, which is sometimes cited as a reason for preferring hospital over alternative treatment settings.

Detoxification

Detoxification is not a treatment for alcoholism, but rather a period of withdrawal from alcohol in preparation for recovery. The dangers of detoxification are often cited as reasons for hospital treatment for alcoholism. Indeed, mortality is a risk during severe alcohol withdrawal. An early review of mortality rates in detoxification reported an average of 10% mortality (with program rates ranging up to 32%) during the treatment of delirium tremens, the most severe form of alcohol withdrawal syndrome (Junne, 1958). Similarly Tavel, Davidson, and Batterton (1961) reported a 13% mortality rate among patients suffering episodes of delirium tremens in a general hospital.

Modern detoxification methods, however, have dramatically reduced mortality rates; more recent research consistently indicates that inpatient medical detoxification is seldom necessary and that less costly nonmedical alternatives are safe and effective for most alcoholics. Feldman, Pattison, Sobell, Graham, and Sobell (1975) evaluated successive admissions to an alcoholism program and found that a relatively small number (9%) required inpatient care to detoxify safely.

An alternative to detoxification in medical programs is social-setting detoxification (SSD). O'Briant, Petersen, and Heacock (1977) found that with minimal exclusionary criteria, individuals can safely detoxify without medications and in a nonmedical setting. Whitfield and his colleagues (Whitfield et al., 1978) reported results from a series of 1,114 alcoholics who entered SSD. Of this group, only 90 (8%) required referral to a hospital emergency unit, and of these 90, 62 were returned to the SSD without need for hospital admission or further medical attention. Outlining his procedures for drug-free detoxification, Whitfield (1980) specified a list of indications for referring an alcoholic in withdrawal to an emergency room. He further asserted that about half of all alcoholics do not require detoxification in any residential facility but can withdraw from alcohol safely at home, given appropriate assistance and support. Outcomes from SSD have also been documented by Sparadeo et al. (1982). Of 987 admissions for detoxification (SSD), only six experienced seizures and 14 required referral to a hospital for a withdrawal-related emergency. No mortalities occurred among 5,357 consecutive admissions over a period of three years. The cost of SSD, relative to medical setting detoxification, was \$88 less per day.

Does residential detoxification have a lasting impact on behavior? In the only controlled study we could locate, Hamilton (1979) randomly assigned repeat offenders, convicted for public drunkenness, to receive the usual sanctions and no treatment or to be given detoxification as an alternative to jail. At 12-month follow-up (85% located), there were no significant between-group differences on measures of drinking or employment, although treated offenders reported better life quality and living arrangements. Treated clients showed a 59% increase in days institutionalized during the follow-up year, as compared with a 21% decrease among controls. The difference was accounted for mostly by increased health care utilization among clients given detoxification.

In summary, although routine detoxification was once assumed to necessitate hospital admission, a majority of alcoholics require no medical detoxification, and fewer than 10% require hospital supervision. SSD offers a safe and less costly alternative for those needing professional attention during detoxification. The detoxification process in itself should not be expected to result in long-term behavior change.

Inpatient Versus Partial Residential Treatment

Inpatient treatment has been compared with partial residential care (day treatment or halfway house) in five controlled studies. Annis and Liban (1979) used official records to match 35 alcoholics entering halfway houses with 35 others receiving only detoxification. Data from three months following treatment indicated no differences in frequency of recorded drunkenness episodes. Those placed in halfway house settings were more likely to return for detoxification but less likely to be arrested for drunkenness. A plausible interpretation is that, although the additional halfway house care did not alter patterns of

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drunkenness, it did influence clients to enter detoxification rather than being arrested following drinking episodes.

Smart, Finley, and Funston (1977) used initial random assignment to place 114 detoxified alcoholics into treatment in outpatient, halfway, or inpatient settings. Patients, however, were permitted to accept the assignment, choose another treatment setting, or refuse treatment entirely. Only 60% of the sample entered treatment following detoxification. Successful outcome was defined as a 50% or greater reduction in recorded occurrences of detoxification, arrest, or conviction. At six-month follow-up, none of the halfway house clients were judged to be successful, as compared with success rates of 25% among inpatients, 50% among outpatients, and 50% among those refusing treatment. The violation of random assignment in this study weakens any conclusions to be drawn from these outcome data. Nevertheless, the findings indicate at least comparable effectiveness of nonresidential settings when *chosen* by clients (cf. Ritson, 1968).

Matched samples of general psychiatric patients in day treatment versus inpatient treatment were evaluated by Penk, Charles, and Van Hoose (1978) at two months after intake. Although the population did not consist of diagnosed alcoholics (48% were identified as schizophrenic), alcohol abuse was among the dimensions evaluated in this study and is common in general psychiatric populations. Indeed, pretreatment measures indicated the presence of alcohol abuse among this sample. On posttreatment ratings by relatives and close friends, the day hospital sample ($n = 24$) fared better than either the matched inpatient sample ($n = 24$) or an unmatched inpatient sample ($n = 79$) on measures of employment, social activity, and anxiety reduction. Treatment setting yielded no differential effect on posttreatment alcohol-abuse ratings, although modest improvement was noted in all groups.

Two other comparisons of day treatment with inpatient care have included random assignment. McLachlan and Stein (1982) contrasted a four-week inpatient stay with treatment through a day clinic. With 97 of 100 alcoholics located at 12-month follow-up, no significant differences were found on any measure of treatment effectiveness including alcohol or drug use, emotional adjustment, suicidal ideation or attempts, marital communication, and assertiveness. The day clinic clients showed 79% fewer days of hospitalization during the follow-up year (as compared with their pretreatment year), whereas those randomly assigned to inpatient care showed a 38% increase in days of hospitalization, a statistically significant difference. Readmissions also differed significantly (75% fewer for day clinic clients, 4% fewer among inpatients). Longabaugh et al. (1983) similarly compared extended inpatient treatment (14 days) with day hospital care (15 weekdays), using random assignment with blocking to determine treatment setting for 174 alcoholics following detoxification. Both groups participated in the behaviorally oriented day hospital program, with inpatients completing 10.5 visits in addition to treatment re-

ceived during the extended inpatient stay. At six months (87% located), no significant differences were observed on measures of drinking, employment, or interpersonal functioning. A reported trend ($p < .07$) indicated greater subjective well-being and life satisfaction among the day hospital clients. Over a full 24-month follow-up period (Fink et al., 1985), the day hospital patients showed a significant ($p < .05$) advantage on measures of abstinence, negative emotions, and life satisfaction, although at the 24-month point alone no significant differences remained.

Staff Density

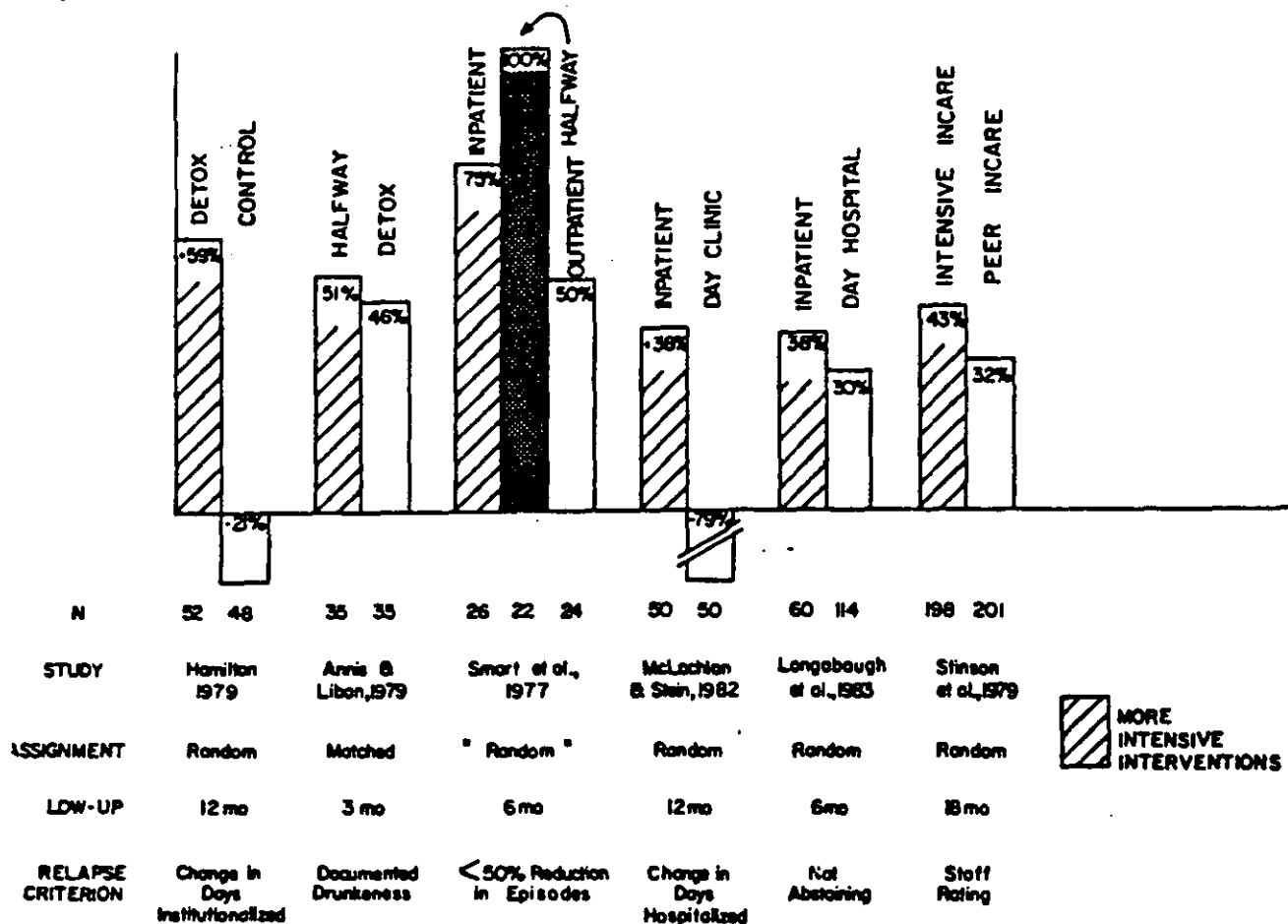
We found only one controlled study evaluating the effects of variation in staff density within residential treatment settings. Stinson, Smith, Amidjaya, and Kaplan (1979) compared two inpatient settings varying in the ratio of staff to patients. A total of 466 alcoholics were assigned at random to either a staff-intensive setting or a peer-oriented program with a lower staff to patient ratio. The latter setting also afforded greater self-direction of treatment. Over 18 months of follow-up (86% contacted) which included collateral confirmations of self-report, patients in the less staff-intensive program were reported to show significantly greater improvement on drinking behavior (analysis and level of significance not reported). No other significant differences were observed on measures of institutionalization, social and vocational functioning, or resolution of other life problems.

The findings reviewed thus far from controlled studies where relapse indices could be derived are summarized in Figure 1. The defining characteristics of a "relapse" vary widely from study to study, and between-study comparisons should not be attempted from this figure. Comparisons are valid within studies, however, where consistent relapse definitions were used for all groups. Algebraically negative "relapse" rates represent decreased rates of institutionalization. In all studies, the less intensive treatment setting, represented by the open bar, showed the lowest relapse rate.

Inpatient Versus Outpatient Care

Ten studies have placed alcoholics into either inpatient or outpatient treatment settings, and all have employed random assignment designs. Edwards and Guthrie (1966, 1967) assigned 40 clients to inpatient (average of nine weeks) or outpatient care (average of 7.5 visits). Contacting all 40 clients at 6- and 12-month follow-up, the authors found no significant differences on drinking and social adjustment measures, with trends favoring the outpatients. Inpatients showed greater use of the hospital during the follow-up period. A decade later, Edwards and his colleagues (Edwards et al., 1977; Orford, Oppenheimer, & Edwards, 1976) published one of the most widely cited studies in the alcoholism treatment field, comparing 50 alcoholics offered inpatient and outpatient treatment with 50 others assigned at random to receive only a thorough evaluation and a single session of outpatient counseling. No significant differences were found between groups on any measure of improvement at either 12- or

Figure 1
Relapse Rates in Controlled Comparisons of More Versus Less Intensive Settings



4-month follow-up (94% and 65% contacted, respectively).

Pittman and Tate (1972) randomly placed 255 alcoholics into two treatment settings. One group ($n = 177$) received three to six weeks of inpatient care plus aftercare consisting of outpatient visits and Alcoholics Anonymous. A comparison group ($n = 78$) received only 7- to 10-day detoxification, with neither inpatient treatment nor aftercare. At 12 months (95% contacted), no significant differences were found on measures of health or employment. Four deaths were reported in the inpatient group, as compared with one in the control group. Although statistical analyses were not reported, findings also indicated no substantial differences in the percentage of patients abstinent for 7 months or more (29% versus 22%) or the percentage showing reduced drinking (60% versus 55%) in the inpatient and control groups, respectively. The authors noted that of the 19 abstinent subjects in the inpatient group, 18 had made extensive use of outpatient aftercare. In a very similar study, Mosher, Davis, Mullin, and Iber (1975) assigned 200 alcoholics to receive three weeks of inpatient treatment in ad-

dition to nine days of inpatient detoxification plus outpatient care. No significant differences were found for abstinence, drinking time, work status, drug use, or anxiety at either three months (91% located) or six months (82% located). Likewise Eriksen (in press) assigned 17 Norwegian alcoholics following detoxification to either immediate inpatient treatment (counseling, discussion groups, lectures, occupational and recreational therapy) or a four-week waiting list with biweekly check-in visits. Contrasting the four postdetoxification weeks in the waiting list group with the four posttreatment weeks in the inpatient group, he found no significant differences between groups on days drinking, days working, sick leave, or institutionalization, according to either self- or collateral reports. A single significant ($p < .05$) difference revealed a higher rate of compliance with disulfiram in the waiting list group. The small sample size, brief critical span of evaluation, and uniformly dismal group outcomes, however, all weaken conclusions to be drawn from this study.

Stein, Newton, and Bowman (1975) randomly assigned 58 alcoholics, following detoxification, to receive

either aftercare alone ($n = 29$) or a 25-day inpatient program plus aftercare ($n = 29$). No significant differences were found at 2, 4, 7, 10, or 13 months on measures including drinking, agency use, readmissions, psychological status, and life adjustment. With all but six cases located at 13 months, 10 from the inpatient group were found to be abstinent as compared with 11 in the control group.

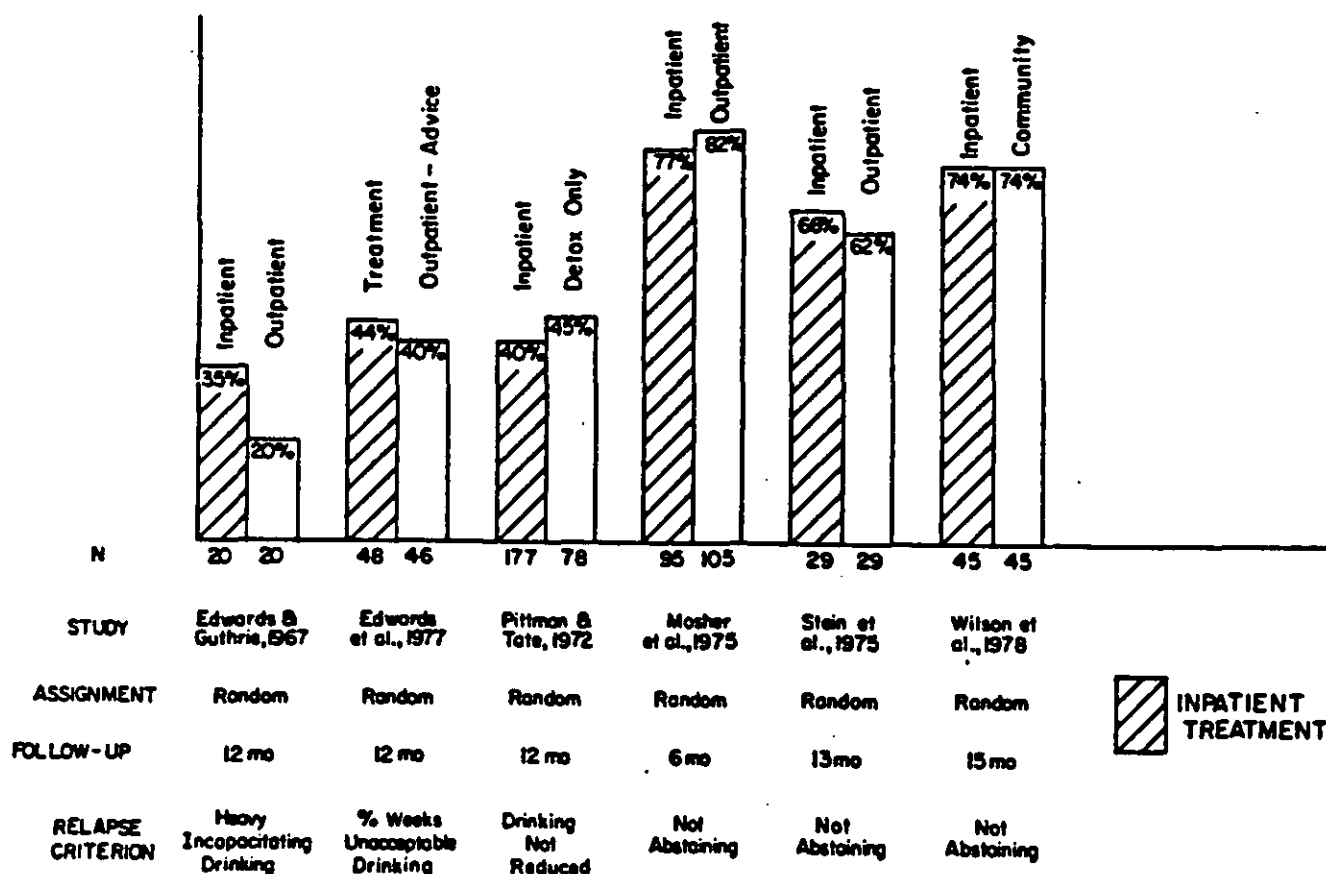
An exception to the trend of no significant differences was reported by Wilson, White, and Lange (1978). Comparing 45 alcoholics receiving inpatient hospitalization with 45 others sent to programs in the community (random assignment), they found significantly better self-concept, general adjustment, and reduction in symptoms of alcoholism among the outpatients at 5-month follow-up (64% located). These differences were no longer significant at 10 or 15 months. These data are consistent with the direction of findings (reported above) of Smart, Finley, and Funston (1977), whose outpatients at 6 months showed a 50% success rate, as compared with 25% among inpatients and no successes among halfway house patients.

Two final controlled studies are flawed by poor fol-

low-up rates. Kissin, Platz, and Su (1970) assigned 458 alcoholics to one of four alternatives: outpatient drug treatment, outpatient psychotherapy, inpatient rehabilitation, or no treatment. Random assignment was violated by allowing inpatients to opt out to either outpatient mode, an option exercised by two thirds of those clients. Although all treatments appeared to be better than no treatment, no substantial differences appeared among treatments over 12 months of follow-up. Interpretability is hindered both by violation of randomness and by the poor follow-up rate (49%). The same limitation applies to a study by Gallant et al. (1973), who assigned 210 alcoholics to inpatient versus outpatient treatment but failed to locate 92% of their sample at 12-month follow-up. The authors concluded that there were no significant differences between inpatient and outpatient alternatives, but their results are essentially uninterpretable.

Figure 2 summarizes outcomes from controlled studies of inpatient versus outpatient treatment where an index of relapse was reported. Inpatient programs are represented by striped bars in all studies. The direction of differences varies, with no significant differences in any study shown.

Figure 2
Relapse Rates in Controlled Comparisons of Inpatient Versus Outpatient Settings



Summary

Although each of these controlled studies of inpatient care could be faulted on specific methodological points, the combined results of all 16 are quite consistent. In no case was residential care found to yield superior improvement relative to less expensive treatment alternatives. To the contrary, all observed differences favored nonresidential settings. In several studies (Annis & Liban, 1979; Edwards & Guthrie, 1966, 1967; Hamilton, 1979; McLachlan & Stein, 1982), patients receiving residential care showed higher subsequent use of hospitalization, but no concomitant advantage in outcome. The consistency of findings is striking, in contrast to the inconsistent data that have emerged from uncontrolled studies.

It should further be noted that these experimental studies compare favorably on methodological grounds with the vast majority of research studies on alcoholism treatment. Unlike most studies in the field (Miller & Hester, 1980), these have included random assignment or matching, large samples, follow-ups ranging from 3 to 24 months, and high rates of contact at follow-up. Several studies verified outcomes by interviewing collaterals, and most examined both drinking behaviors and other dimensions of outcome status. It is clear from several of the reports that the authors had predicted an advantage for more intensive treatment settings; thus, their findings represent a disconfirmation of experimenter expectancies.

Length of Treatment

There is a certain intuitive appeal to the notion that treatment can be made more effective by increasing its length. Indicated earlier, uncontrolled studies sometimes have reported a positive correlation between length of stay and successful remission. In order to control for biasing factors that may influence both length of stay and outcome, however, random assignment or matching designs are needed. We found 13 studies that compared longer with shorter treatment.

Inpatient Settings

Three controlled studies reviewed earlier compared short inpatient stays of 7 to 10 days (detoxification only) with longer inpatient treatment of four weeks (Eriksen, in press), 30 days (Mosher et al., 1975) or three to six weeks (Pittman & Tate, 1972). No study found superior improvement for longer stay patients on any measure.

Page and Schaub (1979) also used random assignment to place 86 alcoholics into either three or five weeks of traditional inpatient treatment. At six-month follow-up there were no significant differences between groups on any measure, including self-reports and collateral reports of drinking, and psychological adjustment as reflected on Minnesota Multiphasic Personality Inventory (MMPI) profiles.

A similar study compared two versus seven weeks of behaviorally oriented inpatient alcoholism treatment, assigning 245 patients randomly, with replacement of dropouts (Walker, Donovan, Kivlahan, & O'Leary, 1983).

Follow-ups were conducted at three, six, and nine months (88%, 84%, and 78% completion rates). Despite the large sample size, no significant differences emerged on any measure of outcome, and the direction of differences favored the group receiving shorter treatment. Regardless of length of inpatient care, improvement was found to be positively correlated with participation in outpatient aftercare.

Finally, a study by Willems, Letemendia, and Arroyave (1973) evaluated 69 alcoholics assigned at random to a maximum of 4 weeks ($M = 20$ days) versus 8 to 26 weeks ($M = 82$ days) of inpatient care. All were offered outpatient aftercare. Follow-ups were completed at 12 months (100%) and 24 months (97%). Differences in rates of successful outcome (abstinent plus improved cases) favored shorter (71% at 12 months, 68% at 24 months) over longer treatment (55% at 12 months, 52% at 24 months), but were not statistically significant. The authors reported a marginal difference in the number of totally abstinent cases at 12 months (13 of 31 in longer treatment, versus 11 of 38 in shorter treatment).

Relapse rates in controlled evaluations of length of inpatient treatment are shown in Figure 3. Longer programs are represented by the striped bars.

Outpatient Settings

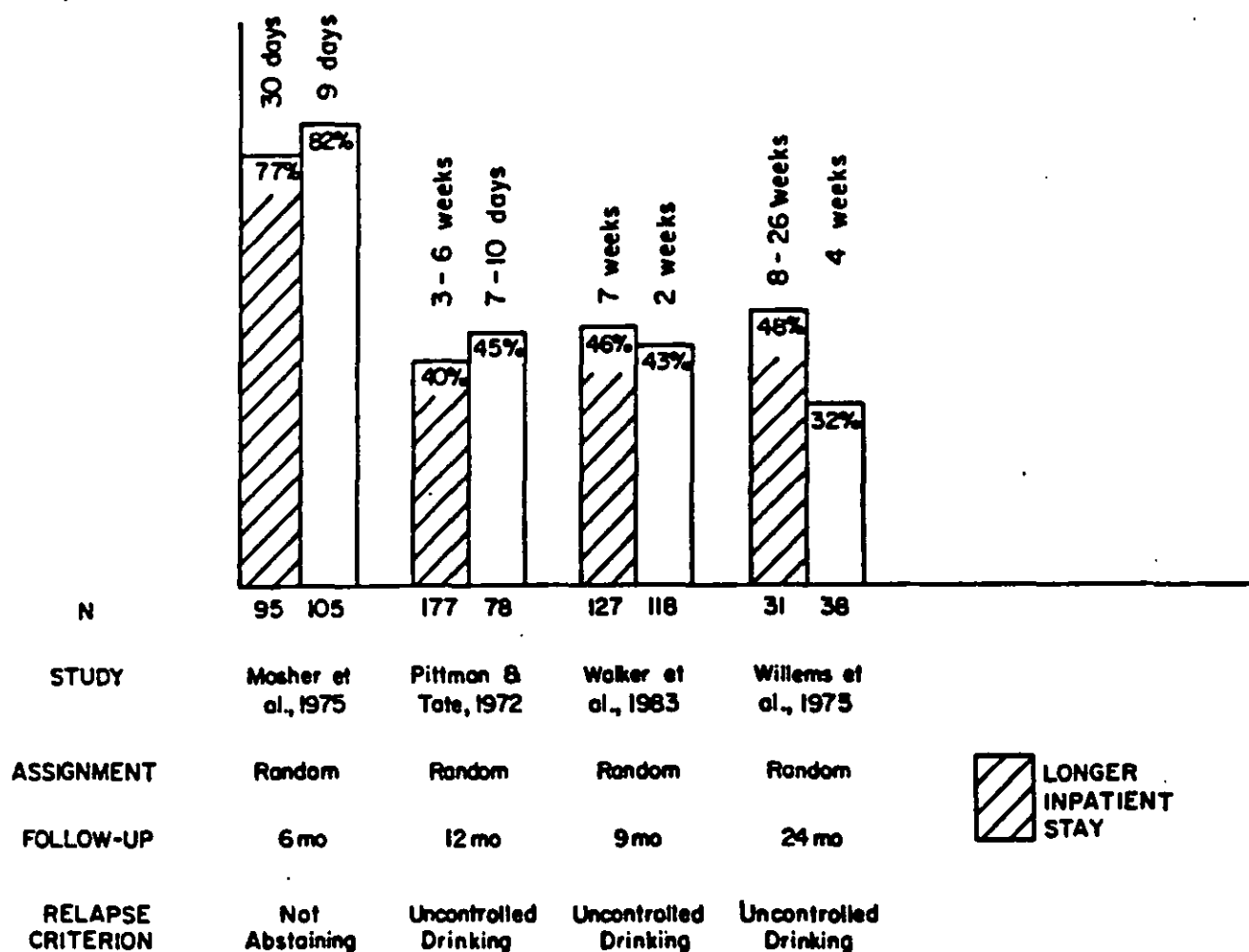
Two inpatient studies reviewed above reported that although length of inpatient treatment did not affect outcome, successful cases were more likely to have participated in outpatient aftercare (Pittman & Tate, 1972; Walker et al., 1983). Is a longer course of outpatient care more beneficial than a shorter one?

Robson, Paulus, and Clarke (1965) constructed two matched groups post hoc, consisting of 200 alcoholics treated in outpatient settings. Half of these had attended one to four sessions ($M = 2.5$), whereas the other half had had five or more visits ($M = 16$). The two groups showed similar rates of abstinence at follow-ups ranging from 10 to 46 months, but those in longer treatment showed greater overall improvement and greater reduction in severity of drinking problems. For clients who reported attending AA meetings, length of outpatient treatment was unrelated to improvement. Among those not attending AA, however, clients with more outpatient visits showed greater improvement (57% versus 37%).

A similar study was reported by Smart and Gray (1978), who constructed post hoc matched groups completing only one outpatient visit ($n = 66$), more than one visit but less than 6 months ($n = 133$), or more than 6 months of visits ($n = 311$). At 12-month follow-up no significant differences were found in improvement, although more patients were reported to be totally abstinent in the longest treatment group (16%) as compared with shorter (11%) and one-session treatment (3%).

Controlled studies employing random assignment have yielded consistent results. Powell, Penick, Read, and Ludwig (1985) randomly assigned 174 males, following inpatient alcoholism treatment, to one of three alternative forms of outpatient aftercare: (a) medication only, con-

Figure 3
Relapse Rates in Controlled Evaluations of Length of Inpatient Treatment



sisting of disulfiram and chlordiazepoxide, with brief monthly visits to adjust dosages; (b) an "active support" condition consisting of medication, individual counseling, marital/family therapy, vocational assistance, special training (e.g., relaxation), and urging to attend Alcoholics Anonymous; these efforts constituted over 100 hours of individual contact; or (c) no additional treatment except for brief monthly medical examinations. At 12-month follow-up (85% interviewed), no significant differences were observed on ratings of drinking behavior, incarceration, hospitalization, compliance, physical health, family and employment adjustment, or overall functioning.

In a series of studies, Miller and his colleagues compared longer with shorter courses of outpatient behavioral self-control training for problem drinkers. The clients in these studies were less severely impaired than typical inpatient alcoholics but were characteristic of outpatient populations: an 8- to 10-year history of alcohol abuse, clear and multiple indicators of pathological and problem

drinking, and mild to moderate symptoms of alcohol dependence. Miller, Gribskov, and Mortell (1981) randomly assigned 31 problem drinkers to receive either (a) evaluation plus a single session to explain a self-directed treatment program, or (b) evaluation plus 10 weeks of outpatient counseling using the same methods contained in the self-help program. Significant reduction in drinking occurred in both groups, with no significant differences at three-month follow-up. Miller and Taylor (1980) similarly found no differences between a minimum contact self-directed approach and 10 weeks of therapist-directed sessions. In a replication, Miller, Taylor, and West (1980) compared self-directed treatment with 6 or 18 weeks of outpatient counseling. No differences in improvement rate were found over 6 to 8 months of follow-up. This absence of differences between self-directed and therapist-directed cases was maintained at 24 months in both of the latter studies (Miller & Baca, 1983). Finally, Buck and Miller (1986) again found no differences between

self-directed and therapist-directed change programs, although both produced superior improvement in comparison to two control groups receiving no intervention self-monitoring only. Throughout this series of studies, when no differences were found between outcomes following a minimal intervention program consisting of a thorough assessment plus written guidelines for self-directed change and those associated with a program of similar content offered via weekly outpatient counseling sessions. This converges with the previously discussed findings of Edwards et al. (1977), indicating that very brief interventions may encompass the necessary elements for change.

Predictor Studies

Even in the absence of overall differences in treatment outcome between inpatient and outpatient settings, it is possible that certain types of clients derive differential benefits (or harm) from being treated in these alternative settings. This is the central issue in matching clients to optimal treatment approaches (Gottheil, McLellan, & Druley, 1981; Miller & Hester, in press-a). Relatively few of the studies reviewed above have reported differential outcome data based on client characteristics. The picture that does emerge from available data, however, is reasonably consistent.

The most commonly studied predictor variables in alcoholism treatment have been measures of problem severity and social stability. Stinson et al. (1979) found no overall differences in outcome from programs differing in staff density but did note that clients who had stable

trials, fewer years of problem drinking, and less prior history of alcoholism treatment were more successful when placed in less intensive treatment. Similarly, Kissin et al. (1970) reported that socially stable clients had more favorable outcomes in outpatient programs. Socially unstable clients, by contrast, chose and showed more favorable outcomes following inpatient rehabilitation. Clients assigned to inpatient treatment, however, had been allowed to opt out to outpatient treatment instead, leaving a select sample in residential rehabilitation. Successful outcome was also positively associated with the number of treatment alternatives from which the client could choose.

In another study allowing opt-out following random assignment, Smart et al. (1977) found that within their outpatient program every successful case had a place to live, whereas 80% of unimproved outpatients had no fixed abode. Outpatient successes also tended to be married. Among inpatients, those defined as successes tended never to have been married and to have had shorter inpatient stays.

In their two-year follow-up comparing brief counseling with combined inpatient-outpatient treatment, Drford et al. (1976) distinguished "gamma" (severe, addicted) from "nongamma" alcoholics at intake and classified outcomes as good, equivocal, or bad. All gamma alcoholics classified as having good outcomes had been in the intensive treatment condition, whereas among

nongamma clients the rate of good outcomes in brief counseling was double that following intensive treatment. Among clients with bad outcomes, the opposite pattern was observed: Nongamma alcoholics were overrepresented among failures from intensive treatment.

Willems et al. (1973), comparing outcomes following random assignment to short versus long inpatient treatment, reported that "socially maladjusted individuals in the long-stay group may have derived more benefit than those in the short-stay population (Table VII)" (p. 646). Unfortunately the table (VII) to which the authors referred was not included in the article, and the data presented indicated that social stability was mildly predictive of outcome among both the long-stay ($r = .31$) and short-stay patients ($r = .42$).

In an uncontrolled retrospective study McLellan, Luborsky, Woody, O'Brien, and Druley (1983) evaluated the predictive validity of a measure of "psychiatric severity." Patients with high severity were found, based on a six-month self-report, to be equally unsuccessful in inpatient and outpatient treatment, whereas low severity individuals showed high rates of success regardless of treatment setting. Within the intermediate range, specific levels of severity of family, legal, and employment problems showed complex relationships to outcome. Lower severity of employment and family problems (but higher severity of legal problems) was associated with more favorable outcome in outpatient settings. These findings provided matching hypotheses that were then tested in a prospective study (McLellan et al., 1983). Attempting to match a new group of 130 alcoholics to optimal treatment settings based on criteria from their retrospective study, the authors succeeded in matching 53% of cases. The remainder were mismatched due to assignment errors, clinical judgment overriding assignment, or unavailability of space in the optimal setting. Matched cases (a nonrandom group) showed superior ($p < .001$) outcome on a multivariate analysis of variance based on 19 ratings of improvement, 8 of which showed univariate differences on separate analyses of covariance ($p < .05$).

Available data, then, suggest that indicators of severity and social stability may be predictive of differential response to alternative treatment settings. The direction of findings is reasonably consistent: More severe and less socially stable alcoholics seem to fare better in inpatient (or more intensive) treatment, whereas among less severe and more socially stable (married, employed) alcoholics, outpatient (and less intensive) treatment yields more favorable outcomes than inpatient treatment. When heterogeneous populations of alcoholics are averaged together, the consistent finding is of comparable (or better) outcomes from outpatient as opposed to residential treatment.

Discussion

Treatment Setting and Outcome

Although uncontrolled studies have yielded inconsistent findings regarding the relationship between intensity and

outcome of treatment; the picture that emerges from controlled research is quite consistent. No study to date has produced convincing evidence that treatment in residential settings is more effective than outpatient treatment. To the contrary, every study has reported either no statistically significant differences between treatment settings or differences favoring less intensive settings. Every controlled evaluation of length of inpatient treatment has found no advantage in longer over shorter stays, or in extended inpatient care over detoxification alone. This is consistent with the overall literature on inpatient psychiatric care (Kiesler, 1982). Evidence on length of outpatient care is more mixed. Two studies based on matched samples yielded inconsistent results, whereas six studies employing random assignment have found no differences in outcome based on varied lengths of outpatient counseling.

Each study reviewed here could be faulted on specific methodologic grounds. The four relying on matching designs may have inadvertently produced pretreatment differences between groups on variables not matched. Penk et al. (1978), for example, reported significant pretreatment differences on ratings of alcohol abuse, a variable not employed in their matching process. This may account for the apparent discrepancies in outcome between matched and random-assignment studies of length of outpatient treatment. Many studies (e.g., Longabaugh et al., 1983; Miller et al., 1980; Willems et al., 1973) analyzed multiple dependent measures without adjusting the alpha criterion for significance based on the experiment-wise error rate (Harris, 1985). This error, however, particularly in combination with the larger sample sizes in many of these studies, would produce a bias in favor of reporting group differences (Type I error). The nature of the treated populations also varies substantially, from general psychiatric patients assessed for alcohol abuse (Penk et al., 1978) to outpatient problem drinkers (Miller & Baca, 1983) and inpatient alcoholics (e.g., Powell et al., 1985; Walker et al., 1983). Generalizability across these populations is subject to question. These methodological variations would be of greater concern were the findings mixed and might account for differences in outcome. It is noteworthy that the null hypothesis has not been refuted across this wide range of alcohol abuse populations despite analysis biases favoring alpha error.

An inherent problem in a review of this kind is that inpatient care is not a kind of treatment—it is a setting for treatment. It is plausible that an inpatient setting may offer differential advantages with certain types of treatment or with certain kinds of clients. Predictor data do provide modest evidence that inpatient settings may be differentially advantageous for the more severely deteriorated alcoholic, whereas outpatient settings may be more effective for those who are less impaired and more socially stable. Nevertheless, the controlled research to date, ranging across a variety of kinds of treatment and patient populations, has yielded not a single study to point to superior overall effectiveness of treatment in intensive residential settings.

To be sure, alcoholics treated in residential programs do improve, sometimes at impressive rates, but current data strongly question whether improvement in any way requires the expensive settings of residential care. Treatment samples in the studies reviewed above were large enough that even very modest advantages for residential settings would have been detected. Posttreatment success appears to be more powerfully influenced by participation in outpatient aftercare (Ito & Donovan, in press; Pittman & Tate, 1972; Walker et al., 1983) and by other posttreatment life circumstances (Finney, Moos, & Mewborn, 1980) than by the intensive phase of residential treatment. The very term *aftercare* implies the importance of a preceding residential phase, whereas current data indicate that the crucial conditions for change may well be contained, for most patients, in minimal outpatient interventions (Heather, in press; Miller, 1982; Ritson, in press).

Provider Accountability

The truly substantial differences between residential and nonresidential treatment of alcoholism are to be found in the cost of each approach. A routine course of inpatient alcoholism treatment now commonly costs between \$4,000 and \$15,000 (e.g., Stinson et al., 1979). By contrast, a course of outpatient treatment of the length indicated by research to be optimal would average less than 10% of this cost, even if delivered by fully-credentialed professionals at prevailing private practice rates. Self-help and paraprofessional interventions can be still more cost effective (Christensen, Miller, & Muñoz, 1978). Even if residential settings afforded a modest advantage in overall effectiveness (a notion that is not supported by current research), preference might still be given to nonresidential treatment based on cost effectiveness. Given a reasonably clear picture of equal benefits regardless of setting, nonresidential treatment offers many advantages including substantially lower cost and less intrusion into the individual's life and work patterns. Also relevant in considering health care costs is the finding in four studies that alcoholics randomly assigned to residential treatment showed substantially greater subsequent health care utilization than those given nonresidential care, but no difference in outcome. Unnecessary placement in residential treatment may foster continued superfluous use of expensive health care resources.

To be sure, certain exceptional client circumstances may warrant at least brief inpatient care. If pharmacologic dependence on alcohol is severe, inpatient medical detoxification may be warranted in certain cases to ensure the person's health and safety. Even in such cases, however, it appears that social-setting detoxification is usually feasible and that there is no overall advantage in extending the inpatient stay beyond the period necessary for detoxification (Mosher et al., 1975; Pittman & Tate, 1972). Naturally, other crisis conditions that would normally warrant brief protective admission (e.g., in the case of an acutely suicidal or violent person) apply as well to alcoholic populations. Treatment of the homeless alcoholic may require residential care for pragmatic and humani-

tarian reasons. Finally, individual difference studies suggest that intensive treatment may differentially benefit the severely deteriorated and socially unstable alcoholic.

In arguing for the necessity of inpatient care in treating alcohol abuse itself, however, the burden of proof is clearly on the primary beneficiaries of intensive treatment: the for-profit providers. Under present policies, there are very few conditions of accountability for quality and effectiveness of treatment beyond minimal standards for institutional care. Alcoholism programs increasingly use public media advertising to promote their services, with few checks on the accuracy of their statements and claims. We informally polled two dozen local alcoholism treatment programs, inquiring (without identifying ourselves as professionals) as to their cost and effectiveness. Slightly fewer than half of the programs quoted percentages of success, averaging in excess of 80%. On further inquiry, no program was able to provide data to substantiate their claims.

One manifestation of this absence of accountability is a nearly complete lack of overlap between treatment approaches found to be effective in changing alcohol problems and those commonly employed in U.S. alcoholism programs (Miller & Hester, 1980, in press-b). Empirically supported treatment methods such as Azrin's community reinforcement approach (Azrin, 1976; Azrin, Sisson, Meyers, & Godley, 1982) remain virtually unused in standard treatment. Indeed, the traditional elements of American residential alcoholism treatment have not changed substantially in 20 years, despite major advances in the field (Miller, in press; Moore, 1977). Babow (1975) argued that

the monopolistic perspective fosters a "closed corporation" mentality, fails to provide accountability, avoids seeking evidence of the outcome of treatment, and does not devise more appropriate criteria for improvement. The tendency, therefore, of such a monopolistic perspective is to have as its major concern the enhancement of the caretaker (or those perceived to have such qualifications) rather than on the people who need help for their drinking problems. (p. 123)

Interim Proposal

Even though the only clear significant overall difference between residential and nonresidential alcoholism programs is in the cost of treatment, it would seem prudent for public and private third-party payers to enact policy that emphasizes the hospitalization model of care where it is nonessential and encourages the use of less expensive but equally effective alternatives. A "3 R's" model of treatment (*remove* from society, *repair* the problem, and *replace* in society) is outmoded and inadequate as a means of addressing alcohol problems (Moore & Gerstein, 1981). The Office of Technology Assessment of the U.S. Congress (1983) recently concluded that

any alcoholism treatment services are not cost effective—i.e., there are less expensive ways of providing treatment than are selected in current reimbursement policy. However, reimbursement systems, particularly the Medicare and Medicaid

programs, have overwhelmingly emphasized the most expensive treatment services—inpatient, medically based treatment. (p. 66)

In practice, a conservative reimbursement policy consonant with current data might require a competent course of outpatient treatment (employing research-supported intervention methods) before residential care is reimbursable. (Such a policy presumes, however, that residential care would be more likely to succeed when nonresidential treatment has failed, an assumption with no current empirical moorings.) Initial use of residential treatment should require justification based on predictive data. Exceptional circumstances such as documented severe dependence, physical violence within the family, social instability and lack of housing, or acute suicidal risk might, of course, still warrant brief hospitalization as a precursor to treatment. A minimal step in the right direction would be at least equally favorable cost-reimbursement coverage for outpatient care, as compared with inpatient care. At present, many insurers provide higher reimbursement rates for inpatient treatment of alcoholism, thereby encouraging its use.

Social policy must also address the fact that the financial interests of alcoholism treatment providers (now a multibillion dollar industry) run precisely counter to the directions that seem wise and prudent in light of current research evidence. Programs tend to recommend the particular services they provide, without regard to differential diagnostic characteristics of the client (Bromet, Moos, Wuthmann, & Bliss, 1977; Hague, Donovan, & O'Leary, 1976; Hansen & Emrick, 1983). Although opinion seems to be shifting (McClellan, 1985), employee assistance programs still frequently emphasize intensive residential treatment for populations that, by virtue of their employment, are likely to be more socially stable and have less severe problems—predictors of less favorable response to intensive inpatient treatment. Indeed, research suggests that individuals most likely to be able to pay (or have insurance to pay) for intensive treatment are also those least likely to need and benefit from it. The extant predictive data indicate that, if there is a population more likely to benefit from residential care, it is the more severely deteriorated and less socially stable alcoholics. Even within such populations the relative cost effectiveness of inpatient care is questionable, because absolute differences in setting effectiveness are typically small, whereas cost differences are substantial. Reimbursement policy consistent with these findings would enact contingencies to restrain the provision of expensive residential care when alternatives are available, while ensuring the availability of publicly funded programs to make intensive care available, when essential, to those most likely to benefit from it.

Responsible social policy remains responsive to new data. Further research may yield clearer guidelines regarding subpopulations likely to derive differential benefit from residential (and nonresidential) settings. More important, as data continue to substantiate the relative effectiveness of particular treatment methods, policy should

more aggressively address the content as well as the setting of alcoholism treatment. It seems likely that whatever impact treatment may have will be more influenced by what is done than by where it is done.

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Is Inpatient Rehabilitation of the Alcoholic Cost Effective? Con Position

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ABSTRACT. Across all sectors of the health care system there is pressure to increase the cost-effectiveness of service delivery. In recent years, a number of official reports in the alcoholism field have called for the establishment of alternatives to traditional inpatient hospitalization for alcoholics. This paper briefly reviews five bodies of scientific evidence that bear on this recommendation. It is concluded that: (i) inhospital alcoholism programmes of a few weeks to a few months duration show no higher success rates than periods of brief hospitalization of a few days; (ii) the great majority of alcoholics seeking treatment for alcohol withdrawal can be safely detoxified without pharmacotherapy and in nonhospital-based units—detoxification with pharmacotherapy on an ambulatory basis has also been shown to be a safe alternative at one-tenth the cost; (iii) "partial hospitalization" (day treatment) programmes have been found to have equal or superior results to inpatient hospitalization at one-half to one-third the cost; (iv) well-controlled trials have also demonstrated that outpatient programmes can produce comparable results to inpatient programmes—one estimate places the cost saving at \$3700 per patient compared with the typical course of inpatient treatment; and (v) a growing body of evidence suggests that if patients could be matched on clinically significant dimensions to a range of treatment alternatives, much higher overall improvement rates in the alcoholism treatment field would be observed. The question that should guide future investigation is "What treatments are most effective for what types of alcoholics?"

Spiralling health care costs in recent years have created community and government pressure on professionals to become more

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sensitive and responsive to cost considerations. Serious attention has recently been focused on evaluating the effectiveness of traditional methods of service delivery compared with alternative care strategies. The alcoholism treatment field is no exception. The critical examination currently ongoing by professionals in the alcoholism area can be seen to have striking parallels in the mental health field generally. In both fields, inpatient hospitalization has evolved as the cornerstone of service delivery. In both fields, a growing body of evidence suggests that this unitary approach is not cost effective for the majority of patients.

It has been noted, that professionals develop strongly-held beliefs about the efficacy of hospitalization that are not empirically based but are nonetheless very difficult to change.¹ Historically, it is perhaps understandable that inpatient care became accepted as the treatment of choice for alcoholics since the cases that came to the attention of professionals were predominantly severe chronic alcoholics admitted to hospital with acute medical and psychiatric problems. However, by the early 1950's it was recognized that the majority of alcoholics in need of specialized alcoholism services did not fit this description. A 1951 Report of the World Health Organization Expert Committee on Mental Health concluded that "successful ambulatory treatment is possible for a very high proportion of (alcoholic) cases; and the question of hospitalization need seldom enter into consideration".² This expert Committee, of which E.M. Jellinek was a member, strongly recommended the establishment of networks of outpatient services for alcoholics and confidently predicted that when such services were available the need for inpatient hospitalization would progressively diminish. This recommendation still has validity today. Very limited progress has been made in many countries in setting up such alternative service networks. In the United States, a 1965 survey of existing models of alcoholism services, conducted by The Joint Information Service of the American Psychiatric Association and the National Association of Mental Health, concluded that outpatient clinics should be considered the backbone of alcoholism services and that most alcoholics would rarely if ever need inpatient hospital care if such alternative services were available.³ In the last few years a growing number of official reports from many countries have called for the establishment of alternatives to inpatient hospitalization for alcoholics. 46

What is the strength of the evidence on which these recommendations are based? How effective are alternative treatment strategies

compared with inpatient hospitalization of the alcoholic? What cost savings could be anticipated through the development of other service delivery networks? It is the purpose of this paper to briefly review five bodies of scientific evidence that bear on these issues: (1) the relationship of length of hospitalization to treatment outcome; (2) ambulatory and supportive care alternatives to the routine use of pharmacotherapy in the inpatient detoxification of alcoholics; (3) the efficacy of day treatment as an alternative to inpatient programming; (4) the comparative efficacy of outpatient versus inpatient treatment alternatives for alcoholics; and finally (5) the role of differential treatment assignment in increasing the cost effectiveness of alcoholism treatment programming.

LENGTH OF HOSPITALIZATION AND OUTCOME

Even among proponents of inpatient hospitalization of alcoholics, there is little consensus regarding the optimum length of stay. Programmes serving similar populations of alcoholics and employing similar therapeutic modalities adhere to vastly different inpatient recovery periods ranging from a week to several months. Historical precedent and unsubstantiated clinical impression appear to play a larger role in determining length of inpatient programming in most settings than reliance on empirical evidence.

Several uncontrolled studies have reported a correlation between length of treatment contact and outcome;^{37,43,44} however, patient self-selection factors such as social stability and the severity of drinking history may well account for both length of stay and successfulness of outcome in these studies. Fortunately, several well-controlled randomized trials have been reported comparing outcomes associated with different lengths of hospitalization for alcoholics within single institutions. These studies, comparing multi-modal alcoholism treatment programmes of varying length, have consistently found no advantage of prolonged hospitalization. No significant difference in outcome has been reported for patients randomly assigned to active inpatient alcoholism programmes of 3 week versus 5 week duration,⁷ 3 week versus 3 month duration,⁸ or even 9 day versus 1 month duration.⁹ The demonstrated comparability of outcome of inpatient stays ranging in length from several days to a few months suggests that factors other than length of treatment may be of greater concern in the design of future alcoholism treatment programming.^{7,10}

Conclusion. Lengthy periods of hospitalization in alcoholism treatment programmes have not been shown to result in better outcome, on average, for unselected groups of alcoholics than hospital stays of brief duration.

ALTERNATIVES IN DETOXIFICATION

In recent years, there has been questioning of traditional assumptions about the routine use of pharmacotherapy in alcohol withdrawal, and of the role of inpatient hospitalization in the detoxification process. In some parts of Canada^{11,12} and of the United States,¹³ nonhospital, social setting detoxification has been found to be safe and cost effective. In such non-hospital based units, staff are trained to refer alcoholics who present with medical complications (2-5% of admissions) to a hospital emergency department. Alcohol withdrawal without pharmacologic intervention has been found to be safe for the majority of community-referred alcoholics.^{14,15}

Several studies have suggested that ambulatory detoxification can be successfully completed with 90% or more of alcoholics who present at hospitals in withdrawal.¹⁶⁻¹⁸ The ambulatory detoxification model encourages the involvement of a friend or family member in supporting the alcoholic through withdrawal, and typically prescribes medication on a day-to-day basis, including an alcohol-sensitizing drug, such as Antabuse, as soon as the patient's BAL level drops to zero. These programmes have reported very high rates of success in involving their patients in outpatient counselling services following detoxification. The costs associated with ambulatory detoxification have been estimated to be as low as one-tenth those of inpatient detoxification.¹⁷

Conclusion. The great majority of alcoholics do not require the use of pharmacotherapy in alcohol withdrawal and can be safely detoxified in non-hospital-units. Ambulatory detoxification with the use of medication has also been found to be a safe alternative at a fraction of the cost of inpatient detoxification.

INPATIENT VERSUS DAY TREATMENT

In an attempt to reduce costs but at the same time maintain an approximately equivalent intensity of treatment, day treatment or "partial hospitalization" alternatives have been proposed to full in-

patient treatment of alcoholics. Early, uncontrolled reports appearing in the literature in the 1960's^{19,20} suggested that the day hospitalization model was promising and warranted further investigation. Very recently, two randomized control trials have been reported on the comparative efficacy of day treatment versus inpatient treatment of alcoholics.

In a report by McLachlan,²¹ from the Donwood Institute in Ontario, Canada, 100 alcoholics who did not require hospitalization for the management of physical illness or withdrawal were randomly assigned to receive the same four week programme on an inpatient or on a day clinic basis. The programme involved detoxification, medical consultation, prescription of an alcohol-sensitizing drug (disulfiram or citrated calcium carbimide), group psychotherapy, education, relaxation training, nutritional counselling, physiotherapy, physical education and individual planning for a life-style free of alcohol. The aftercare component was identical for patients in two groups; all patients were encouraged to attend weekly group meetings for at least one year following discharge. Outcome was assessed on multiple criteria including drinking behaviour, subsequent hospitalization, use of other medical resources, mental state, legal problems and employment record. No outcome measure favoured the inpatient group. Day clinic patients showed significantly fewer hospital readmissions and fewer days hospitalized during the one year follow-up period; this finding agrees with a growing body of evidence in the mental health field¹ indicating that alternatives to inpatient programming foster lower subsequent rates of utilization of hospital beds. Furthermore, a cost analysis indicated that the day clinic alternative was 65% less costly to operate than the inpatient programme. The health-insurance plan in the Province of Ontario now recognizes the potential effectiveness of the day clinic option and provides full coverage for day treatment.

A second well-controlled trial on the cost effectiveness of day treatment versus inpatient treatment of alcoholics has recently been reported by Longabaugh²² from the United States. Following a period of detoxification, 174 patients at the Butler Hospital in Providence, Rhode Island, were randomly assigned to receive the same three week, behaviourally-oriented, treatment programme on an inpatient or a day care basis. Over 90% of the sample had an intake diagnosis of alcoholism and about 60% had prior alcohol-related hospitalizations. Time in treatment amounted to 12 hours/week for the day care group compared to full 24 hours a day care for the three week period for the inpatient group. A cost analysis of the two pro-

grammes indicated that the cost associated with day treatment was approximately half that of inpatient treatment. Six month follow-up data showed no differences between the groups in their consumption of alcohol or in their social and vocational adjustment. There was an indication that feelings of subjective well-being were greater for patients exposed to the day programme. In line with similar findings from the psychiatric treatment field,²³ the authors suggest that the dependency structure of inpatient 24 hour/day institutional care may sustain a lack of a sense of well-being and subjective distress, particularly in patients with low esteem.

Conclusion. The available evidence, although limited to a couple of well-controlled studies, supports the conclusion that inpatient treatment is two to three times more expensive than day treatment, without being demonstrably more effective.

INPATIENT VERSUS OUTPATIENT TREATMENT

Apart from the intensive day treatment alternative, is weekly outpatient treatment any less effective than inpatient treatment for heterogeneous groups of alcoholics presenting for treatment? A number of review articles²⁴⁻²⁷ have concluded that overall improvement rates of alcoholics discharged from outpatient clinics compare very favourably with rates reported for inpatient programmes. A large scale evaluation, conducted by the Rand Corporation, of alcoholics discharged from NIAAA-funded Alcoholism Treatment Centers in the United States failed to find significant differences in outcome for patients treated in inpatient versus outpatient settings.²⁸ These results, however, are difficult to interpret because alcoholic clients who self-select to enter inpatient or outpatient programmes may differ in important but unrecognized prognostic characteristics. Fortunately, a number of controlled clinical trials have now been reported in the literature, involving random assignment of clients to treatment conditions, which permit a direct comparison to be made of the general effectiveness of these treatment alternatives.

In a study conducted in England,^{29,30} 40 male alcoholics were randomly assigned to receive similar services on an inpatient or an outpatient basis. Clients in both conditions received psychotherapy, were encouraged to attend A.A., were given a prescription for an alcohol-sensitizing drug (citrated calcium carbimide) and were offered family casework and help with employment and other social

problems. The length of treatment was about equal in the two conditions (i.e., 9 weeks for inpatients and 8 weeks for outpatients). At one year follow-up, the outcome results, in terms of drinking and consequences of drinking, favoured the outpatient group.

A study by Wanberg, Horn and Fairchild³¹ was designed to determine whether clients who would normally have been admitted to a well-established, in-hospital alcoholism treatment programme in the U.S. would fare equally well if treated in their homes and communities. One-third of a study sample of 180 clients were assigned at random to community treatment in which they were seen at least three times by a worker in the community, while the remaining two-thirds were assigned to the two week inpatient programme. Both groups were offered group aftercare therapy on an outpatient basis. Preliminary results at three months only slightly favoured the inpatient group in terms of general adjustment ratings. However, the community-based intervention was shown to be highly successful for a substantial proportion of the patients.

In an evaluation of alternative treatment settings for alcoholic municipal court offenders, Gallant³² randomly assigned alcoholic offenders to 4 weeks of compulsory inpatient treatment followed by outpatient treatment, or simply to compulsory outpatient treatment. A major question being addressed was whether the additional personnel time and financial expenses for inpatient treatment were worthwhile in terms of greater treatment success. Six month follow-up data failed to show any significant differences in outcome for the two groups.

A well controlled study by Stein, Newton and Bowman³³ found no support for the proposition that inpatient treatment, modelled after the vast majority of such programmes in both state hospitals and private hospitals in the U.S., has any beneficial effects beyond those of outpatient treatment. Fifty-eight alcoholic men admitted to an inpatient Alcoholism Treatment Center (ATC) in Wisconsin were randomly assigned to a control group which received up to 10 days of detoxification plus community after-care services on an outpatient basis, or to a treatment group which received 4 weeks of inpatient programming following detoxification. The inpatient treatment was directed toward helping the alcoholic patient become less defensive and more self-confident through involvement in ward meetings, small group psychotherapy, recreational and occupational therapy, didactic lectures on medical and psychological aspects of alcoholism, religious counselling and A.A. meetings. As with the control

group, arrangements were made prior to discharge for aftercare services in the community. The inpatient unit, accommodating an average of 43 patients, was well-staffed with 3 physicians, a psychologist, 3 psychiatric social workers, an activity therapist, 2 A.A. counsellors, 5 nurses and 14 psychiatric aides. Given this staffing pattern and the diversity and intensity of the programme, this inpatient unit compares very favourably to some of the better ATC programmes in the U.S.³ Follow-up interviews, completed on 90% of the sample at 5 intervals over a 13-month post-discharge period found no significant differences between the inpatient and outpatient groups on any of a wide range of measures of drinking behaviour, social functioning, financial or employment status, use of community agencies or re-admission to treatment. The authors have concluded that inpatient hospitalization has a very limited role to play in the treatment of alcoholism and that its role should be limited to treating the medical sequelae of addiction.

Conclusion. The weight of evidence from well-controlled clinical trials is clear. Outpatient treatment of heterogeneous groups of alcoholics produces an essentially equivalent outcome to inpatient treatment at substantially lower cost.

Summary. Inpatient hospitalization, offering a single multimodal treatment package to all admissions, remains the cornerstone of service delivery in the alcoholism field. Relapse rates are typically high (over 60%),^{35,36} within the first three months after discharge from hospital. The research evidence reviewed above suggests that this single shotgun approach to treatment programming is based on a number of faulty assumptions: (a) that extended hospitalization is more effective than brief hospital stay; (b) that inpatient detoxification is usually necessary or desirable; and (c) that inpatient rehabilitation results in significantly better improvement rates than day or outpatient programming. The model is flawed in other respects. The assumption that a single treatment package is appropriate for all admissions fails to take into account the tremendous heterogeneity of background and type and severity of presenting problems among alcoholics seeking treatment. Furthermore, particular components of multimodal treatment packages have been shown to be contraindicated for some patients resulting in poorer remission rates.⁴⁵ It can no longer be assumed that intensity and diversity of treatment programming will produce better outcome.

Advantages of Day/Outpatient Alternatives. In addition to substantial cost savings,³⁴ there are theoretical reasons for prefer-

ring to treat alcoholics on an outpatient basis. A patient's behaviour on an inpatient unit is not predictive of the adjustment that he/she must make to cope successfully in the outside community. It is perhaps not surprising, therefore, that relapse rates as high as 60-80% have commonly been reported by three months post-hospital discharge.^{35,36} Treatment on an outpatient basis allows a more valid assessment of environmental, cognitive and emotional antecedents of drinking episodes and drinking urges on the part of a patient, and allows the patient to test new coping strategies while still within a supportive counselling relationship. These conditions would be expected to foster greater generalization of learning in treatment to the patient's natural environment. Furthermore, it should be noted that the frequently-voiced argument that inpatient treatment of alcoholics is essential because of high attrition rates associated with outpatient counselling, is not supported by the available evidence. Attrition rates from inpatient programmes have been shown to be as high or higher than from outpatient settings.³⁷

The results emerging in the alcoholism treatment field on the cost effectiveness of alternatives to inpatient hospitalization are entirely consistent with findings in the mental health field generally. Several recent reviews of the research evidence have concluded that alternatives to hospital inpatient programmes are as effective for large proportions of patients currently being admitted to psychiatric hospital beds.^{1,38,39} Moreover, costs for some types of inpatient services have been estimated to be five times greater than for outpatient treatment.¹⁶ Kiesler⁴⁰ reviewed ten studies conducted on samples of seriously disturbed patients, who had been recommended for psychiatric hospitalization, but had been assigned on a random basis to inpatient hospitalization or an alternative mode of care. Across all ten studies, the effects of alternative care were consistently more positive than those of psychiatric hospitalization. Moreover, there was clear evidence that hospitalization was a self-perpetuating phenomenon; patients who were randomly assigned to hospital inpatient treatment had higher rates of readmission to hospital than patients who were assigned to an alternative mode of care.

The self-perpetuating nature of inpatient admissions has also been observed in the alcoholism treatment field.^{21,41} Such findings suggest that the cost advantages of alternatives to inpatient treatment relate not only to the lower operating costs of such programmes but also to subsequent cost savings in reduced hospital stays. These additional cost savings have yet to be adequately estimated. However,

it is clear that the total costs associated with inpatient treatment of a substantial proportion of the alcoholic population are many times higher than those associated with alternative service delivery models of equal or superior effectiveness. It is little wonder, therefore, that many researchers have questioned the wisdom of continuing to invest in expensive inpatient facilities.^{5,26,28,42}

Nevertheless, in the United States, an increase has been reported in the number of alcoholism units in general hospitals.⁴ It seems that general hospitals are finding such units, offering a 3-to-4 week inpatient programme for alcoholics, attractive sources of revenue as declining admissions create surplus beds and mounting overhead costs. Diesenhaus⁴ has pointed out that these inpatient facilities tend to admit alcoholics who are married, employed, socially stable and who have experienced only a few years of heavy drinking, thereby creating a paradox in that those alcoholics with the best prognoses are more likely to be admitted to the most intensive and expensive treatment settings because of the greater availability of third party coverage for inpatient settings. A report released last year by the U.S. Government Office of Technology Assessment,³⁴ concludes that treatment in the alcoholism field in the United States has developed around what is reimbursable and that reaction of carriers to the scientific evidence on the cost effectiveness of alternative outpatient and non-hospital-based services has been slow.

DIFFERENTIAL TREATMENT ASSIGNMENT

There is a growing consensus that the search for a single treatment approach that will be effective for all alcoholics is misguided.^{27,46-49} It has been documented that patients of differing background characteristics, and personality types^{46,50} are attracted to different settings and types of programmes. Such findings suggest that the establishment of multiple complementary treatment alternatives⁴⁶ might be desirable to permit a greater choice of services among alcoholics seeking treatment. Unfortunately, it is not known from these studies whether improvement rates are better among patients who enter self-selected programmes than they would be in alternative treatments.

There is, however, a modest but expanding research literature supporting what has become known as the "matching hypothesis"—namely, that alcoholics matched to treatments on the basis of clinically significant dimensions show a significant increase in improve-

ment rates. Six studies^{28,45,51-54} providing evidence for the value of differential treatment assignment are reviewed below.

One of the earliest convincing demonstrations of a patient-treatment matching effect was reported in a Canadian study on conceptual-level theory by McLachlan.⁵¹ It was proposed that patients high in conceptual level (i.e., independent, empathic, conceptually-complex individuals) should do better in unstructured, non-directive types of therapy, while patients low in conceptual level (i.e., impulsive, poorly socialized, cognitively-simple individuals) should show better response to highly structured types of therapy. For both groups of patients, the results supported the hypothesis; patients matched to the appropriate type of therapy showed more improvement than mismatched patients.

A second Canadian study, by Annis,⁵² demonstrated the importance of a personality variable in assignment to treatment. One hundred and fifty male incarcerated alcoholics of high versus low self-image were randomly assigned to 224 hours of intensive, confrontive, group psychotherapy or to institutional care. Alcoholics of high self-image showed better outcome in the group therapy programme than under institutional care, while the reverse was true of alcoholics of low self-image. For those low in self-image the group therapy programme apparently had a detrimental effect. This controlled trial suggests that in treatment one man's meat may be another man's poison. Treatments helpful to some patients may actually be harmful to others.

Another demonstration of a client-treatment interaction effect is provided by a study conducted in England by Orford.⁴⁵ It was found that gamma (or "dependent") alcoholics responded well to intensive treatment but were not helped by minimal advice counselling. Just the reverse was true of non-gamma alcoholics, who showed better improvement in the minimal advice condition. A significant interaction was also observed between patient type and treatment goal achieved; non-gamma alcoholics had superior results through controlled drinking, while gamma alcoholics fared better through abstinence.

Further evidence for the importance of matching patients to the appropriate treatment goal is reported by Polich²⁸ in the large-scale follow-up of patients discharged from NIAAA-funded Alcoholism Treatment Centers in the United States. Older patients with high levels of alcohol dependency had lower relapse rates through abstinence, while younger patients with low dependency symptoms

showed better outcome through social drinking. These results are consistent with Orford's⁴⁵ findings.

Evidence that the prescription of an alcohol-sensitizing drug may be beneficial to some patients while harmful to others was presented in a study conducted in Boston, Mass. by Mayer.⁵³ Among patients of low social stability, use of disulfiram was associated with improved recovery rates. Conversely, disulfiram use was associated with poorer recovery in patients of high social stability.

Finally, a recent study on matching effects has been completed within the Veterans Administration medical centers in Philadelphia. McLellan⁵⁴ proposed a system of matching patients to six specific inpatient and outpatient treatment programmes on the basis of ratings of psychiatric severity and severity in other problem areas such as employment and family relations. A clinical trial comparing the results of matched and mismatched patients showed an average of 27% better outcomes for matched patients. Overall, patients of similar severity ratings did equally well in the various outpatient programmes, compared with the inpatient programmes. The average saving of outpatient treatment was \$3700 per patient compared with the typical course of inpatient treatment.

Results, such as those emerging from the six studies reviewed here, hold promise for the potential of differential treatment assignment in improving alcoholism treatment outcome results. Our knowledge base concerning clinically significant dimensions on which to diagnose patients for assignment to alternative treatments is currently meager. Nevertheless, some promising dimensions are emerging. Controlled trials are needed in which clients of differing diagnostic profiles are randomly assigned to alternative treatment programmes.⁵² Developmental models have been proposed^{47,55} whereby feedback from outcome results within treatment delivery networks would be used to continually upgrade patient-treatment matches resulting in a gradual improvement in success rates. With the accumulation of research on differential treatment effects, it should prove possible to develop guidelines for the optimal matching of patients to a range of treatment alternatives.

CONCLUSION

In summary, overall outcome results in the alcoholism treatment field have been disappointing with relapse rates typically running to over 60% by three months post-treatment discharge. In terms of the

comparative efficacy of inhospital rehabilitation of the alcoholic, the empirical evidence overwhelmingly supports the following conclusions: (i) inhospital alcoholism programmes of a few weeks to a few months duration show no higher success rates than periods of brief hospitalization of a few days; (ii) the great majority of alcoholics seeking treatment for alcohol withdrawal can be safely detoxified without pharmacotherapy and in non-hospital-based units—detoxification with pharmacotherapy on an ambulatory basis has also been shown to be a safe alternative at one-tenth the cost; (iii) "partial hospitalization" (day treatment) programmes have been found to have equal or superior results to inpatient hospitalization at one-half to one-third the cost; (iv) well-controlled trials have also demonstrated that outpatient programmes can produce comparable results to inpatient programmes—one estimate places the cost saving at \$3700 per patient compared with the typical course of inpatient treatment; and (v) a growing body of evidence suggests that if patients could be matched on clinically significant dimensions to a range of treatment alternatives, much higher overall improvement rates in the alcoholism treatment field would be observed.

Is inpatient rehabilitation of the alcoholic cost effective? When given to unselected groups of alcoholics seeking treatment, clearly the answer is emphatically "no". Comparable results can be produced on an outpatient basis at a small fraction of the cost. Nevertheless, with the growth of research knowledge in the field, it may someday be possible to specify a subgroup of alcoholics who can best profit from this approach. Available evidence suggests that the number of such patients is likely to be relatively small. In the interim, inhospital rehabilitation might best be restricted to the management of the medical sequelae of addiction, and perhaps used as a last resort for patients for whom alternative treatment approaches have failed. Future advances in the alcoholism treatment field will be guided by a more sophisticated question⁴⁹:—What treatments are most effective for what types of alcoholics?

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73 - Criteria for outpt. Pt.
- drop out problems - suggested solution

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ALCOHOLISM OUTPATIENT TREATMENT

STRICTLY SPEAKING, OUT-patient treatment of alcoholism is not a treatment. It is a situational context where treatment takes place, usually labeled as such in order to be contrasted with inpatient treatment. Historically, inpatient treatment was often assumed to be the treatment of choice because alcohol problems only came to the attention of helpers when there were severe manifestations associated with intense or chronic alcohol abuse (i.e., heavy intoxication, addiction, or medical and psychiatric problems). Beyond this, many alcoholics at this stage of drinking were unable to interrupt their pattern of drinking or were too enmeshed in a problematic family context to begin effective treatment. Indeed, for the problems just mentioned, an inpatient setting with a higher degree of control and separation from the community is more desirable. Another advantage of inpatient treatment (although unfortunate) are the policies of payment by third parties for inpatient but not outpatient treatment, although this is changing [11]. The problems of alcoholism have a wide range of expression and inpatient treatment is not only not a prerequisite for success, it may be disadvantageous if the stay is extended for many days. It is also unfortunately true that alcoholics are not well treated by general hospitals; they are

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often viewed as special problems who require too much attention, are unmotivated, and are not suitable for treatment [16].

The advantages for outpatient treatment are basically much lower economic and social cost. The patient being treated on an outpatient basis can expect a continued enmeshment in his or her community roles and benefit from community supports — job and family, to name the most important. Aside from the usual economic difficulties associated with alcoholism, the patient does not have to contend with the continually increasing cost burden of inpatient treatment, nor with the problems of institutionalization and dependency that occur to some extent with anyone, but particularly with alcoholics experiencing a hospital stay that lasts from 2 to 4 weeks. Outpatient treatment is inherently more flexible and accessible, thus giving it greater probability of being individualized. Thus it is simply more practical to treat alcoholism on an outpatient basis, and in fact, the major portion of most alcoholism treatment in this country is done in this way, using inpatient modalities as an adjunct.

CRITERIA

The criteria for outpatient treatment point to a modicum of social functioning as a basis for attempting to use this context. By this is meant that there would be no incapacitating medical or psychiatric problems, the postacute symptoms would be mild, the person would be capable of maintaining sobriety or controlling drinking to some extent, and less than maximal support would be required in order to maintain functioning. Appropriate candidates for outpatient treatment tend to have characteristics similar to persons who benefit from any psychological treatment. In the case of alcoholism literature, those characteristics are social intactness (married), higher socioeconomic class (education and occupation), motivation (fear or avoidance of consequences), a young age, and a low incidence of alcoholism in one's family history. Beyond this, alcoholics do better with counselors with whom they can form a good relationship, and often these will be persons that tend to be dominant and can take charge when appropriate. As treatment continues there is a tendency for lower class patients to be given more medication and environmental intervention, higher class patients to be given more psychologically oriented treatments.

CONTEXTS

The contexts for outpatient treatment are basically four: (1) community mental health centers, (2) general hospital clinics, (3) free-standing alcoholism clinics, (4) and the office of a private practitioner. Although each context will offer simi-

lar types of services (to be iterated shortly), there are some differences to be noted. Community mental health centers have greater access to halfway houses, vocational rehabilitation services, and some psychiatric consultation. Hospital clinics have greater access to medical and psychiatric consultation, but may focus too much on physical problems and be less acceptable because of location, parking, and demands on space and time. Alcoholism clinics are oriented toward a person's drinking behavior, but may have little access to other resources. Practitioners are either therapists or doctors, with one more likely to ignore physical complications, the other the meaning of the symptoms psychologically; both tend to be narrow in their approach because their training was not necessarily relevant to the needs of the alcoholic.

An outpatient clinic offering traditional forms of psychotherapy is usually not satisfactory because an alcoholic typically needs more services than the modal clinic can provide — for example, detoxification and vocational help. The more services available, the better able a facility is to provide for the unique needs of each alcoholic. However, as services proliferate, the crucial issues of organization and coherence become more critical. Any alcohol program must be cognizant of its embeddedness in the local culture, to be aware of local attitudes, support systems (agencies), and helpers (clergy) in order to provide for continuity and coordination of the services available. Ideally services are not applied in a shotgun manner, but rather they are individualized and (it is hoped) have some theoretic coherence [13]. When these difficult issues are addressed, treatment effectiveness increases markedly.

TREATMENT GOALS

The goals of treatment depend largely on the theoretic view of alcoholism that is held, and often on the services available. Traditionally, the goal has been complete abstinence, and abstinence attainment was indicative of a successful outcome. Conventional wisdom held that the termination of drinking would have positive impact on all other areas of life functioning. Abstinence was based on the assumption that the "disease" could not be cured, but its course could be arrested by abstinence. This view is explicit in the philosophy of Alcoholics Anonymous (AA) and dominates the treatment practices of many organizations.

In the last decade, this consensus has been challenged by empirical studies that have evaluated other outcome criteria (and found the correlations to abstinence low), and by advocates of controlled drinking (i.e., a return to some form of nonproblematic, stabilized drinking). These advocates view alcoholism theoretically as learned behavior that can be unlearned, or as symptomatic either of an underlying personality disorder that itself needs treatment or of a familial dysfunction. Those who espouse a learning orientation opt for learning-based strategies of treatment (behavior modification); those who see alcoholism as

symptomatic opt for problem solution or other forms of individual, group, or family psychotherapy. Many studies (over 70) have been collected to show that 5 to 15% of alcoholics can return to some pattern of attenuated drinking. Some have proposed using distinctive labels for differentiation (i.e., problem drinkers vs. alcoholics).

What is emerging out of the empirical studies and the controversy is a more explicit recognition that abstinence is only one of several possible treatment goals in the area of drinking behavior, and that other treatment goals in other important life areas are often as important to address for overall functioning of a person [12]. In terms of drinking behavior, a synthesis is emerging that most alcoholics should abstain (especially early in treatment), but some can, with effort, return to some form of drinking.

The abstinence goal is desirable if: (1) physical damage is occurring or likely to; (2) there are previous failures to learn controlled drinking; (3) there exists a belief in abstinence from experience or philosophy. Controlled drinking is desirable if: (1) a younger person is involved; (2) the person cannot accept the abstinence goal; (3) the person is motivated to persist in a program of treatment. The present authors support this synthesis and suggest that it be based on an assessment of the individual's developed tolerance physiologically, his or her personality organization psychologically, and negotiation with the patient.

In the past, the focus on abstinence has taken attention away from other important treatment goals. Now that abstinence is no longer enshrined, more realistic multiple and sequential treatment goals can be addressed with regard to specifying in the individual case which problems contribute to excessive drinking. Thus in treatment considerations, the alcoholic or problem drinker is now given status as a complex person embedded in a physiological, social, and psychological context, one who is engaging in a multidetermined behavior, overdrinking. Drinking behavior is both problematic in itself and probably symptomatic of overall life adjustment. Treatment must respond to the person and the variables that are controlling the problematic behavior.

MODAL TREATMENT

Because of the variability and diversity, it is inherently difficult to describe the modal treatment that occurs in outpatient settings. This chapter focuses upon the United States, but not upon detoxification programs, emergency care, day care, and halfway houses and quarter-way house programs. Of necessity, behavior modification must be mentioned, although it is covered in greater depth elsewhere in this volume. Certain treatments are not mentioned because they have not been shown to be effective and are no longer viable, including electric aversion, LSD, and multivitamins. Table I presents outpatient treatments in terms of

what is modal in terms of frequency; various aspects of the table are then enlarged upon.

Medication usually involves sedative-hypnotics for withdrawal, then disulfiram for motivation control. Disulfiram alone, however, is not effective without a relationship with a therapist and a strict ritual of treatment—often with the spouse's involvement. If psychiatric symptoms persist, major tranquilizers or tricyclic antidepressants are the most popular treatments. Minor tranquilizers are not desirable because of the abuse potential in this population.

Treatment is usually more intense in terms of frequency in the initial stages. When stability of relatively sober functioning is achieved, frequency is reduced to one or two times each week, with allotment for emergencies. Follow-up is variable, but many centers begin lessening contacts in from 6 to 12 months after the initiation of treatment. Monthly visits or telephone calls in the period from 12 to 18 months are usual, with total treatment time from 2 to 24 months. Long-term follow-up in terms of minimal contact of an organized support system (e.g., group membership) seems to be crucial in terms of monitoring therapeutic benefits.

Group therapy is a very important treatment modality, but its forms are myriad. That it is so popular bespeaks its meeting of the dependency needs of the alcoholic as well as promoting a sense of universality rather than the social isolation.

Table I
Outpatient Treatment Elements

Basic Core	Generally Accepted	Specialized or Peripheral
Social history and drinking inventory	Group therapy	Behavioral therapies
Supportive and Problem-solving counseling	Alcoholics Anonymous	Biofeedback
Medication	Al-Anon	Fee manipulation
	Alateen	Videotape modeling
	Broad spectrum cognitive behavioral therapies	Outpatient detoxification
	Relaxation	Hypnosis
	Desensitization	Night hospital
	Contracting	Telephone follow-up
	Role Playing	Home visits
	Covert sensitization	Recreational counseling
	Rational-emotive therapy	
	Psychotherapy	
	Couples and family therapy	
	Reality therapy	
	Transactional Analysis	
	Analytic psychotherapy	
	Vocational counseling	
	Follow-up visits	

tion so often experienced by them. It is well known that AA meets in groups and has subgroup cells (the buddy system). Beyond this are often reported intake-orientation groups, didactic and pretherapy groups, interpersonal skills training (assertiveness, friendship), psychotherapy groups of various persuasions (usually involving some problem solving), and less frequently couples and relatives groups, employment and budget counseling groups, and even (very infrequently) marathon groups. The other forms of psychotherapy mentioned in Table 1 are currently popular. What evidence is available indicates that all are similarly effective if the person will stick with them for a minimum of five to 10 sessions [1].

The use of hypnosis is variable, but it is usually used as an adjunct to a behavior modification strategy such as relaxation or visualization; it has not been shown effective, nor is it much used to stop or control drinking by direct suggestion.

Aversion treatment runs the gamut from drug-induced vomiting, (in inpatient settings) to electric shock to the forearm, to covert sensitization where there is only visualization of aversive stimuli. Since there is evidence that electrical aversion is ineffective [10], the less intrusive, less physically painful procedures of covert sensitization are probably more popular and utilized. Biofeedback refers to programs that teach people to discriminate blood alcohol levels in order to control their intake of alcoholic beverages. Fee manipulation involves having a client pay a relatively large amount of money at the inception of treatment, with the proviso that he or she can earn it back if attendance or disulfiram-taking behavior is consistent. Videotape modeling involves showing the alcoholic what he or she is like when drunk and/or also showing assertive or coping behaviors for problematic situations that could be modeled; the former type of videotape modeling is an inpatient strategy, the latter an outpatient one. In general broad spectrum behavioral packages of treatments created for empirical study are becoming unpackaged and used to deal with specific problems in individual patients.

OTHER ISSUES

Questions of whether treatment ideally should be on an inpatient or outpatient basis will ultimately depend on the individual being considered. The issue of outpatient or home detoxification is still moot, providing a mix of advantages and disadvantages. By and large, the vast majority of alcoholics (estimates range between 80 and 95%) do not need inpatient detoxification, but on the other hand 20 to 50% of those who begin outpatient detoxification will probably not complete it. Outpatient detoxification has been shown to be quite safe, but of course there should be medical and hospital back-up if unforeseen complications arise. In a few words, outpatient detoxification is safe and desirable, but attention to

the dropout problem is needed (with everyday groups, coercion from the courts, etc.) [7].

The biggest inefficiency in outpatient treatment is the dropout rate, and it will remain a very large problem. However, inroads can be made with fee manipulation strategies or well-organized and well-administered coercion by the court system. The evidence is clear that coerced patients do as well or better when compared to voluntary clients, with the possible exception that AA does not seem to be a good treatment to be coerced into [4, 14, 15]. AA's buddy system, a subgrouping strategy, is another obvious way to deal with the problem of dropouts. This problem is crucial to address because evidence now indicates that if one attends a minimum amount of treatment, improvement can be expected [5]. Backeland and Lundwall [2] have suggested seven ways to decrease the dropout rate:

1. Eliminate waiting lists and offer immediate entry.
2. Satisfy the patient's dependency needs by offering a wide range of ancillary services.
3. Offer a variety of treatment modalities to the patient.
4. Explain clearly to the patient the aims, scope, probable results, side effects, and duration of the treatment to which he or she is assigned.
5. Find out whether the patient has previously dropped out of therapy and if so explore the reasons thoroughly.
6. Maintain contact with significant others and enlist their help if necessary.
7. In more symptomatic patients, put a major emphasis on rapid symptom relief and do not withhold medication during initial treatment.

An important issue of controversy is the pervasiveness of AA in various treatment programs. For some, AA provides a philosophical and practical basis for all of treatment, including Al-Anon and Alateen as well as other treatments under the AA umbrella; for others AA is at best a peripheral adjunct offered only to a few. Thus there are three models of AA involvement—AA operates the program, AA collaborates in the program, or AA is irrelevant to a program. Each model can be used effectively, but if AA is emphasized, one must accept the goal of abstinence, the use of groups, a religious emphasis, and a disease concept of alcoholism—each at times applied with a high degree of rigidity. Although AA has proven exceedingly useful in many cases, these authors do not think it should be the basis for treatment or the only treatment offered. AA has done a great service historically, but has not been shown to be as effective as its proponents have claimed in recent years [3]. It is the opinion of the present authors that AA should be a part, but not the whole of alcoholism treatment. Closely related is the issue of using nonalcoholic paraprofessionals in the treatment of alcoholics. The experience of these authors, as well as that reported by others, would indicate that paraprofessionals should be included in the mix of treatments, as long as there is training and supervision [6, 19].

treatment programs with alcohol abusers. This has seemed indicated because alcoholics often have myriad drug addictions. Programs that are combined have not found a decrement in overall effectiveness if a wide range of services are offered; the problems that often have to be addressed concern differing socioeconomic levels, life patterns, and values. In an era of budget cutting, combined treatment programs may become only an academic question since all substance abusers will likely be treated under one institutional umbrella in terms of psychological treatments. However, if physiochemical research turns up demonstrably different understandings of the dynamics of the various kinds of addiction, different kinds of treatments may be dictated.

Most outpatient facilities are dealing with a decrease in funding from their various sources, and this will necessitate new strategies of treatment delivery and prioritizing of essential services. One potentially useful model of cost-efficient and effective service is the use of imported therapists. In this kind of program, therapists from the community are trained to treat alcoholics in a supportive outpatient context on a part-time basis. This approach seems to provide benefits to therapists, patients, and agencies [4].

In closing, two groups should be mentioned that have not been well served by traditional outpatient facilities — or anybody else — namely women and teenage alcoholics. Women tend to remain hidden, untouched by the services offered by their community; teens feel alienated from adult services. Both groups are often more affected by community denial of their being a problem ("She just keeps to herself," or "It's just a little youthful excess"). These two groups have different needs from adult male alcoholics and require different approaches. For example, drop-in centers and an information-prevention service for teens, and in some cases, a community outreach effort for women have proven useful.

When Gerard and Saenger [8] surveyed outpatient clinics, they found a wide variation in staffing, philosophy, and treatment goals. The same conditions exist today with even more variability. However, alcoholism and its treatment are seen in a more complex and sophisticated fashion today, and efforts are being made to match patients to treatments. While individualized treatment is both desirable and necessary, it is important that programs attain a coherent case management philosophy. It is hoped that the next decade will provide more clarity for the issues mentioned and a more efficient calculus of matching patients, therapists, and treatments.

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Drinker's Choice

Most alcohol users are not alcoholics. Sometimes professionals who have to deal with the effects of alcohol abuse forget that fact. They treat everyone that comes to them for counseling as an alcoholic even if they are only looking for methods to cut back. Treating a "problem drinker" as an alcoholic is a mistake because most people are unwilling to accept a verdict of lifetime abstinence for what they perceive as a minor problem.

Programs to decrease drinking have been in common practice in Europe and Canada for decades, but only recently have gained acceptance in the United States. They offer an alternative strategy for employee assistance counselors.

"Moderate drinking programs give people an option not an ultimatum," said William Miller, an alcohol researcher. These programs offer "options that attract people early," before their problem drinking develops into alcoholism.

As head of the Alcoholic Research Center at the University of New Mexico, Miller has studied treatment strategies for 10 years. He believes early intervention is a neglected aspect of alcoholism counseling.

Treatment programs tend to attract only the chronic alcoholic. Their clients are typically middle-aged with at least 15 years of alcohol abuse. They have "hit bottom," in Alcoholics Anonymous terms, and have lost control of their drinking. Some researchers are questioning whether the process can be cut short.

Martha Sanchez-Craig, a research psychologist at the Research Addiction Foundation in Ontario, Canada, has published extensively on the topic of reduced drinking.

Alcohol reduction programs teach patients to restructure their drinking behaviors. Researchers believe some excessive drinking behaviors can be triggered by anything from a bad day at work to watching others drink at an office party. Clients are taught how to recognize these high risk situations and to avoid them. Sanchez-Craig believes secondary prevention programs have great utility in the workplace, and she has completed research to back up her conclusions.

The desire is strongest during the initial stage of reduced drinking, she said. Sanchez-Craig has developed treatment programs

that allow drinkers the option to either cut back or abstain. She said the option for cutting back could be used by anyone—from the baseball fan who has a couple of beers while watching a game to drinkers on the doorstep of alcoholism. Drinkers are more willing to enter a treatment program that allows the possibility of reduction rather than abstinence, she said.

The first step for a drinker who wants to cut back is to determine if he is an alcoholic or "problem drinker." Sanchez-Craig said an alcoholic has serious medical problems because his drinking goal is intoxication, frequently resulting in withdrawal symptoms. Abstinence is the alcoholic's only realistic option.

A problem drinker has no serious medical problems, only minor withdrawal symptoms, and has received little previous treatment. Sanchez-Craig said.

These two groups drink for different reasons. Internal cues such as physical withdrawal cause alcoholics to drink, while external cues like social pressures induce problem drinking, she said.

The moderation program asks why someone drinks and what are their reasons for wanting to reduce consumption.

"A drinker must look at what they want to do, either put the cork in the bottle forever or cut back," Sanchez-Craig said. "A small minority abstain forever, 90 to 95 percent just cut back."

However, C.D. Emrick, a clinical psychologist in Denver, Colo., said problem drinkers in reduced drinking programs usually end up totally abstaining because too much discipline is required for a long-term drinker to moderate his habits.

"Every time they drink they have to think: What am I drinking and how much am I drinking," Emrick said.

CASE STUDY. In a study by Sanchez-Craig, 70 clients with early drinking problems were randomly put into either a moderate drinking group or an abstinence group. On average, these people had experienced drinking problems for five years without seeking help.

She said people in the moderation group obtained their goals faster, with less cheating and less resistance to the treatment. The abstinence group, however, initially rebelled and required more treatment. But both groups eventually reached their goals. She

Drinking reduction programs offer hope for alcohol abusing clients.

By Retha Cable, Editorial Assistant



concluded that clients should be given a choice of treatments.

Evidence indicates that drinkers choose to abstain or cut back depending on their level of alcohol dependence, she said. Not incidentally, Sanchez-Craig said, because of the brief nature of the reduced drinking program, it costs "tens of thousands of dollars" less than conventional alcoholism treatment programs.

"In the United States, alcoholism is an industry because money is made by labeling people alcoholics," she said.

Alcohol treatment costs anywhere from \$10,000 to \$25,000, but the consequences to someone's life can be even greater, she said. Exposing personal problems to fellow workers can be devastating and threaten someone's job.

"The drinker feels the consequences of this treatment are worse than drinking," Sanchez-Craig said.

The most cost-effective way to treat a problem drinker is early detection and brief intervention, she said.

Emrick uses a variety of procedures to determine reasonable goals, such as personality assessment tests. He recommends taking alcohol out of a problem drinkers' life, but the main goal is to get people involved in treatment.

Sanchez-Craig's program of moderation consists of five steps for maintaining a specified drinking level: 1) assess current drinking problems and identify "high risk" situations, 2) abstain for at least two weeks while deciding on a drinking goal, 3) develop ways to cope with urges and social pressures to drink, 4) determine a long-term goal for drinking, and 5) learn how to regulate and maintain these goals.

Emrick said, "At the outset, the initial phase is abstinence, but cutting back and abstinence go hand-in-hand."

Most traditional alcohol treatment programs attract people with high levels of dependence, Craig said.

Emrick said the moderation treatment offers independent people an

option, and total abstinence usually results.

Miller said, "When they cut back to such a low level of drinking they say, 'What's the point in drinking anymore.'"

Emrick described the traditional treatment program as one that builds on the disease concept of alcoholism that states abstinence is the only option.

Alcohol problems usually begin when people are in their 20s, but the traditional treatment program clients tend to be chronic problem drinkers over 40 years old.

There is an imaginary line one crosses to become an alcoholic, and no agreement to where the line is.

"Since the majority of persons with problems are at the lower end of the severity continuum, it follows that sound planning of treatment services should result in the availability of a little treatment for many and a lot of treatment for few," Sanchez-Craig said.

Miller said there are about two dozen private practices offering reduced drinking treatment with 11 in Albuquerque, N.M.

He said the United States is the only country where treatment for controlling drinking is not accepted.

"One either has it (an alcohol problem) or doesn't," he said. "In the rest of the world, alcoholism is a continuum; everyone is at a different level. It is not such a black and white issue."

Miller said this moderation program also had been used with some success with overeaters and less successfully with smokers.

"You don't ask someone to stop eating for the rest of their life," he said.

DRUG USE. Sanchez-Craig said this program also has been used with people addicted to barbituates, but Miller said it was controversial to sug-



*A drug abuser thinks
his habit enhances his
creativity... but he's
wrong.*

gest cutting back on illegal drug use.

D. Adrian Wilkinson, of the Addiction Research Foundation, said, "Abstinence is recommended for users of illegal drugs, and we would not offer moderation to people under the drinking age."

Mary Kay Malloy, at the National Institute of Alcohol Abuse and Alcoholism, said the NIAAA has set three categories of drinkers: alcoholics, alcohol abusers and problem drinkers.

"We are not advocating a totally sober society," Malloy said. "Alcoholism is a chronic, progressive disease and problem drinkers are on the pathway to alcoholism."

Miller said it is less controversial to call a moderate drinking problem a preventive treatment and health promotion program.

"The moderation program can especially be successful in EAPs because it finds people early and these tend to be people less severely depen-

dent on alcohol," he said.

Richard Bickerton, information officer for the Association of Labor-Management Administrators and Consultants on Alcoholism, said, "I don't know of a single successful program that teaches moderation."

"An AA (Alcoholics Anonymous) saying is 'You can't help anyone until they hit bottom,' but EAPs try to raise the bottom."

"Think of it like an elevator going down, and a drinker has the option to get off at the second floor, first floor or the basement. EAP tries to help the drinker get off before he gets to the basement."

Sanchez-Craig said moderate drinking programs could be applied to an employee assistance program by sensitizing the supervisor and workers to help identify drinkers. And with the goals of improving job conditions and health, the supervisor can raise questions concerning drinking in a

non-threatening way.

She also said this program can be just as effective as more elaborate ones; it could be easily worked into clinical practice and more extensive treatment could always be an option if the program was not successful.

Emrick suggested that more education is the key to adding a control-based program to EAPs using Sanchez-Craig's approach.

"Let people know they won't be labeled as alcoholics and have to abstain from drinking forever," Emrick said.

OPTIONS. Miller said a program with options attracts people early and could be used in EAP because these are the people found by EAP. He said self-help manuals and other literature exist in which these methods are described.

"A health promotion program that gives people an option not an ultimatum would be successful," he said. ■

The Cultural Context of Psychological Approaches to Alcoholism

Can We Control the Effects of Alcohol?

Stanton Peele *Morristown, New Jersey*

ABSTRACT: *The unique history of alcohol use in the United States has led to the ascendance of the disease theory as the dominant conception of alcoholism. Social-scientific research has consistently conflicted with the disease theory, but psychological and other nondisease conceptions of alcoholism are not well represented in the public consciousness, in treatment programs, or in policies for affecting nationwide drinking practices. Conflict in the field has intensified in the last decade, most notably surrounding the issue of controlled drinking in alcoholism treatment. Our current cultural attitude toward alcoholism, one strongly influenced by disease notions, has not led to an improvement in our society's drinking problems. There continues to be a need for psychologists to present alternative views of alcoholism.*

The issue . . . is not whether we know enough; the real questions are whether we have the courage to say and use what we do know and whether anyone knows more.

—Alvin Gouldner, 1961, p. 205

Styles of drinking and attitudes toward alcohol vary tremendously across cultures. The United States has been a battleground of warring conceptions of drinking. Such diversity is not as apparent in contemporary American views of alcoholism, because alcohol problems are now widely considered to be primarily the result of an uncontrollable response to alcohol among those who are classified as alcoholic. This modern disease theory has deep historical roots and represents the experiences of particular groups of drinkers. The disease theory disagrees with social scientific research that finds responses to alcohol to be based on a range of cognitive and environmental factors and thus to be more variable than the disease theory describes. Conflict has been especially intense between the disease theory and behavioral approaches in which abstinence is not seen as essential for the treatment of alcoholism. Despite efforts to accommodate to the disease position—efforts that have significantly influenced psy-

chological theorizing about alcoholism—controlled-drinking approaches are now endangered by dominant treatment attitudes in the field.

Disagreements also exist among social scientific conceptions of alcoholism. For example, there are differences between social-learning and control-of-supply views of the cultural variability in alcoholism rates. Important aspects of social-learning concepts of alcoholism include the extent to which drinkers doubt their own ability to control their drinking and believe that alcohol is a potent and efficacious mood modifier. All social-scientific viewpoints are overridden, however, by a larger cultural ethos that agrees with the disease viewpoint. Yet this ethos, including its emphasis on abstinence and on the potency of alcohol's effects, is one that is often found to coexist with high levels of drinking problems. There is a need for social-psychological examination of our culture's drinking dispositions at the same time that psychologists must maneuver within the reality of this cultural context in dealing with alcoholism.

The Experience of Drinking and Conceptions of Alcoholism in America

Social scientists have traditionally been concerned with cultural recipes that distinguish between socially disruptive and socially integrated drinking (cf. Bales, 1946; Blum & Blum, 1969; Maloff, Becker, Fonaroff, & Rodin, 1982). Moderate drinking is notable in ethnic and cultural groups such as the Chinese (Barnett, 1955), the Greeks (Blum & Blum, 1969), the Jews (Glassner & Berg, 1980), and the Italians (Lolli, Serianni, Golder, & Luzzatto-Fegiz, 1958), where such drinking is modeled for the young and maintained by social custom and peer groups. Children are gradually introduced to alcohol in the family setting; drinking is not presented as a rite of passage into adulthood and is not associated with masculinity and social power. Adult drinking is controlled by group attitudes both toward the proper amount of drinking and proper behavior when drinking. Strong disapproval is expressed when an individual violates these standards and acts in an antisocial manner.

The American experience with alcohol parallels the results of such cross-cultural findings. In colonial America, drunkenness was accepted as a natural consequence of drinking, and habitual drunkenness was not considered to be an uncontrollable disease. Despite higher per capita consumption, alcoholism was not a serious social problem, and problem drinking was less evident than it is today (Beauchamp, 1980; Lender & Martin, 1982; Levine, 1978; Zinberg & Fraser, 1979). Drinking was a universally accepted social activity that took place within a tightly knit social fabric; families drank and ate together in the neighborhood tavern. Between 1790 and 1830, due to expanding frontiers and other social changes, the male-oriented saloon became the typical setting for drinking. Here alcohol was consumed in isolation from the family (the only women likely to be present were prostitutes), and drinking came to symbolize masculine independence, high-spiritedness, and violence. Alcoholism rates rose dramatically.

The temperance movement arose in response to the explosion of alcohol problems in 19th century America. It propagated the view that habitual inebriates were unable to control their drinking, the early version of the disease theory that originated with physician Benjamin Rush (Levine, 1978). Large numbers of Americans came to view alcohol as "demon rum" and regarded drinking as frequently—or inevitably—leading to uncontrolled drunkenness. The solution they proposed was national abstinence. There were regional, social class, religious, sex, and ethnic variations in these views and in the composition of the wet and dry forces that battled throughout the century (Gusfield, 1963). In 1920—at a point when, paradoxically, drinking patterns had moderated substantially—national prohibition was enacted. When prohibition was repealed in 1933, the goal of universal abstinence died with it. The disease theory became transmuted at this time to the view that chronic drunkenness was not an inescapable property of alcohol but was rather a characteristic of a small group of people with an inbred susceptibility to alcoholism (Beauchamp, 1980).

This was the modern disease theory, and it was spread effectively by the Alcoholics Anonymous

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Requests for reprints should be accompanied by one dollar (\$1.00) and sent to Stanton Peele, Human Resources Institute, Tempe Wick Road, Morristown, N.J. 07960.

(AA) self-help movement. AA had many commonalities with 19th century temperance brotherhoods, such as the Washingtonians, an organization in which reformed drunkards took the vow of abstinence. Like members of the Washingtonians, AA members gathered in a highly charged, revival-type atmosphere to relate their struggles with alcohol and to support each other's continued abstinence (as well as to convince others to join them). There are peculiarly American features of AA that made its resounding success in the United States unique. AA's emphasis on public confession, contrition, and salvation through God has its roots in Southern and Midwestern evangelical Protestantism (Trice & Roman, 1970). In no other Western country have AA and the recovering alcoholic attained such a central role in the formulation of alcoholism policy and alcoholism treatment as in the United States (Miller, 1983b).

The AA hegemony over alcoholism treatment and the ascendancy of the disease theory accelerated in the second half of the 20th century. The theory was officially endorsed by the American Medical Association in 1956. Its rapid growth and wide acceptance were due to the melding of its strong ethno-religious support with its backing as medical dogma. Following World War II, public opinion polls indicated a continuous increase in the belief that alcoholism is a disease (Room, 1983). More recently, in August 1982, a Gallup poll (Alcohol Abuse, 1982) found that 79% of Americans accepted alcoholism as a disease requiring medical treatment. In the 1970s, federal financing for the treatment of alcoholism shifted to service contracts and third-party payments. The primary locus for treatment changed from public institutions to private facilities and contractors. A premium was placed on aggressive marketing of alcoholism services, the early identification of those with drinking problems, and compulsory treatment (Hackler, 1983; Weisner, 1983; Wiener, 1981). The emphasis was on the identification of new, previously unrecognized groups of alcoholics and others needing treatment in connection with alcoholism, such as women, functioning workers and professionals, and families of alcoholics.

The aim of the alcoholism movement since the 1940s, as embodied by the National Council on Alcoholism, has been to make people aware of the prevalence of alcoholism and the need to have it treated. The movement has been extremely successful in this endeavor, and postage stamps, media programs, and public service announcements regularly drive its points home. Room (1980) estimated that there was a 20-fold increase in the number of alcoholics in treatment between 1942 and 1976. The sense of the lurking danger of alcoholism has increased further since 1976. The 1982 Gallup poll

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found that one third of American families had had a problem with alcohol, a figure that had doubled over the previous 5½ years (*Drinkers at 38-Year Record Level*, 1982). Some representatives of the alcoholism industry now think there are more than 15 million alcoholics in America requiring treatment (Hackler, 1983).

The disease model has modified our basic conceptions about the nature and prevalence of drinking problems and about the need for treatment, the proper type of treatment, and the efficacy of treatment for alcoholism. Nondisease conceptions have not fared well in this atmosphere. Although psychologists and others present alternate views of alcoholism (many of which will be discussed in this article), educational and other public information programs typically ignore nondisease perspectives (Room, 1983). The markets for psychological services in alcoholism appear to be eroding and beleaguered (Mariatt, 1983; Miller, 1983b; Nathan, 1980).

Conflict Between the Disease Theory and Social Science Research

Given the emotions it is capable of arousing, the disease theory of alcoholism is surprisingly amorphous and variable. Pattison, Sobell, and Sobell (1977) pointed out that, in order to criticize the theory, the critic must often first define it, leaving the critic open to the accusation of having created a "straw man" to attack. This is especially true because prominent defenders of the disease viewpoint acclaim the lay wisdom of AA and endorse its positions although they formally propose models of alcoholism significantly at odds with lay disease notions (cf. Jellinek, 1960; Keller, 1972; Vaillant, 1983). The basic AA (1939) version of alcoholism as a disease is that the true alcoholic cannot control his or her drinking (unlike those who choose to get drunk), an inability that exists before the first drink is taken. The condition is irreversible and progressive and requires complete and utter abstinence.

The idea of an inherited biological mechanism is not always a part of disease theories, although it has been a major impetus for medical research (Goodwin, 1979; Schuckit, 1984). The central trait of disease theories is the alcoholic's loss of control. Jellinek and Keller, founders of the Yale Center of Alcohol Studies, have provided the scholarly underpinnings for the disease theory. Jellinek's (1946) original empirical work traced the stages of alcoholism reported by 98 respondents to questionnaires sent to about 1,600 AA members. Influenced by prevailing views of drug dependence, Jellinek's (1960) book, *The Disease Concept of Alcoholism*, presented a typology of alcoholism. It identified "gamma" alcoholism as the essential disease type and defined

it in terms of physical dependence, along with loss of control. This disease model, unlike the AA version, is unclear about the inbred or irreversible nature of the condition.

Many subsequent investigations have failed to confirm either the stages or the types of alcoholism that Jellinek outlined (Room, 1983). Disease notions have been further undermined by a series of laboratory studies that found that the drinking of chronic alcoholics is not characterized by loss of control (Mello & Mendelson, 1972; Nathan & O'Brien, 1971; Paredes, Hood, Seymour, & Gollob, 1973). Even when intoxicated, these alcoholics regulated their levels of drinking and responded to external rewards. Summarizing this research, Heather and Robertson (1981) found that "alcoholics' drinking behavior is subject to the same kind of laws which . . . describe normal drinking behavior, or . . . goal-directed behavior of any kind" (p. 85). As a response to increasingly complicated findings about alcoholic behavior, Keller (1972) added a note of indeterminacy to loss of control notions. He proposed that alcoholics might be able to control their drinking on occasion but are unable to guarantee when they can do so.

Field investigations of the natural course of drinking problems have evolved separately from the behavioral models of alcoholism generated in laboratory studies. Generally sociological in nature, such field research has agreed with laboratory studies in finding alcoholism to be malleable and situationally determined. In this view, people's alcohol-related problems are so diverse, fluctuate so much with time, and are so strongly influenced by social context that such problems are best conceived of as problem drinking rather than as a disease state of alcoholism (Cahalan, 1970; Cahalan & Room, 1974; Clark & Cahalan, 1976). Cahalan and his co-workers, along with other sociologists, have used the term *problem drinker* in a fundamentally different way from both disease- and nondisease-oriented clinicians. Problem drinking is not a less severe type of alcohol problem than gamma or addictive alcoholism. It is a separate dimension for classifying drinkers where loss of control is one among several kinds of drinking problems and is not necessarily the most severe or the core, defining problem (Clark, 1976).

Field studies have found demographic categories to play an important role in alcoholism. Cahalan and Room (1974) identified youth, lower socioeconomic status, minority status (black or Hispanic), and other conventional ethnic categories (Irish versus Jewish and Italian) as predicting drinking problems. Greeley, McCready, and Theisen (1980) continued to find "ethnic drinking subcultures" and their relationship to drinking problems to be extremely resilient and to have withstood the otherwise appar-

ent assimilation by ethnic groups into mainstream American values. Cahalan and Room also discovered a paradoxical tendency for drinkers from conservative Protestant sects or from dry regions to be binge drinkers. The Rand report's analysis of treated alcoholics in comparison with a Harris poll of nationwide drinking practices made the similarly anomalous discovery that alcoholism was more frequent in the South and among Protestants, demographic categories also associated with abstinence (Armor, Polich, & Stambul, 1978). The predictive power of demographic traits is not limited to problem drinking or alcoholics seeking treatment. Vaillant (1983) found Irish Americans in his Boston sample to be alcohol dependent (i.e., alcoholic) seven times as often as those from Mediterranean backgrounds (Greeks, Italians, and Jews), and those in Vaillant's working class sample were alcohol dependent more than three times as often as those in his college sample.

Group differences in alcoholism are not readily explained in disease or biological terms. Indeed, even Oriental groups such as Native Americans and Chinese Americans, which are noted for their shared, exaggerated metabolic reaction to alcohol, show widely divergent alcoholism rates connected with different socially regulated styles of drinking. Such findings provide a powerful argument against a genetic basis for alcoholism (cf. Mendelson & Mello, 1979). For disease proponents, the idea that social norms control drinking problems translates into the notion that some groups have a greater tendency to *deny* alcoholism. Efforts in the alcoholism movement are generally directed toward uncovering hidden numbers of alcoholics in groups, such as Jews or women, that have traditionally measured low in alcoholism rates. Yet investigators emphasizing genetic contributions to alcoholism or seeking to identify secret alcoholics have continued to note substantially lower alcoholism rates for such groups (Cloninger, Christiansen, Reich, & Gottesman, 1978; Glassner & Berg, 1980).

The most powerful predictor of drinking problems for Cahalan and Room (1974) was not social background, however, but current social environment. The potency of social drinking contexts has been identified not only as a key to causing drinking problems but as a force in socializing moderate drinking and modifying alcohol problems (Jessor & Jessor, 1975; Harford & Gaines, 1982; Zinberg & Fraser, 1979). The idea of using drinking environments to prevent the development of unhealthy drinking styles in the young remains a strong thrust in social learning approaches to alcoholism, one that has continued to exist despite a rising tide of disease conceptions (cf. Kraft, 1982; Nathan, 1983). Social context analyses at the macro level, which point to shifting historical alcoholism rates and

changing cultural conceptions of alcohol problems, have viewed alcoholism as a social construction rather than an actual disease entity (Beauchamp, 1980; Gusfield, 1981; Levine, 1978; Wiener, 1981). This viewpoint is as far from the disease conception as it is possible to get and has come in for a kind of criticism from disease proponents that is ordinarily directed at radical political groups (see comments by Keller, cited in Room, 1983, pp. 52-53).

Social "constructivist" approaches notwithstanding, the full fury of the disease movement has been reserved for studies showing that some alcoholics moderate their drinking. Abstinence has been the fundamental treatment precept in the disease approach as it was with temperance (Roizen, 1977). However, nearly every outcome study has uncovered a return to moderate drinking by alcoholics (Heather & Robertson, 1981; Pattison et al., 1977). Despite the frequency of these discoveries and their often matter-of-fact reporting by researchers (cf. Goodwin, Crane, & Guze, 1971; Schuckit & Winokur, 1972), several key studies of this sort have been ferociously attacked. The most significant of these were the two Rand studies. The first, originally released in 1976 (Armor et al., 1978), found that 22% of alcoholics treated at National Institute of Alcoholism and Alcohol Abuse (NIAAA) treatment centers were drinking without problems at 18 months after treatment (compared to 24% who were stably abstaining). The National Council on Alcoholism (NCA) organized an immediate, concerted assault on this study.

Among a host of often wildly distorted accusations, genuine methodological and theoretical issues were raised about the Rand study. The Rand investigators conducted a second study that included a 4-year follow-up period, breathalyzer tests, reconstructed criteria for moderate drinking, and a careful analysis of drinking outcomes against levels of alcohol dependence shown by clients on admission (Polich, Armor, & Braiker, 1981). Close to 40% of the subjects who were free of drinking problems at 4 years were still drinking, including a substantial minority of those who had been most dependent on alcohol. Peer evaluations of both reports, but particularly the second, were highly positive (see Beauchamp et al., 1980; Hodgson, 1980) as reflected in the statement "this four year follow-up study is one of the best outcome studies in the alcoholism field" (Hodgson, 1980, p. 343). Yet the two Rand studies have simply been buried by most in the alcoholism field. Vaillant (1983) typified this response by consistently dismissing the first study's findings on methodological grounds and generally ignoring the second study.

The Rand studies' primary significance may thus be in their status as cultural documents. Whatever their actual findings, upon their respective

releases they provoked from the two different directors of the NIAAA the assertion that abstinence remained the "appropriate goal in the treatment of alcoholism" (Brody, 1980; U.S. Department of Health, Education, and Welfare news release, reprinted in Armor et al., 1978, p. 230), and funding for controlled-drinking treatment was immediately assailed (Room, 1983, p. 63n). How thoroughly controlled drinking has been repudiated in the aftermath of the Rand studies is apparent when considering in today's climate evaluations of the first Rand report solicited by the NIAAA from two prominent research psychiatrists. In one evaluation, Gerald Klerman asserted, "This is a very important document. I think the conclusions are highly justified. I understand you are under great political pressure. . . . I would strongly urge you and the NIAAA and ADAMHA to stand firm wherever possible" (in Armor et al., 1978, p. 223). In another evaluation, Samuel Guze declared, "What the data do demonstrate is that remission is possible for many alcoholics and that many of these are able to drink normally for extended periods. These points deserve emphasis, because they offer encouragement to patients, to their families, and to relevant professionals" (in Armor et al., 1978, p. 221).

The Rand studies reported outcomes of standard abstinence-oriented treatment at NIAAA centers. Their findings confirm those of Cahalan and Room (1974)—albeit with a treated and more severely alcoholic population—in indicating that the status of people's drinking problems varies considerably over time. The standard disease theory criticism of the Rand studies—that there was no guarantee that nonproblem drinking outcomes would be permanent—does not contravene the picture they present of alcoholics regularly shifting from alcoholic drinking to abstinence or moderation and back again. In addition, there has been a tradition of behavioral research dating from the early 1970s that has aimed at *moderating* alcoholic drinking. In 1982, the prestigious journal *Science* published a reinvestigation by Pendery, Maltzman, and West of a study by Sobell and Sobell (1973, 1976) that had claimed such techniques produced better outcomes for a group of alcoholics than had the standard hospital abstinence-oriented therapy used with a comparison group. Pendery and her colleagues found that most controlled-drinking subjects in the experiment reported instances of severe relapse soon after treatment and were not moderate drinkers 10 years later. The *Science* article was highly publicized and was often accompanied by accusations from its authors that the Sobells had falsified their results.

The Pendery et al. (1982) report was an unusual one. It questioned only subjects in the experimental, controlled-drinking group in the original study with-

out reporting follow-up data for the abstinence comparison group. The data were primarily recollections by subjects of events up to nine years in the past and descriptions of individual episodes of relapse. The only summary data the paper presented were the amount of hospitalization controlled-drinking subjects underwent after treatment. A report by an independent committee (Dickens, Doob, Warwick, & Winegard, 1982) convened by the Addiction Research Foundation of Toronto, which employs the Sobells, noted that the original articles by the study's authors actually reported more hospitalizations for controlled-drinking subjects than did Pendery et al. The committee was frankly critical of the Pendery group's approach for its failure to reexamine subjects treated with abstinence techniques, its reliance on testimony from subjects emotionally involved in the controversy, and the lack of consideration of the larger body of evidence about controlled drinking (cf. Peele, 1983b).

The *Science* article has been invested with significance beyond its own questionable validity because of the cultural context in which it appeared. The article, although agreeing with the near-unanimous portrayals by the media of the disease nature of alcoholism, is one of the few answers to an avalanche of studies contradicting disease notions. The dispute is impossible to understand without considering the history of the controlled-drinking controversy in this country, as even an APA *Monitor* article (Fisher, 1982) on the controversy failed to do. For example, the senior author of the *Science* paper was a primary spokesperson in the NCA campaign against the Rand studies, including an effort to have the first report delayed so that its results could be reanalyzed (see Roizen, 1977, p. 171).

The Status of Controlled-Drinking Therapy in the United States

A leading alcoholism researcher interviewed in the *Monitor* article (Fisher, 1982) about the Pendery-Sobell dispute noted about controlled drinking that "there is no alcoholism center in the United States using the technique as official policy" (p. 8). This situation contrasts with that in other Western countries, such as Britain, where a recent survey found that 93% of treatment facilities accepted the principle that controlled-drinking therapy can be beneficial (Robertson & Heather, 1982). At the same time, even those who continue to endorse such therapy in the United States and Canada, including the Sobells, indicate it should be restricted to problem drinkers and not used with gamma alcoholics or those addicted to or physically dependent on alcohol (Mariatt, 1983). Again, the situation contrasts with that in Britain, where a part of the spectrum of treatment

opinions "regret(s) the tendency to relegate the new methods to a minor and ancillary role . . . as being applicable, for example, to *only* those with less serious problems" (Heather & Robertson, 1981, p. viii; cf. Miller, 1983b).

The Demise of Controlled-Drinking Therapy for Alcoholics

The consensus in American opinion against the applicability of controlled drinking for more serious alcoholism problems began to emerge in the mid-1970s around the time the first Rand study was published. Prior to that time, psychologists reported positive prospects for treating alcoholics through moderation techniques (Caddy & Lovibond, 1976; Schaefer, 1971; Sobell & Sobell, 1973, 1976; Steiner, 1971; Vogler, Compton, & Weissbach, 1975). After 1976, reflecting either a change in terminology, in emphasis, or in their understanding of alcohol problems or a desire to achieve rapprochement with disease notions, psychologists downplayed the possibility (Miller & Caddy, 1977; Vogler, Weissbach, Compton, & Martin, 1977), and they now totally reject it (Lang & Mariatt, 1982; Miller & Muñoz, 1982). Today no clinician in the United States publicly speaks about the option of controlled drinking for the alcoholic.

The factual basis for this shift is the general agreement that the more severe a person's drinking problem, the more successful abstinence outcomes are as compared to moderation outcomes. What makes this resolution less than decisive, however, is the consistent finding that drinking problems occur along a continuum, one that is not well ordered (Clark, 1976; Clark & Cahalan, 1976; Miller, 1983b; Vaillant, 1983). There is no distinct point at which genuine alcoholism or addiction to alcohol can be said to exist. Furthermore, some drinkers at even the most severe levels of alcohol dependence do successfully adopt controlled drinking. The most highly dependent subjects in the Rand Study (those with 11 or more signs of dependence on admission) were far less likely than less dependent subjects to be drinking without problems at four years. (In this sense, and others, the study indicated that its non-problem drinking measures did not lead to random predictions about the possibility of controlled drinking.) Yet the study still found over one quarter of those with the most severe problems initially who achieved remission from alcoholism to be drinking at four years.

Aside from the question of whether alcoholics can become social drinkers, a separate question is whether they can benefit from behavior therapy techniques aimed at moderating drinking. Miller (1983a) reported that 21 out of 22 studies demonstrated benefits, generally substantial, from con-

trolled-drinking therapies (see Miller & Hester, 1980). The populations for these studies were mixed, and although controlled-drinking benefits were greatest for those with moderate drinking problems, there is no indication that moderation training is less effective than abstinence for all types of drinking problems (Heather & Robertson, 1981; Miller, 1983b). In addition to the Sobells' study, other studies have found positive results with alcoholic populations (Caddy & Lovibond, 1976). In their rebuttal to Pendery et al. (1982), Sobell and Sobell (1984) concluded that the reinvestigations of their work "actually strengthen the validity of our original reports and conclusions" (p. 413).

We may wonder then on what grounds the application of controlled-drinking techniques for severe alcoholism has been conclusively rejected, especially considering the poor prognosis resulting from standard treatments for alcoholism (cf. Vaillant, 1983). Reflecting our current cultural attitude toward alcoholism, *Time* magazine quoted John Wallace, an NCA critic of the Rand Study, on the topic of controlled drinking as saying, "The suggestion that an alcoholic might be able to return to social drinking safely is 'a serious ethical problem, because at least 97% of alcoholics, if you let them drink, could die' " ("New Insights into Alcoholism," 1983, p. 69). Compare this with Vaillant's forlorn finding for his severely alcoholic clinical sample that "tragically, abstinence does little to reduce the increased mortality of alcoholics" (Vaillant, 1983, p. 164). Whether greater risk can be demonstrated for the alcoholic who is aiming for controlled drinking, the therapist faces the intolerable risk that he or she will be accused of causing any failures in drinking by the client including those leading to death.

Insinuations that controlled-drinking therapy contributed to the deaths of patients were an important part of the attack on the Sobells' study. Pendery et al. (1982) noted four deaths among the 20 controlled-drinking subjects in the 11 years following treatment. Television depictions highlighted this statistic by shooting scenes at cemeteries or at the sites of patients' deaths. By simply writing to California authorities, Sobell and Sobell (1984) discovered that six of the abstinence-treatment subjects had died in this same period. Moreover, the first of the deaths of controlled-drinking subjects reported by Pendery et al. occurred more than 6 years after treatment (this subject had been abstinent during the prior year), and two of the deaths occurred more than 10 years after. Both these later deaths were apparently due to acute alcohol intoxication; both men had been in traditional alcoholism programs the week before their deaths. Overall, the death rate for subjects in the controlled-drinking condition was lower than that reported for alcoholics undergoing

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Relapse in Alcoholism

Those who propose abstinence as the exclusive goal for alcoholism treatment maintain that any effort to drink carries with it an intolerable danger of relapse. The two Rand studies offered the opportunity to assess the relative risk of relapse at 4 years for those adopting different strategies at 18 months. Relapse was not limited to those drinking moderately at 18 months; in fact, some groups of subjects were identified as being more likely to relapse when they tried to abstain even though interviews indicated that these subjects were serious in their intentions of abstaining (Polich et al., 1981). The Pendery et al. (1982) critique of the Sobells' study took on a special force by considering instances of relapse and death in the absence of comparable data for the group treated with abstinence. Yet alcoholics who progress to the point of hospital treatment are characterized by frequent relapse. Vaillant (1983) reported that among a group of 100 alcoholics treated by hospital detoxification, compulsory AA attendance, and an active follow-up program, only 5% did not relapse to alcoholic drinking.

Although abstinence proponents may aspire to the elimination of drinking in all those with drinking problems, this seems an elusive goal. Only 7% of the total Rand sample did not drink at all in the 4 years following treatment, a figure that seems typical for abstinence-oriented programs (cf. Emrick & Hansen, 1983). At the other extreme, studies of alcoholic patients indicate that a comparable 5% to 10% will evolve into a stable life pattern of controlling their drinking (Vaillant, 1983, p. 220). Miller and Hester (1980) noted a 5% to 15% range of moderation outcomes in abstinence programs. For the 80% to 90% in between, improvement entails the effort to make sure that any drinking they do does not get out of hand. Indeed, this is an issue even for those securely controlling their drinking or abstaining: Vaillant (1983) found that "relatively few men with long periods of abstinence had never taken another drink" (p. 184).

In this light, therapy for alcoholism is best conceived as the effort to minimize relapse. What the Sobells' study ultimately demonstrated was not that controlled-drinking subjects never got drunk or never had drinking problems again, but that they both drank moderately and abstained more frequently and thus had fewer instances of alcoholic relapse (Sobell & Sobell, 1976)—a crucial finding that the Pendery et al. (1982) critique did not purport to challenge. Much of controlled-drinking therapy has taken on this cast of preventing a slip or single drink from turning into total abandonment

of drinking restraint. Social-cognitive models of alcoholism maintain that alcoholics' expectations and self-conceptions will influence how they respond to a single drink. Alcoholics who are convinced that there is no alternative after having a drink other than embarking on a binge will be more likely to undergo this chain of events (Marlatt, 1978; Rollnick & Heather, 1982). Relapse prevention, then, takes the form of preparing drinkers to avoid high-risk (of relapse) situations, to avoid drinking when exposed to such situations, and to avoid binge drinking after having had a drink (Chaney, O'Leary, & Marlatt, 1978; Marlatt & Gordon, 1980).

What Areas of Clinical Disagreement Remain?

Behavior therapists in America have abandoned efforts to turn alcoholics into moderate drinkers and almost exclusively restrict their treatment to those with less severe drinking problems. Given that the hallmark of the disease approach is that only the genuine alcoholic is characterized by loss of control and the need to abstain, why is there so much conflict between controlled-drinking and disease approaches? Some psychologists, social scientists, and others still do not accept the extreme preoccupation with abstinence as the only goal and measure of success in treatment—what Roizen (1977) termed the "abstinence fixation"—that typifies the field. For example, relapse prevention approaches argue for acknowledging that a single drink will not necessarily be a person's undoing and thus downplay the absolute requirement of abstinence. In addition, many continue to believe that the lessening of drinking problems in the absence of abstinence still constitutes improvement for a client. Viewing people's drinking or abstinence in the context of their overall functioning and their other compulsions or substance abuse (Peele, 1981a, 1983a; Peele & Brodsky, 1975) may present a different picture than the disease-oriented clinician sees. Although he defended the abstinence goal, Vaillant (1983) found that abstaining alcoholics commonly formed alternate compulsions but that controlled drinkers did not.

In the view that alcoholism is a progressive condition, the individual who is not fully alcoholic may be a person at an early stage of the disease for whom drinking will inexorably lead to alcoholism. In practice, programs based on a disease model simply deal with all those who present themselves with alcohol problems as though they were alcoholics (Hansen & Emrick, 1983). (This is in contrast to the elaborate arguments made by abstinence proponents that any drinker who has had severe problems but who now drinks moderately could not have been genuinely alcoholic; cf. Pendery et al., 1982, p. 173.) Yet it is just these "early-stage" drinkers for whom controlled-drinking strategies have

proven most effective. Indeed, most younger, socially stable problem drinkers reject abstinence therapies (Sanchez-Craig, 1980). Psychologists and sociologists argue that a national alcoholism policy geared toward the extremely alcoholic individual overlooks the vast majority of those with drinking problems, only a small portion of whom seek treatment (Marlatt, 1983; Room, 1980).

The Classification of Alcoholics

Some of those with drinking problems do better if they endeavor to abstain, and some do better if they try to moderate their drinking. In the absence of a clear distinction between these groups, abstinence tends to be encouraged for all, and therefore psychologists have led the effort to classify drinking problems in terms of the relative benefits of abstinence and controlled-drinking treatment aims (Heather & Robertson, 1981; Miller, 1983a). Severity of drinking problems or alcohol dependence is a major factor in such classification, with those whose drinking problems are worse generally faring better with abstinence. The severity factor does not overwhelm all other considerations, however. The Rand study found that single men under 40—even when highly dependent on alcohol—were more likely to relapse if they adopted an abstinence strategy than a controlled-drinking one (Polich et al., 1981). Abstinence is apparently less effective for younger, single men because it does not conform with their life-styles and the opportunities and pressures they face to drink. Age is an especially important factor in a person's ability to moderate drinking. For example, symptoms of alcoholism such as drinking blackouts in college show a negligible correlation with drinking problems for the same person 20 years later (Fillmore, 1975).

The drinker's self-conception of being an alcoholic also affects the course of drinking problems (Skinner, Glaser, & Annis, 1982). Subjective beliefs about the disease of alcoholism and about the nature of the person's drinking problem can be more important than objective levels of dependence for selecting treatment goals. Those who believe in the disease theory and that they are alcoholics have a poorer prognosis for controlled drinking (Miller, 1983a). Heather, Winton, and Rollnick (1982) found in Britain that alcoholic patients who did not believe or did not know about the theory that one drink leads to relapse were more likely than other alcoholics to be nonproblem drinkers 6 months after treatment. A scale measuring alcoholics' beliefs about alcoholism and their own drinking distinguished whether alcoholics, if they drank, relapsed to alcoholic drinking, whereas an objective measure of alcohol dependence showed no such relationship (Heather, Rollnick, & Winton, 1983). Vaillant (1983) discovered

another factor that determined controlled-drinking versus abstinence outcomes for alcohol abuse: whether the drinker's ethnic group had a disease-like conception of alcoholism or whether it was simply concerned with the differences between moderate drinking and drunkenness.

In its early stages, the modern alcoholism movement relied on the individual's willingness to admit having an alcohol problem voluntarily (Room, 1983). The emphasis today in treatment is on confronting alcoholics' denial—their unwillingness to see clearly the nature of their drinking problems. When faced with a recalcitrant individual who has a lower level of dependence on alcohol, a self-conception of not being an alcoholic, or a group or ethnic identity that does not view alcoholism in terms of a disease, this approach pushes for a transformation of the person's belief system about drinking. This contrasts with a psychological tradition—represented by Rogerian, client-centered therapy—of accepting and using clients' conceptions of their situations. Miller (1983c) analyzed how working at cross-purposes with the client's conception of a drinking problem interferes with the motivation to change. Yet, although it is inconceivable that a therapist would urge someone who is endeavoring to abstain to drink socially, the reverse is standard procedure.

An overreliance on "objective" assessments of appropriate treatment goals could similarly lead psychologists unwisely to deny their clients' self-selected goals for improvement. We see in fact that clients regularly act on their own agendas within a larger treatment framework. What may be so remarkable about the Rand results is that almost 40% of those who were being told to abstain and who were in remission at 4 years did so through modifying their drinking patterns on their own. Subjects assigned to the abstinence condition in Sanchez-Craig, Annis, Bornet, and MacDonald's (1984) study overwhelmingly rejected their assigned therapy goal and displayed as much moderate drinking as those being taught how to do so. On the other hand, controlled-drinking clients who subsequently chose to abstain have shown unusual success at abstinence (Miller, cited in "The Behaviorists," 1984).

Treatment, Self-Cure, and Denial

Although controlled-drinking therapies have demonstrated the most success of any approach to drinking problems, these assessment studies have not used no-treatment comparison groups (Miller & Hester, 1980). Cahalan (1970) found up to 50% natural remission from problem to nonproblem drinking within 4 years. Furthermore, brief controlled-drinking interventions have been as successful as elaborate ones (Miller, cited in "The Behaviorists,"

1984; Nathan, 1980), suggesting that the client's motivation to change is the chief factor in the moderation of drinking. Major outcome studies that have used nontherapeutic (natural history) comparison groups, covered long follow-up periods, and taken into account environmental factors in clients' improvement have struggled to trace additional improvement to the therapy beyond the effects of life changes and the client's prior motivation (Baekeland, Lundwall, & Kissin, 1975; Gerard & Saenger, 1966; Orford & Edwards, 1977; Vaillant, 1983). Such findings have led Moos and Finney (1982) to challenge the whole idea that specific therapeutic interventions significantly alter a person's overall drinking career. From this point of view, the problem with both the Sobells' study and the Pendery et al. critique of it is that a brief period of laboratory training cannot possibly account for behavior up to 10 years later (Marlatt, 1983; Vaillant, 1983).

A number of studies in addition to Cahalan's (1970) have demonstrated substantial natural remission among problem drinkers and alcoholics (cf. Hyman, 1976; Knupfer, 1972; Roizen, Cahalan, & Shanks, 1978; Tuchfeld, 1981; Vaillant, 1983). The limitations of therapy and the potency of people's natural curative powers created a fascinating dilemma for Vaillant (1983) in one of the rare long-term studies by a disease proponent of both the natural history of alcoholism and the effects of disease-oriented treatment. Vaillant's results forced him to jettison such traditional disease notions as that alcoholism represents a clearly demarcated variety of alcohol abuse, that alcoholism inevitably worsens without treatment, and that alcoholics cannot drink again without endangering their sobriety. In defending the medical model of alcoholism as a disease, Vaillant claimed that "attempts to *understand* and to *study* alcoholism . . . [require] us to employ the models of the social scientist and of the learning theorist" but that a medical model is necessary "in order to *treat* alcoholics effectively" (p. 20). His own clinic, however, using hospital detoxification, inpatient treatment, compulsory AA attendance, and an active follow-up program demonstrated results after 2 and 8 years that "were no better than the natural history of the disorder" (pp. 284-285).

Vaillant also studied college and core-city populations of alcohol abusers for which data covering 40 years were available. Among the core-city group, on which most of his analysis is based, 20% were drinking asymptotically and 34% were abstaining at their last assessment. Although Vaillant defended abstinence and criticized the Rand reports, his figures resembled those from the second Rand study. They represented an untreated population, however, and thus the degree of alcohol abuse in Vaillant's sample

is less. On the other hand, Vaillant's definitions of controlled drinking and abstinence affect their relative prevalence. Those who were controlled drinkers were not permitted to have shown any signs of alcohol dependence in the previous year. Abstinence was defined as less than a week's binge drinking in this period and an overall drinking frequency of less than once a month—decidedly non-AA criteria that increased the appearance of abstinence at the expense of controlled-drinking outcomes. Both controlled drinkers and abstainers in Vaillant's study rarely sought therapy for their drinking, and only 37% of abstainers relied on AA.

In our current cultural climate, the idea of self-cure for alcoholism has been discredited. One television spot likens it to trying to operate on oneself. The need for treatment is used as a justification for channeling problem drinkers into therapy through employee assistance programs and legal sentences (Gusfield, 1981; Weisner, 1983), and the refusal of treatment is regarded as proof of denial. Tuchfeld's (1981) interviews with severely alcoholic subjects who had cured themselves revealed that they often had a strong aversion to relying on others for help. Although no one can deny that alcoholics have the right to seek assistance or that any improvement they show comes from the help they receive, there are also no grounds on which to reject the contention of other alcoholics that they are more likely to succeed on their own. One danger is that nondisease-oriented clinicians will see their own version of denial in those alcoholics who resist behavioral or other interventions along with resisting disease ideologies.

Alcohol and Drug Dependence

The emerging opinion among behavioral psychologists that controlled drinking is not possible for the addicted or physically dependent alcoholic is essentially the same position endorsed by Jellinek (1960); both positions are indebted to theories of drug addiction and dependence. However, findings about drug dependence do not provide support for the claims being made in the case of alcohol. Although many of the Vietnam veterans who had been addicted to narcotics in Asia used an opiate at some time stateside, only a small percentage showed signs of narcotic dependence here. Robins, Davis, and Goodwin (1974) concluded that "contrary to conventional belief, the occasional use of narcotics without becoming addicted appears possible even for men who have previously been dependent on narcotics" (p. 236). Harding, Zinberg, Stelmack, and Barry (1980) confirmed this finding with regular heroin users who were currently not addicted but had been so previously. These users were not dependent on any other drug or on alcohol and had not

undergone the kind of radical shift in setting that characterized the returned veterans.

The attribution of behavioral significance of any kind to physical dependence has been challenged. Writing in an authoritative pharmacology text, Jaffe (1980) claimed that "the term addiction cannot be used interchangeably with physical dependence" because such dependence is only tangentially related to the compulsive drug use and "high tendency to relapse after withdrawal" that define addiction (p. 536). Basic research on alcohol dependence likewise does not readily point to an explanation of alcoholic behavior. It has been extremely difficult to entice laboratory animals to drink excessive amounts of alcohol. Falk and Tang (1980) were able to induce physical dependence on alcohol in rats by creating a disturbing, intermittent feeding schedule for the animals. This schedule caused excessive, maladaptive behavior of all types, however. Even when physically dependent on alcohol, the animals preferred a dextrose mixture over an ethanol solution. Furthermore, as soon as the intermittent feeding schedule was terminated, the animals ceased drinking excessively, demonstrating principally "that a history of ethanol overindulgence was not a sufficient condition for the maintenance of overdrinking" (Tang, Brown, & Falk, 1982, p. 155).

The concept of alcohol dependence has been developed furthest by a group of British psychiatrists and psychologists (cf. Edwards & Gross, 1976; Hodgson, Stockwell, Rankin, & Edwards, 1978), perhaps because of a greater recognition in that country of the deficiencies of the disease model. The approach taken by this group has progressed beyond the traditional pharmacological categories used in drug dependence, for example, by regarding the object of dependence to be a psychobiological state rather than as comprising separate components of physical and psychic dependence. Still, critics note that, similar to the disease theory, this model continues to identify alcoholism as a persistent internal condition of drinkers that exists in isolation from other motivations and psychological dysfunction (Shaw, 1979). One problem with this model is that alcoholics' behavior, like that of other addicts, is marked by its intermittent nature. The alcoholic regularly alternates excessive drinking with moderate drinking or with abstinence. When and why does he or she behave as though alcohol dependent?

The variability in addictive behavior is most notable for alcoholics, like other addicts, when they withstand peak periods of withdrawal only to relapse at a later point, often due to stress or social pressure (Marlatt & Gordon, 1980). Behavioral theories of alcohol and drug dependence account for relapse that postdates active withdrawal by proposing conditioned withdrawal symptoms that appear in fa-

miliar drug- or alcohol-using contexts. An ingenious proposal impelled by a dedication to laboratory findings, this model must be maneuvered adroitly to account for street behavior. Most Vietnam veterans did not relapse to addiction even after actually using narcotics, so that Siegel's (1979) explanation of relapse for former addicts as a result of "talking about drugs" and "imagining themselves injecting drugs in their customary settings" (p. 158), as well as sacrificing the specificity that is the model's main appeal, provides seemingly pale motivation as an impetus for returning to addiction.

In fact, addicts rarely report somatic discomfort or unusual physical craving as the cause of relapse (Marlatt & Gordon, 1980). Even if classical conditioning models were able to demonstrate some reliable relationship between craving and specific environmental cues, we would then face the question of why some people respond to craving by yielding to it in the first place and by reestablishing their addiction in the second. On the other hand, how is it that "many, perhaps most, do free themselves" of alcohol dependence (Gross, 1977, p. 121) as most addicts of all sorts outgrow their addictions (cf. Schachter, 1982)? Criticizing pharmacological notions of dependence, Harold Kalant noted that the misguided effort to link addictive behavior to the fact of chronic exposure to a substance ignored "the most fundamental question—why a person, having experienced the effects of a drug, would want to go back . . . to reproduce that chronic state" (cited in "Drug Research Is Muddled by Sundry Dependence Concepts," 1982, p. 12). In other words, dependence theories to date do not tell us why people seek intoxication or other drug experiences or why they cease to need these experiences.

Culture and Alcoholism

How Does a Culture Cause Alcoholism?

The need to incorporate cultural factors has also confused alcohol dependence theorizing (Shaw, 1979). Similarly, Vaillant's early reports on his natural history research noted separate and significant genetic and cultural causality in alcoholism (Vaillant & Milofsky, 1982; cf. Peele, 1983a). His final report was more guarded about inherited factors, however. Vaillant (1983) did not find the distinct differences in alcoholism that Goodwin (1979) and Schuckit (1984) have traced to genetically related compared to adoptive relatives and to inheritance over environment. Vaillant (1983) also found that return to moderate drinking versus abstinence was not a function of having alcoholic relatives but was related to the cultural group of the alcohol abuser. This finding is reminiscent of the higher incidence of binge drinking alternating with abstinence among

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conservative Protestants and others from dry regions in the national survey by Cahalan and Room (1974) and the coincidence of high rates of alcoholism and abstinence for both Protestants and Southerners detected in the first Rand study (Armor et al., 1978). As Vaillant (1983) explained his finding, "It is consistent with Irish culture to see the use of alcohol in terms of black or white, good or evil, drunkenness or complete abstinence" (p. 226).

Although "the existence of cultural differences [in drinking problems] is an undoubted 'social fact,'" sociocultural explanations for these differences have been challenged (Room, 1976, p. 1047). Indeed, the current thrust from social scientists in public policies for preventing alcoholism is on controlling the supply of alcohol, on the principle that there is a constant relationship between overall consumption and the amount consumed by drinkers at the extreme end of the drinking continuum (Beauchamp, 1980; Room, 1984). This control-of-supply approach has itself been challenged (Nathan, 1983). A supply hypothesis is inadequate to explain subcultural differences in alcoholism for groups for whom alcohol is equally available. It also cannot explain historical changes, such as those in America, where per capita alcohol consumption during the colonial period was two to three times its current rate, but problem drinking was below its current level (Beauchamp, 1980). There is a strong parallel here with 19th century developments in attitudes toward addiction and narcotics in England and America. In both countries, although 19th century opiate use was widespread and massive, modern conceptions of narcotic addiction developed only at the turn of the century when general consumption rates declined (Berridge & Edwards, 1981; Musto, 1973).

A social-cognitive dimension in alcoholism and addiction is evident in Levine's (1978) startling discovery that the idea of loss of control was uniformly absent from first-person descriptions of drunkenness in colonial America. In contrast, by 1835, loss of control was the unifying thread in the public confessions of reformed drunkards. If loss of control defines alcoholism, such alcohol abuse as there was took an entirely different form in the earlier era. Criteria such as violent and other aberrant behavior when intoxicated are central to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III; American Psychiatric Association, 1980) definitions of alcohol abuse and alcohol dependence. Similarly, disease proponents concede that "the most sensitive instruments for identifying alcoholics and problem drinkers are questionnaires and inventories of psychological and behavioral variables" (Mayer, 1983, p. 1118). Yet in their classic work, *Drunken Comportment*, MacAndrew and Edgerton (1969) showed that how alcoholic disinhibition is interpreted

and enacted—for example, whether it leads to violence—is socially conditioned and takes completely different forms in different cultures.

Bales (1946) provided an early effort to synthesize cultural and individual attitudes about alcohol. He proposed that the incidence of alcoholism in a society depended upon the degree of cultural arousal of inner tensions, attitudes in the culture about the effectiveness of drinking for relieving such tensions, and the presence or absence of alternate societal means of satisfaction. McClelland, Davis, Kalin, and Wanner (1972) developed a model of alcoholism predicated on a society's ambivalence about power, alcohol's association in that society with displays of power, and the absence of alternate means for an individual to realize a need for power. Later social learning models have expanded the realm of the individual's expectations of desired effects from alcohol—or other substances—to include feelings of sexual potency, personal control, tension relief, lessened self-awareness, and so on (Brown, Goldman, Inn, & Anderson, 1980; Gaines, 1982; Hull & Young, 1983; Maisto, Connors, & Sachs, 1981). These beliefs about alcohol's efficacy as an experience modifier may underlie the effects of parental and cultural attitudes on drinking behavior (Christiansen & Goldman, 1983; Zucker, 1976). At the same time, "virtually all the studies that use adequate control groups have found that alcoholics and problem drinkers are more external in locus of control than nonproblem drinkers are" (Rohsenow, 1983, p. 40). Thus, those who cannot control their drinking may invest alcohol with the power both to bring about otherwise unattainable emotional states and to control their behavior.

Where Is Our Society Headed With Alcohol?

The indications are that the United States is abandoning its former, culturally pluralistic attitudes toward alcohol to create a dominant attitude toward alcohol as having the supreme power to corrupt and control. That is, the attitudes that characterize both ethnic groups and individuals with the greatest drinking problems are being propagated as a national outlook. This approach may work to help those who already hold this view of their drinking, but it carries dangers as a therapeutic policy for others and as a model of drinking for the young. Annual measurements have revealed in the latter half of the 1970s and the beginning of the 1980s that 40% of high school seniors (50% of male seniors) reported drinking at least five drinks in one sitting in the prior two weeks. This behavior has been accompanied by a growth in the endorsement of binge drinking over mild, regular drinking (Johnston, Bachman, & O'Malley, 1981).

Social context and learning approaches have

tried to deal with these trends in the young by creating moderate drinking atmospheres on campuses (Kraft, 1982) and by encouraging attitudes toward health that are incompatible with excessive drinking (Williams & Vejnaska, 1981). In a household survey of drug and alcohol use, Apsler (1982) found that problem drinking was associated with the drinker's reliance on alcohol to bring about desired feelings as opposed to drinking in line with social or personal norms. Furthermore, the problematic style was more associated with youthful drinking, suggesting that emphasizing social standards in drinking over alcohol's ability to modify feelings would have a beneficial impact for youthful drinkers (Apsler & Harding, 1983). On the other hand, consistent findings of the tremendous malleability of drinking behavior with age indicate it is an error to label youthful drinkers as alcoholics, even when they display major drinking problems. However, the policy goal of altering culture-wide attitudes toward drinking and drinking patterns has proved elusive (Sulkunen, 1983). What is clear is that a range of cultural forces in our society has endangered the attitudes that underlie the norm and the practice of moderate drinking. The widespread propagation of the image of the irresistible dangers of alcohol has contributed to this undermining.

Alcoholism is a primary example of how political and social forces blunt and even reverse the thrust of social-scientific research and psychological conceptions. The alcoholism field is one particularly prone to drive social scientists to announce a paradigm shift (cf. Armor et al., 1978; Beauchamp, 1980; Moos & Finney, 1982; Pattison et al., 1977). What may make one less than hopeful about such a shift in conceptions is that prevailing notions about alcoholism have gained popularity despite a lack of empirical support from the beginning. Disease conceptions may be alluring to our contemporary society because they are congruent with general ideas about the self and personal responsibility (Peele, 1981b). Alcoholism viewed as an uncontrollable urge is after all part of a larger trend in which premenstrual tension, drug use and drug withdrawal, eating junk foods, and lovesickness are presented as defenses for murder (Peele, 1982). It may be that contesting disease imagery will remain an unpopular, but necessary, effort for some time.

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CHAPTER 8

TREATMENT V. INCARCERATION

GUEST EDITORIAL

Lost Drug War

by Carl J. Cieslikowski

National and state drug policies are leading to a rapidly escalating catastrophe in the United States. As long as the profit in illegal drugs remains gargantuan, free enterprise will prevail and drug dealers will continue to pollute our society. Today, in spite of the "war on drugs," there is increased violence, street gangs, organized crime, increased cases of AIDS, an exhausted judicial system, overworked police, runaway justice costs, and children with easier access to drugs than hope.

California spends six billion dollars a year in a no-win drug war. The cost will continue to soar unless we take the profit out of illicit drugs. Because heroin, cocaine, and an assortment of other illegal drugs command the same price as platinum, we will continue to lose our 76 year "War on Drugs." Trying to protect people from themselves and to legislate morality is an impossible task and, therefore, a never-ending cost. It is much less expensive to educate our children, introduce prevention programs, and provide jobs than to incarcerate our people.

Abraham Lincoln once said: "Prohibition will work great injury to the cause of temperance. It is a species of intemperance within itself for it goes beyond the bounds of reason in that it attempts to control a man's appetites by legislation and makes a crime out of things that are not crimes."

Politicians continue to pass "tough" laws they believe will keep them elected, but do little to address the genuine issues. History shows that stiff laws, interdiction, and rhetoric designed to affect morals have never stopped the traffic of any drug. We must take the profit out of the illegal drug trade. Let us consider solutions, such as the end of drug prohibition, controlled government distribution, decriminalization,

and the introduction of medical, versus legal solutions for addicts. We should promote an honest drug strategy through prevention and education and recognize that we are faced with a major public health problem.

Let us put the issue of drug distribution and profits into proper perspective. We are a society which has made a discriminatory judgment as to which mood-altering drugs are acceptable. The primary drug pushers in this country are the alcohol and tobacco industries, which are protected by generations of campaign contributions. Alcohol and tobacco are "legal" drugs which are subsidized by our tax dollars. Both enjoy protection through powerful lobbies which exercise great influence upon our elected representatives. For example, in 1988 the tobacco industry became the fourth-largest contributor to candidates. According to the Fair Political Practices Commission, of the 120 state legislators, 111 accepted contributions from the tobacco industry. In the United States, alcohol and tobacco account for approximately 600,000 deaths per year while fatalities attributable to cocaine and heroin are fewer than 10,000. The hypocrisy of some drugs being legal and others being illegal is destroying the integrity of the public's belief in our justice system.

Because many of our politicians are servants of the legal drug and chemical industries, they divert our attention to the illegal drug trade. These powerful and vested people have an aversion to open and honest discussion about illegal drugs, as they profit from this so-called "war." Many of those who seek to obscure the issues are motivated by self-serving interests, such as political benefit, financial advantage, and maintaining a market monopoly or power.

During the past ten years, county and state justice system costs have tripled. These costs do not include the capital expenditures for building jails and prisons. Since 1983, 13 prisons have been built in California and 12 more are scheduled. Prison populations have tripled. Yet crime and drug use continues to skyrocket. For example, hard narcotic arrests rose 382 percent since 1980 and drug-related cases are now choking the courts, resulting in less attention to more serious crime. High incidence of violence and property crimes are directly attributable to the high cost of drugs and their use. While billions are being spent on arrest, prosecution, and incarceration for "illegal" drug use, this past August the governor terminated the ten million dollar Child Abuse Prevention Training Act which served 3.7 million children, many of whom become victims of legal drugs.

The heightened use of mood-altering drugs in our country is symptomatic of a frustrated culture in turmoil and despair. Our society is in need of education, prevention and quality treatment for those who ask, as opposed to repression, retribution, or budgetary suicide as evidenced by our projected ten billion dollar state deficit. Tobacco and alcohol habits in this country are being altered as a result of education and social pressure and not because of prosecution, intimidation, or incarceration. We need to change our outdated practices and support those individuals who present creative, well-founded proposals for dealing with the drug dilemma. Any possible solutions will require patience, honesty, political fortitude, and long term planning.

We have to challenge our cultural values, transcend excessive personal profit, and yet make it clear we do not

condone drug use. The attempt to legislate morality during the prohibition era resulted in an escalation of organized crime in the United States. Both murder and assault rates rose with prohibition and then declined for ten consecutive years after the repeal of prohibition. Today, the same scenario is repeating itself with organizations, such as the Columbian Cartel, Crips, Nuestra Familia and Bloods that supply outrageously profitable products in response to America's craving for illegal drugs.

Most concerned citizens agree drug abuse is a major problem in our country. The dilemma is how to agree upon a method to effectively deal with drug abuse and its related crime. We have had ample opportunity to test the pres-

ent methods of arrest, prosecution, incarceration, and treatment; however, these practices have failed, compromised our liberties, and created financial chaos. Our misguided policies have resulted in social neglect by wasting the funds necessary to prevent this national tragedy. Now is the time for new leadership as we try a fresh approach to this problem. We must rediscover common sense values and employ consistent, contemporary methods to effectively address drug issues.

Let us not deceive ourselves. A new drug policy must be coupled with an effort to seriously and unselfishly address the numerous social issues which have roots deep in the very core of our society. Without hope and justice, people cannot fight addiction and will con-

tinue to alter their consciousness to avoid reality. Now is the time to decisively question the merits of drug prohibition. We must change to a medical model which eliminates criminality and profit and offers a more humane method of addressing drug issues, as opposed to the current punitive model. It is imperative to redirect resources into cost-effective programs of prevention, treatment, maintenance, and education. The reallocation of precious resources will require sacrifice. Change will only occur when we elect citizens with enough knowledge and political courage who will challenge the present drug policies and chart a course for change.

For more information, contact: Carl Cieslikowski, (408) 633-4443. []

Letter from the Editors

From page 4

and Ken Young of the Montgomery County (Texas) Department of Community Supervision and Corrections. The authors describe the elements of the Counties Employment Assistance Program including referral, job readiness training, job search and monitoring and follow-up. Our readers are directed to program documents which will be of interest to agencies contemplating developing or enhancing their own approaches to this critical programming area.

In closing, you are encouraged to submit your comments and suggestions by calling or writing the members of the Editorial Committee

Dr. Robert E. DeComo, NCCD, 685 Market St., Suite 620, San Francisco, CA 94105, (415) 896-6223

Dr. Arthur J. Lurigio, Dept. of Criminal Justice, Loyola Univ. of Chicago, 820 N. Michigan Ave., Chicago, IL 60611, (312) 915-7564

Dan Richard Beto, Director, Community Supervision & Corrections Dept., P.O. Box 6910, Huntsville, TX 77342, (409) 295-8138.

For instructions regarding submissions, see the boxed information on the right. []

Information For Perspectives Contributors

The American Probation and Parole Association's Publication, *Perspectives*, disseminates information to the Association's members on relevant policy and program issues and provides updates on activities of the Association. The membership represents adult and juvenile probation, parole and community agencies throughout the United States and Canada. Articles submitted for publication are screened by a Board of Editors and, on occasion, selected reviewers, to determine acceptability based on relevance to the field of criminal justice, clarity of presentation, or research methodology. *Perspectives* does not reflect unsupported personal opinions. Submissions are encouraged following these procedures:

Four hard copies of the article should be submitted to Amy Hensel, American Probation and Parole Association, c/o The Council of State Governments, Iron Works Pike, P.O. Box 11910, Lexington, KY 40578-1910. The following deadlines must be met:

Summer 1992 Issue	April 1, 1992
Fall 1992 Issue	August 3, 1992
Winter 1993 Issue	October 26, 1992
Spring 1993 Issue	January 27, 1993

If possible, please submit articles in ASCII format on an IBM compatible computer disk along with three hard copies.

Unless previously discussed with the editors, submissions should not exceed ten typed pages which are numbered consecutively and double spaced. All charts, graphs, tables and photographs must be of reproduction quality. Optional titles may be submitted and selected after review with the editors.

All submissions should be in English. Footnotes should be used only for clarification or substantive comments and should appear at the end of the text.

References to source documents should appear in the body of the text with the author's surname and the year of publication in parenthesis, (e.g., Jackson, 1985). Multiple references to sources by the same author should be labeled alphabetically with each year, e.g., (Jackson, 1985a). If the same source is cited more than once, indicate the various pages of the source with each reference, e.g., (Jackson, 1985: 162-165). Alphabetize each reference at the end of the text using the following format:

Anderson, Paul J. "Salary Survey of Juvenile Probation Officers." Criminal Justice Center, University of Michigan (1982).

Jackson, D.J. "Electronic Monitoring Devices." *Probation Quarterly* (Spring, 1985): 86-101.

While the editors of *Perspectives* reserve the right to suggest modifications to any contribution, all authors will be responsible for and given credit for final versions of articles selected for publication. Submissions will not be returned to contributors. []

CHAPTER 9

**COLLECTION OF SAMPLE FORMS FOR COMMUNICATION
BETWEEN COURTS AND SUBSTANCE ABUSE PROVIDERS**

CHAPTER NINE

SAMPLE FORMS FOR COMMUNICATION BETWEEN COURTS AND TREATMENT PROVIDERS

When we think of "forms", we usually think in terms of only one definition, "...a printed document with blank spaces to be filled in....". Webster has 26 other definitions of form, however. For discussion purposes here, let's combine the one above with another by Webster, "...anything used to give shape to something else...". So we end up with "a document used to give shape to something else". In the case of courts and treatment providers, that "something else" is information concerning the client/defendent. From that information, tasks are created. For example, from a referral, intake information is collected (task one), from intake, an assessment is made (task two), from the assessment, a treatment plan is drawn (task three), etc.

Depending on the shape we want the information to take, the forms we use as tools to accomplish a given task will vary in shape themselves. Each person who designs a form perceives the task born from that form a little differently. Each task is seen and performed a little differently in each judicial district. Given these human variations, there are no magic formulas for designing a form correctly. Some people would say that the magic formula is no form at all - and many times they are right.

An additional piece of paper will sometimes, however, increase the quality, efficiency, or relevance of the information collected and, consequently, of the tasks performed. When such a situation becomes apparent, another piece of paper may very well be in order. While we don't have a magic formula for the perfect form, we do have some good guidelines for effective forms. The first set of guidelines tells us the purposes for which we use forms. What general shapes do we want to give our information in order to best understand the tasks we need to perform? There are five basic purposes.

1. Records Keeping: Licensure, funders, statute and agency needs all dictate that client files be preserved for a number of years. Historically, a hard copy kept in a secure cabinet has been the means of doing this. Computers now are sometimes filling that role but, either way, a form is the vehicle on which the preserved information is kept.

2. Complete Information: Each agency has criteria for client assessment. Those criteria dictate that particular information be collected so the assessment is based on complete information gathered with equal thoroughness about each client. We have all had times when we were short handed or distracted in some way. Our human tendency is to slog carelessly through our work at such times in an effort to get through it. A "fill in the blanks" intake form helps jog our memory so we don't forget some items and helps keep us honest about the amount or quality of information we collect when, for whatever reason, we are not operating at peak efficiency.

3. Standardized Information: For legal and ethical reasons, the criteria for client assessment in your agency must be evenly and equally applied to all clients. Us humans, fortunately, each tend to see things in a little different light. This includes the agency criteria for assessment. These different points of view add depth to our understanding of human problems and our reservoir of strategies for solving those problems. But applied literally, they can also add chaos to the assessment process. The intake form assures that all staff gather the same information so all assessments are based on the same knowledge base. A well designed form will require the minimum of information wanted by the agency in order for the form to be completed, but will also accomodate those who wish to gather more information than the minimum.

4. Monitoring: Most agencies must be able to give evidence of a minimum standard of competence or a minimum quality of service to interested outside organizations. Organizations who have a legitimate claim to this sort of monitoring are licensing and credentialing agencies, contract funders, insurance companies, and others. The usual method for this type of monitoring is a site visit which includes a "Client Record Review". In order for you to receive a fair review, your client files must meet the standards being monitored and the information contained in them be easy to locate and easy to understand. Forms are the most efficient way to accomplish these three objectives.

Most competent agencies also have their own internal quality assurance procedures. These procedures may be simply an informal staffing meeting in small agencies or a full blown "Client Record Review" conducted by specially trained staff in larger agencies - or both. Either way, a set of forms necessarily holds the information on which the quality of service is judged.

5. Communication: Whether "inter" or "intra" agency, communications are often well served by forms. Of course, the four prior purposes for forms involve communication. The difference is that they are all primarily concerned with "shaping" the information collected. Here, the content is irrelevant. The only concern is that it is accurately communicated to another. Forms, ranging in complexity from a blank sheet of paper to a CODAP or MIS, suggest the information and frequency needed and identify the intended receiver. It standardizes format when applicable so the receiver can easily decipher it. Additionally, it gives evidence that the communication took place.

This chapter concerns itself with this fifth purpose of forms, those used for the communication of client/defendent information between courts and treatment providers. "A document used to give shape to something else" seems to lend itself to any level of complexity necessary to this purpose. The level of complexity desired in the form depends on how much control you want to exercise over the information being communicated. If you want to present an innovative coordinating idea to the courts and providers in order to elicit their reaction, you will want to write a letter outlining the idea and conveying your own enthusiasm for it. In this case, the form is a blank sheet of paper. At the other extreme is a questionnaire designed to give precisely defined responses for an esoteric research project. Such a form, of course, could make CODAP look like a piker.

Thank goodness, no judicial districts have forms as complex as that for communication between courts and providers. Some districts have virtually no forms at all for this purpose. Others have a plethora of forms mined from the depths of many agencies. The general rule seems to be, the larger the district, the more formal its operations and the more forms are used. The forms presented in this chapter are those used between Third Judicial District Courts and agencies of Criminal Justice Services Division. These are presented simply to let you see some ways people have met their communication needs with forms. It is probably wise to mention some caveats here. First, these are not purported to be all the forms used and they are not claimed to be used exclusively by the agencies mentioned above. Second, these are not presented as perfect forms born from the wand of the elusive magic formula. They are adequate forms which serve the users reasonably well. Some of them, in fact, are being revised at the very moment of this writing. These may give you some ideas you want to use. You may want to use a form exactly as it is presented here. They may convince you more than ever that your formless communications are the most desirable. Feel welcome to use these for any of those three reactions. We are showing you seven forms which are used directly for communication and have written a brief description of each. The forms follow directly behind these descriptions.

1. Presentence Report Worksheet: When the court requests presentence reports from Alcohol Counseling and Education Center (ACEC), the report is prepared with standardized format and content. Format, of course, is governed by the computer program. Content is governed by information received during a presentence interview. This social history assures that standardized information is collected at the interview but also allows the interviewer to pursue events further

when this seems appropriate.

2. Court Referral: Based upon court findings, the judge sentences those defendants found guilty. When the judge elects to put the defendant on probation at ACEC, this form is used. The court completes it and gives to defendant and ACEC. It is used to inform defendant of probation conditions and as a basis for ACEC supervision of that client.

3. Probation Stay Report: This is used for two-way communication between ACEC and courts. Because of the wide array of information to be communicated, this is basically a blank page with some pertinent identifying information. The message occupying this space may be requesting early termination for excellent performance while on probation, suggesting an Order to Show Cause for non-compliance, a periodic report requested by the judge; virtually anything. The judge's response at the bottom will also vary as widely as the message.

4. Order To Show Cause Worksheet: ACEC is frequently asked to prepare Orders to Show Cause for non-compliance. As with presentence reports, formats are standardized by computer program but content is standardized by using this form to present information for processing.

5. Pretrial Release Assessment: Completed by Pretrial Services staff in the jail on the majority of bookings. A copy is given to the judge in all cases and another to the counselor if the defendant is released. This informs the judge of the rationale for release or nonrelease and gives the counselor pertinent information for pretrial case management.

6. Release Agreement: Accompanies number five to judge and counselor upon release. Contains terms of the release and all necessary signatures.

7. Order For Personal Recognizance Release To Pretrial: Signed by judge on all release defendants who appear in court. Given by the court to Pretrial Services.

ALCOHOL COUNSELING & EDUCATION CENTER
SOCIAL HISTORY

JUDGE: _____ DATE OF INTERVIEW: _____
COURT: _____ DEPT.: _____ COUNSELOR: _____
DATE DUE: _____ TIME: _____ OFFENSE: _____
NAME: _____
ADDRESS: _____ CASE NO.: _____
BAC: _____ SOURCE: _____
PHONE: _____ DEF. ATTY.: _____
DOB: _____ AGE: _____ SEX: _____ RACE: _____
SSN#: _____ DATE OF ARREST: _____
CIRCUMSTANCES OF ARREST: _____

RESTITUTION: _____

PRIOR RECORD: _____

BACKGROUND INFORMATION: _____

MARITAL HISTORY: _____

1

EDUCATION: _____

HEALTH: _____

MILITARY HISTORY: YES: _____ NO: _____ BRANCH: _____

FROM: _____ TO: _____ DISCHARGE: _____

EMPLOYMENT AND FINANCIAL STATUS: EMPLOYER: _____

PHONE: _____ JOB TITLE: _____

HOURS AND DAYS WORKED: _____

ALCOHOL/DRUG USE: _____

COUNSELING OR TREATMENT: _____

RECOMMENDATIONS: _____

1A

ALCOHOL COUNSELING & EDUCATION CENTER

231 East 400 South, 2nd Floor
Salt Lake City, Utah 84111
Phone: 538-2279

NAME _____ Date of Birth _____

Address _____ Zip _____

Phone _____

Charge(s) _____

Case Number(s) _____

YOU ARE HEREBY ORDERED TO REPORT TO THE ALCOHOL COUNSELING AND EDUCATION
CENTER IMMEDIATELY FOR:

☐ Presentence Report: Due ____/____/____ Time _____

☐ Probation ☐ Other _____

SENTENCE:

Jail: _____ Days, Suspend _____ Days

Probation: _____ Months

Community Service: _____ hours

Fine: \$ _____, Stay _____.

Rehabilitation Fee: \$ _____, Stay _____.

Victim Restitution Fund: \$ _____, Stay _____.

Other Costs or Fees: \$ _____

Other Conditions: _____

AS ORDERED BY JUDGE _____ Date ____/____/____

COURT _____

Upon the recommendation of the Court, an appointment has been scheduled to

execute a probation agreement on ____/____/____

with _____ Time _____

PLEASE RETURN ORIGINAL TO ACEC

2

A&D AC 8

ALCOHOL COUNSELING AND EDUCATION CENTER

PROBATION STAY REPORT

JUDGE: _____

DATE: _____

NAME: _____

CASE NO.: _____

OFFENSE: _____

**PLACED ON
PROBATION:** _____

PROBATION STATUS/RECOMMENDATIONS:

PROBATION COUNSELOR

JUDICIAL ACTION:

JUDGE/CLERK

DATE

3

ORDER TO SHOW CAUSE WORKSHEET

COURT AND DEPARTMENT _____

_____ vs. _____
(CITY OR STATE) (CLIENT NAME)

CLIENT ADDRESS _____

COUNSELOR _____ JUDGE _____

COURT ADDRESS _____

DATE OF HEARING _____ TIME: _____

CHARGE _____ Case No. _____

CONDITIONS OF PROBATION _____

THAT ON OR ABOUT _____

DEFENDANT VIOLATED PROBATION BY _____

4

SALT LAKE COUNTY CRIMINAL JUSTICE SERVICES DIVISION

NAME _____ BO# _____ DOB _____ RACE _____ SEX _____

DATE PRINTED _____ BOOK DATE _____ RELEASE DATE _____

CHARGES TIME PRINTED _____ BOOK TIME _____ RELEASE TIME _____

AKA'S

PAROLE/PROB? _____ OFFICER _____ PRIORS? _____ UBI# _____ JUVENILE? _____ TOT. BOOKINGS _____

RESIDENCE

ADDRESS _____ CITY _____ STATE _____ PHONE # _____

TIME AT ADDRESS _____ TIME IN AREA _____ LIVING WITH _____

PREV. ADDRESS _____ CITY _____ STATE _____ LENGTH _____

EMPLOYMENT

CURRENT EMPLOYER _____ HRS/WK _____ LENGTH _____

ADDRESS _____ CITY _____ STATE _____ PHONE # _____

PREVIOUS EMPLOYER _____ LENGTH _____

LOCAL TIES

PERSONAL REFERENCE _____ PHONE # _____ LENGTH _____

ADDRESS _____ CITY _____ STATE _____

PERSONAL REFERENCE _____ PHONE # _____ LENGTH _____

MARITAL STATUS _____ # CHILDREN _____ LIVING WITH _____ SUPPORTING _____ STUDENT _____ WHERE _____ HI GRADE _____

FINANCIAL

GEN. ASSIST _____ FOOD STAMPS _____ RETIREMENT _____ DISABILITY _____ SOC. SEC. _____ UNEMP/COMP _____

INCOME **ASSETS** **EXPENSES**

AMOUNT/MO. _____ BANK/CASH _____ UTILITIES/FOOD _____

SPOUSE/MO. _____ EQUITY/PROP. _____ HOUSE/RENT/MO. _____

OTHER/MO. _____ OTHER _____ OTHER/MO. _____

TOTAL _____ TOTAL _____ TOTAL _____

LEAVING? _____ WHEN? _____ WHERE? _____

UNDER PENALTY FOR PERJURY, I AFFIRM THAT THE ABOVE STATEMENTS OF MY FINANCIAL STATUS ARE TRUE TO THE BEST OF MY KNOWLEDGE.

ATTORNEY _____ VETERAN _____ SIGNATURE _____

DECISION _____ ID _____ APPROVAL TYPE _____ JUDGE _____

DETACH THE FOLLOWING CONFIDENTIAL INFO FOR ALL COURT/MAIL COPIES _____

VERIFIED _____ PHONE# _____ INTERVIEW DATE _____ PTS SCREENER _____

ALCOHOL _____ DRUGS _____ MENTAL HEALTH _____ RETARDED _____ PSYCH. EVAL. _____ PF2 _____

5

**SALT LAKE COUNTY
PRE-TRIAL SERVICES
RELEASE AGREEMENT**

Charge(s) _____

Supervised Release ☐
Own Recognizance ☐

DEFENDANT'S NAME _____

YOU ARE HEREBY RELEASED ON THE FOLLOWING CONDITIONS LISTED BELOW:

1. You will attend all court appearances as required.
 - a. Your next court appearance:
JUDGE: _____
ADDRESS: _____ PHONE: _____
DATE AND TIME: _____
 - b. You must also appear:
JUDGE: _____
ADDRESS: _____ PHONE: _____
DATE AND TIME: _____
2. You will not violate any laws of the State of Utah.
 - a. Violations of conditions (arrest, failure to cooperate or failure to appear could result in immediate revocation of release and your return to custody.
 - b. If you fail to appear in court, a bench warrant may be issued and a new complaint may be filed as an additional charge.
3. You will not leave the territorial limits of the State of Utah without consent of Pre-Trial Services and the Courts.

YOU ARE RELEASED ON THE FOLLOWING ADDITIONAL SPECIAL CONDITIONS LISTED BELOW:

You Are To Report <input type="checkbox"/>	<input type="checkbox"/> BY PHONE 538-2149 <input type="checkbox"/> DAILY (8:00 A.M.-5:00 P.M., MONDAY THROUGH FRIDAYS) <input type="checkbox"/> AFTER EACH COURT APPEARANCE <input type="checkbox"/> TO OFFICE 424 EAST 500 SOUTH #200 _____ date _____ time _____ <input type="checkbox"/> SUPERVISED RELEASE <input type="checkbox"/> O.R. REFERRAL
You Are To Reside <input type="checkbox"/>	AT _____ PHONE # _____ WITH _____ RELATIONSHIP _____
You Are To Work <input type="checkbox"/>	By obtaining a job by _____ date _____ By maintaining employment at _____ name _____ phone _____ address _____
Education <input type="checkbox"/>	<input type="checkbox"/> Finish High School <input type="checkbox"/> Vocational Training <input type="checkbox"/> Maintain Student Status <input type="checkbox"/> Other _____ APPT. agency _____ address _____ date _____
Alcohol, Drug and Mental Health Treatment <input type="checkbox"/>	<input type="checkbox"/> Continue treatment at _____ name _____ <input type="checkbox"/> Enter treatment program at _____ address _____ <input type="checkbox"/> Make Appt. With _____ phone _____ date _____
You Are To Report <input type="checkbox"/>	<input type="checkbox"/> Any change in address, telephone number, employer, or court date to Pre-Trial Services.
Other Conditions <input type="checkbox"/>	

DEFENDENT _____

INTAKE COUNSELOR _____

DATE _____

6

PRE-TRIAL SERVICES
424 East 500 South, Suite 200
Salt Lake City, Utah 84111
Telephone 538-2149

CIRCUIT COURT, STATE OF UTAH
County of Salt Lake, State of Utah

The State of Utah
Plaintiff

vs.

Defendant

**Order for Personal Recognizance
Release to Pre-Trial Services**

Case Number _____

Charge _____

Based upon Defendant's motion and good cause appearing, it is hereby ordered that the Defendant be released on Personal Recognizance to Pre-Trial Services.

Dated this _____ day of _____, 199__.

Judge

Delivered a copy of the foregoing to the County Attorney's Office, 231 East 400 South, Salt Lake City, Utah, this _____ day of _____, 199__.

7

CHAPTER 10

WHAT COURTS WANT

CHAPTER TEN

WHAT COURTS WANT TREATMENT PROVIDERS TO KNOW

As workshops were conducted throughout the state, a record was kept of the questions, problems and comments made by the attendees. A few common themes emerged statewide. This chapter will include the common statewide problems that court personnel suggested to treatment providers.

Workshops in most districts were held separately for juvenile and adult courts. This chapter will also separate the juvenile court from the adult although many of the problems for each are similar.

Juvenile court judges and personnel throughout the state are concerned about juveniles who have been through treatment being returned to "sick" families. They stated that the entire family and, in some cases, friends of the defendant also need to be involved in the healing process. It is also very important for school to continue in some form while the defendant is in treatment.

The speed of getting into treatment is a big concern in every district. Most felt that treatment needs to begin at the point of arrest. First arrest with some youth is appropriate. Many have been abusing substances for a long time but have not been arrested. It was suggested that arresting officers should be making referrals. In most cases, waiting lists are usually long and the impact of arrest is lost. Long term after-care was also a major concern. Some people suggested that treatment only lasts until the insurance runs out.

The lack of secure inpatient treatment facilities is a concern of many court personnel. The safety of the community is a primary consideration in ordering treatment rather than sentencing an offender to a secure facility. Few treatment programs are available in jails or juvenile secure facilities. There are no detox facilities for juveniles and the officers have to bring the defendant in while still intoxicated. Services for minorities are also limited or unavailable.

More community based outpatient treatment facilities need to be made available. Judges need to be given more feedback on the progress of the defendant. This is especially important if non-compliance is a problem.

Courts could benefit from a standardization of fees, requirements and accessibility of treatment programs. Referral mechanisms and feedback systems also need to be standardized. The courts would like to see a statewide treatment provider referral system.

Funding is the biggest problem voiced in every district, both juvenile and adult. It was stated that extra funding could provide solutions to many of these problems.

The adult courts are concerned with the accessibility and accountability of the treatment programs. They would like to see more coordination between courts, treatment providers and the state driver's license division. A list of agency requirements for admission and what is offered would be beneficial. Paperwork also needs to be kept at a minimum; some things can be accomplished via the telephone. If a providers is unsure of the court order or it is unclear, the provider can call the court clerk for a clarification. The courts would like to see a statewide system of referral especially in districts that are noted for their recreational areas. Visitors to these areas occasionally

get arrested and need to be sentenced to treatment facilities closer to their home.

A major concern the courts have is allowing defendants to use treatment as a ploy to avoid incarceration. Treatment personnel should not "soften" the court experience for the defendant. The court would like quick, documented notice of violations of treatment policies. This can be more effective than an order to show cause. The courts would like to maintain judicial discretion on the type of lock-up for secure inpatient facilities.

A combination of jail time and treatment seems to be the most effective method for many offenders. Court personnel would like to know what combination, etc. works best with what type client. A definition of "success" is also needed. One answer is if the person does not appear in court on new charges again.

The courts would like to see the elimination of waiting lists. The faster a person can get into a treatment program the more effective it becomes. Feedback is essential both to the courts and treatment providers.

Substance abuse is seen by the courts as a family problem, therefore, the entire family should be involved. They also would like to see treatment programs in the jails. Presently, these are very few. Motivation for successful treatment seems to be stronger when a person is incarcerated. Some judges wondered if motivation is necessary for success.

All districts throughout the state lack sufficient medical detox facilities. Enhancing this area would relieve the pressure on law enforcement officers and jails.

Court personnel stated that individualized pre-sentence reports would be beneficial. These need to reflect past assessments and treatment successes and failures.

The duration of the probation period is a question the courts had. Should a judge keep a person on probation until treatment is completed? Until fees are paid? Who is responsible to see that fees are paid in full?

As with the juvenile courts, funding is the major problem. Funding will continue to be a problem with every aspect of the criminal justice system.

CHAPTER 10

WHAT COURTS WANT TREATMENT PROVIDERS TO KNOW DISTRICT I

This chapter includes an outline of the comments made at the workshop held for District I on October 20, 1992. The juvenile and adult courts were separated at the workshops because the issues for each court were significantly different. In this outline the two courts will also be separate.

Juvenile

1. Communication from providers needs to be timely and periodic.
2. The judge needs ample time to read the report.
3. Each plan needs to be well-prepared and articulate.
4. Parents of juvenile offenders are frustrating.
5. We need a secure program--youth detox must be allowed.
6. The duration of treatment needs to be longer.
7. Address multifaceted areas of problems.
8. Serious offenders are given too many chances.
9. Recognize when treatment is no longer an option.
10. Treatment needs to be shared among agencies.
11. There is very limited funding for in-patient treatment.
12. Is detention treatment?
13. There is a lack of options for juveniles--"Kids feels you can't touch them".
14. The victim's perspective must be considered. Community safety is critical.
15. There is a lack of jurisdiction over adults involved in juvenile cases.
16. Very limited resources for indigent Native Americans with alcohol problems.
17. Counselors should not be manipulated; client learns the right "buzz word", etc.

Adult

1. There is a lack of local treatment programs.
2. Courts need more information regarding the specific program.
3. Communication from programs needs to be improved regarding defendant progress or problems.
4. Courts need to know the cost of program.
5. Does a defendant need to be motivated to change?
6. What are the facts about waiting lists and what should we do in the interim?
7. It would be helpful to know the success rate of the agency.
8. Early intervention is critical.
9. What is available for multi-generations, deep-seated problems?
10. Earlier, better diagnostic tools for those who minimize their substance abuse would be helpful. Exp: MAST
13. What can we do for the repeat or chronic offender?
14. Community safety must be considered before treatment.
15. Matching defendants to programs is necessary.
16. We need to have consistency of communication between courts and treatment.
17. Private-for-profit, long-distance programs are the hardest to maintain communication with.
18. Should we fine the defendant or send him/her to treatment?
19. Treatment vs. Preventions--where should the money be spent?
20. Big-buck treatment doesn't always deliver everything promised.
21. How accessible is "for-pay" treatment?

CHAPTER 10
WHAT COURTS WANT TREATMENT PROVIDERS TO KNOW
DISTRICT II- DAVIS COUNTY ONLY

This chapter includes an outline of the comments made at the workshop held for District II October 22, 1992. Only a juvenile court workshop was held because no adult court judges were able to attend.

1. Treatment seems to be only a "Band-aid". It seems to lack a comprehensive spectrum. Identification of total problem needs to be made.
2. We need a multi-faceted perspective rather than isolating treatment modalities.
3. Treatment needs to be taken to the institution.
4. Public safety in conjunction with treatment must be considered.
5. Consequence can be beneficial to the offender.
6. Evaluations need to be done on first offenses with drug cases.
7. Public school suspension may be a "double-whammy"--may be a reward to the student.
8. Is antabuse an option for juveniles?
9. We need aggressive, timely communication concerning child's progress, or lack of, in treatment.
10. Resources need to be shared among the counties.
11. Repeat or chronic offenders are not being treated successfully.
12. Residential programs need to be secure. They are not secure at present.
13. How far can the juvenile court reach when the child is before them on a charge?
14. What shall we do with a child when the home is the main problem?
15. There is a great lack of family-oriented treatment institutions.
16. Socio-economic status is a factor in parental cooperation.
17. There are not enough resources for lower income families.
18. We fail to acknowledge poverty or working poor in the district.

19. Can we interface between adult and juvenile treatment agencies so we don't send kids home to sick families?
20. Budgetary constraints are a dilemma for family intervention.
21. We cannot restrain kids involuntarily without court order, or commitment.
22. Treatment lacks funding. There are too many waiting lists.

CHAPTER 10
WHAT COURTS WANT TREATMENT PROVIDERS TO KNOW
DISTRICT II WEBER AND MORGAN COUNTIES

This chapter includes an outline of the comments made by court personnel at the workshop held January 21, 1993 in District II for Weber and Morgan counties. The juvenile court issues were discussed separately from the adult issues. They will be reported in this outline separately also.

Juvenile

1. We need feedback from treatment providers to probation officers.
2. Give office to drug and alcohol providers on court premises.
3. The roles between court and treatment need to be defined:
 - court decides guilt
 - treatment decides guilt
 - treatment decides successful completion including costs.
4. Treatment should provide alternative fee completion.
5. Is substance abuse a disease or just bad choices?
6. Who chooses the treatment philosophy?
7. Problems exist in treatment's philosophy:
 - message that consequences exists
 - source and supply reduction
 - demand reduction--prevention/consequences
 - consistency
 - court time
 - lock up facilities
8. Treatment needs to recognize that school is important.
9. Court decisions are based on specific fact situations but treatment addresses the whole picture/person.
10. Juvenile court has statutory jurisdiction until 18 yrs. of age (with few exceptions).
11. Move toward decriminalization or provide social services.

Adult

1. Treatment may not be effective.
2. Jail may not be effective as a deterrent.
3. The correct combination of treatment and jail may be effective.
4. Not even jail and treatment works for every individual.
5. Court would like feedback about treatment progress.
6. What kind of feedback?
 - How often?
 - To whom?
7. Pre Sentence Investigations (corrections) format is useful.
8. Do programs work?
9. Feedback should be timely and complete to be useful.
10. Feedback must go both ways and have clear expectations.
11. Feedback: effectiveness of treatment in general--
 - What is working?
 - What isn't working?
 - What is changing?
12. At the circuit court level, the judge actually supervises substance abuse probation.
13. Treatment would like to see use of limited lock-up as part of treatment.
14. Judges would like some discretion on the kind of lock up facility.
15. Does treatment address the issue of "change of behavior" in addition to the substance abuse?
16. Better information systems need to be available to judges.
17. Better coordination between treatment, courts and driver's license division is critical.
18. Criminal defendants sometimes go into substance abuse treatment only to avoid a harsher sentence.

19. Independent audits should be done to find out if particular treatment works.
20. Who is notified when treatment is stopped after formal probation?
21. Courts follow through is cumbersome, as is Administrative overhead.
22. Is there a difference in results between public and private providers?
23. Court system is cumbersome and timely and a lot of work.
24. Court sometimes doesn't relay information to treatment so they can know what is expected of them.
25. Treatment provides skills to change behavior and gives opportunities to learn.
26. Treatment can be effective.
27. "Big Stick" that the courts carry can work.
28. Treatment can address more than one specific problem.
29. It is very difficult to measure success in treatment.
30. Independent source of determining success are necessary.
31. Collaborative efforts work.
32. Courts provide punishment aspect.
33. Courts provide entrance into treatment.
34. When measuring success, should we compare apples to apples?

CHAPTER 10

WHAT COURTS WANT SUBSTANCE ABUSE PROVIDERS TO KNOW

DISTRICT III

The Third District Juvenile Court's workshop was held June 4, 1992. Many valuable issues were discussed. This chapter includes an outline of the comments made by court personnel to substance abuse providers. The adult workshop for District III was held February 17, 1993. The juvenile court workshop was held June 4, 1992. Both outlines are included but are separated.

Juvenile

1. More in home tracking services are needed.
--1 week session is not enough
--12 step programs 4-5 times/week
2. More aftercare follow up is also needed.
3. Offenders need to be placed in treatment sooner.
4. Police officers could make referrals on substance abuse cases.
5. Assessment fees need to be standardized.
6. Treatment fees also need to be standardized.
7. Accessibility for treatment needs to be easier.
8. Substance abuse programs need to coordinate with police officers.
9. Change guidelines such as holdable offenses and home detention.
10. Identify offenders and place on a continuum:
*Risk for future use
*Appropriate level of treatment
11. Treatment providers run diversion groups.
12. Educate the community that alcohol is a drug.
13. Treatment should have a long term involvement (shouldn't end when the money runs out).
14. Who takes responsibility for follow up?
15. More options are needed between day treatment, intervention and inpatient.

16. Close court file--but reopen it if treatment is not followed.
17. Find mechanism to report provider accountability.
18. An electronic data base for program availability would be very helpful.
19. Geographic locations are a factor. Where are the best site/s for the offenders?
20. Simple information sheet with all programs, fees, limitations etc. for all agencies and programs would help.
21. Match offender with appropriate treatment.
22. We need a better determination of "success".
23. Protect environment: make drugs less available on site (re: day treatment programs).

Adult

1. The courts want qualified programs with treatment expertise.
2. Provider needs to assure that consequences of non-compliance come quickly. Monitor and track the offender and communicate with court clerk quickly.
3. Providers don't always give feedback on how client (defendant) is doing.
4. Keep paperwork to minimum. Many reports can be verbal.
5. Providers communicate with courts and AP&P, depending on probation.
6. Probation officers give meaningful recommendations with reports, probation or conditions. (If probation is always recommended the public loses confidence.)
7. We need to know treatment agency requirements: If we don't get report until fifth appointment is missed, action is slow.
8. Need longer follow-up with clients as needed. Indicate if offender is compliant with treatment.
9. Have offender make an informal court appearance when non-compliant. Informal has the same impact as an order to show cause but less time and paperwork.

CHAPTER 10

WHAT COURTS WANT TREATMENT PROVIDERS TO KNOW

DISTRICT IV

At the workshop held November 3, 1992 in District IV many issues were brought to light. This chapter is an outline of the comments made by all who attended. The juvenile and adult courts were separated and will be here also.

Juvenile

1. The courts need to know the cost of the programs.
2. Drug and alcohol assessments need to be preformed on all who are suspected of substance abuse problems.
3. What programs are equipped to handle which type client?
4. Does a person need to be motivated to change?
5. Does the Court have any leverage in getting evaluations done?
6. Follow up-after care would help when insurance starts running out.
7. The parents must be involved.
8. We need resources for the chronic offender.
9. There is no access to treatment centers. The closest is in Salt Lake. More programs for older juveniles are needed including a residential program.
10. County boundaries need to be dissolved when it comes to helping substance abusers.
11. Generate more prevention programs like:
 - Dare
 - Parenting
 - Parent referral
 - Early involvement of programs
12. Coordination and awareness of available programs is necessary.
13. Special Education programs are needed in schools.
14. Time is a problem for juveniles. They are involved in many other activities.
15. Consequences need to be invoked for criminal activity: immediate punishment;

meaningful program in the beginning stages.

16. Need more staff:
Utah Alcohol Foundation is free
Lack of coordination
17. It is very hard to get rid of "labels". Label the behavior not the child.
18. Therapy should be connected to detox.

Adult

1. Know of treatment programs and standards out of your jurisdiction.
2. Completion of programs is essential.
How effective is the program?
3. Early referrals are important. Mental health treatment for AP&P waiting lists would help the offenders stay clean while waiting.
4. Resources for minorities are scarce. Language barriers are a problem.
5. Involve other groups like family and friends.
6. Which programs suit which type offender.
7. Programs need to be closer to jurisdiction.
8. Education classes need to be oriented to alcohol and other abuse, and low cost.
9. Bed space availability is a problem.
10. Feed back from treatment to Judge and courts is important.
11. Know the success rate of programs.
12. Providers need more staff.
13. Cost of the plan and payment arrangements need to be know.
14. Are programs available in the jail? If so, what are the restrictions?
15. Bill of Rights protection must be adhered to when doing drug searches.
16. Who is responsible to see programs are paid for?
17. What is the role of the treatment provider?
18. Random drug analysis would be beneficial.
19. Sometimes treatment doesn't work
20. Firmness in follow up and consequences is necessary.
21. Denial is a big problem.

22. Defendants play one judge against another. Judges need to coordinate with each other.
23. Client has a responsibility!

CHAPTER 10

WHAT COURTS WANT TREATMENT PROVIDERS TO KNOW

DISTRICT VI

The workshop held January 28, 1993 for District VI was very successful. Many issues were discussed. This chapter includes an outline of the comments made by court personnel to treatment providers. The workshops separated juvenile and adult courts and this outline will also.

Juvenile

1. People court ordered for treatment often don't get admitted for several weeks. Momentum is lost.
2. Not enough kids for alcohol school and individual counseling is not available leaving the court with no treatment resources.
3. Court representative would like to attend alcohol school. They have not been allowed.
4. Often first charge kids have moderate to severe problems. What are we to do?
5. Are present laws effective? Does drug and alcohol use decrease? Is the recidivism rate down?
6. Alcohol is often a substitute when other drugs are not available. Need to address other drugs more.
7. More community based outpatient therapy is needed.
8. Alcohol school needs to be available within a couple weeks of sentence. Is counterproductive when delayed.
9. More individual counseling is needed.
10. If more effort is spent in prevention and education, maybe less problem in enforcement.
11. Schools vary considerably in prevention efforts.
12. Kid taken from diseased family. After growth and healing, s/he is put back into the unhealthy family.
13. Coordination between broader community services is needed.

14. More services for Hispanic people are needed.
15. Unemployment is a serious contributor to the problem:
 - 20% in Sanpete
 - 43% in Garfield
 - 27% in SevierUnderemployment is also common. Insurance payments for treatment are rare.
16. Distances create voids in many services:
 - Daycare
 - Alcohol classes

Adult

1. Courts want treatment programs to be effective.
- 2.* Information is needed on treatment programs telling effectiveness, inpatient, outpatient, therapy model, etc.
- 3.* Follow up on the part of the program so court knows what happened to the client is necessary.
4. Treatment programs should have full history and knowledge of client.
5. Sevier County has a combination of penalties and treatment coordination with court.
6. Defendant should have a court experience which will be remembered. Treatment should not soften this.
7. Defendant needs to be clean when beginning treatment.
*Motivation should be present.
8. Does treatment become more intense for those who have been through it?
- 9.* Does treatment work or is it used just as a defense ploy?
- 10.* Therapist should avoid being an enabler. Should make a difference.
11. Therapy should take place after defendant has had penalties for having committed a crime.
12. Treatment should not simply keep a person out of jail.
- 13.* Does client need to be motivated for therapy to work?
- 14.* How do you know when someone is motivated?
- 15.* Cost effectiveness of treatment?
- 16.* Where should the debate take place: should courts deal punishment or rehabilitation?
17. Does residential treatment or jail inhibit the breadwinner and what happens then?
18. Is family brought into therapy?
19. Public safety

- accountability of treatment
- conditions of treatment

CHAPTER 10

WHAT COURTS WANT TREATMENT PROVIDERS TO KNOW

DISTRICT VII

The workshop held February 3, 1993 in District VII was very informative. Both treatment providers and court personnel pointed out several areas for improvement. This chapter contains an outline of the issues and comments made by court personnel to treatment providers. The workshops separated the juvenile court from the adult court so this outline will also.

Juvenile

1. Are there levels of DUI classes depending on number of offenses?
2. Too long a time (sometimes) from adjudication to therapy.
3. Courts don't always hear back from the treatment agency.
- 4.* Are people turned away from treatment because of a lack money?
- 5.* What services are given to parents?
6. Courts need progress reports from treatment providers.
7. Need to know community resources for better treatment. Who are they? Where are they? Is treatment available for court ordered youth?
8. Is treatment effective?
- 9.* What are the costs of therapy?
10. Treatment providers can give judge pre-adjudication assessment, resources and recommendations.
11. Providers inform probation officers of resources.
- 12.* What is the capacity of treatment providers and what happens when they are full and we have referrals?
- 13.* What programs are there for people in custody?
- 14.* At what point should courts intervene in alcohol and drug behaviors and do treatment providers have therapy for different levels of involvement?
15. Section 39 -- flexibility in jurisdiction.

16. Is alcohol use by juvenile a status or criminal offense? Makes a difference in court's options.
- 17.* How long should we court order treatment?
- 18.* Treatment mentality of least restrictive. If one level of treatment doesn't work, will treatment provider recommend something else?

Adult

1. Lack of communication both ways (court to treatment and vice versa).
2. Where is the money?
 - how much can be allocated for what?
 - From \$85 surcharge on DUI's
 - Needs to be investigated for answers
 - re: Money is gone---where?
3. Judge Truman will find out where the surcharge funds are.
4. Courts would like to order defendant to pay for treatment in lieu of \$85.
5. State substance abuse will pay (from surcharge) \$150 per DUI--mostly for classes and assessment.
6. What services other than DUI classes are available for eighteen year olds with charges other than DUI: what services other than classes? Have them ask for therapy or counseling, not classes.
7. A.A. -- court can order
A.A. -- can refuse but don't
A.A. -- is used to unwilling people attending
8. Do treatment providers have services for family of defendant?
9. Do treatment providers treat problems other than alcohol and drug when observed? Mental Health does through dual diagnosis program.
10. Are there after hours outpatient? Mental Health--6:00-9:00 PM intensive outpatient program in Carbon County and San Juan County.
11. Is treatment denied for lack of ability to pay? Kids--no; Adults--yes
12. Is there a program available 6-18 months from detox - on?
13. Unclear instructions from court. Treatment provider can call court clerk for details.
14. Judge Cox gets program reports from Tom Seymor. The Judge likes the form Tom uses.
15. Would like court to enforce alternatives when defendant doesn't comply with treatment, classes, etc.

16. Don't send defendant back to jail (on same charge) after successful treatment completion.
17. How effective are DUI classes? Class gives information on which to make informed decisions. A number of offenders change behavior on this.
18. Second offender goes through same classes but the repetition is good. Judges should repeat classes for repeat offenders.
19. Make PSR's individualized for each offender. Recommendation should reflect this individualized assessment.

CHAPTER 10

WHAT COURTS WANT TREATMENT PROVIDERS TO KNOW

DISTRICT VIII

The workshop held February 16, 1993 was very successful. Court and treatment providers suggested some very important issues. This chapter includes an outline of those comments. Although this chapter should be issues courts want providers to know, it will contain both court and treatment concerns.

1. Do courts know what treatment has to offer?
2. When state funds come to District, courts are not involved in determining use of money.
3. Courts do not get feedback from treatment on clients referred. (Rocky Mountain Consultants are good at reporting).
4. Need a closer working relationship between courts and treatment.
5. Need statewide referral program for courts. Recreation areas bring many from other districts; need to use funds from clients' District.
6. District Court defendants are served by their district on felonies. Misdemeanors are not served as well.
7. Can people off the reservation have access to Native American money? Cannot discount for race. Residential services \$150.00
8 males
6 females
8. Greatest local need is for medical detox for juveniles and adults.
9. Need to have follow up care for people leaving residential treatment. (transitional housing or therapy)
10. Mental Health, alcohol and drug, outpatient, assessments, but no PSR's.
11. Need tracking between courts and treatment providers.
12. If court sends sentencing order to treatment agency it should include: client due to report by ____ (date). Agency will report to court on that date.
13. Treatment providers request due date for conditions imposed. Sentencing order has deadline. Treatment agency doesn't always see it.
14. DUI referrals work well for tracking. Other treatment has more problems.

15. Few programs and no staff time have reduced effect on tracking and coordination.
16. *Must duplicate programs for juvenile and adults.

*Numbers are too small to support continuous program.

*No help for mental health problems in jail. (M.H. staff attend as able--but no funds, so not consistent.)
17. H.B. 39 provided money for risk reduction through LICC's.
(Local interagency coordinating counsel)
18. May judges send defendants to specific programs or are there reasons to not specify?
19. Some court referrals to residential treatment use treatment for easier time than alternatives.
20. Are PSR's helpful for the above consideration?
21. Can judges impose penalties if treatment is not successfully completed?

CHAPTER 11

WHAT TREATMENT WANTS

CHAPTER ELEVEN

WHAT TREATMENT PROVIDERS WANT COURTS TO KNOW

The workshops held throughout the state highlighted many issues. Substance abuse treatment providers in every district expressed concerns about issues that are in critical need of solution. Many issues can be solved with some level of coordination. Additional resources and funding could solve most of the problems but that probably is not a possibility.

This chapter will include issues defined by treatment providers during the workshops. The juvenile court issues will be separated from the adult issues as they were in the workshops. Although the juvenile court and adult court are very different, many of the problems are similar.

The treatment providers would like to see judges obtain release of information forms from the defendants who are sent to their facilities. 42 CFR Part 2 has some very stringent requirements for confidentiality, especially with juveniles. If an information release is signed, feedback between providers and courts can be accomplished.

Adolescents need to be referred to Mental Health on the first arrest. Mental Health also needs to coordinate with the schools to reach the "at-risk" population before they become involved in the juvenile system.

Treatment needs to be individualized. Better assessments need to be done to ensure the correct treatment for the defendant. Parents need to be involved, especially at the intake sessions. Can the court order the parents to be at the intake?

Providers need the orders from the court to be more clear on what the judge is requiring. A standardized referral and tracking system could help in this area.

Probationary periods need to be extended to accommodate the completion of treatment. Sanctions should be in place for non-compliance. Punishment should be part of treatment, not instead of treatment. A combination of both is most effective.

Volunteers are a problem in the rural areas of the state. They can extend tight budgets in more populous areas, but more money is needed in the rural areas. Lack of money is the problem in all areas.

Similar issues were identified in the adult courts. Certainly lack of resources is the number one concern throughout the entire state.

Communication is major problem between courts and providers. An avenue to open up communication is needed. One area of concern is the clarity of court orders. With a better communications link, providers would not have to guess what the judge wants. Frequently clients arrive at a treatment facility with no paperwork and no idea what the agency is to do.

Providers would like to see longer probation periods for more serious offenses. Once treatment is started jail time should not interrupt. If the client does not comply, jail is a great consequence.

Judges should not expect "miracle cures" but should understand the relapse phenomenon. A definition of success is not standardized, therefore very subjective. Also, the court should insist on attendance in aftercare programs. This is as important as the initial treatment.

Fines should be commensurate with the client's ability to pay. If the client has

completed treatment successfully, but still owes fines, perhaps the fine could be waived.

When a defense attorney intends to ask for treatment for a client, providers would like to have the arrangement made in advance. Bed space would not be a problem with this type of solution.

Substance abuse treatment providers are having trouble meeting the needs of minority clients. Language barriers exist as do cultural differences. More minority therapists need to be hired to overcome this barrier.

CHAPTER 11

WHAT TREATMENT PROVIDERS WANT COURTS TO KNOW

DISTRICT I

During the workshop, held October 20, 1992 for District I, court personnel were asked first to identify their concerns then the treatment providers could respond and add their concerns. This chapter contains an outline of the comments and issues treatment providers voiced. Because the juvenile court was separated from the adult court the comments will be outlined separately here also.

Juvenile

1. When probation ends, "review" instead of terminating probation.
2. Staffing needs to be provided from treatment providers to Juvenile authorities.
3. Involvement with other community agencies, schools, etc. would help greatly.
4. Restarting the entire period of probation for a violation would be helpful.
5. Proposed "ideal" treatment would last at least one year.
6. Jurisdiction in lieu of probation may make it possible for longer treatment periods provided no other offenses were committed.
7. Prevention efforts and parenting classes, etc. would make a dent in the problem.
8. We need to be creative in our programming for younger offenders.
9. Can there be some sanctions or pressure for parents who fail to follow through with treatment?
10. Recognize public health issues regarding tobacco and juveniles.

Adult

1. Communication is needed. We need to sit down with Judges on regular basis to discuss issues, needs, etc.
2. We need to be able to accurately portray client behavior.
3. Court orders to client regarding treatment need to be very clear.
4. Consequences for non-compliance need to be spelled out clearly.
5. The courts need to understand relapse etiology.
6. We need concise instructions from the court regarding length of time to make intake appointment.
7. We need to get past the assumption that a private hospital is not affordable.
8. Communication between agencies (treatment) about what they offer would help courts.
9. Is court ordered payment for treatment possible?
10. It is procedurally cumbersome to enforce treatment plans. We must maintain a court record.
11. Make a distinction between court and formal probation.
12. Questions regarding recommendations by treatment agencies are not being used by courts.
13. The court feels financing of a program should be addressed in PSI, along with other factors to be considered.

CHAPTER 11
WHAT TREATMENT PROVIDERS WANT COURTS TO KNOW
DISTRICT II DAVIS COUNTY ONLY

During the workshop, held October 22, 1992 in District II (Davis County only) treatment providers were asked to respond to court personnel's comments. This chapter contains an outline of the comments made by treatment providers. These are only the juvenile court comments because no judges were able to attend the afternoon, adult session.

1. The courts fail to acknowledge juvenile system as part of treatment.
2. Treatment does not want to be viewed as the enforcers.
3. Kid's believe there are consequences for treatment non-compliance.
4. Successful treatment should not necessarily wipe-out consequences of the law.
5. Treatment is considered the punishment component but it needs to be in conjunction with other methods, i.e. fines, community service, etc.
6. Providers need an understanding of adjudication limitations, statutes, etc.
7. Should suspension of fines be used as incentive for treatment?
8. Define roles consistently of treatment and punishment.
9. Issues of status vs. criminal offenses need exploring.
10. Education and treatment are different.
11. Treatment is best in conjunction with consequences.
12. We only have one local detention center for three counties. Do we mix serious and less serious offenders in same population? Legislative guidelines are a consideration.
13. Fine amounts are set state-wide.
14. Courts need to have leverage on a juvenile long enough to complete treatment.
15. Police guidelines do not fit "front-line" people.

CHAPTER 11
WHAT TREATMENT PROVIDERS WANT COURTS TO KNOW
DISTRICT II WEBER AND MORGAN COUNTIES

During the workshop held January 21, 1993 for District II, treatment providers were asked to identify their concerns and comments. This chapter contains an outline of those comments. Because the juvenile court was separated from the adult court the comments will be outlined separately here also.

Juvenile

1. Providers requested that counselors go to court more with their clients.
2. Court personnel should go see the treatment process.
3. Ground rules need to be established for when and under what circumstances court personnel could visit.
4. We need more knowledge and updates on changes in court jurisdiction.
5. Treatment needs an office on the court premises to act as a liaison.
6. Public v. private treatment:
 - public not in competition with private
 - assessments should be made with costs v. ability to pay issue addressed
7. Residential treatment
 - lock up with treatment added
 - social services
 - funds
 - "turf"
 - each part should contribute so no one gets stuck with all.
8. Weber County needs adolescent residential Treatment for low income families.
 - at least 40 beds
 - for stabilizing
9. Courts need to speak out to public officials on treatment needs locally, regionally or even statewide.
11. Currently, insurance companies are dictating treatment situations. When lobbying for youth residential treatment facility fund, several sites should open to bid rather than per capita funding.

Adult

1. When talking about treatment, identify differences between people (i.e. chronic v. simple education).
2. System treats all people with the same facts the same.
3. Treatment treats individuals.
4. Six weeks treatment does not mean the client is "cured".
5. Longer probation is needed if substance abuse is identified as more serious.
6. Treatment that is less than 18 months is not effective.
7. It may be necessary to change the type of treatment.
8. Treatment should not be interrupted by jail (mandatory).
9. Discretionary jail as treatment punishment is helpful.
10. Jail time can be used to assist with treatment.
11. If jail time can offer a work release, can it offer a treatment release?
12. Costs and fees need to be identified.
13. If ordered into treatment, time for treatment should be clear to offender by court.
14. Treatment providers also want justice.
15. Neither court nor treatment should be enablers.
16. Courts may not really expect miracle cures.
17. Providers want to treat, not adjudicate facts.
18. Treatment persons generally begin with optimism.
19. Aftercare is really continued care.
20. AA is used widely. AA is not for everyone.
21. AA can be tool to get involved--AA is not treatment--AA is self-help.
22. AA may be religious.

23. AA plus aftercare (treatment) may be most effective.
24. Aftercare is very important.
25. Supply reduction offenses are important.
26. Can information be traded through computer systems?
 - It is possible
 - may be provided(at least in part)
 - legal issues re: confidentiality

CHAPTER 11

WHAT TREATMENT PROVIDERS WANT COURTS TO KNOW

DISTRICT III

The adult workshops for District III was held February 17, 1993. The juvenile court workshop was held June 4, 1992. Treatment providers offered many valuable comments and responses to court personnel statements. This chapter includes an outline of those comments. The juvenile and adult courts workshops were held separately and are reported separately here.

Juvenile

1. Release of information form is required. It needs to be one time limited form.
2. We need to reinforce with families that inpatient work is stabilization "care/treatment" comes afterwards for about 2 years.
3. Treatment costs money, but lots of free treatment is being given.
4. Check out information the family is giving you with treatment provider and vice versus.
5. Treatment needs to be earlier: intervention somehow, someplace, at some cost!
6. Someone has to have the authority to make decisions and referrals.
7. Have confidence in the program you are recommending.
8. We both need realistic expectations.
9. Assessment procedures are greatly underused.
10. Order a "clinical discharge" not just hours when giving credit for community service hours at treatment program.
11. Court staff would benefit from this workshop.

**"IF WE DON'T WORK TOGETHER TO FIGURE IT OUT--IT WILL BE DONE FOR US
AND WE WON'T LIKE IT!"**

Adult

1. Amount of fines should be commensurate with ability to pay. Too high of fine can have a negative outcome.
2. Sometimes conditions of probation need to be clearer. How much treatment, etc.?
3. Deadlines on sentencing orders and conditions of probation need to be set.
4. Providers have expertise in assessment. Courts leave sentencing orders flexible when they have confidence in providers.
5. Communication should follow an assessment.
6. Court need to allow enough time for defendant to pay fine after treatment is completed. Inflexibility has resulted in jail time even though client is doing well.
7. When courts rely on provider evaluation, how is this stated so providers understand?
*Provider will develop a form with court involvement comment section. For example: "Treatment as needed. Please respond."
8. Providers need to learn about court's philosophy and deliver services as appropriate.
9. Criteria should be set for qualified providers and the courts need to be aware of the criteria.
10. Defendant needs fees up front to start treatment. Court wants treatment to start quickly:
 - *cost is condition of probation
 - *Court not a collection agency
 - *Court is and providers need to communicate their stance
11. Form for referral from courts to treatment agencies which meet needs of courts and all providers.
12. Defendant may claim to judge s/he needs money to start treatment in order to get out of treatment. Courts can call providers to verify.
13. Client payment is a contract issue for providers in county funding system.
14. Payment of treatment fees is a clinical issue. Make payment a part of successful completion.

15. Fines and fees have increased tremendously. Money is not the primary consideration; if defendant has done well accept full payment and forgive fine.
16. Surcharge is the favorite legislative act for all judges.
17. Want programs to last a meaningful length of time. "Quicker they admit, the more intense, the longer, the better" is a general rule.
18. Judge has a responsibility to determine a defendant's needs within broad strokes.
1st time DUI's:
 - 1- 20 year old .27, 3rd alcohol related
 - 2- 40 year old .09, 1st alcohol related
19. Would courts entertain lengthier programs than required by statute?
Much longer aftercare is essential to recovery.

CHAPTER 11 WHAT TREATMENT PROVIDERS WANT COURTS TO KNOW DISTRICT IV

Treatment providers present at District IV's workshop on November 3, 1992 responded to court personnel's comments and added a great deal of valuable information. An outline of these comments are presented in this chapter. The juvenile and adult courts were separated at the workshop and the comments are separated here also.

Juvenile

1. Ask providers for after-care plans for the offenders.
2. Signed release of information forms are very important.
3. Courts have options of community service that should be kept at a minimum. Courts also have an option of sentencing to treatment programs. This option should be maximized. It is easy to get into treatment.
4. More on-going involvement from courts after the program is over is important.
5. Give kids the same information that is given to courts.
6. Public and private agencies need to coordinate with each other.
7. Feed back to probation officer from aftercare need to be weekly or at least monthly. Also feedback is needed between therapists and probation officers.
8. Start treatment on first offense. Early referrals are essential.
9. Identify youth "at-risk".
10. Mental Health and the school system need to work together.
11. Utah Alcoholism Foundation has offered services with no response.
Juvenile:
 - free assessment
 - 1 1/2 hour assessment
 - appropriate referrals
 - 1x per week team group
 - family involvement
12. Do we have overlapping services? Expanding or continuing services? Current services?
13. Coordinating council is looking at the overlapping question.

14. Tobacco and shoplifting offenses are being handling with prevention, referrals and education.
15. 45% of all crimes are committed by juveniles.
70% property crimes are committed by juveniles. They are from 14-17 year old.
Tobacco and curfews may help.
16. Court does not have money to cover programs.

Adult

1. Did AP&P and the court follow up?
Probation to court?
Release of information to talk with court and AP&P is necessary.
2. Helpful for providers to see the court order.
3. Court should be aware of the regulations of treatment agencies.
4. Sometimes treatment doesn't work. Sometimes the client is not motivated.
5. What does treatment mean?
May need treatment 3-5 times
Relapsing disorder
Relapse part of recovery
Education
6. The detox center in Utah County Jail could be used more:
Social detox
6 days--commitment
Public Intox -- 3 days
Educate defendant on what is available
(Call Lana Morris. Her number is in the manual)
7. What if treatment is ordered but client can't afford program?
8. Some defendants have insurance or private resources.
9. Start treatment on the first arrest on alcohol related offenses.

CHAPTER 11

WHAT TREATMENT PROVIDERS WANT COURTS TO KNOW

DISTRICT V

The workshop held February 17, 1993 for District V was very successful. Treatment providers added many interesting comments. Many issues and problems were identified. This chapter is an outline of the comments treatment providers made to court personnel. The juvenile and adult courts were separated at the workshop and are separated here also.

Juvenile

1. Substance abuse is treated under an acute care model by insurance companies. "Success" is difficult to determine. What is definition of success?
2. Categorical money precludes treatment for local needs. Let's all lobby for flexibility.
3. External and internal motivation are equally effective.
4. Classes give opportunities for hard core and first time users to mix. Becomes training for first time users.
5. Better assessment of problem severity in order to make more appropriate referrals.
6. Rapid growth of abusive population. Categorical money deters meeting needs. The decision-making committee for funds appropriation needs to be changed.
7. When receiving referrals from courts and AP&P, no paper work comes to agency. Court order "counseling of client's choice". This precludes sending paper work in advance.
8. Access to alcohol and tobacco can be reduced through community efforts.
9. Report to court if client abuses substances when an adolescent. Abstinence may not be best therapy goal for youth but it is illegal to do otherwise. Treatment programs seem to deal with this well.
10. Drug testing is done by probation. Treatment may recommend testing on a specific client.

(Horizon House will do limited PSR's for \$20)

14. Why are some people refused or expelled from programs?
Refuse to enter?
Noncompliance with program rules?
Probation?
Court needs specific report to them.
Name, date, time and place of each incident of violation.

Adult

1. Horizon House:
 - Residential
 - 5-County area
 - sliding fee \$5-\$46 per day
 - 60 day minimum
 - 12-step model & other tx approaches
 - Focused on house responsibilities
 - Frequently a waiting list (no waiting activity)
 - Require 52 weeks of aftercare for graduates
2. Need clearer instructions from court about what they want treatment agency to do.
3. Tracking mechanics
 - name and address
 - (clear and legible)
 - carbon copies must be readable
4. Need one unified referral sheet.
5. Brightway
 - Subacute--28-31 Day
 - Detox if needed (24 hour) 24 hour R.N.'s
 - Cooks and nutritionist
 - Psychotherapy
 - Recreational therapy
 - AA/NA required
 - One year aftercare
 - \$7,500
6. What is "success" according to judges?
 - They won't be back in court.
 - Relapse can be part of it.
7. Treatment programs need to let courts know their services.
8. Probation requirements need to be more clear, i.e., length of treatment, payment (treatment may use civil remedies--report to court for non-payment).
9. Treatment programs can require a client to furnish: Order of probation judgement; order; and commitment.
10. Pauite Program
 - Outpatient
 - 2 year

Holistic approach

Aftercare

PSR's

Psych evals

CHAPTER 11

WHAT TREATMENT PROVIDERS WHAT COURTS TO KNOW

DISTRICT VI

The workshop held January 28, 1993 for District VI was very informative. This chapter includes an outline of the issues and comments made by treatment providers to court personnel. The workshops separated juvenile and adult courts so this outline will also.

Juvenile

1. Increased dollars are needed for more individual therapy and alcohol school.
2. Referrals from court are sometimes unclear:
 - A. Is this a court referral?
 - B. What are the specific conditions of agreement?
 - C. What exactly is a violation?
 - D. Doesn't mention anything about cost.
3. Clients may be unclear whether their attendance at mental health is ordered or suggested.
4. Can parents be court ordered into parenting classes? (Funding is available in Garfield County. Classes held twice per week for four hours for 6 weeks.)
5. Wasatch Front, St. George: rest of the state is the wilderness; 6th District feels this way.
6. Parents are not responsible for juvenile's actions. Need legislature to create closer legal relationship.
7. First time tobacco offender is often hardcore therefore doesn't belong in a tobacco class.
8. Presentence reports are not needed as such in juvenile court. The Court will order assessment at disposition.
9. Lack of judicial discretion ties the hands of juvenile court and often interferes with appropriate penalties or treatment.
10. Cannot teach juveniles to be responsible drinkers--it's illegal.
11. Kids don't understand drinking laws.
12. Delays getting kids into school are partially systemic, correspondence, deadlines

for responses, etc.

13. Can school be made open-ended to reduce waiting time? Are there enough referrals for that?
14. Volunteerism is fraught with problems in rural area.

Adult

1. We can connect court with people who can evaluate services around the state.
2. We have a dearth of local services.
3. Pre-sentence reports need to have resource evaluations on statewide basis.
4. Court retains jurisdiction but gives probation to treatment agency to determine treatment needs and resources.
5. Judges don't have time to research decision.
6. Defense should have treatment arranged when recommending it (a good defense will have defendant in therapy at trial time).
7. Judge will choose from alternatives s/he knows. Who should research alternatives?
 - Defense council
 - Prosecutor
 - Treatment agency
8. What is effectiveness? What is success? Sober the rest of person's life?
Drinks significantly less?
9. What motivates the client?
Suffering the consequences of use -- including legal consequences.
10. Research indicates people forced into treatment have same success as people who are motivated.
11. Clients go to treatment agency but are not clear on what court wants them to do.
12. Judge Nielson has form for treatment agencies. Can this be standardized?

CHAPTER 11

WHAT TREATMENT PROVIDERS WANT COURTS TO KNOW DISTRICT VII

The workshop held February 3, 1993 for District VII was very productive. Many issues were discussed by both court and treatment personnel. This chapter includes an outline of the comments made by both providers and court personnel.

1. Limited funds mean limited treatment services at no charge. Surcharge is for DUI services:
 - Carbon County: Therapy is less extensive if client has no funds (determined by time constraints.)
 - Emery County: Treatment same. Fewer staff constraints
 - Grand County: Equal treatment, but soon it won't be
 - San Juan County: Equal treatment but waiting lists are forming
2. Kids referred by court either don't show up or wait until too late to get into treatment. Kids aren't referred.
3. Too much time between offense and adjudication.
4. Can treatment intervene at the pre-adjudication point?
5. Courts need monthly updates and coordination?
6. Unclear what forms courts want.
7. Treatment intake needs all available information: rap sheet, etc. Are there restrictions in getting this?
8. Would like parents ordered to assessment and treatment. Judge Johansen said he will do this on request.
9. The Juvenile court contact person is always a probation officer.
10. Mental Health delivers treatment in detention center but are not paid.
11. Too many reports sent to too many agencies make updates difficult.
12. Can court order parents to intake with kid? Court rules 7-304 (about) are newly revise. They outline courts confidentiality restrictions.
13. Can court get treatment release signed? Judge Johansen said yes.

14. Release and process report will be done:
Progress -- showing up? How is s/he doing?
15. Treatment encourages courts to be more coercive probation, etc. Is combined punishment and therapy effective?
16. Does DFS have funds for treatment? Minimal
17. Mental Health doesn't want to go to detention unless arrangements can be made for funding.
18. Justice courts can transfer juvenile to juvenile court at any time. Juvenile court has greater authority with parents.
19. First offender will receive a 10 hour education class -- Second and third offense will repeat and receive treatment or more depending on assessment.
20. Can we develop process to see kids before trial? Between treatment and probation officer. But it is voluntary.

CHAPTER 11
WHAT TREATMENT PROVIDERS WANT COURTS TO KNOW
DISTRICT VIII

Refer to chapter 10 because District VIII did not have two separate sessions due to a small, but very important, number of participants. Treatment and court issues were discussed together in Chapter 10.

CHAPTER 12

ELEMENTS OF JUVENILE TREATMENT

CHAPTER TWELVE

THE ELEMENTS OF JUVENILE TREATMENT

The elements of juvenile treatment, like any treatment, depends a great deal on the characteristics of the problem being treated. The following articles offer several vantage points from which to examine the characteristics of juvenile substance abuse. We have historically believed that the older a child is at onset of drug use (including alcohol), the greater the chance that he or she will remain drug free. This literature allows a much closer look at that hypothesis. For example, six longitudinal studies found six variables present during adolescence which were common to alcoholism or severe alcohol problems in adulthood. They are:

1. antisocial behavior
2. difficulty with achievement-related activities
3. males with loose connections to other people
4. more conflict between parents
5. inadequate parenting skills in parent-child interactions
6. parents are inadequate role models

Other studies link childhood (mean age six years old) risk factors to adolescent outcomes. Still others suggest a continuity of causal relationships beginning with preschoolers (ages three to five). Obviously much more research needs to be done before we have any data approaching conclusive, but an image of possible risk factors is beginning to form long before that first youthful experience with drugs.

Paralleling the six variables predicting adult alcohol abuse, another article discusses the high risk of poor adolescent decision-making around drug use. Anyone making such decisions brings to them the same basic cognitive capabilities as they bring to other types of decision-making. These capabilities include:

1. judging the degree of your own knowledge
2. evaluating relevance of other people's experience
3. estimating cumulative risk from repeated exposure
4. generating alternative courses of action
5. determining what is important to you
6. estimating how good your previous decisions have been

The degree to which we practice these skills relies in part on environment; in other words, our opportunities to learn and practice them. This environment includes the six variables predicting adult alcohol problems which were previously outlined.

Health risks are also discussed. While much is not understood about the physiological effects of drugs and alcohol on adolescents, enough is known to recognize the increased dangers of abuse at young ages. In addition to present dangers such as increased incidents of accidents, eating disorders and reduced metabolism of certain nutrients, there is a host of adult health problems linked to adolescent substance use.

And finally, a system of assessment, referral, treatment planning and case management of adolescent substance abusers is described. Many of you may be familiar with this system, Youth Evaluation Services (Y.E.S.). While it is community based (15% are court referrals), it demonstrates a number of coordination opportunities and ideas which are applicable to our situation. It appears to combine proven, traditional methods with innovative new approaches to old problems.

This chapter is only a springboard to further study. It merely suggests the close relationship needed between courts and providers. It barely hints at the multitude of opportunities for coordination and knowledge-sharing which will make our work easier and more effective. It gives evidence of the close ties between treatment and prevention. References following the articles allow one to research at any depth desired. Hopefully, this will whet your appetite if you are not currently well versed in the subject.

Alcohol Use and Abuse

Some Findings from the National Adolescent Student Health Survey

MICHAEL WINDLE, Ph.D.

Most people are aware that adolescents drink alcohol, but the patterns of alcohol use among adolescents are not well known. What can identifying patterns of adolescent drinking tell us that will lead to more effective prevention and treatment of alcohol-related problems?

This article presents some results of a recent national survey of adolescent drinking behavior. Specifically, three topics related to adolescent drinking are described:

- The prevalence of alcohol consumption and heavy drinking in nationally representative samples of 8th- and 10th-graders
- The prevalence of combined alcohol and drug use in a single setting
- The relationship between the age of first alcohol use and the development of heavy drinking and the combined use of alcohol and other drugs (termed "polydrug" use).

NATIONAL ADOLESCENT STUDENT HEALTH SURVEY

The data presented in this article were compiled primarily from the National

Adolescent Student Health Survey (NASHS). The survey was initiated in 1985 by the American School Health Association, the Association for the Advancement of Health Education, and the Society for Public Health Education (1989). The organizations worked in conjunction with the National Institute on Drug Abuse, the Office of Disease Prevention and Health Promotion, and the Public Health Service to plan and develop the survey.

Survey questions pertained to various features of adolescent health, including alcohol and other drug use. Not all questions were asked of all students. This was done to allow as wide a range of issues related to adolescent health to be included in the questionnaire as possible. Thus, a core set of 11 questions, concerning, for example, demographic and general alcohol-use information, was presented to all students. Other questions, such as those related to heavy drinking, were administered to only one-third of the sample.

The survey sample consisted of 11,400 students, in 8th and 10th grades, from 224 schools in 20 States. Thirty-four schools were private, and 190 were public. The students represented a cross-section of students in the United States.

The data were collected during the fall of 1987. Survey assessments were conducted by trained survey administrators in the classrooms, and students remained anonymous.

Eighth-grade students represented the junior high school population, and 10th-grade students the senior high school population. Tenth-graders were chosen rather than 12th-graders to reduce the impact of school dropouts on prevalence estimates. Approximately 89 percent of eligible 8th-graders and 86 percent of eligible 10th-graders participated in the survey assessment. (Nonparticipation was

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•due to absenteeism on the day that the survey was administered or to lack of parental or adolescent informed consent.)

Alcohol Consumption Among Adolescents

Two indexes of alcohol consumption among adolescents were computed. The first pertained to whether adolescents had ever in their lifetime used alcohol; the second pertained to the frequency (the number of occasions) of alcohol use in the past 30 days. Table 1 provides a summary of findings for these indexes.

Consistent with earlier findings from surveys of adolescents (Barnes and Welte 1986; Johnston et al. 1986), the results of the NASHS indicated that many adolescents (75.9 percent of 8th-graders and 87.3 percent of 10th-graders) have used alcohol in their lifetime. The numbers of male and female students who had used alcohol during their lifetime were similar

for the two grade levels. Racial and ethnic group comparisons across grade levels consistently indicated that fewer black students have used alcohol than white or Hispanic students.

Gender differences in the numbers of students who drink are dwindling.

To determine the frequency of alcohol consumption, students were asked to indicate the number of occasions in the past 30 days when they had consumed alcoholic beverages. Questions about the quantity of alcohol consumed per occa-

sion were not asked; therefore, standard quantity-frequency indexes of alcohol use could not be calculated. Nevertheless, to determine the strength of the association between the number of occasions of heavy drinking and the frequency of alcohol use, a Pearson correlation¹ test was performed. Heavy drinking was determined by asking students how many times during the past 2 weeks they had consumed five or more drinks consecutively. The Pearson correlation for the total sample was 0.70, and the magnitude of this correlation indicates a strong association between the frequency of alcohol consumption and the number of occasions of heavy drinking.

As the values in Table 1 indicate, more 10th-grade students consume alco-

¹Pearson correlations describe how strongly variables influence one another. Values range between -1 and +1. The closer the correlation value is to +1, the stronger the relationship between the variables.

Table 1. Alcohol Consumption Among 8th- and 10th-Grade Students^a

Frequency of Alcohol Use During the Past 30 Days (In Percent)						
Student Sample	Sample Size	Students Who Had Ever Used Alcohol	Students Who Abstained	Infrequent Use	Occasional Use	Frequent Use
8th Grade						
Total	5,859	75.9	67.8	20.2	6.9	5.1
Males	2,787	76.8	67.9	19.3	6.7	6.1
White	2,026	79.5	66.8	20.6	6.8	5.8
Black	325	68.3	75.2	12.1	6.7	6.0
Hispanic	218	75.2	58.9	22.3	10.7	8.1
Females	2,875	75.1	67.6	21.1	7.1	4.2
White	2,125	77.6	66.9	21.7	7.5	4.0
Black	300	64.3	75.3	16.1	4.3	4.3
Hispanic	237	75.1	62.6	23.0	9.0	5.4
10th Grade						
Total	5,560	87.3	47.7	25.6	13.6	13.2
Males	2,696	87.3	46.1	24.7	13.9	15.3
White	1,954	90.4	43.2	25.5	14.7	16.6
Black	352	75.9	60.8	22.2	7.9	9.1
Hispanic	235	84.7	45.1	22.8	17.2	14.9
Females	2,687	87.2	49.2	26.5	13.2	11.1
White	1,967	89.9	45.4	27.1	15.0	12.4
Black	365	79.7	65.7	23.8	5.9	4.6
Hispanic	232	81.0	54.8	24.4	10.6	10.1

^aNumbers in columns may not add up to total or to 100 percent, as not all data for all subgroups are reported.

hol than 8th-grade students. This is reflected by the decrease in the percentage of abstaining students in 10th grade, the relatively stable percentage of infrequent drinkers in both 8th and 10th grades, and the approximate doubling of the number of 10th-graders who drink occasionally and who drink frequently.

Again, consistent with past research (Barnes and Welte 1986; Johnston et al. 1986), gender differences in the numbers of students who drink are dwindling. However, more male adolescents than female adolescents fall into the frequent-drinking category. Two findings are significant with regard to racial and ethnic group comparisons: black students represent the largest percentage of abstainers both across grade levels and gender groups. Tenth-grade white and Hispanic students represent the largest percentage of adolescents falling into the category of frequent drinking.

Heavy Drinking Among Adolescents

To evaluate heavy drinking among adolescents, the students were asked if they had consumed five or more drinks consecutively on at least one occasion in the past 2 weeks. Values in Table 2 are similar to those in Table 1 in that more 10th-grade students than 8th-grade students had consumed five or more consecutive drinks on at least one occasion during the past 2 weeks.

Table 2 also compares the findings on heavy-drinking patterns for the 8th- and 10th-grade students from the NASHS with findings for 12th-grade students from another survey. Monitoring the Future (Bachman et al. 1991; Johnston et al. 1986). The question posed was identical in both studies (see above). The values for 10th-grade and 12th-grade students were comparable (36.6 percent and 36.2 percent, respectively).

Table 2 also shows a slight decrease in the heavy-drinking category for 12th-grade females compared with 10th-grade females. Further inspection of racial and ethnic subgroups among females indicates that the decrease is most prominent among black and Hispanic females. A possible explanation for this decrease may be that the sample in the NASHS contained more students who were engaging in problem behaviors than did the sample of 12th-grade students in the Monitoring the Future survey. (Such problem behaviors might include a high-

Table 2 Adolescents Who Consumed Five or More Drinks Consecutively on at Least One Occasion During the Past 2 Weeks^a

	8th-Graders	10th-Graders	12th-Graders
Total number of students			
in sample	1,947	1,842	70,560
Percent of students who drank			
	23.7	36.6	36.2
Males			
Total in sample	920	945	33,942
Percent who drank	23.5	40.0	45.0
White			
Number in sample	662	673	28,056
Percent who drank	23.4	42.2	48.1
Black			
Number in sample	107	119	3,688
Percent who drank	15.1	26.9	24.0
Hispanic			
Number in sample	78	94	2,198
Percent who drank	35.9	46.8	41.0
Mexican-American			
Number in sample			1,518
Percent who drank			45.3
Puerto Rican and Latin American			
Number in sample			680
Percent who drank			31.4
Females			
Total in sample	1,016	891	36,618
Percent who drank	23.9	33.0	28.1
White			
Number in sample	744	663	29,808
Percent who drank	24.1	33.3	31.3
Black			
Number in sample	106	118	4,499
Percent who drank	16.8	27.1	9.3
Hispanic			
Number in sample	92	64	2,311
Percent who drank	33.7	39.1	20.8
Mexican-American			
Number in sample			1,599
Percent who drank			23.6
Puerto Rican and Latin American			
Number in sample			712
Percent who drank			14.5

^aValues for 8th-grade and 10th-grade students are from the National Adolescent Student Health Survey (NASHS) (American School Health Association et al. 1989). Values for 12th-grade students are from Monitoring the Future studies and include data combined from 1985 to 1989 (Bachman et al. 1991).

^bNumbers in columns may not add up to totals or to 100 percent, as not all data for all subgroups are reported.

^cHispanic subgroups were not assessed separately in the NASHS.

er incidence of alcohol and other drug use and increased sexual activity that may have contributed to student dropout, because of pregnancy, for example.)

Students who had left school because of increasing problem behaviors beginning in 10th grade might not, therefore, be represented in a 12th-grade sample. This

Table 3 Percentage of Adolescents Using Alcohol and Other Drugs in Combination in the Past Month

	8th-Graders	10th-Graders
Total number of students in sample	1,947	1,842
Total percent who drank	12.1	18.5
Males		
Total in sample	847	897
Percent who drank	12.5	21.0
White		
Number in sample	617	638
Percent who drank	11.3	21.0
Black		
Number in sample	94	114
Percent who drank	8.5	17.5
Hispanic		
Number in sample	69	90
Percent who drank	14.5	22.2
Females		
Total in sample	961	859
Percent who drank	11.8	15.8
White		
Number in sample	707	644
Percent who drank	12.6	16.5
Black		
Number in sample	99	110
Percent who drank	11.1	10.9
Hispanic		
Number in sample	86	61
Percent who drank	17.4	14.8

Numbers may not add up to totals or to 100 percent, as not all data for all subgroups are reported.

interpretation is consistent with information from current studies on school dropouts (Dryfoos 1990).

Other possible explanations for the discrepancies between 10th-grade and 12th-grade student-drinking rates include geographical differences between samples or factors that can be attributed to cohort effects. (Cohort effects are unique factors that influence the results of some subgroups in the study population but not all.) A possible cohort effect might be a trend among adolescent females to engage increasingly in episodes of heavy drinking (five or more drinks on one occasion). Another might be school-dropout prevention and intervention programs, such as programs to provide in-school babysitting, that retain a higher percentage of heavy drinkers in the 12th grade. Subsequent studies will be able to evalu-

ate the potential influence of cohort effects.

Among racial and ethnic groups, the numbers of students who had engaged in heavy drinking during the past 2 weeks paralleled the findings for frequencies of drinking (Table 1). That is, white and Hispanic adolescents were much more likely to have consumed five or more consecutive drinks in the past 2 weeks than were black adolescents. Although the National Adolescent Student Health Survey collapsed the sample representing Hispanic students (Mexican-Americans, Puerto Ricans, and Latin Americans), the Monitoring the Future survey (Bachman et al. 1991) separated Hispanics into two subgroups—Mexican-American students and Puerto Rican and Latin American students—and, between the subgroups, the rates of heavy drinking during the

past 2-week interval were quite different: Mexican-American students were much more likely to have engaged in heavy drinking than were Puerto Rican or Latin American students (Table 2). Similar differences in drinking practices among adult Hispanic subgroups have been reported as well (Caetano 1988). Sensitivity to and measurement of such subgroup differences is essential to a more comprehensive understanding of drinking behavior among Hispanic youth.

Combined Alcohol and Drug Use

It is widely recognized that some adolescents use both drugs and alcohol, although the prevalence of illicit-drug use among adolescents has decreased in recent years (Johnston et al. 1986). Alcohol and other drugs may be taken in combination for their synergistic enhancement of euphoric feelings. Furthermore, adolescents who tend to use alcohol and drugs in combination tend to use greater quantities of each (Frank et al. 1985). An issue of considerable interest to researchers and treatment providers who study alcohol and other drug use is how frequently individuals use alcohol and other drugs in combination (polydrug use) in one episode.

In the National Adolescent Student Health Survey, the following question was posed to determine how many students use alcohol and other drugs in combination: "If you used alcohol or drugs during the past month, on how many occasions (if any) did you use a combination of alcohol and [other] drugs?" The data were summarized to obtain a measure of the prevalence of polydrug use among the students in the sample (Table 3). Among 10th-grade students alone, more males combine alcohol and drugs than do females, and the pattern is similar for 8th-grade males and females. Racial and ethnic group comparisons indicate that whites and Hispanics manifest the highest prevalence of combination use. Overall, the prevalence of combined use by both 8th-grade and 10th-grade students is relatively high, and such usage patterns merit increased attention from health care professionals.

Age at First Use of Alcohol

The earlier a child begins to use alcohol, the earlier the child will manifest problem behaviors and the more likely the child is to become intensely involved

with alcohol (Barnes and Welte 1986; Jessor and Jessor 1977). To determine the age at which students begin to consume alcohol, survey participants were asked to indicate the grade in which they first consumed an alcoholic beverage (not just a sip). (Because the question was retrospective, grade level rather than age of first consumption was requested to provide contextual information that might minimize memory distortion.) To investigate the association between the onset of alcohol use and current drinking practices, comparisons were made between heavy drinkers (those who drank five or more consecutive drinks during the past 2 weeks) and nonheavy drinkers (those who drank at least once during the past 30 days, but who did not drink five or more consecutive drinks during the past 2 weeks). (Abstaining students were excluded from these analyses.)

Among 10th-grade males, heavy drinkers, relative to nonheavy drinkers, had an earlier onset of first alcohol use. Similarly, compared with nonheavy drinkers, heavy drinkers were likely to have consumed their initial drink in grades 4 through 8 (Figure 1). Relative to heavy drinkers, more nonheavy drinkers were likely to have consumed their initial drink in grades 9 and 10. Similar trends were indicated for the 10th-grade females and for the 8th-grade sample as a whole.

Data from the survey also were used to investigate the relationship between the early onset of alcohol use and the current combined use of alcohol and other drugs. Similar to the findings for current heavy alcohol use, current polydrug use in 10th-grade males was associated with an earlier age of first alcohol consumption (Figure 2). Compared with students who consumed alcohol but did not use alcohol in combination with other drugs, more of the students who combined alcohol and other drugs had consumed an alcoholic beverage by the 6th grade. This trend reversed in grades 7 and 8, and by grades 9 and 10, the percentage of students who consumed alcohol only exceeded the percentage of students who combined alcohol and other drugs. The findings for 10th-grade females and 8th-grade students as a whole paralleled the findings for 10th-grade males.

SUMMARY

The National Adolescent Student Health Survey was used to study the prevalence

of drinking among teenagers. The NASHS was particularly well suited to this task because it included representative samplings of both early (8th-grade) and middle (10th-grade) adolescents, thus complementing the representative senior level samples included in an earlier survey, *Monitoring the Future* (Johnston et al. 1986).

Between students in 8th-grade and those in 10th-grade, there were clear trends toward increasing levels of alcohol involvement. Not only were more 10th-grade students drinking, but a greater proportion of those who consumed alcohol were drinking much more frequently. The discrepancy between the numbers of male and female students who consumed alcohol was small, but males were more highly represented in the more frequent and heavier drinking categories.

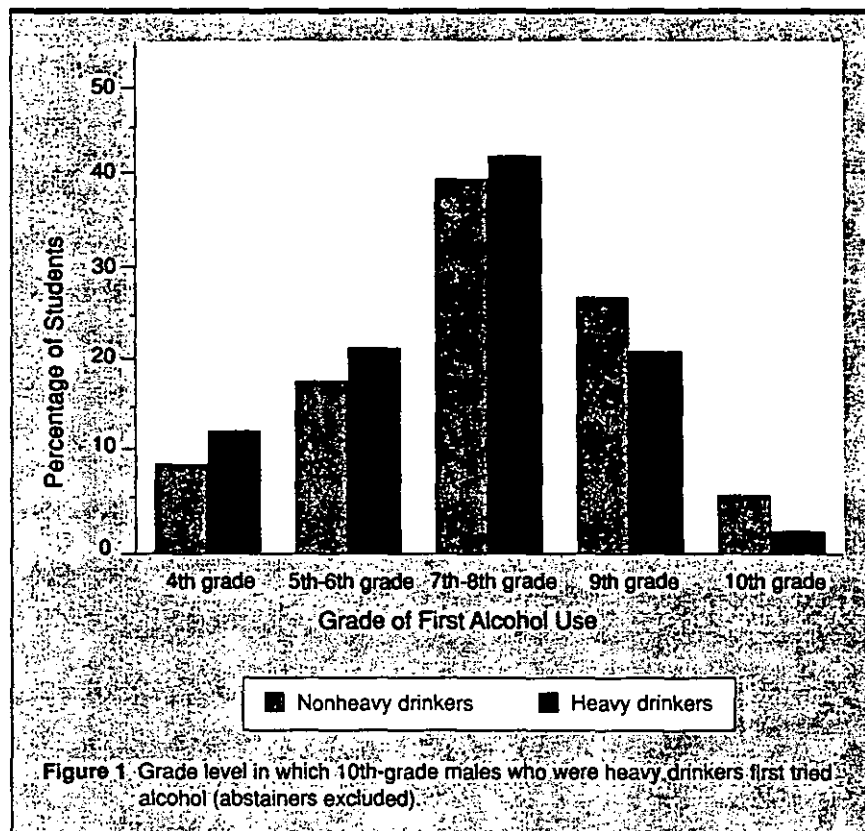
Racial and ethnic group comparisons indicated that more white and Hispanic students consumed alcohol than did black students; black students had the lowest overall rates of alcohol consumption. Additional research is required to establish the prevalence of drinking behavior among ethnic groups, including Native American and Asian students.

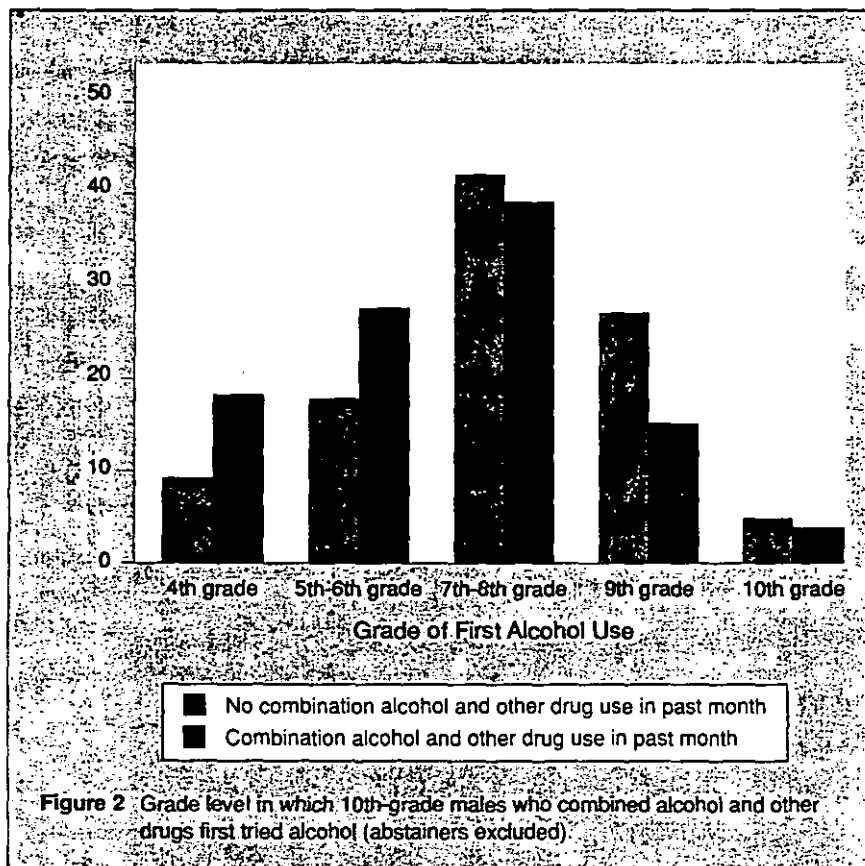
The prevalence of the combined use of alcohol and other drugs was relatively high across gender and racial and ethnic groups, and may be prognostic of subsequent serious problems of abusing alcohol and other drugs. An earlier age of first consumption of alcohol was associated at the time of the survey with higher levels of heavier drinking and combination drug use. These findings provide a broader perspective for evaluating alcohol use among adolescents and indicate that while not pervasive, a large percentage (approximately 15 percent to 20 percent) of adolescents are engaging in high levels of alcohol use and polydrug use, meriting increased attention from researchers and health care professionals. ■

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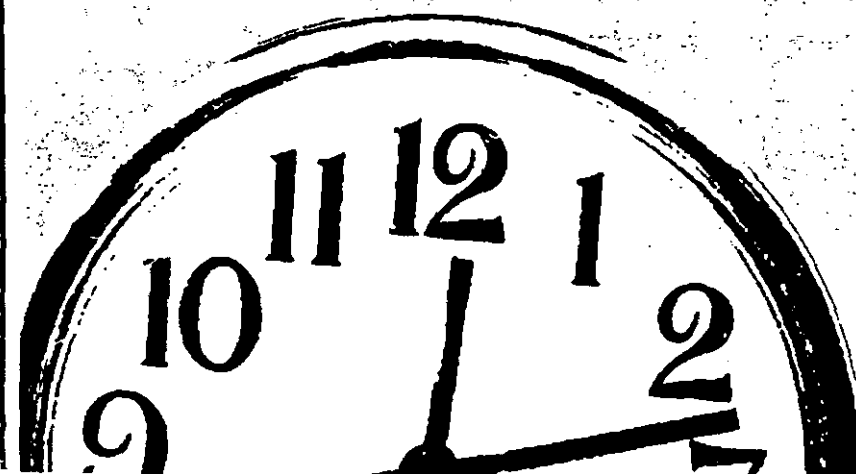
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Genetics of Alcoholism

Can and Should Youth at Risk Be Identified?

JAMES R. WILSON, PH.D., AND LAWSON CROWE, PH.D.

Genetic and behavioral markers of alcoholism may one day be used for early detection of individuals at risk. However, the concept of early detection raises concerns as to the possible biological and social consequences for the young person identified as predisposed to becoming alcoholic.

The excessive use of alcohol by a significant number of individuals in our society is a major cause of and contribution to human suffering, death, disease, crime, and domestic disorder (U.S. Department of Health and Human Services 1990). Although the scale of misery has grown with the expansion of the population, alcohol abuse has been a continuing social problem from earliest times.

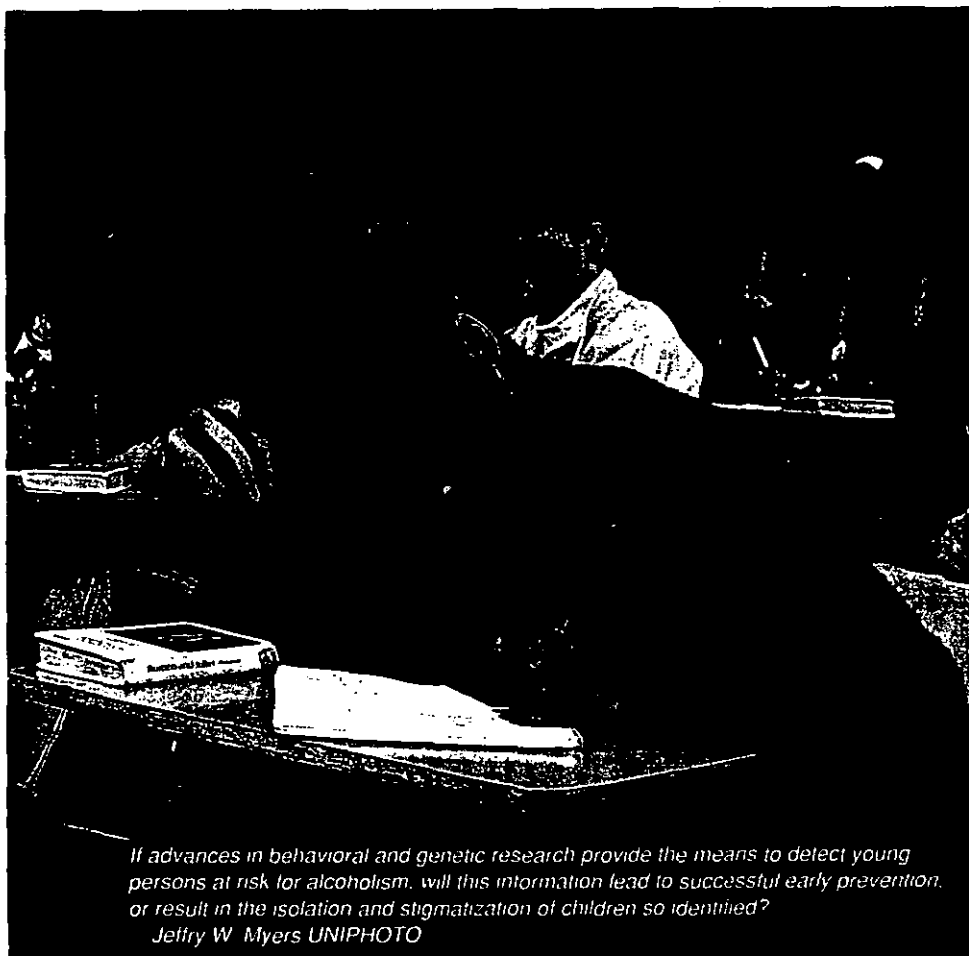
Historically, different societies have viewed the problem of excessive drinking in different ways. In Colonial America, drunkenness was seen as a sign of moral weakness (Rorabaugh 1979). The first serious suggestion that excessive drinking was itself a disease appeared near the beginning of the 19th century (Rush 1785; Marconi 1959). The prevailing view of alcohol use advanced by the 19th and early 20th century Temperance Movement in the United States, Great Britain, and continental Europe, however, was that alcohol was itself a "poison" harmful to various body parts and that this harm

could be transmitted to the offspring of the drinker. From this perspective, all persons who ingested alcohol were at risk for the destruction of their health and for transmitting the deleterious effects of drinking to their children (Beauchamp 1980; Crowe 1985).

The idea that drinkers were at risk for transmitting acquired disabilities to their offspring was discredited early in the 20th century (Elderton and Pearson 1910). Primarily for social and political reasons—emerging individualism as well as the advance of science—the concept of alcoholism as a disease and the view that only some drinkers were at risk emerged fully after the repeal of Prohibition (Moore and Gerstein 1981). The view of alcohol as a poison was abandoned in favor of the idea that a significant distinction could be made between "normal" and "abnormal" drinkers. Abnormal drinkers were thought to be susceptible or predisposed to becoming alcoholic. That some people seem able to drink more than others without apparent ill effect is a

commonplace and ancient observation (for example, see Hamilton and Cairns 1982).

Thus, the stage was set to search for an underlying biological or psychological cause of excessive drinking (Jellinek 1960; Lender 1979; Patison et al. 1977). In recent years, the disease concept of alcoholism has been reinforced by the hypothesis that at least some persons are at risk because they inherit a genetic predisposition to alcohol abuse. Many scientists believe that a genetic predisposition to alcohol abuse helps to explain the wide variability in the human response to alcohol. In addition, many researchers and clinicians believe that the best hope for prevention and effective treatment lies in the identification of genetic determinants responsible for susceptibility to alcohol abuse, knowledge that could be applied, for example, to the development of screening tests for detecting those at risk long before the onset of alcohol use. If such tests were available for young people at risk, it is assumed that appro-



If advances in behavioral and genetic research provide the means to detect young persons at risk for alcoholism, will this information lead to successful early prevention, or result in the isolation and stigmatization of children so identified?

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appropriate preventive measures could be developed. As we explain below, although continuing efforts to elucidate genetic and behavioral factors predisposing an individual to alcoholism may well lead to methods for early detection, such information will need to be interpreted and applied with caution.

IS THERE A GENETIC BASIS FOR ALCOHOL ABUSE?

That some families show a disproportionate amount of alcohol abuse has been well documented (for review, see Goedde and Agarwal 1987 and Cotton 1979).

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Less obvious is whether this increased incidence should be attributed to genes or to shared environment or, perhaps more accurately, to how much of each. Vivid early writings about families consisting of drunks, prostitutes, lazybones, imbeciles and ne'er-do-wells (Crowe 1985) failed to take into account the economic hardship and class prejudice, or both, in which many of these families were immersed. Although modern behavioral genetic designs make due allowance for both genetic and environmental influences and their potential interactions and correlations, it seldom is possible to examine all influences adequately in a single study.

The relatively simple, powerful methods of single-gene (Mendelian) analyses have repeatedly been used to study the occurrence of alcoholism in families. To date no single-gene pattern of inheritance has been found to fit the data. The situation is reminiscent of the state of affairs early in this century, when researchers in the emerging field of genetics complained that Mendel's rules were good only for trivial characteristics, such as the color of peas; and that the inheritance pattern of "important" traits, such as human abilities, did not fit simple Mendelian ratios.

This controversy was resolved by postulating the existence of "polygenes." Polygenes, also known as quantitative trait loci, do not produce a dramatic all-or-none effect such as those that Mendel worked with: instead, two or more polygenes must be present and summate their effects before a phenotypic result (or physical or behavioral manifestation) can be observed, each adding its increment to the expression of color, or height, or IQ.

Other approaches to understanding the transmission pattern of alcohol abuse have involved the development of metrical and statistical techniques in conjunction with quantitative genetic theory, by such English theorists as Sir Ronald Fisher (1918) and J.B.S. Haldane (1936), and by the American theorist and experimentalist Sewall Wright (1931, 1977).

Studies of Twins

One behavioral genetic methodology has contrasted the incidence of alcoholism or alcohol abuse in a group of monozygotic (MZ: one-egg or identical) twins with the incidence in a group of dizygotic (DZ: two-egg or fraternal) twins. The general expectation in twin studies is that a trait with an important genetic component is more likely to be concordant (meaning that the trait is expressed by both twins within a pair) in a sample of MZs than in DZs, because MZs share all their genes while DZs share only one-half their genes on average (as do nontwin siblings). Indeed, results from studies on alcoholism in twins have quite consistently found a higher concordance between the drinking habits of MZ pairs than between DZ pairs (see, for example, Kaij 1957). Furthermore, studies of a Finnish twin sample have demonstrated a heritable component for frequency and quantity of alcohol use (Partanen et al. 1966), providing good presumptive evidence that there is a genetic component to this phenotype.

However, there is concern as to how representative twins are of the general population, since twin births occur only about 1 percent of the time. There also is concern as to the potential effects of modeling or mimicking behaviors within the pair, since the members of a twin pair usually share large amounts of their time and experiences. If modeling behavior is an important source of twin resemblance, then this behavior could contribute to the higher MZ resemblance upon which the genetic interpretation depends.

Studies of Adopted-Away Sons of Alcoholics

Studies of parent-to-offspring transmission of alcoholism would seem to be a definitive means for testing a genetic hypothesis. But the issue is complex: along with the set of genes that parents transmit to each child, the parents typically furnish food, home, love, care, attitudes, and more—a shared environment that must also be considered as a potential influence on the development of the offspring. It is exactly this joint effect of heredity and environment that makes early familial theories about the etiology of alcoholism less than convincing as evidence for genetic involvement (Goedde and Agarwal 1987).

An alternative approach has involved the study of children placed in adoptive homes soon after birth (Goodwin et al. 1973; Schuckit et al. 1972a,b). Thus, the biological parents furnish the genes that the child receives, but little or none of the common environment. The adoptive parents furnish essentially all of the common environment, but none of the genes. Adoption studies have provided compelling evidence that some genetically transmitted characteristic has a marked effect on the later development of alcoholism. For example, Goodwin and colleagues (1973) showed a 33-percent incidence of alcoholism among adopted-away sons of alcoholic fathers, representing a 26-percent increase over that found among adopted-away sons of nonalcoholic fathers.

Do these investigations answer the question "Is there a genetic basis for alcoholism?" Unfortunately, the answers are not clear cut. About two-thirds of people in the United States drink, while about one-third do not (U.S. Department of Health and Human Services 1990). Regardless of their genetic makeup, the latter group will have no problem with alcoholism as long as they do not drink. Currently, about 6 percent of American men and women are diagnosed as alcohol-dependent; this percentage is higher in some studies, and depends partly on sampling and diagnostic criteria as well as gender (U.S. Department of Health and Human Services 1990). While a 26-percent increase in incidence of alcoholism found in the Goodwin studies may provide a useful datum for estimating the probability of future alcoholism, at least for the sons of alcoholics, discerning exactly who among these individuals will

become alcoholic is a separate question. After all, two-thirds of the sons of alcoholics investigated in this study *did not* become alcoholics (Goodwin et al. 1973). Provision of intervention or prevention strategies for the sons of alcoholics could thus potentially be wasted effort two-thirds of the time, and would overlook the alcoholic sons of nonalcoholics. Still worse, there is no good evidence as to whether efforts following early identification of these persons will prevent alcoholism. Such well-intentioned efforts might even do more harm than good, a point that will be elaborated upon later in this article.

CAN THOSE AT RISK BE IDENTIFIED?

Can *individuals* at risk for alcoholism be identified? We think the answer is "not adequately"—at least not yet. Research exploring risk factors and relevant concerns is discussed below.

In one attempt to evaluate risk research, Wilson and Nagoshi (1988) listed six general factors that have been hypothesized as prospective markers of risk for alcoholism. These factors, and evidence for and against their contribution to risk, are briefly summarized:

1. *Individuals with a first-degree alcoholic relative (family-history-positive: FHP) may have personality characteristics that predispose them to alcoholism.* Examples include neuroticism, adverse reaction to stress, lack of socialization, and external locus of control (or an inability to accept personal responsibility for problems). Most studies (for example, those by Saunders and Schuckit 1981; Tarter et al. 1984; Manning et al. 1986) have not found consistent differences between FHP and FHN (family-history-negative) groups based on these personality dimensions.
2. *FHP individuals may have neuropsychological deficits that predate the onset of alcohol abuse.* Such deficits may include lower IQ, measured in terms of poorer performance on cognitive ability and perceptual tasks. Individuals with lower IQs may have more problems with social and socioeconomic adjustments, which may lead or contribute to a greater susceptibility to alcoholism. Data from several

laboratories, including Gabrielli and Mednick (1983), Schaeffer et al. (1984), Tarter et al. (1984), Drejer et al. (1985), and Wilson and Nagoshi (1988), support this difference in cognitive ability between FHP and FHN individuals. The cognitive disadvantage for those who are FHP, however, is small or not always found (see, for example, Workman-Daniels and Hesselbrock 1987).

3. *FHP individuals may metabolize alcohol more efficiently than do FHN individuals,* perhaps encouraging greater consumption. Studies testing this possibility have not found an FHP-FHN difference in alcohol metabolism, measured in terms of the rate of blood alcohol clearance (Wilson and Nagoshi 1988).
4. *FHP individuals may be less sensitive to the effects of alcohol than FHN individuals.* For example, Schuckit (1985) found a smaller increase in body sway after alcohol consumption in a group of young FHP males, compared with FHN males. However, O'Malley and Maisto (1985) found that FHP subjects showed greater sensitivity to (were more impaired by) alcohol as assessed by their performance on a timed motor task. Recently, McCaul and colleagues (1991) reviewed findings from several laboratories (including their own) that also found FHP subjects to be more sensitive to alcohol than FHN subjects. Despite its early promise, relative insensitivity to alcohol of young FHPs does not seem to be a robust or consistent finding or marker.
5. *FHP individuals may acquire more acute tolerance to alcohol,* perhaps facilitating alcohol abuse. FHP-FHN differences in tolerance to alcohol's effects have not been studied extensively. However, evidence furnished by Wilson and Nagoshi (1988) runs counter to this hypothesis, since no significant relationship was found between the degree of tolerance demonstrated by subjects and the amount of alcohol each consumed.
6. *FHP individuals may expect less effect from anticipated drinks or may feel less intoxicated after drinking, in comparison with FHN individuals, at the same blood alcohol concentration.*

Those at increased risk for alcoholism may have a decreased ability to control their drinking, either because their expectations or internal cues (self-assessment of intoxication), or both expectations and internal cues about their dose are reduced. Evidence on this issue is relatively scanty and equivocal. O'Malley and Maisto (1985) found no FHP-FHN differences in expected intoxication, but both they and Schuckit (1984) found lower self-perceived intoxication in FHP individuals. However, Lipscomb and Nathan (1980) found no differences in FHP-FHN subjects' abilities to gauge their blood alcohol levels (based on self-perceived degree of intoxication) after various doses. Thus, reduced expectations and internal cues do not appear to identify individuals at risk consistently or reliably.

A promising, current research program concerned with identifying risk factors for alcoholism has evaluated "the inheritance of alcohol abuse in a large adoptee population identified in Stockholm" (Cloninger et al. 1981, p. 862). This sample included 862 men born out of wedlock in Stockholm from 1939 through 1949, who were adopted prior to age 3 by nonrelatives. Data about adoptive and biological parents were obtained from a register of child welfare officer appointments; alcohol abuse and treatment data were obtained from community Temperance Boards and from agencies of the National Health Insurance; and data relevant to criminal convictions, diagnoses, sick leave, hospitalization, and other information were obtained from appropriate local and national agencies.

Following their identification, these male adoptees were categorized for alcohol abuse as follows: *none*—the 711 who had no contact with a Temperance Board; *mild*—the 64 who had 1 registration with a Temperance Board; *moderate*—the 36 who had 2 or 3 contacts with a Temperance Board; and *severe*—the 51 who had 4 or more registrations with a Temperance Board, and who had received treatment or a diagnosis of alcoholism. The researchers then determined that all four groups had distinct genetic backgrounds. Data concerning biological fathers revealed that *mild* abusers' fathers had higher occupational status, little criminality, and recurrent alcohol abuse not requiring treatment, while *moderate* abusers' fathers were characterized by

low occupational status, criminality, and recurrent alcohol abuse. Interestingly, *severe* abusers' fathers were similar to those of *mild* abusers' fathers, except that *severe* abusers' fathers had the lowest occupational status of any group.

After further study of the genetic and environmental backgrounds of the adopted men in their sample, Cloninger and colleagues (1981) identified two types of alcohol abuse. Alcoholism in some adoptees, identified as Type 1 (milieu-limited) alcoholism, usually was associated with "isolated or mild problems, but may be severe" (p. 866). Both biological parents generally had mild alcohol abuse and minimal criminality. However, the adoptive home environment played a major role in the development of Type 1 alcoholism: a home of low occupational status seemed to contribute to development of later alcohol abuse. When reared in homes of higher occupational status, relative risk for Type 1 alcoholism was not increased; but if reared in homes of low occupational status, relative risk for these males was doubled. Alcoholism in some adoptees, identified as Type 2 (male-limited) alcoholism, tended to be associated with "recurrent or moderate problems, but may be severe" (Cloninger et al. 1981, p. 866). Biological fathers' characteristics included severe alcohol abuse, severe criminality, and extensive treatment for alcoholism, while biological mothers' characteristics were normal (little or no alcohol abuse or criminality). There was no effect of the environment (that is, of low occupational status) on frequency of alcohol consumption, though the environment may have had an effect upon severity of drinking problems. Relative risk of Type 2 alcoholism in these adoptees was found to be nine times that of control subjects.

Cloninger and associates (1981) also noted, in their discussion of sporadic (nonfamilial) cases of alcoholism, that there are no observable characteristics associated with vulnerability to alcoholism among many biological parents of alcoholic sons. They concluded their paper by pointing out that regardless of genetic predisposition, major changes in social attitudes about drinking styles can dramatically change the prevalence of alcohol abuse, and that alcohol researchers should focus on more clearly defined subtypes of alcoholism in examining factors that contribute to the development of this disease: as the patterns of inheritance seem to be different for Type 1 and Type

2 alcoholics, a different etiology, including a different genetic etiology, may be involved.

In a subsequent paper, Cloninger (1987) related the Type 1 and Type 2 alcoholics identified in his study to two types from Jellinek's (1960) classification, with Type 1 corresponding to Jellinek's gamma alcoholic ("loss of control" drinkers), and Type 2 corresponding to Jellinek's delta group (those with an inability to abstain from alcohol). Cloninger then characterized these types in terms of heritable personality dimensions that were measured in childhood: Type 1 alcoholics rated low on novelty-seeking behaviors, but high on harm avoidance and reward dependence behaviors; while Type 2 alcoholics rated high on novelty-seeking behaviors, and low on harm avoidance and reward dependence behaviors (Figure 1). In the same study, Cloninger associated each personality/alcohol type with different neuromodulator and neurotransmitter systems in the brain.

In a later report, Cloninger and co-workers (1988) reevaluated, in terms of alcohol problems, 431 men and women in Sweden who had been assessed at age 11 on personality dimensions relevant to Cloninger's Type 1 and Type 2 classifications. The authors reported dramatic confirmation of the association between Type 2 alcoholism and a personality cluster of high novelty-seeking, low harm avoidance, and low reward dependence. In the group whose personality dimensions were found to be the most extreme, the accuracy of predicting alcoholism was 75 percent; the authors' theory actually predicted a 97-percent risk for persons who measured at the extreme on all three personality dimensions. However, the authors have cautioned that this success of prediction for groups does not translate directly into similar success of prediction for individuals, because of the relatively low rate of alcoholism in the general population, the opportunity for personality to change with experience, and other factors. They stated "... to detect two of every three alcohol abusers [in the general population] based on childhood personality, a criterion must be used that gives the wrong prediction in 74 percent of cases that an individual is predicted to be alcoholic" (Cloninger et al. 1988, p. 504). They also recommended that clinicians and researchers think in terms of probability of risk, rather than in

terms of a dichotomy of high versus low risk.

The provocative findings and theories of Cloninger and colleagues currently are the focus of a great deal of discussion and research. Will use of these personality measures identify individuals at risk for alcoholism? The promise seems great that groups at risk can be identified; however, prospects for identifying individuals are more problematic. For example, the likelihood of 74-percent misclassification noted above is worthy of thought. A number of other puzzling or problematic aspects remain. For example, why do mild and severe abusers have such similar antecedents, while moderate abusers have different antecedents? Is low occu-

a specific gene was received with great interest and excitement. However, this finding has not been replicated in other laboratories (Bolos et al. 1990). An even more recent development in the search for genetic linkage is the recent funding by the National Institute on Alcohol Abuse and Alcoholism of a "massive study... on the genetics of alcoholism... a multisite, multilevel study including everything from psychological tests to DNA probes that will involve 600 alcoholics and potentially thousands of their family members" (Holden 1991, p. 163). Under its principal investigator, Henri Begleiter, this study represents the largest effort yet to investigate alcohol and other drug use in alcoholics and their families,

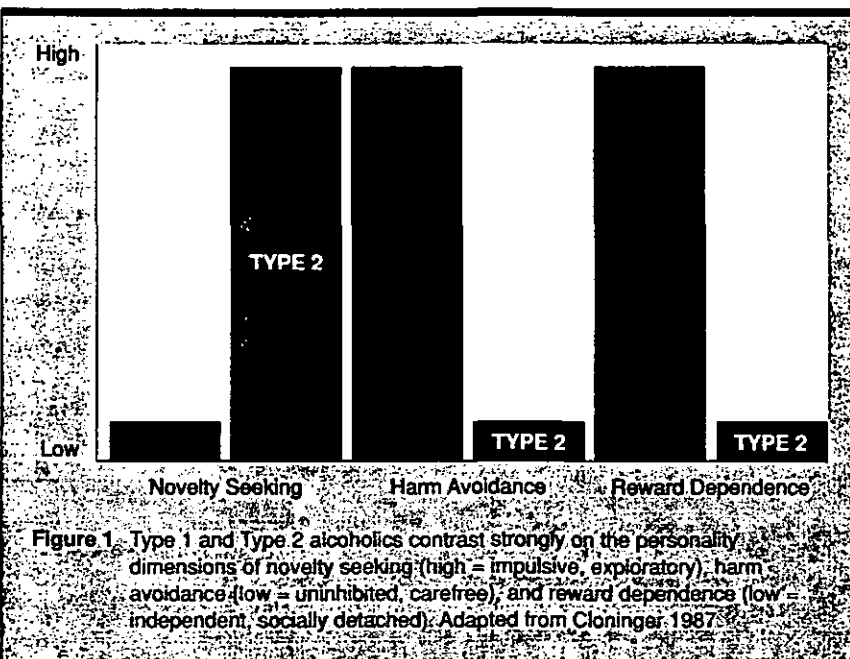
some alcohol-related behaviors have a significant genetic component. For example, studies of mouse lines selectively bred for different responses to the anesthetic effect of alcohol (SS or "short-sleep" mice are less sensitive, while LS or "long-sleep" mice are more sensitive to this effect) offer clear proof that polygenes contribute to a differential expression of this kind of sensitivity (McClearn and Kachhiana 1973). However, the applicability of such findings in mice to studies of alcoholism in humans is not clear, especially in light of the equivocal results observed in FHP-FHN sensitivity differences discussed earlier. Use of the LS/SS genetic stocks has been extensive, however, and many important pharmacological, anatomical, and biochemical discoveries about alcohol actions have resulted from their use.

Among the many other animal models currently used or being developed for alcohol research, a particularly interesting example is a rat model under development by Li and colleagues at Indiana University. These rat lines are selected for either high-preferring (for alcohol-laced water) or low-preferring characteristics (Li et al. 1981). Since the normal route of alcohol ingestion is through the mouth, these lines may yield important information about genetic mechanisms underlying taste and avidity for alcohol and about control of intake.

GENETIC PREDISPOSITION: ETHICAL QUESTIONS

What ethical difficulties will arise if and when genetic makeup can be used to identify young people at risk for alcohol abuse? As a general rule, social conduct on a professional and personal level should be guided by three principles: (1) respect for the personal autonomy of others; (2) the moral duty to do good and to avoid harm to others; and (3) the moral duty to act justly and fairly toward others. In light of these principles, it is important to examine the reasons for identifying youth at risk, and to consider relevant ethical questions.

First, researchers recognize that the advancement of research in human genetics may not itself reveal the determinants of a complex human behavior such as alcoholism. In addition, the discovery of particular genetic variations will not necessarily indicate which are harmless and which are harmful to human health and



pational status in (presumably meritocratic) Sweden associated with lower IQ? If so, could the strong effect of low occupational status of adoptive fathers on Type 1 alcoholics be due to inadequacies of teaching or to inappropriate modeling? Are the general findings replicable in other countries, societies and groups, or are they somehow idiosyncratic to Sweden? Despite these and other questions that remain, the results from Cloninger and colleagues' research appear to be the strongest indicators or markers of risk currently available.

Among recent studies of human molecular genetics, a report by Blum and co-workers (1990) linking alcoholism to

including aspects of their cognitive and motor skills, medical and psychiatric history, and biochemistry. The research team will use the newly advanced tools of molecular biology to identify candidate genes, model potential mechanisms of inheritance, characterize gene effects, and establish linkage by testing and characterizing dozens of family members for the candidate genes. These and related efforts may succeed in defining molecular and other genetic markers in those at risk for alcoholism.

Another perspective on genetic markers for alcoholism can be gained by considering evidence from animal studies. Animal models offer good evidence that

development, especially in cases of behaviors and diseases thought to have a multifactorial etiology. Such uncertainty leads to theoretical questions regarding the clinical application of knowledge about genetic variations, and to ethical questions concerning the use of information having unknown implications for complex behaviors. Furthermore, an emphasis on searching for specific genetic determinants responsible for the development of alcoholism may cause investigators to overlook genetic determinants that may protect against this disease.

Should Youth at Risk Be Identified?

It is important to remember that the question considered here asks not only whether youth at risk for alcoholism can be identified, but whether these individuals *should* be identified. The young people in question are asymptomatic: the onset of alcohol abuse has not occurred. In the absence of any clear clinical indications, under what circumstances would genetic testing be medically and ethically acceptable? Further, as noted earlier, testing only those young people whose families have a history of alcoholism would have the effect of reaching only a portion of potential alcoholics.

Similar questions can be raised concerning theories about heritable personal traits that would predispose an individual to alcoholism. Although earlier efforts by Jellinek (1960) and others to identify types of personalities susceptible to alcohol abuse were unsuccessful (Lender 1979; Mello 1972), Cloninger and his colleagues (1988) have made a persuasive case that childhood (premorbid) personality traits are strongly related to later alcohol abuse. These researchers suggest that it may be possible to determine to what extent the inheritance of personality traits accounts for susceptibility to alcohol abuse. But they also acknowledge that other biological and genetic factors may be important, and that environmental and developmental processes also will contribute to eventual behavioral outcomes. As we have noted, the predictive power of heritable personality traits seems to be strong for groups, but much less certain for individuals. Hence clinical applications would be based on the probability of risk for a particular individual, rather than on a specific diagnosis. The uncertainty associated with predicting such a risk might then render the prediction innocuous and

therefore trivial, or medically and ethically dubious, if the prediction is considered as a basis for future behavior or treatment. A prediction of high risk for later alcoholism based on statistical probability may not meet the ethical requirements of respect for personal autonomy, the active avoidance of harm to others, and fairness.

Possible Interventions and Potential Consequences

Assuming, however, that these objections can be overcome by accurate assessment to allow early identification of an individual at risk for alcohol abuse, identification would then lead to interventions designed to prevent it. A variety of intervention strategies for these persons might be devised, including educational programs, restructuring of the external environment, or pharmacologic or nutritional interventions, all designed to interfere with the developmental processes leading to alcoholism. Intervention strategies might even involve genetic engineering, aimed at correcting or overriding the predisposition to alcohol abuse, by directly altering the genetic determinant(s) or defect(s) (in the fertilized embryo) implicated in causing or contributing to alcoholism.

All of these possible interventions could be justified by the prior assumption that alcohol abuse is a form of socially deviant behavior. But the implementation of any or all of these strategies (with the exception of educational intervention) could potentially threaten personal autonomy. For example, would identification of a young person at risk for developing alcoholism result in his or her removal from the home, or lead to drug treatment intended to overcome this predisposition, or both? Social values (specifically, the social objection to alcohol abuse) shape the use of scientific knowledge and the technologies that support it. If early identification of individuals at risk becomes possible, the ethical question then becomes: How will society determine when the need for intervention outweighs respect for individual autonomy, the avoidance of harm, and the moral duty to act justly? Furthermore, at the time that intervention is theoretically required, the individual may not display any of the behavioral manifestations of alcoholism. To measure and then to act upon the potential for alcohol abuse by some overt intervention, in the absence of any actual

behavioral signs of alcohol abuse, seems ethically questionable.

Moreover, it seems unlikely that a single gene, such as that responsible for Huntington's chorea or cystic fibrosis, will be identified as the cause of alcoholism. At present a multifactorial, polygenic etiology of this complex behavior seems more plausible. Might there not then be an indefinite number of genetic combinations of these quantitative trait loci that predispose different individuals to certain behaviors, and to different degrees?

Finally, if the means are found to identify youth at risk, will such individuals be stigmatized, denied employment, denied life and accident insurance, coerced to enter prevention programs, and monitored perhaps over extensive periods of time? Will predictions about the future behavior of children become self-fulfilling prophecies? Questions of autonomy, privacy, and justice are intimately involved in these worries. Because society in general insists upon respect for individuals, each person must be judged on the basis of his or her own merit. As is the case with race, gender, or religion, a person's genetic constitution is, from a moral point of view, irrelevant.

The reader may find these questions to be excessively negative. Our intention, however, is not to deter research on the genetic basis for alcohol abuse. Genetic research may uncover powerful means of dealing with the perennial problem of alcohol abuse; however, this new knowledge will inevitably raise these kinds of ethical problems. It seems appropriate, therefore, to identify such questions now.

Indeed, it is necessary to learn as much as possible about the genetics of human beings and of all living things, but it also is necessary to remember that values and assumptions will shape the use of this knowledge. The diversity and pluralism of societal values suggest the need for considerable caution. Present research programs seem to assume that the means will be available to identify with great confidence an individual at risk; that the prospects without treatment are devastating; and that the individual, family, and society will accept the costs associated with intervention, including, if necessary, loss of autonomy. These aspects of the effort to identify youth at risk for alcoholism need careful thought. ■

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Early Developmental Factors and Risk for Alcohol Problems

ROBERT A. ZUCKER, PH.D., AND HIRAM E. FITZGERALD, PH.D.

Researchers are making headway in establishing factors that may lead children to heightened risk for alcohol problems in adulthood. The developmental approach to studying behavioral patterns emphasizes the importance of early behaviors, processes, and contexts.

Unlike the goddess Athena, who was full grown when plucked from the head of Zeus, severe alcohol problems and alcoholism do not arise suddenly and in full form in adults; rather, they develop gradually over a considerable period of earlier life. This observation is the basis for a powerful research methodology that emphasizes the importance of studying earlier behaviors, the processes involved in creating them, and the contexts in which they emerge, persist, and decline. This developmental methodology assumes that such facts are clues to what takes place later (Baltes 1987; Zucker in press). From this perspective, the processes occurring during youth and earlier childhood that relate to the emergence of alcohol and other drug involvement during the teen years may help us to understand the causal chain leading to severe problems in adulthood.

In this article, we focus on the utility of this perspective in opening up new lines of research that have helped us to

understand further these processes. It is important to note a few cautions at the outset. When the developmental method is used in field research, it most often takes the form of the longitudinal study, wherein a group or several groups of individuals are followed over time and are assessed at regular intervals. Using appropriate statistical techniques and being careful to examine and, if possible, control a variety of influences related to parallel processes, the developmental scientist can begin to understand sequences in the causal chain. This powerful, sometimes intriguing and demanding methodology is only one of several approaches that scientists can use to begin to understand causal relationships. Laboratory and field experiments are examples of other approaches vital to establishing causal order. What scientists look for ultimately is the ability of a variety of methods to establish convergence of findings. Each method has weaknesses, but when multiple methods point to similar processes, then conclusions about the

mechanisms may be accepted with greater confidence.

From a developmental perspective, patterns of change (such as the move from nondrinking to first regular alcohol use, or from a pattern of heavier alcohol involvement to one of alcoholism) and patterns of stability (such as sustained moderate, but never intemperate, alcohol use) are equally important to understanding how ongoing drinking styles are achieved. Given the inconstancies in our environment and the large variety of social and biological events to which we are exposed, the achievement of stability suggests the operation of internal mechanisms that regulate alcohol involvement.

The developmental method also emphasizes the importance of viewing patterns of adaptation and change as dynamic systems operating in multiple contexts and through time. Developmentalists use the term "contextual embeddedness" to refer to a process involving the interweaving of person and context in a way that frequently produces change in both. The term is used to convey the intimacy and reciprocity of such exchanges. The importance of individual factors, such as genetic vulnerability, peer pressure to drink, and parental values concerning abstinence, is likely to be misinterpreted unless researchers understand the interplay of these factors in a system that adjusts and often develops a momen-

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tum of its own as maturation proceeds (Lerner 1984; Sameroff 1989).

The utility and power of this methodology have led some alcohol researchers to examine more carefully the earlier years of life in the hope of identifying markers of later difficulties. Researchers are pursuing two lines of investigation that hold considerable promise for increasing our understanding of risk for both earlier and later alcohol problems. One line focuses on ways in which children are exposed to and learn about the idea that alcohol is a substance that can be used to create a change in how one feels and how one acts. The other line of investigation examines factors that are not specific to alcohol use, but that precede it and are parts of the causal chain of problem alcohol involvement.

EARLY ALCOHOL-SPECIFIC RISK FACTORS

Youth has been defined as the part of life that succeeds childhood and as the period between puberty and maturity. This developmental period is commonly viewed as the time when significant alcohol involvement starts (Jessor and Jessor 1975;

Kandel 1978), although some evidence indicates that causal factors begin to be shaped earlier.

Several recent studies suggest that perhaps because of societal trends, the ages of onset for alcoholism and for the first regular experience of drinking may be declining (Flett et al. 1987; Reich et al. 1988). A number of studies recently have demonstrated that children's awareness of alcoholic beverages as special substances, and children's ability to recognize and name these substances, to recognize the cultural rules of their use, and to formulate expectancies about the cognitive and behavioral effects of use can occur well before adolescence, and in some cases as early as the preschool years (Zucker and Noll 1987; Miller et al. 1990; Noll et al. 1990). This work has indicated that familial patterns of heavier or problematic alcohol use predict to a significant degree the children's developing cognitive structures related to alcohol use (Miller et al. 1990; Noll et al. 1990).

The study by Noll and co-workers involved a community sample of children ranging from 31 to 69 months in age. In the study, the children engaged in a smelling game, in which they were asked

to identify, based on odor, a variety of substances, including alcoholic beverages and common items in the children's environment (for example, apple juice and Play-Doh). A first trial was based solely upon olfactory exposure and recall. In a second trial, photographs of the substances were used as cues. After a successful identification, additional questions inquired about the child's knowledge of who used the substance, whether or not the child liked the substance, and whether or not the child planned on using it in the future. Collateral information obtained from parents allowed the researchers to evaluate the relationship between parental use of alcohol and the child's responses.

Figure 1 summarizes the results of the study. Older children (49 to 69 months) exhibited significantly greater recognition than did younger children (31 to 48 months); photographic cues improved recognition; and identification of the alcohol and cigarette stimuli was less successful than identification of uncontrolled substances. In addition, among children who correctly identified the alcoholic beverages, 86 percent knew that such substances are used by adults and not children. Success at olfactory recog-

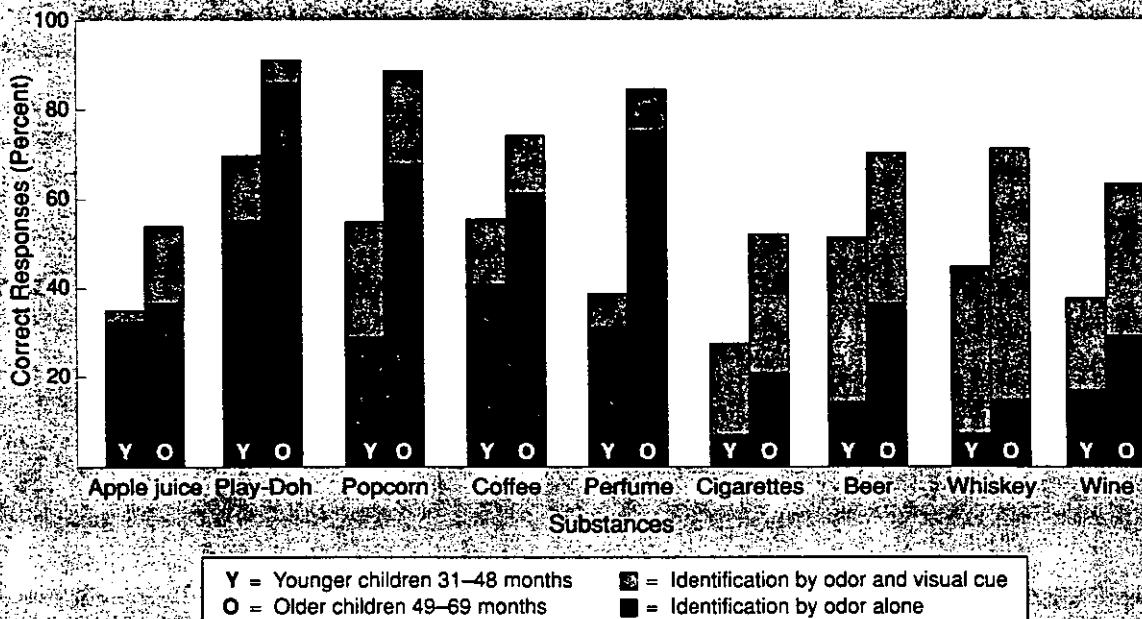


Figure 1: The results of a study in which preschool children were asked to identify, by smell, a number of substances. Younger subjects (Y) were between the ages of 31 and 48 months; older subjects (O) were between the ages of 49 and 69 months. Subjects first were asked to identify a substance by odor alone; then each was offered an additional visual cue to help identify the substance. Adapted from Noll et al. 1990.

nition was related to heavier parental drinking and to the use of alcohol by parents for purposes of escape.

These findings show a linkage between patterns of parental alcohol use and the preschooler's knowledge of alcoholic beverages. And they indicate that socialization pertaining to drinking practices has been taking place indirectly. Such learning involves the acquisition of a grammar that includes a cognitive structure about alcohol. The child cannot learn to identify objects by smell by watching television, but must be exposed to the smell directly; and in order to identify the substance by name, the child must learn the name.

Given that success in the task of recognition was related to patterns of heavier alcohol use by parents, it is reasonable to ask whether the early ability to recognize alcohol is evidence for an early manifestation of risk. At the least, the nature of this risk pertains to the precocious development of a knowledge base and an interest in alcohol. There may be other developmental implications that have not been studied longitudinally. Nonetheless, the conclusion becomes more robust in light of evidence from other studies linking children's expectations about alcohol to patterns of use in adolescence and to patterns of parental drinking behavior (Christiansen and Goldman 1983; Brown et al. 1987).

CONTEXTUAL EMBEDDEDNESS: A CLUE TO ETIOLOGY

One significant advance in the last decade in studying the epidemiology of alcoholic disorders was the documentation that alcoholism and alcohol abuse frequently do not occur in isolation. Data from the National Epidemiologic Catchment Area Study of the U.S. adult population indicate that comorbidities, excluding drug disorders, occur in 37 percent of the alcohol abuse/dependence population and in 55 percent of such patients visiting specialized treatment settings (Regier et al. 1990). Frequently observed comorbidities include anxiety disorder (19 percent), antisocial personality (14 percent), affective disorders (13 percent), and schizophrenia (4 percent).

Such contextual co-occurrences may be clues to the operation of etiological mechanisms. Two hypotheses concerning comorbidity are that the disorders result from the same causes, and that the

nonalcohol disorder precedes and is a cause of the alcoholism. Epidemiologists are cautious, however, because prevalence data are confounded by two other factors. First, comorbidity may occur because the nonalcohol disorder follows, and may even be an outgrowth of the alcoholism—for example, affective disorder may occur because alcoholism produces chronic depression. Second,

may appear randomly but frequently in conjunction with alcoholism.

Researchers compensate for the latter effect by using the odds ratio, which indicates the extent to which co-occurrence is elevated above the base rate. When this statistic is used, antisocial personality disorder emerges as the single strongest candidate for a causal connection, with an odds ratio of 21.0—indicating



comorbidity can be influenced by the base-rate expression of a condition in the absence of common causes—for example, because base rates for anxiety and affective disorders in the general population are high, either of these diagnoses

that it is 21 times more likely to be found among individuals with an alcohol abuse/dependence disorder than among the general population. The odds ratios for other comorbidities are 4.9 for bipolar disorder, 3.3 for schizophrenia, 2.6 for

panic disorder, and 2.1 for obsessive compulsive disorder. Anxiety disorder and a variety of the affective disorders have odds ratios of less than 2.

Given the exceptional strength of the contextual association between alcohol problems and antisocial personality in adulthood, it is reasonable to posit a causal connection that begins very early in life. As we note below, other evidence

PROGRESSION OF RISK FROM EARLY ADOLESCENCE TO ADULTHOOD: NONALCOHOL-SPECIFIC FACTORS

When behavioral scientists have worked outside the laboratory, they have turned to longitudinal studies to establish sequences of causes. Sometimes called experiments of nature, longitudinal studies

involving a sample of individuals known to be at statistically elevated risk for later alcohol problems. A comparable, but lower-risk group is also located and assessed. When different degrees of difficulty with alcohol are eventually observed, investigators note which of the premorbid measures were predictive of the later damage. And if the data set is broad enough, it can be evaluated for the presence of variables that predict an outcome devoid of damage—in other words, protective factors.

To date, only a handful of longitudinal projects in this country have had such a high-risk design, and an even smaller number have been carried on long enough to track subjects through adulthood, thereby covering fully the period of risk for the onset of alcoholism. These include the Oakland Growth Study (Jones 1968, 1971), the St. Louis Child Guidance Clinic Study (Robins 1966), the Columbia Follow-up Study (Berry 1967), the Cambridge-Somerville Youth Study (McCord and McCord 1960), the Vaillant/Glueck Boston Study (Vaillant 1983), and the Physique and Delinquency Study (Monnelly et al. 1983). With the exception of the Cambridge-Somerville project, which began with 10-year-old subjects, all of the studies employed children who were initially in early to middle adolescence.

A review by Zucker and Gombert (1986) described common findings of these studies: (1) Adolescent antisocial behavior was consistently related to alcoholic outcome. Five studies found more antisocial and aggressive activity among future alcoholics. (2) Difficulty in achievement-related activity in adolescence was consistently found in subjects who later became alcoholic. Five studies documented the following problems among those who later became alcoholic: poorer school performance, less productivity in high school, greater truancy, and greater incidence of dropping out of school. (3) Males who later became alcoholic were more loosely connected to others. Four studies revealed a range of interpersonal deficits, from being less dependent, less considerate, and less accepting of dependency, to having a greater likelihood of leaving home early, and to being more indifferent to mothers and siblings as a teenager. (4) Heightened marital conflict was reported in the homes of study participants who were prealcoholic. This finding was replicated in four of the studies. (5) Parent-child interaction

Findings show a linkage between patterns of parental alcohol use and the preschooler's knowledge of alcoholic beverages. An early ability to recognize alcohol may be evidence for an early manifestation of risk for future problems with alcohol. (This scene is a simulation.) Photograph by M. Stacey Hudson.

drawn from earlier developmental periods reinforces the notion that antisocial behavior is a strong candidate for a risk pathway to adult disorders (also see the article by Pihl and Peterson in this issue, pp. 25–31).

are costly and exceptionally time consuming, but, at this point, they represent the only field method that firmly establishes etiology. In the arena of alcoholism research, most of the studies in recent years have used a high-risk design,

in these families was characterized by inadequate parenting. All six studies reported this effect. Parental behaviors included inadequate or lax supervision, an absence of parental demands, lack of parental interest or affection for the child, and, most frequently, inadequate contact. (6) Parents of prealcoholics were inadequate role models. Five studies reported this finding. Parents were likely to be alcoholic, antisocial, and/or involved in deviant sexual behavior.

These results clearly support the hypothesis gleaned from the epidemiologic data, namely, of a causal relationship between early antisocial behavior and later alcoholism. In addition, these findings suggest that antisocial behavior on the part of the parents may play a significant role. It is beyond the scope of this review to pursue these issues in detail; the interested reader might refer to papers by Tarter and co-workers (1985), Cloninger (1987), Sher (1987), Zucker (1987; in press), and Pihl and Peterson (this issue, pp. 25-31) for extended discussions of these topics. It should be noted that from a dynamic-systems perspective, it would be wrong to attribute such outcomes to a single precursive variable, such as antisocial behavior in parents, which enters the risk equation 10 to 20 years before the subject's later pathology is manifested. Other factors undoubtedly contribute to the outcome in ways that have yet to be elaborated.

This last point should be underscored in another way. The studies summarized above have established causal linkages of risk for alcoholism in the timeframe from adolescence to adulthood. For evidence of possible linkages of risk in the period before adolescence, another group of longitudinal studies needs to be examined.

LINKING CHILDHOOD RISK TO ADOLESCENT OUTCOMES

A recent review of studies of the childhood-to-adolescence period used common findings in the adolescence-to-adulthood, high-risk-for-alcoholism studies noted above as a basis for inquiring whether generalizations about antecedents of alcohol problems might be found in childhood-to-adolescence data (Zucker 1989). In the review, four studies were examined: the Rydelius/Nylander Stockholm study (Rydelius 1981); the Woodlawn study (Kellam et al. 1983); the study by Brook and co-workers

(1986); and the study by Block and co-workers (1988). The age ranges covered by these studies were from 3 to 12 years (mean of 6) at the time the studies were initiated, and from adolescence to young adulthood at the time of final followup. In contrast to the studies covering adolescence to adulthood, these studies of younger subjects included a broader range of populations and involved both genders. Only the Stockholm study included children from families with alcoholic members. The Woodlawn study involved an ethnic minority sample, in which the greater presence of risk factors would be anticipated; however, it and the remaining two studies involved samples drawn from the general community.

Antisocial behavior on the part of the parents may play a significant role.

Because riskiness is less common in the general population than it is in groups constructed to be high risk, we would expect risk-outcome relationships to be weaker in the four studies of childhood to youth than in the studies of older, high-risk individuals. For this reason, the level of correspondence between the two types of studies is impressive. In every area in which a comparison could be made, the evidence observed in the studies of younger subjects paralleled or did not contradict what was observed in the studies of older, high-risk subjects.

Although studies of the childhood-to-adolescence period are commonly thought to provide information only about the antecedents of problematic alcohol involvement in adolescence, they also may be used to shed light on antecedents of risk for problematic alcohol involvement after adolescence. While no single study has tracked the processes all the way from middle childhood to adulthood, the correspondences observed were sufficiently strong for us to conclude that for some individuals, especially those with a sustained and elevated burden of multiple risks, the progression toward problematic use of alcohol is likely to be

continuous. Nevertheless, the remarks made at the conclusion of the last section need to be reiterated. The available data are best regarded as markers of risk, which, in many cases, are not independent of each other. The interplay of causes in the data has yet to be elaborated.

EVIDENCE FOR RISK DURING PRESCHOOL YEARS

Given the evidence for some continuity of processes, at least from the school years onward, a question may be posed: How much earlier can indicators of risk be found? Like the studies of middle childhood, longitudinal studies of the earlier years have not been completed. However, if parallel findings can be considered evidence that similar processes operate during earlier years, then findings from the Michigan State University (MSU) Longitudinal Study indicate that markers for heightened vulnerability exist in the preschool period (Zucker unpublished data 1986; Zucker 1987). This continuing project is following families with children who were initially 3 to 5 years of age and who are at high risk for alcoholism in adulthood because they are male and have alcoholic fathers. The study is sensitive to the generality of risk, because families are drawn systematically from a geographic area rather than from treatment settings, where selectivity of the clientele is likely to be found.

The MSU study is employing the Child Behavior Checklist (CBCL), a standard instrument that employs parents' reports on their children's behavior. This measure is used heavily in clinical and nonclinical contexts to assess children's symptomatic status (Achenbach and Edelbrock 1983). It has an extensive history of validation in a wide array of settings, and allows for the evaluation of global difficulties (by measuring total behavior problems) as well as difficulties in areas pertaining to aggressiveness and depression. Table 1 presents the findings, obtained with the CBCL, for high-risk boys in the MSU study, and contrasts these with ratings from the normal, standardization sample. It shows percentages in each of these groups that would be classified in the clinical range. These data show a consistent pattern of elevated symptomatology among preschool, high-risk children in all the behavioral areas measured except depression. The results were consistent whether the CBCL was

completed by mothers or fathers. The magnitude of the differences between the high-risk and normal children is of the order of 3 to 1 for overall problem behaviors, for a global measure of externalizing symptoms (impulsivity, hyperactivity, aggressiveness), and for a content-specific measure of aggressiveness. The magnitude of the difference for a global measure of internalizing symptoms (fear, anxiety, depression) is of the order of 2 to 1.

These results, indicating significantly elevated levels of difficulty among high-risk preschoolers, represent one small part of a large process which needs to be tracked into adulthood. The evidence of symptoms very early in life demonstrates parallelism with the evidence of symptoms at later stages of childhood and adolescence, particularly in the domain of aggressiveness. The data therefore point to the possibility of continuous processes extending back to a period long before adolescent or adult psychopathology becomes obvious. That such data were predicted by developmental theory (Zucker unpublished data 1986) and resemble results obtained by high-risk studies of older children of alcoholics (Jacob and Leonard 1986; Sher et al. in press) lends additional credence to the hypothesis.

THE NATURE OF RISK AND IMPLACABLE FATE

This brief overview suggests that early attributes of risk for later alcohol problems are starting to be identified and that for people with a heavy risk burden, the process of becoming alcoholic may be well underway by adolescence. However, a developmental perspective on this process requires consideration of the variable and somewhat random nature of the way risk unfolds (Zucker 1989; in press). Being male, being hyperactive, having a family history of alcoholism, and having a genetic vulnerability are attributes that may or may not coexist and may or may not aggregate into a pattern of later trouble. How might these factors coalesce? Developmental theory is clear on this point. Ongoing events elicit response repertoires that are already partially developed. Thus, living in an environment where peers expect and elicit aggressive behavior is likely to lead a person to a more well-developed pattern of aggressiveness.

Table 1. Percentages of High-Risk Boys, Aged 3 to 5 Years, Found to Be in the Clinical Range for Behavior Problems. Results Are Compared to a Normal Standardization Sample

CBCL Index ^a	Percentage of Children in the Clinical Range, Rated on the Child Behavior Checklist (CBCL)		
	MSU Study Based on Reports of Mothers	MSU Study Based on Reports of Fathers	CBCL Standardization Sample, Primarily Reports of Mothers
Total Behavior Problems ^b	33	32	10
Internalizing Problems ^b	22	22	11
Externalizing Problems ^b	32	33	10
Depressed Behaviors ^c	9	8	4
Aggressive Behaviors ^c	29	21	6

^aThe normal standardization sample is based on reports of mothers (83.1 percent), fathers (13.5 percent), and others (3.5 percent), and the sample size is 100. The Michigan State University (MSU) study sample size is 90.

^bWith the exception of the Depressed Behaviors Index, all differences between the high-risk and standardization samples are statistically significant at $p < 0.05$ or better.

^cA classification of "clinical-range" problems indicates that the child has been rated at the 90th percentile or higher on this index.

^dA classification of "clinical-range" problems indicates that the child has been rated at the 98th percentile or higher on this index.

To put the matter more abstractly, a preexisting structure of risky behavior (or risky biology) is likely to be enhanced by a contextual structure that elicits risky behavior; this, in turn, leads to increasing differentiation and crystallization of behaviors. Specialization starts to take place, and the process develops its own momentum. Conversely, if a person encounters environments that do not trigger high-risk repertoires, then behavioral or biological patterns that engender risk can be diluted. This is the theoretical basis for the idea that drug involvement can be reduced substantially by delaying the onset of drug use (Kandel and Yamaguchi 1985). The delay of onset prevents the initial pattern of use from entering the behavioral repertoire; in addition, delaying the age of use until a time when environments are less likely to encourage alcohol

or other drug involvement reduces the likelihood that the repertoire becomes more rehearsed and more crystallized.

The view that there is an implacability associated with dangerous environments and risky backgrounds is common. Such a conclusion is usually reached in the aftermath of a series of outcomes that move in a negative direction—leading to increasingly heightened risk and eventually to a bad result. A developmental perspective requires understanding the interactions of risks and the ways in which contexts affect those interactions. There is evidence that, even after adolescence, patterns of cumulation of risk for problematic alcohol involvement exist for some individuals, whereas patterns of discontinuity of risk exist for others (Blane 1979; Cloninger 1987; Zucker 1987; Pickens et al. 1991). Evidence

from studies of later life and other drugs (Fillmore et al. 1979; Yamaguchi and Kandel 1984) indicate that this phenomenon is not restricted to adolescent alcohol problems, and that changeability and discontinuity during development may be as likely as the simple progression of risk. This observation leads to an optimistic view concerning prevention and early intervention. ■

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Adolescent Alcohol Decisions

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Making decisions related to alcohol consumption requires both specific knowledge and general cognitive skills. Decision theorists have studied knowledge and skills in a variety of settings. A review of those results suggests some explanations for adolescents' alcohol-related decisions.

Alcohol consumption involves a wide variety of decisions. Some are "strategic," setting commitments for future behavior (e.g., Should I begin drinking? Should I ever drive with people who have been drinking? Should I look for friends who drink less?). Others are more "tactical," responding to immediate situations (e.g., Should I have this beer now? Should I call my parents to take me home, instead of going with my date who has had three beers in the last hour?). Some decisions involve drinking itself, whereas others involve managing its consequences. Some are made alone, whereas others are made in social settings. Some are made while sober, whereas others are made while under the influence.

To make these decisions well, people must balance the risks and perceived benefits of alcohol use in ways that are in their own best interest. There is ample reason to believe, however, that these decisions are not being made well. Indeed, many of our society's responses to alcohol involve efforts to change how people, especially young people, make such decisions (Dryfoos 1990; Feldman and Elliot 1990). These efforts include public service announcements, warning labels,

high school health classes, and self-help groups. Other societal responses reflect a belief that people's decision-making processes are not to be trusted. These include legal restrictions on consuming and serving alcohol. In May 1989, the outcome of a widely publicized court case hinged on whether a pregnant woman had been adequately informed about the risks that drinking posed to her fetus.

Although the substance of each alcohol-related decision is unique, people bring to it the same basic cognitive capabilities that they bring to other kinds of decision making. These capabilities include some degree of success at judging the extent of their own knowledge, evaluating the relevance of other people's experiences to their own situation, estimating the cumulative risk from repeated exposure to a hazard, generating alternative courses of action, determining what is important to them, and considering how good their previous decisions have been.

All of these processes have been studied extensively, both as general cognitive processes and in the context of many specific decisions. These studies have revealed complex but recurrent patterns of strengths and weaknesses (Fischhoff 1988; Kahneman et al. 1982; Yates

1990). For example, people generally remember how frequently they have seen or heard about various events (e.g., crashes attributed to drunk drivers). However, they are much less able to correct for systematic biases in their exposure to information that might influence how they perceive risks. For example, because blood alcohol concentrations cannot be observed directly, people may not realize how often drinking is related to diminished driving ability or poor school work. In other words, people tend to underestimate the frequency of events or relationships that are hard to observe and to overestimate the likelihood of more observable events or relationships.

THE DECISION THEORETIC APPROACH TO DECISION MAKING

The common tie in the above-mentioned studies is decision theory's notion of decision making. It conceptualizes decisions as choices among alternative courses of action (including, perhaps, inaction). Decisions can be characterized qualitatively by the following:

- A set of actions (or options), describing what a person can do
- A set of possible consequences of those actions, describing what might happen (in terms of desirable and undesirable effects)
- A set of sources of uncertainty, describing the obstacles to predicting the connection between actions and consequences.

Decisions can be characterized quantitatively by the following:

- Value tradeoffs among consequences, describing their relative importance

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- Consequence probabilities (beliefs), describing the chances that they will actually be obtained.

This basic conceptual scheme has been used by investigators to describe a wide variety of decisions, including decisions to go to war (Jervis 1976; Lebow and Stein 1987), to have children (Beach et al. 1976), to operate on the basis of x-rays (Eddy 1982), and to guess which of two sequentially presented lights is brighter (Coombs et al. 1970). In some cases, the usage has been descriptive, attempting to show how people actually make decisions in these situations. In other cases, the usage has been normative, attempting to show how decisions ought to be made if decision makers are to choose wisely. In some cases, both approaches are used, in order to show the difference between how well people actually make decisions and how well they might. Often, there is also a prescriptive

purpose, attempting to bridge that gap by showing people how to make better decisions (Raiffa 1968; Von Winterfeldt and Edwards 1986; Watson and Buede 1988).

Decision theory offers a number of potential advantages. First, its basic concepts (e.g., probability and values) are well understood and universally accepted, allowing a degree of comparability and coordination among investigators that is unusual in the social sciences. Second, decision theory provides a systematic way of identifying discrepancies between optimal and actual behavior, pointing to where help may be needed. Third, such discrepancies often prove theoretically useful; there may be many explanations for appropriate behavior (e.g., instruction, modeling, conditioning), but only one for a particular pattern of errors. Fourth, decision theory helps ensure comprehensiveness when attempting to document actual decision making.

As a result, decision theory provides a natural point of departure for studying adolescents' alcohol-related decisions. The formal tools of decision theory provide a way to describe decisions. The descriptive research of decision theory provides a default account of decision making in any particular area. That is, one should assume that adolescents' alcohol-related decisions invoke the same psychological processes as other decisions, except to the extent that there is something special about alcohol or adolescents. As a result, the set of potentially relevant research is very large. This article provides guideposts to the literature, along with illustrative results.

As a device for surveying this literature, we will focus on a single alcohol decision, whether to ride with a friend who has been drinking. To illustrate how decision theorists would study this decision, we will consider first a normative and then a descriptive approach. Our dis-

Peer pressure may influence an adolescent's decision whether or not to accept a ride from a driver who has been drinking.

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cussion will draw on relevant existing research where possible. Typically, however, we refer to decision research on other topics. The need to do so reflects, in part, the difficulties inherent in the measurement requirements of the decision theoretic approach, as described below.

NORMATIVE ANALYSIS

As stated earlier, normative analysis attempts to show how decisions ought to be made if decision makers are to choose wisely. The first step in studying a decision is to describe it as accurately as possible. Figure 1 (see next page) shows a decision tree, a common way of summarizing such a description. It includes the available options, the possible consequences (with some measure of their attractiveness), and the critical intervening events (and their probabilities). This particular example is fairly rudimentary. It could be refined in a number of ways, such as by including different ways of declining the ride. A second refinement

might be to distinguish accidents of different severity. A third would be to refine the consequence estimates. A fourth would be to assess the probabilities of those consequences actually occurring.

Such a representation is "objective" in the sense of trying to capture the actual options, uncertainties, and consequences facing the decision maker. Any discrepancy between that representation and the decision maker's perceptions threatens the optimality of the pending choice, that is, the extent to which the choice is in the decision maker's best interest. Such "gaps" also suggest opportunities for interventions (e.g., refining beliefs, identifying overlooked options). The representation is inherently "subjective" in the sense of reflecting the individual's evaluations of the attractiveness (or aversiveness) of the consequences. In this sense, it respects decision makers' sovereignty in determining what is important to them.¹

Even the rudimentary normative analysis in Figure 1 suggests some potentially significant features of the decision facing an adolescent offered a ride by a friend who has been drinking. Initially, the decision seems fairly simple, insofar as it involves only two options. However, both options have many variants, each with its own profile of consequences. On the plus side, this means that an adolescent facing this situation might be able to design more satisfactory ways to accept or decline the ride;² on the negative side, this increases the number of options requiring analysis.³ Another feature of the decision is that it involves a very small probability about which there are some relevant scientific data (the chance that

such a trip will end in an accident) and a much larger probability, about which the adolescent is the closest thing there is to an expert (the chance of being criticized for declining the ride). A third feature of the decision is that the set of central consequences is small, but contains elements that are very hard to compare (e.g., the tradeoff between enjoyment and bodily injury). Unless an adolescent has strong prior commitments, this is a difficult decision, of the sort that might cause frustration and prompt abrupt choices.

In addition to providing a description of people's perceptions, a formal model of decision making can serve several other functions. One is to show the sensitivity of choices to variations in how problems are perceived. For example, it is often the case that decisions with continuous options (e.g., drink X ounces of alcohol, wait Y minutes before driving) are relatively unaffected by moderate variations in assessed probabilities and values (Von Winterfeldt and Edwards 1982).⁴ Although such situations are, in a sense, easy for decision makers, they can be difficult for investigators. Where many combinations of options, beliefs, and values could lead to the same choice, observers cannot confidently infer which perceptions actually motivated the decision maker's actions (Dawes 1979). Thus, if different sets of perceptions could lead adolescents to drive with drinkers, then one must be cautious in trying to interpret (or alter) their behavior.

Where particular perceptions do make a big difference, they should be made the focus of communications about a risk. All too often, public health messages tell people things that they already know or else do not need to know, wasting their valuable attention and demonstrating insensitivity to their informational needs. For example, in its fine report *Confronting AIDS*, the Institute of Medicine (1986) still lamented a survey showing that only 41 percent of the public knew that AIDS is caused by a virus. Yet, one would be hard pressed to identify any decision that would be affected by knowledge of this fact.⁵ The absence of standards for determining which infor-

¹Deciding that someone has the wrong values would indicate another gap that might be closed through intervention. However, there is a fundamental difference between telling people, "you do not know how disabling paraplegia would be" and telling them, "you shouldn't value the high of binge drinking so much."

²There might also be better ways to take a ride from someone who has been drinking (e.g., sit in the back seat, wear a seatbelt, ask to be dropped off first).

³In a study of sexual assault decisions, Fischhoff and co-workers (1987a) identified more than 1,100 options, each sufficiently different from the others that it might be expected to have a different profile of consequences. Unless they can be combined somehow, such arrays of options defy systematic analysis, even by trained investigators (Furby and Fischhoff in press).

⁴This analysis assumes that decision makers act optimally on the basis of their perceptions.

⁵One also might wonder whether 41 percent of the population really knew what a virus was.



mation is relevant for making a particular decision can complicate life for information providers as well as for information recipients.

Some studies have found that adolescents' decisions to drink are unrelated to how much they know about the effects of alcohol (Berberian et al. 1976; Botvin 1986). That could mean that information makes no difference, or that one needs to look at adolescents' understanding of the information that they receive. For example, in a study in progress (Quadrel et al. unpublished data 1991), we asked teenagers to interpret information about risk, including several posters designed to deter them from drinking and driving. Five of 19 subjects (26 percent) reported that these ads told them not to get drunk and drive.⁶ When asked to describe someone who was drunk, respondents typically used terms such as "had 10 glasses" of beer, "would go into a blackout," or "can't stand up." These teens understood that accidents may result from drinking, and that heavy drinking

results in observable effects on judgment and coordination. However, there was little indication that they realized the detrimental effect on a person's judgment of just one or two drinks. (Two subjects did say that some people could be legally drunk from a "couple" or "three" beers, and one noted that the "legal alcohol level is lower than most people recognize as being drunk.")

A final use of formal analysis is estimating the sheer difficulty of the decisions that people face. Just how many options, consequences, and uncertainties must they consider? Is there a dominating alternative to be found, one that is at least as good as all others in all respects? Are there awkward tradeoffs to be made (e.g., money versus health)? Are there irreducible uncertainties? As the difficulty of decision making increases, so should the chances of suboptimal performance and the decision makers' degree of frustration. Adolescents may be particularly disturbed by the realization that decision making is not always facilitated by concentrated thought. Accepting the fact that life is a gamble is a part of maturation and may be a buffer against the emotional stress generated by insoluble problems. In work in progress (Beyth-Marom et al. in submission 1991), we are finding few differences in how decisions are described by adolescents and

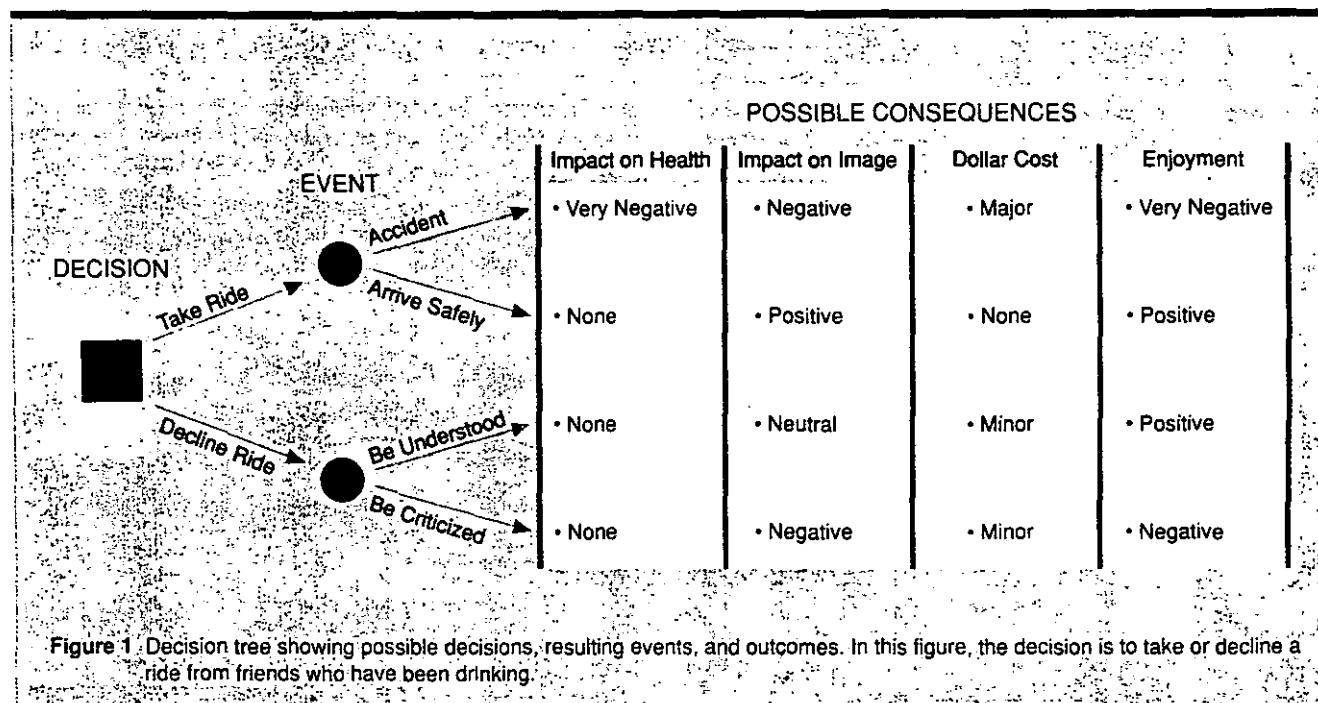
adults (typically their parents). We suspect, however, that greater differences may lie in how they cast their lots and make choices in situations where no dominating alternative emerges. Adolescents and adults may be sensitive to different immediate factors (e.g., hormones, habit, peer pressure, vivid images) when the time comes to resolve their quandaries and take action.

DESCRIPTIVE ANALYSIS

As opposed to normative analysis, descriptive analysis attempts to show how people actually make decisions. Like other kinds of behavioral research, approaches to identifying deviations from a normative model can be divided into those that are structured and those that are open ended. The former approaches assume that decision makers share the model's qualitative description, then focus on how its quantitative components (i.e., the probabilities and tradeoffs) are judged. The latter approaches accept the possibility that critical pieces (i.e., options, consequences, uncertainties) may be missing entirely from people's thought processes or, if present, may be defined differently than the way they appear in the normative analysis.

The advantages and disadvantages of these approaches reflect the difficulties

⁶This result was also observed in Quadrel (1990), where teens were asked to estimate the probability of becoming involved in a car crash while driving after drinking. Our goal was to uncover what information respondents assumed or requested in order to make their judgments. Although no information was provided on how much the person had to drink, over half assumed that the driver in question was drunk.



measuring decision theory's central concepts (e.g., the perceived probabilities of occurrence of different consequences). These difficulties are often quite daunting. However, to the decision theorist they represent inherent features of decision situations. For example, surveys often ask people general questions about the "importance" of different decision criteria (e.g., pay versus benefits versus fulfillment in choosing a job, style versus performance versus safety in buying a car). From a decision theoretic perspective, however, importance depends on context: pay matters only if job offers vary on that dimension. Similarly, people cannot show an aversion to risk if all options entail some risk, although people might show a relative aversion to one kind of risk (e.g., the chance of physical harm) over another kind (e.g., the chance of social censure)—if those consequences vary across their options. Recognizing these possibilities, decision theory's procedures measure tradeoffs in context (e.g., Keeney and Raiffa 1976; Von Winterfeldt and Edwards 1986). In order to accomplish this, investigators must first uncover that context and, then, represent it to interviewees.

Structured Approaches

Substantive Issues. Of decision theory's two quantitative components, people's probability judgments are typically much easier to evaluate than their value tradeoffs. Often, there are relatively hard statistics against which those judgments can be compared. Such comparisons are the basis of such claims as, "people overestimate the likelihood of overreported events" (Combs and Slovic 1979; Tversky and Kahneman 1974). Eliciting such judgments requires attention to many methodological details, in order to cope with respondents' inexperience in making explicit numerical estimates concerning life events (Fischhoff et al. 1987b; Linville et al. in submission 1991; Poulton 1988). One cannot just look up a risk probability and then ask people to guess what it is. For example, Fischhoff and MacGregor (1983) found that changes in the way a question is worded could produce hundredfold differences in estimates of the risk of dying from a disease (e.g., tuberculosis) among those afflicted by it.⁷

Although, to the best of our knowledge, people have not been asked about the specific health risk in Figure 1, stud-



Teens' drinking decisions might be traced to their beliefs about the consequences of the options that they consider or to the tradeoffs that they are willing to make.
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ies have elicited estimates of the population risk of motor vehicle crashes (e.g., Lichtenstein et al. 1978). These risks are judged fairly accurately, suggesting that they are observed roughly in proportion to their actual frequency. Perceptions of personal risks, however, seem less trustworthy. For example, most people in most countries judge themselves to be safer and more skilled than the average driver (e.g., Svenson 1981), a claim that could be true for at most one-half of the population. This exaggerated sense of personal control over accident situations would be encouraged by the difficulty of observing other drivers' intoxication and one's own unintentional lapses (even when one has not been drinking). The tendency to view oneself as less at risk than others has been observed in many other settings (Weinstein 1987).

This "optimism bias" is a good example of the sort of "illusion of invulnerability" often attributed to adolescents (Elkind 1967)—although, ironically, most of the evidence for invulnerability

comes from studies with adults. Because invulnerability is such a widely accepted explanation of teens' risk-taking behavior, we recently conducted a study comparing the illusion of invulnerability among 86 matched pairs of adolescents and adults (parents of the teens) from middle-class neighborhoods. Among other risks, we asked about the probability of becoming an alcoholic. The adolescents showed no more illusion of invulnerability for this question than did adults. Some 62 percent of both teens and adults estimated their risk to be smaller than that of an acquaintance; 19 percent of teens (compared to 23 percent of adults) reported equal probabilities for themselves and the acquaintance, and 20 percent (compared to 15 percent) reported higher probabilities for themselves. A group of teens recruited from group homes for teens with previous chemical dependencies (and therefore at high risk for alcoholism) provided similar judgments: 61 percent thought their probability of becoming alcoholic was lower than that of an acquaintance, 17 percent reported the same probability, and 22 percent reported higher personal probabilities (Quadrel et al. unpublished data 1991). These rates of perceived invulnerability were similar to those found for technological risks in the study (e.g., pes-

⁷The (conditional) risks were much larger when people were asked, "for each person who dies of [malady X], how many have it and survive?" than when they were asked, "of each 100,000 people who had X, how many died?" As in other studies, the relative risk from different sources was largely independent of response mode.

ticide poisoning), but indicate greater similarity across teens and adults than was true for other "behavioral" risks. Typically, for risks such as auto accidents and muggings, adults were likelier than teens to perceive no difference in risk probability between themselves and an acquaintance: 40 percent of adults, compared to 27 percent of their teenaged children, saw no difference in risk. More teens than adults perceived themselves as less vulnerable than an acquaintance (52 percent versus 45 percent). However, more teens than adults also saw themselves as more vulnerable than an acquaintance (21 percent versus 15 percent). Thus, teens were likely to make distinctions of both kinds.

People cannot know every fact about every risk in their lives. As a result, it is critical that they understand the limits of their own knowledge, so that they know when to hedge their bets or when to collect more information. Many studies have found that people are only moderately successful in assessing how much they know, with the most common overall result being overconfidence (Lichtenstein et al. 1982; Yates 1990).

Quadrel and Fischhoff (unpublished data 1991) found a similar pattern in responses to a quiz with 100 2-alternative questions about risk behaviors, including drinking and driving. For each question, respondents chose the alternative they believed to be true, and then assessed the probability that their answer was correct. Respondents were divided into three groups: middle-class teens, their parents, and teens at risk for becoming alcoholic. Results for the first two groups were similar and indicated moderate overconfidence (e.g., they had chosen correctly only about 85 percent of the time when they gave probabilities of 1.00). The at-risk youths were much more overconfident (and had many fewer correct answers), despite their much greater direct experience with the effects of alcohol. For example, only 45 percent of the at-risk teens knew that having a beer would affect their driving as much as drinking a shot of vodka. However,

their mean probability of having answered this question correctly was 84 percent. For this particular question, the adults were just as overconfident as the at-risk teens, while the not-at-risk teens judged their chances of a correct response more realistically.

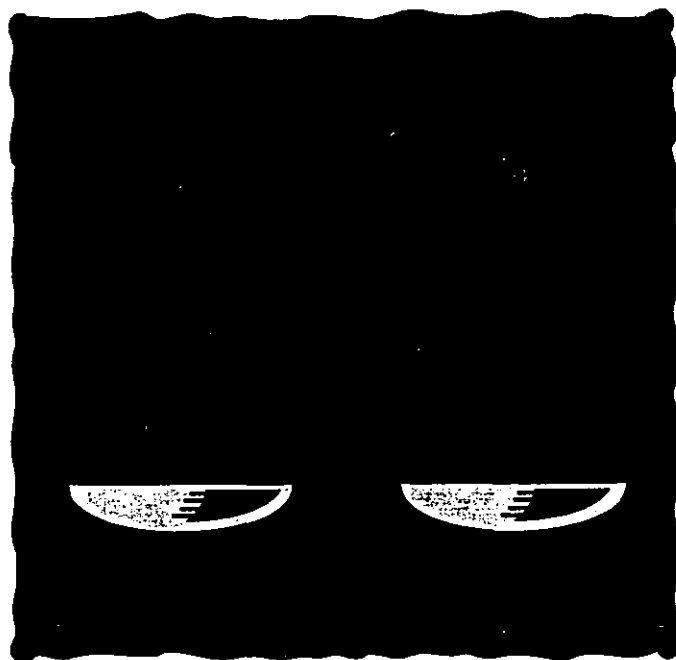
Methodological Issues. These evaluations require subjects to report their risk estimates using numerical scales. However, most surveys of risk perceptions, including ones studying teenagers' perceptions of alcohol-related risks (Bauman 1985; Bauman and Bryan 1983;

Unfortunately, responses to such verbal scales are difficult to interpret because they may connote very different numerical values to different people in a given context or to the same person in different contexts. A "great risk" of feeling drunk after four beers may indicate a 70-percent or 80-percent likelihood, whereas even 1 percent may constitute a "great risk" of having a fatal accident (Wallsten et al. 1986; Beyth-Marom 1982). The same ambiguity can arise in risk communications. Being told that rain is "likely" may suffice when deciding whether to have a picnic or carry an umbrella. Being told that AIDS in the blood supply is "rare" or that there is a "great risk" of car crashes from drinking may not convey enough information for effective decision making (Merz and Fischhoff 1990).

Similar imprecision frequently characterizes the wording of the questions that respondents evaluate as well as the scales that they use to convey their beliefs. For example, a National Center for Health Statistics survey (Dawson et al. 1987) posed the following question: "How likely do you think it is that a person will get the AIDS virus from sharing plates, forks, or glasses with someone who had AIDS?" We presented this question to a relatively homogeneous group, psychology students at an Ivy

League college. After answering, they were asked what they had understood to be the frequency and intensity of the sharing.⁸ There was considerable disagreement among respondents about the presumed frequency of sharing: single occasion (endorsed by 39 percent of respondents), several occasions (20 percent), routinely (28 percent), and uncertain (12 percent). There was considerable agreement about intensity: sharing utensils during a meal (82 percent), using the same washed utensils (11 percent), and uncertain (6 percent). One still must ask whether readers of this report would have guessed correctly how respondents interpreted the question. Interestingly, all of the subjects who reported uncertainty

⁸Readers might want to guess at their answers before reading the results in the text.



Institute for Social Research 1986; American School Health Association 1988), rely on nonquantitative scales. For example, the National Adolescent Student Health Survey (American School Health Association 1988) asked: "How much do you think people risk harming themselves (physically or in other ways) if they drink alcoholic beverages occasionally?" The response options were: no risk, slight risk, moderate risk, and great risk (with a "can't say—drug unfamiliar" category). Similarly, Bauman (1985) asked respondents to estimate the likelihood of each of 57 possible consequences of drinking 1 beer or glass of liquor each week. Response options were: sure it would happen, it probably would happen, it probably would not happen, sure it would not happen.

about the frequency and intensity of sharing still made likelihood judgments (Fischhoff 1989).

Such ambiguity is common in surveys of adolescents' perceptions of the risks of alcohol and other drug use. For example, the National Adolescent Student Health Survey question cited above does not define "harm," "alcoholic beverages," or "occasional use." In a study underway, we asked middle-class teens and adults to write down what type of "harm" they thought about when responding to the same question for smoking marijuana (Q1) and using cocaine powder (Q2) for "occasional" or "frequent" use. Subjects could write down more than one interpretation. Preliminary responses (31 teens and 19 parents) to Q1 included 4 interpretations involving social effects (e.g., "loss of friends"), 28 involving general physical effects (e.g., "physical harm"), 3 involving suicide or death, 12 involving mental or emotional harm (e.g., "emotional instability"), 8 involving brain damage (e.g., "kills brain cells," "slows down the brain"), 6 involving addiction to marijuana or other drugs, 13 involving other criminal or risk-taking behaviors (e.g., "criminal problems," "accident from bad driving") and 1 involving violence toward others. On the other hand, the definition of "harm" for Q2 included no social effects, more concern with further addictions (10 versus 6), fewer concerns with criminal activities (6 versus 13), and more concern with violent behavior (4 versus 1).

Measuring the other quantitative component of decisions, people's values, presents its own methodological challenges (Von Winterfeldt and Edwards 1986). Evaluating the quality of what has been measured is, however, a rather different enterprise. Claiming that people have the wrong values means denying them sovereignty over their own choices.⁹ Rather than assume this role, investigators have focused on identifying inconsistencies (which people would, presumably, wish to avoid). An extensive literature now documents the changes in expressed values that can accompany seemingly trivial variations in how questions are posed (Dawes 1988; Fischhoff

1991; Hogarth 1982; Tversky and Kahneman 1981).

For example, we recently found 88 percent of a sample of college students willing to allow a condom to be labeled as "effective" if it had a 95-percent success rate in stopping transmission of the AIDS virus; however, the endorsement rate dropped to 42 percent when the condom was described as having a 5-percent failure rate (Linville et al. in submission 1991). Slovic and co-workers (1978) found that seatbelt usage was judged more positively when the risks of driving were described in terms of the lifetime chance of a fatal accident rather than in terms of the (formally equivalent) one-trip risk. In such situations, people's choices are sensitive to how decisions

People are only moderately successful in assessing how much they know, with the most common overall result being overconfidence.

happen to be posed or viewed at the moment they are made. An additional complication with this particular "framing" problem is that, even when people do evoke the long-term consequences of repeatedly engaging in an act such as drinking and driving, they may greatly underestimate the cumulative risk (Shaklee and Fischhoff 1990).¹⁰

Open-Ended Approaches

The inconsistencies between the values that decision makers assign to single versus multiple risk exposures raise the question of how people naturally think

about such risks. The open-ended approach seeks to answer this question by documenting how people actually structure their decision making, rather than assuming the appropriateness of the investigator's perspective. This requires quite different methodologies from those of the structured approach. For example, Quadrel and colleagues (unpublished data 1991) asked adolescents to think aloud as they tried to assess the probabilities of deliberately ambiguous events, such as "getting into an accident when driving after drinking." Other questions pertained to the risks of sexuality and the use of other addicting substances. With respect to drinking and driving, 48 out of 61 subjects reported assumptions or asked for information about how much drinking was involved; far fewer (6) asked about how much driving. With varying frequency, subjects also wanted to know about a number of other factors with differing objective relevance (e.g., driving skill, age, the social atmosphere, the type of alcohol, physical tolerance).

Dose information (e.g., how much drinking) was routinely requested for seven of nine ambiguous events (e.g., the probability of getting cancer from smoking cigarettes or of becoming alcoholic from drinking). However, it was not requested for the two events concerning sex (the probabilities of pregnancy and of AIDS virus transmission); only 2 of 61 subjects mentioned dose information in relation to AIDS, and only 6 of 61 did so for pregnancy. Theoretically, these results suggest that adolescents have a more accurate intuitive understanding of the effects of drinking and other drug use than they do of the risks of sexuality. Methodologically, they suggest that surveys asking adolescents to evaluate alcohol-related risks without specifying dose are too vague to produce meaningful answers.

In another open-ended effort, Fischhoff and colleagues (unpublished data 1991) asked 105 teens to talk at length, in their own terms, about recent difficult decisions in their lives. None of the decisions that the teens chose dealt with drinking and driving, although quite a few dealt with drinking. For those decisions that were mentioned, few had an option structure as complicated as that in Figure 1. That is, most were described in terms of a single option (e.g., whether to go to a party where alcohol would be served). In a two-option decision as in Figure 1, the consequences of the alterna-

⁹Some of the most controversial research on adolescents has, in fact, centered on the possibility that they reject values that adult society would have them adopt (e.g., Brown 1990; Gardner et al. 1989; Luker 1975).

¹⁰For example, on average, the subjects in Linville and colleagues (in submission) estimated the probability of the AIDS virus being transmitted from a male to a female as 10 percent in 1 case of protected sex (a great overestimate, according to public health estimates) and as 25 percent in 100 cases (a more reasonable estimate, but much too small given their 1-case estimates).

tive option are logically implied. However, that need not mean that they are intuitively obvious to the decision maker.

Beyth-Marom and co-workers (in submission 1991) asked teenagers and their parents to list consequences of a number of scenarios in which the teen chooses either to engage or not to engage in a particular risk behavior, including the accept-ride or reject-ride options in Figure 1. Responses from 69 middle-class adults and teens were surprisingly similar with respect to the number and type of consequences mentioned. One modest difference was that teenagers were more likely than adults to mention the physical (e.g., being hurt in an accident) and legal (e.g., being caught by police) consequences of accepting the ride. Adults were more likely to mention continuing behaviors (e.g., one drink leads to another).

These are but suggestive results. Like those from the structured studies, they provide guidance for researchers seeking a fuller account of adolescents' judgments and decisions about alcohol. Normative decision theory provides the conceptual framework for determining what should be studied. Descriptive decision theory provides the methodological tools for pursuing that study.

CONCLUSION

Decision theory suggests several general explanations of teenagers' drinking behavior. If teens are drinking in ways that are ill advised, it may be because they are not considering options that would make it more attractive not to drink. Life-skills training programs (e.g., Botvin 1986; Schinke and Gilchrist 1984) attempt to create such options by teaching "refusal skills," socially adroit ways to avoid taking risks. Teens' drinking decisions might also be traced to their beliefs about the consequences of the options that they consider or to the tradeoffs that they are willing to make. Finally, adolescents may have difficulty making sense of complex decisions and keeping track of all the relevant considerations. As a result, they may resort to quick solutions reflecting only some of their personal beliefs and values (e.g., do what your friends do, do what your parents tell you to do). Attention to methodological detail is critical when studying drinking decisions. Decision variables will explain little if they are measured poorly.

As with other conceptual frameworks, decision theory has potential pitfalls. As mentioned, one pitfall is assuming, without evidence, that teenagers (or adults) follow the model of optimal decision making (i.e., they always make the choice that is in their own self-defined best interests). A more subtle pitfall is assuming that the conceptual framework of decision theory is the one actually used by teenagers, even if they make suboptimal choices. A third pitfall is assuming that the model circumscribes all relevant dimensions of judgment and decision-making behavior, even though it ignores the roles of emotion (Fiske and Taylor 1990; Janis and Mann 1979) and self-control (Thaler and Shefrin 1981) in choosing courses of action, as well as the roles of the family or other social forces in shaping cognitive processes (Bronfenbrenner 1986; Majoribanks 1979). The best defenses against these pitfalls are awareness and a willingness to entertain more complex accounts than the simplistic ones that are possible when working entirely within one paradigm (Fischhoff in press).

This discussion has also highlighted a number of methodological challenges in applying a decision theoretic perspective to the question of adolescent drinking behavior. These include specifying the risks to be evaluated, measuring values and beliefs, and identifying the information needed to make decisions. Clearly, multi-method approaches are necessary, including open-ended questions that allow the discovery of decision variables not anticipated by investigators. It will be hard to describe a process that is only partly revealed. It will also be hard to influence adolescents' decision making with programs that focus only on teaching "correct" processes and "correct" perceptions, while ignoring what teens actually do or can do. ■

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The Effects of Alcohol Abuse on the Health of Adolescents

AMELIA M. ARRIA, B.S., RALPH E. TARTER, PH.D., AND
DAVID H. VAN THIEL, M.D.

A person's physical and mental states change rapidly and profoundly during the developmental period known as adolescence. The amount of research into the possibly deleterious effects of alcohol abuse on development and general health in adolescents is surprisingly light.

Research on alcohol use by adolescents has focused on the extent of adolescent alcohol involvement, the psychological predictors of problematic use, and adolescent attitudes and beliefs about alcohol. Additional research has meant to help devise effective assessment, prevention, and intervention strategies. Perhaps the most underrepresented area of research about alcohol use by adolescents is that dealing with the effects of alcohol use and abuse on the health of adolescents.

In the following discussion we summarize the prevalence of adolescent alcohol use and abuse; examine the reasons for the lack of attention directed at adolescent health issues; review the current status of knowledge about the biomedical consequences of adolescent alcohol abuse; and suggest research strategies that might lead to clarification of the influence of adolescent alcohol abuse on health.

PREVALENCE OF ADOLESCENT ALCOHOL USE AND ABUSE

The misuse of alcohol and other substances by young people is recognized as a major public health problem. Estimates of the prevalence of alcohol use among American youth have been fairly consistent and have revealed that as many as 95 percent of high school seniors have drunk alcohol (Johnston et al. 1985). One national sample revealed that 26 percent of 8th-graders and 38 percent of 10th-graders had consumed five or more drinks on single occasions during the 2 weeks prior to being surveyed (Centers for Disease Control 1989). Another study reported that 33 percent of sampled high school students admitted to fitting the criteria for moderate to heavy drinking, and 15 percent admitted to consuming five or more drinks per occasion on a weekly basis (Rachal et al. 1982).

In still another study, 14 percent of graduating seniors were found to have

drunk to intoxication on a weekly basis, and 6 percent were found to have drunk on a daily basis during the 30 days preceding the study (Johnston et al. 1985). A full description of the epidemiology of alcohol-related problems among adolescents is covered in a separate article in this issue (see the article by Windle, pp. 5-10). Because the use of alcohol by adolescents is widespread, research on the possible effects of alcohol on adolescent growth, maturation, and overall health is strongly warranted.

Several findings from epidemiologic surveys bear on the biomedical consequences of alcohol use by young people. First, initial use of alcohol occurs at an early age (an average of 11.0 years for boys, 12.7 years for girls; U.S. Department of Justice 1983), when young people are experiencing major changes in physical and mental growth and development. It is likely that an older adolescent who first consumed alcohol in the preteen years will experience greater alcohol-related medical complications than will an adolescent who has been drinking for a shorter period of time. However, duration of use is only one variable relevant to health. There are others; for example, early heavy drinking episodes may lead to acute intoxication and accidental injury.

Second, because of a societal trend in polydrug abuse, it is necessary to keep in mind that adverse health may be the result of the combined use of alcohol and other drugs. It is common for an adolescent who abuses a number of drugs to have begun with cigarettes and alcohol, and to have progressed to illicit substances such as LSD, cocaine, and crack. The polydrug abuser is likely to be older and perhaps more at risk for medical complications. Adolescents who drink heavily are more likely to progress to polydrug abuse. (For reviews of the biological effects of marijuana and cocaine, see Nicholi 1983 and 1984.)

Third, most large studies have employed self-reports from national samples of students between the ages of 10 and 18. It is difficult to assess specific health effects of alcohol use from such population-based studies. One exception is worth noting, however. Newcomb and Bentler (1987) conducted a longitudinal study of 654 older adolescents, in which alcohol and other drug use was assessed at the start, and health and health-care utilization were assessed, using self-reports, 4 years later. This study revealed

that (1) general drug use was related to a small but significant decrease in physical hardiness; (2) use of illicit drugs was associated with an increase in the number of emergency room visits; (3) cigarette use during adolescence was associated with several specific health problems in young adulthood; and (4) early marijuana use led to a decrease in physical hardiness and an increase in symptoms of illness.

The researchers concluded that general drug use may increase an adolescent's risk for specific health problems later in life by causing a decrease in physical hardiness during young adulthood. It is important to emphasize that the results were obtained using a general demographic sample rather than a sample of adolescents seeking treatment for alcohol and other drug problems. Clinical samples can provide more specific information about the health-related consequences of alcohol abuse; however, the results of clinical studies may be biased, because health problems usually propel a person into a clinical setting. A number of variables in addition to alcohol interact to result in health problems in clinical populations—examples are psychiatric disorders and environmental stresses. It is important to assess the interactions between these variables and adolescent health when studying clinical samples.

Alcohol use is also prevalent among juvenile offenders (Segal et al. 1984) and

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Brain: Adult alcoholic patients have been found to suffer from a variety of neurologic impairments. There is little data on the effects of alcohol on the developing brain of adolescents.

Digestion/Nutrition: Alcohol can affect the uptake, storage, and utilization of vitamins and minerals; alcohol abuse has been associated with bulimia and anorexia nervosa.

Liver: Adolescents who use alcohol have been found to have increased levels of iron in the blood. In adult users of alcohol, enhanced deposition of iron in the liver may be one precursor to liver damage.

Injuries: Accidental injury is one of the most frequently identified "health consequences" of teenage alcohol and other drug use.

Bones: Acute and chronic consumption of alcohol suppress the levels of growth hormones important for bone and muscle development.



Possible effects of alcohol on health of young people. Illustration by James Sottile, Jr.

runaway youth (Council on Scientific Affairs 1989). The adverse health consequences of the combination of poor environmental conditions and alcohol and other drug use in these adolescents are unknown.

THE LACK OF HEALTH DATA

There are several reasons for the lack of empirical data concerning the biomedical consequences of alcohol use during adolescence. Only in the last decade have studies documented the widespread and increasing use of alcohol and other drugs by adolescents. And only after the magnitude of the problem was recognized did researchers begin to determine the key factors involved in the initiation of alcohol use and the subsequent transition to the use of illicit drugs (Kandel and Logan 1984). Research was also directed at determining the prevalence and significance of coexistent psychiatric disorders such as anxiety and depression. Very recently, studies have begun to focus on the possible biomedical consequences of adolescent alcohol use and abuse.

Another reason for the lack of data on the biomedical consequences of alcohol use by adolescents is the way in which adolescents with alcohol problems enter the health care system. Psychologists, social workers, school officials, and workers in the legal system are usually the first to identify cases of adolescent alcohol abuse. Medical doctors are not the primary source for identifying alcohol-related health problems. Cypress (1984) determined that only 4.9 percent of 15- to 24-year-olds seeking help for medical problems visited an internist. Furthermore, only 6.7 percent of an internist's practice comprised patients aged 15 to 24. Singer and Anglin (1986) reported that health care professionals estimated that only 3 percent of adolescents in each of their health clinics had an alcohol or other drug problem, whereas the estimated prevalence rate in that community was 13 percent. A recent study of adults indicated that only 10 percent of alcoholics in treatment facilities were referred by physicians (Mendelson et al. 1986).

Current medical education does not provide future physicians with adequate training in detecting and treating problems resulting from alcohol abuse (Babor 1990; Saunders and Conigrave 1990). For example, physicians are not trained to use screening instruments to inquire about

alcohol consumption (Babor 1990). Standard pediatric textbooks contain a paucity of information relating to alcohol- and other drug-assessment procedures. There is, instead, an emphasis on the management of acute intoxication. The adverse health consequences of illicit drugs are more fully presented than are the consequences of alcohol consumption (Behrman et al. 1987; Schonberg and Coupey 1987; Sargent 1990). Only 4.9 percent of accredited medical schools in the United States require students to attend a course on alcohol and other drug abuse (Association of American Medical Colleges 1991).

Underreporting by physicians of alcohol problems in patients underscores the need for training of physicians to detect and treat alcohol and other drug abuse. The detection by physicians of alcohol

Researchers have documented associations between alcohol abuse and the eating disorders.

and other drug use among adult patients varies by subspecialty (Moore and Malitz 1986; Moore et al. 1989): psychiatrists have the highest rate of detection (greater than 50 percent); internists have rates between 25 and 50 percent; and surgeons and obstetricians/gynecologists have rates lower than 25 percent. No studies have determined detection rates for physicians who examine adolescents. Alcohol and other drug abuse have been identified as probably the most commonly missed pediatric diagnoses (MacDonald 1984).

Because of the inadequate detection of alcohol and other drug abuse and the absence of empirical data about related medical consequences, there exists in the medical literature an assumption that biomedical disorders in adolescent alcohol users are not prevalent. The most frequently identified "health consequences" of teenage alcohol and other drug abuse are accidental injury, suicide, and motor vehicle fatalities. It is argued that other

health consequences in the adolescent population may merit examination.

It frequently is assumed that the health consequences of alcohol abuse are associated with chronic alcohol consumption, and therefore occur only in adults. However, researchers have shown that the chronicity and severity of alcohol consumption explain only part of the etiology of medical consequences of alcohol abuse. Many complications, such as hepatic and neurologic dysfunctions, depend on individual vulnerability, including possible genetic factors (Saunders and Williams 1983). And there is some evidence that early onset of drinking places the individual at a greater risk for certain alcohol-related medical complications (Novick et al. 1985). Moreover, it can be argued that significant alcohol-related problems in young adulthood have their onset at an earlier age.

Although alcohol use during adolescence may affect developmental processes such as bone growth, it is not known whether alcohol abuse is detrimental to such processes. The ecological context of adolescence may be important: patterns of sleeping, eating, and stress experienced by adolescents differ from those experienced by adults. The ways in which these variables interact and affect the health of the adolescent alcohol user have not been determined. In summary, it may be premature to assume, on the basis of available data, that adolescents who use alcohol do not experience alcohol-related medical consequences because their use of alcohol is not of a duration needed to produce harmful effects in adults. The physical and psychological changes in adolescence might be such that alcohol exerts special influences.

ALCOHOL USE AND NUTRITION

Alcohol use reduces the metabolism of macronutrients (carbohydrates, proteins, and fats) and impairs the uptake, storage, and utilization of micronutrients (vitamins and minerals) (Morgan and Levine 1988). Furthermore, despite an increased requirement for nutrients during adolescence, eating is often sporadic and not especially nutritious (Bull 1988). Deficient intake of calories, iron, calcium, magnesium, zinc, and vitamins A, B (various), and C have been found in U.S. adolescents (Greger et al. 1978; Pao 1980; Lai et al. 1981). A recent report found that 32 percent of adolescent boys

and 48 percent of adolescent girls ate breakfast on 2 or fewer days during the week (Centers for Disease Control 1989). The combination of a typical teenage diet and consumption of alcohol may be especially problematic for growth and development, because of the substitution of alcohol for high-energy foods such as carbohydrates and protein.

Only two empirical studies have examined the relationship between adolescent alcohol intake and nutritional status. Farrow and co-workers (1987) studied male adolescents in a county detention facility, and found that those who used alcohol and marijuana consumed

more snack foods. These subjects also displayed greater symptoms of poor health, including weakness, gastrointestinal complaints, bleeding gums, memory loss, nervousness, and insomnia.

It is well known that adults who consume alcohol experience enhanced absorption of dietary iron, which is deposited in the liver and may be a precursor to liver damage. Friedman and co-workers (1988) used data from the National Health and Nutrition Examination Survey of 591 males and 614 females to document that adolescents who use alcohol also have increased levels of serum iron.

Eating disorders are most commonly observed in adolescent or young-adult females, although they have been reported to occur also in males. Researchers have documented associations between alcohol abuse and the eating disorders bulimia (purging) and anorexia nervosa (self-induced starvation) (Eckert et al. 1979). A recent survey of 1,728 10th-grade students revealed that 13 percent (mostly females) engaged in some form of purging behavior (Killen et al. 1987), and such females were more likely to drink and to drink heavily. A case of severe alcoholic hepatitis was reported in a bulimic adolescent who used alcohol only moderately (Cuellar et al. 1987).

In summary, although the effects of alcohol on nutritional health during adoles-



The abuse of alcohol and other drugs by teenagers can lead to serious accidental injuries. © Bob Daemmrich/UNIPHOTO

cence are not fully known, data on adults and evidence from a few recent studies on adolescents suggest that nutritional deficiencies in adolescents probably affect the relationship between alcohol consumption and adverse health.

EFFECTS OF ALCOHOL ON DEVELOPMENT DURING PUBERTY

Puberty is an important physical and psychosocial process occurring during adolescence. The effects of alcohol consumption on this process have not been studied adequately. Studies on animals and adult humans nevertheless suggest that alcohol can disrupt some of the biological mechanisms involved in physical growth that occurs during puberty (Van Thiel 1983). Normal physical growth is dependent on a complex interaction between genetic, hormonal, and environmental influences.

Both acute and chronic alcohol consumption suppress the levels of growth hormones that are important for postnatal bone and muscle development (Van Thiel 1983). Ultimate adult height depends on the adolescent growth spurt. Research is needed to determine whether alcohol intake during adolescence could affect height, because of alcohol's effect on growth hormones.

Alcohol consumption decreases gonadal steroid production, but enhances adrenal hormone production and secretion (Cicero 1983). Gonadal steroids, particularly androgens, are essential for bone and muscle development. Research is needed to determine whether increased production of adrenal hormones can cause premature closure of the epiphyses (endparts of long bones, which eventually fuse to the bones), thereby reducing a person's potential height.

In adult males, prolonged alcohol consumption has a toxic effect on the testes, decreasing levels of

testosterone. Also, because alcohol consumption can enhance the conversion of testosterone to estrogen, estrogen levels increase. In adult females, alcohol consumption disrupts the menstrual cycle. Alcohol can delay maturation of the follicle, which contains the egg, preventing ovulation and leading to decreases in levels of progesterone (Välimäki et al. 1984). Also, alcohol consumption can cause an increase in levels of testosterone in females. Overall, these processes may lead to feminization in males and masculinization in females. Studies of effects of alcohol consumption on the endocrine systems of young people are underway.

EFFECTS OF ALCOHOL ON NEUROPSYCHOLOGIC FUNCTION

Chronic alcoholics exhibit a variety of neurologic and neuropsychologic impairments. In one study, between 45 and 70 percent of alcoholics in treatment facilities exhibited deficits in a variety of neuropsychologic areas, including memory, abstraction, and motor capacity (Parsons and Leber 1981). Deficits in cognitive performance appear to have multiple causes, including direct effects of alcohol on the brain, indirect effects related to coexistent medical illnesses, and envi-

ronmental factors such as head injury and malnutrition (Tarter and Edwards 1986).

There is little data concerning the effects of alcohol on cognitive processes during adolescence. One study found evidence of motor dysfunction in young male alcoholics (Alterman et al. 1984). The effects of chronic alcohol consumption on brain function have been studied extensively. The effects of alcohol consumption on cerebral function of the maturing adolescent brain merit study.

It is well known that consumption of alcohol can cause fluctuations in the body's blood-glucose level. A hypoglycemic response is observed occasionally following moderate alcohol consumption, and can be severe in people who are fasting or are carbohydrate deficient (Marks 1978). Hypoglycemia causes nervousness, restlessness, and an inability to concentrate. Coupled with likely deficiencies of calories and nutrients, these effects could potentially result in learning difficulties for the student who consumes alcohol. More research is needed to establish whether this is the case. The acquisition of new knowledge and skills is crucial during the adolescent years; therefore, it is important that future researchers assess the influence of alcohol and substance use on cognitive development.

EFFECTS OF ALCOHOL ON THE LIVER

Alcohol-related cirrhosis of the liver, which is thought to result from prolonged alcohol consumption, typically is manifested in the fourth or fifth decades of life. A few studies documented early onset of alcoholic liver disease (earlier than the age of 35) (Novick et al. 1985; Sarin et al. 1988). Risk factors for the early onset of hepatic disease—which need to be confirmed—include a family history of alcoholism (Arria et al. 1990), genetic risk factors (Saunders and Williams 1983), and the use of intravenous drugs (Novick et al. 1985).

It generally is assumed that for adolescents, hepatic complications of alcohol abuse are a clinical rarity. It is true that cirrhosis is diagnosed infrequently in young adults (Garagliano et al. 1979; Vingilis and Smart 1981). Nevertheless, alcoholic liver disease might begin in adolescence. Whether adolescents who abuse alcohol and are asymptomatic during adolescence eventually develop clinical

signs of liver disease as young adults needs to be documented by long-term studies. Because of the shift of first experience with alcohol to an earlier age, it is possible that the following decades will reveal a corresponding shift in the age-specific incidence rates of cirrhosis.

A recent study of more than 100 medical records indicated that 20 percent of alcohol-abusing adolescents admitted to a psychiatric treatment facility showed evidence of liver injury, evidenced by elevated liver enzymes (Arria et al. in press). This group had a significantly higher mean age than did the subjects without liver injury (17.4 years versus 15.3 years). Also, the group with elevated liver enzymes included a greater percentage of males. Further work is needed to determine (1) factors that can be used to predict the likelihood of early hepatic injury, and (2) whether early hepatic injury is a marker for subsequent alcoholic liver disease.

Vingilis and Smart (1981) pointed out methodological difficulties in studies of the physical consequences of alcohol use by youth. In particular, they emphasized the lack of controls in investigations and problems in diagnosing alcohol-related health effects in light of confounding influences. In their report they noted the results of physical examinations of seven adolescents admitted to an alcohol research center in Toronto. One adolescent displayed minimal evidence of liver injury, and two others reported experiencing blackouts and signs of withdrawal. The average duration of alcohol use in this small sample was 2 years, and the average daily alcohol consumption was 9.9 ounces.

FUTURE DIRECTIONS

There is a great need for information about the physiological effects of adolescent alcohol use. To understand the extent to which alcohol can affect developing systems, researchers must study the functioning of several different organ systems in each subject, so that interactions between systems can be determined.

Researchers must also investigate the relationship between physiological and psychological development. An example of this kind of work is the study of the interaction between depression and immunologic function in adolescent alcohol abusers. It is well known that both alco-

hol and depression can affect the activity of natural killer cells—one measure of immune function. Preliminary data suggest that the presence of both factors is more deleterious to immune function than is the presence of either factor alone (Irwin et al. 1990). And, indeed, alcohol use and depression often coexist, especially in females. Finally, studies in basic science are needed to confirm the work of clinical investigators and to serve as starting points for clinical investigations. ■

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Just Say Y.E.S.

Matching Adolescents to Appropriate Interventions for Alcohol and Other Drug-Related Problems

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The past 10 years have seen a dramatic increase in the number of adolescents with behavioral and psychological disorders, many associated with the use of alcohol and other drugs. In response to the complex and largely uncoordinated adolescent treatment network, the Y.E.S. program for the early identification, referral, and treatment of adolescent abusers of alcohol and other drugs was developed.

A recent expert committee report (National Institute of Mental Health 1990) stated that America is wasting its most precious natural resource: its children and youth. More than 12 percent of America's children and adolescents suffer from mental disorders, and many of these disorders are associated with the use of alcohol and other drugs. On the basis of 1988 household survey data (Gerstein and Harwood 1990), an estimated 396,000 adolescents have a clear and probable need for treatment. Although progress has been made in the development of treatment services for this population, the complex child and adolescent service system is still uncoordinated, expensive, and of unknown effectiveness. Recent attempts to understand and to improve adolescent treatment services (Institute of Medicine 1990; Tarter 1990; Gerstein and Harwood 1990) have

inspired new service models, similar to the one described in this article.

Youth Evaluation Services (Y.E.S.) is an assessment and case management program for the early identification, referral, and monitoring of adolescents in need of intervention services for alcohol and other drug problems. This article describes the rationale and the procedures used in designing the program, and in guiding client assessment, treatment planning, and case management. A review of data from the program's first 200 clients is provided to illustrate clinical profiles, alcohol and other drug use patterns, and treatment needs. The initial experience of the Y.E.S. program demonstrates the complex diagnostic profile typical of youth involved with alcohol and other drugs, and the need for better coordination among the components of the treatment referral network for adolescents.

TOWARD A NEW CONCEPT OF ADOLESCENT TREATMENT SERVICES

The Y.E.S. program grew out of the Regional Youth Substance Abuse Project (RYSAP), a community-based effort to coordinate regional alcohol and other drug abuse services into a continuum of care that would be accessible to urban, suburban, and rural adolescents in the Greater Bridgeport (Connecticut) region, which includes Connecticut's poorest city as well as its most affluent suburbs. As the concept for the program developed, it was decided that an independent assessment and case management agency should serve as the catalyst for the identification of cases, coordination of treatment, development of new services, and containment of service costs. To understand the development of the Y.E.S. program, it is necessary to review three

related approaches to the planning of services for adolescent abusers of alcohol and other drugs and how they contributed to the Y.E.S. concept.

The first approach, the Chemical Dependency Adolescent Assessment Project (Henly and Winters 1988), focused primarily on the development of a self-report diagnostic instrument, the Personal Experience Inventory (PEI). The PEI was validated in part on clients admitted to an independent adolescent evaluation unit in Minnesota, and has

abuse through a variety of cooperating community agencies. Clients who are found to have alcohol and other drug abuse problems are referred for a more systematic evaluation based on an objective, sequential assessment procedure. The final component of the IOM model is the referral of clients to appropriate services by means of guidelines for matching treatment needs with appropriate treatment services. As conceived by the IOM committee, identification, assessment, and referral should be orga-

The Y.E.S. program, while influenced by each of these approaches, added new components designed to create better linkages between the referral sources, the assessment agency, and the service network. In the Y.E.S. program, as illustrated in Figure 1, *screening* is conducted in a variety of community settings, including the courts, schools, and human service agencies. *Referrals* can come directly from adolescents, their families, or their physicians. Y.E.S. serves as a central assessment and case management

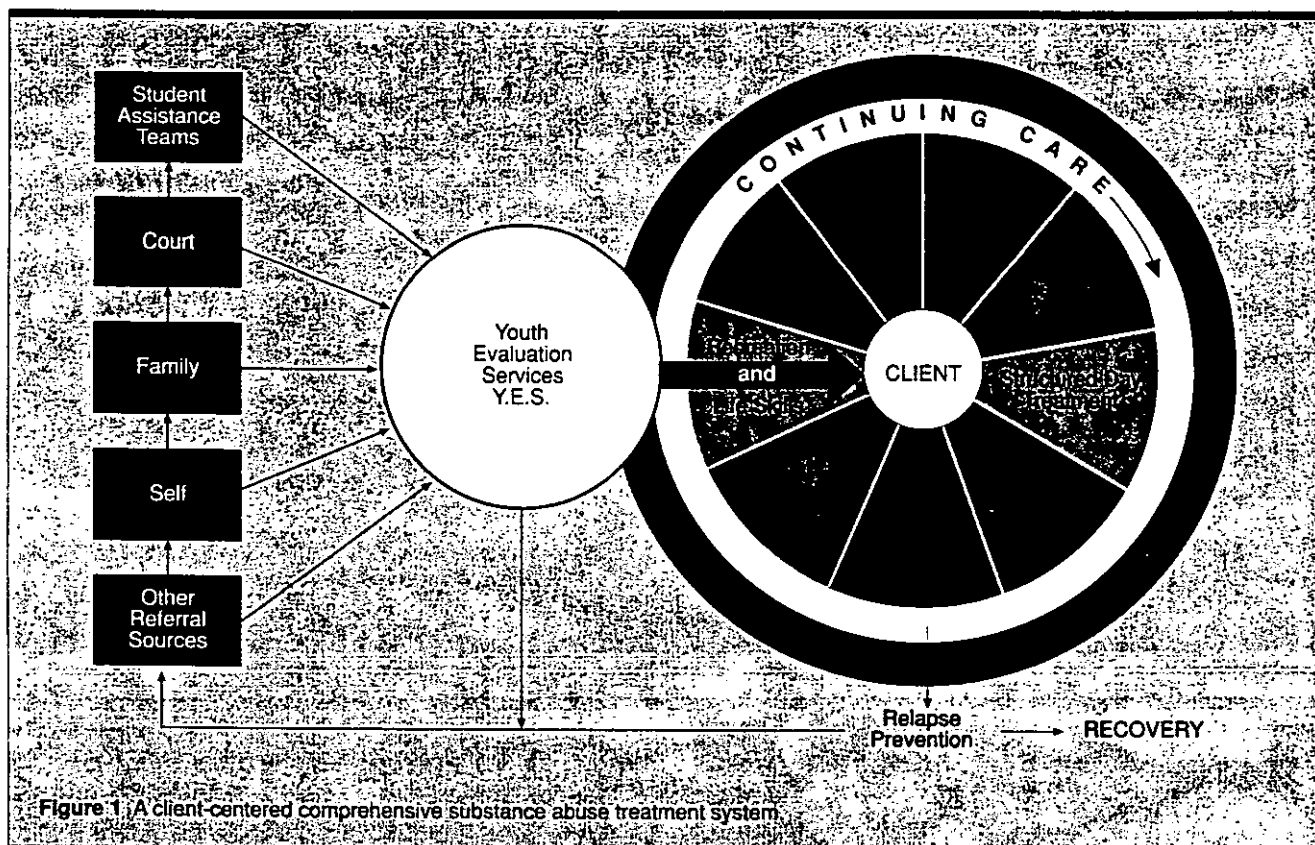


Figure 1: A client-centered comprehensive substance abuse treatment system

demonstrated its usefulness as a tool for diagnostic evaluation, treatment planning, and treatment referral (Winters and Henly 1987). The PEI is part of the Y.E.S. program assessment procedure, and will be discussed in more detail later in this article.

The second approach is one recommended by the Institute of Medicine (IOM) expert committee's report, *Broadening the Base of Treatment for Alcohol Problems* (1990). The IOM report describes a hypothetical treatment service system that includes the early identification of alcohol and other drug

nized within independent assessment and case management agencies that have no financial, professional, or ideological interest in any particular form of treatment.

The third approach, which is similar to the integrated approach proposed by the IOM committee, is the Adolescent Assessment/Referral System (AARS) developed by the National Institute on Drug Abuse (Rahdert 1991; Tarter 1990). The AARS is organized around a multidimensional screening procedure used to filter positive cases into a more extensive battery of diagnostic tests to provide information for treatment referral.

service for all referrals. A sequential *diagnostic assessment* battery is designed to yield the most appropriate and least costly *treatment plan*. *Case management* is intended to guide the client through the service network.

As illustrated in Figure 2, the Y.E.S. assessment and case management system comprises six complementary but independent components. The first component consists of initial identification procedures to screen and to involve adolescent users of alcohol and other drugs and their families in the program. The second component consists of a core

evaluation that focuses on substance use, psychosocial functioning, and psychiatric history. A related supplemental evaluation (the third component) collates data from clients, parents, student assistance teams (composed of teachers and administrators trained to identify students whose personal or social problems are interfering with their school performance), school officials, and outside specialists to develop a comprehensive diagnostic picture of the client's treatment needs. Following this assessment phase, the

tions describe these components in greater detail, using client diagnostic data and the results of an initial program evaluation to illustrate how the system performs in practice.

SCREENING AND RECRUITMENT

Screening is a brief, efficient way of identifying individuals at risk for developing a problem. It is sometimes distinguished from case finding, which

the Y.E.S. program are summarized in Figure 3, based on data obtained from 200 Y.E.S. clients. Approximately 50 percent of Y.E.S. referrals for both males and females come from student assistance teams. The other major sources of referral for both males and females are the judicial system and community service providers. If adolescents are considered in need of assessment, they are referred to Y.E.S. for further screening and diagnostic evaluation. At that time, Y.E.S. initiates its own formal screening

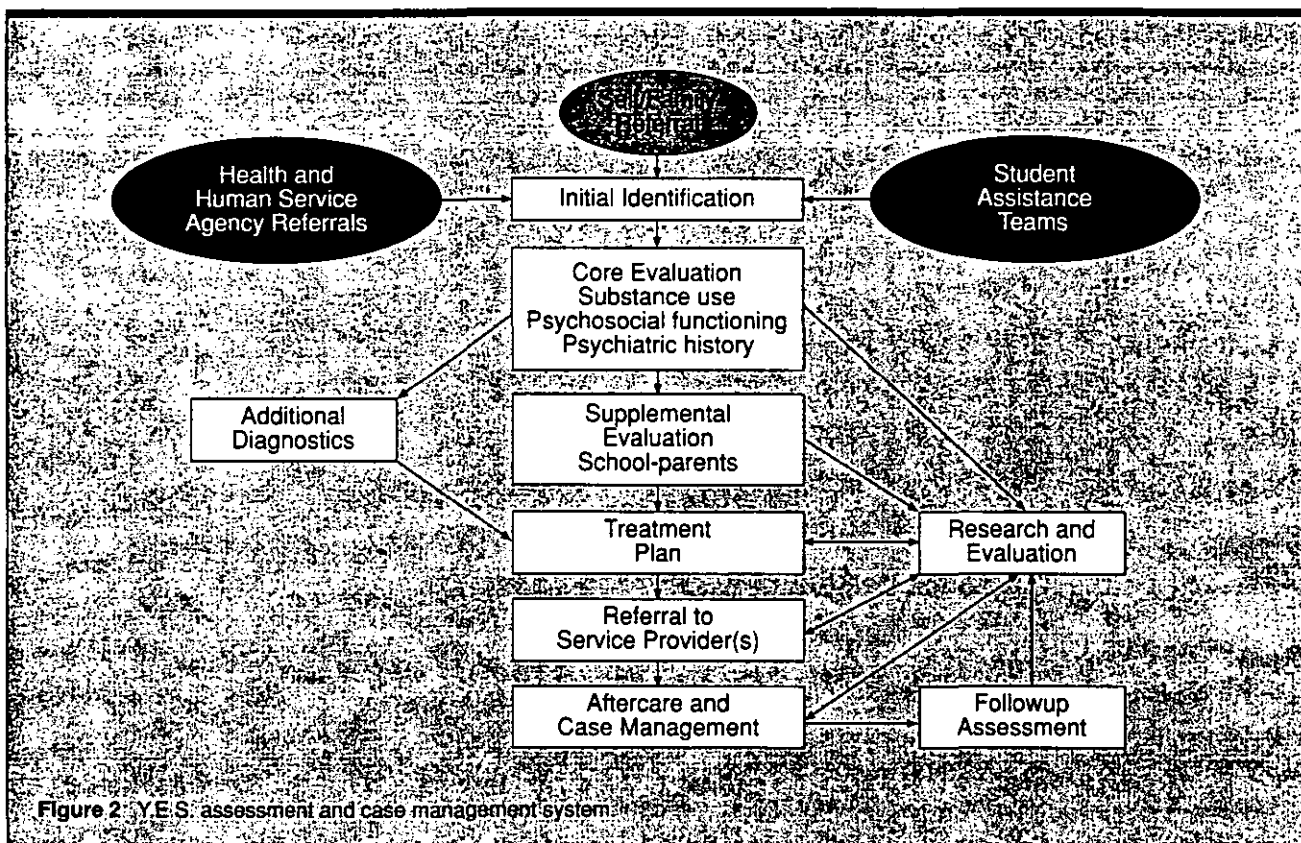


Figure 2 Y.E.S. assessment and case management system

fourth component of the Y.E.S. program is the development of a treatment plan designed to address the client's current alcohol and other drug use problems and to prevent the recurrence of problems. This is accomplished by the fifth and sixth components, referral and case management. Referral is based on a systematic set of treatment-matching criteria developed for this program, while case management consists of a regular program of consultations among the client, the client's family, service providers, school personnel, and the Y.E.S. case management team. The following sec-

involves the identification of those who have already developed a health problem or psychological disorder that warrants treatment. Because the Y.E.S. program is interested in both high-risk youth and those youth who have already developed alcohol and other drug use problems, we will use the term "screening" to refer to both early identification and case finding.

Preliminary screening is conducted through a variety of referral sources that have been advised of the Y.E.S. program's capabilities and role through public announcements and personal contacts. The major referral sources working with

procedure as the first stage of a multidimensional, sequential assessment.

ASSESSMENT

A thorough, comprehensive assessment of the client is required for clinical decision making, management information reporting, objective documentation of the need for treatment, and outcome evaluation. There is a growing literature (McCord and McCord 1960; Kandel 1973; Jessor and Jessor 1975; Kellam et al. 1983; Robinson et al. 1987; Newcomb

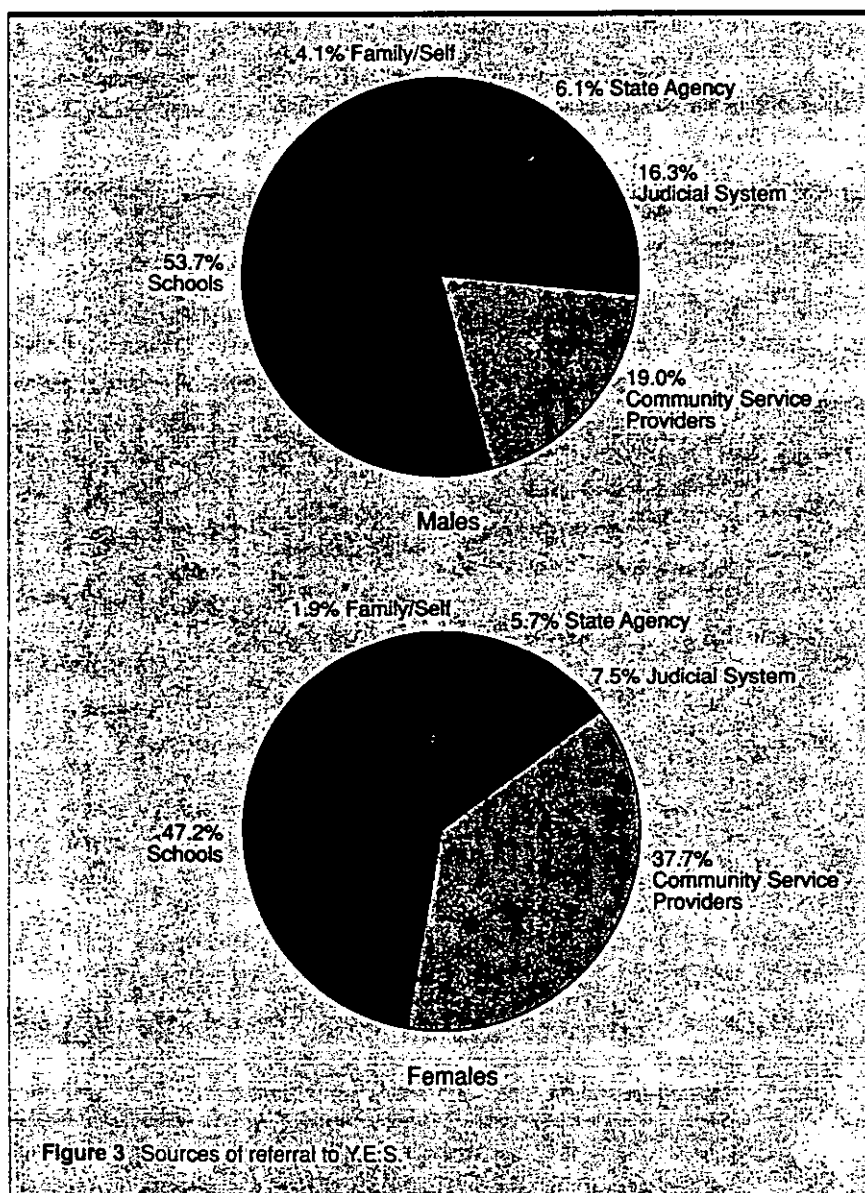


Figure 3 Sources of referral to Y.E.S.

et al. 1987; Henly and Winters 1988) which indicates that the nature, severity, and course of adolescent alcohol and other drug use can be estimated by means of assessment procedures that focus on demographic characteristics, personality factors (e.g., shyness and aggressiveness), childhood vulnerability (e.g., hyperactivity, attention deficit disorder), poor academic achievement, early use of "gateway" substances, emotional distress, peer relationships, family history of alcohol or other drug abuse, family dysfunction, psychopathology, and prior involvement with the legal system.

Adolescent alcohol and other drug use problems generally are assessed using unstandardized questionnaires or clinical interviews. Until recently, there have been no generally accepted assessment protocols for screening and diagnosing adolescent alcohol and other drug users, and guidelines have not been available for assessing treatment needs and matching these needs with appropriate interventions. To address the historical lack of accepted assessment protocols and guidelines, Y.E.S. program consultants selected both a battery of diagnostic instruments specifically developed for ado-

lescents and a procedure for evaluating and treating adolescent users of alcohol and other drugs recently developed by an expert committee of clinicians and scientists commissioned by the National Institute on Drug Abuse (Rahdert 1991). This procedure consists of three stages: (1) identification of health problems, psychiatric disturbance, and psychosocial maladjustment by means of a brief screening instrument; (2) a detailed diagnostic evaluation of the problems identified in the screening stage; and (3) formulation of a treatment plan to address the medical, psychiatric, and psychosocial problems identified in the screening and diagnostic assessments.

The first stage of the assessment procedure for the client is a general orientation to the Y.E.S. program. The assessor conducts a semistructured personal interview with the client to record the presenting problem, treatment history, and relevant demographic, medical, and psychosocial information. This is followed by administration of the Problem-Oriented Screening Inventory for Teenagers (POSIT), a 139-item questionnaire (Rahdert 1991) designed to measure problem severity in 10 domains that often are related to alcohol and other drug abuse and that are amenable to treatment intervention.

The 10 domains of the POSIT are presented in Table 1, along with the proportion of males and females in the first cohort of Y.E.S. clients whose responses indicated a need for further evaluation. These clients (72 percent male; 28 percent female) had an average age of 16 years. Although the majority were Caucasian (54 percent males; 62 percent females), a significant number of African-American and Hispanic youth were referred to Y.E.S. More than 50 percent of the male sample screened positive for problems in the areas of substance abuse, family relationships, peer relationships, educational status, and aggressive behavior/delinquency. Significant proportions of the females screened positive in many of these same categories. These data clearly reflect the multidimensional nature of problems associated with adolescents' use of alcohol and other drugs, and suggest that their use often is embedded in a broader context of problem behavior and psychopathology.

The second, diagnostic stage of the assessment procedure consists of further evaluation in those areas identified as problematic in the screening stage.

Following the previously mentioned AARS protocol, a number of standardized assessments are recommended for more intensive evaluation. Table 2 lists the data collection procedures of Y.E.S. in terms of method, source, time requirements, and purpose. An essential component of the core diagnostic battery consists of the previously mentioned Personal Experience Inventory (PEI), developed by the Chemical Dependency Adolescent Assessment Project (Winters and Henly 1987).

The PEI is a 300-item paper-and-pencil questionnaire that assesses two broad content areas: (1) symptoms, problem severity, consequences, and patterns of alcohol and other drug use; and (2) genetic, sociodemographic, intrapersonal, social, and environmental influences. An important diagnostic area covered by the PEI is alcohol and other drug use. The data pertaining to the patterns of alcohol and other drug use reported by Y.E.S. clients show that alcohol and marijuana are the preferred drugs, and that males are more likely to use marijuana, and females more likely to use alcohol. Although the validity of self-report data is suspect under certain circumstances (e.g., the respondent is intoxicated, the information requested is very sensitive), (Babor et al. 1990a), responses to the PEI questionnaire items among the first cohort of Y.E.S. clients indicate that 15.2 percent of the males and 8.6 percent of the females use alcohol regularly (six or more times a month), and that 41.4 percent of the males and 45.6 percent of the females "get high" or drunk on the majority of drinking occasions. Responses to this questionnaire also indicate that drugs other than alcohol are used regularly by 29.3 percent of males and 17.4 percent of females surveyed. Besides alcohol, the drugs used most regularly by Y.E.S. clients are marijuana (used by 18.8 percent of the males and 6.5 percent of the females) and cocaine (used by 3.1 percent of the males and 10.9 percent of the females).

These data, supported by urine toxicology tests, suggest that many clients referred for assessment do not have regular or serious patterns of alcohol and other drug abuse; the clients have been identified at the point at which they need some type of intervention, but before their problems have become severe. This early identification is one of the primary goals of the Y.E.S. program. In addition, few clients manifest sufficient numbers of de-

Table 1. POSIT Summary Data: Percentage of Clients Scoring Positive on One or More "Red Flag" Items that Strongly Indicate the Need for Further Diagnostic Evaluation.

Domain	Males (N = 135)	Females (N = 50)
Substance Abuse	68.1	70.6
Physical Health Status	42.2	31.3
Mental Health Status	37.0	49.0
Family Relationships	57.0	43.4
Peer Relationships	88.9	84.3
Educational Status	62.9	64.7
Vocational Status	51.1	45.1
Social Skills		
Leisure and Recreation	28.1	19.6
Aggressive Behavior/Delinquency	63.7	49.0

* The Social Skills scale used in the early version of the POSIT employed by Y.E.S. did not contain "red flag" items.

pendence signs and symptoms to warrant medical detoxification. Finally, for most of the moderate and serious cases of drug use, alcohol abuse is an important part of the clinical picture.

The final section of the PEI screens for problems other than alcohol and other drug use (e.g., eating disorders, sexual abuse), using categories that complement those of the POSIT. The percentage of cases in the Y.E.S. sample positive for these other problems, as identified by the PEI, is shown in Table 3. What is striking about these data is the proportion of adolescents who screened positive for psychiatric problems, sexual abuse, physical abuse, family substance abuse, and suicide potential.

When individuals screen positive for other psychopathology on both the PEI and the POSIT, it is recommended that a more systematic diagnostic interview be conducted. The Diagnostic Interview for Children and Adolescents (DICA; Welner et al. 1987) is used to obtain DSM-III-R diagnoses for substance use disorders, conduct disorder, anxiety disorders, and depression. Even if family problems are not suspected, the Family Assessment Measure (Skinner et al. 1983) is given routinely to obtain information about the client's functioning within the family. The Genogram procedure (McGoldrick and Gerson 1985), a family systems assessment popular in human service settings, was added at the request of program staff to facilitate further exploration of family dynamics and intergenerational patterns.

The information generated by the client assessment battery is supplemented

with data gathered from parents, case managers, and schools. Parents are queried by telephone or in personal interviews about the client's alcohol and other drug use, problem behavior, social adjustment, family relationships, and need for treatment services. Case managers complete a brief rating form indicating the need for treatment in a variety of domains, including alcohol and other drug abuse, psychological adjustment, family relationships, and school involvement. Schools provide information on current and past academic performance and involvement in student activities, as well as attendance records and conduct reports. Finally, all clients are asked to provide a urine specimen, which provides objective verification of recent alcohol and other drug use.

TREATMENT PLANNING

Treatment planning involves matching client characteristics with therapeutic needs; finding therapists, programs, and settings that best conform to those characteristics and needs; and bringing the two elements together. An underlying principle of the Y.E.S. approach to adolescent alcohol and other drug abuse is that treatment should be tailored to the nature and severity of the medical, psychological, and social problems identified in the screening and diagnostic stages of assessment. Another principle is that treatment should have targeted objectives whose outcomes can be clearly delineated and measured. Following the procedures suggested by the AARS pro-

Table 2. Y.E.S. Data Collection Procedures

Assessment	Method	Source	Time Required	Purpose
Demographic/ Personal History	Interview	Client/Family	30 min	Provides basic personal and demographic information
POSIT	Interview or questionnaire	Client	20 min	Screens for problems in 10 domains
Personal Experience Inventory	Self-report questionnaire	Client	60 min	Estimates problem severity and risk factors
Family Assessment Measure	Self-report questionnaire	Client/Family	20 min	Assesses family functioning
Genogram	Interview	Client/Family	40 min	Assesses family structure
School Records	Record	School records	30 min	Records baseline data on grades, absences, etc.
Urine Screen	Lab tests	Client	5 min	Verifies verbal report
DICA	Interview	Client	20-60 min	Yields DSM-III-R diagnoses
Followup Assessment	Interview and questionnaires	Client/Parents	60 min	Evaluates client outcomes and satisfaction with services

tolol (Rahdert 1991), and based on a system for translating the assessment data into a set of referral options. Y.E.S. personnel develop specific recommendations for intervention.

This treatment-matching procedure, developed specifically for the Y.E.S. program, is based in part on Skinner's problem-oriented approach (Skinner 1981) and on the Cleveland Criteria (Hoffmann et al. 1987). Both approaches match clients to specific types or intensities of treatment (e.g., self-help group versus residential treatment) on the basis of particular characteristics and behaviors. In addition, in developing the treatment-matching component of the Y.E.S. program, a taxonomy of adolescent services was identified in a comprehensive regional facilities survey (Babor et al. 1990b) and a review of the treatment and prevention literature was conducted. Y.E.S. treatment-matching guidelines are shown in Table 4.

Once the diagnostic profile of the client has been compiled, it is presented to the case management team with a set of treatment options associated with each area of treatment needed. Members of the case management team then draw up a treatment plan based on the diagnostic in-

formation, their own clinical judgment, and the treatment services available in the community. The treatment plan is presented to the client and the client's family with evidence of the need for treatment. Treatment options are presented on the basis of what the case managers believe the client's family will accept and can afford. The client is then assigned to one of the treatment options within a comprehensive continuum of care orchestrated by the case manager.

Although there are few comparative data available on treatment service utilization by adolescents, the Y.E.S. treatment recommendations reflect the wide range of treatment options available in the Greater Bridgeport area. Consistent with the Y.E.S. treatment-matching guidelines, recommendations vary widely in terms of cost and in terms of the intensity of the program (e.g., inpatient and outpatient programs). For example, 29.3 percent of clients are referred to more expensive residential programs, and 26.4 percent are referred to inexpensive programs, such as mutual help groups (11.5 percent) and school programs (14.9 percent). The largest proportion of clients (41.6 percent) are assigned to some form of outpatient treatment.

CASE MANAGEMENT PROCEDURES

The case manager is the staff person who makes the first contact with the client and family, arranges the assessment, participates with the interdisciplinary team in the formulation of the treatment plan, presents the treatment plan to the client and family and negotiates with them, identifies the appropriate treatment resources, makes referrals for treatment, and follows through with the service provider by sharing assessment information. The case manager also monitors the client's progress in treatment, provides support, and coordinates aftercare services. In addition, administrative staff perform system-specific functions, such as identification of new services, marketing of the Y.E.S. program, increasing accessibility to resources, network development, and advocacy for systems change. This advocacy includes efforts aimed at improvement of existing services in terms of access, quality of access, and quality of care, and the creation of new services that would fill important gaps in the continuum of services. For example, the Y.E.S. program might have 15 Hispanic youths for whom there is no

Table 3 Percentage of Clients Screening Positive for Problems Other than Substance Abuse on the PEI

Problem	Males (N = 121)	Females (N = 46)
Psychiatric Referral	20.7	31.4
Eating Disorder	0.0	29.4
Sexual Abuse	11.9	41.2
Physical Abuse	26.7	37.3
Family Drug/Alcohol History	48.9	58.8
Suicide Potential	18.5	29.4
Overdose Potential	11.9	23.5
Loss of Control	20.7	33.3
Severe Family Problems	45.9	45.1
Psychiatric Problems	31.9	41.2

Spanish-language treatment program; Y.E.S. might then try to expand an existing service or create a new service to meet the needs of these Spanish-speaking youths.

PROGRAM MONITORING

During the first 2 years of the Y.E.S. program's operation, the assessment battery and administration procedures were field-tested and modified as needed in collaboration with the Alcohol Research Center of the University of Connecticut. The center is conducting a comprehensive process evaluation that has been complemented by an epidemiologic school survey, a needs assessment study, and a 6-month followup of a representative sample of 100 Y.E.S. clients.

The epidemiologic school survey was conducted in the Greater Bridgeport region to describe the actual and potential market for Y.E.S., as well as the alcohol and other drug-abusing population not being served by Y.E.S. (Del Boca and Babor 1989). The results indicated that approximately 10 percent of the high school population surveyed is using alcohol and other drugs with sufficient intensity and regularity (six or more times per month) to place them at risk for medical, social, and psychological problems.

A related part of the Alcohol Research Center's research was a facilities survey that mapped the treatment service network in the Greater Bridgeport region (Babor et al. 1990b). The purpose of this survey was to provide referral information to the Y.E.S. program, to develop a baseline assessment of the nature and integration of the service network at the beginning of the Y.E.S. initiative, and to

generate estimates of the costs of local services most likely to be used by Y.E.S. clients. The survey and its accompanying needs assessment indicated that the demand for services is only a small proportion of the estimated need in the region. This suggests that adolescents and their families are reluctant to seek services, and that more active screening and recruitment efforts are needed in the schools and in the broader community.

The 6-month followup evaluation was designed to gather information about changes in alcohol and other drug use, current psychosocial adjustment, service utilization, satisfaction with services, and service costs. Although the outcome study by the University of Connecticut Alcohol Research Center is still under way, preliminary analysis of data from the first 40 Y.E.S. clients indicates that service costs for the various treatment options ranged from zero to \$67,000, with an average client cost of approximately \$8,000. The data also indicate that the more seriously impaired clients are being referred to inpatient services, which is consistent with the treatment-matching guidelines and cost containment priorities of the Y.E.S. program.

A final aspect of the research at the Alcohol Research Center is a process evaluation designed to measure the effects of the program against its goals. The Y.E.S. program was intended to put into practice critical elements of an idealized model of assessment and case management in order to reduce the prevalence of alcohol and other drug abuse, and to improve the quality, availability, and cost-effectiveness of treatment services. As the first 2 years of practical experience have shown, social service programs such as Y.E.S., and the

environments in which they operate, are not as neat and accommodating as the evaluator would expect.

OBSTACLES ENCOUNTERED DURING THE EARLY PHASES OF Y.E.S.

Although independent assessment and case management are obvious in concept, they are services that many payors (e.g., insurance companies) and providers (e.g., inpatient treatment programs) are reluctant to take advantage of without some incentive to change their usual manner of business. School-based student assistance teams, initially expected to be a primary means of recruiting Y.E.S. clients, experienced difficulties in identifying and referring adolescents, whose parents often are reluctant to deal with an unfamiliar part of the social service territory. Soon after the Y.E.S. program was established, barriers were encountered in the health care financing system that influences the affordability of assessment and case management for the typical family. Competition and rivalry within the existing service network also were encountered, so that Y.E.S. had to compete like any other program in a complex economic environment.

Within the Y.E.S. program itself, additional obstacles to realizing the original concept were encountered. As a consequence of low recruitment rates, staff allocated considerable time and effort to marketing the program's services and to building relationships with potential sources of referrals. Case managers with clinical backgrounds frequently found it difficult to effectively utilize the objective assessment instruments, and subjective clinical judgments tended to dominate the treatment-planning process. Prior experience of staff contributed to the development of a family systems orientation toward assessment and diagnosis, rather than a medical/psychiatric or psychometric model; this made it difficult to obtain third-party reimbursements, thus delaying the ability of the program to become self-sufficient. Finally, the case management function of Y.E.S. developed slowly, driven more by the needs of individual clients than by a coherent philosophy of case management or specific procedural guidelines.

The emphasis on cost containment in the idealized program model was difficult to translate into specific program policies. Treatment referrals were based on the quality of care offered by providers, and cost containment considerations were minimized. Low rates of client referrals gave Y.E.S. little leverage in terms of brokering treatment services; formal agreements with human service agencies, HMOs, and other relevant organizations were slow to develop. Finally, the current system of health care financing (which includes public assistance and insurance provided to employees, among other components) is extremely complex and created problems as Y.E.S. attempted to evolve into a self-sufficient, fee-for-service program.

The obstacles that Y.E.S. encountered during the early phases of its operation, although not fully anticipated, are not surprising considering the nature of the existing treatment delivery system for adolescent abusers of alcohol and other drugs. Within the context of this system, Y.E.S. has evolved in response to many challenges, and currently has a steady flow of clients; enjoys good community relations; and has been highly successful in placing clients, particularly those with limited financial resources, in appropriate treatment settings. Program evaluation data indicate that 77 percent of those clients completing the diagnostic evaluation were successfully referred to treatment and followed the recommended treatment plan. Interviews with the parents of the program's first 100 clients, 6 months after the diagnostic evaluation, revealed a high degree of satisfaction with Y.E.S. services. More importantly, 66.1 percent reported that their child's general functioning had improved, while only 10.7 percent reported that it had deteriorated. The program's continued development and success will depend on the ability of Y.E.S. administrators to formulate a viable business plan and to secure financial support for the future.

SUMMARY AND CONCLUSIONS

During the past 10 years, there has been a dramatic increase in the number of adolescents identified with and treated for behavioral and psychological disorders, with alcohol and other drug abuse figuring prominently among the reasons for treatment referral. Epidemiologic and program evaluation studies have provid-

ed some insight into the characteristics of adolescent substance abusers (Beschner 1987; Loney 1988; Johnston et al. 1988; Hubbard et al. 1989). Consistent with the clinical profile of Y.E.S. clients, these individuals demonstrate psychological disturbances (anxiety, depression), rebelliousness, poor school performance, delinquency, and personality disorder, especially sociopathy. After alcohol, marijuana is the primary drug of use, although multiple drug use in conjunction with frequent alcohol intoxication is often a distinguishing characteristic of the clinical picture. Their family, social, and personal problems, as well as their patterns of substance abuse, differ sufficiently from those of adult abusers to warrant different treatment approaches (Beschner 1987). Seeking help is a complex process for these individuals that often is precipitated by school, family, or legal problems, rather than by alcohol or other drug abuse itself. Treatment evaluation studies (Hubbard et al. 1989; Rahdert and Grabowski 1988), while somewhat inadequate because of methodological limitations and sampling difficulties, suggest that treatment interventions can be effective both in reducing alcohol and other drug use and in improving psychosocial functioning.

With the growing recognition of the enormous societal and personal costs of alcohol and other drug abuse, there is a pressing need for an improved knowledge base in at least five critical areas: (1) screening and early identification of adolescent substance abuse; (2) diagnostic evaluation procedures in a variety of interrelated social and psychological ar-

reas; (3) criteria for treatment matching and referral; (4) treatment efficacy associated with the many different therapeutic interventions; and (5) case management and coordination of services.

As mentioned previously, Y.E.S. is the focus of a research demonstration project, being conducted by the University of Connecticut Alcohol Research Center, which is attempting to improve the knowledge base in these areas. After 2 years of operation, the program has been successfully established, along with an onsite evaluation component. More than 300 adolescent clients have been referred and subsequently evaluated by means of a 6-hour assessment battery. The assessment battery has performed well in terms of client acceptance, information feedback to parents, and usefulness for treatment planning. Most clients have been referred to treatment and intervention services, using treatment assignment guidelines that link the diagnostic test results to specific referral options. To the extent that the mix of inner city and suburban youth recruited from the Greater Bridgeport area is representative of adolescents in other metropolitan areas, the experience of the Y.E.S. program should be useful to program planners and policy makers. As process, outcome, and followup data continue to be analyzed by the evaluation team, it should be possible to answer some of the important policy and clinical questions that are currently being asked about assessment and case management for adolescent alcohol and other drug abusers. ■

Table 4. Y.E.S. Treatment Matching Guidelines for Alcohol and Other Drug Abuse

Problem Severity	Category of Service	Criteria Used to Match Clients to Treatment Programs
Low	School programs	PEI Problem Severity Scales PEI Clinical Scale C
Moderate	After school programs Intensive outpatient programs	DSM-III-R Diagnosis of Substance Abuse Urine results Mode of administration
Severe	Therapeutic community Inpatient programs	DSM-III-R Diagnosis of Substance Dependence Substance-related problems in multiple domains

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CHAPTER 13

GLOSSARY

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42 CFR: Federal Regulations governing confidentiality of substance abuse treatment clients.

8-ball: One-eighth of an ounce of cocaine which is the equivalent of 3.5 grams in the metric system. An ounce contains 28.35 grams. While a gram of cocaine may sell for about \$100, an eight-ball may sell for \$250 to \$300 indicating a discount for buying in a larger quantity.

AAIM: Alliance Against Intoxicated Motorists

abstinence goal: A treatment goal of no substance use (as opposed to a goal of "controlled" use).

abstinence: No use of substances.

ACEC: Alcohol Counseling and Education Center; an agency of Salt Lake County Criminal Justice Services. ACEC serves court referrals convicted of substance related misdemeanors, supervising probation and arranging treatment and ancillary services.

Acetylcholine (ACh): Acetylcholine (ACh) is the primary neurotransmitter in the central nervous system and the only neurotransmitter in the peripheral nervous system. Nicotine substitutes for acetylcholine in the nervous system.

ACoA: Adult Children of Alcoholics.

alcohol amnestic episode: See alcohol blackout.

alcohol abuse disorder: (1) A maladaptive pattern of alcohol consumption which interferes with social, occupational, psychological, or physical functioning or (2) persistent use of alcohol in situations which are physically hazardous. (This definition is paraphrased from the DSM-III-R, q.v.).

alcohol blackout (more properly called alcohol amnestic episode): A period of alcohol induced amnesia sometimes experienced by persons who are intoxicated on alcohol. During the episode of amnesia the affected person may not even appear intoxicated to the casual observer. Alcohol blackout does not refer to fainting or losing consciousness during intoxication.

alcohol-induced amnesia: Alcohol blackout (q.v.).

alcohol dependence disorder: The cluster of symptoms including distorted thought process, behavioral problems, and biological disturbances which indicate that the person cannot control the intake of alcohol or use alcohol in spite of consequences which diminish the person's quality of life. (This definition is paraphrased from the DSM-III-R).

alcoholic denial: Lack of acknowledgement by the drinker that alcohol is a problem in his/her life.

alcoholism: The "disease" of consuming alcohol to such an extent that a person experiences significant detriments in functioning in such social, occupational, psychological, or physical areas. More precise terms are alcohol abuse disorder and alcohol dependence disorder (q.v.).

alkaloids: Nitrogen containing base chemicals from plants which are physiologically active. Nicotine, morphine, and cocaine are a few examples of alkaloids.

amobarbital (sodium): A short to medium acting barbiturate. Proprietary name is Amytal.

amphetamine: A powerful stimulant of the central nervous system with many effects and side effects similar to cocaine. Methamphetamine is closely related.

arithmetic progression: A sequence of numbers in which each number is formed by adding a fixed constant to the number before it. Important for understanding the rate at which alcohol is eliminated from the body.

Ativan: One brand name for lorazepam, a benzodiazepine prescribed for sleep.

attrition rates for treatment programs: Decrease of caseload size through successful and unsuccessful discharge of clients.

auditory hallucinations: Hearing sounds which are not actually present. Can be a symptom of physical withdrawal from central nervous system depressants, notably alcohol.

authoritarian discipline: A parenting style of discipline which precludes offspring from having any involvement or discussion.

aversion therapy: Therapy based on the premise that negative experience related to substance use will decrease the compelling nature of the substance use. A form of behavioral modification.

BAC: Blood Alcohol Content or amount of alcohol in the blood. Most states have a legal blood alcohol content level for drunk drivers of 0.10%, with the remaining states having 0.08% BAC.

BADD: Blacks Against Drunk Drivers

bad trip: A recreational use of a hallucinogenic drug which leads to panic or psychotic reaction in the user.

barbiturates: A class of central nervous system depressants used for treatment of sleep and anxiety disorders beginning with the first decade of the twentieth century. In the 1970's medicine turned to other medications, most notably the benzodiazepines. The barbiturates have a high potential for abuse and fatal overdose.

behavioral model: A model of therapy where behavior is modified by the experiences related to use. A behavioral model can be aversion therapy or reframing in a psycho-therapeutic context.

benzodiazepines: A class of central nervous system depressants for the treatment of sleep and anxiety disorders. Beginning in the 1970's, the benzodiazepines have largely replaced the barbiturates. They have the same high potential for abuse as do barbiturates but less potential for fatal overdose.

CODAP: Client Oriented Data Acquisition Process. Management information data concerning demographics and other client information required with federal funds in the early 70's.

cannabinoid: One of the alkaloids (q.v.) in cannabis (marijuana plant).

cannabis: Cannabis refers to the marijuana plant. The marijuana plant contains at least 68 alkaloids, or base chemicals. Some are psychoactive, some are not, and some have not been adequately researched. The most abundant psychoactive substance is called Δ^9 -THC, and it has been researched extensively. Nevertheless, cannabis remains a drug about which more is unknown than known.

carcinogens: Cancer-causing substances.

cardiac arrhythmia: Inefficient pumping action of the heart.

cardiovascular collapse: Fall of blood pressure to the point of threatening life.

Categorical Grants: Federal grants with more restrictive parameters drawn around the use of the funds, creating "categories" of services or populations served. "Categories" are preserved by more stringent monitoring and guidelines than might otherwise be imposed.

CDC: Center for Disease Control

central nervous system (CNS): The central nervous system is the brain and the spinal cord.

certification of a minor: Officially acknowledging adult responsibility for actions performed by a specific minor. Shifting the jurisdiction of adjudication of these acts from the juvenile court to the adult court.

child abuse and neglect reporting: Laws require the reporting of these actions in spite of confidentiality protection.

chloral hydrate: A central nervous system depressant used historically in medicine for treatment of sleep and anxiety disorders. It has a high potential for abuse.

chlordiazepoxide: A benzodiazepine prescribed for anxiety disorders. One proprietary name is Librium.

cirrhosis of the liver: A chronic disease of the liver resulting in many deficient liver functions often but not always caused by chronic exposure to alcohol.

citrated calcium carbamide: An alcohol-sensitizing drug.

clinician: A practitioner who works directly with clients or patients in a clinical or therapeutic setting.

CNS depressants: The central nervous system can be defined by a simple analysis of the words. An analysis of the words leads to two parts: "central nervous system" and "depressants". Central nervous system refers to the brain and spinal cord. Depressant means reducing physiological functioning and arousal. Therefore, central nervous system (CNS) depressants are drugs which reduce the physiological capability of the brain and spinal cord. Some depressants are: alcohol, sedative/hypnotics and narcotics.

CNS stimulants: Stimulant drugs arouse the central nervous system. Because they work in a variety of ways, they are not a cohesive class of drugs as are the CNS

depressants and the opioids. The stimulant drugs are grouped together because of their final action, not because they operate in the same way. A partial list of stimulant drugs includes nicotine, methylxanthine derivatives (e.g. caffeine), amphetamine, and cocaine.

codeine: An opioid drug and ingredient of opium. It is valued because it is a pain reliever which is effective orally.

cognitive therapy: Therapy based on the belief that an intellectual understanding of a person's behavior will contribute to the change of that behavior.

cold turkey withdrawal: To stop the use of a substance one is dependent on with no gradual reduction or medications to ease withdrawal symptoms.

collateral information: Information concerning a client obtained through sources other than the client.

community model: A model of treatment which involves a two way contributing interaction between the client and community.

confidentiality: The right to privacy of a treatment client.

contempt of court: A lack of respect for the court, the judge, or the court proceedings. A judge can issue a warrant of arrest for contempt of court for various reasons including failure to comply with court orders.

control-of-supply theory: The theory that substance use can be controlled by controlling the supply of the substances. Supports interdiction as a strategy, among others. This is opposed to a control-of-demand theory.

controlled drinking: A treatment goal of drinking only in accordance with rational parameters, as opposed to a goal of abstinence.

crack: A form of smokable cocaine. The oily free base of cocaine is contained within the crystals of sodium bicarbonate (baking soda).

cross-tolerance: Tolerance which develops to drugs with similar pharmacological action. Cross-tolerance makes it possible to become tolerant to drugs which one has never used if the user is taking a similar drug. Cross-tolerance makes it possible to substitute one drug for another to ease the pain of drug withdrawal in certain cases.

culturally caused alcoholism: Alcoholism which occurs within a cultural context. For example, protestants have hazy rules around alcohol use while Jews define clearly

where, when, how, and why alcohol is used. The Jewish alcoholism rate is low, while the Protestant is high.

delta-9 THC (delta-9 tetrahydrocannabinol): The primary and most widely studied of the psychoactive chemicals (alkaloids or cannabinoids, q.v.) in cannabis (marijuana).

Dalmane: A benzodiazepine commonly prescribed for sleep. One proprietary name for flurazepam HCL.

Darvon: An opioid often prescribed for pain relief. One of many proprietary names for propoxyphene. Often compounded with aspirin or acetaminophen.

decriminalization of drugs: Removing criminal sanctions but not necessarily civil penalties from the use of currently illicit drugs. Not to be confused with legalization of drugs. (q.v.)

delirium tremens: A withdrawal syndrome from central nervous system depressant drugs, usually alcohol, characterized by frightening visual hallucinations and cardiovascular collapse (q.v.). Sometimes fatal.

dextroamphetamine: A powerful central nervous system stimulant closely related to amphetamine.

diacetylmorphine: The chemical name for heroin which is made by combining morphine with acetyl.

didactic: Lecture; teaching by lecture method.

Dilaudid: The proprietary name for hydromorphone (dihydromorphenone), an opioid drug and potent pain killer approximately eight times stronger than morphine.

distribution/possession: Legal terminology for controlled substance charges. Possession will be charged on smaller, non-packaged, quantities. If scales and packaging material are also found, or larger than personal use quantities, a distribution charge may be filed.

disulfiram: Commonly known by the brand name Antabuse, a chemical which, when ingested and mixed with ingested alcohol, causes the person to be sick. Acts as a deterrent to consuming alcohol. Effects range from none to death, both extremely rare, but most will experience severe nausea.

dolophine: A proprietary name for methadone, a potent, orally effective opioid often used in the treatment of heroin addiction. Methadone was first synthesized by Nazi chemists as a substitute for morphine, and Dolophine was named to honor Adolph Hitler.

dopamine: A neurotransmitter in the central nervous system, which may be necessary to experience pleasure. Cocaine acts on it to prevent its reuptake.

DSM-III-R: The abbreviation for the *Diagnostic and Statistical Manual*, third edition, revised. The DSM-III-R is published by the American Psychiatric Association and is considered by most professionals as the official list and criteria of behaviors considered as mental disorders.

EAP: An Employee Assistance Program.

effects: The action which a drug has on the organism including on behavior. Effects other than those the drug is intended are called side effect (q.v.). It is important to know that *effects vary with dose, route of administration, social setting, and expectations of the user.*

endorphin system: Referring to a family of neurotransmitters (q.v.) called endorphins (q.v.) and their receptor sites in the central nervous system. It is thought that the endorphin system is a biological basis to feeling pleasure and avoiding pain.

endorphins: A family of neurotransmitters (q.v.) thought to be a biological basis to feeling pleasure and avoiding pain.

esophagitis: Inflammation of the esophagus, often seen in persons who consume alcohol in unhealthy amounts.

ethanol: Beverage alcohol. There exist many alcohols, some with pharmaceutical and/or industrial application. Other alcohols often have irreversible toxic consequences, often fatal, even in small amounts for humans and other animals.

ether: A central nervous system depressant commonly used as an anesthetic for surgery until the 1960's. Flammability is a major disadvantage. More recently used as an organic solvent in rendering smokable cocaine (free base) from cocaine HCL (hydrochloride), the powder purchased on the street.

etiology: Beginning; place or circumstance of origin.

expungement: Clearing a person's criminal record by removing all or part of it so it appears that the offense never occurred.

fear of parental rejection: Often the most powerful influence in the moral development of children. Not to be confused with parental rejection.

Federal Block Grants: Federal funding of large categories of services which allow states' options in its use, as opposed to Categorical Grants which have more stringent definitions and accountability, giving little flexibility in choice of services or delivery.

freebase: A form of smokable cocaine, so-named because the cocaine ion is stripped of (free of) the HCL (hydrochloride) ion and the cocaine ion is the most basic form in which cocaine can exist and still have its psychoactive properties. It is an oily substance.

gamma alcoholics: Chronic long term, "last stage" alcoholics according to the Jelenik development chart of alcoholism.

ganglion (plural, ganglia): The point of synapse for muscle controlling neurons from the central nervous system and neurons which actually conduct impulses to the muscle fibers. Numerous ganglia lie along the spine and are part of the path of muscle control throughout the body. Nicotine overwhelms the ganglia and leads to partial paralysis which individuals interpret as relaxation.

geometric progression: A progression of numbers of which each one is a set multiple of the number before it. Important for understanding the concept of half-life (q.v.), the rate at which most drugs, with the notable exception of alcohol, are eliminated from the body.

grand mal seizures: A surge of uncontrolled activity from the central nervous system which results in uncontrollable body movements and unconsciousness. Often the result of unsupervised withdrawal from central nervous depressants, notably alcohol and barbiturates.

guilt: Guilt is intense embarrassment which comes internally from one's own sense of right or wrong or conscience. Most persons who abuse substances suffer guilt and shame (q.v.).

Halcion: The proprietary name for triazolam, a benzodiazepine prescribed for sleep.

half-life: Half-life is the amount of time required for the body to eliminate one-half of the drug present in the body. Most drugs are eliminated according to this geometric progression, that is, with the ratio of one-half eliminated in a fixed amount of time. Drugs which are eliminated according to this geometric progression are virtually eliminated after four half lives have elapsed. At the end of the first half-life, 50% of the drug remains; at the end of the second half-life, 25% of the drug remains; and

the end of the third half-life, 12.5% of the drug remains; and at the end of the fourth half-life, 6.25% of the drug remains. Alcohol is an exception to this rule because alcohol is eliminated according to an arithmetic progression with a fixed amount, rather than a fixed ratio, eliminated in a fixed amount of time.

hallucinogens: The hallucinogens are a group of drugs which reliably alter and distort the perception of one's surroundings. The hallucinogens include LSD, mescaline, peyote, psilocybin, and psilocin.

HB 119: Licensure of Youth Services Programs. An act relating to social service licensing; providing for licensure of nonresidential youth programs designed to provide behavioral, substance abuse, or mental health services.

HB 30: Intoxicated Drivers' Fines. An act relating to persons convicted of driving while under the influence of intoxicating liquors and drugs; providing that persons convicted under statutes or local ordinances may be assessed up to \$150 above any fine imposed.

HB 286: Local Alcohol and Drug Authority. This moved much of the authority for treatment service delivery back to the Alcohol and Drug Districts. This allows more independence in order to meet unique needs of each district.

HB 388: Private Probation Provider Licensing Act. An act relating to occupations and professions; establishing the private probation provider licensing act; providing definitions, board duties and responsibilities; and provided penalties.

HB 87: Brewery Licensee Amendments. An act relating to alcoholic beverages; making technical changes regarding breweries that allow consumption of beer on their premises.

HB 101: Utah Substance Abuse Council. An act relating to State affairs; creating the Utah Substance Abuse Coordinating Council and subcommittees to coordinate State efforts to curb substance abuse.

HB 222: Drinking Driving Intervention and Treatment Act. This provided for interventions with those convicted of DUI and fees on fines to fund rehabilitative treatment.

HB 109: Amendments to Controlled Substances Act. An act relating to controlled substances that are in Federal Law to the Controlled Substances Act.

HB 183: Public Intoxication Treatment Act. This provided for law enforcement officers taking public intoxicants to a detoxification facility as an alternative to incarceration. Funding was provided for through increased revenues from alcoholic beverages.

HB 436: Trial Court Organization and Jurisdiction. An act relating to the judicial code; consolidating District and Circuit Courts; phasing out all Circuit Courts; granting exclusive jurisdiction to Justice Courts over Class C misdemeanors, traffic violations, infractions, and ordinance violations; amending court fees and surcharges; repealing separate fees and consolidating fees into the victim reparation surcharge and increasing the surcharge proportionately; providing for a split in Circuit Court fines between state and local government; increasing authority of city prosecutors; authorizing Judicial Council to recommend reallocation of judgeships when a vacancy occurs; providing limited retirement options; defining the role of magistrates; clarifying the organization and staffing of courts; raising Small Claims and Circuit Court jurisdiction amounts.

heroin: An opioid drug compounded from morphine and acetyl. Approximately three times more potent than morphine.

higher order behaviors: Functions of the brain such as cognition and judgment as opposed to lower order behaviors necessary for basic physical survival.

hydrochloride (HCL): A common chemical ion formed from hydrogen and chlorine. When combined with cocaine it forms a white powder which chemists would refer to as a salt of cocaine.

hydrocodone: An opioid often used as a cough suppressant rather than a pain reliever. Often abused by persons who take doses higher than necessary to suppress cough. One proprietary name is Hycodan.

hydromorphone: An opioid drug and potent pain killer approximately eight times stronger than morphine. Proprietary name is Dilaudid.

hypervigilance: A milder form of paranoia often seen in intoxication and withdrawal from stimulant drugs, such as cocaine, amphetamine, and methamphetamine.

Ice: A smokable form of methamphetamine.

IHRD: Institute of Human Resource Development; a non-profit organization which delivers multiple services to the Utah Hispanic population.

IHS: Indian Health Services

imitation controlled substance: "Look alike drugs" made to appear like controlled pharmaceuticals, usually amphetamine but actually containing caffeine or some other mild and not ordinarily controlled stimulant. Imitation controlled substances are illegal in some jurisdictions.

inpatient: A residential client in a hospital or medical setting.

insularity: The property of some persons' behavior who have limited exposure and experience but do not realize their limitations.

intensive, confrontive group therapy: A feature of some therapeutic communities, that is, treatment programs where the participants live together for months. Intensive, overly confrontive therapy is not effective in outpatient programs and short-term residential programs.

legalization of drugs: The notion of making the use of currently illicit drugs a legal activity. The model can range from free-market controls to highly restrictive governmental distribution.

legislating morality: Using the power of the state to create and enforce laws that may have more to do with religious beliefs than with clearly delineated health and safety factors in the public good.

Librium: The proprietary name of chlordiazepoxide (q.v.).

LSD (lysergic acid diethylamide): A hallucinogenic drug.

MAD: Mothers Against Drugs

MADD: Mothers Against Drunk Drivers

"magic mushroom": Mushrooms of the species, *psilocybe mexicana*, which are highly hallucinogenic.

major tranquilizers: Psychoactive medications primarily prescribed for the control of schizophrenia and other psychotic disorders. These medications are not tranquilizers in the laypersons' sense of causing inebriation and they are rarely, if ever, abused. The preferred term for these drugs is neuroleptic medications. Major tranquilizer is an outdated term meant to distinguish neuroleptic drugs from the so-called minor tranquilizers (q.v.).

mandated by contract: A condition of a contract delineating that the contractee must perform specific duties in order to legitimately receive funds.

mannitol: A sweetener that is not nutritive to humans. It is a powder that is used to cut (dilute) cocaine to allow a larger profit margin for the vendors.

MAO (monamine oxidase): An enzyme in the central nervous system which enables the metabolism of dopamine, norepinephrine, and other neurotransmitters.

matching treatment to client: Matching the environment and modality of treatment to the problem level, substance of abuse, and assets of the client in overcoming the substance problem.

medical detox: The detoxification process which includes the use of medications to mitigate withdrawal symptoms.

medical model: A model of therapy where the major focus of treatment is the application of medications and the milieu that dictates.

meperidine: An opioid drug. One common brand name is Demerol.

meprobamate: A central nervous depressant that was once thought to be a safe substitute for barbiturates. Meprobamate enjoyed a brief spell of popularity until it was replaced by the benzodiazepines.

mescaline: A hallucinogenic drug and the active alkaloid of the peyote cactus plant.

metabolites: Chemical compounds in the body produced by the break down of parent compounds. Most drugs are eliminated from the body first by being broken down into metabolites which are then eliminated. Some metabolites are psychoactive and some are not.

methadone: An opioid which is effective orally with just one dose a day. Often used in the detoxification and maintenance of persons who have become dependent on heroin or other opiodes.

methamphetamine: A powerful central nervous system stimulant closely related to amphetamine. Usually made in clandestine laboratories and sold illegally. Sometimes referred to as crystal meth or crystal.

methylphenidate: The brand name is Ritalin. It is a powerful stimulant of the central nervous system and commonly diverted from legal supplies for abuse. In some children who suffer from Attention Deficit and Hyperactivity Disorder (ADHD), this drug paradoxically causes sedation rather than stimulation.

methylxanthene derivatives: Compounds which cause varying degrees of central nervous system stimulation. Common derivatives include caffeine, theophylline, and theobromine which can be found in coffee, some soft drinks, tea, and chocolate.

minimum mandatory sentence: The legislature has required judges to adhere to sentencing parameters in specific type cases. For example, selling drugs within 1,000 feet of a school will result in a five year minimum sentence.

minor tranquilizers: Used to describe meprobamate and the benzodiazepines to distinguish them from the so-called major tranquilizers (q.v.) or neuroleptic drugs. This outdated term is a misnomer because there is nothing minor about the minor tranquilizers which have a high potential for abuse.

MIS: Management Information Systems. A broad term signifying a computer generated data collection system used to guide management decisions.

MMPI profiles: The results of the Minnesota Multiphasic Personality Inventory and the Minnesota Multiphasic Personality Inventory-2 (MMPI-2).

morphine: Opioid drug and most prominent psychoactive agent in opium.

mythology of poverty: The belief that poverty is the result of personal character deficits of those who are disadvantaged. The denial of the fact that poverty reduces the quality of life for all citizens and not just for the persons who are disadvantaged.

natural consequences: Desirable and undesirable results of behavior. Allowing a person to experience undesirable natural consequences is subtly different from punishment and more effective than punishment in modifying behavior.

neuroleptic: One of a class of drugs often prescribed to control the symptoms of schizophrenia and other psychotic disorders. This term is preferred to the older one of major tranquilizer (q.v.).

neuron: Neuron is the basic nerve cell in the central nervous system and the peripheral nervous system. In the brain the term brain cell could be a synonym, although there are brain cells other than neurons.

neurotransmitter: Neurotransmitter is a chemical in the nervous system which allows one neuron to excite or inhibit the activity of another neuron. There may be upwards of 100 different neurotransmitters. The primary neurotransmitter in the central nervous system and the only neurotransmitter in the peripheral nervous system is acetylcholine (ACh). Two other neurotransmitters are dopamine (DA) and norepinephrine (NA).

nicotine: A psychoactive alkaloid of the tobacco plant which can substitute for acetylcholine, the neurotransmitters of the peripheral nervous system and an important neurotransmitter in the central nervous system.

no-knock warrants: A judge-authorized warrant allowing an officer, or group of officers to enter a residence without knocking. They announce they are police officers as

they are entering. These type warrants are used when a person's life is in danger or when evidence can be destroyed before a person answers the door. These warrants authorize kicking doors in if necessary.

norepinephrine: Norepinephrine is a neurotransmitter in the central nervous system, and its presence may be necessary to experience pleasure. Cocaine acts on it to prevent its reuptake (q.v.).

opioids (opiates, narcotics): The opioid drugs are derived from the dried exudate of the opium poppy, or they are synthesized chemicals with similar properties. A partial list of opioid drugs includes: opium, morphine, codeine, heroin, oxycodone, meperidine, hydrocodone, propoxyphene, hydromorphone, and methadone.

opium: The dried exudate of the ripened pod of the opium poppy. On average it consists of approximately 10% morphine, 2% to 3% codeine.

OSAP: Office of Substance Abuse Prevention. A Federal agency that assists with funding of prevention projects.

outpatient: A form of treatment precluding the patient being on premisses except during specific treatment episodes -- usually individual, group or family therapy in time blocks of 1 to 2 hours.

oxycodone: An opioid often compounded in pharmaceutical mixtures with aspirin and acetaminophen. Common brand names include Percodan, Percocet, and Tylox.

PAAG: Problems Anonymous Action Group, based in Ogden and responsible for many community projects including the PAAG Hotel for homeless and diversion people.

PADA: Pharmacists Against Drug Abuse

PADD: Parents Against Drunk Drivers

pancreatitis: Inflammation of the pancreas often caused by alcohol consumption.

paranoia: A syndrome of delusions of persecution and/or grandeur.

paregoric: A preparation of opium often used to treat diarrhea and/or cramping. Sometimes abused when persons addicted to heroin are unable to obtain heroin.

parenting factors: Styles of raising children, some of which are associated with either increased or decreased substance use by the children.

Pearson Correlation Coefficient: A statistical computation used to analyze the significance, or existence, of a relationship between two independent variables.

peer model: A model of treatment which relies on peers to perform the required tasks.

Percocet: A proprietary mixture of acetaminophen and oxycodone.

Percodan: A proprietary mixture of aspirin and oxycodone.

peripheral nervous system: Those parts of the nervous system beyond the brain and brain stem (central nervous system).

peyote: A cactus sometimes known as mescal from which are derived button growths which can be chewed to obtain mescaline (q.v.).

pharmacotherapy: Treating disorders with drugs.

phencyclidine (PCP): A psychoactive drug with the power to cause hallucinations or central nervous system depression. Sometimes referred to as "angel dust".

phenmetrazine: A pharmaceutical drug with properties of central nervous system stimulation similar to amphetamine. Proprietary name is Preludin.

phenobarbital: A long acting barbiturate often prescribed to control grand mal seizures associated with epilepsy.

phenothiazine: A family of neuroleptic (q.v.) drugs. The proprietary name of its best known member is Thorazine.

phenytoin: A medication with properties of central nervous depression indicated for control of grand mal seizures associated with epilepsy. The common proprietary name is Dilantin.

physical addiction: Physical addiction is the physiological craving for a drug which will temporarily end the withdrawal syndrome. Because certain drugs are capable of inducing physical addiction and some are not, physical addiction can be seen as a property of some drugs. While the connection between physical addiction and continued abuse of a drug seems obvious, the fact is that physical addiction does not explain substance abuse. Some drugs which cause physical addiction are not abused. For example, tricyclic antidepressants are physically addicting, but persons who use them give them up readily.

PL 96 180: Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act Amendments of 1979, 1980.

PL 96 181: The Drug Abuse Prevention, Treatment, and Rehabilitation Amendment of 1979, 1980.

post-traumatic stress disorder (PTSD): A syndrome caused by experiencing a stressor which goes beyond the scope of usual human experience such as chronic and/or brutal abuse, sexual exploitation, combat, disasters, etc. Signs and symptoms include intrusive thoughts, nightmares, grossly impaired interpersonal relationships, etc. Often associated with episodes of major depression, dysthymia (chronic depression), substance abuse and dependence disorders, etc.

potentiation: Potentiation is the multiplying effect from consuming two different drugs at the same time so that the combined effects of both drugs are greater than equal doses of only one of the drugs.

Pre-Trial Services: A division of Salt Lake County Criminal Justice Services Division. Pre-Trial Services provides non-financial releases for defendants booked into the Salt Lake County Jail who qualify for release. A staff of supervised release counselors work with clients throughout their court hearings. This staff also recommends treatment when necessary for clients. Pre-Trial provides a 6-week lifestyles course called CHANCE for people who are awaiting trials or other court proceedings.

probation: Usually given in lieu of incarceration. The sentencing judge usually will require performance of specific terms such as drug treatment, community services, etc. Jail or prison time is usually given as a condition of non-compliance with terms of probation. An officer with the probation department supervises the completion of the terms of probation and reports any violations to the courts.

Provider accountability: Providers of services are accountable to licensure or certification authorities and, if they receive public funds, to governmental funders. They must meet certain criteria established by these organizations and are monitored to assure they do. Providers are also accountable to clients and the public although there is no objective way of measuring the degree to which they meet this accountability.

psychological addiction: Psychological addiction is a person's subjective craving to use a drug. Psychological addiction is an unfortunate concept for two reasons. The first is that it implies that certain drugs cause substance abuse by having the property of psychological addiction. The fact is that the majority of persons exposed to mood altering drugs do not abuse them. For example, only 10% of persons who use alcohol or heroin abuse it. The second reason is that the concept of psychological addiction describes a craving; the concept has no explanatory power,

only descriptive power. Psychological addiction is really a property of a person and not of a drug, and the roots of the concept are in biology, psychology and sociology.

psychopharmacology: The study of the effect of drugs on behavior.

punishment: The deliberate application of an aversive stimulus to modify behavior.

punitive model: A model of intervention based on the premise that punishment will change behavior for the better.

QSOA: Qualified Service Organization Agreement. Under 42 CFR Part 2, certain agencies may share client information if all QSOA conditions are met.

receptor sites: In the central nervous system, the receiving sites for neurotransmitters which excite or inhibit the neurons to which they are attached.

reduced inhibition: Inhibitions are lowered, allowing a person to behave uncharacteristically. Reduction may be caused physiologically or psychologically.

relapse: Reverting to an old behavior which is considered undesirable.

respiratory depression: Reduction of the normal functioning of the respiratory center in the medulla of the brain to the point where respirations may not be sufficient to sustain life.

restitution: An order by the court requiring a defendant to repay the victim or victims of the crime committed when that crime resulted in monetary loss to the victim.

reabsorption: (see reuptake)

reuptake: The process in which a neuron secretes a neurotransmitter, the neurotransmitter affects an adjacent neuron, and then the neurotransmitter is reabsorbed into the original neuron.

reverse tolerance: Reverse tolerance is the capacity to experience the effects of a drug as more intense with repeated use of the same dose.

RID: Remove Intoxicated Drivers

route of administration: Method of consuming a drug into the body such as orally; inhaling gas or smoke; injecting into a vein, artery, muscle, or under the skin (subcutaneously); dissolving into the mucous membranes of the upper respiratory system; dissolving into the eye; dissolving into the mucous membranes of the

system; dissolving into the eye; dissolving into the mucous membranes of the rectum with suppositories; dissolving into the mucous membranes of the mouth under the tongue (sublingual);, etc.

SADD: Students Against Drunk Drivers

SB 109: Liquor Law Enforcement Amendments. An act relating to intoxicating liquors and drugs; providing an increase in the mark-up on intoxicating liquor; providing for distribution of liquor profits to cities, town, and counties, and establishing limitations on the use of those profits; providing for a formula for distribution; increasing the tax on beer; appropriating \$2,000,000 to the Division of Alcoholism and Drugs for alcohol and drug abuse prevention.

SB 7: Reporting of AIDS and HIV Positivity. An act relating to acquired immunodeficiency syndrome; requiring reporting of AIDS and HIV positivity; and requiring partner notification.

SB 115: Teen Drug/Alcohol Intervention and Prevention Act. An act relating to alcoholism and drugs; providing for an educational service for juvenile drug/alcohol offenders and their parents; providing for the establishment of teen drug/alcohol schools; providing that the responsibility for funding of this educational service be borne in part by the juvenile drug/alcohol offender, through the assessment of a fee not to exceed \$40; and providing that the State Treasurer for credit to a special account established within the general fund to be used by the Division of Alcoholism and Drugs for purposes of operating teen drug/alcohol programs in each juvenile court district.

SB 141: Alcoholic Beverage Laws Revisions. An act relating to alcoholic beverages; completely revising the alcoholic beverage control laws of Utah; appropriating \$300,000 from the general fund for liquor law implementation and enforcement.

SB 74: DUI Technical Amendments. An act relating to criminal law; making amendments to clarify sentencing provisions of DUI laws.

SB 106: Creation of the Division of Alcoholism and Drugs. An act...providing for the creation and composition of a Board and a Division of Alcoholism and Drugs within the Department of Social Services; providing for the powers and duties of the Board and the Division of Alcoholism and Drugs; and repealing section 55-13-1.

SB 45: Administrative Subpoenas Act. An act relating to criminal law; providing the Attorney General and County Attorneys authority in issuing administrative subpoenas in controlled substances investigations.

schizophrenia: A mental disorder in which the person loses contact with consensually validated reality to a degree sufficient to impair the person's social, occupational, psychological, or physical functioning for at least six months duration and the break with reality is not associated with known physical factors such as physical disease, brain trauma, drug overdose, etc.

secobarbital: A short to medium acting barbiturate. Proprietary name is Seconal.

Seconal: Proprietary name for secobarbital often referred to as "reds" because they are dispensed in red capsules.

sedative/hypnotic: A drug, usually a central-nervous-depressant, consumed to allay anxiety (sedative) or to induce sleep (hypnotic).

seizure threshold: The point above which a sudden stimulus will produce a grand mal seizure. Some drugs may raise or lower the seizure threshold. For example, central-nervous-depressants increase the seizure threshold during intoxication but lower it during acute withdrawal.

sexual exploitation: The act of one person of greater actual or perceived power persuading or coercing another person of lesser actual or perceived power to participate in any sexual act ranging from lewd gestures to penetration of body cavities. Sexual exploitation of children and adolescents by adults is a major risk factor for subsequent substance abuse and dependence.

shame: Intense embarrassment generated externally from the perceived negative judgment of others. Closely related to guilt (q.v.).

side effects: The effect of a drug other than those for which the drug is taken. They may be desirable or undesirable but generally are associated with undesirable effects.

Signed consent form with proper format: 42 CFR part 2 requires six conditions be met in a release of information. Proper format has all conditions.

SJI: State Justice Institute, the sponsor of this manual.

social detox: The detoxification process which, generally, does not use medications to mitigate withdrawal symptoms.

sodium hydroxide: A chemical used to render freebase from cocaine HCL.

sodium pentothal: An extremely fast acting barbiturate.

speed: A slang term usually referring to amphetamine, methamphetamine and related agents.

SSD (social-setting detoxication): A non-medical environment for the detoxification process. (See social detox)

statistical significance: An arbitrarily defined standard of assuming that an effect happened for a stated reason rather than by chance. Often set at the 5% or 1% level.

stimulant drugs: Stimulant drugs arouse the central nervous system. Because they work in a variety of ways, they are not a cohesive class of drugs as are the CNS depressants and the opioids. The stimulant drugs are grouped together because of their final action, not because they operate in the same way. A partial list of stimulants drugs includes nicotine, methylxanthine derivatives (e.g. caffeine), amphetamine, and cocaine.

substance abuse: Substance abuse is behavior characterized by continued use of psychoactive substances in spite of social, occupational, psychological, or physical problems or continuing use in situations which are physically hazardous (DSM-III-R).

substance dependence: Substance dependence is behavior which is characterized by at least three of the following behaviors: (1) using larger amounts of substance than intended, (2) unsuccessful efforts to quit or cut down, (3) inordinate time devoted to obtaining substances, (4) frequent intoxication or withdrawal which interferes with one's obligations, (5) forgoing important activities in favor of substance use, (6) using substances in spite of problems caused or exacerbated by substances, (7) tolerance, (8) withdrawal symptoms, (9) using substances to manage the signs and symptoms of the withdrawal syndrome (DSM-III-R).

synapse: Synapse is the space between two neurons, sometimes called the synaptic cleft.

synaptic cleft: (See synapse)

tactile hallucinations: The false belief of feeling objects touching the skin. Sometimes seen in delirium tremens where the affected can feel nonexistent insects or spiders crawling on the skin.

the shakes: Tremors of the extremities, usually of the hands and seen in withdrawal from central-nervous-system depressants, most notably alcohol.

theobromine: A methylxanthene derivative (q.v.) closely related to caffeine and found in chocolate candy and cocoa beverages (not coca, the plant from which cocaine is derived).

theophylline: A methylxanthene derivative (q.v.) closely related to caffeine and found in tea.

therapeutic ratio or index: Therapeutic ratio or index is a relative measure of how dangerous a drug is in terms of potential for a lethal overdose. The more times the usual dose required for a lethal overdose, the safer a drug is thought to be. Therapeutic ratio can be calculated by the following formula: $TR = \frac{LD}{ED}$

where TR is therapeutic ratio, ED is effective or usual dose and LD is lethal dose.

tolerance: Tolerance is the capacity to experience the effects of a drug as less intense with repeated use of the same dose. Increasing the dose may or may not lead to increased effects if tolerance is operating. Tolerance may exist for some effects and not for other effects of the same drug. Tolerance may develop at different rates for the different effects of the same drug. Tolerance can be demonstrated for some drugs and not for other drugs so that tolerance can be said to be the property of a drug, although the rates of tolerance vary from individual to individual.

toluene: A hydrocarbon with some similarities to gasoline and used as an industrial solvent. Can be deliberately misused to cause inebriation similar to that of CNS depressants. Toluene is the ingredient in glue for plastic model kits.

tranquillizer: An inexact term for sedative/hypnotic (q.v.) sometimes mistakenly applied to neuroleptic (q.v.). See also major tranquilizer and minor tranquilizer.

tremors of extremities: Uncontrollable shaking generally of the arms and hands. Sometimes seen in withdrawal from CNS depressants.

tricyclic antidepressants: A class of psychoactive drugs often prescribed as mood elevators for persons experiencing depression. These drugs have no potential for recreational abuse from intoxication but they can cause death by deliberate overdose.

trip: A reference to the recreational use of hallucinogenic drugs.

Tuinal: A proprietary name for a mixture of amobarbital (q.v.) and secobarbital (q.v.). The red and blue capsules are sometimes called "rainbows."

Tylox: A proprietary mixture of acetaminophen and oxycodone (q.v.).

UAF: Utah Alcoholism Foundation, the largest non-profit corporation in Utah delivering substance abuse treatment.

UCCODAR: Utah County Council on Drug Abuse Rehabilitation (The Gathering Place)

vagus nerve: The tenth and longest nerve which extends from the brain to many parts and organs of the body. One of its many functions is to regulate heart rate in response to changes in blood pressure. It is thought that in some cases of cocaine overdose impairment of the vagus nerve caused by cocaine contributed to heart failure.

ventricles: The two larger chambers of the lower mammalian heart. Also the four fluid filled chambers of the human brain.

volatile solvents: Hydrocarbons which readily turn from liquid to gas at room temperature. They can be deliberately misused to cause inebriation. Examples include toluene (q.v.), gasoline, paints and paint thinner.

withdrawal syndrome: Withdrawal syndrome is the signs (externally demonstrable) and symptoms (reported by the sufferer) experienced by the person who has become physically addicted to a drug and has ceased taking the drug. The signs and symptoms are opposite the effects of the drug.

working poor: Refers to persons who are employed in marginal jobs without benefits who do not qualify for government assistance. The working poor are often disenfranchised and suffer disproportionate social injustice which is a risk factor for substance abuse.

x & y chromosome theory: Biological predisposition to substance abuse may be sex linked to the Y chromosome which puts males at greater biological risk. (Males have an X and Y chromosome and females have two X chromosomes.) However, it is a biological fact that women do metabolize alcohol slower than men and can become intoxicated with about half the amount required for men.