

ALCOHOL ABUSE AND CITIZEN ACTION
THE COMMUNITY COUNSELOR/CONSULTANT APPROACH

by

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Recently political and economic circumstances have combined to generate much new activity to counteract alcohol abuse, but there is good news and there is bad news.

Good news: Out of the increased activity may come more effective rehabilitation and prevention programs.

Bad news: But they may not come soon enough to forestall strong public reaction to the inefficiency and ineffectiveness of much of today's activity. Progress to date is marked more by action than by results. And the action is marked more by solutions in search of a problem than by efforts to develop new solutions.

Good news: The increased research activity may lead to more useful understanding of the causes and treatment of alcoholism.

Bad news: So far it has not. The scientific search for the cause of alcoholism, and for an effective treatment or prophylactic has so far had little success. Certainly there have been no prevention or rehabilitation breakthroughs.

Good news: Hospitals and physicians are more accepting of the alcoholic today. More alcoholics are receiving medical treatment, and receiving it under that diagnostic label. While physicians, generally, are more willing to treat the "ic", they are not inclined to treat the "ism". They can hardly be faulted for this until "alcoholism" is defined in terms that tell a physician what to do about it. Still, the growing willingness of physicians to practice medicine on the alcoholic is good news indeed to those of us who believe that getting everyone to contribute his bit to the rehabilitation process may be the only reasonable hope for progress.

Bad news: Here the bad news is the growing number of hospitals which are turning empty wings into alcoholism treatment wards; keeping the patient for 30 days, 90 days, and even longer, and charging the alcoholic, or the taxpayers, for medical and nursing care, more than 90% of which is unnecessary. Here is a solution searching for a problem - so long as payment is assured. Two recent studies report the same success rate for nine days treatment as for 30 days.

Still, medical treatment for the alcoholic who needs it is the humane thing to do; even if it means only that many alcoholics are alive and drinking today who otherwise would be dead and sober. But it means more than that. Keeping the alcoholic alive allows the natural forces affecting the recovery process time to operate. Most alcoholics do recover sooner or later - sooner, with some help we believe; later, (in some cases never) without help.

More good news is the increasing number of alcoholics being exposed to a growing variety of treatments.

Bad news: They all have a frustratingly low and monotonously similar, success rate. One treatment is as good (or as harmful, or as ineffectual) as another. If any one of them was really effective, why haven't the rest disappeared? It may turn out that any therapeutic modality - so long as it involves a fair measure of "Tender Loving Care", gives the alcoholic an imperceptible boost toward recovery, hastening the day when he will be a recovered alcoholic.

Good news: Many preventive educational programs have been instituted.

Bad news: There is no evidence as to what kinds of messages delivered to what kinds of audiences by what means achieve what results.

A final bit of bad news: A growing army of administrators is already consuming half of all the funds appropriated for alcoholism programs. This is according to the NIAAA monitoring system reports.

In summary, the good news is increased action. The bad news is, efforts to make the alcoholism problem fit the solutions at hand (and especially the efforts to fit the alcoholic into the medical model) have led to the application of expensive treatments that don't work, to a disease that has not been defined, in a target population that denies the disease and rejects the treatment. At the same time, prevention programs proliferate despite the fact that we don't really know how to educate people not to get the disease.

There may be especially bad news ahead for programs that have not generated public support and are mere government bureaucracies. Like the earlier prohibition movement, today's action and its government funding have been propaganda and political achievements, not scientific achievements. Continued funding is therefore subject to changing public emotions and to shifting political winds.

Community self-help programs which maximize citizen participation and generate local government support are relatively secure. A community is not likely to abandon a program which represents the labors of many community members who are proud of their achievements. Many communities in the state of Iowa have had several years experience with this do-it-yourself approach to finding improved rehabilitation and prevention programs. This is a report on that experience.

First, a theoretical view of alcoholics which provides a rationale for the community self-help approach. There is a way of looking at alcoholics, how they get that way, and how they recover, which does not require them to fit the medical model. From this perspective, becoming alcoholic and becoming recovered are seen as long-term (several years) dynamic processes affected by multiple interacting social, psychological, and biological factors, none of which makes more than a weak causal

contribution. This would explain why no single cause or cure for alcoholism has been found.

This view of the alcoholic requires a shift in thinking from a single cause operating at a point in time to multiple weak, interacting causes operating over several years. The alcoholic process and the recovery process are seen as co-existent, not sequential, as in the Jellinek phases model. Even as the person progresses in the alcoholic process, forces are building toward recovery. Both processes normally begin when the person is in his late teens and continue into late middle age. And both are influenced by many of the same causal factors. It is likely that the alcoholic process involves a large element of learning - learning to use alcohol to deal with life's everyday problems until it becomes an all-consuming way of life. The recovery process, likewise, involves a large learning factor - learning to live without undue dependence upon alcohol.

Whether the person is an alcoholic or a recovered alcoholic at any given time depends upon the relative strength, of the several interacting forces. Treatment, or any type of help is merely an added force designed to tip the balance toward recovery. We cannot with any certainty specify the factors involved or partial out the cause. However, Mark Keller, has compiled a long list of variables which have been found to be weakly correlated with alcoholism. Many factors have also been found to be weakly correlated with recovery.

There is also the fact that every community somehow prevents some 90% or more of the drinkers from abusing alcohol. And considering that this rate varies from society to society, from community to community, and for different social segments of a given society or community, suggests the existence of certain natural forces which influence the alcoholic process. Also, the fact that many alcoholics become ex-alcoholics without any formal treatment, suggests the influence of natural forces in the recovery process.

From this viewpoint, what every community needs is a friend for the alcoholic, and a consultant for the community. The alcoholic needs someone who cares enough to help him, and the community needs someone to help it mobilize its resources to help the alcoholic to rehabilitate himself. In short, there is need for a counselor/consultant to help the community harness the natural forces which effect the alcoholic and recovery processes. If some societies and some communities can minimize alcohol abuse, others can too.

In 1966, the University of Iowa Alcoholism Center began training such alcoholism workers. Beyond the ability to work with both the alcoholic and the community, it was not clear what the counselor/consultants qualifications should be. Successful work with alcoholics is not highly correlated with academic degrees, or professional titles.

We had observed a tendency for professional counselors to expect the alcoholic to fit his needs to their therapy. When he does not do so, they take refuge in their degrees and titles, blaming the alcoholic for lack of motivation. Indeed, treatment centers and even Alcoholics Anonymous tend to favor the alcoholic who "really wants help".

Basically the counselor/consultant should be a highly client-oriented, task-oriented person determined to accept the alcoholic and work with him whatever his stage in the recovery process. Even if the alcoholic is not yet "ready for help", the counselor accepts the challenge to motivate him and accelerate his progress toward recovery. He should also expect to be judged by his results on the battlefield because he has no license to fail.

A dozen years ago the psychiatrist, Frederick LeMere, with long years of research and clinical experience working with alcoholics, wrote, "...the basic aptitude for treating alcoholics comes only from interest, tolerance, common sense, dedication, understanding, patience, and a natural ability to deal with these difficult cases."

There has been nothing in the literature since to convince us otherwise. Indeed, an empathic, trusting relationship between the helper and the helpee seems to be the one element of success common to the great variety of treatments being offered alcoholics. In addition to caring, the counselor must have the empathy to understand what the alcoholic has been through, what he is going through, and what he is likely to go through. He must have the "tough concern" to recognize and counter a "con job" when he sees it. He must be able to talk the alcoholic's language in a manner that will gain his trust and confidence. In addition, he needs a large measure of common sense and general competence to get things done.

These qualities are more likely to come from experience than from the classroom. The academic and professional backgrounds of our counselor trainees have ranged from a near Ph.D. in physics to masters degrees and bachelors degrees to less than eight years of formal schooling. They have included ex-nuns, ex-nurses, ex-teachers, and ex-denizens of skid row. One was a native Alaskan Eskimo. Another had worked as a "bunny" in a Playboy Club. About three-fourths of them are recovered alcoholics.

There are no standard operating procedures for the counselor/consultant, nor should there be, at least until more is known about what works and what doesn't. Meanwhile, diversity and experimentation should be encouraged, with the operations being closely monitored and evaluated for their pay-off to the alcoholic and to the community. If we don't know where we are going, let us at least try to learn something by carefully recording where we have been.

The counselor/consultant's work with the community is largely a by-product of his work with alcoholics. His functions as community advisor,

leader, and educator regarding alcohol problems are performed in the process of reaching out to contact alcoholics through other community agencies, employers and service professionals, and in turn, enlisting and coordinating their services for the alcoholic. Having contacted the alcoholic, he establishes rapport with him, motivates him, helps him sort his problems, helps him decide what professional services he needs, aids him to obtain those services, and counsels him in the process. He provides the alcoholic a continuum of long-term support assistance and encouragement to rehabilitate himself.

The community counselor is careful to do nothing for the alcoholic he can get the alcoholic to do for himself, or that he can get someone else in the community to do; especially if that someone else is more qualified. The counselor does not practice medicine or law, or pastoral counseling, or social work, or provide other professional services. His task is to help the alcoholic assess his needs and to know who in the community is best qualified to provide a particular service. Thus, utilization of community services is determined by the consumer's needs not the provider's needs.

The successful community counselor spends little time counseling the alcoholic in the usual sense of attempting to reconstruct his personality in a 50-minute hour. Being uncommitted to any particular brand of psychotherapy, he is freer to fit services to the individual's needs. The community counselor who slips into the role of "junior psychiatrist" sitting behind a desk offering to adjust the alcoholics' psyche attracts few alcoholics. Fewer still fit his treatment. On the other hand, if the counselor and the alcoholic together decide that psychological counseling might be beneficial, it is the counselor's job to know what local professional counselors can relate to alcoholics and make an appropriate referral.

While recognizing the reciprocal relationship between thinking and acting, the community counselor emphasizes helping his client act his way into new ways of thinking rather than think his way into new ways of acting. He spends more time helping people solve immediate problems, and less time adjusting psyches. He acts as a, "shoehorn" - helping the alcoholic fit himself back into community life through job, family, church, AA, etc., getting as many others involved in the alcoholic's recovery as possible. Some of the most effective counseling occurs as the counselor drives down the street helping the alcoholic find a job, or keep an appointment.

If the counselor/consultant knows alcoholics and knows his community, and fully utilizes existing resources, then there is no service or facility or other resource of known value to the alcoholic that is not available to him. This is with the possible exception of the need to establish a half-way house.

Community counselors/consultants have helped many Iowa communities develop self-help alcoholism programs. In the late 1950's and early 1960's there was a growing conviction in Iowa that there must be a better way of coping with alcohol abusers. Concerned citizens in many communities began doing something about it.

They formed local citizen's committees on alcoholism. These private, non-profit corporations then established their own community alcoholism service centers and employed counselor/consultants to staff them. Following two unsuccessful attempts, the first center was opened in 1967 with a total budget of \$600 of borrowed funds. A personal bank note was signed by a committee member.

By 1974, there were some 35 centers. Although they were mainly locally funded, some did receive start-up money and others received supplementary funds from a federal grant obtained by the then Governor, Harold Hughes. It is noteworthy that when the federal grant expired after two years, some centers which had not generated local support were closed. Others floundered for a couple of years until they could generate local support. Still, in 1973, some two-thirds of the funding for the community center was local and there was only a minimum of state central control. The State Director had an administrative budget of only about \$50,000.

The University's Role:

While the local communities were coming to grips with their alcohol problems, the State University was developing an alcoholism treatment center, and the counselor/consultant training program as well as a monitoring and evaluation system to assist the local communities in their self-help, trial and error endeavors.

Thus client services, personnel training and monitoring and evaluation, were integrated with each of the three components providing feed-back for the other two. What was learned through monitoring and evaluation was fed into the training component, which fed trained personnel back into the service component. They in turn fed new data back into the monitoring system, and so on. All of this was a voluntary cooperative achievement and was not dictated by a central authority.

In order to be of more assistance to local communities, the University Treatment Center was reorganized and reoriented in 1972. The Center had been established eight years earlier to provide long-term (six weeks) treatment - offering the alcoholic all of the usual professional counseling services. The staff included psychiatrists, psychologists, social workers, vocational rehabilitation counselors, pastoral counselors, and alcoholism counselors, as well as physicians, nurses and orderlies.

Following reorganization, this counseling staff was replaced with two graduates of the counselor/consultant training program. Medical services

are now provided by a half-time medical director and a central nursing staff which is shared with another ward. Patient length of stay has been reduced to average about one week - but it depends upon the patient's needs and the ability of his community to meet the needs. The patient's admission and discharge are coordinated with the efforts of his community counselor to help him. Patient admissions soon tripled so that three times as many alcoholics were being served with a greatly reduced staff and budget. Per-patient costs are now about one-tenth what they would be if the six-week regimen was still in operation. Follow-up studies showed a slight, but not significant, increase in success rates.

The new objective of the Treatment Center was to demonstrate the appropriate cost-effective role of a local general hospital as a tool for use by the community counselor and his client. Counselors in the local centers are encouraged to refer alcoholics to the University Center only on a differential basis depending upon the alcoholic's needs and only if those needs cannot be met in his home community. The Center's services are intended to supplement and compliment those of the community. They include detoxification, evaluation, and rehabilitation planning. The goal is to restore the patient physically, get his attention, motivate him, evaluate his needs - and help him set a realistic course of action that his community counselor can help him execute. The Center staff does not deceive itself or the alcoholic and his family, that his personality can be reconstructed, or his alcoholism treated away during his hospital stay. After all, 7 days, or 7 weeks or even 7 months is but a brief interlude in the alcoholic's drinking career. In other words, treatment of alcoholism in the popular sense is de-emphasized in favor of patient services that are, simple, direct common sense, and cost effective, without slighting any of the alcoholic's needs in any way. The fact that this approach enjoys a recovery rate no less than that of the earlier six-week treatment regimen, suggests that there is nothing of proven value to the alcoholic's recovery that the center could do that it is not doing. And when these in-patient services are followed by (and often preceded by) the services of the community counselor, we are even more confident that he is receiving all the help there is available at any price. This is not to deny the possibility that some alcoholics might obtain some added benefit from a particular treatment that is not available at the center. In fact, for some cases, transfer to a long-term treatment center is recommended.

A unique innovation is that all discharged patients (along with the center's written evaluation and recommended long-term rehabilitation plan which has been worked out with, and agreed to by, the patient) are all hand-carried by the hospital counselor back to the community counselor.

Do the counselor/consultant, community self-help concepts work? More importantly, what's in it for the alcoholic? The monitoring and evaluation studies of the community centers through 1974, while they were largely locally funded and controlled, revealed them to be a highly cost effective means of reaching increasing numbers of alcoholics, reaching them earlier in their drinking careers, and with a recovery rate

comparable to that of the University based residential treatment center. Although there was variation from center to center, on the average, they showed the following trends:

1. There was a steady increase in the number of alcoholics served. If the success rate is no greater for the community counselor, at least he raises the base for that rate.
2. There was a clear trend toward reaching alcoholics earlier in the alcoholic process providing an opportunity for secondary prevention. Yet, the data showed that the more advanced cases were not slighted.
3. There was also a trend toward increased self and family referrals indicating that as the centers established themselves they gained credibility with the community.
4. There was a trend toward seeing a broader range of the alcoholic/problem drinker population. In fact, each year the client profile more closely resembled that of the normal population on many demographic, drinking pattern, drinking consequences, and other characteristics.
5. In a more critical vein, relatively few clients implicated their employer, physician, clergymen, or the welfare office as playing a role in their coming to the center. The courts and law-enforcement agencies played a greater role.

It is encouraging, however, that this varied by center. One center demonstrated more success in getting referrals from physicians, another from clergymen, and yet another center gets more referrals from employers. This illustrates a major advantage of encouraging diversity and experimentation by the centers.

6. In 1974, the annual expenditure per alcoholic served averaged about \$310 for the well established centers. Dividing the total number of alcoholics served by all community centers in 1974 (conservatively estimated at 6000) into their total expenditures of \$2.8 million yields an annual per-client expenditure of \$467. This does not include the cost of hospitalization of those clients needing it.

The approach has received some recognition outside the alcoholism field. Two Iowa communities that have implemented the counselor/consultant concept have received recognition by the U.S. Dept. of Housing and Urban Development (HUD) as Bicentennial Projects. They were cited as models of local community self-help programs to solve a local problem.

The one center must be the most cost-effective in the nation. Serving a county of only 19,000 citizens, the center has strong community support. It is staffed by one counselor and a secretary. Its active caseload numbers about 100. Depending upon the client's needs, some are counseled for an hour at a time; others may require only 5 minutes; others may involve only a phone call either to the client himself or to a community resource to arrange for a particular service. About one in five patients is hospitalized at the University Center.

The center reaches 10-15 new clients per month. Some two-thirds of them come by way of the court. It serves approximately 200 individuals a year with a total annual expenditure of \$50,000, and this includes the costs for those who are hospitalized. Thus, the annual unit cost (including hospitalization for those needing it) is about \$250 per client. Excluding hospitalization, the per client cost is about \$125.

The essential ingredients of this model of cost-effectiveness are: 1) a dedicated, hard working counselor/consultant who can relate to alcoholics and to the community and whose efforts are not restricted to a 40-hour week, 2) maximum community participation and utilization of existing resources, 3) sensible referrals based on individual needs. The operation is simple, direct and common sense, yet the alcoholic's needs are fully met within the limits of present knowledge. Other than the large paper work load recently imposed by the State, the center requires little administration. It is almost entirely locally funded. If it were also locally controlled, perhaps only 5% of staff effort would be needed for administration. As compared with a more common figure of 50% or more.

While the center's effectiveness has not been directly researched, there are indications that its success rate at least equals that of other treatments. City and county officials point to the program with pride. The county sheriff reports an impressive decline in the number of chronic drunkenness offenders. Many clients are now receiving their release papers from the court after having discharged their court-imposed obligation to work with the counselor for one year as a condition of their parole. Alcoholics Anonymous membership and participation has increased dramatically.

While this self-help approach is most easily implemented in smaller communities, I was recently impressed by the extent to which it is also being successfully developed in a large metropolitan area, Kansas City, Mo. The program has been developing over the past four years under the leadership of an agency called Community Alcohol Programs of Kansas City. This agency employs eleven counselor/consultants whose services are closely integrated with those of the local general hospital, a Salvation Army residential facility, and numerous community service agencies. The counselor/consultants are assigned to the different community agencies to assist them in delivering services to alcoholics and in coordinating their services with other agencies. If you are looking for a model for a large metropolitan area, I highly recommend the Kansas City program to you.

Certainly the local centers have not been without their problems and growing pains. Some counselors who entered the field to work with alcoholics soon found themselves as center directors, an administrative role for which they were ill-equipped, by either training or experience. As center budgets and staff size increased, instances of financial mismanagement, and even abuse, have come to light. These few, but highly publicized, instances caused some voices to argue for tighter state control. However, the daily news gives us pause to wonder how much honesty and fiscal responsibility there is at any level of government. We favor the local level because there are fewer funds to be mismanaged or abused. In fact, even if several local center directors were to abscond with their center's entire budget for the year, the loss to the taxpayer would not equal the added costs of the new state administrative office and the cost of added paper work for the centers.

Another hazard is a tendency for centers, as they grow in size, to prematurely formalize and standardize their operations before they know what works and what doesn't. While this may be "sound administration" and suit the convenience of the staff, it discourages innovation and experimentation. "Consistency is the last refuge of the unimaginative." Even worse, given the present state of knowledge, a standard operations manual may well perpetuate operations that are in fact counter-productive. The mischief is only multiplied when the uniformity is dictated at the state level and imposed on all centers.

The accomplishments of Iowa's community centers through 1974 were achieved in the absence of a strong, state central authority. The local programs were not the result of a master plan uniformly imposed on all communities. While the community self-help effort can benefit from wise leadership, by definition it will perish from strong directorship.

The essentials of the self-help approach - citizen interest and volunteer work, extra time and effort given by a dedicated center staff, community agency involvement - are all things that come from the hearts and desires of people, and cannot be dictated. Programs of people, by people and for people cannot long survive efforts to formalize, standardize, bureaucratize or even professionalize them.

During the past two years, the funding of Iowa's local programs and the control that goes with it, have been shifting to the state level. This will provide an opportunity for comparing the "bottom up", self-help approach with the "top down" centrally directed approach. Fortunately, the monitoring of the centers since their inception through 1974 provides baseline data for such a comparative study.

The shift to state control was a purely political move without benefit of either logic or evidence as to what the shift would mean for the alcoholics or the taxpayers of the state. Although hard, reliable data are not yet available, it is known that total expenditures have greatly increased. State central administration costs and the cost of the

new monitoring systems have increased by a factor of about 7 or 8. In addition there is the added cost to the local centers of completing the increased paper work which has quadrupled and now consumes about 25% of local center staff effort. It is hypothesized that the annual cost per alcoholic served has more than tripled and may approximate \$1500. Who is getting what out of the shift to state control, the increased costs, and the added paper work remains to be determined.

In summary, we have offered a multi-causal processual view of the alcoholic as an alternative to the medical model. We have described a community self-help approach to the problems of alcohol abuse as an alternative to state controlled programs. We have described the community alcoholism counselor/consultant and his role in helping the community help the alcoholic. And finally, concern has been expressed for the future funding of the current movement. It was suggested that the community self-help approach is the one most likely to survive in the long run.

To most succinctly summarize, we would quote Pogo, "We have met the enemy and he is us."