REPORT TO THE CONGRESS

BY THE COMPTROLLER GENERAL OF THE UNITED STATES

Progress And Problems In Treating Alcohol Abusers

National Institute on Alcohol Abuse and Alcoholism
Department of Health, Education, and Welfare

Problems noted in the planning procedures and coordination of the National Institute on Alcohol Abuse and Alcoholism have kept available resources from being applied to areas of greatest need and have slowed the development of a concerted Federal approach to combating alcohol abuse. The Institute needs to more fully develop and use its performance standards.

This report contains several recommendations to the Congress. For example, the Congress needs to clarify the extent to which it wants to use the Supplemental Security Income program as a mechanism for requiring alcohol abusers to receive treatment for their alcoholism problems.

HRD-76-163

APRIL 28, 1977

COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

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To the President of the Senate and the
Speaker of the House of Representatives

This report describes the major activities of the National Institute on Alcohol Abuse and Alcoholism to treat the Nation's alcohol abusers. It discusses progress made and problems encountered by the Institute in funding, monitoring, and evaluating alcohol abuse treatment programs, as well as activities directed toward coordinating Federal efforts to combat alcohol abuse.

Our review was made because alcoholism has been recognized as a major health problem in the United States, and the Institute has been designated as the focal point for Federal efforts to address this problem.

We made our review pursuant to the Budget and Accounting Act, 1921 (31 U.S.C. 53), and the Accounting and Auditing Act of 1950 (31 U.S.C. 67).

Copies of this report are being sent to the Director, Office of Management and Budget, and the Secretary of Health, Education, and Welfare.

Comptroller General
of the United States

COMPTROLLER GENERAL'S
REPORT TO THE CONGRESS

PROGRESS AND PROBLEMS IN TREATING ALCOHOL ABUSERS
Department of Health, Education, and Welfare

D I G E S T

Federal efforts to treat alcohol abusers have improved since the National Institute on Alcohol Abuse and Alcoholism was established in 1970. However, increased Federal leadership and improved Federal and State programs are essential if a cohesive, coordinated national program is to be fully developed.

By the most recent estimates, alcohol abuse in the United States costs society about $32 billion annually. Over the past 6 years, the Institute has spent about $710 million for alcoholism programs.

PLANNING FOR TREATMENT PROGRAMS NEEDS IMPROVEMENT

The Institute and State planning processes are not adequate for development of program plans which will allocate the greatest amount of resources to areas having the greatest needs. More attention must be devoted to:

--Obtaining better estimates on the size of the alcohol-abusing population.

--Developing information as to geographic distribution and demographic characteristics of this population.

--Bringing inventories of existing treatment facilities up to date and collecting data on the capacities of treatment facilities.

--Allocating funds on the basis of relative need for more treatment programs, as well as relative population and State financial needs.

--Developing measurable program objectives.

Furthermore, the Institute's plans to support treatment projects must be better communicated to States, and State authorities must be more responsive in commenting on applications for specific Institute-funded projects. In July of last year, the Congress placed statutory requirements on the Institute and the States which should alleviate many of the problems GAO identified in the planning process. (See pp. 24 and 25.)

CONCERTED NATIONAL EFFORT TO COMBAT ALCOHOL ABUSE SLOW IN DEVELOPING

The Institute should do more to develop a concerted national attack against alcohol abuse. It could provide better opportunities for Federal agencies to volunteer their assistance, exchange information, and seek its help. The informality of its coordination procedures is not conducive to permanent relationships with other agencies. More formal coordination mechanisms at policy-making levels are needed.

A 2-year delay in establishing the Interagency Committee on Federal Activities for Alcohol Abuse and Alcoholism contributed to the problem. Prompt establishment of this committee might have alleviated some of the coordination difficulties the Institute experienced. Expectations that other agencies would help significantly to alleviate alcohol problems are not being realized. Potential of the Supplemental Security Income program for identifying individuals suffering from alcoholism and requiring them to accept appropriate, available treatment has been diminished. (See p. 35.) Alcoholics should not be entered on this program's rolls solely on the basis of some other qualifying impairment when alcoholism also is present because this could deny someone the opportunity to benefit from the treatment.

STRENGTHS AND WEAKNESSES OF INSTITUTE'S EVALUATION SYSTEM

The Institute has made progress toward better evaluations of program and project activities. The development of performance standards for alcohol treatment centers is an impressive first step. (See p. 47 .)

Between December 1975 and August 1976, the number of projects that report to the Institute's automated data collection system increased significantly. Over 56 percent of the 556 projects funded are now being monitored using this system.

Recent training to help project officials and Institute program managers interpret and use such reports should result in improved management of alcohol treatment projects. Periodic training in these areas should be continued and additional emphasis should be placed on completing the necessary followup reports.

IMPACT OF INSTITUTE FUNDING ON PEOPLE, COMMUNITIES, AND STATES

It is difficult to determine the overall impact of the Institute's program on the alcohol-abusing population. Much information on what has been attained is available. As discussed in chapter 4, the Institute has published draft standards of expected levels of program performance for the alcohol treatment centers. Standards are also being developed for the Institute's other types of treatment projects. Until standards are refined and finalized, it will not be possible to conclude whether changes in drinking patterns are reasonable in relation to the costs involved.

Even without these standards it is possible to conclude that the Institute needs to do a better job in admitting into treatment more persons who make contact with treatment projects or seeing to it that they are referred elsewhere for treatment.

Many clients served by Institute supported projects believe they (1) have been helped, (2) are drinking less as a result, and (3) are leading more productive lives. Many community agencies believe these projects have had a positive impact on the alcoholism problem in their communities, and many States believe the Institute has been a positive stimulus in expanding treatment capabilities to serve more individuals and in encouraging the passage of the Uniform Alcoholism Intoxication and Treatment Act.

NONGRANT FUNDS HAVE NOT MATERIALIZED

Continuation of the Institute's support for alcohol treatment projects is required because revenues from third-party sources have generally not materialized. (See ch. 6.) Federal/State medical assistance programs and private insurance carriers have generally limited the amount of alcohol abuse services covered by their programs.

The Institute has initiated action to reduce the barriers limiting nongrant revenues, including the development of accreditation and certification standards to insure quality of care at alcohol abuse projects. However, the Institute has not required its own projects to adopt these standards. In addition, consultation, education, and outreach/referral services which many projects provide will never generate sufficient revenues to cover cost.

OTHER ACTIVITIES WHICH NEED IMPROVEMENT

Although the projects included in this review had established objectives, the objectives did not express, in quantitative terms and with target dates, what the projects were to accomplish. Consequently, project and Institute officials cannot measure progress in the achievement of the projects' goals. Continuity of care was not insured at all

projects because they were not systematically conducting followup on clients.

RECOMMENDATIONS

GAO makes several recommendations to the Secretary of Health, Education, and Welfare, regarding improvements in:

--The Institute's and the States' program planning and evaluation processes and funds allocation procedures (See p. 25.)

--Coordination among Federal agencies. (See p. 40.)

--The Institute's program monitoring and evaluation system. (See p. 52.)

--Client intake and referral procedures at the Institute's treatment projects. (See p. 70.)

--Work done to increase the reimbursements that alcohol abuse treatment projects get from public and private health insurers. (See p. 82.)

GAO also recommends that the Department revise confidentiality regulations to permit legitimate evaluations of the effectiveness of client referral mechanisms. (See p. 90.)

AGENCY ACTIONS

On August 4, 1976, GAO submitted a draft of this report to HEW for comment. On January 19, 1977, HEW responded and advised GAO that it agreed substantially with GAO's recommendations. HEW commented that there are problems of planning and coordination among Federal, State, and local government levels; assessment and evaluation issues are not completely resolved; financing of treatment continues to be inadequate; and the establishment of Federal leadership still is evolving. (See p. 112.)

RECOMMENDATIONS TO THE CONGRESS

As a means of achieving a more concerted Federal effort against alcohol abuse, the Congress may wish to give the National Institute on Alcohol Abuse and Alcoholism sufficient authority to

--establish mechanisms for coordination among Federal agencies and

--monitor agencies' alcoholism programs.

The Supplemental Security Income program's potential for combating alcoholism has been weakened because there is uncertainty as to whom the mandatory treatment provisions apply. The Congress should clarify the purpose and scope of these provisions. (See p. 42.)

The Congress should explore the need for legislation to require Federal medical insurance programs to recognize services delivered by certain providers as covered for reimbursement purposes. (See p. 84.)

The Congress should also explore the need for legislation to authorize continuous Federal funding for non-revenue-producing alcohol abuse services--consultation/education, outreach, and referral--which will probably never generate revenue to cover costs. (See p. 84.)

Contents

ABBREVIATIONS

ADAMHA	Alcohol, Drug Abuse, and Mental Health Administration
ATC	alcohol treatment center
DOT	Department of Transportation
DWI	driving while intoxicated
GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare
HSA	Health Services Administration
LEAA	Law Enforcement Assistance Administration
NHTSA	National Highway Traffic Safety Administration
NIAAA	National Institute on Alcohol Abuse and Alcoholism
NIDA	National Institite on Drug Abuse
NIMH	National Institute for Mental Health

ABBREVIATIONS

RSA	Rehabilitation Services Administration
SRI	Stanford Research Institute
SRS	Social and Rehabilitation Service
SSA	Social Security Administration
SSI	Supplemental Security Income
VA	Veterans Administration

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CHAPTER 1

INTRODUCTION

ALCOHOL ABUSE PROBLEM

Alcohol, the most abused drug in the United States, is a mood-changing substance as are cocaine, heroin, barbiturates, and amphetamines. The problems related to its misuse are increasing and have reached major proportions. Alcohol abuse is a serious drug problem in terms of number of individuals affected, cost to society, and damage to the body. Although it ranks among the major national health threats along with cancer, mental illness, and heart disease, alcohol abuse did not become a major health concern of the Federal Government until 1970 when the National Institute on Alcohol Abuse and Alcoholism (NIAAA) was created to deal comprehensively with the problem.

Defining the problem

Many professional organizations accept the concept that alcoholism is a disease. Among these are the World Health Organization, the American Medical Association, the American Hospital Association, the American College of Physicians, the American Bar Association, and the American Psychiatric Association. The Department of Health, Education, and Welfare (HEW) also recognizes it as a disease.

Although alcoholism has no universally accepted definition, the American Medical Association believes enough agreement exists to support the accuracy of the following broad definition.

> "Alcoholism is an illness characterized by preoccupation with alcohol and loss of control over its consumption such as to lead usually to intoxication if drinking is begun; by chronicity; by progression; and by tendency toward relapse. It is typically associated with physical disability and impaired emotional, occupational, and/or social adjustments as a direct consequence of persistent and excessive use."

Distinctions are sometimes made between individuals with drinking problems and those suffering from alcoholism. Problem drinkers are often defined as those who drink to such an extent that self-control is impaired and normal social

behavior patterns are disrupted. However, it is often difficult to distinguish between problem drinkers and alcoholics. Except in the most extreme cases of alcoholism, hard and fast differentiations are rarely made. Professionals agree there is no exact dividing line and each individual's case must be diagnosed by a physician, psychiatrist, or other therapist. 1/

Causes of alcohol abuse are unknown

Despite continuing research, the causes of alcohol abuse are not known. However, it is known that alcohol by itself is not the cause of the problem. If it were, everyone who drinks would become an alcohol abuser.

Theories abound on the causes of alcohol abuse. Some researchers contend it is a psychological disturbance and believe that alcohol abusers possess a number of distinctive traits which make up the "alcoholic personality." Others believe physiological factors, such as metabolism or unknown glandular deficiency, are the cause. Many sociologists see environment, the pressures of daily life, and cultural and ethnic differences as major factors. Many physicians, psychiatrists, and sociologists suggest that the cause of alcohol abuse may be an interaction of physiological, psychological, and sociological factors.

Treating alcohol abuse

Alcohol abuse is treatable. Treatment objectives are concerned with

--managing acute episodes of intoxication to save life and overcoming the immediate toxic effects of excess alcohol,

--altering long-term behavior of alcoholic individuals so as to discontinue destructive drinking patterns, and

--correcting the chronic health problems accompanying alcohol abuse.

1/Thus the term "alcohol abusers" is used in this report to refer collectively to alcoholics and problem drinkers, and alcohol abuse to refer collectively to alcoholism and problem drinking.

Generally, treatment services are delivered in one or more of the following settings: emergency, inpatient, intermediate, and outpatient care. However, within each setting, various treatment methods are used to deal with the complex problems associated with alcohol abuse. No single treatment method can be successful with all persons, since individual problems and needs vary.

Many in the field of alcohol abuse believe that alcoholism cannot be cured but can be arrested if the alcoholic abstains from alcohol. Although abstinence and total sobriety are sought, some contend that additional considerations, including improved social, familial, and occupational relationships can be used to assess the success or failure of treatment.

Several researchers have concluded that some alcohol abusers apparently can develop the capacity to change their drinking behavior and successfully adjust to life without becoming total abstainers. The primary goal of treatment for these persons is the development of new lifestyles. They are encouraged to handle problems without resorting to the irresponsible use of alcohol.

Consequences of alcohol abuse

The personal price

Many illnesses can be related to excessive alcohol consumption. Among these are emotional disorders and chronic progressive diseases of the nervous system, liver, heart, gastrointestinal tract, and other bodily organs and tissues.

Life expectancies of persons whose alcohol abuse is not successfully treated are as much as 10 to 12 years shorter than those of the general public. Such persons also are subject to a disproportionate number of violent deaths.

An accurate estimate of the number of alcohol abusers in the United States does not exist. Although various attempts have been made to define this population, these estimates may not be reliable. 1/

Although the inhabitants of skid rows across the Nation are the most visible victims of alcohol abuse, NIAAA estimates that they comprise only a small segment of the alcohol-abusing

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1/See p. 14 for further information on these estimates.

population. Most people who abuse alcohol lead otherwise acceptable lifestyles.

The consequences of alcohol abuse are not limited to the abuser. The abuser's behavior often harms the family, employer, and society at large. According to NIAAA, each alcohol abuser affects approximately four members of society either directly or indirectly.

The economic cost

An NIAAA-contracted study of the economic costs of alcohol-related problems, released in 1974, estimated a loss to society of over $25 billion in 1971. A more recent study done for the National Institute on Drug Abuse estimated the loss at $32 billion in 1975.

Dollar Value of Loss to Society Caused by Alcohol Abuse in 1975

	(billions)
Lost production	$12.0
Health and medical	10.3
Motor vehicle accidents	8.3
Alcohol programs and research	0.8
Criminal justice system	0.6
Total	$32.0

ALCOHOL CONSUMPTION IN THE UNITED STATES

The amounts of alcoholic beverages--distilled spirits, wine, and beer--produced in the United States are shown below.

Type of alcoholic beverage	Amounts produced in millions of gallons			
	1960	1965	1970	1973
Distilled spirits	186.9	185.1	212.3	183.1
Wine	152.6	173.4	237.3	292.0
Beer	2,895.9	3,354.9	4,126.8	4,606.5

Selected studies of the drinking habits of the Amercian people have shown that:

--During 1973 the apparent consumption of alcohol beverages for each person 15 years of age or older was about

--2.61 gallons of distilled spirits, or 1.2 gallons of absolute alcohol;

--2.25 gallons of wine, or 0.33 gallons of absolute alcohol; and

--27.49 gallons of beer, or 1.24 gallons of absolute alcohol.

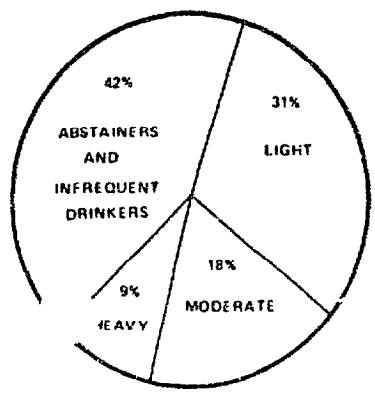
--The average alcoholic person drinks about 11 times as much as the average nonalcoholic person.

--About 15 percent of the drinking population consumes about 60 percent of the alcohol.

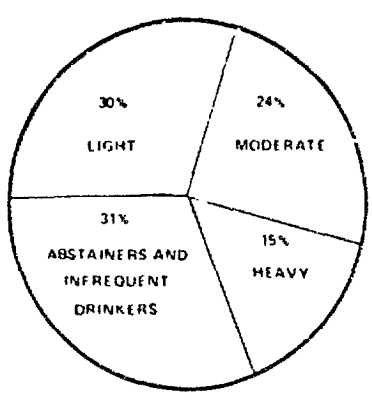
--Approximately 58 percent of the adult population (18 years of age and older) drank at least once a month.

The following charts show information obtained in a nationwide survey conducted for NIAAA from September 1972 through January 1974.

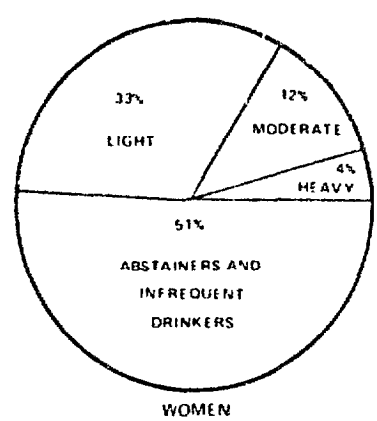
PERCENTAGE OF DRINKERS AND TYPES OF DRINKERS
AMONG PERSONS 18 YEARS OF AGE AND OLDER



PERCENTAGE OF DRINKERS AND TYPES OF DRINKERS
BY SEX



MEN



WOMEN

- Abstainers and infrequent drinkers Drink less than once a month or not at all
- Drinkers Drink once a month or more
  - Light drinkers Drink less than 0 22 ounce of absolute alcohol per day.
  - Moderate drinkers Drink over 0.22 but less than 1.0 ounce of absolute alcohol per day.
  - Heavy drinkers Drink 1 ounce or more of absolute alcohol per day.
- One ounce of absolute alcohol is considered to be 1 to 2 cans of beer, 1 to 2 glasses of wine, and 2 to 3 shots of distilled spirits.

CREATION OF NIAAA

Federal encouragement of prevention and treatment activities directed at the alcohol problem started in 1966, with the establishment of the National Center for Prevention and Treatment of Alcoholism as a component of the National Institute of Mental Health (NIMH).

The first congressional action on alcohol abuse was the enactment of the Alcoholic and Narcotic Addict Rehabilitation Amendments of 1968, Public Law 90-574, Title III (formerly 42 U.S.C. 2688(e) et seq.(1970)), which added a new part to the Community Mental Health Centers Act (formerly 42 U.S.C. 2681 et seq.(1970)) authorizing Federal grants for constructing and staffing alcoholism prevention and treatment facilities. The Community Mental Health Centers Amendments of 1970, Public Law 91-211 (formerly 42 U.S.C. 2681 et seq.(1970)) extended and expanded the provisions of Public Law 90-574 by authorfunds for (1) training, (2) program evaluation for treatment and prevention programs, and (3) programs to demonstrate new or relatively effective or efficient methods of delivering services.

In December 1970 the Congress passed Public Law 91-616 (42 U.S.C. 4551 et seq.(1970)), the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970. This act is the most significant piece of legislation in the alcohol abuse area because it established NIAAA as a separate Institute and mandated that the Secretary of HEW, acting through NIAAA,

> "develop and conduct comprehensive health, education, training, research, and planning programs for the prevention and treatment of alcohol abuse and alcoholism and for the rehabilitation of alcohol abusers and alcoholics."

The Congress intended that NIAAA be the national focal point for coordinating Federal efforts to deal with the alcohol abuse problem. The Congress believed that "Institute" status was necessary so that adequate resources could be focused, coordinated, and applied to one of the Nation's most serious health problems. Federal funding of the activities authorized by the act was to be provided through formula grants to States, project grants to public and private nonprofit organizations, and contracts with public and private organizations and individuals.

Public Law 93-282 (42 U.S.C. 3511, 4541 et seq. (Supp. V 1975)), enacted in May 1974, extended the provisions of Public Law 91-616, created the Interagency Committee on Federal Activities for Alcohol Abuse and Alcoholism, estabisned the Alcohol, Drug Abuse and Mental Health Administration, and provided for Federal grants to States enacting uniform alcoholism treatment and rehabilitation legislation. Further amendments took place in July 1976 with the enactment of Public Law 94-371 (42 U.S.C. A. 4541 (Supp. Dec. 1976)). This act continued and expanded NIAAA's spending authority and required that specific actions be taken by NIAAA and the States to improve the Nation's alcohol abuse programs.

Formula grant program

The formula grant program is intended to effect a nationwide effort on the alcohol abuse problem by making it possible for each State to stimulate and encourage the establishment of alcohol abuse programs and to provide assistance for programs based on the particular needs of the State. To receive formula funds, each State is required to develop a plan outlining its intended use of formula grant funds.

The program is administered by HEW's regional health administrators who review and approve State plans. NIAAA provides technical assistance to the States and consultation services to the HEW regional offices. Program funds are distributed on the basis of a formula which considers population and average income per person in each State. 1/

Project grant program

The project grant program, administered by NIAAA, provides financial assistance for local community programs designed to meet the needs of special target populations, such as Indians and the impoverished. It also enables NIAAA to fund research and demonstration projects leading to improvements in alcohol abuse prevention and treatment methods.

1/See p. 20 for further information on this formula.

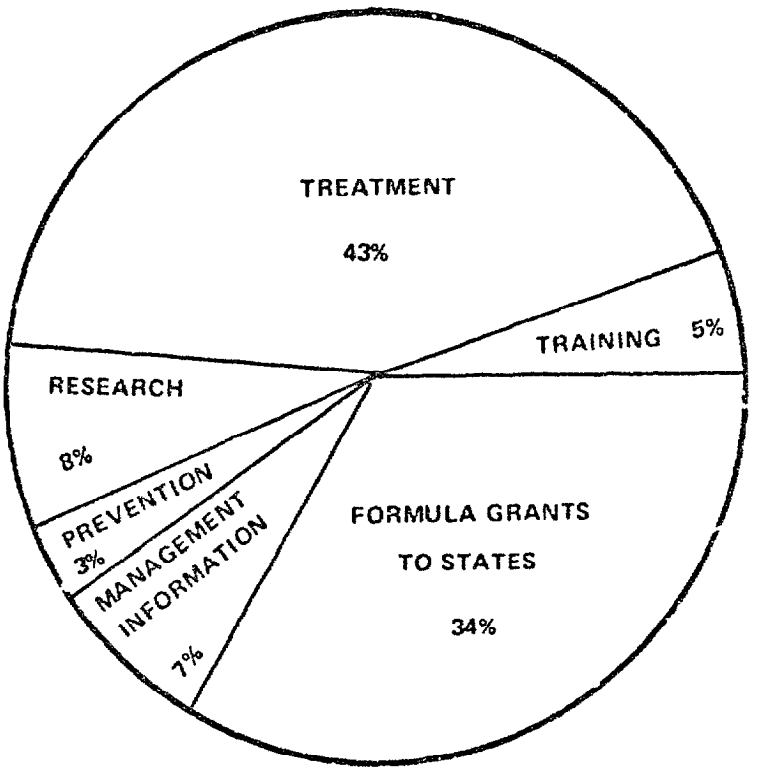
NIAAA FUNDING

Between July 1, 1970 and June 30, 1976, NIAAA obligated about $710 million for formula and project grants, contracts, and other expenses. (See app. I.)

The following chart shows the percent of funds obligated in the major areas.

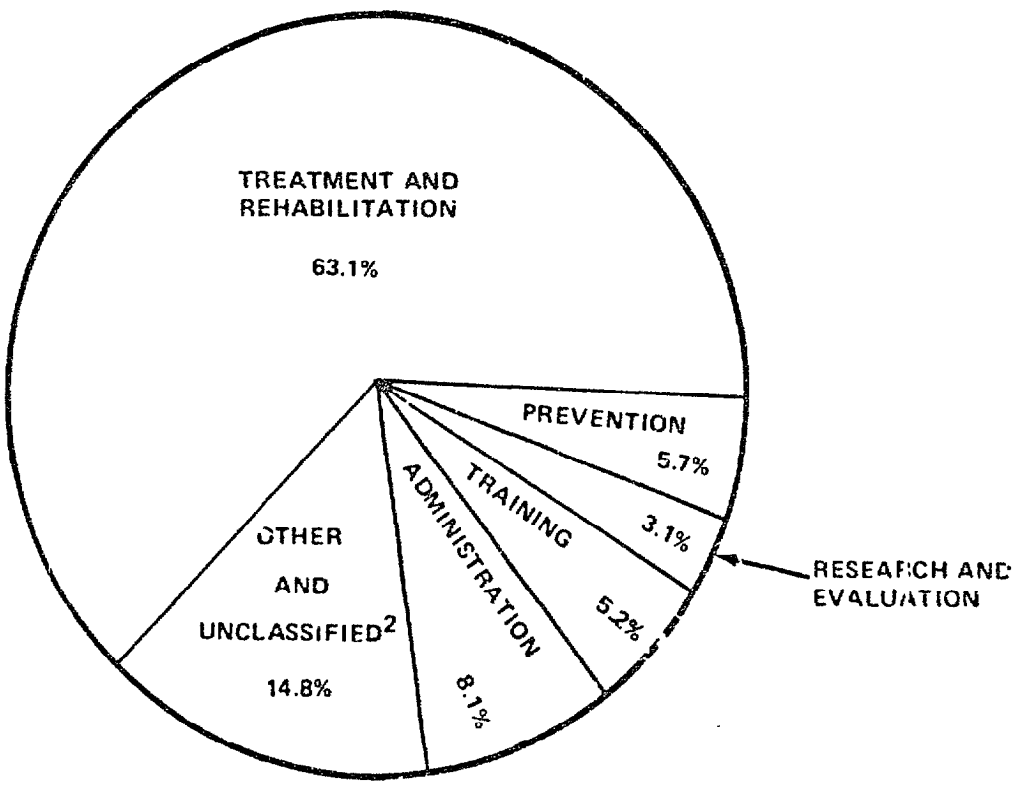
AMOUNTS OBLIGATED BY ACTIVITY

JULY 1, 1970 THROUGH JUNE 30, 1976



For a 1-year period, generally ending in June 1975, 1/ 39 States that had received about $43 million in formula funds reported expenditures in the following areas.

DISTRIBUTION OF STATE FORMULA FUNDS



1/Information on how States distributed their formula funds in prior years is not available.

2/Some States were not able to provide a complete breakdown of funds by program areas.

OTHER EFFORTS TO COMBAT ALCOHOL ABUSE

In addition to NIAAA, many other Federal agencies and departments fund alcoholism programs. Also, private organizations and educational institutions are concerned with the alcohol abuse problem.

Other Federal efforts

The Office of Management and Budget estimated that during fiscal year 1976, $221.1 million was spent for alcohol-related programs by the following Federal departments and agencies. 1/

Department	Amount (millions)
HEW:	
Social and Rehabilitation Service	a/$81.0
Office of Human Development	a/33.0
NIMH	9.4
National Institutes of Health	.6
Veterans Administration	58.1
Department of Transportation	21.1
Department of Defense	16.8
Department of Labor	.3
Civil Service Commission	.2
Other	.6
Total	$221.1

a/Includes amounts for medical assistance and rehabilitation provided to alcohol abusers which are not necessarily related to direct alcohol abuse treatment activities.

In addition, other Federal agencies aid alcohol abusers through programs designed to assist individuals with other health and social problems.

Some private efforts

Alcoholics Anonymous is probably the most well known organization concerned with alcohol abuse. Founded in 1935, it

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1/See app. II for a brief description of these agencies' activities.

is a fellowship of men and women devoted to helping each other maintain sobriety through the sharing of similar experiences. Alcoholics Anonymous is solely concerned with the personal recovery and continued sobriety of those who turn to it for help. It is self-supporting through its own groups and members and declines contributions from outside sources. Alcoholics Anonymous has more than 18,000 local groups in 92 countries.

The National Council on Alcoholism, organized in 1944 is a major national voluntary health organization working for the prevention and control of alcohol abuse. It is affiliated with local councils in 170 communities. These councils offer information and referral services to alcohol abusers, their families, and friends.

The Center of Alcohol Studies, Rutgers University, is a world clearinghouse for alcohol information. It developed from a program to survey scientific literature on alcohol in the early 1940s. In addition, it conducts laboratory, psychological, and sociological research and is involved in demonstration projects for the treatment of alcohol abuse.

CHAPTER 2

PLANNING FOR ALCOHOL ABUSE TREATMENT PROGRAMS NEEDS IMPROVEMENT

National Institute on Alcohol Abuse and Alcoholism and State alcohol abuse program planning efforts are being carried out without accurate information on the size or whereabouts of the alcoholism problem or the number and capacity of facilities available to cope with the problem. In addition, program objectives have often been stated in broad, imprecise terms which do not define what is to be accomplished or how or when goals are to be attained. Formula funds have been allocated to the States without considering the relative need for treatment facilities as required by the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (Public Law 91-616).

NIAAA plans for the direct funding of treatment projects in selected geographical areas have not been adequately communicated to the States. State officials told us that in some cases the State did not find out about the projects until after NIAAA had funded them. In other cases, where the States have been made aware of NIAAA plans, they have not provided NIAAA with meaningful comments on the proposed projects, primarily because they did not want to jeopardize a proposed project regardless of where the project was being placed.

The combined effect of these factors is a planning process which is not capable of determining where alcohol abuse is most critical, what additional treatment capacity needs to be developed, or what impact existing treatment efforts have had on the overall problem.

Developing an effective planning process is not easy. Because of the stigmas traditionally associated with alcoholism, identification of persons suffering from the disease is very difficult. Those who do seek treatment frequently are diagnosed as having some other more socially acceptable impairment. Moreover, treatment is carried out using a variety of approaches and in many different settings. If NIAAA is to carry out the mandate given to it by the Congress, these problems must be dealt with more effectively.

NEED FOR BETTER DETERMINATION OF THE SIZE AND CHARACTERISTICS OF THE ALCOHOL ABUSE PROBLEM

No one knows, with any certainty, the size of the alcohol-abusing population and its distribution among the various geographical regions and political subdivisions of the country. Since the length of time required for alcoholism symptoms to surface in an individual's life-style varies and since social stigmas associated with alcohol abuse exist, obtaining data on the number of people who abuse alcohol is difficult.

NIAAA efforts

NIAAA estimates there are between 9 and 10 million alcohol abusers in the United States. This figure was derived from a formula developed by Dr. E. M. Jellinek in the 1940s to estimate the rate of alcoholism in a given geographic area by using data on the number of deaths resulting from an alcohol-related disease. NIAAA used this formula to provide an indication of the number of alcoholics in the United States. To arrive at an estimate of the number of alcohol abusers--alcoholics and problem drinkers--NIAAA in effect doubled the estimate produced by the Jellinek formula. Critics of the Jellinek formula believe it underestimates the prevalence of alcoholism, and an NIAAA official stated that the 9-million figure is probably conservative. In 1959 Dr. Jellinek recommended that his formula or any modification of it no longer be used to estimate the number of alcoholics because too many factors which he originally considered to be constant were actually fluctuating and affecting the value of formula components.

NIAAA encourages potential grant applicants to use an alternative method for estimating the size of the alcohol-abusing population. This method, first used by NIAAA in 1974, recognizes that alcohol abuse problems vary among the population of a geographic area in relation to such basic demographic characteristics as age, sex, socioeconomic status, ethnicity, religion, marital status, and urban-rural residence. NIAAA had discussed these factors and their relationship to alcohol abuse in its First Special Report to the U.S. Congress on Alcohol and Health in 1971.

This alternate method estimates the alcohol-abusing population by determining the number of people in each

demographic category (information usually readily available from census reports) and applying statistically determined incidence rates of alcohol-related problems for each category. The final estimates obtained from this procedure are supposed to reflect the total incidence of alcohol abuse in a specific area and provide estimates of alcohol abuse among the various subpopulations.

Although NIAAA is encouraging the use of this method at the local level, an NIAAA official told us he believes this method could also be adapted for estimating the size of the problem at State and national levels.

State efforts

Each of the five State alcohol agencies we visited 1/ used the Jellinek formula to determine the number of alcoholics in the State.

New Jersey, New York, and Washington noted in their State plans that the value of the formula was suspect. New Jersey and New York said they continued to use it because a more accurate measurement was not available.

Only Oregon estimated the total number of both problem drinkers and alcoholics. It supplemented the Jellinek formula by applying the results of a 1965 survey which found that 12 percent of all adult Americans are heavy drinkers. After calculating the number of heavy drinkers in the State, the Oregon alcohol agency assumed that about two-thirds were problem drinkers.

By using several indicators, Oregon also estimated the incidence of alcoholism and other social problems by county and ranked each county accordingly. These indicators are

--estimated alcoholism rate based on the Jellinek formula,

--mean motor vehicle fatality rate per 100,000 population,

--alcohol diagnoses as percent of admissions to State mental hospitals,

--liquor sales per person aged 20 years and older, and

--various other indicators of social problems.

1/ See ch. 8 for scope of review.

Although we did not determine whether the Oregon procedure provides a better estimate than the Jellinek formula alone, it illustrates how available data pertinent to the alcohol abuse problems in a given area could be considered in estimating the alcohol-abusing population.

MORE COMPLETE INFORMATION NEEDED ON THE NUMBER, LOCATION, AND CAPACITIES OF TREATMENT FACILITIES

NIAAA and four of the five States we visited had an inventory of alcohol treatment facilities. These listings, however, were not kept up-to-date. Since they were prepared, a large number of new facilities had been established. For the most part, the inventories did not contain information on treatment capacities of the facilities listed. Such data could be useful to program planners of new treatment projects by identifying areas where insufficient treatment capacity is available.

NIAAA inventory

In 1972 NIAAA awarded a grant for developing a compendium on alcohol treatment facilities in the United States and Canada. NIAAA believed a much-expanded and updated directory was needed since the most recent one available at that time had been published in 1969. The new compendium was published in 1973 and contained information on over 2,500 treatment facilities in operation on July 30, 1973. The information included facility location, types of treatment provided, and admission requirements, if any. The compendium did not, however, provide information on the facilities' capacities.

Since 1973 the number of treatment projects funded by NIAAA and the States has greatly increased. We identified about 300 treatment projects initially supported by NIAAA during fiscal years 1974 and 1975. A sampling of these projects showed that about 70 percent of their facilities were not listed in the 1973 compendium. In addition, in the five States included in our review, we found that the number of treatment projects supported by the States' alcohol agencies increased from 171 in fiscal year 1973 to 284 in fiscal year 1974.

The grantee that prepared the 1973 compendium told us that plans to update the document in 1975 were rejected primarily because funds were not available. An NIAAA official told us that, although the compendium was used for estimating

staff needs and the number of projects that could possibly be accredited, it was not used in NIAAA's planning process because non-federally supported facilities have a high termination rate. This factor made the compendium continuously out-of-date.

In January 1977 an NIAAA official told us that a new compendium had been published in July 1976. However, NIAAA had not considered obtaining data on treatment capacity for inclusion in this compendium.

State inventories

Of the five State alcohol agencies included in our review, four had an inventory of treatment facilities. New York's and Oregon's inventories had been developed in 1974, Colorado's in 1973, and New Jersey's in 1970 with updates in 1972 and 1975. Oregon had data on all inpatient facility capacities while Colorado had capacity data for a few facilities. New York and New Jersey did not include capacity data. However, New Jersey's 1976 State alcoholism plan does show bed capacity for inpatient alcoholism treatment facilities.

Officials in New York and Oregon told us they were updating their lists. A Colorado official said that the State's inventory noted only "major" facilities, while New Jersey officials told us they had no idea how complete their list was.

A Washington State official told us that no master list was available but one could be compiled from the various county plans which list facilities and their capacities. However, a sample of these plans disclosed that capacities were included for very few facilities. We were informed that shortly after our review in Washington, the State alcohol agency published a list of State approved, publicly funded alcoholism treatment facilities. This list does not show the capacities of the facilities.

NIAAA AND STATE OBJECTIVES MUST BE MORE PRECISELY STATED TO BE USEFUL FOR PLANNING PURPOSES

NIAAA has not established program objectives that can be related to progress made in achieving its stated goals. For the most part, neither have the five States we reviewed.

According to an NIAAA manual entitled "Management Program for Alcoholism Services Projects," a program objective

expresses, in quantitative terms, the desired results of program activities. The manual also states that, for sound program planning and program evaluation, objectives should specify (1) what is to be achieved, (2) the target of the program activities, (3) where the activity will occur, and (4) when the desired result will be achieved.

NIAAA goal and objectives

Although NIAAA has stated that its most immediate goal is to make the best alcohol treatment services available to everyone who needs them, it has not complemented this goal with measurable program objectives. NIAAA's long-range planning documents describe its objectives over a 5-year planning period and outline general strategies to be followed in attaining these objectives. For example, the NIAAA fiscal year 1976-80 plan contains objectives to improve alcohol abuse service systems by:

--Improving the program administration and financial management capabilities to recover the maximum third-party reimbursement in community programs as well as to insure best use of various types of block revenue sharing.

--Insuring effective and high-quality program development through Federal financial assistance provided to State and community agencies.

--Maintaining and augmenting staff to meet expanding national health insurance coverage for services.

--Providing assistance and expertise for new and improved service delivery systems, particularly to special target populations which are often neglected.

These objectives do not include quantitative factors which could be used to measure the effectiveness of NIAAA's activities. The action strategies proposed by NIAAA provide some general insights as to how NIAAA plans to address these objectives. They do not, however, provide any criteria which can be used to determine the (1) amount of progress expected within a specified time, (2) level of increased activity or program improvements needed to reach the objective, and (3) impact that achievement of the objective will have on progress made toward NIAAA's overall goal.

State goals and objectives

Although the five State alcohol agencies we visited had established goals, only New Jersey had developed measurable objectives. Our review of the State plans disclosed that their overall goals were similar to NIAAA's. For example, Oregon's goal was "to identify, stabilize, reduce and then to minimize alcohol problems and alcoholism * * * ." Colorado's was "to reduce the number of persons adversely affected by alcohol and to assist those persons already so affected." These goals were not accompanied by measurable objectives necessary for determining how and when these goals were to be attained.

The objectives contained in the 1974 New Jersey State plan generally included information on what was expected within specified times, such as:

--"Detoxification services shall be included as part of the emergency ward of at least 20 percent (20) of the general hospitals of the State within the next year."

--"The number of companies, employing more than 1,000, initiating an employee alcoholism program shall be increased by fifteen (15) within the next year."

The attainment of these objectives, like the NIAAA ones, would not necessarily indicate the extent of progress toward achieving the State's overall goal, which was to reduce the prevalence and severity of alcoholism. In commenting on our draft report a New Jersey official stated that several long range indicators had been developed which could, in his opinion, prove useful in assessing progress made toward the State's goal.

The Colorado, New York, Oregon, and Washington plans listed objectives in varying degrees of detail. Like the examples below, most were not measurable.

--Encourage orderly development of a variety of models and modalities of alcohol treatment and restoration services.

--Increase the efficiency and effectiveness of client tracking and identification procedures without violating the essential requirements of client confidentiality.

--Assist counties in formulating and implementing plans for responding to the needs generated by the decriminalization of public intoxication.

--Encourage more detailed planning and priority setting at the local and regional levels.

A Washington State official commenting on our draft report agreed that the program objectives for 1974 were not measurable but believed that objectives established for 1975, 1976, and 1977 are measurable. We agree that these objectives are an improvement over those we reviewed for 1974. We believe however, that Washington, as well as the other States, needs to do more to establish program objectives that identify specific actions to be taken within specific time periods. Such objectives will enable the States to more effectively measure progress made toward the achievement of the States' overall goals.

GREATER EFFORT NEEDED TO ALLOCATE FUNDS BASED ON NEED

Neither NIAAA nor the alcohol authorities in the five States in our review had sufficiently considered the need for treatment facilities when allocating formula grant funds. Public Law 91-616 stipulates that formula grant funds are to be allocated to the States on the basis of their relative population; financial need; and need for more effective prevention, treatment, and rehabilitation programs to deal with alcohol abuse and alcoholism. NIAAA's formula for distribution of these funds, however, is based only on the relative population and average income per person in each State. NIAAA officials told us that no serious effort has been made to distribute funds on the basis of need because of the difficulty of quantifying need.

State allocations of alcohol funds

The five State alcohol agencies we visited had different procedures for allocating combined State and formula funds. However, none adequately considered needs. Although Public Law 91-616 does not specifically require the States to allocate their funds on the basis of need, it does require their alcoholism plans to include a survey of need for the prevention and treatment of alcoholism and alcohol abuse throughout the States.

Personnel in Washington and Colorado advised us they had not allocated funds according to need. In Washington funds were generally distributed to counties on a per capita basis without considering need. A State official claimed this method was satisfactory because the need was so great in relation to the amount of available funds that there was little chance of funding services which were not needed.

Comments on our draft report received from officials in the State of Washington indicated that the priority need in Washington was to make basic alcoholism services available to all residents of the State. This was to be accomplished by using available funds to establish basic alcoholism services programs in each county of the State. Once these basic programs were established across the State, available funds would be used to increase each program's capability so that a full range of alcoholism services would be available to all persons wanting these services.

A Colorado official told us that the State emphasized "getting something going" in each region and funded all "acceptable" proposals. Applicants, however, were required to demonstrate community support and approval. He added that the State had not received enough proposals to be selective but thought that, in the future, funding determinations would be based on need.

The remaining three States had established some criteria for determining need. New Jersey program officials told us that an applicant had only to supply statistical data on the total population of the community and an estimate of the population with alcohol problems. No effort was made to identify other activities in the area already offering services which the applicant planned to provide. However, the applicant was required to demonstrate community involvement in the planning process and community support of the project which could provide some assurance that the program was needed. After our review was completed, a New Jersey State official informed us that the 1976 New Jersey alcoholism treatment plan included new procedures for assessing needs and a revised grant application review process had been adopted to give greater consideration to treatment needs.

In Oregon, projects were to be funded in accordance with the current State plan and were to supply services otherwise not available to the proposed target area. The

unavailability of these services was determined from evidence presented in project applications, comments from health-planning committees, and data contained in the current State plan.

A New York official told us that New York provided funds on a first-come, first-served basis to applicants whose proposals were developed in accordance with their county's alcohol plan and had been approved by the appropriate county alcohol group. An official told us that, as an adequate indication of need, they accepted any one or a combination of the following: general demographic data on the catchment area, an estimate of the target population, and a statement that the existing services in the county were either nonexistent or inadequate.

NIAAA PLANS FOR PROJECT GRANTS NEED TO BE BETTER COMMUNICATED TO STATES

Public Law 91-616, as amended (42 U.S.C. 4577 (Supp. V 1975)), to directly support alcohol abuse treatment projects at the local level. The Congress intended that this authority be used to continue the support of special projects begun by NIAAA and meet the urgent needs of special populations not being served by State and local projects.

NIAAA has used this direct funding authority to support treatment projects primarily designed to serve special target populations. 1/ In contrast, projects funded by the five States we visited were generally designed to serve all persons within a designated geographic area. Officials at the five State alcohol agencies stated that inadequate knowledge of NIAAA's funding priorities, NIAAA's project grant program, and the uncertainty of where and when NIAAA would place a project were impeding their ability to develop effective plans.

Public Law 91-616 specifically requires that each project grant applicant provide a copy of the application to the State at the time of submission to NIAAA. The legislation encourages the States to comment on the proposed project's relationship to other projects in the State and the State alcohol program

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1/Target groups funded by NIAAA include the aged, American Indians, Alaskan natives, Blacks, Spanish American, women, youth, migrant farm laborers, the criminal justice population, the impoverished, public inebriates, alcoholic employees, and drinking drivers.

plan. An NIAAA official informed us, however, that State comments are received for only 40 to 50 percent of all applications submitted to NIAAA.

Officials at the five States we visited attribute low response rates to the fact that they had not received applications from all potential grantees that were submitting applications to NIAAA. According to them, while project applications are obtained from State alcohol agencies, not all project applicants submit copies of their applications to the States as required by law. Moreover, NIAAA does not routinely consult with the States before approving and funding projects. Consequently, the State authorities have no way of knowing which applications have been submitted and are being considered for NIAAA support until after the projects are funded.

Officials in three States informed us that they routinely give favorable reviews to project applications which they do receive and comment on. The officials cited the need for increased alcoholism services projects regardless of where the projects are placed, the desire for more Federal dollars coming into their jurisdictions, and the belief that NIAAA does not seriously consider their comments as the reasons for not providing substantive comments.

Subsequent to our review, an official of one State informed us that communications with NIAAA had improved in recent months and that, in most cases, NIAAA funding decisions on proposed grant applications have been consistent with the recommendations made by the State alcoholism agency.

Unless procedures for coordinating NIAAA and State planning activities are improved, duplication of efforts could result, since the people served by NIAAA's special target population projects are essentially the same type of people who would be served at a State project serving all people in a specific geographic area.

CONCLUSIONS

NIAAA and State planning processes are not adequate to insure the development of program plans which will allocate the greatest amount of available resources to areas having the greatest needs. Greater attention must be devoted to:

--Developing better estimates on the size of the alcohol-abusing population.

--Developing information concerning the geographic distribution and demographic characteristics of the alcohol-abusing population.

--Updating out-of-date inventories of existing treatment facilities and collecting data on treatment facility capacities.

--Allocating funds on the basis of relative need for more treatment programs, as well as relative population and financial needs of the State.

--Developing measurable program objectives.

Furthermore, NIAAA's plans to support treatment projects at the local level must be better communicated to the States, and State authorities must be more responsive in commenting on applications for specific NIAAA-funded projects in their States.

NEW LEGISLATION REQUIRES IMPROVEMENTS IN PLANNING PROCESS

In July 1976 the Congress enacted Public Law 94-371, The Comprehensive Alcohol Abuse and Alcoholism Prevention Treatment and Rehabilitation Act Amendments of 1976 (42 U.S.C.A. 4541 (Supp. Dec. 1976)). This act places specific requirements on NIAAA and the States which, if implemented properly, should alleviate many of the problems in the NIAAA and State planning processes that we have identified.

Among other things, this legislation requires

--The Secretary, HEW, to issue regulations establishing a methodology to assess and determine the incidence and prevalence of alcohol abuse within the States. These regulations are to become effective no later than January 23, 1977,1/ and the methodology developed is to be used in determining the relative need for more effective prevention, treatment, and rehabilitation of alcohol abuse and alcoholism within each State.

1/A notice of proposed rulemaking for these regulations was published in the Federal Register on Feb. 1, 1977. HEW estimates that final regulations will be published about June 1, 1977.

--The States to include in their State alcohol plans (1) a complete inventory of public and private resources available for alcohol abuse and alcoholism treatment, prevention and rehabilitation and (2) reasonable assurance that prevention or treatment projec's or programs supported by formula grant funds have provided the State with proposed performance standards to measure the effectiveness of such prevention or treatment projects or programs.

--The Secretary, HEW, to issue regulations requiring each State participating in the formula grant program to report to the Secretary on progress made in implementing the State plan. Such reports are necessary for Federal approval of State plans.

RECOMMENDATIONS

We recommend that the Secretary of HEW direct NIAAA and encourage the States to:

--More accurately determine the magnitude of the alcohol abuse problem on the national and State levels and develop information on the geographic distribution and demographic characteristics of the alcohol-abusing population.

--Maintain accurate and current inventories of treatment facilities and information on their capacities.

--Make a greater effort to distribute funds in accordance with the relative need for more treatment programs.

--Establish measurable objectives which specify, to the extent possible, when and how stated goals are to be attained.

Furthermore, the Secretary should direct NIAAA to improve its communications with the States before awarding project grants and to give greater attention to the impact these grants have on States' alcohol abuse programs, especially those aimed at special target populations, since a potential exists for overlapping with State projects serving specific geographic areas. To facilitate greater awareness by State alcoholism authorities of proposed projects within their jurisdictions, NIAAA should develop a mechanism to assure that project applications are submitted to the State alcoholism

agencies. The State agencies should be encouraged to provide NIAAA with objective comments on each proposal within 30 days.

AGENCY COMMENTS AND OUR EVALUATION

HEW stated that actions taken or planned in response to the requirements of Public Law 94-371 are also responsive to our recommendations.

According to HEW, action has been taken to develop methodologies for determining the incidence and prevalence of alcohol problems in the States and in the general population. NIAAA plans to use State prevalence data as a component in its distribution formula for the formula grant program.

HEW advised us that NIAAA has also initiated action to develop a national inventory of alcoholism resources. This inventory will assist the States in developing State inventories required by Public Law 94-371. An NIAAA official stated that to the extent possible these inventories will include data on treatment project capacity.

HEW commented that Public Law 94-371 requires State alcoholism plans to include assurances that projects funded with State formula grant funds have provided the States with proposed performance standards useful for measuring project effectiveness. The act also requires the States to report to the Secretary on progress made in implementing the State plan. HEW believes these requirements will lead to the development of measurable program objectives in the States. Additionally, NIAAA is developing methodologies to assess the impact of its programs and believes that as a result of these activities the information and capability for establishing measurable objectives for its directly funded projects will also be developed.

We agree that certain provisions of Public Law 94-371 specifically address issues involved in several of our recommendations regarding the planning processes for alcoholism programs, and it appears that most of the actions cited in the Department's comments are responsive to our recommendations. The HEW actions and the requirements placed on the States by Public Law 94-371 should contribute to improved alcohol abuse program planning procedures at both the State and national levels.

With respect to our recommendation that NIAAA improve communication with the States and develop a mechanism to notify States of proposed direct project grants, HEW cited the provision of Public Law 93-282 and OMB Circular A-95 which requires action by project applicants to notify States when applications are submitted to NIAAA. The Department also stated that NIAAA automatically notifies States when direct project grant applications are received at NIAAA.

As we pointed out above, existing legislation requiring project applicants to submit copies of applications to the States was not being complied with in the five States where we conducted our review. Although we did not specifically include the provisions of OMB Circular A-95 in our review, none of the State authorities we talked to cited these provisions as alleviating the problems we noted. We believe that if these regulations are to be effective, additional efforts are needed.

We were informed by a NIAAA official that the automatic submission of project applications to the States occurs in those instances where State comments have not been received on a proposed project which is scheduled for review by NIAAA's initial review groups. NIAAA anticipates that the States will review the application, contact the proposed applicant for any additional information necessary, and submit comments to NIAAA in time for consideration by the review groups. Although we have not evaluated the results of this procedure, it appears that the State alcoholism agencies will be in a position to fully communicate their assessment of proposed projects to NIAAA, and NIAAA will be able to more fully consider the impact its projects will have on the States' alcoholism plans.

CHAPTER 3

CONCERTED NATIONAL EFFORT TO COMBAT ALCOHOL ABUSE HAS BEEN SLOW IN DEVELOPING

National Institute on Alcohol Abuse and Alcoholism was established to spearhead a national attack on alcohol abuse. The Congress intended that this attack would be supported by all Federal departments and agencies providing such services as medical assistance, medical care, treatment, rehabilitation, and social services. The Congress believed that substantial legislative authority existed to assist persons suffering from disabilities or disease and expected that Federal agencies would cooperate with NIAAA to insure that recipients of this assistance would include alcohol abusers. NIAAA was expected to specify how existing Federal legislation could be used to most effectively combat alcohol abuse and to coordinate all Federal efforts in the fight against alcohol abuse.

This concerted Federal approach to combating alcohol abuse has been slow in developing because

--NIAAA has been unable to establish and maintain effective coordinating relationships with all appropriate Federal agencies,

--HEW was slow in establishing the legislatively required Interagency Committee on Federal Activities for Alcohol Abuse and Alcoholism, and

--all HEW programs capable of contributing to a national effort to combat alconolism have not done so.

COORDINATION BETWEEN NIAAA AND OTHER FEDERAL AGENCIES NEEDS IMPROVEMENT

NIAAA has been unable to develop a coordination mechanism which insures that all Federal alcohol-related activities are integrated into a single coordinated Federal approach to the alcohol abuse problem. The development of such a mechanism was a major concern expressed in the congressional committee reports on Public Law 91-616.

The Senate Committee on Labor and Public Welfare(now known as the Senate Committee on Human Resources) report(S. Rep. No. 1009, 91st Cong., 2d Sess. (1970)) stated that one of NIAAA's functions would be to develop a national plan for attacking the alcohol abuse problem.

This plan, which was to specify how Federal health, rehabilitation, and welfare legislation could be used and how all components of the Federal Government could contribute to a coordinated national approach, has not been developed by NIAAA. The Committee report further stated that NIAAA was to serve in a coordinating and consulting capacity to assist Federal departments and agencies in their alcohol abuse efforts. The House Committee on Interstate and Foreign Commerce report (H.R. Rep. No 1663, 91st Cong., 2d Sess. (1970)) also cited the need for action by the many Federal departments and agencies if progress was to be made in dealing with alcohol problems.

Problems in coordinating the national effort

NIAAA officials said they were not fully aware of all the Federal programs providing treatment to alcohol abusers and that a formal coordination policy for NIAAA relations with other Federal agencies had not been developed.

NIAAA has no legal authority over Federal agency activities, and Federal agencies are not required to coordinate with and report to NIAAA regarding their alcohol abuse programs. An NIAAA official cited this lack of authority as the main reason why more extensive coordination has not developed.

NIAAA's coordination efforts depend on its ability to persuade other Federal agencies to cooperate. According to an NIAAA official, this ability is limited because NIAAA lacks sufficient staff to seek out the cooperation of all Federal agencies. Consequently, NIAAA has restricted its coordination efforts to those agencies that it believes could have the greatest impact on the alcohol abuse problem and that have responded positively and quickly to coordination requests.

As of December 20, 1975, NIAAA had 130 authorized permanent positions, but only 106 had been filled. NIAAA's Division of Special Treatment and Rehabilitation Programs and Division of Resource Development, which coordinate most of NIAAA's activities, had a combined staff authorization of 38 permanent positions at December 20, 1975; 33 of these were filled. These divisions also were responsible for monitoring about 637 project grants and the formula grant program in 56 States and territories.

NIAAA's relationships with other Federal departments and agencies engaged in alcohol-related activities have been

conducted very informally. Coordination activities delegated to individual staff members are in addition to normal work assignments. Staff members, in some instances, have relied on periodic, often infrequent, telephone contact with their counterparts in other agencies. NIAAA has established no formal coordination policy or provided its staff with instructions to assist them in carrying out coordination responsibilities.

We recognize that informal, unstructured interagency relationships often produce excellent results. NIAAA's informal system, however, has not resulted in the continuous exchange of current information among Federal agencies. The system depends heavily on personal relationships established by individual staff members and is not controlled by record-keeping requirements or uniform procedures. Increased workloads and/or staff changed within NIAAA or the other Federal agencies could adversely affect the system's effectiveness and continuance.

NIAAA coordination activities

We identified 14 Federal agencies in 5 departments and 2 independent agencies--Veterans Administration (VA) and Civil Service Commission--which have had some contact with NIAAA since its inception in 1971. Appendix II gives a brief description of these agencies' alcohol-related activities. Examples of the types of interagency relationships NIAAA has developed with some of these agencies are discussed below. For the most part, coordination has been limited.

Department of Justice

NIAAA's contacts with the Department of Justice and its Law Enforcement Assistance Administration (LEAA) and Bureau of Prisons have consisted primarily of participation in study groups and information-gathering projects regarding alcohol abuse problems of the criminal justice population. LEAA and NIAAA officials stated that no formal coordination arrangements have been worked out. LEAA officials indicated that contacts with NIAAA have been minimal. An NIAAA official indicated that telephone contacts with LEAA occurred a few times a month but could not provide documentation of this.

Veterans Administration

VA supports alcohol treatment programs at 71 of its 171 hospitals throughout the country. VA reported that about 3 million veterans suffer from alcoholism; that alcoholism is the number-one diagnosis in the VA hospital system, and

that about 157,000 veterans were treated for alcoholism or a related condition during fiscal year 1974. Despite the large number of veterans with alcohol abuse problems and the large alcoholic population in the VA hospital system, coordination between NIAAA and VA at the headquarters level has been minimal. The only direct relationship we found between NIAAA and VA was the ex-officio VA representative on the National Advisory Council on Alcohol Abuse and Alcoholism.

We were informed that no person or division within NIAAA has the responsibility for coordination with VA. NIAAA believes there is no need for formal involvement with VA since the latter has the required skills to carry out what NIAA believes is an adequate alcohol treatment program.

NIAAA has periodically exchanged information with individual VA hospitals regarding the monitoring and evaluation of alcohol treatment projects and has provided some consultation services to VA headquarters personnel. According to one NIAAA official, general knowledge of VA's alcohol activities is acquired primarily through information provided in NIAAA grant applications submitted for areas served by VA facilities.

Department of Transportation

Before fiscal year 1974 NIAAA enjoyed a close working relationship with the Department of Transportation. In 1971 the Department's National Highway Traffic Safety Administration (NHTSA) and NIAAA embarked on a closely coordinated attack on the drinking driver problem. Through increased highway surveillance by State and local police supported by NHTSA grants, problem drinking drivers were identified and referred to treatment projects which NHTSA or NIAAA supported. Referral was usually an alternative to traditional penal sanctions.

Beginnning in 1970 NHTSA funded 35 alcohol safety action projects while NIAAA funded 16 services for problem drinking driver projects and 9 comprehensive treatment centers in the same geographic areas served by the NHTSA projects. NIAAA and NHTSA held regular bimonthly meetings to discuss problems and activities. However, in 1974, NHTSA discontinued support of 25 projects because of budgetary constraints and because they were only considered demonstration projects. Since that time, coordination activities have been reduced to periodic telephone conversations and occasional meetings between staff members of the two agencies.

An NHTSA official stated that differences in program goals and objectives have created some problems in coordination efforts. However, NHTSA recognizes NIAAA as the Federal authority on alcohol abuse problems and looks to it for advice and consultation whenever necessary.

Other HEW agencies

NIAAA has had contact with several agencies within HEW that administer health, rehabilitation, and social welfare programs offering benefits to individuals with alcohol abuse problems. For the most part, those efits result from an individual's general eligibility to icipate in an agency's program rather than as a direct resu.. of his alcohol abuse.

NIAAA has maintained a close working relationship with National Institute of Mental Health. The physical proximity and personal relationships among the Institutes' staffs are very conducive to NIAAA's tendency toward informal coordination. Also, the dual responsibility for implementation of the Community Mental Health Centers Act requires close cooperation between the two Institutes. The 44 comprehensive alcohol treatment centers supported by NIAAA were initially funded under part c of the act and about one-half of the treatment centers are affiliated with community mental health centers supported by NIMH.

An official of the National Institute on Drug Abuse (NIDA) said NIAAA and NIDA coordination has been successful in instances involving demonstration projects for combined drug and alcohol abuse treatment and joint support of substance abuse teaching programs at educational institutions. However, they do not have a free exchange of information. An NIAAA official generally agreed with the NIDA official's assessment of this situation.

A formal cooperation agreement between the Rehabilitation Services Administration (RSA) and NIAAA was signed in 1972. Jointly sponsored rehabilitation projects began shortly thereafter. However, funding limitations and conflicts over the scope of project activities have subsequently reduced the cooperative efforts between the two agencies significantly. An RSA official informed us that little contact now occurs between NIAAA and RSA principally because of staffing limitations and RSA's low priority on alcoholism.

This low priority resulted from provisions in the Rehabilitation Act of 1973 (Public Law 93-112, 29 U.S.C. 701

et seq. (Supp. V 1975)), which requires that first priority be given to the severely physically or mentally handicapped. In contrast to congressional reports supporting the enactment of Public Law 91-616 in 1970 which recognized alcoholism as a major health problem, the conference report supporting Public Law 93-112 made it clear that the conferees viewed alcoholism as a social disability to be given low priority in federally assisted vocational rehabilitation programs.

In 1972 NIAAA entered into an agreement with the Social and Rehabilitation Service (SRS) for the programming and funding of alcohol abuse prevention, control, treatment, and rehabilitation programs. The agreement paralleled the one entered into with RSA but extended the scope of activities to the full range of social services provided by SRS. However, no activities were ever started as a result of this agreement, although it remained in effect until June 30, 1975. The agreement called for NIAAA to reimburse SRS for its expenditures up to $1 million each year, but no funds were made available for this purpose.

NIAAA has expressed its intention to seek SRS assistance in urging State authorities to increase services provided to alcohol abusers under the Medicaid program (title XIX of the Social Security Act) and the Social Services for Individuals and Families program (title XX of the Social Security Act). Under these State-administered programs the amount of services available to alcohol abusers is determined by the State authorities. 1/

TWO-YEAR DELAY IN ESTABLISHING INTERAGENCY COMMITTEE

In May 1974 amendments to Public Law 91-616 directed the Secretary of HEW to establish an Interagency Committee on Federal Activities for Alcohol Abuse and Alcoholism.

This committee, with the Secretary of HEW or the Director of NIAAA acting as chairman, is to include appropriate scientific, medical, or technical representatives from the Departments of Transportation, Justice and Defense, the Veterans Administration, and such other Federal agencies and offices (including those within HEW) as the Secretary determines and five individuals from the general public appointed by the Secretary, who by virtue of training or

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1/See ch. 6 for further information on the Medicaid program.

experience are qualified to participate in the committee's functions.

The Congress expected that this committee would be used to help NIAAA meet its responsibilities as the focal agency for the Federal attack on alcohol abuse. Specifically, the committee was expected to:

--Evaluate the adequacy and technical soundness of all Federal programs and activities which relate to alcohol abuse.

--Provide for the communication and exchange of information necessary to maintain the coordination and effectiveness of such programs and activities.

--Coordinate efforts undertaken to deal with alcohol abuse in carrying out Federal health, welfare, rehabilitation, highway safety, law enforcement, and economic opportunity laws.

The Secretary of HEW was also given the responsibility to report annually to the Congress on the extent to which other Federal programs and departments are concerned and dealing effectively with the problems of alcohol abuse. The first of these reports was due December 1974. In January 1975 the Secretary reported to the Congress on the progress being made in establishing the Interagency Committee. An NIAAA official told us that HEW believed this report met the Secretary's responsibility. However, as of January 1977 no formal report on Federal agencies' activities has been issued.

Although NIAAA officials recognized the importance of the Interagency Committee to the Secretary's reporting responsibilities, not until December 10, 1974, did the Assistant Secretary of Health request chartering of the committee. 1/ The Secretary of HEW approved the charter on February 4, 1975. However, the Alcohol, Drug Abuse, and Mental Health Administration did not submit nominations for the five representatives from the general public until November 1975. In March 1976 the Secretary approved these nominations. The committee met for the first time in May 1976, 2 years after the Congress mandated its establishment.

1/Under provisions of the Federal Advisory Committee Act no advisory committee may meet until a charter has been approved.

LIMITED USE OF SUPPLEMENTAL SECURITY INCOME PROGRAM TO GET ALCOHOL ABUSERS INTO TREATMENT

Title XVI of the Social Security Act, as amended (42 U.S.C. 1381 et seq. (Supp. V 1975)) authorizes the Social Security Administration (SSA) to provide Federal financial assistance to low-income persons who are blind, disabled, or over 65 years of age, and who meet various eligibility requirements. The authorizing legislation, section 1611(e)(3)(A), states that:

> "No person who is an aged, blind, or disabled individual solely by reason of disability * * * shall be an eligible individual * * * for purposes of this title * * * if such individual is medically determined to be a drug addict or an alcoholic unless such individual is undergoing any treatment that may be appropriate for his condition as a drug addict or alcoholic * * *."

In addition, the act provides that in the case of an individual referred to above, supplemental security income benefits must be paid to a person or public or private agency interested in the individual's welfare rather than to the individual himself.

The purposes of these provisions are set out in congressional reports supporting the legislation. The House Ways and Means Committee report (H.R. Rep. No. 231, 92d Cong., 1st Sess. (1971) expresses the Committee's belief:

> "* * * that those people who are disabled, in whole or in part, as a result of the use of drugs or alcohol should not be entitled to benefits under this program unless they undergo appropriate, available treatment in an approved facility, and the bill so provides. Your committee, while recognizing that the use of drugs or alcohol may indeed cause disabling conditions, believes that when the condition is susceptible to treatment, appropriate treatment at Government expense is an essential part of the rehabilitation process of people so disabled."

The Senate Committee on Finance report (S. Rep. No. 1230,92d Cong., 2d Sess. 1972)) states:

> "The committee is particularly concerned that persons who are disabled because of alcoholism or drug

addiction be provided rehabilitative services under a program of active treatment rather than simply being provided income with which to support their addiction or alcoholism. Accordingly, alcoholics and drug addicts under the committee bill would be able to receive maintenance payments only as a part of a program of active treatment."

Moreover, a November 1972 joint publication of the Senate Committee on Finance and the House Committee on Ways and Means summarizing the Social Security Amendments of 1972 states:

"No disabled person will be eligible if he is medically determined to be a drug addict or an alcoholic unless such individual is undergoing appropriate treatment, if available. Payments for addicts or alcoholics will be made only as protective payments to third parties."

An NIAAA official informed us that the SSI program has not been used to get alcohol abusers into treatment because SSA does not determine whether an individual applying for benefits is an alcoholic in need of treatment and SSA's implementation procedures require few persons with alcohol problems to undergo treatment. Personnel at three disability determination service units told us that the mandatory treatment and third-party payee provisions of title XVI were rarely applied in their disability determination decisions. Each expressed the opinion that SSA's instructions discourage the use of the provisions.

Personnel at one local unit stated that alcoholism is considered only as a last resort and then only if it can be related to an SSA list of specific nonpsychotic impairments. Personnel at another unit told us that, because of past difficulties in getting SSA to approve a case requiring treatment for alcoholism, they no longer try.

Pesonnel at a third unit stated that, when an applicant can be judged disabled without considering alcoholism, no further actions are taken even though the applicant's medical reports indicate the existence of alcoholism.

SSA instructions used by these disability determination service units state that the mandatory treatment and third-party payee provisions apply only to disabled individuals whose alcoholism or drug addiction contributes to the decision that disability exists. These instructions further state:

"Whether DA or A [drug addiction or alcoholism] contributes to the disability will depend first on whether the individual's impairment, independent of his DA or A, meets the severity and duration requirements. If so, the individual will not be considered a medically determined DA or A for title XVI purposes since DA or A does not contribute to the disability; thus, the mandatory treatment and representative payee requirements will not apply.

"An individual may be found to be disabled independent of any DA or A involvement if any of the following criteria apply (1) the individual meets or equals the Listing of Impairments [specific disabling impairments established by SSA] on the basis of impairment(s) * * * unrelated to DA or A; (2) the individual meets or equals the Listing of Impairments on the basis of impairment(s) which may conceivably be related to DA or A, but which impairment(s) is of such severity and expected duration that he would be found disabled even if DA or A did not exist * * *; or (3) the individual's impairment(s) does not meet or equal the level of severity in the Listing of Impairments but because of other considerations (e.g., adverse vocational factors), the impairment is disabling irrespective of any DA or A. In the foregoing instances, DA or A will not be determined to be a contributing factor in the disability."

Under these instructions, an alcoholic individual eligible for SSI benefits on the basis of some physical or mental impairment other than alcoholism will not be required to undergo treatment for his alcoholism problem and will not receive his SSI benefits through a third party.

Data obtained from a case file on an SSI applicant illustrates how a disability case involving alcohol was adjudicated under the present implementation procedures. The disability determination service unit had adjudged the applicant as disabled and listed alcoholism as the primary diagnosis. As the basis for this determination the applicant's file stated:

"According to medical records, claimant is a chronic alcoholic who has been hospitalized

three times during the past five months each time for acute alcoholism and seizure disorder. * * * Claimant has a long history of alcoholism drinking 1 to 2 pints of whiskey and several beers per day. * * * A recent neurological examination established a chronic brain syndrome and peripheral neuropathy caused by chronic ethenol intake and head trauma. It is determined that alcoholism contributes to the disability already established."

Subsequent review of this case by SSA personnel changed the diagnosis, omitting any reference to alcoholism. SSA commented:

"[Claimant] has peripheral neuropathy, spasticity, unsteadyness, chronic brain syndrome and abnormal E.E.G. and brain scans. * * * Since the claimant's impairments are severe enough to establish disability without a diagnosis of alcoholism the DA/A designation is not necessary. * * *"

This case file appears to support a finding of alcoholism on the basis of medical determinations and, in our opinion, this individual could have been required to undergo treatment as a condition for receiving SSI benefits.

When SSA assumed its responsibility for administering the SSI program in January 1974, about 1.2 million disabled persons were converted from the States' programs to the Federal program. We noted that only about 12,900, or about 1 percent of these persons, have been required to undergo treatment for their alcohol or drug problem as a condition to receiving supplemental security income assistance. SSA records show, however, that about 12,600 of these persons came from 8 States where the State program had permitted disability payments solely on the basis of alcoholism or drug addiction. For conversion purposes, SSA had agreed to accept these cases as eligible for SSI benefits.

State personnel, acting under the guidance of SSA instructions, had originally identified about 44,000 disability conversion cases as possible alcoholics or drug addicts. SSA regional personnel, however, reevaluated these cases and, as of April 1975, determined that 31,000 cases were erroneously coded as alcoholics or drug addicts.

SSA stated that its reevaluation was necessary because amendments to the law changed the periods for eligibility and

because it believed that State personnel had misinterpreted SSA instructions for determining whether an individual's alcoholism or drug addiction contributed to his disabling impairment.

SSA has considered and rejected an interpretation of the mandatory treatment provisions which would have required all disabled individuals suffering from alcoholism to undergo treatment without regard to whether their alcoholism was related to their disability determination.

SSA believes that the legislative history on title XVI supports its position that individuals eligible for SSI must undergo appropriate, available treatment only if the individual is considered disabled in whole or in part by his alcoholism.

In our opinion, the statutory language of title XVI of the Social Security Act of 1972 (see p. 35) and the legislative history of this act could also support the position that any individual suffering from alcoholism who is eligible for SSI should be required to undergo appropriate, available treatment regardless of whether or not the alcoholism was considered in the disability determination.

While the legislative intent of the SSI provisions relating to appropriate, available treatment for disabled individuals suffering from alcoholism is unclear, the legislative histories of Public Laws 91-616 and 93-282 state that whenever possible all Federal legislation should be used to combat alcoholism.

CONCLUSIONS

In our opinion NIAAA needs to do more to develop a concerted national attack against alcohol abuse. We recognize that NIAAA is not legally able to require interagency cooperation and coordination and may not have sufficient staff to continually persuade Federal agencies to coordinate their activities. We believe, however, that NIAAA could provide better opportunities for Federal agencies to volunteer their assistance, exchange information, and seek NIAAA's help in developing alcohol abuse programs. The informality of NIAAA's current coordination procedures is not conducive to permanent relationships between NIAAA and other agencies. More formal coordination mechanisms at policymaking levels are needed to supplement these procedures.

The 2-year delay in establishing the Interagency Committee on Federal Activities for Alcohol Abuse and Alcoholism

has contributed to the problem of developing a broadly based coordinated Federal response to the alcoholism problem. The prompt establishment of this committee might have alleviated some of the coordination difficulties NIAAA has experienced.

Expectations that agencies other than NIAAA would contribute significantly to alleviate alcohol problems are not being realized. SSA officials have interpreted the SSI program's authorizing legislation in such a way that the program's potential for identifying individuals suffering from alcoholism and requiring them to enter appropriate, available treatment has been diminished. In our opinion, alcoholics should not be entered on the SSI rolls solely on the basis of some other qualifying impairment when alcoholism also is present because this could possibly deny someone the opportunity to benefit from treatment and become more socially productive. Congressional clarification as to who is subject to the mandatory treatment provisions of title XVI is needed if the SSI program is to meet its potential to aid in combating alcoholism.

RECOMMENDATIONS

We recommend that the Secretary of HEW

--require NIAAA to improve its coordination procedures with other Federal departments and agencies by establishing more formal, structured coordination mechanisms;

--insure that sufficient staffing resources are available to NIAAA to carry out its coordination responsibilities;

--require NIAAA to develop a national plan for attacking the alcohol abuse problem which specifies how all Federal departments and agencies can contribute to a coordinated Federal approach; and

--require the Interagency Committee on Federal Activities for Alcohol Abuse and Alcoholism to promptly evaluate the adequacy and technical soundness of all Federal programs and activities which relate to alcohol abuse.

AGENCY COMMENTS AND OUR EVALUATION

HEW stated that it believes the establishment of the Interagency Committee on Federal Activities for Alcohol Abuse and Alcoholism will do much to alleviate Federal agency coordination problems identified in this report and will provide input to NIAAA's formulation of a national plan for attacking the alcohol abuse problem.

According to HEW, each participating Federal agency has been requested to provide the Committee with information regarding alcohol abuse expenditures and budget projections and to make recommendations for additional programs and areas where increased coordination is needed. The Interagency Committee will use this information to review and evaluate the effectiveness of the Federal agencies' programs. HEW stated that NIAAA will use this information to meet its coordination responsibilities and has designated specific staff members as having primary responsibility for coordinating data collection and other activities of the Interagency Committee.

We agree that the Interagency Committee has a high potential for alleviating some of the coordination problems we identified. We continue to believe, however, that more direct communication channels between NIAAA and other Federal agencies must be established to insure that a unified Federal effort is developed and maintained. Such channels need to be available at all times and should not be limited to the anticipated infrequent meeting schedule of the Interagency Committee. We further believe that specific coordination responsibilities of NIAAA staff should not be limited to the activities of the Interagency Committee. Rather, the coordination responsibilities of all appropriate staff positions should be clearly defined and, considered together, should constitute a formal coordination mechanism.

We recognize that Interagency Committee input to a national plan for attacking the alcohol abuse problem would be desirable. However, a more important issue, in our opinion, is NIAAA's timely formulation of a comprehensive plan which describes national needs, priorities, and contributions expected from Federal agencies to meet these needs. Such a document would enhance the Interagency Committee's effectiveness. In this connection, the Interagency Committee stated during its May 1976 meeting that it was chartered to review and evaluate Federal agencies' programs but not to develop or suggest programs necessary to meet the national

needs. NIAAA's comprehensive national plan would serve as review and evaluation criteria for the Committee.

RECOMMENDATIONS TO THE CONGRESS

The Congress may wish to give NIAAA authority to establish Federal coordination policies and procedures, and to monitor Federal departments' and agencies' programs as a means of achieving a more concerted Federal effort against alcohol abuse.

We also recommend that the Congress clarify whether section 1611(e)(3)(A) of the Social Security Act applies to all disabled SSI recipients suffering from alcoholism or drug abuse or only to those recipients whose disability determination depends on alcoholism or drug abuse.

CHAPTER 4

STRENGTHS AND WEAKNESSES OF NIAAA'S EVALUATION SYSTEM

National Institute on Alcohol Abuse and Alcoholism should be commended on its early actions in (1) developing an automated data collection system capable of monitoring the progress of individuals in treatment and (2) drafting expected standards of performance for its comprehensive alcohol treatment centers. Project officials generally believe the system is useful, data inputs are reasonably accurate, and indicators of client change are meaningful.

NIAAA has made significant progress in increasing the number of projects on the system. As of August 1976 over 56 percent of the total number of projects being funded were providing data to the system. Data on additional projects and followup data on more clients would appear to be needed to insure the reliability of judgments on the overall performance of projects and programs.

Also, the development of additional standards for projects other than the alcohol treatment centers is necessary to provide a basis for assessing their performance. Furthermore, NIAAA needs to improve its site visitation program to insure that individual projects are adequately complying with Federal guidelines and operating efficiently and economically.

DEVELOPMENT OF AUTOMATED PROGRAM MONITORING SYSTEM

In fiscal year 1971, its first year of operation, NIAAA awarded a contract for the design and implementation of an automated system capable of monitoring client performance and other activities of its alcohol treatment centers (ATCs). These centers provide comprehensive alcohol treatment to all types of alcohol abusers. It was postulated that the monitoring system must serve program management and evaluation personnel at participating ATCs as well as NIAAA and that without active and enthusiastic ATC support the system would not realize its full potential.

Other contracts were subsequently awarded to develop automated systems for the drinking driver, public inebriate, Indian, occupational, and poverty programs. A set of core data

forms was developed which applies to any client-oriented alcoholism program. Additional data items peculiar to the special target group projects were also collected.

When a client is admitted for treatment, data is collected on his or her age, sex, ethnic characteristics, marital status, occupation, income, education, physical condition, drinking habits, behavioral problems, and source of referral. This information is compared with other data collected after 180 days in treatment to determine client change over time.

This system also provides project managers, NIAAA officials, and others with information concerning project operations. The four major activities monitored are

--alcohol treatment services provided,

--staffing patterns and use,

--expenditures, and

--revenue from all sources.

An indication of NIAAA's commitment to developing an automated monitoring system is reflected by the amount of funds that it has spent for developing and implementing this system. The following table shows the cost to develop and implement the system and to evaluate the information for each type of treatment program for June 1971 through October 1975.

Program	Cost
ATCs	$1,029,210
Drinking driver	526,087
Public inebriate	134,200
Occupational	296,251
Indian	538,552
Poverty	176,736
Total	$2,701,036

In addition, NIAAA had obligated approximately $1.04 million for data processing and the preparation of output reports through October 1975. These figures do not include the salaries of such treatment project personnel as data coordinators who are responsible for preparing and processing data.

Reliability of client-reported data

Project officials advised us that, in their opinion, most client data on demographic characteristics; occupational status; and past treatments, both at admission and after treatment, is reported in a reasonably accurate manner at least 75 percent of the time. Officials also believed that at the time of admission about 60 percent of the information on drinking behavior was accurate. They believed such data was more accurate when submitted after clients had been in treatment.

Usefulness of indicators

NIAAA uses the following indicators to measure client change.

--Abstinence (lack of consumption of alcoholic beverages).

--Quantity-frequency index (average daily consumption of absolute alcohol over the past month).

--Impairment index (the degree of behavioral problems stemming from excessive use of alcohol over the past month--measured on a scale of 0, minimum impairment, to 33, maximum impairment).

--Self-perception indicator (the client's opinion of his own drinking behavior).

--Interviewer perception indicator (the interviewer's assessment of the client's drinking behavior and the change in drinking behavior since intake.)

While project officials felt all indicators were useful, they considered abstinence to be the most useful measure of client change.

NIAAA and project officials' use of the system

NIAAA officials said their staff responsible for individual project management initially did not make extensive use of reports generated by the NIAAA system because the data was difficult to interpret. Since the time of our discussions, however, the format for output reports has been changed and the NIAAA staff has been given more training in interpreting the data for individual projects.

We also asked officials from 75 projects to respond to a questionnaire on the usefulness of NIAAA's automated monitoring system. Sixty-one complied with our request. Approximately 75 percent of these indicated that they used the output reports from the system for managing project operations. Selected comments indicated that the system was useful for

--providing a basis for assessing project efficiency,

--comparing one project with another,

--identifying areas where costs were disproportionately high,

--summarizing information which could be used by others,

--making changes in staff assignments, and

--determining the profile of clients served.

Problems being experienced by some project officials were:

--More technical assistance from NIAAA was needed to interpret the data.

--Reports were not received on time.

--Extensive details required by the system made it cumbersome.

An NIAAA official said that the above matters were discussed in training sessions held after our questionnaire was administered and that corrective actions had been taken.

Data on additional clients and projects needed to insure reliable evaluation results

For calendar year 1974, the system contained data on 19,749 clients who were admitted into treatment at either an ATC, a drinking driver project, or a public inebriate project. According to system procedures, a 180-day followup report should have been submitted on all these clients. For 38 percent of the 19,749 clients admitted into treatment, no followup report was made. For the remaining 12,158 clients for whom a followup report was on file, useful data for measuring client change was available for about 45 percent of these clients--or only 28 percent of the total num-

ber of clients. NIAAA officials advised us that they were aware of the problem of incomplete followup reports and have made project officials aware of the need for complete and accurate information. They indicated that some projects do better than others in submitting completed followup reports.

As of December 1975, the monitoring system was collecting data on 102 of the 637 active projects funded by NIAAA. Between December 1975 and August 1976 NIAAA added 219 projects to the system. As shown in the following table NIAAA had over 56 percent of its active projects reporting data as of August 1976.

	Total number of projects August 1976	Number of projects on the monitoring system August 1976
ATCs	43	39
Drinking driver	20	20
Public inebriate	23	19
Occupational	46	18
Indian	147	35
Poverty	173	136
Other (see note a)	114	54
Total	566	321

a/Includes projects serving such groups as women, youth, blacks, and Spanish Americans.

Some of the projects not on the system provide primarily outreach and referral services or support the activities of State occupational alcoholism consultants.

An NIAAA official told us that funding limitations and staff restrictions have prevented NIAAA from placing more projects on the system sooner. He also told us that NIAAA eventually would like to have all the treatment projects, including those that provide primarily outreach and referral services, on the system.

DEVELOPMENT AND USE OF STANDARDS

NIAAA has prepared effectiveness and efficiency standards that can be used to measure the performance of ATCs. The

standards are based on historical data contained in the program monitoring system, opinions of the project directors, and discussions with the NIAAA staff responsible for managing project operations. The standards concern staff use, treatment effectiveness, and cost efficiency and are expressed by a range of percentages, ratios, and dollar values.

At the time of our review, NIAAA had made little use of these standards to determine the effectiveness and efficiency of individual ATCs or whether support for these projects should be continued. In addition, only limited use was made of the standards to identify areas needing improvement or to initiate studies as to why projects were unable to meet expected levels of performance. NIAAA officials advised us that the standards were still being developed and further refinement was still considered necessary. Following are examples of ATC standards that have been developed.

--55 to 70 percent of the clients contacting the program should be admitted into treatment.

--For each hour spent on general administrative activities 3 to 5 hours should be spent on delivering direct alcoholism services.

--For clients admitted into treatment an acceptable dropout rate is between 25 and 33 percent.

--50 to 75 percent of the clients should have been drinking for less than 10 years.

--From 50 to 70 percent of the clients should be abstaining 180 days after the treatment is initiated.

--For those that drink, the average consumption at 180 days should be between 0.4 and 1.2 ounces of absolute alcohol each day for the last 30 days.

--From 25 to 45 percent of the project's revenue should come from third-party or client payments.

--Inpatient cost should be between $30 and $50 a day.

--Cost of an hour of outpatient services should be between $14 and $20.

NIAAA is in the process of developing additional standards for special target population projects, such as the

public inebriate, drinking driver, and occupational projects. A NIAAA official told us that delays have been experienced in the development and use of these standards due to

--a lack of staff,

--the need to develop and obtain acceptance of the standards for the ATCs before proceeding with those for the special target population projects, and

--a need for additional meetings with project directors and NIAAA staff before obtaining acceptance of the standards.

He added that, to a lesser extent, there were delays in obtaining clearances from HEW and the Office of Management and Budget on the forms used to collect data for the monitoring system.

NIAAA SITE VISIT EVALUATION ACTIVITIES

In addition to obtaining information from the 321 projects on the automated program monitoring system, NIAAA uses site visit teams to monitor and evaluate the 566 projects it was supporting as of August 1976. For the 10 projects we reviewed we found that

--projects were visited infrequently,

--information contained in some site visit reports was of limited scope and not adequately documented, and

--information pertaining to site visits was not always quickly communicated to the project managers.

From the time each grant was awarded until the time of our review, NIAAA made a total of 27 site visits to the 10 projects we visited. The projects had received NIAAA funds for periods ranging from 19 to 42 months. The number of site visits made after the grants were awarded ranged from 1 to 6. Information on the number of site visits is as follows.

--Three projects were visited each grant year.

--One project was not visited during its first or second grant year.

--Another project was not visited during its first grant year.

--Three projects were not visited during their second grant year.

--Two projects were not visited during their third grant year.

Officials at the Perth Amboy ATC, the Paterson poverty, and the Montana ATC projects told us that NIAAA had made some useful recommendations during the visits. Officials at the Bedford-Stuyvesant ATC, the Denver poverty, the New York City occupational, and the Seattle public inebriate projects said the site visit teams gave them technical assistance. Personnel at the Montana ATC, the Denver poverty, and the New York City occupational projects said they did not always receive site visit reports. At the time of our review seven site visits had been made to these projects but project personnel had received only three site visit reports. At the Montana ATC project we were told that recommendations to remove the project director caused many administrative problems and disrupted the staff. The director of the Denver poverty project noted that during the visits he and the visitor had no "face to face" discussions and that he had to wait for the reports to learn the visit's results.

An official at the Paterson poverty project said it was not feasible to implement some recommendations. For example, one site visit report suggested that the project place more emphasis on recruiting family cases. However, the project director contended that the poor inner-city alcoholic at whom the project is directed generally is not part of a family unit.

The site visits made to the 10 projects we visited varied greatly in scope and length--from 1 to 4 days--and in the number of site visit team members--from 1 to 9. Each of the four alcohol treatment centers was the subject of a lengthy comprehensive site visit headed by NIAAA personnel. These visits addressed program environment and agency structure and functions, identified and documented problem areas, and made appropriate recommendations. Followup visits were made to assess the progress in implementing the recommendations and to provide technical assistance.

The visits made to the two poverty and two Indian projects were conducted by representatives from th National Council on Alcoholism and the Amercian Indian Commission on Alcoholism and Drug Abuse, respectively, because NIAAA did not have adequate staff. These visits appeared limited, and the resulting reports--generally a brief pro forma schedule--usually provided only disclosure information on the projects' organization and program structure. Occasionally, problem areas were noted and recommendations were made. However, we were unable to determine the scope of the work done to support these recommendations.

In April 1975 NIAAA awarded a contract for over $1.3 million for technical assistance and monitoring of approximately 450 treatment projects, including all poverty projects. While we did not review the work of the contractor, an NIAAA official told us that the contract to provide annual site visits had been partially terminated because the contractor personnel did not have the necessary experience to provide the intended programmatic technical assistance.

MONITORING STATES' USE OF FORMULA GRANTS

Although the States and territories have received over $243 million of formula funds from fiscal year 1972 to fiscal year 1976, NIAAA only recently made an effort to determine how these funds were being spent. NIAAA officials told us that they have developed a system which should provide information on the impact of formula funds on States' activities. The system is designed to collect data annually from each State on the use of staff and funds in the areas of treatment, training, prevention and research. In June 1976, NIAAA published the system's first report which summarized information received from 39 States and territories.

CONCLUSIONS

NIAAA has made progress toward implementing a monitoring system that is capable of providing useful information for evaluating program and project activities. The development of performance standards for ATCs is an impressive first step for identifying specific areas that warrant improvement. We believe that, as standards are refined, they should be used to assess the relative effectiveness of projects seeking continued NIAAA financial support.

To insure that the system provides a reliable base for managers to make programmatic decisions, the number of projects on the system--especially Indian projects--should be expanded. Also, additional emphasis should be placed on completing 180-day followup reports for all clients who enter a treatment program.

Recent training to help project officials and NIAAA program managers interpret and use output reports should result in improved management of alcohol treatment projects. Periodic training in these areas should be continued.

NIAAA apparently will continue to have difficulty providing for site visits to each treatment project it funds. The Secretary, HEW, should thus insure that adequate personnel are made available to carry out this task or that adequate resources are available so that NIAAA can contract for this service.

RECOMMENDATIONS

The Secretary of HEW should direct NIAAA to

--continue developing the performance standards, particularly those that relate to the special target population projects;

--use existing standards developed for alcohol treatment centers as a means of assessing their overall effectiveness and efficiency, and for determining whether financial support should be continued;

--improve its mechanisms for obtaining information on each treatment project by developing a system for site visits based on project size and complexity and the need for technical assistance by project personnel.

AGENCY COMMENTS AND OUR EVALUATION

HEW generally agreed with our recommendations. The Department stated that development of performance standards for special target population projects is being continued and that additional standards have been developed for driving while intoxicated (DWI) projects, public inebriate projects and cross-population projects (projects designed to serve all segments of an area's population). The Department commented, however, that it believes additional analysis

of the standards is necessary before their role in project effectiveness appraisals can be increased. HEW also stated that an increase in authorized staff levels at NIAAA will be used to improve the Institute's project monitoring and site visit activities.

We agree that continued analysis of performance standards for alcohol abuse treatment projects is necessary to insure improvements in the quality of care provided to alcohol abusers. We continue to believe, however, that the refinement of the ATC standards we reviewed had progressed sufficiently to allow NIAAA to identify problem areas, assess individual project performance, and make funding decisions for the existing ATC projects.

CHAPTER 5

IMPACT OF NIAAA FUNDING ON PEOPLE, COMMUNITIES, AND STATES

Our analysis of data in the National Institute on Alcohol Abuse and Alcoholism automated monitoring system and in a NIAAA 18-month followup study 1/ on clients that came in contact with selected ATCs indicated that:

--Most people who contacted a project did not enter treatment.

--Many people who are not admitted to treatment are not referred elsewhere for treatment.

--Persons convicted of driving while intoxicated were more likely to complete treatment and drink less after treatment.

--Data showing the extent to which persons entering treatment achieved abstinence or reduced their level of drinking was lacking in more than 70 percent of the cases. For those persons on whom data was available, significant results were reported.

--Only 22 percent of all clients completed their treatment regime; 64 percent left before treatment was completed.

In addition, we contacted a number of clients being treated at three of the projects we visited and found that most of them believed they had benefited from the treatment they received.

Many representatives from community agencies and organizations providing services within the same area where the projects were located believed that the alcohol treatment projects funded by NIAAA had a positive impact on their community. State alcohol agency officials also believed that NIAAA's formula grant program had a positive impact on their activities.

1/A Follow-up Study of Clients At Selected Alcoholism Treatment Centers Funded By NIAAA, Stanford Research Institute, May 1975.

One of the analyses we made concerned client behavioral indexes. This analysis was based on only those clients who had entered treatment and for whom a 180-day followup report was completed. The Stanford Research Institute (SRI) study was based on a sample of clients who had come into contact with eight alcohol treatment centers irrespective of whether a 180-day followup report was completed. SRI's report contains information on

--clients who had one contact with the ATC and did not return,

--clients who had a few contacts with the ATC but who were never formally taken into the treatment program,

--clients who were admitted to the program but dropped out before 1 month,

--clients who were admitted to the program and stayed more than 30 days but dropped out before 6 months, and

--clients who stayed in more than 6 months or who completed treatment (stay-ins).

MOST WHO CONTACTED A PROJECT DID NOT ENTER TREATMENT

Data NIAAA collected as part of its automated system shows that 54 percent of those individuals contacting a project did not enter treatment. At 70 projects 1/ in 1974, 42,588 initial contacts were made and 19,749 persons were admitted to treatment. Of the initial contacts, 2,730 were originally placed on waiting lists. Of these, 758 or 27.8 percent were admitted within 1 month. Of the remaining 1,972 clients, 1,766 were not admitted to treatment. The following table contains information on those that did not enter treatment.

1/We reviewed automated monitoring system data for 44 alcohol treatment centers (ATCs), 17 problem drinking driver projects, and 9 public inebriate projects. Data was analyzed for clients who came in contact with one of these programs in calendar year 1974 and for whom a 180-day followup report was completed before July 1975.

Reason for not entering treatment	Type of project ATC	Drinking driver	Public inebriate	Total
Client placed on waiting list but not admitted	1,098	8	660	1,766
Client refused admission	2,163	21	421	2,605
Center refused to admit client	7,026	44	1,020	8,090
Client or center undecided	1,467	50	158	1,675
Client reported as intake but no evidence of admission	7,637	155	239	8,031
No response	58	594	21	673
Total	19,449	872	2,519	22,840
Initial contacts	34,774	3,931	3,883	42,588
Percent of contacts that did not enter treatment	56	22	65	54

Of the 22,840 clients who did not enter treatment, 8,031 were reported as intakes to a project, but the monitoring system records showed no evidence of admission into treatment. An NIAAA official told us that, although these clients had completed an initial contact form, the decision to enter treatment was voluntary. Many of them apparently never showed up for treatment at the project. He also told us that some of the clients may have received some pre-intake services without ever formally entering treatment. The NIAAA standard for ATCs states that intakes should be 55 to 70 percent of contacts. (See p. 48.)

MANY WHO ARE NOT ADMITTED ARE NOT REFERRED

There were 9,856 persons who were refused admission by the centers or who were placed on waiting lists and not subsequently admitted by the centers. The reasons included:

Reason for not being admitted	Type of project: ATC	Drinking driver	Public inebriate	Total
Required service was not available at center	969	15	345	1,329
No space at center	635	-	1,204	1,839
Client was untreatable at center (note a)	586	10	39	635
Subtotal	2,190	25	1,588	3,803
Client was in another program	4,410	5	53	4,468
Client was in a hospital, jail, or other institution	1,187	2	24	1,213
Other and no response	337	20	15	372
Total	8,124	52	1,680	9,856

a/Includes people who do not live in the catchment area or who are considered beyond help.

Apparently, at a minimum, the 3,803 clients who were not admitted because service or space was not available or because they were considered untreatable at the centers should have been referred to other service providers. However, only 46 percent of these clients were referred by the various programs.

Referrals by type of project

Type of project	Clients not admitted	Clients referred	Percent referred
ATC	2,190	987	45
Drinking driver	25	20	80
Public inebriate	1,588	729	46
Total	3,803	1,736	46

The NIAAA data system contained no explanations as to why referrals were not made. However, the NIAAA project guidelines for alcoholism programs stress the need for referral services to insure that required services are made available to clients.

WHAT HAPPENED TO CLIENTS WHO ENTERED TREATMENT?

We analyzed NIAAA's data to determine if there was a positive correlation between such variables as sex, years of heavy drinking, age, employment status, occupation, education, and monthly income; and treatment outcomes as measured by

--completion of treatment,

--abstinence,

--quantity and frequency of consumption, and

--degree of impairment.

Our analyses showed that treatment outcomes were most significantly affected if the client was referred by a court as a result of a conviction for driving while intoxicated. Other variables which affected treatment outcome were sex, age, occupation, monthly income, and years of heavy drinking. For example, those clients who were younger or more affluent than others had lower quantity-frequency indexes and were less impaired. These were also the characteristics of the typical person entering treatment as a result of a DWI conviction.

Completion of treatment

A measure of program accomplishment is the ability to retain a client until his individual treatment program is completed. The determination as to whether a client completed treatment is made by the counselor and client on an individual basis.

Our analyses disclosed that only 22 percent of all clients completed their treatment and 64 percent left before the treatment was completed. The remaining 14 percent were still receiving treatment. The following table shows the completion rates by program.

	Type of program							
	ATC		Drinking driver		Public inebriate		Total	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Entered treatment	15,326	100	3,059	100	1,364	100	19,749	100
Completed treatment	3,321	22	890	29	87	6	4,298	22
In treatment	2,380	15	144	5	239	18	2,763	14
Left before completing treatment	9,625	63	2,025	66	1,038	76	12,688	64

Reported reasons for not completing treatment were that the client voluntarily dropped out, was inaccessible, died, or was inactive for 3 months. The NIAAA standard for ATCs states that the client dropout rate should not exceed 25 to 33 percent. (See p. 48.)

Although the Stanford Research Institute study does not contain information on the number of clients who completed treatment on the basis of the projects' records, it does contain client responses on the reasons for leaving treatment. The reasons most often given were:

--Alcoholism was cured or client was in control of his drinking (23 percent, or 269 clients).

--Court-ordered period of attendance was completed (11 percent, or 130 clients).

--ATC personnel discharged client (10 percent , or 120 clients).

Our analysis also showed that clients who were referred to treatment by a court for a DWI conviction generally had a better treatment completion rate than other clients. The following table illustrates the differences between the two groups.

	DWI	Non-DWI	Total
Intakes	7,553	12,196	19,749
Completed treatment	2,627	1,671	4,298
Percent	35	14	22

According to the SRI report, the bulk of DWI clients are those with the longest treatment duration, "probably because many DWI clients are under court order to remain in treatment for a specified period of time." Twenty-six percent of driving while intoxicated clients were still in treatment or had completed treatment at 180 days, in comparison with 16 percent for all clients.

An NIAAA official told us that DWIs must usually satisfy a prescribed period of treatment before regaining their drivers licenses. DWI referrals, therefore, have an incentive to remain in treatment.

Reported abstinence

Of the 19,749 clients who entered treatment, abstention data was available on 5,715, or 29 percent of the clients. Of these, 2,89[illegible], or 51 percent, reported abstaining for the 30 days before the 180-day followup. NIAAA's ATC standard for abstention at 180 days is 50 to 70 percent of the clients.

We found that 41 percent of 2,147 DWI clients and 56 percent of the 3,568 nonDWI clients were abstaining at 180 days. Our analysis of SRI's report showed that 32 percent of 175 DWI clients and 48 percent of 758 nonDWI clients were abstaining 30 days before the 18-month followup (46 percent of the total number of clients were abstaining). SRI also reported that 26 percent of the clients reported that they had abstained for the preceding 6 months. The SRI report concluded that "* * * the modal pattern of recovery is either intermittent drinking (but abstention during the 30 days before the followup interview) or drinking at modest levels below one ounce of ethanol [absolute alcohol] per day."

On the basis of our analysis and the SRI study, we believe that DWI clients are less likely to adopt a pattern of abstention.

Changes in quantity-frequency and impairment indexes

As shown in the following table, alcohol consumption dropped substantially between intake and the 180-day followup for 5,524 clients for whom data was available.

	Average daily consumption		
	DWI	NonDWI	Total
Number of clients	2,104	3,420	5,524
At intake (average in ounces)	1.78	6.00	4.39
180 days later (average in ounces)	0.46	1.34	1.00
Difference	1.32	4.66	3.39
Percent of change in amount of consumption	74	78	77

Our analysis showed, however, that at least 15 percent of clients' quantity-frequency levels exceeded NIAAA's ATC standard of 0.4 to 1.2 ounces of absolute alcohol per day at 180-days after intake.

The following table illustrates the relative changes in the quantity of drinking per day.

Changes (in ounces of absolute alcohol)	Number of clients			
	DWI	NonDWI	Total	Percent
Stayed at less than 1 (includes abstainers)	832	644	1,476	27
From 1 to 4 to under 1 (includes abstainers)	664	840	1,504	27
From over 4 to under 1 (includes abstainers)	136	1,041	1,177	21
Reduced to less than 4 but more than 1	48	264	312	6
Reduced but still more than 4	3	71	74	1
Got worse	127	190	317	6
No change	294	370	664	12
Total	2,104	3,420	5,524	100

Specifically, our analysis of all cases showed

--39 percent showed no change,

--55 percent showed moderate to significant change, and

--6 percent showed a change for the worse.

In addition, about 5 percent of the clients were still drinking at least 6 ounces of absolute alcohol a day at followup.

Our analysis of the SRI report showed that the average amount of alcohol consumed daily for the 30 days before followup was as follows.

Quantity-frequency index	DWI	NonDWI
	(ounces)	
At intake	1.68	7.54
18 months later	.88	2.29
Difference	0.80	5.25
Percent of difference	48	70

Stanford Research Institute concluded from the above that, "Basically, DWI clients do not appear to be severely addicted * * * at intake, and this can explain why their outcome results are so much better than those of non-DWI clients." SRI also stated that DWI clients were less impaired at intake.

The changes in a client's perceived degree of impairment stemming from excessive use of alcohol varied similarly to the changes in his quantity of drinking. For example, for all clients, the amount consumed dropped 77 percent from 4.4 ounces to 1 ounce a day. The degree of impairment from intake to 180 days later dropped from 9.4 to 2.7, or 71 percent, on a scale of 0 (minimum impairment) to 33 (maximum impairment). NIAAA considers a score of 6 or above to indicate an unacceptable impairment level for normal lifestyles.

SRI reported similar findings. Average consumption and impairment levels both dropped about 68 percent for all clients.

OTHER SRI OBSERVATIONS

Although our analysis of client outcomes was not related to treatment processes, the SRI report contains several significant observations concerning the influence of such factors as type of treatment, length of time in treatment, and intensity of treatment on treatment outcomes.

According to SRI, regardless of treatment settings (inpatient versus outpatient) or modality used (group versus individual counseling sessions and counseling versus therapy), most clients showed dramatic improvement. SRI recommended that in the absence of compelling evidence of therapeutic

superiority for one treatment method over another, clients may be assigned to treatments according to other goals. For example, clients might be assigned to the least costly treatment compatible with personal situations. SRI also recommended that NIAAA conduct further investigations aimed specifically at determining the type, extent, and effectiveness of specific therapies.

Stanford Research Institute concluded that clients who dropped out of treatment at an early stage achieved success rates only slightly lower than those of "stay-ins." (See p. 55.) Consequently, SRI suggested that NIAAA not spend a major effort trying to keep clients in treatment if they choose to leave after intake.

SRI also reported that

> "The more treatment a client receives, the better his chances for recovery. Clients who received high amounts of treatment experienced recovery rates 25 percent higher than clients who contacted a treatment center only once and received [little or no treatment]. * * * the findings suggest two implications worth consideration. First any amount of treatment may have a positive effect on recovery, compared with no treatment at all, and high amounts of treatment generally produce a larger effect. Second, however, even without treatment, we observe a remission rate approaching 50 percent. It is possible, then, that a client's recognition that he has a drinking problem and his decision to enter treatment may be the critical operative factors in recovery."

CLIENTS BELIEVED TREATMENT HELPED THEM

We distributed questionnaires to 51 clients at three projects to see whether they believed they benefited from treatment. Forty-nine clients said they believed they benefited from the treatment they received. The questionnaires were distributed to clients who visited either the Bedford-Stuyvesant ATC, the Perth Amboy ATC, or the Denver Indian project on a day that we were reviewing the project's activities.

According to the client responses,

--35 had stopped drinking,

--14 were drinking less, and

--11 of 13 who reported they were working were doing better at work.

In addition, the respondents generally indicated that they were relating better to people. Several of the clients commented that they thought they could be further helped by treatment and jobs.

DIRECTLY FUNDED PROJECTS BENEFITED COMMUNITIES

Many of the representatives we talked to from community agencies and organizations providing services within the catchment areas of 9 of the 10 projects we reviewed believed the NIAAA-supported projects affected their communities positively. 1/ Fifty-six representatives of hospitals, police, courts, probation departments, welfare departments, other alcohol treatment programs, missions, and social service programs gave us comments on the projects' impact on their communities. Thirty-two of these individuals said the projects had either motivated people to enter treatment or provided treatment to those needing it, 28 said that the projects had either improved their communities' attitudes toward alcohol abuse or reduced the stigma attached to it.

FEDERAL EFFORTS HAVE STIMULATED STATES' ALCOHOL-RELATED ACTIVITIES

NIAAA's formula grant program has generally had a positive impact on the efforts of the State alcohol agencies we visited. In addition, NIAAA's support of model legislation decriminalizing public intoxication has stimulated passage of this type of legislation in a number of States.

Officials at four of the State alcohol agencies said that NIAAA had encouraged their efforts by providing technical

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1/The tenth project, the New York City occupational project, primarily provides referral services to employees of the municipal government. These employees reside throughout the metropolitan area and, consequently, local community organizations would not be familiar with the project.

assistance, guidelines, and standards. They also told us that formula funds have enabled them to support additional projects, create a greater visibility of the alcohol abuse problem, and increase the funding of existing projects.

Overall, at the five State alcohol agencies, we found that the number of treatment grants awarded and the number of clients treated had substantially increased since their receipt of formula funds.

Passage of Uniform Alcoholism and Intoxication Treatment Act

Public Law 93-282, passed in May 1974, amended Public Law 91-616 and authorized special grants to those States adopting the basic provisions of model legislation developed by the National Conference of Commissioners on Uniform State Laws--the Uniform Alcoholism and Intoxication Treatment Act. The purpose of these grants is to help the States implement the provisions of the act which

--commits each State to the concept of care for alcohol abuse through community health and social service agencies and

--repeals those portions of criminal statutes and ordinances under which drunkenness constitutes a petty criminal offense, such as loitering, vagrancy, or disturbing the peace.

At the time of our fieldwork, four of the five States we visited had passed such legislation. They were Colorado, New York, Oregon, and Washington. At the fifth State, New Jersey, a bill was pending in the legislature. An official of that State's alcohol agency later told us that the bill became law in February 1976

Officials of the Colorado, New Jersey, and New York State alcohol agencies told us NIAAA had encouraged their States to develop legislation similar to the Uniform Alcoholism and Intoxication Treatment Act (Uniform Act). Their comments follow:

--The Director of the Colorado program praised NIAAA's efforts to develop and promote the legislation. However, he told us that the amendments to Public Law 91-616 which authorized the special grants did not affect his State, since Colorado had passed the act before the amendment.

--The Chief of the New Jersey program said that without the development of the model act and NIAAA's encouragement, the act would never have passed the State legislature. He added, however, that the special grants authorized by amendments to Public Law 91-616 had not really influenced New Jersey's passage of the act since the State had begun its development of the legislation before the amendments.

--The Associate Commissioner of the New York State alcohol agency told us that, without Federal support, many State legislators would not have been convinced of the need for the legislation. He added that the model act had served as a guide for the State and the amendments to Public Law 91-616 had demonstrated Federal commitment to the legislation.

Personnel at the Oregon and Washington State alcohol agencies told us that their States' efforts to pass the legislation had predated Federal sanctioning of the model act; therefore NIAAA and the special grant program had not influenced their early efforts to adopt the provisions of the Uniform Act.

As of December 1976, 23 States, the District of Columbia, and Puerto Rico had enacted a uniform act including decriminalization. The District of Columbia, Puerto Rico, and 19 of the 23 States have also implemented the provisions of the Uniform Act and received from NIAAA an additional $100,000 plus 10 percent of their formula fund allotments. Eleven other States have enacted some form of alcohol legislation which is not in accord with all the basic provisions of the Uniform Act.

Increased States' treatment and other alcohol-related activities

Officials at the Colorado, New Jersey, New York, and Oregon alcohol agencies believe that NIAAA's efforts in general, and the formula grant program specifically, have had a positive impact on their States' treatment and other alcohol-related activities. They told us that NIAAA has stimulated the States by providing technical assistance, guidelines, and standards. The following are the various comments they made about the impact of formula funds.

--Officials of the four States said that the formula funds have enabled their States to support additional projects which would not have been funded due to insufficient State funds.

--Officials of the New Jersey and Oregon alcohol agencies told us that formula funds have allowed them to create a greater visibility of the alcohol abuse problem throughout their States.

--Officials at the Colorado and New York agencies said that formula funds have enabled them to increase the funding of existing projects.

An official at the Washington alcohol agency told us that:

--NIAAA had no impact on his agency's efforts because NIAAA's technical assistance and guidelines were valueless.

--Formula funds had limited impact because these monies represented only about 20 percent of his agency's expenditures.

In commenting on our draft report, a Washington State official stated that NIAAA's lack of influence on the Washington alcoholism program was due primarily to insufficient NIAAA staff to provide technical assistance at a time when the Washington program was developing. The official further commented that NIAAA's formula grant funds had stimulated increased State funding of alcoholism programs.

Information on the number of treatment projects supported and the number of clients treated in the States we reviewed indicates that progress has been made in State efforts to combat alcohol abuse since Federal formula funds were awarded. For example, in fiscal year 1971 the five States we visited were supporting 67 treatment projects; in fiscal year 1974 these States were supporting 284 treatment projects. Although all the States did not have information on the number of clients being treated at these projects, information we obtained from some projects or the States showed that about 12,800 clients were served in fiscal year 1971 and about 56,300 clients were served in fiscal year 1974. While State alcoholism agencies generally did not have information which showed the extent of the increase due solely to the increase in formula funds, it appears that, since the formula grant program was intitiated, the States have substantially increased their efforts to provide treatment to alcohol abusers.

CONCLUSIONS

Determining the overall impact of NIAAA's program on the alcohol abusing population is difficult. Much data is available on what has been attained. What is needed to arrive at an overall conclusion on program effectiveness and impact are standards of expected levels of program performance. As discussed in chapter 4, NIAAA is developing these standards and has already published draft standards for alcohol treatment centers. Additional standards are being developed for other programs. Although we recognize that many clients in treatment have reduced their quantity and frequency of drinking and level of impairment, until standards are refined and finalized, it will not be possible to conclude whether changes in drinking patterns are reasonable in relation to the costs involved.

Even without the benefit of such standards it is possible to conclude, however, that NIAAA needs to do a better job in (1) admitting into treatment more persons who make initial contact with treatment projects and (2) seeing that prospective clients, who are not admitted because of lack of either available service or space, or because they were not suitable for treatment at a particular center, are referred elsewhere for treatment.

Since there are significant differences between DWI and nonDWI clients, as identified in our analysis of the monitoring system data and the SRI report, it is not appropriate to evaluate Alcohol Treatment Centers serving large numbers of driving while intoxicated clients against ATC standards currently being developed.

Many clients served by National Institute on Alcohol Abuse and Alcoholism-supported projects believe they (1) have been helped by treatment, (2) are drinking less as a result of treatment, and (3) are leading more productive lives. Furthermore, many community agencies believe NIAAA-supported projects have had a positive impact on the alcoholism problem in their communities, and many States believe NIAAA's efforts have been a positive stimulus in expanding treatment capacities to serve more individuals and in encouraging the passage of the Uniform Alcoholism Intoxication and Treatment Act.

RECOMMENDATIONS

We recommend that the Secretary of HEW direct NIAAA to:

--Analyze projects serving large numbers of DWI clients in a manner that considers the differences between DWI and nonDWI clients.

--Encourage more persons who make an initial contact with its treatment projects to enter treatment.

--Insure that prospective clients who are not admitted into treatment are appropriately referred.

AGENCY COMMENTS AND OUR EVALUATION

HEW generally agreed with our recommendations but stated that NIAAA recognizes the difference between DWI and nonDWI clients and has maintained this distinction in its analyses of data obtained from its monitoring system. We wish to emphasize that our recommendation pertains to those projects which serve both nonDWI and DWI clients, such as ATCs. It is within this context that we believe separate standards should be used to analyze a project's effectiveness.

HEW also stated that studies are underway to examine the reasons why some persons do not enter treatment after making initial contact with a treatment project. The results of these studies will be disseminated to the field. HEW also reported that NIAAA projects such as the occupational alcoholism program emphasize referral services and, as experience with these projects increases, additional data on referral services will be available to NIAAA's other projects.

CHAPTER 6

NONGRANT FUNDS HAVE NOT MATERIALIZED

Third-party support (such as private insurance, Medicare or Medicaid) for alcoholism treatment services generally has not developed. Since fiscal year 1974, one of the National Institute on Alcohol Abuse and Alcoholism principal objectives has been to increase health insurance coverage for alcohol treatment. HEW's policy regarding directly funded health service delivery projects, such as those providing alcohol treatment, specifically states that projects are expected to maximize nongrant revenues so that Federal grant dollars can be used more productively. According to HEW regulations published on January 9, 1974, each project is expected to develop a plan to recover, to the maximum extent feasible, funds from private insurance companies, Federal medical assistance programs, State and local governments, patient fees, and other sources.

Only two of the 10 projects which we reviewed received more than 50 percent of their funds from nongrant sources. However, the NIAAA grants to these two projects covered only personnel costs, in effect necessitating larger amounts of additional revenues from nongrant sources.

Although NIAAA has initiated a number of efforts that would help alcohol treatment projects increase their nongrant revenues, impediments to achieving this objective remain. For example:

--Many alcohol treatment projects serve clients who are unlikely to have private health insurance or who have incomes sufficient to cover only a small portion of the cost of the services they receive.

--Many projects, particularly those serving special target groups, provide such services as consultation and education, outreach, and referral which are not reimbursed under any health insurance plan.

A description of the types of services provided by each of the projects included in our review is contained in appendix IV.

PROJECTS' SOURCES OF REVENUE

The largest single source of funds for the projects we reviewed, with one exception, has been NIAAA. NIAAA direct-grant support ranged from about 30 percent at one of the alcohol treatment centers to almost 100 percent at one of the poverty projects. The ATCs generally obtain a larger percentage of their revenues from nongrant sources because the NIAAA grant is only for personnel costs. In the last half of fiscal year 1975, the ATCs received about 47 percent of their funds from NIAAA, 27 percent from State and local governments, 21 percent from various types of thi d parties and patient fees, and the rest from other sources. The following table shows the sources of financial support for each of the projects reviewed.

Sources of Funds Received By Projects

Location and type of treatment project	Total revenue (note a)	Percent of total revenues									
		Federal					Services				Fund-
		NIAAA	other	State	Local	Fees	Insurance	Medicare	Medicaid	Other	raising
Perth Amboy ATC	$ 350,678	65.0	-	3.4	3.4	10.3	9.7	3.1	5.1	-	-
	362,892	64.6	-	3.3	3.3	3.2	13.2	1.8	10.6	-	-
	364,061	60.3	-	3.3	3.3	4.5	14.5	2.0	12.1	-	-
Seattle ATC	1,966,564	31.9	5.1	16.4	22.1	16.2	(b)	-	(b)	1.1	6.4
	2,261,883	42.4	(b)	4.2	36.9	11.0	(b)	-	(b)	1.7	2.8
Southwestern Montana ATC	184,959	73.9	-	11.8	8.0	5.6	-	-	-	-	(b)
	204,304	66.2	-	19.5	8.9	4.2	-	-	-	-	1.2
	225,478	64.7	-	21.7	6.3	3.4	-	-	-	-	3.9
Bedford-Stuyvesant ATC	1,410,734	39.4	-	4.6	56.0	-	-	-	-	-	-
	1,755,733	31.6	-	4.3	39.9	-	-	-	24.2	-	-
	1,524,242	32.4	-	15.7	11.0	-	-	-	40.9	-	-
	1,338,111	34.6	-	6.4	12.5	-	-	-	46.5	-	-
Paterson poverty	54,900	83.6	-	16.4	-	-	-	-	-	-	-
	75,692	67.1	-	32.9	-	-	-	-	-	-	-
Denver poverty	451,924	76.2	-	-	-	-	-	-	-	-	23.8
	c 300,763	99.8	-	-	-	-	-	-	-	-	(b)
Portland Indian	82,607	98.4	-	-	-	-	-	-	-	-	1.6
	89,979	90.3	-	-	-	-	-	-	-	-	9.7
	c 104,762	98.4	-	-	-	(b)	-	-	-	(b)	1.1
Denver Indian	136,191	91.7	-	-	5.9	-	-	-	-	-	2.4
	156,475	79.9	-	2.0	12.5	-	-	-	-	1.6	4.0
	160,649	87.2	4.8	2.6	(b)	-	-	-	-	-	4.9
New York City occupational	253,999	78.4	-	-	21.6	-	-	-	-	-	-
	355,563	53.5	-	-	46.5	-	-	-	-	-	-
	368,798	58.0	-	-	42.0	-	-	-	-	-	-
Seattle public inebriate	564,319	95.8	-	3.3	(b)	(b)	-	-	-	-	(b)
	820,359	70.2	-	2.7	25.1	2.0	-	-	-	-	-

a Revenues available to the project for each 12-month grant period. In some instances this amount includes the cash value of in-kind service

b Less than 1 percent.

c Does not include all revenues received during the grant period from fees, miscellaneous sources, and or fundraising projects.

As shown, NIAAA support as a percent of total revenues for most projects has not changed considerably since it began funding these projects. In some cases, the projects were unable to sustain their support from other sources. One indication that the increased funding from other sources has not developed is that NIAAA, since January 1975, has awarded over 120 fourth-year grants to projects originally intended to be funded for only 3 years.

Recognizing that alcohol projects will be unable to generate sufficient sources of income within their first 3 years of operation, the Secretary of HEW has approved a plan which would permit the funding of alcohol treatment projects for a 6-year period. Except for Indian projects, which NIAAA would fully fund for the 6-year period, the other projects would receive declining amounts of NIAAA support. In September 1976 the Office of Management and Budget approved this plan. Full implementation is expected during fiscal year 1978.

EFFORTS TO INCREASE NONGRANT REVENUES

NIAAA efforts since the beginning of fiscal year 1974 have focused on increasing and broadening health insurance coverage for alcohol treatment throughout the United States. NIAAA recognizes that third-party payments, especially from private health insurers, are the only financially viable means to guarantee that alcohol abusers will receive the timely and appropriate care they need. NIAAA's efforts are aimed at strengthening project management, developing standards for providing alcohol treatment services, and obtaining information related to the cost of providing these services.

Specifically, NIAAA's efforts have included awarding contracts to:

--Develop accreditation standards for alcohol treatment programs. These standards developed by the Joint Commission on Accreditation of Hospitals are designed to provide insurers with a standardized, independent assessment of the services offered by alcohol treatment programs.

--Develop standards leading toward certification of treatment staff for use by the States or a certifying body in certifying alcoholism counselors.

--Develop a model health insurance alcohol benefits package designed to provide insurance carriers with information on the length of stay necessary for alcohol treatment and the cost of treatment services.

--Demonstrate that selected projects can attract enough third-party payments to enable them to become self-sustaining in a relatively short time.

--Train project personnel to improve their skills in the general management and financial management of their projects.

--Develop a model cost-accounting system for use by NIAAA-funded projects and seminars informing project officials on ways to identify and secure funding from sources other than NIAAA.

Although NIAAA has sponsored these various efforts aimed at increasing third-party revenues, it has not placed requirements on projects which it funds to adopt the accreditation or certification standards or procedures which have been developed for NIAAA.

Despite the efforts to increase the amount of revenues from insurance companies, revenues for third-party carriers continue to provide only a small portion of the total funds spent by alcohol treatment projects. For example, the amount of funds received by the ATCs from private insurance companies was 2.4 percent in 1973, 1.6 percent in 1974, and 2.5 percent from January to June 1975. Of the projects we reviewed, only the Perth Amboy alcohol treatment center was receiving a measurable amount of funds from private insurers. The project director attributed this to the installation of an employee guidance service at the ATC and the fact that clients who are seen through this service are covered by major medical plans. The special target population treatment projects included in our review received no reimbursement from insurance carriers.

Project officials told us that some of the difficulties in obtaining funds from insurance companies or other sources were:

--Insurance companies do not cover all services. In addition, some projects primarily provide a referral service and cannot be expected to charge for these services.

--Clients are not able to afford health insurance or to pay patient fees.

--Treatment facilities were not licensed.

While we did not include any drinking driver projects in our review and the occupational project we reviewed provided primarily referral services, an NIAAA report indicates that these types of projects generally have been more successful in obtaining funds from patient fees and private insurers. An NIAAA official told us that this could be attributed to the fact that the clients served by these projects are more likely to have health insurance coverage or larger incomes than the clients of the special target population projects.

BARRIERS TO OBTAINING NONGRANT REVENUES FOR ALCOHOL TREATMENT PROJECTS

It is unlikely that NIAAA-supported alcoholism projects will be able to generate significant amounts of nongrant revenues from third parties in the near future because coverage for alcoholism treatment services is usually limited under private health insurance plans, many State Medicaid programs, and Medicare. Also, many services provided by NIAAA-supported projects are not likely to be reimbursed under any type of health insurance plan.

Limited private health insurance coverage for alcoholism services

Some recent improvements in the health insurance coverage for alcoholism have sometimes been the result of State legislation; others were initiated by the insurance carriers. Coverage limitations often, however, preclude reimbursement for a full range of alcohol-related services, including emergency, inpatient, intermediate, and outpatient care; consultation and education; outreach; and management. The majority of the health services are provided by paraprofessionals and nonphysician professionals.

About 20 percent of the States have developed insurance regulations and passed legislation which requires group health insurance coverage for alcoholism treatment. Unfortunately, benefits assured by legislation vary widely. One State may require coverage for alcohol treatment services, while another may only have to offer treatment coverage as an option to be exercised by the company with whom the policy is written. Most States have required that treatment services be delivered

in a licensed or approved facility. Many States require that the services be provided by a physician. Improvements in health insurance coverage initiated by selected insurance companies provide that the policies will honor claims for treatment in other than the usually identifiable and accredited surgical, medical, and diagnostic facilities.

Although these improvements are beginning to take effect, a widespread concern about the costs of including treatment for alcoholism in health insurance benefit plans remains. A May 1975 study of health insurance coverage for alcoholism, based on information developed by NIAAA, states that:

--Available data which reflects the cost of alcohol treatment is limited.

--While a large number of carriers provide alcoholism benefits, they are frequently highly restrictive and built mainly around short-term inpatient care.

--Benefits are often included under mental health diagnoses.

--Little experience data which contrasts insurance claims and benefits is available.

--Little is known about the impact availability of health insurance coverage for alcoholism will have on the demand for treatment services.

--An unknown area concerns the potential impact of health insurance coverage for alcoholism on the future demand for other health services.

--When alcoholism is included as a benefit, very few claims have been recorded, perhaps because of the stigma attached to alcoholism.

Some of NIAAA's efforts to increase revenues from private insurers are aimed at providing information to resolve these issues. For instance, the development of the model benefits package was based on the cost experiences of a number of treatment facilities. Also, information from the automated program monitoring system indicated that, while 13.8 percent of the clients admitted to the alcohol treatment centers in fiscal year 1975 were hospitalized during the 30 days before intake, this was reduced to 4.4 percent during the 30 days before the 180 days followup.

Limited alcoholism coverage provided under many State Medicaid programs

Under the Social Security Act, Federal and State aid (Medicaid) is available to eligible persons needing medical care. Within certain limits, each State may define the extent of benefits it will provide under the Medicaid program and to whom it will provide various services. According to a December 16, 1974 memorandum from the Acting Administrator of Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) to the Assistant Secretary for Health, the varying ways in which the Medicaid program is administered by the States and the fact that most Medicaid services which relate to ADAMHA programs are optional lead to inadequate care in many States. In November 1975 ADAMHA analyzed data obtained from representatives in the HEW regional offices regarding variations in third-party reimbursements in the States. ADAMHA's analysis included the following examples of limitations found in Medicaid coverage.

--Clinic services are an optional service under Medicaid and some States do not include these services in their Medicaid plans.

--Medicaid reimbursement for outpatient services is restricted to services provided in an outpatient facility of a certified hospital or institution.

In addition, the analysis noted the following variations in State administration of Medicaid programs.

--In some States Medicaid payment for services rendered by State supported facilities revert to the States and not to the facilities providing the services.

--In one State, service providers are reimbursed only if a physician is on the premises when services are rendered.

--In some States, Medicaid reimbursements may be reduced by that percentage of the project costs provided from Federal sources.

Limited Medicare coverage available for alcohol treatment services

SSA considers alcoholism to be a psychiatric disorder in administering the Medicare program. As such, alcoholism is covered by Medicare in the same way as other mental disorders. Medicare payment to projects funded by NIAAA for alcohol treatment services is frequently limited because:

--Reimbursements for treatment services relating to mental disorders are limited to two-thirds of the actual expenses, or $250, whichever is less, for outpatient services.

--Reimbursement for inpatient psychiatric care is limited to 190 days during a lifetime.

In addition, various NIAAA officials told us that most alcohol treatment projects primarily provide outpatient services delivered by nonprofessionals at facilities which frequently are not directed by a physician.

As interpreted by SSA, however, the Social Security Act provides that:

--Only the personal and identifiable services of a physician are allowable for Medicare reimbursement.

--Services must be provided in a physician-directed clinic to be eligible for Medicare reimbursement.

Information prepared by the Office of Program Planning and Evaluation, ADAMHA, indicates that limitations for outpatient care encourage hospitalization for patients who have not used their 190-day lifetime coverage. NIAAA information shows the inpatient hospital care is much more expensive than outpatient services provided by a paraprofessional.

For the year ending September 1975, the average ATC cost per inpatient emergency-detoxification day was $136 and the average cost per inpatient hospital day (nonemergency care) was $93. The average costs of an outpatient visit at an alcohol treatment center for this period was $20.

In April 1974 NIAAA contacted Social Security Administration about the possibility of increasing Medicare coverage of alcoholism treatment services. NIAAA also expressed concern about SSA's policy which considers alcoholism

to be a psychiatric disorder. NIAAA's position is that alcoholism is a health problem separate from mental health and that alcohol abuse treatment programs should not be subject to the same reimbursement limitations imposed on mental health treatment programs.

NIAAA contends that, through a broader interpretation of the Medicare program's authorizing legislation (title XVIII of the Social Security Act, as amended, 42 U.S.C. 1395), SSA could revise its policies and change its regulations and guidelines to recognize accredited alcohol abuse treatment programs as Medicare providers of health care services. According to NIAAA, standards developed by the Joint Commission on Accreditation of Hospitals for alcoholism programs are sufficient to insure that alcohol abuse treatment facilities provide adequate and appropriate standards of care. SSA contends, however, that major changes in Medicare's authorizing legislation are needed before Medicare coverage can be extended to the type of projects NIAAA normally supports.

Negotiations between the two agencies have been unproductive in resolving the major differences in the agencies' views of alcoholism as a health problem and the way the Medicare program could be expanded to provide additional coverage for alcohol abusers. NIAAA officials said in December 1975 that no attempt had been made to determine whether SSA had the necessary authority to revise its regulations and guidelines to recognize alcohol abuse treatment facilities without seeking amendments to the Social Security Act. Furthermore, NIAAA has not actively pursued resolution of this issue by the Assistant Secretary for Health or the Secretary of HEW.

In July 1974 NIAAA formally requested SSA's Bureau of Health Insurance to see that Medicare operating manuals discontinue reference to alcoholism as a psychiatric disorder and that Medicare regulations be revised to recognize accredited alcoholism treatment facilities as providers of health care services.

Officials at SSA's Bureau of Health Insurance told us that, in their opinion, they had made it clear to an NIAAA official that the recommendations contained in NIAAA's July 1974 request could not be implemented until major changes were made to title XVIII of the Social Security Act. They also told us that there was an informal agreement that no formal response to NIAAA's request was necessary.

According to NIAAA officials, SSA's Bureau of Health Insurance officials did not respond to this request either formally or informally. They also told us that no further action had been taken on the issues discussed in the July 1974 request.

Many nonreimbursable services provided by NIAAA projects

According to National Institute on Alcohol Abuse and Alcoholism officials, many NIAAA projects offer (1) outreach and referral services and (2) consultation and education services which are not likely to be reimbursed under any Federal, State, or private health insurance plan.

Two of the projects we reviewed provide primarily referral and outreach services. These (1) encourage individual to receive treatment and (2) place them in contact with an existing treatment program.

Project officials told us that it is unlikely that referral and outreach or consultation and education services would ever generate revenues sufficient to cover the costs of providing them. Officials for NIAAA and the National Council on Alcoholism agreed that these services are worthwhile and essential to encouraging individuals to enter treatment and to reduce the stigmas associated with alcoholism.

In enacting title III of Public Law 94-63, the Community Mental Health Centers Amendments of 1975 (42 U.S.C. 2689 et seq. (Supp. V 1975)), the Congress recognized that the consultation and education services provided by the community mental health centers are not reimbursable under existing health insurance plans and authorized annual grants to provide for these services. Similar legislation may be required for the NIAAA funded alcoholism projects.

CONCLUSIONS

Continuation of NIAAA's support for alcohol treatment projects is required if a concerted national effort to combat alcohol abuse is to be maintained. Drinking driver projects, occupational projects, and projects designed to serve a specific geographic area are obtaining the most significant revenues from third parties. Other special target population projects will have to rely on funds from governmental sources--NIAAA, State, or local.

Until adequate cost data relating to the provision of treatment services is developed, both private insurance carriers and Federal/State medical programs (Medicaid title XIX) will be reluctant to reimburse projects for the services they deliver. Furthermore, the classification of alcohol abuse as a psychiatric disorder for Medicare (Title XVIII) purposes will continue to limit the amount of reimbursement projects can receive from this source.

Although NIAAA has fostered the development of accreditation standards for alcoholism programs and certification standards for project staffs, amendments to the Social Security Act may be necessary before alcoholism treatment services delivered by NIAAA-supported projects meeting these standards will be reimbursed under the Medicare program. Requirements that NIAAA-funded projects and personnel meet these standards, when applicable, should result in an improved quality of care which is so necessary if NIAAA is to convince insurance carriers and others that alcohol treatment services should be covered in a manner similar to other health care services.

Apparently, consultation, education, and outreach/referral services which many projects provide will never generate sufficient revenues for NIAAA-funded projects to cover costs. If the Congress believes these services are desirable and should continue, it ought to consider providing a permanent source of financing to cover costs, such as it did for community mental health centers.

RECOMMENDATIONS

The Secretary of HEW should:

--Direct NIAAA to continue its efforts to develop alcohol abuse treatment cost data and disseminate the data to public and private third-party payers as soon as possible.

--Direct NIAAA to require its projects to meet the standards that have been developed for accreditation of alcohol abuse treatment programs and certification of treatment personnel.

--Develop a more consistent HEW policy regarding reimbursement for treatment provided to alcohol abusers by examining the bases for SSA's classification of alcoholism as a psychiatric disorder and NIAAA's

classification of alcoholism as a health problem separate from mental health.

AGENCY COMMENTS AND OUR EVALUATION

HEW concurred with our recommendation regarding the development and dissemination of alcohol abuse treatment cost data and cited several ongoing projects with private health insurance groups, a State employees health insurance group, and its own incentive contract treatment projects which are designed to compile data on alcoholism treatment costs and model insurance benefits packages. This data will be disseminated by the National Clearinghouse for Alcohol Information.

HEW did not agree with our recommendation that NIAAA projects should be required to meet the standards developed for accreditation of treatment projects and certification of treatment personnel. HEW stated that NIAAA's proper role is to increase projects' capability to meet standards but not to mandate standards. We believe that if federally funded projects are to be exemplary providers of care to the alcohol abuser, these projects should be required to meet the standards developed for NIAAA. To allow federally funded projects to operate with somewhat less assurance that the projects meet accepted alcohol abuse treatment standards would be unfortunate. We recognize that all projects may not meet the standards when initially funded but within a reasonable time period after initial funding we believe the projects should be required to meet the standards.

HEW concurred with our recommendation regarding the development of a consistent departmental policy regarding reimbursement for alcohol abuse treatment among HEW agencies. HEW commented that it plans to convene a special task force to examine the legal, administrative, fiscal and health related factors associated with Medicare coverage of alcoholism and make policy recommendations to the Secretary. We believe that such a task force could have a significant impact on developing consistent HEW policies regarding alcohol abuse programs.

RECOMMENDATIONS TO THE CONGRESS

We recommend that the Congress:

--Explore the need for legislation that would require fuller coverage of alcohol treatment services delivered by programs meeting the Joint Commission on Accreditation of Hospitals' standards for alcoholism programs and by certified counselors under Medicare (title XVIII) and Medicaid (title XIX).

--Explore the need to amend Public Law 91-616 to provide Federal funding for non-revenue-producing services similar to that made available under the Community Mental Health Centers Act, as amended.

CHAPTER 7

OTHER PROJECT ACTIVITIES WHICH NEED IMPROVEMENT

Directly funded National Institute on Alcohol Abuse and alcoholism treatment projects have not established measurable objectives, and procedures for followup of clients need improvements.

PROJECTS HAVE NOT ESTABLISHED MEASURABLE OBJECTIVES

The 10 projects we reviewed had established goals, objectives, and strategies for achieving objectives; however, the objectives they had developed could not be related to progress in achieving project goals. As stated in chapter 2, to be meaningful, objectives must relate to goals and be expressed in measurable terms which specifically define both the project activities to be accomplished and when they are to be accomplished. NIAAA has recognized this. Its Management Program for Alcoholism Services Projects manual cites as an example of such an objective--"to reduce the number of federal government employees abusing the use of alcohol from 240,000 to 200,000 by 1979."

Examples of projects' objectives which do not clearly define how and when they are to be accomplished and how implementation relates to the projects' goals follow.

At the Seattle public inebriate project, a stated goal was "to develop a system of services for residents which will decrease the destructive consequences of Skid Road life and allow residents greater self sufficiency and choice of life style." The project's objective--to "develop an overall plan for the delivery of social services among existing agencies"--did not define how or when the goal would be accomplished. Its following strategies likewise did not specify times for accomplishment.

--"Inventory existing services,"

--"Develop feasibility studies,"

--"Respond to research department needs survey," and

--"Develop plan reconciling needs resources with full citizen participation."

The goal of the King County alcchol treatment center was

"* * * to coordinate the functions and services of affiliated agencies and professionals working in the field of alcoholism. Central to this purpose is a commitment to establish a comprehensive community program aimed at assisting all those individuals suffering from the illness of alcoholism toward recovery."

An objective of the project, "to expand early identification and referral programs for the 'troubled employee', youth, the alcohol offender, and the elderly," did not specifically define how or when this was to be accomplished.

Project officials advised us that the overall goal of the Denver poverty project was to provide necessary services to their target area alcoholics. Project objectives were stated in the following terms which did not specifically define how or when this goal would be accomplished.

--"Conduct a rehabilitative program in the skidrow community to serve the needs of the skidrow alcoholic."

--"Operate a program which will ultimately contribute to the reduction in alcoholism and alcohol-related problems among the program's participants."

Officials at two projects admitted that the lack of measurable objectives hindered their efforts to measure their project's progress. One of these officials said no attempt was made to develop specific objectives because he believed that it was too difficult and time consuming. The other official stated that measurable objectives were not developed because NIAAA did not provide any criteria or guidelines in this area. An official of a third project stated that he did not see the need to develop definitive objectives but added that he was unable to measure project effectiveness due to the general nature of the existing objectives.

Following are additional examples of broadly stated objectives which are not easily measured.

Project	Objective
New York City occupational	"To intensify, improve and expedite the care and services provided for our clients."

Project	Objective
Perth Amboy ATC	"To continue to improve the quality of patient care by increasing the skills and competency of professional and paraprofessional staff through clinical supervision, in-service education and clinical workshops and seminars."
Southwestern Montana ATC	"* * * to eliminate factionalism wherever it exists among various groups working in this field in the Catchment area."
Paterson poverty	"To provide help for the alcohol dependent person * * *."
Bedford-Stuyvesant ATC	"* * * [to provide] education, early identification and attitude change for the community at large."
Portland Indian	"* * * to reduce abusive drinking, improve job performance and stability, improve nutrition and general health, improve personal, family, and community relationships, and develop interest in basic vocational and academic areas."
Denver Indian	"To return American Indians afflicted with the disease of alcoholism to society as rehabilitated people able to render maximum contributions as useful and productive citizens."

FOLLOWUP OF CLIENTS SHOULD BE MORE SYSTEMATIC

The projects reviewed generally did not systematically followup on clients who were referred to other service providers. In addition, 5 of the 10 projects did not systematically followup on clients who either dropped out of or completed treatment at the projects.

NIAAA grant program guidelines emphasize that the effective delivery of services involves, among other essential factors, followup care for clients and their families. The guidelines stress that continuing interest in clients and

potential clients helps "motivate" the "unmotivated" and prevent relapses or aggravation of problems. They further state that

> "continuity of care is essential and requires careful and continuous liaison among all * * * agencies involved in providing treatment and service. This monitoring of the processes and steps, from one source of help to the next, is necessary if the alcoholic is to get the service he needs."

In addition, the Joint Commission on Accreditation of Hospitals, in its Accreditation Manual for Alcoholism Programs, includes aftercare or followup as a necessary component of treatment programs. These standards, developed under contract to NIAAA, note that aftercare is "The process of providing continued contact which will support and increase the gains made to date in the treatment process."

Although the projects were referring many clients to other service providers, as illustrated in the following table, only three projects--the New York City occupational, the Paterson poverty, and the Denver poverty--had systematic followup procedures to determine whether these clients actually reported to and were assisted by such service providers.

Type of service provider	Number of clients referred (note a)	Percent referred
Hospitals/medical facilities	1,447	16.8
Drug/alcohol programs	1,775	20.6
Social programs	1,974	22.9
Private physicians	101	1.2
Alcoholics Anonymous	2,685	31.2
Miscellaneous	626	7.3
Total	8,608	100.0

a/The time period for the above statistics averaged 32 months per project for eight projects maintaining comparable statistics.

Paterson and Denver poverty project officials told us that they personally transported their clients to service providers

to insure that they reported. Officials of these projects also told us that they either visited or telephoned the agencies to followup on the status of referred clients.

Officials at the New York City occupational project stated that they furnished their clients with an introduction form which had to be completed and returned by the service provider. They also told us they sent a followup form to the service provider at specified intervals to determine clients' status.

Followup procedures at the remaining seven projects were not systematic enough to insure continuity of care. Procedures varied for verifying that clients reported and were assisted. Some projects relied on the clients and resource agencies to provide feedback. At other projects, followup was conducted at counselors' discretion or on a sample of clients. Some projects did not routinely followup clients who dropped out of or completed treatment. Here again, followup was generally conducted at counselors' discretion or on a sample of clients.

Although we had intended to trace a sample of referred clients to determine whether they reported to the other service providers and were assisted by them, rules and regulations published in the Federal Register and finalized in July 1975 concerning the confidentiality of alcohol abuse patient records did not allow us to disclose patient identities to referral agencies.

CONCLUSIONS

Although the projects included in our review had established objectives, the objectives did not express, in quantitative terms and with target dates, what the projects were to accomplish. Consequently, project and NIAAA officials cannot measure progress in the achievement of the projects' goals.

Continuity of care was not insured at all projects because they were not systematically conducting followup on clients.

RECOMMENDATIONS

The Secretary of HEW should direct NIAAA to require that projects

--develop meaningful and measurable objectives which can be related to progress in achieving overall goals and

--improve followup procedures for clients to insure continuity of care.

The Secretary should revise the regulations relating to confidentiality of patient records to permit legitimate evaluations of the effectiveness of client referral mechanisms.

AGENCY COMMENTS AND OUR EVALUATION

HEW concurred with our recommendations regarding the development of measurable objectives at the project level and improvements in client followup procedures. HEW stated that NIAAA is continuing its efforts to assist projects in these areas. We believe more positive steps could be taken by NIAAA to require federally supported alcohol abuse treatment projects to establish specific program objectives and initiate specific aftercare procedures which would insure continuity of care for alcohol abusers.

HEW disagreed with our recommendation that the confidentiality regulations be revised to permit evaluations of client referral mechanisms. HEW stated that neither the confidentiality legislation nor the regulations would prohibit evaluations of the effectiveness of a client referral system. HEW based its statement on an interpretation by its General Counsel that neither the law nor the spirit of the law would be violated if an evaluator, such as GAO, performs a record search in an agency to which referrals have been made (under that agency's supervision if necessary) but does not disclose the identities of persons being traced.

HEW's interpretation of the confidentiality regulations requires that evaluators have unlimited access to an agency's records so that patients' identities can be fully protected. Agencies may or may not agree to grant unlimited access to their records. We continue to believe, therefore, that to avoid potential conflicts between treatment service providers and legitimate evaluators, the confidentiality regulations should be revised. In our opinion, revision of section 2.52(b)(2) of the confidentiality regulations [42 C.F.R 2.52(b)(2)] to read as follows would allow GAO and other legitimate evaluators to properly carry out their functions.

> (2) The inclusion of patient identifying information in any written or oral communication between a person to whom a disclosure has been made pursuant to paragraph (a) and the program

making such a disclosure, a qualified service organization providing services to such program (including ancillary treatment services), or the patient does not consitute the identification of a patient in a report or otherwise in violation of paragraph (a). (New language underscored.)

The new language will permit communication between legitimate evaluators and the qualified service organizations serving a program with respect to particular patients and will enable evaluators to determine whether patients actually are receiving the services to which they are entitled. This addition is particularly appropriate in light of the provision in section 2.11(p)(2) that communications between a program and a qualified service organization of necessary information do not constitute disclosures of records.

The addition of the words "or the patient" is suggested to clarify what may already be the intent of the regulations that researchers, auditors and examiners may contact patients to determine the extent to which they are receiving services from a program. These functions are essential to the implementation of GAO's audit responsibility.

HEW suggested that several technical changes be made to clarify our discussion of the Medicaid program. Where applicable these changes have been made at appropriate points in the report.

CHAPTER 8

SCOPE OF REVIEW

Our review was concerned with progress made by National Institute on Alcohol Abuse and Alcoholism, designated State alcohol agencies receiving formula grants, and directly funded treatment projects in developing and conducting programs for treating alcohol abuse. We particularly emphasized:

--The planning processes followed by NIAAA and the State alcohol agencies to insure that treatment services are provided to areas having the greatest need and in a way which best serves individual and community needs.

--NIAAA's efforts to fulfill its role as the national focal point by coordinating related activities of other Federal departments and agencies.

--NIAAA's activities to develop a management information system to monitor and assess the effectiveness of treatment projects.

--The impact of directly funded treatment projects on individuals served.

--The impact of the formula grant program on enabling the States to provide more treatment services to an increasing number of alcohol abusers.

--NIAAA's efforts to increase the availability of third-party payments for treatment services.

--The adequacy of defined project goals or objectives to permit measurement of effectiveness.

--The extent to which clients were being referred by the the projects to organizations providing services.

--The adequacy of project followup procedures to insure continuity of care.

We reviewed applicable Federal statutes, congressional committee reports, and hearings related to the alcohol abuse problem. We interviewed officials and reviewed pertinent records, guidelines, instructions, and procedures at the national, State, and local levels.

We analyzed the results of special evaluation studies prepared for NIAAA, and we conducted a client impact study using data from NIAAA's management information system. To assess the reliability of this data and the extent to which projects use NIAAA evaluation reports, we mailed a questionnaire to projects submitting such data to NIAAA.

We also distributed a questionnaire to clients at three projects to determine the projects' impact on them.

To determine what effect treatment projects had on their communities, we contacted representatives of community agencies in catchment areas of directly funded projects included in our review.

We interviewed recognized alcohol authorities and others involved with alcohol-related services and reviewed literature provided by them and others concerned with alcohol abuse.

Our review was primarily made at

--NIAAA headquarters in Rockville, Maryland;

--the 10 directly funded treatment projects described in appendix IV; and

--the designated State alcohol agencies in Colorado, New Jersey, New York, Oregon, and Washington.

We also made limited inquiries of

--other Federal departments and agencies involved in alcohol-related activities as described in appendix II;

--the HEW regional offices in New York, Denver, and Seattle; and

--organizations and institutions involved in alcohol abuse activities, including Alcoholics Anonymous, the National Council on Alcoholism, and Rutgers University's Center of Alcohol Studies.

We did not attempt to assess the impact that State-assisted projects have had on the alcohol abuse problems in the States we visited or how the States have used the federally provided formula grant funds.

We did not determine what effects the Social Service Program for Families and Individuals (title XX of the Social

Security Act) would have on the treatment of alcohol abusers. Although this title was signed into law on January 4, 1975, the first services program under this new title was not begun by the States until October 1975. Under this program the States will receive funds each year for social service programs and they have discretion as to whether title XX funds will be used for appropriate combinations of services for alcohol abusers.

NIAAA GRANTS, CONTRACTS, AND ADMINISTRATIVE ACTIVITIES

NUMBER, TYPE, AND AMOUNT
(000's omitted in dollar amounts)

Project type/ activity	Fiscal year 1971 Number	1971 Amount	1972 Number	1972 Amount	1973 Number	1973 Amount	1974 Number	1974 Amount	1975 Number	1975 Amount	1976 Number	1976 Amount	Total amount
Research	87	$ 6,135	120	$ 7,934	102	$ 6,921	180	$ 13,254	159	$ 11,009	171	$ 11,718	$ 56,976
Prevention	-	-	2	328	9	1,019	40	6,457	46	5,899	37	4,442	18,145
Training	25	1,301	48	4,861	62	4,997	76	8,651	120	11,420	112	7,458	38,688
Treatment:													
Occupational State and other	-	-	60	4,344	61	3,871	78	6,536	26	3,346	34	4,702	22,803
Comprehensive alcohol treatment centers	32	7,748	41	11,692	31	7,746	45	11,840	44	10,423	44	7,964	57,413
Special projects:													
Indian	-	-	85	3,342	97	6,498	124	12,486	133	16,591	111	10,680	49,597
Alaska native	-	-	-	-	44	473	119	1,179	5	50	-	-	1,702
Public inebriate	-	-	6	2,540	5	2,616	20	8,642	9	1,999	18	4,818	20,615
Criminal's driver	-	-	16	2,656	16	2,802	17	2,924	17	2,689	17	2,306	12,575
Courts	-	-	3	5,732	160	9,530	186	14,910	172	15,325	102	7,004	52,501
State Program	-	-	-	-	-	-	-	-	-	-	49	9,533	9,533
Information	8	4,[illegible]	[illegible]	[illegible]	33	3,733	41	21,334	76	16,963	34	6,516	56,491
Uniform Act													
Grants under s	-	-	-	-	-	-	-	-	16	2,679	16	2,760	5,439
Increase income- five and other	-	-	12	962	11	1,166	15	4,025	17	4,411	47	5,143	16,107
Formula grants to States	-	-	-	30,000	-	30,300	-	75,600	-	52,000	-	55,500	243,100
Management and [illegible]	--	1,819	--	[illegible]	--	11,280	--	12,137	--	10,533	--	7,955	48,203
Total	152	$[illegible]	417	$80,460	631	$[illegible]	941	$144,975	850	$165,837	792	$168,499	$709,488

[illegible] grants to States for [illegible] the provisions of the Uniform Alcoholism and Intoxication Treatment Act.

APPENDIX I

OTHER FEDERAL DEPARTMENTS WITH ALCOHOL PROGRAMS

CIVIL SERVICE COMMISSION

The Civil Service Commission is responsible for developing and maintaining, in cooperation with other Federal agencies and departments, Federal civilian employee alcoholism programs. The Commission estimated expenditures during fiscal year 1976 were about $204,000 principally for program planning, evaluation, coordination, and staff training.

DEPARTMENT OF DEFENSE

Each branch of the Armed Services--Army, Navy, and Air Force--has established a program to deal with the alcohol-related problems of its military and civilian personnel. The programs encompass prevention, treatment, and rehabilitation activities. During fiscal year 1976 Defense expenditures for alcohol programs were about $17 million, most of which was directed toward treatment and rehabilitation of alcohol abusers.

HEW

Several agencies within HEW, other than NIAAA, fund programs which include services or activities categorized as alcohol related. The Social and Rehabilitation Service contributes funds for medical assistance (Medicaid) and social welfare service to alcohol abusers and their families. The Vocational Rehabilitation program of the Office of Human Development provides vocational training to many alcohol abusers. The NIMH-supported community mental health centers provide direct treatment to alcohol abusers. Research projects of the National Institutes of Health include research directed at the alcohol problem. During fiscal year 1976 these agencies spent about $124 million on alcohol-related activities. Additionally, the National Institute on Drug Abuse has participated in funding projects for combined alcohol and drug abuse treatment and has supported substance abuse teaching programs at educational institutions. Also, Social Security Administration and Health Services Administration (HSA) fund medical assistance (Medicare and health maintenance organizations) and health care programs which provide general medical services to eligible alcohol abusers but are not specifically concerned with treating alcohol abuse problems.

DEPARTMENT OF JUSTICE

Alcohol-related activities at the Department of Justice are administered by the Bureau of Prisons and Law Enforcement Assistance Administration (LEAA). Programs of the Bureau are aimed at alcohol abusers incarcerated in Federal prisons. LEAA provides block grants to States for the support of projects in crime prevention, law enforcement, and the judicial system.

During fiscal year 1976 the Department reported no direct alcohol-related expenditures. However, Department funds are used to support combined alcohol and drug abuse programs. No accurate means exist to determine how much of these funds are alcohol related. LEAA officials have indicated, however, that a heavier emphasis has been placed on funding drug abuse programs.

DEPARTMENT OF LABOR

The Department of Labor provides some alcohol treatment services in the form of sheltered workshop research and demonstration projects. These projects are intended to provide a work-like atmosphere to recovering alcohol abusers not yet capable of functioning in competitive job situations. The Department also provides counseling services to alcohol abusers participating in the Job Corps program. It reported expenditures of about $300,000 for these activities during fiscal year 1976.

DEPARTMENT OF TRANSPORTATION

The Department of Transportation (DOT) has established an alcohol countermeasures program aimed at lessening the number and extent of alcohol-related fatalities, injuries, and property damage occurring on the Nation's highways. This program encompasses law enforcement, use of sanctions ranging from punitive to rehabilitative, public information, and education as interrelated activities in reducing the drinking driver problem. Between 1971 and 1974 DOT funded 35 alcohol safety action projects to demonstrate the effectiveness of the countermeasures program. Ten are still receiving support. These projects identify the problem drinker on the road through State and local law enforcement agencies, cooperate with the judicial system in determining needed corrective measures, and put these measures into effect. Local alcohol treatment programs, some funded by NIAAA, provide rehabilitation services to the problem drinkers identified by these

projects. DOT also provides block grants to the States for highway safety projects. These funds are available for support of alcohol-related projects. Estimated expenditures during fiscal year 1976 for these activities were $21.1 million.

VA

VA provides alcohol treatment services to all eligible veterans and has established alcohol treatment units at 71 of its 171 hospitals. These units provide both inpatient and outpatient services to veterans who abuse alcohol. During 1974, 47,900 veterans were treated as inpatients at the treatment units while about 105,000 were treated as outpatients. VA also engages in alcohol research, training, evaluation, and other related activities. VA spent about $58.1 million on alcohol programs during fiscal year 1976.

STATE ALCOHOL AGENCIES REVIEWED

COLORADO

Colorado's program to control alcohol abuse was formally initiated in 1949 with the creation of the Colorado Commission on Alcoholism. In 1962, the Commission's responsibilities were transferred to the Department of Health. The Governor, in 1972, designated the Division of Alcohol and Drug Abuse, Department of Health, as the single State planning authority for alcohol and drug abuse services.

As of December 10, 1974, the division was authorized 31 positions, of which 26 were staffed.

State Department of Health and NIAAA funding for alcohol programs for fiscal years 1969 through 1975 follows.

Fiscal year	State funds expended	NIAAA formula funds
1969	$ 63,348	$ -
1970	42,754	-
1971	92,160	-
1972	91,989	305,630
1973	83,018	b/649,207
1974	95,330	487,723
1975	a/844,380	577,830
Total	$1,312,979	$2,202,390

a/Estimated. Increase in State funds due to passage of Uniform Alcoholism and Intoxication Treatment legislation.

b/Includes $339,737 in impounded fiscal year 1973 funds released in fiscal year 1974.

NEW JERSEY

In 1948 the State Department of Health was charged with the responsibility to initiate, develop, and administer a program for rehabilitating alcoholics and promoting temperance education in New Jersey. The Governor, in 1970, designated New Jersey's Department of Health as the single State agency primarily responsible for the care and treatment of alcoholics.

As of November 27, 1974, the Department's alcohol control program was authorized 26 positions, of which 19 were staffed.

State Department of Health and NIAAA funding for alcohol programs for fiscal years 1969 through 1975 follows.

Fiscal year	State funds expended	NIAAA formula funds
1969	$ 178,819	$ -
1970	193,694	-
1971	201,962	-
1972	124,976	875,219
1973	149,976	a/1,852,327
1974	93,412	1,391,575
1975	163,206	1,575,040
Total	$1,106,045	$5,694,161

a/Includes $969,342 in impounded fiscal year 1973 funds released in fiscal year 1974.

NEW YORK

In 1962 the Division of Alcoholism was established within the New York State Department of Mental Hygiene. State legislation passed in 1965 and recodified in 1972 charged the department with the responsibility to plan and execute a comprehensive program for alcohol abuse. In 1971 the Governor designated the Department of Mental Hygiene as the agency to administer the State's alcohol abuse plan.

As of January 20, 1975, the department's Division of Alcoholism was authorized 48 positions, of which 45 were staffed.

State Department of Mental Hygiene and NIAAA funding for alcohol programs for fiscal years 1970 through 1975 follows.

Fiscal year (note a)	State funds expended	NIAAA formula funds
1970	$ 1,451,949	$ -
1971	2,736,600	-
1972	3,989,000	2,161,096
1973	4,111,300	b/4,560,298
1974	4,782,600	3,425,960
1975	7,862,000	3,885,279
Total	$24,933,449	$14,032,633

a/The State's fiscal year is April 1 to March 31.

b/Includes $2,386,450 in impounded fiscal year 1973 funds released in fiscal year 1974.

OREGON

Oregon's initial alcohol abuse program was established in 1943 as part of the Oregon Liquor Commission. In 1962 it was transferred to the Mental Health Division of the Department of Human Resources. The Governor, in 1972, designated the Department of Human Resources as the single State agency to supervise the administration of Oregon's alcohol plan and noted that the department had delegated the authority to operate the program to the Mental Health Division.

As of February 24, 1975, the alcohol unit of the division was authorized four positions, three of which were staffed. In addition, the Mental Health Division had five alcohol and drug program specialists throughout the State.

The State Department of Human Resources and NIAAA funding for alcohol programs for fiscal years 1968 through 1975 follows.

Fiscal years	State funds budgeted	NIAAA formula funds
1968-69	$a/269,038	$ -
1970-71	a/317,001	-
1972	-	288,598
1973	a/450,173	b/621,393
1974	1,199,863	466,827
1975	1,235,418	546,890
Total	$3,471,493	$1,923,708

a/Two-year totals. Amounts for each fiscal year were not available.

b/Includes $325,181 in impounded fiscal year 1973 funds released in fiscal year 1974.

WASHINGTON

In 1959 State legislation directed the Washington State Department of Health to establish a program for the study, treatment, and rehabilitation of alcohol abusers. The functions of the department were assumed by the newly created Department of Social and Health Services in 1970.

As of December 1, 1974, the Office of Alcoholism of the Department of Social and Health Services had nine positions authorized and staffed.

State Department of Social and Health Services and NIAAA funding for alcohol programs for fiscal years 1970 through 1975 follows.

Fiscal year	State funds expended	NIAAA formula funds
1970	$ 598,638	$ -
1971	729,207	-
1972	752,077	443,755
1973	1,214,397	a/951,000
1974	1,264,475	714,446
1975	b/3,245,666	809,979
Total	$7,804,460	$2,919,180

a/Includes $497,668 in impounded fiscal year 1973 funds released in fiscal year 1974.

b/Increase in State funds in 1975 due to passage of Uniform Alcoholism and Intoxication Treatment legislation.

DESCRIPTIONS OF

TREATMENT PROJECTS REVIEWED 1/

THE COMMUNITY ASSISTANCE STAFFING GRANT PROGRAM

Staffing grants help communities develop comprehensive approaches to alcoholism services by providing funds to meet some compensation costs of professional and technical personnel for the initial operation of new facilities or for the operation of new services in existing facilities. These grants were made to provide support for an 8-year period. The following maximum Federal participation was established by law.

Year of support	Nonpoverty area	Poverty area
	(percent)	
1	80	90
2	80	90
3	75	80
4	60	80
5	45	70
6 through 8	30	70

An applicant for a staffing grant had to be

--a community mental health center,

--a public or private nonprofit organization affiliated with a community mental health center, or

--a public or private nonprofit organization in an area which had no community mental health center and which agreed to appropriately use community resources and to affiliate with any future community mental health center serving the area.

To qualify for Federal funds, projects or their affiliates had to offer emergency, inpatient, intermediate, and outpatient care, consultation and education services. In fiscal year 1973 NIAAA adopted a policy of no longer awarding 8-year staffing grants.

1/A table showing the level of financial support provided by NIAAA to each of the projects reviewed is included on p. 73.

The Perth Amboy Alcoholism Treatment Program

In May 1972 NIAAA awarded an 8-year grant to Perth Amboy General Hospital in Perth Amboy, New Jersey, to provide comprehensive alcohol services. Previously, the hospital had treated alcoholics only when they were seen for other medical ailments.

Since inception the project has offered all the required services. Through an affiliation agreement, a local mental health center provides the intermediate care and outpatient services while the hospital conducts the remaining activities.

From May 1972 through March 1975, the hospital and its affiliate treated 963 clients in the inpatient unit, 42 in the intermediate care unit, and 285 in the outpatient unit. The project director reported that 1,669 clients were seen in the emergency services unit during calendar years 1974 and 1975.

The King County Division of Alcoholism Services

In June 1972 NIAAA awarded an 8-year grant to the Seattle/King County Department of Public Health to establish an agency which would provide a comprehensive and coordinated delivery system for alcohol abuse services in King County, Washington. Now known as the King County Division of Alcoholism Services, the agency has responsibility for managing all public alcohol programs and funds within King County. It coordinates a wide variety of alcohol-related services through its own central staff functions, contractual services provided by numerous affiliated agencies in the county, and operation of those public agencies that are part of the county.

The agency directly operates two projects to provide detoxification and inpatient services. In addition, it has affiliations with 20 other organizations. Through contractual agreements, 14 of these provide a variety of services, including referral, information, outpatient, inpatient, rehabilitative, and domiciliary care. The agency has cooperating agreements with the remaining six to provide detoxification, rehabilitative, inpatient, outpatient, and referral services.

From October 1972 through March 1975, the agency and its affiliates provided services to 6,756 clients.

Alcoholism Rehabilitation
Association of Southwestern Montana

In April 1972 NIAAA awarded an 8-year grant to the Alcoholism and Drug Association of Helena, Inc., to provide alcohol services initially to the residents of three Montana counties.

Now known as the Alcoholism Rehabilitation Association of Southwestern Montana, the project has expanded its activities and offers emergency, inpatient, intermediate care, outpatient, and consultation and education services within a 12-county catchment area. It directly provides services in six of these counties while the remaining six are serviced by organizations under contract to the project.

From April 1972 through June 1975, the project and its affiliates provided treatment services to about 1,715 clients.

The Bedford-Stuyvesant Comprehensive
Alcoholism Treatment Center

In February 1972 NIAAA awarded an 8-year grant to the Kings County Hospital Center to sponsor a comprehensive community-based treatment center in Brooklyn, New York. The Bedford-Stuyvesant Comprehensive Alcoholism Treatment Center became operational in October 1972.

The Bedford-Stuyvesant Center provides emergency inpatient, intermediate, and outpatient services to clients and consultation and education services to the community.

From October 1972 through June 1975, the project provided services to 1,550 clients.

THE POVERTY GRANT PROGRAM

The poverty grant program supports special projects which provide information, education, treatment, and other assistance to lower-income persons and families affected by alcoholism. These activities assist the poor in gaining access to appropriate medical, psycotherapeutic, social, educational, and other services. Projects should develop close relationships with existing service providers to discourage the development of a system of separate and distinct services for the poor. Project goals should be to identify the poor alcoholic and family and insure that they receive the services required to initiate and complete treatment and rehabilitation. An underlying assumption of the poverty grant program

is that the poor do not have adequate access to alcoholism or other health services.

The Paterson Alcoholism Rehabilitation Program

The Alcoholism Rehabilitation Program of the Paterson Task Force for Community Action, Inc., in Paterson, New Jersey, was established in June 1970 by the Office of Economic Opportunity. The project grant was transferred to NIAAA in July 1972.

Project activities are directed toward

--identifying alcohol abusers,

--referring clients to existing community treatment and other services, and

--educating the community on problems of alcohol abuse.

From January 1971 through December 1974, the project provided services to 361 clients and made 293 referrals for treatment and other services.

The Denver Alcoholic Rehabilitation and Counseling Program

The Alcoholic Rehabilitation and Counseling Program of Denver Opportunity, Inc., located in Denver, Colorado, was established in July 1971 by the Office of Economic Opportunity. The project grant was transferred to NIAAA in July 1972.

The project provides counseling, emergency, and referral services, general social service assistance, and conducts alcohol information campaigns.

From January 1974 through September 1974, the project provided services to 684 clients and made 983 referrals. From January 1973 through March 1975, it made a total of 3,276 referrals.

THE INDIAN GRANT PROGRAM

The Indian grant program supports special projects which provide information, education, counseling, and other assist-

ance to Indians 1/ and their families affected by alcoholism. These activities are to enhance the likelihood and ease with which Indians will receive appropriate medical, psychotherapeutic, social, educational, and other services. Counselors should motivate clients and their families to seek appropriate services. Projects should use existing community resources and contribute to th development of comprehensive alcoholism services. Representatives, consumers, and concerned citizens of the Indian community must be involved in administration, operation, and staffing.

The Native American Rehabilitation Association

The Native American Rehabilitation Association in Portland, Oregon, was established in 1970 to help alcoholic Indians and their families establish and maintain sobriety. Until it received its first grant from NIAAA in June 1972, the association developed primarily through the voluntary efforts of Indian alcoholics and contributions from various churches in the Portland area.

The Association operates a halfway house and a three-quarters-way house. Activities include Alcoholics Anonymous meetings, cultural and educational pursuits, individual and group counseling, and assistance in job and training placement.

From June 1972 through March 1975, the Association provided services to 439 clients.

Eagle Lodge, Inc.

In March 1971 the Teepee Center Group, Inc., was established to provide alcohol education counseling and referral services to Indians in Denver. In June 1972 it received a grant from NIAAA to expand services and establish a halfway house. The project is now known as Eagle Lodge, Inc.

Project activities include group therapy; individual counseling; Alcoholics Anonymous meetings; health, religious, and cultural sessions; athletics; and occupational therapy. In addition, it provides referral services and conducts educational activities within the community.

1/Indian refers to American Indians and Alaskan natives.

From November 1972 through September 1974, the project counseled 408 clients of which 340 were admitted to the halfway house.

THE OCCUPATIONAL GRANT PROGRAM

The occupational grant program supports projects which meet the needs of employed persons with problems related to their use of alcohol. Such projects may provide casefinding techniques within work settings or community-based treatment services for employed persons.

In some cases, projects are oriented not toward therapy but toward problem evaluation, guidance, motivational counseling, and referral to community services best suited to meet employees' needs. In accordance with the broad brush approach, projects are encouraged to assist employees not only with alcohol problems but also with others, such as credit, legal, drug, and marital. Experience has shown that, in about half the cases, employees' problems will be related to alcohol.

The New York City Employee Counseling Service

In June 1972 NIAAA awarded a grant to the Health Services Administration of New York City to develop an alcohol abuse program for the city's more than 400,000 employees. The Employee Counseling Service adopted the "broad brush" approach by not limiting its clientele to those employees whose job performance is impaired by their use of alcohol.

The project's activities are not treatment oriented but are directed toward

--training supervisors to identify troubled employees,

--conducting medical examinations and psychiatric evaluations of troubled employees,

--referring employees to appropriate treatment services, and

--monitoring employees' treatment progress and job performance.

From June 1972 through March 1975, the project provided services to 541 employees with alcohol problems and referred about 390 to treatment resources.

THE PUBLIC INEBRIATE GRANT PROGRAM

The public inebriate grant program supports projects providing comprehensive and integrated services for public inebriates. The primary focus is on chronic drunkenness offenders and the most debilitated and chronic alcoholics known as "skid row men." These persons often need food, clothing, shelter, medical care, alcoholism treatment, public assistance, and vocational services. Projects should provide or arrange for services to meet these needs, develop cooperative agreements with existing service providers in the community, and make the best use of these resources.

Projects are expected to offer

--24-hour-a-day, walk-in service principally providing physical care, diagnosis, screening, referral, outreach, medical care, psychological testing, social services, counseling, and aftercare;

--transitional residential treatment providing a socialized living experience; alcoholism treatment; and health, welfare, vocational, and legal services;

--short-term inpatient rehabilitation providing intensive treatment, social programs, social welfare services, and vocational rehabilitation; and

--sheltered boarding home care providing a homelike living condition for those unable to arrange it for themselves or are unprepared to be completely independent of the project.

The Skid Road Community Council

The Skid Road Community Council in Seattle was established in 1970 to assist that city's public inebriates. Its early efforts concentrated on providing such basic survival needs as food, shelter, and clothing. In June 1972 NIAAA awarded a grant to the council to provide alcohol treatment and rehabilitation services.

In December 1972 the council opened a walk-in service center and a transitional residential treatment facility. Intensive treatment services, provided by an affiliate, became available in July 1973. Although the sheltered boarding home was never established, a council official advised us that they have a formal agreement with one to use its services and have, on a few occasions, referred clients to it.

In addition to providing services to public inebriates, the council also conducts a research program to

--assess the project's impact on its clients and the community and

--examine the changing cultural scene of skid road and the role of alcohol within this community.

From January 1973 through December 1974, the council provided services to 1,268 clients. Of these, 488 were admitted to the transitional residential treatment facility and 100 to the intensive-care facility.

APPENDIX V

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY
WASHINGTON D.C. 20201

JAN 19 1977

Mr. Gregory J. Ahart
Director, Human Resources
Division
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

The Secretary asked that I respond to your request for our comments on your draft report entitled, "Efforts to Treat Alcohol Abusers: Progress and Problems." The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,

John D. Young
Assistant Secretary, Comptroller

Enclosure

APPENDIX V

Comments of the Department of Health, Education, and Welfare on the Comptroller General's Report to the Congress entitled, "Efforts to Treat Alcohol Abusers: Progress and Problems," August 4, 1974, B-164031(5)

General Comment

The draft report "...is GAO's first report on NIAAA's activities and deals primarily with efforts directed at treating the alcohol abuser." The review is comprehensive and the Department agrees substantially with the thrust of the GAO recommendations. There are problems of planning and coordination among Federal, State and local governmental levels; assessment and evaluation issues are not completely resolved; the financing of treatment continues to be inadequate; and the establishment of Federal leadership is still evolving. The disagreement of the Department with the GAO report appears due principally to the passage of time since the GAO collected its information. New legislation has been passed; the NIAAA has obtained new leadership in its Director and Deputy Director; the staff of NIAAA is increasing; and the NIAAA has made significant progress in developing policies, programs, and research.

GAO Recommendation

That the Secretary of HEW should direct NIAAA and encourage the States to more accurately determine the magnitude of the alcohol abuse problem on the national and State levels and develop information on the geographic distribution and demographic characteristics of the alcohol abusing population.

Department Comment

Public Law 94-371, July 26, 1976, provides that, "In determining the extent of a State's need for more effective prevention, treatment, and rehabilitation of alcohol abuse and alcoholism, the Secretary shall (within 180 days after the date of enactment of this sentence) by regulation establish a methodology to assess and determine the incidence and prevalence of alcohol abuse within the States."

APPENDIX V

The formula for determining the extent of a State's need is currently being developed and will be a composite of the following variables:

1. The population of the State

2. Financial need as derived from per capita income of the residents of the State

3. The need for prevention, treatment and rehabilitation services as determined by the relative prevalence of alcohol problems by State.

The Department's National Center for Health Statistics, in cooperation with NIAAA, is developing the formula for determining relative prevalence of alcohol problems by State; relevant demographic characteristics of the alcohol abusing population will be built into the prevalence formula. The needs formula, including the relative prevalence methodology, will be available on January 23, 1977, as required by law.

Independent of this effort, NIAAA has contracted for the development of alternative methodologies for estimating incidence and prevalence of alcoholism problems in the general population as well as within geographic and demographic sub-populations. Upon the development of an acceptable methodology or methodologies, estimates of incidence and prevalence will be obtained. It should be noted that this effort differs from that of the National Center for Health Statistics, in that the latter prevalence formula will measure prevalence of alcohol problems by State relative to prevalence of other States. The formula being developed under contract will address prevalence of alcohol problems from the perspective of the general population and specific sub-populations.

In addition, a system (the State Alcoholism Profile Information System) has been designed and implemented to collect standardized information on sources and distribution of alcoholism funding, persons served, and numbers and types of programs by State. Data were received from 42 States in FY '76 and are presented in a National States Report as well as in separate analyses that compared each participating State with a composite of up to seven other States. Data will be collected again in FY '77, and effort is underway to encourage participation by all States.

GAO Recommendation

That the Secretary of HEW should direct NIAAA and encourage the States to maintain accurate and current inventories of treatment facilities and information on their capacities.

Department Comment

Public Law 94-371, requires that any State wishing to participate in the formula grants program must now submit a State plan that will, "contain, to the extent feasible, a complete inventory of all public and private resources available in the State for the purpose of alcohol abuse and alcoholism treatment, prevention, and rehabilitation, including but not limited to programs funded under State and local laws, occupational programs, voluntary organizations, education programs, military and Veterans' Administration resources and available public and private third-party payment plans."

In addition, work being done by the Council of State and Territorial Alcoholism Authorities will culminate in a national inventory of alcoholism resources. This study will identify, compile and tabulate information from available data sources which indicate the available public and private alcoholism resources on a State-by State and national basis. This inventory, which will be completed in February 1977, will provide useful information to NIAAA for planning and evaluation and will assist the States in developing the inventory portion of their State plans.

The State Alcoholism Profile Information System, as discussed above, will provide an additional inventory of treatment facilities and their capacities by State.

GAO Recommendation

That the Secretary of HEW should direct NIAAA and encourage the States to make a greater effort to distribute funds in accordance with the relative need for more treatment programs.

Department Comment

The NIAAA recognizes the need for distributing funds to the States in accordance with the relative need for more treatment, prevention and rehabilitation programs. Upon the

APPENDIX V

completion of current projects such as the establishment of methodologies to assess and determine the incidence and prevalence of alcohol abuse within the States and the State resource inventories, both NIAAA and the States will be better able to distribute funds in accordance with these relative needs.

GAO Recommendation

That the Secretary of HEW should direct NIAAA and encourage the States to establish measurable objectives which specify, to the extent possible, when and how stated goals are to be attained.

Department Comment

The NIAAA is developing methodologies to assess the impact of its research, training, education, and treatment programs. We anticipate that as a result of these activities we shall develop the information and capability for establishing measurable objectives on a schedule compatible with that of the States.

Public Law 94-371, requires that measurable objectives be included in State plans. States now must, "provide reasonable assurance that prevention or treatment projects or programs supported by funds made available under section 302 have provided to the State agency a proposed performance standard or standards to measure, or research protocol to determine the effectiveness of such prevention or treatment programs or projects."[1] Furthermore, the same legislation requires that, "The Secretary shall by regulation require, as a condition to the approval of the State plan, that the State for which such plan was submitted report to the Secretary (in such form as the Secretary shall prescribe) an assessment of the progress of the State in the implementation of the State plan. After making an initial such report, a State shall make additional reports every third year thereafter in which it receives an allotment under this part."

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[1] Section 302 refers to the allotment of formula grant monies to the states (PL 91-616, December 31, 1970).

APPENDIX V

GAO Recommendation

That the Secretary of HEW should direct NIAAA to improve its communications with the States prior to award of project grants and to give greater attention to the impact these grants have on States' alcohol abuse programs, especially those aimed at special target populations since a potential exists for overlapping with State projects serving specific geographic areas. To facilitate greater awareness by State alcoholism authorities of proposed projects within their jurisdictions, NIAAA should adopt a mechanism for insuring that copies of project applications are submitted to the State alcoholism agencies. NIAAA should also encourage the State agencies to submit objective comments on each proposal within 30 days.

Department Comment

Public Law 93-282 provides that a grant applicant must furnish a copy of its application to the State agency designated under section 303 of this Act, if such designation has been made. The State agency has thirty days to furnish HEW with an evaluation of the project or program including comments on the relationship of the project to other projects and programs pending and approved to the State plan.

The Division of Special Treatment and Rehabilitation has attempted to facilitate communication with the States by designating the State alcoholism authority as the official distributor of project grant applications. In addition, copies of all grant applications, upon receipt, are automatically sent to State Alcoholism Authorities by NIAAA.

The Project Notification and Review System, mandated by OMB Circular A-95 requires that applicants for Federal financial assistance (for a project which will impact on area and community development) to notify the State Clearinghouse of its intent to apply for Federal support and provide a copy of its application to the Clearinghouse. State Clearinghouses are responsible for coordinating review of the request with area wide and local government agencies and jurisdictions to determine if there are actual or potential problems in relation to the programs and plans of local agencies or jurisdictions. NIAAA currently requires that grant applications be submitted to State Clearinghouses prior to their review by NIAAA.

GAO Recommendation

That the Secretary of HEW require NIAAA to improve its coordination procedures with other Federal departments and agencies by establishing more formal, structured coordination mechanisms.

Department Comment

It should be noted that the first meeting of the Interagency Committee on Federal Activities for Alcohol Abuse and Alcoholism took place on May 17 and 18, 1976, and that the responsibilities of the NIAAA as the focal point for the coordination of Federal-wide activities related to alcoholism were outlined at that meeting. NIAAA has requested from each participating Agency or Department the following information:

1. Resources (manpower-professional and non-professional by type and dollars) expended in FY'74, '75, '76 and projected for FY'77, for research, training, prevention and treatment to combat alcohol abuse and alcoholism.

2. Recommended areas of collaboration and/or coordination based on the information shared at the first meeting, as well as an indication of needed programs.

The committee met again on October 18 and 19, 1976, and will meet thereafter at least four times a year.

Individuals within NIAAA have been designated by the Director of NIAAA as having primary responsibility for coordinating data collection and other activities of the Interagency Committee on Federal Activities for Alcohol Abuse and Alcoholism.

GAO Recommendation

That the Secretary of HEW ensure that sufficient staffing resources are available to NIAAA to carry out its coordination responsibilities.

Department Comment

This recommendation is in reference to Interagency coordination. Individuals within NIAAA have been designated

by the Director of NIAAA as having primary responsibility for coordinating data collection and other activities of the Interagency Committee on Federal Activities for Alcohol Abuse and Alcoholism.

GAO Recommendation

That the Secretary of HEW require NIAAA to develop a national plan for attacking the alcohol abuse problem which specifies how all Federal departments and agencies can contribute to a coordinated Federal approach.

Department Comment

Please refer to earlier comments pertaining to the Interagency Committee on Federal Activities. Material provided by and recommendations of the Committee will input to NIAAA's formulation of the National planning process.

GAO Recommendation

That the Secretary of HEW require the Interagency Committee on Federal Activities for Alcohol Abuse and Alcoholism to promptly evaluate the adequacy and technical soundness of all Federal programs and activities which relate to alcohol abuse.

Department Comment

We concur with the recommendation. The Interagency Committee is currently collecting information on Federal programs and activities which relate to alcohol abuse. Such an activity is a necessary prerequisite for evaluation.

GAO Recommendation

That the Secretary of HEW should direct NIAAA to continue development of the performance standards, particularly those that relate to the special target population projects.

Department Comment

We wish to clarify the understanding that the term "performance standards" refers to criteria used in exception reporting to aid in assessing project strengths and weaknesses.

NIAAA is continuing development of these criteria for additional special target population projects. At present, the criteria have been developed for the ATC projects, the Cross-Population projects, the DWI projects, and the Public Inebriate projects. Criteria for the Occupational projects are being finalized as of this writing, and criteria for subsequent projects will be developed in turn.

GAO Recommendation

That the Secretary of HEW should direct NIAAA to use existing standards developed for ATC's as a means of assessing their overall effectiveness and efficiency and for determining whether financial support should be continued.

Department Comment

"Standards", or criteria, as they are developed are used as one of several aids for assessing the ATC's and other treatment projects. Data continue to be amassed and analyzed to test their validity. As the criteria are refined their role will become more prominent in the assessment and decision-making process.

GAO Recommendation

That the Secretary of HEW should direct NIAAA to improve its mechanisms for obtaining information on each treatment project by developing a system for site visits based on project size and complexity and the need for technical assistance by project personnel.

Department Comment

We concur with the recommendation. The Division of Special Treatment and Rehabilitation recently was authorized to increase significantly its staff. Procedures are being developed for using this staff, augmented by consultants, in an optimum fashion to obtain project information through site visits and other means.

GAO Recommendation

That the Secretary of HEW direct NIAAA to analyze projects serving large numbers of DWI clients in a manner that takes into consideration the differences between DWI and non-DWI clients.

Department Comment

It has been the practice of NIAAA to analyze DWI and non-DWI clients separately. All routine analyses of Monitoring System data maintain this distinction. In addition, special studies, e.g., 18-month and 4-year follow-up studies, specifically take this into account in design, sample selection, analysis, etc.

GAO Recommendation

That the Secretary of HEW direct NIAAA to encourage more persons who make an initial contact with its treatment projects to enter treatment.

Department Comment

We concur with the recommendation. The NIAAA is pursuing studies of the kinds of people who do not enter treatment and the contributing factors. Both individuals who have made only initial contact at treatment centers as well as those who have recovered without any formal treatment are being studied. In addition, many NIAAA direct treatment programs, such as the occupational alcoholism program, emphasize case-finding, early identification, and referral services. As experience and information are acquired from these activities their implications will be disseminated to the field.

GAO Recommendation

That the Secretary of HEW direct NIAAA to insure that prospective clients who are not admitted into treatment are appropriately referred.

Department Comment

We concur with the recommendation. Please see the comment on the preceding recommendation.

GAO Recommendation

That the Secretary of HEW should direct NIAAA to continue its efforts to develop alcohol abuse treatment cost data and disseminate the data to public and private third party payers as soon as possible.

Department Comment

We concur with the recommendation. For several years, the NIAAA has undertaken both treatment cost studies and the

development of model insurance benefit packages. Currently underway are projects with the Blue Cross Association, the Group Health Association of America, a California State Employees Program, and a series of incentive contract treatment projects. Information from all these activities is being compiled in a Health Insurance Resource Kit which will be distributed by the National Clearinghouse for Alcohol Information.

GAO Recommendation

That the Secretary of HEW should direct NIAAA to require its projects to meet the standards that have been developed for accreditation of alcohol abuse treatment programs and certification of treatment personnel.

Department Comment

A number of issues are involved in establishing quality assurance for treatment projects and providing a persuasive basis for third-party funding. The NIAAA supported the development of accreditation standards by the Joint Council on Accreditation of Hospitals and works with treatment projects to develop their capability to meet the standards. Similarly, the NIAAA is actively involved with a number of national organizations developing a treatment personnel credentialling process. Other mechanisms, such as PSRO, are being explored as well. Thus, it is felt that, currently, NIAAA's proper role is to continue to support the development of standards to develop project capability to meet standards, but not to mandate standards.

GAO Recommendation

That the Secretary of HEW should develop a more consistent HEW policy regarding reimbursement for treatment provided to alcohol abusers by examining the basis for SSA's classification of alcoholism as a psychiatric disorder and NIAAA's classification of alcoholism as a health problem separate from mental health.

Department Comment

This recommendation refers to the Medicare Program. We concur with the recommendation. With the guidance and review of the office of the Secretary, HEW, a SSA/ADAMHA Task Force will be

convened to examine the legal, administrative, fiscal, and health-related factors associated with coverage of alcoholism. The mandate of this task force will be to amass appropriate information, agree on specific SSA/ADAMHA actions where feasible, and present policy recommendations to the Secretary.

GAO Recommendation

That the Secretary of HEW should direct NIAAA to require that projects develop meaningful and measurable objectives which can be related to progress in achieving overall goals.

Department Comment

This recommendation refers to the monitoring system. We concur with the recommendation. Continued collection and analysis of monitoring system data will enable the NIAAA to provide guidance to projects in developing measurable objectives. The recent establishment of a Services Analysis Branch in the Division of Special Treatment and Rehabilitation will also enhance the capability of the Institute in this regard. Study is underway of revisions to grant application guidelines regarding the establishment of project objectives.

GAO Recommendation

That the Secretary of HEW should direct NIAAA to require that projects improve follow-up procedures for clients in order to assure continuity of care.

Department Comment

We concur with the recommendation. The extent and quality of aftercare is one of many areas in which the Institute is pressing projects through review processes, development of standards, dissemination of information, etc.

GAO Recommendation

That the Secretary of HEW should revise the regulations relating to confidentiality of patient records to permit legitimate evaluations of the effectiveness of the client referral mechanism.

Department Comment

We do not concur with the recommendation. The regulations, 42 CFR Part 2, (as published in the Federal Register, July 1, 1975) implement the legislation pertaining to confidentiality of alcohol and drug patient records as amended by Public Law 93-282, May 14, 1974. These state, in pertinent part, that

"Whether or not the patient, with respect to whom any given record...is maintained gives his written consent, the content of such record may be disclosed as follows:

(A) ...

(B) To qualified personnel for the purpose of conducting scientific research, management 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."

It is the interpretation of the Office of the General Counsel, DHEW, that neither the law nor the spirit of the law are violated if an evaluator, such as GAO, studying the effectiveness of a program's referral procedures, for example, performs a record search in an agency to which referrals have been made (under that agency's supervision if necessary) but does not verbally or in writing disclose the identity of the persons being traced who have been referred for treatment. The Department thus feels that neither the regulations nor the legislation would prohibit evaluations of the effectiveness of a client referral system.

With respect to GAO's discussion of "limited use of Supplemental Security Income Program to get alcohol abusers into treatment" (see page 41), the following information outlines the significant factors in the development of SSA's policy position on SSI.

Provisions of the Law

Section 1611(e)(3)(A) of the act provides that a disabled individual who is medically determined to be a drug addict or alcoholic shall not be considered to be an eligible individual or eligible spouse with respect to any month unless he is undergoing treatment that may be appropriate for his condition as a drug addict or alcoholic at an institution or facility approved by the Secretary (so long as such treatment is available) and demonstrates that he is complying with the terms, conditions and requirements of such treatment. Section 1631(a)(2) further provides that such an individual must be paid his benefits through a representative payee.

Definition of Disability

With regard to determining whether a person is disabled under title XVI, the definition of disability is set forth in section 1614(a)(3)(A) and (B) of the law. This is the same definition of disability that is used

APPENDIX V

in the title II social security disability insurance program, which of course, was the expressed intent of Congress. This definition specifies that an individual will be considered to be disabled if he is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. In deciding whether an individual meets this definition, primary consideration is given to the severity of the individual's medical impairment.

Application of the Drug Addiction and Alcoholism Provisions

While the law clearly specifies that the definition or disability for title XVI applicants be the same as that for title II applicants, the law does not specify how to determine which SSI disabled applicants would be found to be drug addicts or alcoholics in order to invoke the provisions for treatment and third party payment. Since the discussion regarding this provision in the Committee Reports was limited, prior to the implementation of these provisions, the proposed policy was presented and discussed with representatives of a number of Federal and State agencies, including the White House Special Action Office for Drug Abuse Prevention, the Council of State Administrators of Vocational Rehabilitation Agencies, Social and Rehabilitation Service-Rehabilitation Services Administration, National Institute of Drug Abuse, and National Institute on Alcohol Abuse and Alcoholism. These discussions led to the expression of concern for the complexities of administering the drug and alcohol provisions, and the need for a realistic interpretation of the provisions. While these groups were concerned with the rather narrow results predictable on the basis of the proposed policy, no alternative provision was advanced. Therefore, with their approval, it was decided to apply the treatment and representative payee requirements to all disabled individuals whose drug addiction or alcoholism contributes to the determination of disability.

Following this decision, title XVI regulations were issued on July 29, 1975, with section 416.906(d) clearly specifying that the presence of a condition diagnosed or defined as addiction to alcohol or drugs will not, by itself, be the basis for a finding that an individual is or is not under a disability. As with any other condition, the determination as to disability in such instances shall be based on symptoms, signs, and laboratory findings. Specific medical criteria for determining disability are enumerated in the Listing of Impairments in the Appendix to Subpart I of the Regulations. Additional regulations finalized on November 6, 1975, specified that an SSI disability recipient would be determined to be a drug addict or alcoholic only if that condition were necessary to the finding of disability. Thus, where the existence of drug addiction or alcoholism is not material to the disability issue, no effort is made to make a medical determination of drug addiction or alcoholism or to classify the recipient as a drug addict or alcoholic.

APPENDIX V

Low Incidence of Allowed Cases Where Drug Addiction and Alcoholism Provisions Apply

Relatively few new SSI applicants have been found disabled where the drug addiction and alcoholism provisions apply. However, this was anticipated and documented prior to the passage of the SSI legislation. In April 1972, the Senate Committee on Finance asked for information with respect to the number of drug and alcohol abusers on the social security benefit rolls and the number who could be expected to be placed on the disability rolls under the proposed SSI program. The committee was informed that the records of SSA showed a very low incidence of allowed cases in which the primary diagnosis was either drug addiction or alcoholism. Moreover, it was pointed out that SSA had no basis for expecting a different incidence of disabling drug addiction or alcoholism in a program where new applicants were subject to the same adjudicative requirements for establishing disability that are required for applicants under the title II program.

Experience with Referral and Treatment Process

With regard to implementation of the provision requiring referral and treatment of drug addicts and alcoholics, this has been difficult to administer. This difficulty was enhanced by the fact that Congress did not authorize funds specifically for the payment of such treatment, nor provide for a new administrative structure to assume the operational responsibilities. The Rehabilitation Services Administration was selected as the agency of choice to coordinate the referral and treatment process. Certain administrative problems have been encountered; however, the major problem has been the lack of treatment facilities. Efforts are being directed to implement a process which should provide more effective management control and an improved capacity to coordinate the treatment program. We interpreted the congressional intent and the statute to mean that the drug addiction and alcoholism referral and treatment provisions apply only where the disabled individual would be restored to the point where he could resume substantial gainful activity. Thus, where an individual is found to be disabled independent of any consideration of his drug addiction or alcoholism, undergoing treatment for his addiction would not accomplish the objective of restoring his capacity to engage in substantial gainful activity.

COMMENTS WITH RESPECT TO MEDICAID MATTERS

The report does not make the point that a Medicaid eligible recipient who is an alcoholic is authorized all the medical services provided by the State on the same basis as other Medicaid recipients. The State cannot arbitrarily deny or reduce any of the required medical services to an otherwise eligible individual solely on the basis of the diagnosis, type of illness, or condition. This point should be included in the report.

(GAO note 1)

On page 37, the last sentence of the first paragraph is somewhat misleading with regard to Medicaid. It is true that States determine to a great degree the extent of coverage for optional services; however, for required services such as physician services, inpatient hospital services and outpatient hospital services, the setting of limitations must adhere to Medicaid's requirements concerning amount, duration, and scope.

(See GAO note 2)

GAO notes:

1. The page number cited refers to a draft of this report and does not correspond to the page numbers in the final report.

2. Deleted comments refer to material contained in the draft report which was revised in the final report.

GAO REPORTS ON FEDERAL ACTIVITIES TO COMBAT ALCOHOL ABUSE

Title	Report number	Date
Substantial Cost Savings from Establishment of Alcoholism Program for Federal Civilian Employees	B-164031(2)	9-28-70
Alcoholism Among Military Personnel	B-164031(2)	11-02-71
Difficulties of Assessing Results of Law Enforcement Assistance Administration Projects to Reduce Crime	B-171019	3-19-74
Veterans Administration Program for Alcoholism Treatment Often Insufficient: More Action Needed	MWD-76-16	9-02-75
Alcohol Abuse is More Prevalent in the Military than Drug Abuse	MWD-76-99	4-08-76

PRINCIPAL HEW OFFICIALS

RESPONSIBLE FOR ADMINISTERING

	From	To
SECRETARY OF HEW:		
Joseph Califano	Jan. 1977	Present
David Mathews	Aug. 1975	Jan. 1977
Caspar W. Weinberger	Feb. 1973	Aug. 1975
Frank C. Carlucci (acting)	Jan. 1973	Feb. 1973
Elliot L. Richardson	June 1970	Jan. 1973
Robert H. Finch	Jan. 1969	June 1970
ASSISTANT SECRETARY FOR HEALTH:		
James F. Dickson III (acting)	Jan. 1977	Present
Theodore Cooper	May 1975	Jan. 1977
Theodore Cooper (acting)	Feb. 1975	Apr. 1975
Charles C. Edwards	Mar. 1973	Jan. 1975
Richard L. Seggel (acting)	Dec. 1972	Mar. 1973
Merlin K. DuVal, Jr.	July 1971	Dec. 1972
Roger O. Egeberg	July 1969	June 1971
ADMINISTRATOR, HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION (note a):		
Harold O. Buzzell	May 1973	June 1973
David J. Sencer (acting)	Jan. 1973	May 1973
Vernon E. Wilson	May 1970	Dec. [illegible]

a/Effective July 1, 1973, the Health Services and Mental Health Administration was abolished and the Public Health Service was reorganized into six health agencies under the direction and control of the Assistant Secretary for Health. Most Health Services and Mental Health Administration functions were transferred to four new agencies: the Center for Disease Control; the Health Resources Administration; the Health Services Administration; and the Alcohol, Drug Abuse, and Mental Health Administration.

APPENDIX VII

	Tenure of office	
	From	To
ADMINISTRATOR, ALCOHOL, DRUG ABUSE AND MENTAL HEALTH ADMINISTRATION:		
Francis N. Waldrop (acting)	Jan. 1977	Present
James D. Isbister	Aug. 1975	Jan. 1977
James D. Isbister (acting)	Sept. 1974	Aug. 1975
Robert L. Dupont (acting)	July 1974	Sept. 1974
Roger O. Egeberg (interim)	Oct. 1973	June 1974
NIAAA:		
Ernest P. Noble	Feb. 1976	Present
John A. Deering (acting)	Sept. 1975	Jan. 1976
Morris E. Chafetz	May 1971	Aug. 1975