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ALCOHOL AND ALCOHOLICS IN IOWA 1965

SYMPATHETIC EMPLOYERS
[MEN]TAL HEALTH CENTERS
RESEARCH
PHYSICIANS
SOCIAL WELFARE AGENCIES
ALCOHOLICS ANONYMOUS
HOSPITALS
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in Iowa, 1965

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ALCOHOL AND ALCOHOLICS IN IOWA 1965

by

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and

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Iowa City

1965

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INTRODUCTION

In 1955 the 56th General Assembly of Iowa at the urging of Senators Earl Elijah, Tom Dailey, and others appropriated $30, 000 to The University of Iowa College of Medicine for a survey of the alcoholism problem in the state. Much of the credit for this expression of legislative concern for the intemperate drinker is due to many years of effort by Dr. Leo Sedlacek (1), Judge Ray Harrison, and to some fifteen years of successful Alcoholics Anonymous activity in the state. While certainly this was not the first Iowa legislation regarding the use of beverage alcohol, it did launch the state's first program of scientific research on the subject.

The survey was duly made and the results were published in 1957 (2). Subsequently, the Director of the State Psychopathic Hospital, Dr. Paul Huston, recognizing the importance of continued research, established the Division of Alcoholism Studies which then became a University-sponsored center for the study of problems related to the excessive use of alcohol. To broaden the alcoholism program at the Psychopathic Hospital, a clinic was established in 1960 to serve alcoholic patients, train personnel, and stimulate research. The program was furthered in 1961 by another special legislative appropriation of $25, 000 to the Psychopathic Hospital for alcoholism research.

Purpose of this Booklet

The major purpose of this booklet is to summarize the knowledge that has been acquired concerning problems related to the use of alcohol in Iowa. Hopefully, it will be useful to the professionals and agencies; e.g., hospitals, physicians, police, clergy, etc., who by the nature of their work routinely encounter alcoholics; to policy makers, administrators, and others who seek a more effective and humane program for dealing with alcoholics; and to the general public. Hopefully, it will contribute to the welfare of those who have already become alcoholics and to the ultimate prevention or reduction of the incidence of such extreme deviant drinking and consequent social problems.

The work will summarize: a) the history of liquor control legislation and of drinking practices and attitudes in the state; b) the state's current drinking practices and attitudes and comparisons with other states and the nation; c) available knowledge regarding the number and social distribution of extreme deviant drinkers

("alcoholics"); and d) reactions to the alcoholic, by the general public and by the agencies and professionals who encounter him. The work will conclude with certain recommendations for a more effective attack on the alcoholism problem.

Your Assistance Please

While this work presents much information regarding alcohol use and alcoholics in Iowa, it is only a beginning. Actually it raises more questions than it answers. This is necessarily true of the initial studies of any subject. Most of all it does not offer the final answer to the alcoholism problem. To help the state move closer to a solution of the problem we need "feedback" from the readers of this booklet. May we draw upon your knowledge and experience? The reader is asked to share with us any information, ideas, or suggestions he may have related to the alcoholism problem and its solution. For a time-saving aid in organizing and presenting your information and suggestions a form will be found on the next page. Please complete the form and return it to the Director of Alcoholism Studies, State Psychopathic Hospital, Iowa City, Iowa.

YOUR ASSISTANCE, PLEASE!

1. How much of a problem are alcoholics in your community? Do you judge them to be: (check one)
   a. ________a major problem
   b. ________a minor problem
   c. ________hardly a problem at all

2. What is your estimate of the number of alcoholics in your community?______________

3. Please list the agencies and professionals in your community that have gained a reputation for rendering substantial help to alcoholics.

4. In your judgment, what specific resources are needed in your community to more effectively cope with alcoholics?

5. Do you have any suggestions for a state or local program for attacking the alcoholism problem? (Use reverse side of page if necessary).

6. Please provide the following information:
   a. Your sex________Male________Female
   b. Your age___________
   c. Occupation______________________________
   d. Religion_______________________________
   e. Number of years school completed__________________

7. Size of community________Rural ___________Town under 2, 500 population
   ________City 2, 500 or more population

Name_____________________________________

Address___________________________________

Chapter I

HISTORY OF ALCOHOL CONTROL LEGISLATION

Liquor Control Laws

Alcohol has been used as a beverage by a certain portion of the inhabitants of what is now Iowa ever since the first settlers entered the area carrying with them their European drinking heritage. Throughout the history of the state, the public has been rather evenly divided between drinkers and abstainers.

While public sentiment undoubtedly has exerted much informal restraint on alcohol use, it has not precluded intemperate drinking, and there has always been enough abuse of the beverage to arouse public reaction. Consequently, the state has resorted to more formal controls; i.e., laws and police action, to restrict the number of users and the amount of individual consumption. The nature and degree of legal controls have always been matters of controversy, confounded by the fact that liquor is an important source of tax revenue enjoyed by "wets" and "drys" alike. Moreover, alcohol has always provided a convenient if overly simple explanation of a great variety of social evils.

Robert Lucas, first governor of the Territory of Iowa, in 1838 in his first message to the legislature said: "These two vices may be considered the foundations from which almost every other crime proceeds, as the statistical reports of the penitentiaries conclusively show. They have produced more murders, robberies, and individual distress than all other crimes put together. . . . Could you in your wisdom devise ways and means to check the progress of gambling and intemperance in this Territory, you will perform an act that would immortalize your names and entitle you to the gratitude of posterity."* (3, p. 197).

However, the history of the state's liquor control legislation begins before the turn of the nineteenth century. Prior to 1805 when Iowa was still part of the old Northwest Territory there were few liquor laws. The existing laws were designed to raise revenue and protect the community against intoxicated Indians and soldiers and were not an expression of strong moral sentiments.

During the period (1805-1838) when Iowa was first part of the Michigan and then part of the Wisconsin Territory, about two dozen regulatory laws were passed reflecting a rising sentiment against intemperance. Sales were forbidden on Sundays and in the

*This history of liquor control legislation up to 1916 draws heavily upon a series of articles by D. E. Clark. (3, 4, 5, 6, 7)

vicinity of religious gatherings and to minors. Punishment for habitual drunkenness included whipping and a term in the house of correction. Here, also, is found the first law against drunk driving. Owners of stage coaches were forbidden to employ drivers addicted to strong drink. Thus, by the time Iowa became a separate territory in 1838, there was a fairly comprehensive code of liquor laws and a well-developed public sentiment against intemperance as an immoral practice.

In response to Governor Lucas' first message, the first territorial legislature passed several control laws. These included the prohibition of sales to Indians as well as the sale of liquor within two miles of worshipping congregations (unless by a legally licensed business). Fines for violation were appropriated to the education of any poor orphan child or children of the proper county. Other pertinent legislation was contained in acts which incorporated cities. To some extent the history of liquor control laws in Iowa is a history of powers given by the legislature to towns and cities. When the first territorial legislature incorporated Bloomington (now Muscatine) and Davenport, it impowered the corporation to regulate the retailing of ardent spirits provided the regulations did not conflict with territorial laws. These municipalities were also permitted to license retailers and retain the revenue. Incidentally, licensing has always been a favored device because it is at the same time a means of control and an effective means of collecting revenue.

Governor Lucas continued his active interest in the temperance movement which was gaining momentum. In his second annual message (1839) he held the vender of spirits morally accountable for all the crimes and wretchedness produced by the use of such spirits. He recommended legislation to repeal all license laws then in force and leave the whole matter entirely to the control of public opinion, or, if this was not expedient, then to pass a law giving voters in each county the right at each annual election to vote upon the question of whether or not licenses should be granted within that county.

However, the legislature did not act on these recommendations, and with one notable exception there was no further important legislation until Iowa became a state in 1846. The exception was an act incorporating the community of Farmington, which contained the first application of the principle of local option. The electors of the community were given the right annually to vote for or against the licensing of liquor retailers.

Although the temperance movement seems to have lost much of its vitality during the later years of the territorial period and

there was little agitation for new control legislation, still, in 1847, the First General Assembly of the State of Iowa passed the first state-wide local option law. It required that a vote be taken at the annual township election on the question of whether the county commissioners should grant licenses for the retail sale of intoxicating liquor in their county. In the following election (April 5, 1847), every county in the state except Keokuk County voted against licenses. In effect, the state, except for one county, was now under legal prohibition for the first time. But the law was not enforced, and violations were widespread.

The next General Assembly, in 1849, impowered the Board of County Commissioners to grant or deny retail licenses. In essence, this returned the state to the license system prevailing during the territorial period. Those who favored the license system argued that no more liquor was sold under the license law than under prohibition, and that the sale of licenses was a fruitful source of revenue.

The next major change came in 1851 when the first law prohibiting sales of "liquor by the drink" was passed. Package sales were permitted, but the state rejected any share of profits from liquor sales. This law pleased no one because it neither prohibited beverage alcohol nor gave the state the benefit of revenue.

The prohibitionists renewed their activities with vigor. In the election campaign of 1854 they reversed their policy of avoiding politics and backed James W. Grimes, who was elected governor. In 1855, the legislature enacted the first prohibition law with the proviso it be submitted to popular vote. It was approved by the voters in April, 1855, by a close popular vote of 25, 555 votes for the law and 22, 645 votes against it. Interestingly enough, the vote by counties was equally divided--thirty-three counties for, thirty-two against, and one tie. The law prohibited the manufacture or sale of intoxicating liquors with the exception that homemade cider and wine might be sold in quantities of not less than five gallons for medicinal, mechanical, or sacramental purposes only. Liquor could also be imported in the original packages, but county judges were to act as agents for the purchase and sale of liquor for legal purposes. The prohibitory law went into effect in July of 1855, and while saloon-keepers generally closed their shops, it was only temporary. Within a month, they began to reopen them and there was little effort to enforce the law. A weakness of the law was the means of enforcement it provided. It relied mainly upon complaints brought by at least three citizens. However, the prohibitionists who had fought

so long and hard for the law sat back with folded hands, secure in the knowledge their law had passed. Citizens who opposed the law were even less inclined to complain against violators.

In an effort to strengthen the prohibition law of 1855, it was amended in 1857 to place a special duty on police officers to enforce prohibition. The same General Assembly enacted a license law with a local option clause, but it was declared unconstitutional.

In 1858, as a concession to the large German element in the state, the 1855 law was again amended to permit "the manufacture and sale of beer, cider, and wine from fruits grown in this state." By 1859 prohibition had fallen into such disfavor that the Democratic party declared against it in its platform.

During the Civil War, there was little legislation relating to liquor except for certain attempts to make the 1855 prohibition law more stringent. All the while, liquor was being sold almost without restriction. One amendment is of special interest because it is the first appearance in Iowa of the so-called Dram Shop Law. Enacted in 1862, it made the seller of liquor, contrary to the law, responsible for the care of any person who thereby became intoxicated. In addition, it provided that anyone who should be injured as the result of intoxication in another person could bring suit for damages against the seller who furnished the liquor.

Following the Civil War, liquor control was to be an issue in nearly every election up to the present time,with the Whigs (later Republicans) consistently favoring prohibition or at least stricter controls, while the Democrats have consistently favored a more liberal license system.

In 1868 an act was passed giving incorporated towns power to regulate or prohibit the sale of beer, wine, and cider. In effect, this meant local option for these beverages while ardent spirits were still prohibited. Nearly all the larger cities chose to "regulate" rather than prohibit the sale of these beverages and imposed a tax on sales.

Another attempt at local option in 1870 was struck down by the courts as unconstitutional on technical grounds. In 1878, the General Assembly enacted a law making it unlawful to sell ale, wine, or beer within two miles of any municipal corporation except under authority of the municipality in question.

Beginning in 1878, the temperance forces focused their efforts on absolute prohibition and sought to bring this about through a prohibition amendment to the state constitution. The advocates of the amendment reasoned that statutory law was subject to change

with the political winds, while the constitution could be changed only by a vote of the people. It was thought that the temperance question thus would be removed from the political arena and decided by the people on its merits.

The "wets" and "drys" fought a spirited battle during the next several years. The net result was that the proposed prohibition amendment was passed by two consecutive legislatures (1880 and 1882) to be submitted to the voters as required by the constitution. However, the matter was complicated by a Senate Resolution in 1882 which declared that while the amendment prohibited the sale and manufacture for sale of liquor within this state, it was not designed to prohibit the manufacture of liquor for sale outside the state.

With widespread interest and high feelings, the voters went to the polls on June 27, 1882, and cast 155,436 votes for the amendment and 125,677 votes against it. Seventy-five counties declared for, twenty-three voted against, and in one county the vote was a tie. Polk County had the largest majority for, and Dubuque County led in the opposition. It is also interesting that ten counties which had voted for the prohibition law of 1855 now declared against the amendment, while twenty-three counties which had opposed prohibition in 1855 now voted in favor of it.

On July 29, 1882, Governor Sherman proclaimed the amendment had been legally adopted. However, the prohibition forces were yet to be denied their victory. The following January, the Supreme Court declared the amendment invalid on a technicality. The court found that the wording of the amendment as approved by the voters was not identical with the resolution adopted by both houses of the Eighteenth General Assembly and was therefore invalid.

The prohibition issue played an important role in the next (1883) political campaign. The Democrats again came out for a license system while the Republicans held to prohibition. The Republican candidate, Buren R. Sherman, won reelection as governor, and in his message to the legislature (1884) he recommended the enactment of prohibitory legislation. Accordingly, the legislature enacted two laws which imposed prohibition as absolute as that contemplated by the defeated constitutional amendment. The first of these laws repealed the famous wine and beer clause which had been on the statute books since 1858. The definition of intoxicating liquors was made to include ale, wine, and beer, and the manufacture and sale of these drinks along with all other liquor was prohibited. Another law detailed further restrictions on liquor traffic and provided heavier penalties for violation of the law. The obvious intent

was to make the manufacture or sale of liquor impossible within the state. However, it did permit the manufacture and sale of liquor for medicinal, mechanical, culinary, or sacramental purposes under strict state regulation. A significant feature of the law was its provision that one-half of the fines for violation should go to the person who brought information of violation, and that the other half would go to the school fund of the county.

Thus, absolute prohibition was to be given its first trial in Iowa, July 4, 1884. It will be recalled that the prohibitory law of 1855, even before its modification by the wine and beer clause of 1858, had not imposed absolute prohibition. There was much opposition and defiance of the law and no little violence ensued. In Burlington, the front doors of saloons were closed but the rear entrances stood open (6, p. 542). According to one newspaper, Dubuque saloons ignored the new law as they had the old one for over twenty years. There was mob violence and riots aimed at informers, police, and prosecutors who attempted to enforce the law. At one point, a company of militia was held in readiness at Marengo to assist Iowa City officials in handling unruly mobs who stoned the residences of an attorney and a citizen who had been prosecuting law violators. In other cities there were bombings and stone throwing. Some cities, e.g., Council Bluffs, were inclined to overlook violations if the retailers paid taxes on their sales. A survey by a Davenport newspaper editor concluded that in some places prohibition was entirely successful--in others the number of saloons was unchanged, and in many places there had been an increase in the number of saloons. Another newspaper declared that in scores of smaller cities and towns the law was absolutely enforced. While there were many violations of the stringent prohibition law of 1884, by 1889 the manufacture of liquor within the state was practically abolished and there was a great reduction in the number of places openly selling liquor. What this meant in terms of number of drinkers and extent of individual consumption is not known.

Within a few years, the desire for liquor on the part of a sizable segment of the population was manifested in a growing reaction against prohibition. The Democrats, taking advantage of this reaction, succeeded in electing their candidate for governor in 1889 and again two years later. The Republicans reacted by declaring prohibition no test of Republicanism and suggested changing the law so that the local communities could control liquor traffic. Thus, in 1894, the legislature enacted the so-called Mulct Law. For all practical purposes this was a local option measure. The prohibition

law of 1884 was not expressly repealed, but under the new law saloons might operate in counties where petitions requesting licenses were signed by 65 per cent of the voters voting in the last general election. Larger cities needed signatures of a simple majority and smaller cities needed signatures of 85 per cent of such voters to legally sell liquor.

The liquor legislation of the next fifteen years consisted mainly of amendments to the Mulct Law and to the earlier prohibition law. The next significant change appeared in 1909 when the thirty-third General Assembly passed several liquor laws. The number of saloons was limited to no more than one per 1,000 inhabitants of a community. However, towns of less than 1,000 population might permit one person to sell liquor. It was provided that only a qualified elector of the town, city, or township could engage in retail sales. Also, manufacturers of liquor were forbidden to retail it. Still another provision prohibited drinking on passenger trains or streetcars. Following the passage of these laws, the number of saloons in the state decreased from 1,600 in 1908 to 740 in 1912.

The next notable change appeared in 1915. Recent legislatures had been steadily tightening the restrictions on liquor traffic. This trend to prohibition paralleled a nationwide increase in prohibition sentiment. There was a growing feeling of opposition to the public saloon, and the thirty-sixth Iowa General Assembly in 1915 reestablished absolute prohibition in the state by repealing vital portions of the Mulct Law and subsequent amendments, leaving in effect the old prohibition act of 1884. In other words, it removed the means by which the 1884 prohibitory law could be "legally" violated.

Thus, Iowa returned to statutory prohibition. The same legislature passed a resolution to again submit to the people the question of a prohibition amendment to the State Constitution. This was ratified the second time by the legislature in 1917 and the question was submitted to popular vote October 15, 1917. The proposal was defeated by less than 1,000 votes. This was the fourth time that Iowans had voted on the prohibition question, but the first time it was defeated.

It was just over one year later (January 1919) that the legislature ratified the Prohibition (18th) Amendment to the Federal Constitution. It is interesting to note that this was done by an overwhelming vote in both houses in the face of the recent rejection by the voters of a similar amendment to the State Constitution. This portended the ultimate failure of prohibition.

SAVING AT THE SPIGOT....
PROHIBITION
PROBLEM DRINKING
WASTING AT THE BUNG!

The temperance forces had finally achieved victory beyond expectation. Statutory prohibition plus federal constitutional prohibition was all and more than they had hoped for. In 1919 the Anti-Saloon League of America expressed confidence that "the situation was well in hand" by declaring "the state would no more think of going back to saloons now than to return to dueling and the tomahawk" (8, p. 117). Since it appeared that beverage alcohol had been forever banned and since it was believed to be the cause of most, if not all, other crimes, it is understandable that some communities sold their jails. In 1919, Buckgrove sold the town jail to a farmer who converted it to a combination pig and chicken house and the following year the town of Vinton converted its jail to a tool house(9, p. 28).

However, John Barleycorn was by no means dead. In 1922 the governor complained of the illegal manufacture of alcohol in the state and the difficulty of enforcing prohibition. The legislature of 1922 passed several laws to strengthen enforcement. This included the first law against operating a motor vehicle while intoxicated and provided $1, 000 fine for violation.

The temperance forces continued to wage an active propaganda campaign with mailed literature, lectures to schools and civic groups, State Fair exhibits, etc. The Anti-Saloon League boasted that in 1924 for the first time in the state's history "a 100 per cent dry delegation" was elected to Congress, and that in addition, the drys had complete control of the state legislature (10). The General Assembly continued to enact legislation to strengthen existing prohibition laws, but the negative reaction to prohibition was mounting. In 1931, a bill to repeal the state prohibition laws was introduced but defeated in the legislature. This legislature did pass a law providing stiffer penalties for operating a motor vehicle while intoxicated, including a mandatory prison term for the third offense.

In 1933, the electors of the state ratified the 21st Amendment repealing the Prohibition Amendment to the Federal Constitution. The popular vote was 376, 661 for and 249, 534 against repeal. It is noteworthy that while the legislature itself ratified the Prohibition Amendment, it chose to shift responsibility for a decision on the repeal amendment to the voters.

Repeal of the Federal Prohibition Amendment left the state with statutory prohibition, but the next legislature completely overhauled the liquor laws by enacting the 1934 Iowa Liquor Control Act which was to be the basis of liquor control for the next thirty years. Here, the state borrowed ideas from Scandinavia and tried an entirely different approach to liquor control by assuming a monopoly on the

retail sale of beverages containing more than 4 per cent alcohol by weight. The basic features of this comprehensive act included:

1. The sale of liquor by the drink was prohibited except for beer containing no more than 4 per cent alcohol by weight (3.2 per cent by volume). Liquor could be sold only in packages and only in state-owned liquor stores.

2. A three-man liquor control commission was created to establish and maintain such stores and to otherwise regulate the distribution of liquor in the state.

3. Before individual citizens could make purchases from the state stores, they were required to pay $1.00 for a permit book which was valid for one year. A record of each purchase was entered in the book and the permit could be revoked for any law violation involving liquor--including nonsupport and desertion of family.

4. Special licenses could be issued to liquor manufacturers and wholesalers.

5. A liquor control fund was created to provide working capital for the commission with any excesses over 1.5 million dollars to be transferred to the General Fund of the state treasury.

6. Semiannually, 5 per cent of the gross amount of sales of state stores was to be distributed to the cities and towns in proportion to their population, to be used for any lawful municipal purpose.* Presumably, the underlying rationale was that this would help municipalities meet problems created by excessive alcohol use since they were otherwise denied liquor revenue. In addition to these major features, the Liquor Control Act of 1934 detailed many minor rules and regulations. Another set of laws was passed to govern the sale of beer containing less than 4 per cent alcohol. These laws provide a licensing system for the sale of beer in taverns and grocery stores.

The following three decades saw only minor changes in the liquor laws. The next major change came in 1963 when the Sixtieth General Assembly amended the Liquor Control Act to permit retail sales of liquor by the drink under licenses issued by the Liquor Control Commission. Such licenses were to be issued only upon approval of the application by the local government. However, the state retained its monopoly on the sale of packaged liquor, and all retailers were still required to purchase their supply from state-owned stores. The commission was given authority to establish a

*According to the Iowa Liquor Control Commission report for 1964, every incorporated town and city received approximately $1.29 per capita.

liquor law enforcement division with an attorney as director and five assistant directors.

Provision was also made for "reverse" local option. That is, licenses might be issued in a county unless and until voted against in popular election called for by petitions containing signatures representing 25 per cent of the votes cast for governor in the last election. Such an election cannot be repeated more than once in four years and a license issued before the election is valid for three years or until it expires. Thus, even after a county has voted dry, it may actually have legal sales of liquor by the drink for another three years.

As of February 1, 1965, a year and one-half after the liquor by the drink law became effective, twenty-one counties had held elections. Twelve of them voted wet and nine voted dry. The fact that the counties that have voted dry are mostly located in the south central part of the state which traditionally has been the driest section of the state lends support to the notion, first, that a population is slow to change its drinking practices and attitudes and, secondly, that a population with the strictest liquor controls probably has least need for them.

The change to liquor by the drink was in no small measure a response to the widespread violations of the 1934 law prohibiting such sales. A survey by the Des Moines Register in May, 1962 (11), found that liquor by the drink was available in two-thirds of the state's counties. The major argument for the change was that liquor by the drink already existed in practice and that legal sanctioning of it would give the state greater control and increased revenue.

Interestingly enough, in the 1962 political campaign the two political parties each maintained their traditional position on the liquor issue. The successful Democratic nominee for governor, Harold Hughes, advocated passage of a liquor by the drink law, while the Republican candidate evaded the issue by calling for more study.

The Iowa Poll Organization of the Des Moines Register reported (12) that just prior to passage of the law, 55 per cent of Iowa adults favored liquor by the drink. While among city residents, a majority of 62 per cent favored such a law, only a minority of 42 per cent of farm dwellers were in favor. This is only one of many indications of rural-urban differences in public sentiment regarding alcohol. Some nine months after the law went into effect, the proportion of adult Iowans favoring the law was 57 per cent (13).

Summary. Since territorial days, Iowa has sought by various laws to discourage the use of beverage alcohol. The control laws have generally alternated between licensing and complete prohibition. In 1934, a different tack was taken. The state assumed a monopoly on the sale of the stronger intoxicating beverages. Regardless of the legal distribution system in operation, law violations have always been common and the vigor of enforcement efforts has varied greatly. Perhaps this is not surprising in view of the close division of public sentiment on the matter. There is no precise measure of the success of the various laws, but it is certain that none eliminated all problems related to alcohol use.

History of Legislation Dealing Specifically with Alcoholics

Except for laws providing punishment for drunkenness, there has been little legislation dealing specifically with those who become addicted to alcohol; today they are called "alcoholics." In earlier years they were called first "habitual drunkards," then "dipsomaniacs," or "inebriates." Prior to 1902 they were jailed as vagrants. In the early 1870's, a law was passed providing for the appointment of a guardian for habitual drunkards and for their reformation under orders of the district court. The law was broadened by the Twenty-ninth General Assembly in 1902 to provide for the commitment of dipsomaniacs, inebriates, and drug addicts to state mental hospitals by district court order. Pursuant to this law, a department for inebriates was opened at the Mt. Pleasant State Hospital in July, 1902, but the number committed by the courts was so great that a similar department was opened at Cherokee State Hospital in October, 1902, and at Independence in January, 1903 (14, p. 34). A majority of the commitments were for one to two years, and the remainder were for two to three years. However, the law provided for parole of certain cases after thirty days.

By the end of June, 1903, these hospitals had taken a total of 476 inebriate commitments (14, p. 34). The hospitals and the Board of Control complained that they were ill equipped to handle such a large number of commitments and that the inebriate patients, once they were built up physically, were a source of great annoyance and trouble to the hospital staff and to the other patients. A majority of them were escaping as soon as they were physically able to do so.

Interesting enough, the superintendent of the Mt. Pleasant Hospital, C. F. Applegate, in his biennial report of 1903 argued for the disease concept of alcoholism. He looked upon the inebriate

not as a sinner but as "an unfortunate man suffering from a disease, not fully recognized by an unjust public" (14, p. 800). He believed the inebriate should be committed by the county commissioners of insanity and not be treated by the courts as a criminal.

He went on to report 29 per cent recoveries among his inebriate cases, which is not unlike recovery rates reported by most therapeutic approaches today. On the other hand, the superintendent of the Independence State Hospital in his report seemed more inclined toward a penal view of the inebriate (14, p. 822), and like the superintendent at Cherokee (14, p. 940), he was rather pessimistic that such cases could be rehabilitated.

The Board of Control agreed with the superintendents of all three hospitals that the inebriates should be provided for in a separate institution. Two years later (1905) a special hospital was built at Knoxville for male inebriates and opened in January, 1906. Women inebriates continued to be institutionalized at Mt. Pleasant.

Initially, the daily average population at Knoxville was nearly 200 (15, pp. 1-2). A decade later, in 1914, it was 174 (16, p. 35). Thereafter there was a sharp decline in inebriate commitments, which probably reflected the public's preoccupation with World War I. Whatever the cause, by 1919 there remained only eleven patients at Knoxville, and the hospital, after fourteen years of operation, was closed and sold to the federal government (17, p. 11). The state has not since had a special hospital for inebriates.

In 1924 a law was passed giving County Commissioners of Insanity (now called "County Boards of Hospitalization") authority to commit inebriates. At the same time all laws pertaining to the insane were made applicable to inebriates. Today, alcoholics are committed by the County Boards of Hospitalization to the four State Mental Health Institutes and by district court order to the Psychopathic Hospital. While inebriates committed to the State Mental Institutes by the county boards lose their civil rights, this is not true of patients committed to the State Psychopathic Hospital by court order.

For several reasons, some of which are mentioned below, the number of inebriates admitted to the state hospitals may have little meaning; still, perhaps it is noteworthy that admissions were relatively high in the early 1900's, up to 1914, then decreased to a low point in 1922, then began a steady increase to a peak during the late 1930's, dropped to a low during World War II, then rose again. During the past decade alcoholic admissions have amounted to about 15 to 20 per cent of all admissions to the four hospitals. In fiscal

year 1964, there were 770 admissions an increase of about 22 per cent over the 630 admitted in 1963. Half of the alcoholic admissions were voluntary admissions under a 1949 law which required the hospitals to accept such admissions (18).

It is impossible to interpret the variations in alcoholic commitments through the years. It is significant that, at least since 1934, there has been little if any association between alcoholic commitments and per capita legal alcohol sales. We can only speculate that the variations in commitments reflect one or more of the following: 1) changes in public attitudes regarding the handling of inebriates, 2) changes in public and professional definitions of what constitutes "alcohol addiction," 3) changes in the kind and amount of deviant drinking which the public will tolerate, 4) changes in commitment and hospital admission policies, and 5) changes in law enforcement policies.

A "New Approach."

When the Fifty-sixth (1955) General Assembly made the special appropriation calling for the first survey of the alcoholism problem, Iowa was following a national trend in progress since about 1940 that has been termed the "new approach" to the whole subject of alcohol--its use and abuse (19, p. 1). In essence, this is a three-pronged attack consisting of education and treatment in addition to research. The three major driving forces behind the movement for the past two to three decades have been the Rutgers (formerly Yale) Center of Alcohol Studies, the National Council on Alcoholism, and Alcoholics Anonymous. In addition, numerous state, local, and national agencies have joined the movement. Following the trend, the 1961 Iowa legislature passed a law creating the nine-member Iowa State Alcoholism Commission and charged it with responsibility for developing a research, treatment, and educational program for the state. Here for the first time the legislature defined the term "alcoholic." It was defined to mean . . . "any person who chronically and habitually uses alcoholic beverages to the extent that he has lost the power of self-control with respect to the use of such beverages, or while chronically or habitually under the influence of alcoholic beverages endangers public morals, health, safety, or welfare."

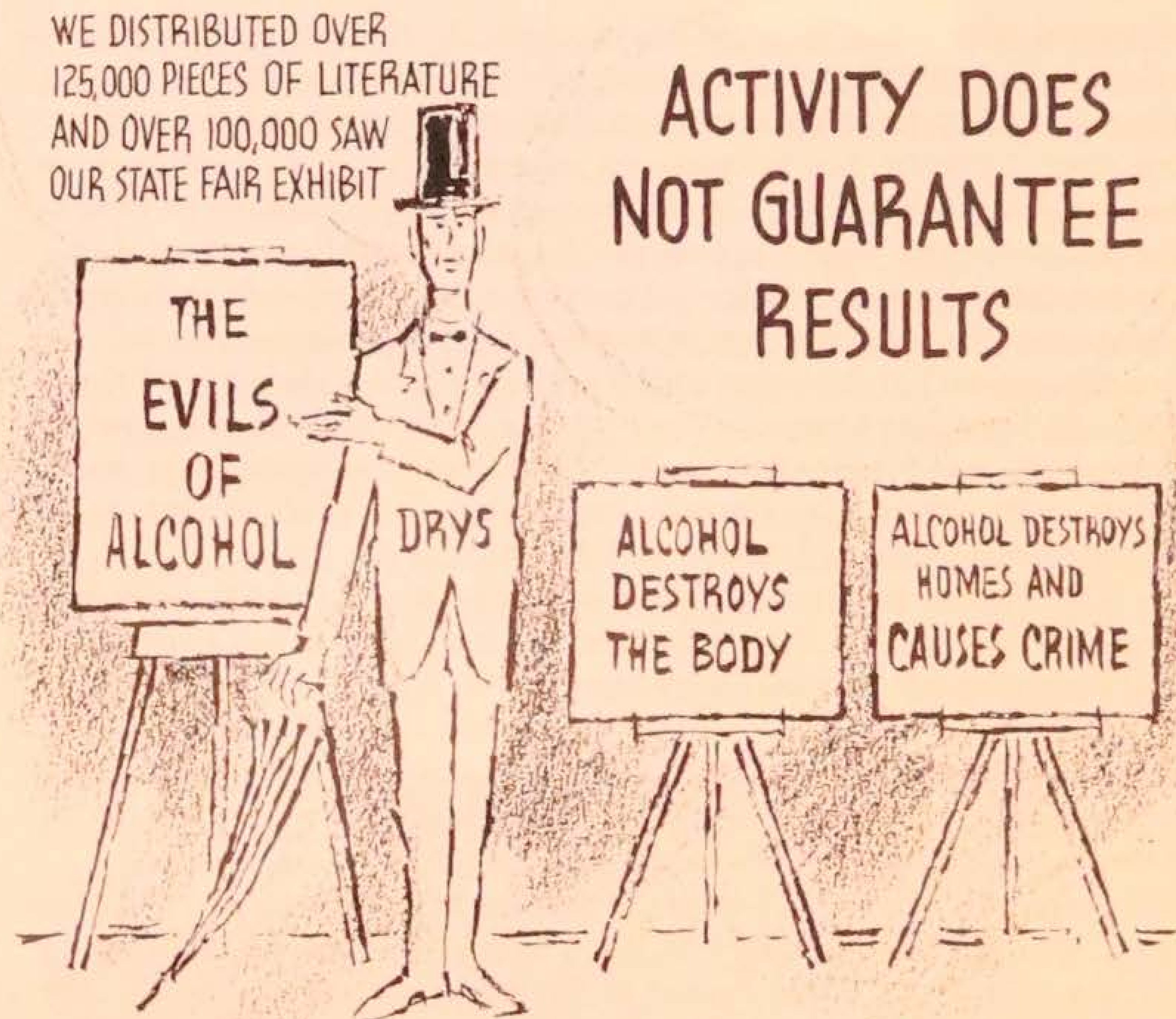
However, this new approach, when seen in historical perspective, turns out to be not entirely new; and some historical comparisons may contain certain lessons for us. One of the

essential features of the new approach is its concentration on the extreme deviant drinker-the "alcoholic"- while essentially ignoring the question of drinking versus abstention. But this is not a new concept. Initially, the temperance movement stood for temperance, and only later defined all drinking as immoral. A backward look at the failure of the "noble experiment"--prohibition--suggests that the temperance forces merely dissipated their tremendous energies and resources attempting to persuade, coerce, and even force nearly one-half of the population to give up a long cherished "right." The new approach attempts to avoid this mistake by placing greater emphasis on a) the development of better treatment for those who are already addicted to alcohol, and b) the prevention of uncontrolled drinking through education to modify drinking practices.

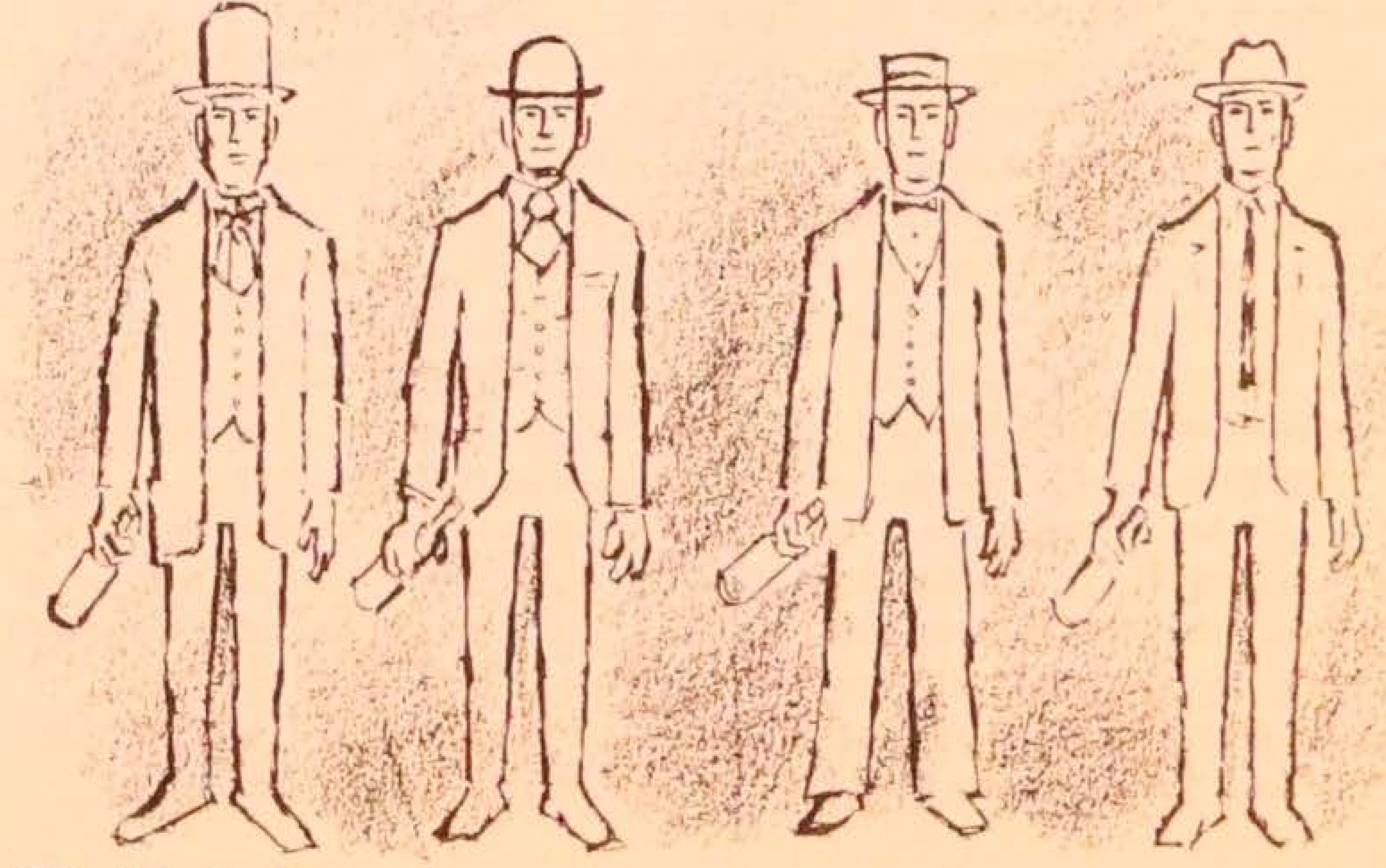
Nor is the idea of public education about alcohol a new one. For nearly a century the temperance forces have waged extensive and intensive educational campaigns. In 1923, for example, the Anti-Saloon League (20, p. 100) distributed 125,000 pieces of literature in the state, sent 16,000 copies of its monthly publication to subscribers, sent 11,000 "carefully prepared" newsletters to newspapers, carried paid advertisements in daily papers, and sponsored a "Scientific Temperance Exhibit" at the State Fair which was "visited by more than 100,000 persons." This kind of activity persisted right up to the repeal of the prohibition amendment. The lesson here, of course, is that activity is too often confused with results. Yet this is to be expected unless the activity is carefully studied and evaluated as it unfolds.

Today's approach emphasizes objectivity in teaching the latest scientific knowledge regarding the nature of alcohol and the physiological, psychological, and social effects of excessive drinking. But objectivity in these matters is hardly a new idea. Nearly 2,400 years ago the ancient philosopher, Plato, in his "Laws" called for objectivity in dealing with the questions of drinking and drunkenness. Incidentally, the use of beverage alcohol even then was a complex and difficult social problem. Plato observed that it takes no mean legislator to deal with questions of drunkenness.

Another aspect of the new approach is its emphasis on the illness concept of alcoholism. The alcoholic is defined as suffering an illness called "alcoholism" deserving treatment the same as any other illness. The goal is to redefine the alcoholic in medical rather than criminal or moral terms and to shift responsibility for him from the police to the medical profession. While there has



IN SPITE OF EXTENSIVE MEETINGS, EXHIBITS, AND LITERATURE....



DRINKING PRACTICES HAVE REMAINED RELATIVELY STABLE.

never before been such a concerted effort to propagandize the illness concept, the concept itself is not new. Jellinek (19, p. 1) traces it back at least to the turn of the nineteenth century and the writings of Dr. Benjaman Rush. Nor is the idea new to Iowa. It will be recalled that in 1903 Superintendent Applegate of the Mt. Pleasant State Hospital defined the alcoholic as suffering from a disease.

If there is anything really new about the new approach it is the application of modern scientific research methods to the understanding of alcoholics and other social problems associated with alcohol use. The bulk of all scientific research that has been done on the subject is dated since World War II. While it is easy to become impatient with the slow pace of science, it goes without saying that reliable verified knowledge is essential to intelligent, effective, and efficient action.

Chapter II

IOWA'S DRINKING PRACTICES AND ATTITUDES, PAST AND PRESENT

The use of beverage alcohol is not a sufficient cause of "alcoholism." Still, just as marriage is a necessary condition for divorce, so drinking and heavy drinking are necessary for alcoholism. Logically then, alcoholics and the alcoholism problem can be better understood if viewed against the broader background of alcohol use generally.

Knowledge of who drinks, how much, under what conditions, with what attitudes, and with what consequences is essential to alcoholism program administrators for identifying target populations and designing effective educational messages. Education designed to modify public attitudes toward alcohol in the hope of preventing deviant drinking will, at best, be highly inefficient unless existing attitudes and practices are known. In addition, knowledge of current practices provides a base line for observing future trends in drinking behavior and for evaluating the effects of educational programs. And theoretically, such knowledge holds clues as to the genesis of extreme deviant drinking--"alcoholism."

Past Drinking Practices

Since today's drinking practices and attitudes are rooted in the past--a part of the social heritage--we shall begin with a brief examination of the drinking practices of earlier generations of Iowans.

There is little direct evidence of the prevalence of drinkers or the extent of individual consumption in the state prior to 1958 when the Division of Alcoholism Studies first investigated Iowa's drinking practices. For many years, the Anti-Saloon League annually reported the number of saloons in the state. But we cannot agree that this was any indication of how many drinkers there were, or of the extent of individual consumption. As noted earlier, the close division of the several popular votes on prohibition over the past century indicates there was a rather even division between drinkers and abstainers. But, again, this reveals nothing of individual consumption patterns because there is no way of classifying the drinkers according to whether they were light, moderate, or heavy consumers.

An examination of the yearly sales figures presented in Chart 1 and in Table 1 permits a study of trends in total consumption

and beverage preference since the repeal of prohibition. Complete figures on sales in years prior to the fiscal year ending June 30, 1935, are not available. Furthermore, the figures that are presented do not take into account illegally produced alcohol that enters consumption. Distilled spirits sales showed a steady increase from .28 gallon per capita* in 1935 to .91 gallon in 1942 -- the fiscal year bracketing our entry into World War II. This increase may be as much a reflection of the increase in legal supply after prohibition as an actual increase in consumption. After a sharp decline to a low of .58 gallon in 1944, sales rose again to .88 gallon in 1948 and 1949. Since then, spirits' sales have stabilized at about two-thirds to three-fourths of a gallon per capita--a level approximating that prevailing in the years immediately prior to the war. However, sales were up to .82 gallon in 1964 compared with approximately .74 gallon in each of the preceeding five years. Beer sales, which were about eleven gallons per capita before the war, have stabilized at between fourteen and fifteen gallons per capita following the war. Per capita consumption of beer was 43 per cent greater in 1964 than in 1940. Per capita consumption of absolute alcohol has been fairly stable at nearly nine-tenths of a gallon since 1953--a level about one-tenth of a gallon higher than the pre-war level. However, in 1964 it was up to .96 gallon. Part of the 1964 increase may be due to legal sales replacing illegal ones after the change to liquor by the drink.

Table 1 also indicates a trend in beverage preference from distilled spirits to beer. In 1940, 40.3 per cent of the absolute alcohol consumed was taken in the form of spirits. In 1963 this had dropped to 32.5 per cent, but rose to 34.2 per cent in 1964. During the same period, the per cent of alcohol consumed in the form of beer had risen from 58.2 to 64.7 in 1963 and 62.6 in 1964. It is doubtful that the 1964 data indicate a reversal in the trend toward beer, but this remains to be seen.

The Iowa data are consistent with the national trend. Although beverage preference shifted from beer in colonial days to spirits just prior to the Civil War, it has since been shifting back to beer. Nationally, during the past century, the per capita of drinking age (aged fifteen years and over) consumption of distilled spirits has declined from 4.2 gallons in 1850 to 2.0 gallons in 1962, and beer rose from 2.7 gallons per capita in 1850 to 23.0 gallons in 1962 (21). At the same time, the per capita (of drinking age)

* Ideally, "per capita" would be based on the drinking-age population--persons aged fifteen years and over--but since the age composition of the Iowa population has varied little since 1935, the comparisons made here would not be affected.

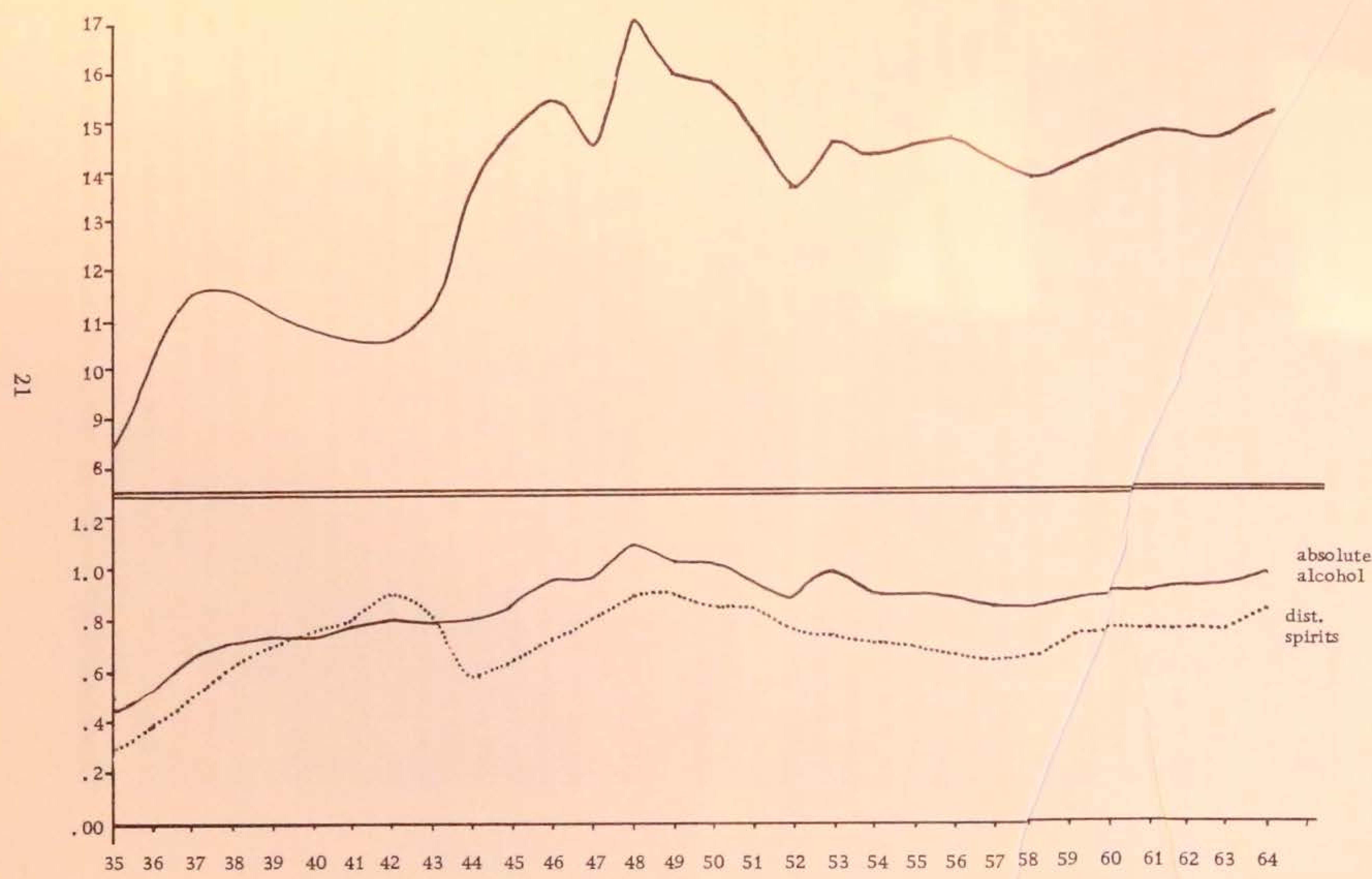
Table 1

APPARENT PER CAPITA CONSUMPTION AND THE DISTRIBUTION OF CONSUMPTION BETWEEN BEER, WINE, AND SPIRITS
IOWA, 1935-1964*

1	2	3	4	5	6	7	8
	Per cent Make-up of Yearly Consumption of Absolute Alcohol			Per capita Consumption (Gallons)			
Fiscal Year	Beer	Wine	Spirits	Beer	Wine	Spirits	Ab. Alc.
1935	74.7	0.5	24.4	8.53	.01	.28	.46
1936	71.7	0.9	27.0	10.03	.03	.38	.56
1937	68.6	1.4	29.6	11.63	.06	.50	.68
1938	63.9	1.5	34.3	11.59	.06	.62	.73
1939	60.2	1.4	38.2	11.14	.06	.71	.74
1940	58.2	1.3	40.3	10.92	.06	.76	.75
1941	54.0	1.3	44.6	10.54	.06	.79	.78
1942	52.5	2.0	45.3	10.51	.09	.91	.80
1943	56.6	3.3	40.1	11.22	.16	.79	.79
1944	68.0	2.9	29.1	13.53	.13	.58	.80
1945	68.0	2.9	29.0	14.69	.15	.63	.86
1946	64.4	4.7	30.9	15.47	.27	.74	.96
1947	61.2	5.0	33.8	14.52	.28	.80	.95
1948	63.7	3.2	33.1	17.01	.20	.88	1.07
1949	62.5	3.2	34.2	15.98	.19	.88	1.02
1950	62.4	3.3	34.2	15.71	.20	.86	1.01
1951	61.6	3.3	35.0	14.84	.19	.84	.96
1952	61.4	3.6	35.0	13.58	.18	.77	.88
1953	63.6	3.4	33.0	14.49	.18	.75	.99
1954	64.5	3.2	32.3	14.30	.17	.72	.89
1955	65.0	3.2	31.8	14.54	.17	.71	.89
1956	66.7	3.0	30.3	14.66	.15	.67	.88
1957	66.3	3.0	30.8	14.25	.15	.66	.86
1958	65.2	3.0	31.9	13.78	.15	.67	.85
1959	64.3	2.9	32.8	14.06	.15	.72	.87
1960	64.3	2.8	32.9	14.43	.15	.74	.90
1961	64.3	2.8	32.9	14.72	.15	.75	.92
1962	64.6	2.7	32.7	14.62	.15	.74	.91
1963	64.7	2.8	32.5	14.64	.15	.74	.91
1964	62.6	3.2	34.2	15.07	.18	.82	.96

*Data for computing these values were obtained from the Iowa Liquor Control Commission Reports, and The Brewers Almanac. To compute absolute alcohol, beer was taken as 4 per cent alcohol, wine as 17 per cent, and spirits as 43 per cent until 1940 and 40 per cent thereafter.

CHART 1



consumption of absolute alcohol has remained stable since 1850 at about 2.0 gallons. In fact, the consumption was 2.1 gallons in both 1850 and 1962.

It is interesting that the per capita consumption of absolute alcohol is more stable than the type of beverage consumed. In other words, when beer sales increase, spirits sales usually decrease, but the amount of absolute alcohol consumed remains relatively constant. This is shown for Iowa in Chart 1. The notable exception to this is 1948 when both spirits and beer sales were higher.

In summary, despite the untold time, energy, and resources expended in the battle between wets and drys, there is no evidence of dramatic shifts in drinking practices over the past century and more. In 1855 the first popular vote on the question of prohibition favored prohibition only by a narrow margin. Indications are that drinkers have always constituted about half of the adult population. We can only guess that a large majority of the drinkers have always been light or moderate consumers and that the proportion abusing alcohol probably never has differed greatly from what it is today--approximately 3 to 6 per cent. Perhaps the most notable change has been the shift in beverage preference from spirits to beer.

Number and Social Distribution of Today's Drinkers

While we have only begun to research the state's drinking practices, Iowa is in the enviable position of already having collected more information on the subject than has any other state. The first Iowa study was done in 1958. With the assistance of the Iowa Poll Organization of the *Des Moines Register* and *Tribune*, 1,185 persons chosen to represent the adult population of the state were interviewed about their drinking practices and attitudes (22-28). The findings of that investigation were subsequently validated in a replication study conducted in 1961 (29-33). The overall distribution of the population according to the extent of alcohol use is depicted graphically in chart 2.

Who drinks? Table 2 shows that overall 59 per cent of Iowa adults drink (22, 29). Drinkers are here defined as persons who are not total abstainers as indicated by their response to the question, "Do you ever have occasion to use beverage alcohol such as liquor, wine, or beer, or are you a total abstainer?"

Socio-cultural variations were pronounced, ranging from 92 per cent drinkers among college-educated Catholics to 23 per

Table 2

PER CENT WHO DRINK BY SEX AND OTHER SELECTED FACTORS

	Males %	Females %	Total %
A. Total	68	50	59
B. Residence			
City	77	56	66
Town	65	44	55
Farm	55	43	49
C. Age			
21-25	65	57	60
26-30	75	67	71
31-35	84	63	74
36-40	68	53	61
41-45	74	51	64
46-50	68	51	59
51-60	68	44	55
61+	49	23	37
D. Education			
Grade School	60	37	51
High School	67	54	60
College	79	49	63
E. Religion			
Catholic	85	73	79
Lutheran	75	51	61
P.D.U.*	63	51	58
Methodist	56	41	49
F. Church Membership			
Catholic			
Church member	82	74	77
Nonmember	100	34	85
Other Religious Preferences			
Church member	58	41	48
Nonmember	78	57	70

*Protestant, denomination unspecified.

Source: Mulford, H. A. and Miller, D. E. Drinking in Iowa I. Socio-cultural distribution of drinkers. Quart. J. Stud. Alc. Vol. 20, p. 717, 1959.

cent among women over sixty years old. Thus, it is evident that drinkers tend to be more highly concentrated in some social segments than in others.

Sex. While two out of three (68 per cent) men reported themselves as drinkers, only one-half of the women were found to be drinkers. Sex differences in rates of drinkers was one of the strongest and most consistent differences observed. In all social segments studied there were always more men than women drinkers.

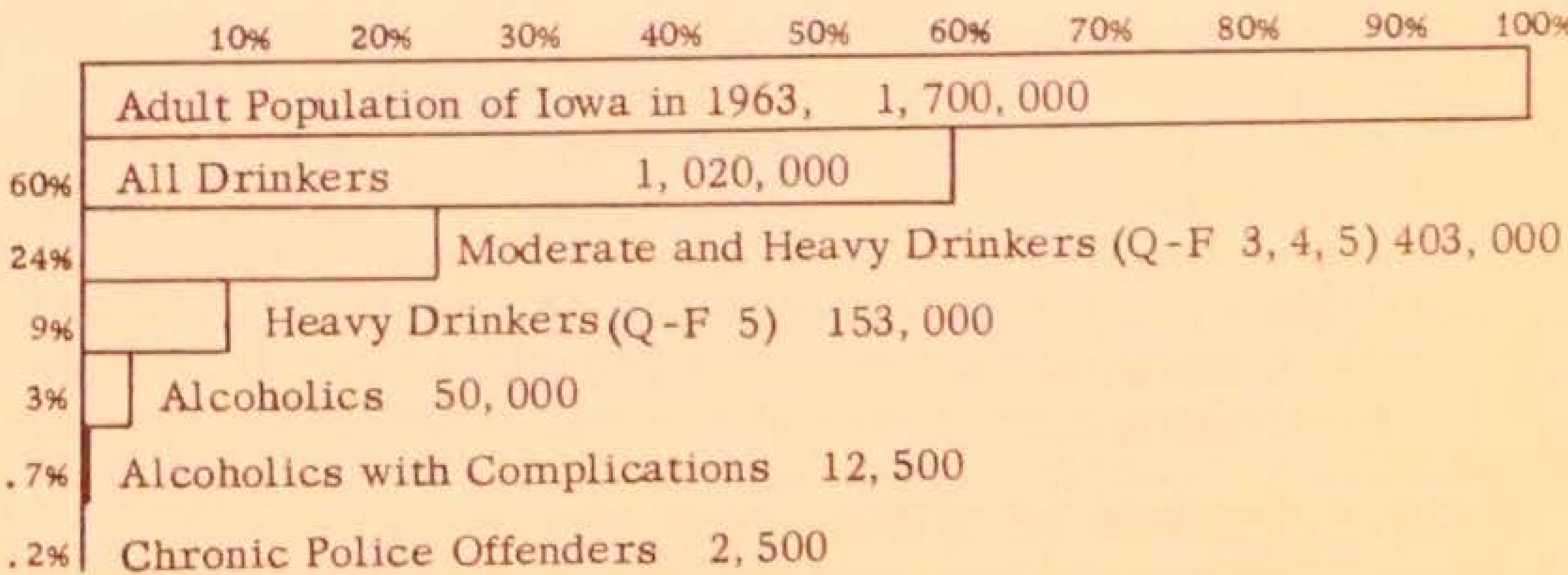
Residence. Nearly two-thirds (66 per cent) of the city residents, 55 per cent of town residents, and 49 per cent of the farm population classified themselves as users of alcohol. The farm-reared group who had migrated to cities demonstrated an urban prevalence of drinking rather than a rural one.

Age. Differences ranged from a high of 74 per cent drinkers in the age class thirty-one to thirty-five to a low of 37 per cent among persons aged sixty-one and over. Among those aged forty-six years and over, educational differences did not obtain as they did in the younger age groups.

Education. The college educated had the highest prevalence rate, 63 per cent compared with 51 per cent of those with a grade-school education. Overall, there was little difference in prevalence rates between the high school and college educated. A college education seemed to promote more drinking among men than among women.

Religion. Differences between religious groups were marked, ranging from 79 per cent drinkers among Catholics to 49 per cent among Methodists, and only 23 per cent of the Baptists were drinkers. While this is probably accurate, we have less confidence

CHART 2



in the figure for Baptists due to their relatively small representation in the sample. Methodists living in cities and Methodists with a college education had higher prevalence rates than other Methodists. Church members, other than Catholics, had a lower prevalence (48 per cent) than nonmembers (70 per cent). Differences between religious groups tended to diminish with increased education. That is, the college educated in the various Protestant groups differed little from one another in prevalence rates. Greater religious differences were found among the Protestant grade school educated.

The findings indicate strong cultural influences on whether or not an individual will use alcoholic beverages. The evidence would seem to point to some increase in the prevalence of drinking in the future as more Iowans become city dwellers and acquire more education than their parents.

It remains for future studies to attempt to specify what there is about each of the five socio-cultural factors which makes for either a higher or lower prevalence of drinking and also to determine prevalence rates under conditions where three or more of these cultural factors are present. That is, we need to know the rates in smaller social segments of the population, e.g., Methodist men living in the city with a college education.

Extent of Consumption

The 1958 Iowa Survey gathered the first direct evidence regarding the extent of individual consumption (23). The extent of drinking was measured by a Quantity-Frequency (Q-F) Index. The Q-F Index is based on the respondent's report of the number of drinks (converted to absolute alcohol) which he ordinarily consumes at a sitting, combined with the reported frequency of such "sittings" in a given period of time. Various response combinations yield the five Q-F Index types shown in Chart 3. For present purposes however, Q-F Index types 1 and 2 will be combined and referred to as "light" drinkers, types 3 and 4 will be combined and called "moderate" drinkers, and type 5 drinkers will be labeled "heavy" drinkers.

Table 3 shows that 40 per cent of the adult population of Iowa are Q-F type "O," i.e., are abstainers; and that 22 per cent are Q-F type 1, i.e., drink infrequently (once a month at most) and consume small amounts (not more than 1.6 ounces of absolute alcohol) at a setting. At the other extreme, 9 per cent are Q-F type 5, i.e., report that they drink more than once a week and consume medium (1.6 to 2.88 oz. of absolute alcohol) or large (more than 2.88 ounces of absolute alcohol) amounts at one sitting.

Chart 3 -- The Quantity-Frequency (Q-F) Index

light	Type 1.	Drinks infrequently (once a month at most) and consumes small amounts (not more than approximately 1.6 ounces of absolute alcohol).
	Type 2.	Drinks infrequently (once a month at most) and consumes medium (1.6 to 2.88 ounces of absolute alcohol) or large amounts (more than 2.88 ounces of absolute alcohol).
moderate	Type 3.	Drinks more than once a month but consumes small amounts.
	Type 4.	Drinks two to four times a month and consumes medium or large amounts.
heavy	Type 5.	Drinks more than once a week and consumes medium or large amounts.

Table 3 also shows that 25 per cent of Iowa men are light drinkers (Q-F 1 and 2), which differs little from the percentage of women in this category. At the other extreme, 14 per cent of the men are heavy drinkers compared to only 4 per cent of the women. Sex differences are also pronounced with regard to moderate drinking.

Sex and other differences in the extent of drinking are more apparent when the population considered is restricted to drinkers only, as in Table 4. Table 4 shows in which segments of the population men and women heavy drinkers tend to be concentrated. "Heavy drinking" is a relative matter. Here it refers to the 9 per cent of adult Iowans who have the highest quantity-frequency of consumption. That is, they consume two or more drinks three or more times a week. The moderate drinkers are omitted from Table 4 in the interest of simplicity. However, the values of the moderate drinkers are easily derived by adding the per cent light drinkers to the per cent heavy drinkers and subtracting the sum from 100 per cent. It should be emphasized that the percentages in Table 4 are based on drinkers only. For example, 16 per cent of all drinkers are heavy drinkers, 47 per cent are light drinkers and 37 per cent (100 [16+47]) are moderate drinkers.

Just as men and women differ as to whether they drink or abstain, they also differ greatly as to how much they drink.

Table 3

CLASSIFICATION OF ADULT POPULATION OF IOWA ON Q-F INDEX OF DRINKING, BY SEX

Q-F Index Type	Males %	Females %	Total %
Light drinkers			
Type 1	20	23	22
Type 2	5	5	5
Moderate drinkers			
Type 3	18	12	15
Type 4	7	3	5
Heavy drinkers			
Type 5	14	4	9
X*	5	4	4
Abstainers	31	49	40
TOTALS	100	100	100

*Drinkers, but insufficient data for Q-F scoring.

Source: Mulford, H. A. and Miller, D. E. Drinking in Iowa II. The extent of drinking and socio-cultural categories. Quart. J. Stud. Alc. Vol. 21, p. 28, 1960.

Twenty-two per cent of the men drinkers compared to 8 per cent of the women drinkers are heavy drinkers. The proportion of heavy drinkers among men increases with increased education--from 18 per cent of the grade school educated to 25 per cent of the college educated--but declines among women--from 12 per cent of the least educated to 5 per cent of the most educated category.

The extent of drinking varies by rural-urban residence, 58 per cent of drinkers in the city being either moderate or heavy drinkers compared to 43 per cent of farm residents. The extent of drinking increased among the farm-reared who had migrated to the city, but the increase was manifested entirely in moderate rather

Table 4

DISTRIBUTION OF LIGHT AND HEAVY DRINKERS AMONG DRINKERS IN THE IOWA ADULT POPULATION, BY SEX AND OTHER SELECTED FACTORS

	Males		Females		Total	
	% Light	% Heavy	% Light	% Heavy	% Light	% Heavy
A. Total	38	22	60	8	47	16
B. Education						
Grade School	35	18	65	12	44	16
High School	38	23	56	9	47	16
College	41	25	66	5	51	17
C. Residence						
City	32	26	54	10	42	18
Town	43	21	65	8	51	16
Farm	47	16	69	6	57	11
D. Age						
21-25	30	30	75	0	53	15
26-35	42	21	60	9	51	15
36-45	39	20	46	14	42	17
46-60	35	25	67	9	52	17
61+	40	17	63	0	52	8
E. Religion						
Catholic	29	29	47	11	38	20
Lutheran	43	25	54	0	48	13
Methodist	48	21	71	9	57	16
P.D.U.*	40	13	72	3	54	9
F. Church Membership (Protestants only)						
Church member	47	16	70	6	57	11
Nonmember	28	28	45	10	33	22

*Protestant, denomination unspecified.

Source: Mulford, H. A. and Miller, D. E. Drinking in Iowa II. The extent of drinking and socio-cultural categories. Quart. J. Stud. Alc. Vol. 20, p. 30-31, 1960.

than heavy drinking. In fact, the rate of heavy drinking was slightly lower among farm-reared city dwellers than among the farm-reared who remained on the farm.

Catholic drinkers displayed a higher proportion of heavy drinkers and a lower proportion of light drinkers than the Protestant groups. Nonmembers who stated a Protestant church preference had substantially higher rates of heavy drinkers than did church members.

Age differences in the extent of drinking were not pronounced. The age class thirty-six to forty-five had the lowest proportions of light drinkers while the oldest age class (sixty-one years and over) had the lowest proportion of heavy drinkers.

Just as it was concluded earlier that the prevalence of drinking is more likely to increase than to decrease, we may similarly conclude here that the extent of drinking in Iowa is not likely to decline in the near future, but instead that some slight increase may be expected as the population becomes increasingly urbanized and attains higher levels of education.

Extreme Deviant Drinking

In keeping with the fact that for all practical purposes alcoholics are currently defined in terms of their drinking and related behavior and the assumption that alcoholics and the alcoholism problem can be best understood in these terms, the 1958 (and the 1961) Iowa Survey employed yet another measure of drinking behavior a measure of extreme deviant drinking. This is the Iowa Scale of Preoccupation with Alcohol. A technical discussion of the development of this scale to date is presented elsewhere (25-27, 30).

All drinkers were asked whether the items shown in Chart 4 described their own drinking. About 3 to 6 per cent of the sample responded positively to enough of these items that they could be considered alcoholics. To be more specific, approximately 3 per cent said that most but not necessarily all of these items described their drinking, and another 3 per cent said the lower half but not the upper half of the items described their drinking.

Chart 4--The Iowa Scale of Preoccupation with Alcohol

1. I stay intoxicated for several days at a time.
2. I worry about not being able to get a drink when I need one.
3. I sneak drinks when no one is looking.

IOWA STATE TRAVELING LIBRARY
DES MOINES, IOWA

4. Once I start drinking it is difficult for me to stop before I become completely intoxicated.
5. I get intoxicated on work days.
6. I take a drink the first thing when I get up in the morning.

7. I awaken next day not being able to remember some of the things I had done while I was drinking.
8. I take a few quick ones before going to a party to make sure I have enough.
9. I neglect my regular meals when I am drinking.

10. I don't nurse my drinks; I toss them down pretty fast.
11. I drink for the effect of alcohol with little attention to type of beverage or brand name.
12. Liquor has less effect on me than it used to.

Studies are now underway to test the validity of this scale, but until they are completed, and probably additional ones conducted, we cannot use the scale as a precise measure of the prevalence of alcoholics in the state. Nevertheless, it is useful information to know that approximately 6 per cent of adult Iowans admit that they engage in the kind of drinking behavior (indicated in Chart 3) that is generally taken as indicative of alcoholism and that renders a person in our society a likely candidate for the label alcoholic. More will be said of these extreme deviant drinkers presently.

Where, When, and with Whom Do People Drink?

Unfortunately, there has been relatively little research on the conditions surrounding drinking activity. However, the Iowa studies have gathered some pertinent information, which together with the findings regarding the prevalence of drinkers and the extent of consumption, reveal the vast majority of Iowa drinkers to be quite reasonable and moderate consumers.

More than one-third of the drinkers had no beverage alcohol in their home at the time of the study. Less than three out of ten (28 per cent) of them were "well stocked" to the point of having more than one kind on hand. For over 90 per cent of the drinkers the amount on hand was no more than a six-pack of beer and/or a bottle of spirits. Three-fourths of the drinkers and 9 per cent of the abstainers had offered alcoholic beverages to guests during the

year preceding the study. On the other hand, 90 per cent of the drinkers and nearly one-third of the abstainers had been offered drinks as guests in others' homes.

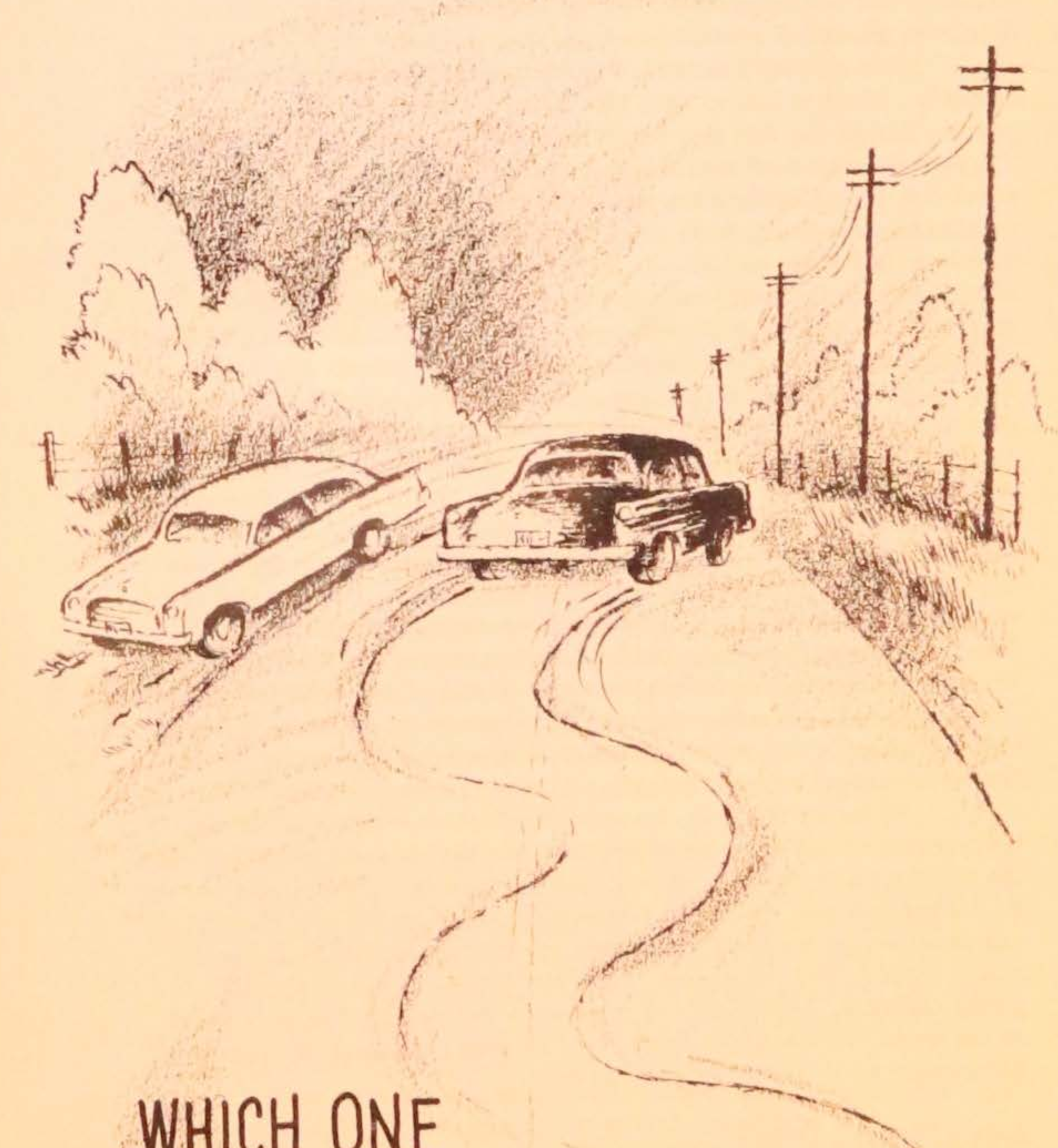
The majority of Iowa drinkers report that they drink mostly at home. If not at home, then they drink mostly at parties. Supporting this is the fact that more than three-fourths of all beer sales are package sales. Presumably, most of this is carried home. Only about one-fourth of the drinkers--and they tend to be the heaviest drinkers--do most of their drinking in public places. Iowans drink mostly with family and friends and mostly on the weekends. Consumption varies greatly with the season of the year. Distilled spirits sales are about 50 per cent greater in December than in any other month. Sales also are relatively high in October and March. Beer sales are nearly 50 per cent greater in the summer months than in the winter. These findings support the notion that alcohol serves mainly a social function and are in keeping with the findings to be presented later showing that virtually all drinkers define alcohol for its social effects.

Iowans today seem to be approximating the drinking practices prevailing in colonial days of the early eighteenth century where both men and women used beverage alcohol as a matter of course. They mainly drank beer and wine, and mostly in the home. We have seen evidence that: a) the prevalence of drinkers in Iowa is increasing and apparently the rate for women is increasing faster than for men (34); b) there is a shift from spirits to beer as the preferred beverage; c) most drinking is done at home.

If, as we suppose, informal controls operating in the primary group situation more effectively restrain deviant drinking, then the trend toward drinking at home rather than in public places should be encouraged and the target population should be the heaviest drinkers because, as we have seen, they are more inclined to drink in public places, and, of course, they are more in need of the primary group controls. Moreover, to the extent that drinking is restricted to the home, to that extent there will be fewer persons driving an automobile with alcohol in their system.

Iowa's Drinking Driver

The 1961 Iowa Survey sought to identify and describe some of the drinking drivers' social, attitudinal, and behavioral characteristics (33). Educational and other efforts to eliminate drunk driving could be much more effective if more were known about the target population. Very little is known about who drinks and drives,


WHICH ONE
IS THE DRINKING DRIVER ?

with what amount of alcohol in his system, under what conditions, and with what consequences.

The sample of 1,213 Iowans interviewed in the 1961 survey of drinking practices contained the expected number of drivers--921. Efforts to classify these drivers according to the likelihood that they ever appear on the highway with alcohol in their systems isolated 17 per cent of them in the "highest probability" category. That is, 17 per cent reported having driven an auto within two or three hours after having consumed three or four drinks. Thus, it can now be estimated that at least 17 per cent or 218,000, of Iowa's drivers do, on occasion, appear on the highway with a blood alcohol level approximating 0.10 per cent--a level generally considered sufficient to affect driving ability.

These "high probability" drivers are disproportionately males, living in the city, with more than a grade school education, under the age of forty, and they hold higher status jobs but differ little from other drivers with respect to religion or marital status. They drive more miles, drink more often, and consume greater amounts of alcohol than other drivers. They do more drinking away from home and do most of it on weekends. In addition, they believe that three or four drinks do not necessarily impair driving ability but, rather, they think "it depends upon the person." The high probability drivers described earlier have more accidents than other drivers, but it is not known whether this is due to their heavier alcohol consumption or the fact that they are younger males who drive more miles; all of these factors are associated with higher accident rates. The proportion of the high probability drivers reporting an accident during the past three years was 15.6 per cent. This is 50 per cent greater than the proportion (10 per cent) for all other drivers, but the high probability drivers also drove at least 40 per cent more miles.

The study failed to reveal a strong distinct association between accidents and drinking behavior when other factors were considered. The drivers with the highest quantity-frequency of drinking did not have the highest accident rate (per 100,000 miles driven). Rather, it was the heavy but infrequent drinkers who had the highest rate. Moreover, the most frequent drinkers did not have the highest accident rate. Drivers who drink once a week or more had a lower rate (1.36 per 100,000 miles) than those who drink two to three times a month (2.28), and also lower than those who drink one to twelve times a year (2.12). In fact, the rate for the most frequent drinkers is slightly less than for abstainers,

DRIVER **WAIT** METER*

time allowance chart

IF YOU DRINK**

cocktails		highballs		beer	effects	alcohol concentration in the blood	before you drive WAIT***
within	or	fifteen	or	minutes	If even one cocktail is taken on an empty stomach, absorption may be so rapid that alcohol piles up in the blood stream for a brief period and produces an exaggerated effect for a short time.	.03%	½ hour
within	or	one half	or	hour	Warmth — mental relaxation — decrease of fine skills — less concern with minor irritations and restraints.	.06%	1 hour
within	or	one	or	hour	Buoyancy — exaggerated emotion and behavior: talkative, noisy or morose. Perceptible loss of fine coordination.	.09%	2 hours
within	or	two	or	hours	Clumsiness — unsteadiness — tunnel vision.	.12%	3 hours
within	or	three	or	hours	Intoxication: Obvious and unmistakable impairment of bodily functions and mental faculties. Even after considerable alcohol has been eliminated, acute hangover symptoms remain.	.15%	5 hours

* Based on a person of average size -- 150 lbs. The effects will increase or decrease with corresponding weight differences.

** The body reacts quicker to alcohol taken when the stomach is empty.

*** After finishing the last drink.

Chart reproduced by permission of the Dept. of Mental Health, Division on Alcoholism, State of Connecticut.

which was 1.38. It was also found that among men who drive less than 5,000 miles a year, the abstainers had a higher accident rate than the men who admitted they had recently driven with alcohol in their systems i.e., the high probability drivers. The reverse was true for women who drive less than 5,000 miles a year; this includes about 80 per cent of women drivers. The women high probability drivers had a higher accident rate than other women drivers.

In short, when the population is broken down by sex and age and when mileage is controlled, the heaviest drinkers do not always have the highest accident rate--suggesting that alcohol is only one of several factors causing accidents. This failure to find the expected strong consistent pattern of evidence that automobile accidents are related to alcohol use certainly does not disprove the hypothesis, but it does raise many questions deserving scientific investigation. It may be that alcohol is so obvious and so convenient as an explanation for accidents (as well as for other evils) that we have been blinded to other possible causal factors. One highly significant question that arises is: How many of the "extra" accidents reported by the drinking drivers (our high probability drivers) are attributable to their being disproportionately men of younger age who do more driving in the city and drive more miles than other drivers? All of these factors make the drinking driver a higher accident risk, and if they account for any of his extra accidents it leaves few accidents to blame on alcohol.

The subject of the drinking driver, perhaps more than any other aspect of the alcohol problem, is beset with ill-founded answers. If this initial study describing the social attitudinal and behavioral characteristics of the drinking driver leads to the asking of more intelligent questions, then the first step will have been taken toward more intelligent answers.

While three-fourths of the abstainers think that alcohol impairs driving ability, three-fourths of the drinking drivers--the high probability drivers--think it depends upon the person. We must face the fact that thousands of Iowa drivers--we have estimated at least 218,000--do on occasion drive with alcohol in their systems and most of them do so without accident. They thereby have demonstrated to themselves that they can drink and drive without accident. While each of them may vaguely feel that alcohol does affect driving ability, he believes this is more true for other drivers than for himself. His attitude toward drinking and driving might be expressed in these words:

"I have met the drunken driver--
I have even been one--
and I tell you this for certain,
I would rather be than meet one."

In any case, it is hoped that this initial description of the drinking driver will provide researchers as well as safety program directors a better idea of their target population.

Drinking in Iowa Compared with Other States and the Nation

Drinking practices and attitudes in Iowa generally follow national trends, but at a lower level. The author conducted a national survey in 1963 (34) and found that, overall, and in every social segment studied, Iowa has a lower prevalence of drinkers than does the nation (see Table 5). A similar but smaller difference exists between Iowa and Washington--the only other state where such data have been collected (35). However, the socio-cultural distribution of drinkers is essentially the same in both states and for the nation. We earlier noted evidence of an increase in the proportion of drinkers in Iowa. Table 5 shows this to be a nationwide trend. In every social segment, the rate is higher in 1963 than in 1946 (36).

Not only does Iowa have a relatively low rate of drinkers, but it will soon be seen that the state has a lower per capita annual consumption of liquor. Moreover, based on the Jellinek formula estimates, Iowa has one of the lowest rates of alcoholics (37). These facts beg explanation. A convenient one is that Iowans drink less because of stricter control laws. But this may be a hasty, ill-considered conclusion. The fact that more restrictive legislation is accompanied by fewer drinkers, and lower consumption as well as lower alcoholism rates, doesn't necessarily mean that the former causes the latter. It is more likely that both the conservative legislation and the conservative practices are products of the long-standing, more conservative attitudes toward alcohol in Iowa.

This matter can be illuminated by examining the data in Table 6. Here, the several states are compared with regard to their distribution system, beverage alcohol consumption, public attitudes toward the use of alcohol, and degree of urbanism. Urbanism is taken as an index of the degree of liberalism in attitudes toward alcohol use.

Table 5

PER CENT WHO DRINK IN SELECTED SOCIAL SEGMENTS: IOWA COMPARED WITH THE NATION AND THE STATE OF WASHINGTON

	1	2	3	4	5
	Riley-Marden USA(1946) N - 2677	Washington State (1951) N - 478	Iowa (1958) N - 1185	Iowa (1961) N - 1213	Mulford USA (1963) N - 1509
Total Adult Population (21 years and older)	65%	63%	59%	59%	71%
Male	75	76	68	67	79
Female	56	51	50	52	63
21-29 years old	75	75	66	70	79
30-49 years old	73	75	65	70	76
50 and over	48	45	45	44	61
Catholic	79	69	79	81	89
Protestant	59	61	53	53	63
Jewish					90
College	70*	64	63	66	80
High School	62*	65	60	64	75
Grade School		61	51	45	53
Population over 1 million	77	66			79
Population under 1 million	72		66	67	70
2, 500-50, 000	61	61			
Rural Non-Farm	57	63	55	51	60
Rural Farm	46		49	49	

Sources:

1. Riley, J. W. and Marden, C. F., The Social Pattern of Alcoholic Drinking. Quart. Jour. Stud. Alc., 8:265-273, 1947.
2. American Institute of Public Opinion, Princeton, N. J. (Press Release, May 8, 1960).
3. Maxwell, M. A., Drinking Behavior in the State of Washington. Quart. Jour. Stud. Alc., 13:219-239, 1952.
4. Mulford, H. A. and Miller, D. E., Drinking in Iowa I, Sociocultural Distribution of Drinkers with a Methodological Model for Sampling Evaluation and Interpretation of Findings. Quart. Jour. Stud. Alc. 20:701-726, 1959.
5. Mulford, H. A. and Miller, D. E., The Prevalence and Extent of Drinking in Iowa, 1961: A Replication and an Evaluation of Methods. Quart. Jour. Stud. Alc., 24:39-53, 1963.
6. Mulford, H. A., Drinking and Deviant Drinking USA, 1963. Quart. Jour. Stud. Alc., 25: 634-650, 1964.

*The educational categories in the Riley-Marden study are not comparable with those of other studies. In the former study 70 per cent of those who had completed high school and 62 per cent of those who had not completed high school were drinkers.

In column 1 of Table 6 the states are classified according to their degree of urbanism; i.e., the proportion of the population living in places of 2,500 or more. The states are then subdivided according to whether they have a licensing system or a more conservative state monopoly distribution system. In addition, the states having liquor by the drink (in 1960) are designated by an asterisk. Column 2 of the table shows the per cent of the total vote for repeal of the 18th Amendment. This is taken as an indication of the relative wet-dry sentiment in the state. Columns 3 through 6 permit comparisons of the states on two different measures of beverage alcohol sales in 1960 and 1961. These are the most recent years such data are conveniently available, and it should be pointed out these years are just prior to Iowa's change to liquor by the drink. Wine consumption figures are omitted because they were not readily available. However, although wine sales have been increasing, still, wine accounts for only a small portion (2 per cent in Iowa) of the absolute alcohol consumption, making this omission of small consequence for the comparisons being made.

The table shows that the more highly urbanized states tend to have: a) more liberal attitudes toward drinking (as indicated by their vote for repeal); b) a higher consumption rate; c) a license system; and d) liquor by the drink. For example, only nine of the seventeen low-urbanism states had liquor by the drink in 1960, compared with nineteen of the twenty-one medium-urbanism states and seven of the nine high-urbanism states. It would appear that the dominant factor here is urbanism, or, more particularly, the prevailing attitudes toward alcohol which are more liberal in the more urban areas. Within the three different urbanism groupings in Table 6, the average consumption for the monopoly states differs little from that of the license states.

When degree of urbanism (taken as a measure of public attitudes toward alcohol) is controlled, there is little if any association between consumption rates and the distribution system. That is, not all of the states which maintain a monopoly on liquor sales--and presumably this is more restrictive than the license system--have lower liquor consumption. Furthermore, consumption rates vary greatly among states with the same type of distribution system. The consumption rate in the monopoly states varies from 538.3 "fifths" per 100 population in Alabama to 2,089 in New Hampshire. Within the license states, the range is from 500.3 fifths to 1,851.9. While the average consumption rate in states with liquor by the drink is higher than it is in states without liquor by the drink, still, with-

in the states that prohibit liquor by the drink, consumption varies from a low of 500.3 "fifths" for Arkansas to 740.7 for South Carolina. The variation in consumption is much greater among states that have liquor by the drink. Again, Alabama and New Hampshire are the extremes. (Nevada is even higher than New Hampshire, but this may be due in part to its large tourist trade.)

While the control laws undoubtedly have some influence on drinking practices, both the laws and the practices, including the drinking behavior called "alcoholism," are largely determined by the prevailing public attitudes toward alcohol. Thus, those states with the most restrictive liquor laws have the least need for them because the same attitudes that gave birth to the laws would also tend to restrict consumption even without the laws. Moreover, to whatever extent the laws influence drinking practices, the influence is probably greatest on the drinkers who need it least--the light and moderate drinkers who are not highly motivated to drink in the first place.

Herein may lie an explanation of the failure of past attempts at prohibition. Stricter laws making liquor more difficult to obtain undoubtedly reduce total consumption. But the reduction is accomplished by driving the light and moderate drinkers out of the market. While they may resent a law denying them the right to an occasional drink, if and when they want it, still they will go to no great bother to get it.

The heavier drinker, on the other hand, being more committed to alcohol use, will go to greater lengths to continue his drinking unabated. In so doing, he will have the sympathy and support of the light and moderate drinkers who feel they have been denied their rights. Thus, it is understandable that although public sentiment in favor of prohibition may be strong enough to obtain passage of prohibitory laws, it is not strong enough that the laws can be enforced.

The lessons of history show that we indulge in oversimplification, if not the luxury of self-deception, when we think that drinking habits can be legislated very far beyond prevailing public sentiment. Moreover, although the liquor laws may lag behind public sentiment, sooner or later the laws will change. The 1963 liquor by the drink law is a case in point. This change in Iowa liquor laws is a reflection of the liberalization of attitudes toward alcohol use and is in keeping with a national trend. It was pointed out earlier that even before the Liquor by the Drink Act was passed, the public had informally, although illegally, established liquor by the drink in many parts of the state. Today's efforts to modify drinking habits,

Table 6

THE SEVERAL STATES COMPARED ON THE APPARENT CONSUMPTION OF BEVERAGE ALCOHOL BY DEGREE OF URBANISM, REPEAL VOTE, AND DISTRIBUTION SYSTEM, 1960-1961

(1)	(2)	(3)	(4)	(5)	(6)
I. HIGH URBANISM (1.00-74.9)	% Voting Repeal of 18th Amend. (1933)	Abs. Alc. Gals. per Capita[1] Tot. Pop. (1961)	Av. Ab. Alc. Gals. Per Cap. Tot. Pop. (1961)	1/5ths per 100 pop. (Age 18-64)[2] (1960)	Av. 1/5ths per 100 pop. (Age 18-64) (1960)
A. License States					
*New Jersey	86	1.61		1486	
*Rhode Island	88	1.41		1031	
*California	76	1.38		1398	
*New York	89	1.57		1433	
*Massachusetts	82	1.42	1.43	1403	1320
*Illinois	78	1.47		1275	
*Connecticut	87	1.59		1852	
Texas	61	.98		679	
B. Monopoly States					
Utah	60	.68	.68	716	716
II. MEDIUM URBANISM (74.5-56.8)					
A. License States					
*Arizona	77	1.11		835	
*Florida	70	1.38		1590	
*Colorado	68	1.21		1037	
*Maryland	82	1.41		1182	
*Nevada	--	2.77		2948	
*Missouri	76	1.17	1.27	971	1171
*New Mexico	79	.89		826	
*Delaware	77	1.48	(1.16	1434	(1034
*Wisconsin	82	1.66	Omitting	1190	Omitting
*Louisiana	--	1.11	Nevada)	1180	Nevada)
*Indiana	64	.93		657	
*Minnesota	65	1.23		1140	
Kansas	44	.77		686	
Oklahoma	41	.71		712	
B. Monopoly States					
*Ohio	71	1.20		1000	
*Michigan	75	1.30		966	
*Pennsylvania	76	1.23	1.29	885	1185
*Washington	71	1.16		1121	
*Oregon	65	1.10		1054	
*New Hampshire	71	1.83		2089	
*Wyoming	72	1.18		1179	

Table 6 (cont.)

(1)	(2)	(3)	(4)	(5)	(6)
III. LOW URBANISM (55.6-35.2)	% Voting Repeal of 18th Amend. (1933)	Abs. Alc. Gals per capita[1] Tot. pop. (1961)	Av. Ab. Alc. Gals. Per cap. Tot. pop. (1961)	1/5ths per 100 pop. (Age 18-64)[2] (1960)	Av. 1/5ths per 100 pop (Age 18-64) (1960)
A. License States					
*Nebraska	60	1.20		909	
*Kentucky	62	.88		809	
*South Dakota	57	.98		882	
*North Dakota	44	1.07	.82	847	723
Georgia	50	.62		593	
Tennessee	51	.63		501	
Arkansas	59	.54		500	
South Carolina	48	.68		741	
B. Monopoly States					
*Alabama	59	.50		538	
*Maine	68	1.16		1096	
*Montana	--	1.30		1072	
*Idaho	58	.90	.94	834	896
*Vermont	67	1.23		1246	
Virginia	63	1.06		1178	
Iowa	60	.91		662	
North Carolina	28	.65		723	
West Virginia	62	.75		716	

*Denotes states which had liquor by the drink in 1960.

1. Source. Brewers Almanac, 1962, Apparent Consumption of Distilled Spirits 1952-61, Distilled Spirits Institute.
2. Source. Trends in Liquor Consumption, Bureau of Advertising, American Newspaper Publishers

Since Mississippi had legal prohibition, it is omitted from this table, nor is Alaska, Hawaii, or Washington, D.C. included.
Absolute alcohol content of distilled spirits was figured as 45 per cent, and beer 4 per cent. Wine, which constitutes approximately 2.1 per cent of total absolute alcohol consumption, is not included here.

whether by legislation or education, may be no more successful than those of the past and for the same reason--failure to begin with an accurate assessment of existing attitudes.

Effects of Liquor by the Drink

As yet, the effects of the new liquor by the drink law have not been carefully investigated. Since Iowa is in the unique position of having at hand the results of two state-wide studies of drinking practices, plus other pertinent studies conducted prior to the change in the law, an important opportunity will be missed if we do not soon make an "after study" of drinking practices since the change in the law.

Meanwhile, there is some basis for certain speculations. Considering the essential stability of drinking habits and attitudes, no dramatic changes are expected. There were none in the state of Washington after a similar change in the law was made in 1949. Total consumption of beverage alcohol in that state remained essentially the same in subsequent years (38).

There was some increase in beer consumption, but we have seen that beer consumption has also been increasing in Iowa and nationally.

While there was no significant change in drunkenness arrests in Washington following the adoption of liquor by the drink, this has little meaning because had such changes occurred, they may simply have been indicative of variations in law enforcement and reporting policies rather than drinking practices. In Iowa, variations in law enforcement and reporting policies may be especially significant because for some months prior to its adoption, law enforcement agencies made special efforts to enforce the ban on liquor by the drink. Thus, it is hazardous to attribute the 3.5 per cent increase in intoxication arrests for the year following liquor by the drink to the change in the law--especially in the face of a 7.8 per cent increase in such arrests for the year prior to liquor by the drink.

OMVI convictions had not increased during the year prior to liquor by the drink, but they increased 9.4 per cent during the year following its adoption. Again, variations in law enforcement policies are undoubtedly involved.

Changes in liquor sales may be more meaningful, but here we are plagued by the fact that there is no measure of illegal sales, and, in addition, such sales, of course, vary with variations in law enforcement policies. Total legal sales of distilled spirits were up

approximately 12 per cent in the year following the change to liquor by the drink (39). Part of this increase may be a real increase, but undoubtedly part of it is due to purchases now being made from state stores by persons, especially retailers, who previously were illegally importing liquor from neighboring states. Evidence of this is the fact that certain border counties had more than their proportionate share of the total sales increase for the State. Scott County, with 4 per cent of the state's population, accounted for 12 per cent of the total increase in sales. Woodbury County, with 4 per cent of the population, accounted for 7 per cent of the increase. The four most urban border counties--Woodbury, Scott, Pottawattamie, and Dubuque--have 14 per cent of the population, but accounted for nearly one-fourth (24 per cent) of the increased sales. The three interior urban counties--Polk, Blackhawk and Linn, with 19 per cent of the population, accounted for the same proportion (24 per cent) of the total increase in sales. Incidentally, again we can see urbanism as a factor in drinking practices. The seven largest counties--listed above--contain one-third of the population, but accounted for nearly half (48 per cent) of the total increase in sales. Conceivably, part of the greater increase in sales in these urban counties was consumed by out-of-state visitors attending conventions rather than the natives of these counties.

Another interesting aspect of changes in sales in the several counties is that many of them with relatively large increases following liquor by the drink had fairly large decreases the previous year. For example, Scott County with an 11 per cent decrease in sales from 1962 to 1963, had a 52 per cent increase the next year following liquor by the drink. Again, the special efforts to enforce the law prior to adoption of liquor by the drink are undoubtedly involved. A final piece of evidence that Iowans have not flocked to the bars to consume great quantities of liquor by the drink is an Iowa Poll report (40) that some ten months after the new law went into effect only one-third of the state's adults had purchased liquor by the drink.

In summary, evidence regarding the effects of liquor by the drink is scant, but what little evidence there is indicates no dramatic changes in drinking practices or the consequences of drinking. Yet, any firm conclusions must await another state survey.

Speculations about the results of changing the liquor laws and any studies of such changes must take into account certain trends already in progress. These include: a) Iowa is steadily becoming more urbanized, and b) this is being accompanied by a liberalization of attitudes toward the use of alcohol; c) there is a trend toward a

higher prevalence of drinkers; d) beer, and to some extent wine, is replacing distilled spirits in popularity; e) there is a trend toward consumption in the home (by both men and women) and away from the tavern; and, finally, f) law enforcement and reporting policies probably vary more than do drinking practices.

Chapter III

IOWA'S ALCOHOLICS AND THEIR PUBLIC IMAGE

The nature, etiology, treatment, and prevention of alcoholism as a disease are little understood. Alcoholism has not been defined in terms of any organic etiology or in terms of any recognizable mechanisms; as yet it is a disease presumably suffered by persons called "alcoholics." The dearth of knowledge about alcoholism does not negate the fact that there are alcoholics, and it need not and should not deter scientific investigation of those few drinkers whose extreme deviant drinking behavior is the sine qua non of the "alcoholism problem."

Alcoholism cannot be diagnosed, or alcoholics recognized, without knowing something about their drinking behavior, and most definitions are mainly in terms of such behavior. Here, for working purposes, an alcoholic is defined as a person who habitually indulges in alcoholic beverages beyond the limits of the "normal drinker" to the point where his life--his relations with his family, employer, friends, associates, the law or his health--is adversely affected by his drinking behavior. This segment of the Iowa population will be the main interest of the present chapter.

The most commonly used means of estimating the prevalence of alcoholics is the Jellinek Estimation Formula which is based on liver cirrhosis deaths. The number and distribution of the alcoholics identified by the preoccupation scale discussed earlier are consistent with findings based on the Jellinek Formula. Still, it must be born in mind that although these are the two best available means for making prevalence estimates, the validity of neither one has been established.

Number and Distribution of Alcoholics

Both the Jellinek Formula and the findings based on the Preoccupation Scale lead us to estimate that more than 50, 000 of the state's 1.7 million adults use beverage alcohol in a manner which renders them likely candidates for the label "alcoholic." The Jellinek Formula applied to 1963 liver cirrhosis deaths yields a total of 53, 190 alcoholics. It was noted earlier that the vast majority of the state's one million drinkers are not heavy users and contribute little, if anything, to the alcoholism problem. About 85 per cent of them consume no more than two drinks a week. The remaining 15 per cent of the drinkers who have three or more drinks at a "sitting"

two or more times a week consume approximately three-fourths of all the beverage alcohol consumed. But, even so, most of these "heavy drinkers" are not alcoholics. The alcoholism problem is attributable to the excessive drinking of only about 5 per cent of all drinkers. Incidentally, since these deviant drinkers, i.e., the 5 per cent who are alcoholics, probably account for close to half of the state's revenue from the sale of beverage alcohol, alcoholics can be considered to have prepaid their fees for any service the state might offer them.

Most of the alcoholics (80 to 85 per cent) are married, have a family, and are employed. The male-female ratio among alcoholics is 5 or 6 to 1. While they are found in all parts of the state, they are more highly concentrated in urban areas. Approximately one-third or more of the state's alcoholics are located in the following seven counties: Polk, Linn, Woodbury, Scott, Dubuque, Blackhawk, and Pottawattamie (2).

For the practical purpose of developing an improved state alcoholism program, the state's alcoholics may be classified into three categories according to a) their immediate needs, b) their motivation to seek help, and c) their personal resources for rehabilitation.

Chronic police offenders. These alcoholics, numbering some 2,000 to 3,000, are the stereotype--homeless, jobless, skid-row alcoholics for whom the jail door is a revolving door. They are well advanced in their alcoholic drinking careers, with few remaining personal resources for rehabilitation. They are without friends, family, job, finances, or motivation. Most of them suffer physical deterioration. The police and courts having control of them can employ coercion to motivate them to expose themselves to treatment. They need a facility to replace the jail, preferably a farm, where they can be committed and which offers a comprehensive treatment program including medical services and a variety of therapeutic procedures.

Alcoholics with complications. An additional 12,000 to 13,000 of the state's alcoholics are advanced cases with physical complications, but they are not police offenders and they, therefore, seldom fall under court commitment authority. On the average, they have more personal rehabilitation resources such as job, family, etc., than the chronic police offenders. While their physical complications may lead them to seek medical attention, still their greatest immediate need is motivation to seek medical attention, which

should be followed by counseling and assistance--probably in several areas of life--to learn to live without alcohol. They have little need for institutionalization beyond hospitalization for physical repair. Their "alcoholism" can best be dealt with on an out-patient basis in their home community.

Alcoholics without complications. The remaining alcoholics, some 35, 000 to 40, 000 in number, have not reached the point in their drinking careers where physical complications have developed. In general, they have the most rehabilitation resources. Most of them have jobs and families and are functioning members of the community. They are least inclined to recognize their problem and least motivated to seek help. The greatest immediate need for these alcoholics is a means of motivating them to recognize the importance of doing something about their drinking. The role which the employer might play in motivating these alcoholics will be discussed later. They have the least need for institutionalization.

Attitudes Toward Alcohol

The study of attitudes toward alcohol reveals important clues as to why some people abstain, some drink, some drink more than others, and some become extreme deviant drinkers and achieve the label "alcoholics." Virtually all Iowans, regardless of the extent of their drinking, define alcohol for its social effects. That is, they drink for the social reasons indicated by the items in the lower part of the Iowa Scale of Definition of Alcohol, shown in Chart 5 (24, 25, 30, 41, 42). The heaviest drinkers, including alcoholics, in addition to defining alcohol for its social effects, also drink for the very personal kind of reasons seen in the upper part of the definitions scale. It is as though they are not satisfied with themselves or their relationships with other people or their environment generally. Alcohol helps them overcome their shyness, their self-consciousness, their lack of satisfaction with the kind of person they think they are, and helps them feel more comfortable in their relationships with others. In short, alcohol aids them to redefine themselves and their environment in a manner more to their liking.

CHART 5
The Iowa Scale of Definitions of Alcohol

Liquor helps me forget I am not the kind of person I really want to be.

ALCOHOL IS GENERALLY DEFINED AS "INSTANT SOCIAL LUBRICATION"

Liquor helps me get along better with other people.
Liquor helps me feel more satisfied with myself.

Liquor gives me more confidence in myself.
Liquor helps me forget my problems.
Liquor makes me less concerned with what other people think of me.
Liquor helps me overcome my shyness.
Liquor makes me less self-conscious.

Liquor makes me more carefree.
Liquor peps me up.
Liquor gives me pleasure.
Liquor helps me enjoy a party.
Liquor helps me relax.

Liquor improves parties and celebrations.
Liquor makes a social gathering more enjoyable.
Liquor goes well with entertainment.
Liquor sometimes helps me feel better.

Liquor is customary on special occasions.

For most drinkers, alcohol is "instant" social lubrication--just open and serve. For a few, it is, in addition, instant courage, self-assurance, etc. The difficulty, of course, is that such changes wrought by alcohol are, at best, only temporary and at worst create more problems than they solve. The danger is that the drinker will rely too heavily upon alcohol for these personal effects at the expense of learning more effective ways of dealing with himself and his environment. Not only does such reliance on alcohol interfere with--indeed renders impossible--normal social interaction, but using alcohol to improve relations with others may eventually be self-defeating. Then the drinker tends to withdraw from other people, thus further denying himself valuable experience in normal social relations. A drinker who comes to define alcohol as an effective, quick-acting crutch may discover too late that its dependability is only temporary. It soon becomes a rubber crutch that lets him down, and his relationships with others, his health, and his ability to manage his life all deteriorate. This only leads to more drinking--a frenzied grasping for his old crutch. Thus, the more he depends upon alcohol for its personal problem-solving effects, the greater his need for more alcohol.

DEPENDENCE ON ALCOHOL TO SOLVE LIFE'S PROBLEM'S....

MAY PROVE SELF-DEFEATING!

It is generally held that the person who repeatedly and excessively relies upon alcohol for its personal effects has lost control of his drinking. However, it is just as reasonable to hypothesize for further study that he has never learned to drink in a controlled fashion and perhaps has had inadequate training in self-control generally. He has failed to acquire the kinds of definitions of alcohol and of himself which make for controlled drinking.

Certain cultures--for example, the Jews and Italians--define alcohol in a different way and in much more specific detail (43, 44). And because the definitions are widely shared, they serve as effective informal control of individual excess. Both the Jews and Italians define alcohol as a beverage to be used by all, but it is to be used only for certain specified purposes--for religious rituals by the Jews, and as a food condiment by the Italians. Moreover, their definitions forbid excess and forbid the use of alcohol for the very personal reasons which our society tends to encourage, or at least does not prohibit. The definitions found in our society permit and even encourage heavy drinking, especially by men. For example, we define drinking, even heavy drinking, as "manly." It is never defined as "womanly." Drinking is something that is done by "men (never women?) of distinction." It is also significant that until recently women did not appear in distilled spirits advertisements. And our most manly fiction characters are more often depicted as "two-fisted" drinkers than as abstainers. The existence of these and other such definitions helps explain why more men than women drink and why the men are heavier drinkers and more often alcoholic. Other definitions suggest the personal effects of alcohol. A drink is often referred to as a "bracer." It is not uncommon for a person to be told "what you need is a drink," especially if he has just had a trying experience. "Drowning your sorrows" is a phrase often heard. These few examples are given only to illustrate that definitions do exist in our society which permit and even encourage intemperance, especially for men. Unfortunately, we are left with questions as to why only certain drinkers become alcoholic while most do not. While awaiting further studies, we can only speculate.

Matters are complicated by the fact that it is not simply definitions of alcohol that must be considered if we would understand why some drinkers become excessive users while most do not. Other definitions are also involved--especially one's definitions of himself. Only about one in four Iowa drinkers who drink for the extreme personal effects shown in the top items of the definitions scale are alcoholics (25). It is likely that some potential alcoholics, although they have acquired the personal effects definitions of alcohol, never

HEAVY DRINKING IS "MANLY" (MEN ARE HEAVIER DRINKERS)

ALCOHOL USED FOR RELIGIOUS PURPOSES (LESS ABUSE)

ALCOHOLIC BEVERAGES USED AS FOOD CONDIMENTS (LESS ABUSE)

HEAVY DRINKING "UNLADYLIKE" (WOMEN LIGHTER DRINKERS)

DRINKING BEHAVIOR REFLECTS DRINKING ATTITUDES

become alcoholic because they have definitions of themselves which take precedence. For example, the man who defines himself as one who gets to work every day, and on time, and who defines himself as one who meets his domestic and other obligations, cannot achieve these goals and yet drink alcohol to the extent that his personal-effects definitions of it might otherwise dictate.

The alcoholic, no less than anyone else, obtains his definition from those about him--first his parents and later his peers. The Iowa surveys have revealed that a person's drinking habits and attitudes are closely related to those of his parents (45). When both parents are very negative in their views of alcohol, only about one-fourth of the children become drinkers. On the other hand, when both parents hold views favoring the use of alcohol, over 80 per cent of the children will drink. Interestingly enough, when the parents disagree, and it is nearly always the father who is the more liberal, 71 per cent of the children drink. In other words, the children are inclined to follow the lead of the parent who drinks. This may be due, in part, to the influence of peer associates outside the family who are more likely to be drinkers than abstainers. (Incidentally, this is another indication that the prevalence of drinkers is increasing.)

Further studies should attend to the possibility that excessive drinkers somehow are spawned out of the inconsistencies and contradictions inherent in our society's definitions of alcohol. An individual reared in an environment where parents disagree with each other and/or disagree with the drinker's peers regarding whether he should drink at all, how much, for what reasons, and under what conditions is in a poor position to acquire an integrated set of attitudes making for controlled drinking. There are indications that children from families strongly opposed to the use of beverage alcohol are less likely to drink, but if they do drink they are more likely to be deviant drinkers. Straus and Bacon (46) found this to be true of Mormon college students. Thus, it appears that abstaining parents can, in most cases, influence their children to abstain, but the few who do drink do so with fewer specific definitions of how to drink in a controlled fashion. Here alcohol may be likened to an automobile. If we can imagine certain parents being as strongly opposed to the automobile as some parents are to drinking, they may influence some of their children to refrain from driving or even riding in a car, but those who do drive would be poorly equipped by experience, training, or attitudes to drive sensibly and safely.

If definitions or attitudes toward alcohol are as important to drinking behavior as they seem to be, then the only real solution

to the alcoholism problem lies in modifying the prevailing public definitions. The goal should be the evolution of a set of widely agreed-upon definitions which discourage the use of alcohol for personal effects, as proof of manliness, to "drown one's sorrows," as a "bracer," etc. We should develop more negative attitudes and stronger sanctions against excessive drinking. It is impossible to be more specific about what definitions should be encouraged and how to promote them until more is known about existing attitudes and the possible effects of contemplated changes. It would undoubtedly take many years, even a generation or more, to accomplish, but such changes in public attitudes and drinking practices are not inconceivable and could be fostered by a well-planned educational program, perhaps supplemented by carefully designed legal controls. Other cultures, such as the Jews and Italians, offer proof that effective informal controls can be evolved. In fact, our society now is relatively successful in controlling the drinking behavior of one-half of the population--namely, the women. Since the formal legal controls apply equally to both sexes, the more restrained drinking by women undoubtedly reflects differences in the way alcohol is defined for them. Here, it would seem the "double standard" works to the women's advantage. There is hope that as more is learned about existing public attitudes toward alcohol, we can discover how to modify them in order to prevent excess.

Public Attitudes toward the Alcoholic

Today's alcohol educational programs are designed in part to redefine the alcoholic as a sick person suffering from a disease called "alcoholism" who can be helped and who deserves help.

Such educational endeavors involve a set of assumptions which hold that replacement of the long-standing and widely held moralistic conception of the alcoholic by the disease conception would lead to the view that he needs, deserves, and could profit from expert help. This in turn would encourage the alcoholic and those about him more readily to seek expert assistance, especially medical treatment.

In the absence of reliable information about earlier public attitudes toward the alcoholic it is impossible to judge how much progress, if any, has been made in this educational endeavor. We can only assess current attitudes. Recent studies show that the illness conception of the alcoholic has not been widely accepted by either the general public or the professionals (28, 32, 47). While a number of studies have indicated an apparently high degree of public

acceptance of the alcoholic as a sick person, as Jellinek (19, pp. 182-185) has noted, this probably is a very shallow kind of acceptance. McCarthy and Fain (47) found that 93 per cent of a sample of Connecticut urban dwellers believe that "alcoholism is an illness," yet their data also show that many who expressed this view were not convinced that the alcoholic could be helped or that the medical profession was necessarily the best source of assistance.

In the 1961 Iowa Survey, Iowans were asked whether they would define the alcoholic as a criminal, a sick person, morally weak, weak willed, some combination of these, or some other definition (32). Nearly two out of three of the respondents defined the alcoholic as "sick," 31 per cent defined him as "morally weak," and 60 per cent defined him as "weak willed." Obviously, many respondents expressed some combination of these views.

While 41 per cent of the sample defined the alcoholic as <u>both</u> morally weak and sick, 34 per cent rejected the sickness view and defined him as morally weak. Only 24 per cent accepted the sickness view alone. However, only 14 per cent accepted the educator's entire message; i.e., agreed that the alcoholic is sick, needs help, would openly discuss a family drinker's problem, and would seek help from a medical source. Thus, while a majority of Iowans will assert that the alcoholic is sick, most of those who express this view qualify it with the opinion that the alcoholic is also morally weak and are not prepared to act on the illness concept.

Acceptance of the alcoholic as a sick person was significantly associated with certain other definitions and plans of action consistent with the assumptions underlying alcoholism education programs. That is, as we would expect, those who defined the alcoholic in purely medical terms were most likely to follow the alcoholism educators' advice to a) acknowledge the alcoholic's need for help, b) to reveal and discuss a personal drinking problem, and c) to seek expert help. Those who held the purely moral view were least inclined to follow the educators' advice, while those who held both definitions fell between the two extremes.

The findings that acceptance of the medical definition varied significantly among the several social segments of the sample helps identify target populations for further educational efforts. Complete acceptance of the medical view was most common among urban dwellers, those with more than eight years of formal education, those specifying a Catholic or Lutheran religious preference, those under the age of fifty, and those who reported some use of alcoholic beverages. Women, and persons intimately acquainted with an alco-

holic, were only slightly more inclined than their counterparts to accept the purely medical view. On the other hand, they were significantly less inclined to accept the purely moralistic view.

If 34 per cent of adult Iowans reject the notion that the alcoholic is sick, another 41 per cent define him as both sick and weak, and only 14 per cent fully accept the educators' message that the alcoholic is sick, needs help, and should get it, then a very formidable educational task remains to be performed.

As Philp (48) has suggested, much of the apparent public acceptance of the idea that the alcoholic is sick may be merely a parroting of slogans frequently contained in alcoholism educational campaigns. Or, the rejection of the illness view and the moralistic qualifications held by many who do accept it may mean, as Jellinek (19) and Philp (48) have suggested, that our present educational materials are too vague, ambiguous, logically inconsistent, and confusing to compete effectively with predominantly held moralistic conceptions. It is understandable that the public would be confused by educational messages which in effect say that alcoholism is a disease, yet help for this disease is more likely to come from Alcoholics Anonymous or a clergyman than from a physician.

Further research may reveal that regarding acceptance of the disease concept, different factors are involved to different degrees in different subgroups of the population. For example, much of the resistance to the illness concept by abstainers, the older age groups, and certain Protestant sects may be due to the presence of strong religious views, while the lesser degree of resistance of the college-educated and younger age groups may be a function of the ambiguities and contradictions contained in present alcoholism educational messages. These are only some of the questions that must be answered by further research. It goes without saying that educational efforts to change attitudes toward the alcoholic no less than efforts to change attitudes toward alcohol will be highly inefficient in the absence of knowledge about existing attitudes.

Chapter IV

SOCIETY MEETS THE ALCOHOLIC

A study of community agencies and professionals who encounter alcoholics

We have noted two rough indicators of the scope of the alcoholism problem in the state; viz., Jellinek Formula estimates and estimates based on the number of extreme deviant drinkers identified by the preoccupation scale. Another indication of the ubiquitousness of the alcoholic and the consequences of his excessive drinking is the fact that more than half (55 per cent) of the state's adults are personally acquainted with one or more alcoholics. More than one-fourth (28 per cent) of them have a relative or close friend who has trouble with his drinking. Since the average alcoholic is married he directly affects the lives of perhaps two or three other persons. Thus, possibly one-half of the Iowa population has a personal involvement with, or is indirectly affected by, one or more alcoholics. The drinking and related behavior of the alcoholics of the state have always been so disruptive to the social organization that society has never been able to ignore them.

The fact that our society today reacts to alcoholics by channeling them toward certain social agencies and professionals such as police, physicians, clergymen, hospitals, etc., makes possible yet another indirect assessment of the scope and nature of the problem. At the same time, the extent to which these agencies and professionals have accepted the disease concept of alcoholism can be investigated.

This chapter reports the results of a study of how the above mentioned community agencies and professionals of the state perceive and manage the alcoholics they encounter. The purpose of the study was to discover; a) the number of contacts with persons having a drinking problem made by such agencies and professionals in a year's time, b) how the cases encountered are dealt with, c) how the alcoholic is defined--whether in medical or moral terms, d) the amount of time and resources devoted to alcoholic cases. In addition, evidence was sought bearing on the efforts of the past two or three decades to redefine the alcoholic and to shift responsibility for him from the police to the medical profession.

Limitations of the Study

Certain methodological limitations dictate cautious interpretation of the findings. In the first place, a major professional group is omitted, viz., the lawyers. Undoubtedly, attorneys en-

counter many alcoholics in their work and often give them advice which is no less helpful than that given by other professionals. However, time and resources were not adequate to study this large group.

Secondly, the study employed a mailed questionnaire. Since not all questionnaires were returned, results based on actual returns probably are biased by a tendency for those recipients most interested in the alcoholic, and who therefore presumably see more of them, to be more inclined to reply. If this is the case, then projections from the sample returns to all such agencies or professionals in the state would be inflated, and the magnitude of the alcoholism problem as actually encountered by them would be overstated. On the other hand, even where all of a given type of agency or professional group received a questionnaire, presumably some recipients who in fact had encountered alcoholics during the service year (1963) covered by the study failed to reply. Thus, a simple summation of the sample returns would understate the problem as actually encountered by all such agencies in the state. Furthermore, the amount of duplication is not known. Some alcoholics probably are included in the report of more than one agency. Yet, it will soon be seen that duplication may be less than one would think due to the shortcomings of the referral system.

Questionnaires were mailed to the entire population of police chiefs, welfare offices, hospitals, AA groups, and Community Mental Health Centers, but only a 20 per cent sample of the physicians and a 5 per cent sample of the clergy were contacted, and only business and industrial firms with at least 250 employees were sent questionnaires. In all, 1, 406 questionnaires were mailed, and later two follow-up letters were sent.

Table 7 shows the total population in each type of agency and professional group studied, the number receiving questionnaires, and the number and per cent returning them. The average ("total") return rate of 58 per cent is much higher than the usual mailed questionnaire return.

Contacts with Persons Having a Drinking Problem

Even in the absence of precise definitions, presumably there is some degree of consensus among those who label alcoholics regarding criteria for applying the label. Moreover, persons so labeled presumably possess certain characteristics in common. Still, account must be taken of differences in the way alcoholics are defined if we are to achieve the goal of enumerating all persons who came to the agencies and professionals during the period studied with

TABLE 7

QUESTIONNAIRE DISTRIBUTION AND RETURNS
Iowa Mailed Questionnaire Survey, 1963

	Population	Sample		
		Received Questnre.	Returned Questnre.	
Agency or Professional	N	N	N	%
Physicians (Totals)	2286	548	282	51
GP's, Internists	1566	283	121	43
Psychiatrists	95	95	29	31
Others	625	170	39	23
Returned but not usable	---	---	93	--
Hospitals (Totals)	146	146	74	51
General	136	136	66	49
Mental	7	7	7	100
V.A.	3	3	1	33
Mental Health Centers	14	14	14	100
Clergy	3427	178	112	63
Alcoholics Anonymous	80	80	47	59
Welfare Offices	132	132	80	61
Employers	123	123	79	64
Police Chiefs	179	179	119	67
Totals	6387	1400	808	58

a problem attributable to excessive drinking. For example, the physician's use of the term "alcoholic" or "alcoholism" as a medical diagnosis is likely to be much more restricted than, let us say, the welfare worker's use of the term. Thus, it was not reasonable simply to ask these diverse agencies and specialists how many "alcoholics" they saw.*

In an effort to obtain at least a minimum of comparability of responses, police chiefs, business firms, clergymen, and welfare agencies were asked to report cases fitting the following definition:

> An alcoholic is a person who habitually indulges in alcoholic beverages beyond the limits of the "normal drinker" to the point where his life--his relations with his family, employer, friends, associates, the law, or his health--is adversely affected by his drinking behavior.

Where it seemed feasible and necessary to do so, questions were phrased so as to distinguish "alcoholics" from "problem drinkers." This distinction is especially pertinent with regard to physicians, hospitals, and mental health centers where a relatively restricted medical diagnosis may be used. It will presently be seen that to have asked the medical services for only the diagnosed alcoholics would have missed a much larger number of persons seeking help for a drinking problem. On the other hand, it was expected that some conservative clergymen may tend to the opposite extreme and consider nearly everyone who drinks to be an alcoholic.

Persons included under the heading "alcoholics" (column 1 of Table 8) are not defined in exactly the same way for all study groups. In the case of physicians, hospitals, and mental health centers, "alcoholics" refers to persons who were given either a primary or secondary diagnosis of alcoholic. For the clergy, alcoholics are persons judged by the responding clergyman to meet our formal definition of "alcoholic"; in the case of police, "alcoholics" refers to persons arrested three or more times during the previous year on a charge involving alcohol. And for AA, the figure in the table refers to current (early 1964) membership. In the case of business firms and welfare offices, no attempt was made to distinguish alcoholics from problem drinkers.

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* The physicians' returns have been analyzed and reported in more detail elsewhere (49).

Table 8

NUMBER OF AGENCIES REPORTING CONTACTS AND NUMBER OF REPORTED CONTACTS WITH PERSONS HAVING DRINKING PROBLEM
Mailed Questionnaire Survey, Iowa 1963

Agency or Professional	Type of Contact						
	Alcoholics		Problem Drinkers		Relatives		Total
	Contacts	Agencies	Contacts	Agencies	Contacts	Agencies	Contacts
Physicians (Totals)	1886	128	3205	129	1039	122	6130
GPs and Internists	1043	92	2219	88	678	91	3940
Psychiatrists	685	22	632	23	285	16	1602
Other Specialists	158	14	354	18	76	15	588
Hospitals (Totals)	2216	57	464	30	---	---	2680
General Hospitals	765	49	314	27	---	---	1079
Mental Hospitals	757	7	150	3	---	---	907
V.A. Hospitals	694	1	---	---	---	---	694
Mental Health Centers	20	8	110	8	98	8	228
Clergy	211	60	322	68	469	66	1002
Alcoholics Anonymous	1152	47	---	---	---	---	1152
Welfare Offices	---	---	1545	69	---	---	1545
Employers	---	---	1028	53	---	---	1028
Police Chiefs	1091	50	---	---	---	---	1091
Total	(6576)	(350)	(6674)	(357)	(1606)	(196)	(14856)

Some of the respondents, especially physicians, clergy, and mental health centers, receive requests for help from the spouse or other relative of an alcoholic and these cases, shown in column 5 Table 8, are counted as part of the total direct and indirect contacts with persons seeking help for a drinking problem.

Table 8 shows that physicians, mental health centers, and clergymen see far more "problem drinkers" than "alcoholics." It is also noteworthy that nearly half (47 per cent) of the clergymen's and 43 per cent of the mental health centers contacts are with the alcoholic's family rather than with the alcoholic himself. Hospitals report more diagnosed alcoholics than problem drinkers.

About one-half, or less, of all 808 respondents reported at least one contact with an alcoholic (or problem drinker or relative). Approximately one-fourth of the GP's, psychiatrists, hospitals, and mental health centers reported no contacts, nor did about one-third of the business firms, nearly one-half of the clergymen, and 14 per cent of the welfare offices.

In comparing the number of contacts by the different agencies, it must be recalled that questionnaires were sent to only a 5 per cent sample of clergymen and to only 20 per cent of the physicians. While precise comparisons are not feasible with the data at hand, these findings suggest that the clergy and physicians along with the police have the greatest total number of contacts with alcoholics. This is a matter deserving more careful study.

Although a majority of each type of agency and professional group studied had contact with at least one alcoholic, a small minority carry the load. Less than one-fifth of the GP's and internists saw almost 90 per cent of all alcoholics diagnosed by these practitioners, and 6 per cent of these physicians reported nearly three-fourths of the problem drinkers seen by GP's and internists. Moreover, two-thirds of the patients treated for alcoholism *per se* by GP's and internists were treated by only 12 per cent of them.

Likewise, one-fourth of the psychiatrists saw more than 80 per cent of all patients diagnosed alcoholic by these specialists, and five psychiatrists treated nearly three-fourths of all cases treated for alcoholism by psychiatrists. Furthermore, only fourteen (21 per cent) of the general hospitals admitted as many as 15 alcoholics, and they reported 590 or 55 per cent of all alcoholic admissions.

The same phenomenon appears among police departments. The twelve police chiefs reporting ten or more persons arrested three or more times for intoxication reported 870 or 80 per cent of

such arrests. Interestingly enough, Des Moines was the only one of the state's seven largest cities among the twelve. Undoubtedly this is another indication of variations in law enforcement and reporting policies, because it is unlikely that the number of alcoholics varies this much from one community to another. Likewise, only fifteen of the eighty-one responding welfare departments reported 20 or more cases, and they reported a total of 1,112 or 72 per cent of all the cases reported by welfare agencies.

Finally, only seventeen clergymen, or 15 per cent of those who responded, reported three out of four of all clergymen's contacts with alcoholics and problem drinkers; and only twelve Catholic priests counseled 68 per cent of all persons counseled by all clergymen for a drinking problem. A general impression gained from this is that most professionals who might be expected to encounter alcoholics, whether clergymen, physicians, welfare workers, or hospitals, do occasionally, but reluctantly, receive an alcoholic; and those few who willingly work with them find much work to do. Although the individual agencies and professionals who see an unusually large number of alcoholics tend to be concentrated in the larger cities, still they are scattered enough that this phenomenon of a minority carrying the alcoholic load can hardly be entirely a function of population size or density.

In spite of the propaganda drive by numerous private and government agencies to present the alcoholic as a sick person and to define alcoholism as a medical disease, and in spite of the official acceptance of this concept by the American Medical Association, the American Hospital Association and other government and private agencies, the fact remains that alcoholics cannot simply go to a physician or other medical service and be cured of alcoholism; and the distribution of alcoholic contacts among the several types of agencies and professionals studied here suggests that as a matter of practice many alcoholics do not go directly to a medical service, if they go at all. Further relevant findings will appear later in the analysis of the cross-referral of alcoholics.

What Is Done With Alcoholics?

The question of how each agency handles its alcoholic cases could not be probed in detail, but certain relevant information was obtained, and it further illuminates the practical success of efforts to redefine the alcoholic in medical terms.

Physicians. It will be recalled that ninety-two (75 per cent of the GP's and internists) reported contact with a total of 3,940

alcoholics, problem drinkers, and relatives. However, they reported only 1,043 diagnosed alcoholics.

About 62 per cent of all responding GP's and internists reported treating alcoholism per se. Of the ninety-two GP's and internists who diagnosed any alcoholics, seventy-five (82 per cent) reported treating a patient for alcoholism but they treated only 428 patients or less than half (41 per cent) of all diagnosed cases.

Twenty-two of the twenty-nine responding psychiatrists reported diagnosing 685 alcoholics and, in addition, twenty-three of them reported 632 problem drinkers. About half (15) of the psychiatrists reported treating a case for alcoholism and treated 422 such cases. This is 62 per cent of their diagnosed alcoholics and 32 per cent of their 1,317 alcoholic and problem drinker contacts.

In addition, four other specialists treated nine alcoholics for alcoholism. The 859 alcoholics treated for alcoholism by all GP's, psychiatrists, and other specialists represent 14 per cent of all their contacts, including alcoholics, problem drinkers, and relatives; they represent 17 per cent of all alcoholics and problem drinkers seen, and less than one-half (46 per cent) of the total cases actually diagnosed as alcoholic.

Physicians generally refer the alcoholic to other community resources. Approximately two-thirds of the physicians and 83 per cent of the psychiatrists referred 53 and 66 per cent of their cases respectively. Nearly half of the GP's and internists referred 617 cases to AA. The next most popular agency as a destination for referrals was the hospital, followed by psychiatrists and mental health clinics.

General Hospitals. Questionnaires were returned by 66 of the 136 general hospitals and by all of the mental hospitals in the state--the four state mental health institutes, the State Psychopathic Hospital, and the two private mental hospitals. One of the three Veterans Administration Hospitals was also heard from.

Three-fourths (49) of the general hospitals that replied reported admitting one or more patients whose illness or complaint was attributable to excessive drinking. Of the total 1,079 such admissions, 765 or 71 per cent were diagnosed as alcoholics. These alcoholic admissions amount to less than 1 per cent of all admissions. Four of the fifty-one general hospitals that reported their admission policy said that they do not admit alcoholics under any circumstances; nineteen (37 per cent) will admit them, but only on an emergency basis; six (12 per cent) will admit if ordered by staff physicians,

and twenty (39 per cent) will admit without restriction. If, as we suppose, those hospitals that did not reply are even less favorably inclined toward alcoholics, then less than one in three of the state's general hospitals admit alcoholics without special restriction. The average length of hospitalization was four and one-half to seven days. The larger hospitals seem inclined to keep them a day or two longer than the smaller hospitals.

Only seven of the sixty-six responding hospitals feel that they are adequately equipped to care for alcoholics, and only four reported any special facilities for such patients; yet, 94 per cent of the hospitals said they had no plans for adding such facilities. Only 17 per cent were favorably disposed to adding a clinic with trained personnel, even with financial assistance to do so. Seven hospitals reported a total of 69 cases who were referred to another agency in place of admission, and 38 per cent of the general hospitals referred a total of 123 patients for further help with their problem.

Veterans Administration Hospitals. As a matter of policy, the VA hospitals do not admit alcoholics as such. However, it is not unusual to find alcoholics among their patients--alcoholics who have been admitted under another diagnosis. This complicates the matter of obtaining meaningful figures on the number of alcoholics actually treated in such hospitals. One of the three VA hospitals in the state did estimate that 694 alcoholics were admitted during 1963. These hospitals serve other states in addition to Iowa, and it is not known how many of these admissions were from outside the state.

State Mental Institutes. According to the State Board of Control records (18) the four state mental health institutes admitted 630 patients with a major primary psychiatric diagnosis of alcoholism in 1963. This includes both first admissions and readmissions and is 18 per cent of all admissions to the state hospitals (18). Two of the hospitals have had special programs for alcoholics for some years. In answer to our questionnaires, three of the hospitals reported 150 patients with a complaint attributable to excessive drinking, but who were not diagnosed alcoholic. The fourth hospital was unable to estimate the number of such problem drinkers. Thus, patients with a drinking problem accounted for about 20 per cent of all admissions to these four hospitals. The length of hospitalization reported ranged from approximately six weeks at two hospitals, to eight weeks at a third and eleven weeks at the remaining hospital. All four state hospitals make post-treatment referrals. Referrals are most often made to AA.

Two private mental hospitals. One of the two private mental hospitals reported only five patients with a primary diagnosis of alcoholism, but could not estimate the number of admissions where alcoholism was the secondary diagnosis or the number of problem drinkers admitted. The five alcoholic cases represent less than 1 per cent of all admissions. Alcoholics are hospitalized about four and one-half days on the average.

The other private mental hospital admitted 120 diagnosed alcoholics, which is 16 per cent of its total admissions, but it, too, was unable to estimate the number of problem drinkers. This hospital keeps alcoholics an average of five to seven days. The length of hospitalization for both of these mental hospitals is about the same as for general hospitals. Both hospitals believe their facilities are adequate to deal with alcoholic patients, and neither has plans for increasing them. While the first mentioned hospital has no special facilities or specially trained personnel to deal with alcoholics, the second one does have special facilities. This includes an alcoholic ward and close cooperation with AA. Both hospitals report that alcoholics are admitted without special restrictions.

The State Psychopathic Hospital. This hospital, which until recently saw only one or two alcoholics a year, established an out-patient clinic in 1960. The purpose of the clinic was to provide: 1) a small population of alcoholics for research pertaining to diagnosis, treatment, and prognosis; 2) training and experience for professional personnel in the management and treatment of alcoholics; and 3) a certain amount of service to the community.

For the service year ending June 30, 1963, approximately forty-five new alcoholic cases came to the clinic for out-patient services. This is about 2.6 per cent of all new out-patient cases. In addition, some fifteen patients who had begun treatment the previous year returned for further service. These sixty patients made a total of about 300 visits to the clinic. Eight alcoholics were admitted to the hospital for in-patient care; this is about 2 per cent of all admissions. Different types of therapy are being tried and evaluated and a number of research projects have been completed (50-55). Deliberate efforts are made to establish liaison with AA and various other community agencies for assistance in the total management of the patient in his home environment.

Comparisons with 1955. Considering that information was obtained from all the mental hospitals as well as from a relatively large representation of general hospitals, it may be meaningful to project the sample findings to the state and estimate the total num-

ber of alcoholics admitted to all hospitals. Then, with due regard for methodological limitations, we can make comparisons with 1955 admissions as revealed by our earlier survey (2).

Since 61 per cent of the larger (50 or more beds) general hospitals reported admitting 693 diagnosed alcoholics in 1963, it can be estimated that all such larger hospitals in the state admitted 1, 136 alcoholics; and since 38.5 per cent of the smaller hospitals reported 72 diagnosed alcoholics, it can be estimated that all such smaller hospitals admitted 187 cases. Thus, the state's general hospitals admitted a total of 1, 130 plus 187 or 1, 317 alcoholics. This is a 48 per cent increase over the 889 admissions in 1955. Moreover, it appears that more of the general hospitals are now admitting alcoholics; 74 per cent of the sample reported at least one admission in 1963 compared with 60 per cent in 1955.

The four state mental institutes are also admitting more alcoholics today--630 in 1963 compared with 421 in 1955. And the Psychopathic Hospital treated forty-five new cases in 1963 compared with only one or two in 1955. However, alcoholic admissions to the two private mental hospitals have greatly diminished--from 279 in 1955 to 125 in 1963.* The admissions to one of them dropped from 169 to 120, and for the other one the decline was from 110 to only 5 admissions.

Admissions to all seven of these mental hospitals was 700 in 1955 and 800 in 1963--an increase of 14 per cent compared with an increase of 48 per cent for general hospitals. Total alcoholic admissions to all hospitals in the state (excluding VA hospitals) increased from 1, 589 to 2, 117--an increase of 33 per cent. While it appears that more hospitals are admitting more alcoholics today than in 1955, still, even if we added all alcoholic admissions to VA hospitals and included cases where alcoholics are admitted under another diagnosis, probably not more than 5 per cent of the state's alcoholics were hospitalized in 1963.

Mental Health Centers. Questionnaires were sent to and returned by all fourteen community health centers. (Today there are sixteen of them.) The information obtained supplements official annual reports by the centers to the Iowa Mental Health Authority.

The following findings are based on returns from only ten centers. One center is not included because it is a child guidance

*A third small private mental hospital was taken into account in the earlier study. It is now defunct and while it was not heard from in the earlier study, we estimated that it may have admitted about thirty-eight patients in 1955 (2, p. 39). It is not included in the comparisons being made here.

center, and three others were excluded because they had been in operation less than a year when the study was conducted. Only eight of the ten centers recorded any alcoholism (addiction) cases in their 1963 official annual report. They reported a total of twenty cases. This compares with ten, twenty-one, and eleven cases reported in the previous three years. The official reports do not show problem drinkers or relatives seeking advice. However, in response to our questionnaire, eight of the centers reported a total of 110 problem drinkers and 98 relatives seeking counsel. Presumably the other two centers had some contact with problem drinkers and relatives, but did not estimate the number. The diagnosed alcoholics accounted for just over 1 per cent, and problem drinkers accounted for an additional 7 per cent, of the total 1,641 patients under care during the year.

The official reports show that seven of the twenty alcoholism cases were not treated, and of the thirteen who were treated, ten withdrew. Only one diagnosed alcoholic was referred, and he was referred to a mental hospital. Most of the centers rely on psychotherapy, and six of the ten referred problem drinkers to AA and/or physicians and hospitals. None of the ten reported any special treatment program for alcoholics. However, two did report personnel with a special interest in alcoholism. In both cases it was a social worker.

Business and industry. Of the 123 firms receiving questionnaires, 79 answered them and 57 reported one or more alcoholic employees. It was mostly the smaller firms, employing between 250 and 500 workers, that reported no alcoholics. All but four of the larger firms reported at least one case.

The fifty-seven firms reporting any alcoholics reported a total of 880 of them. However, only one in four (or 228) cases had come to the direct attention of personnel management. The remaining cases were estimated on the basis of absence records, medical reports, and "personal knowledge." The 880 alcoholics estimated by these firms represent just over 1 per cent of their total work force. Most companies that have made diligent efforts to identify alcoholic workers usually find 3 to 5 per cent.

Iowa companies mostly dismiss, or warn and then dismiss, problem drinkers. Only ten of the seventy-nine responding firms reported any kind of formal program for detecting or helping alcoholic employees. About one-half of the firms reported referring alcoholic employees for help. However, only 14 per cent of all the alcoholic workers known to these employers had been referred.

Nearly half (43 per cent) of referrals were to AA and nearly one-fourth of them (23 per cent) were to physicians.

Only 13 per cent of the firms thought that existing community facilities for alcoholics were not adequate, and 80 per cent were not inclined to cooperate with other firms or community agencies to develop a local community program to aid alcoholics. However, if a formal community program was started, 15 per cent desired to cooperate; 27 per cent said that although they had no problem they would cooperate nevertheless. Nearly half of the firms asserted that they had no alcoholism problem and had no desire to cooperate in any community alcoholism program. Thus, it would appear that most Iowa firms are little aware of alcoholic employees.

Clergy. Of the 178 clergymen receiving questionnaires, 112 responded; 68 (59 per cent) of those responding reported contacts with one or more persons seeking help for a drinking problem--their own or a family member's. One Catholic clergyman reported an unusually large number of alcoholic counselees and will be discussed separately. He reported counseling 200 persons for a personal drinking problem. One-third of these he judged to be alcoholics by our definition. In addition, he counseled 150 relatives about the excessive drinking of a family member. He made 185 referrals to other agencies, 60 of which were to Catholic charities. The remaining referrals were rather evenly divided among AA, physicians, mental health centers, welfare agencies, psychiatrists, other clergymen, and private sanitaria. (This dispersion of referrals suggests an awareness that there is no specific treatment equally appropriate to all alcoholics.)

In addition to the above mentioned priest, sixty-seven clergymen counseled 333 persons about their own drinking and counseled 319 persons about the excessive drinking of a family member. Catholic priests reported counseling more persons about a drinking problem than did protestant clergymen. Catholic clergy made up 29 per cent of the sample and 40 per cent of the returns, but they reported 68 per cent of the counseling and this does not include the above priest who counseled 200. Including him, Catholic priests counseled 80 per cent of all alcoholics counseled; and counseled 74 per cent of those counseled about the drinking of a family member. (Presumably, confessionals are excluded, as expressly noted by some priests.)

Four out of ten of the responding clergymen counseled no one about a drinking problem. Only seventeen of them counseled as many as ten persons on this topic. Most of those who counseled ten

or more were Catholic--in fact, twelve out of seventeen. One Lutheran reported twenty-three contacts and two Episcopals, one Methodist, and one Baptist each saw between ten and fifteen. These seventeen clergymen who had ten or more contacts make up only 15 per cent of all responding clergymen, but they account for 76 per cent of all contacts reported by clergymen.

Excluding the priest who saw 200, nearly one-half (47 per cent) of the clergy reported making referrals, and they made 268 of them, which is about 80 per cent of all their contacts with persons seeking counsel for a personal drinking problem. Some 120 or 45 per cent of the referrals were made to AA. The next most popular referral destinations were psychiatrists and physicians, each receiving about 12 per cent of the clergymen's referrals.

Police Chiefs. Questionnaires were returned by 119 of the 179 police chiefs who received them. Questionnaires were received from police departments in all except one city with over 20, 000 population, from police departments in three-fourths of the cities with a population of 2, 500 to 20, 000, and from 49 per cent of those in towns under 2, 500. Returns were well distributed geographically, seventy-seven of the ninety-nine counties were represented.

Ninety-five police chiefs reported a total of 14, 571 arrests for intoxication and OMVI, plus 677 arrests for other liquor law violations, and reported that 1, 050 persons were arrested three or more times for intoxication or OMVI. Considering these repeaters to be alcoholics, then alcoholics account for a minimum of 3, 150 or 22 per cent of the total drunkenness and OMVI arrests. The ratio of these arrests to all arrests varied by city size. In Des Moines, intoxication arrests were half of all arrests. In the six next largest cities (50, 000 to 100, 000 population) they accounted for 29 per cent of all arrests, but in cities under 50, 000 population, they were only 10 per cent of all arrests.

Some 1, 457 drunkenness and 91 OMVI arrests resulted in jail sentences. This is 11 per cent of all such arrests. The person arrested for drunkenness is much more likely to serve a jail sentence in the smaller towns. (However, we suspect, without proof, that he is less likely to be arrested and formally charged in the first place. Instead, he is dealt with informally.) One-third of them were jailed in towns under 20, 000 population compared with only 3 per cent in the six cities with 50, 000 to 100, 000 population. In Des Moines, 13 per cent of the arrests resulted in jail terms.

County welfare directors and overseers of the poor. Questionnaires were sent to 132 county directors of social welfare and to overseers of the poor in counties with such a position. Completed questionnaires were received from eighty of them. Respondents were asked to give the total number of cases (or family units) that were handled during the previous year and the number of such cases where an alcoholic was involved. Sixty-nine (or 86 per cent) of the responding agencies reported one or more alcoholics among their welfare cases. They estimated that 1, 334 of the families on their service rolls contained one or more alcoholics and that the total number of alcoholics in these families was 1, 545. If, as a rough estimate, these agencies handled a total of about 45, 000 cases during the year, then alcoholics are involved in about 3 per cent of the cases. However, there was a wide range in the estimated number of alcoholic contacts relative to total cases--ranging from less than 1 per cent for some agencies to 10 per cent for others, and one agency estimated that 15 per cent of its cases involved an alcoholic.

Some fifty-six welfare offices, or 81 per cent of the sixty-nine who reported any contacts, referred alcoholics to other sources for help. A total of 936 referrals were made. This is 61 per cent of the 1, 545 alcoholics contacted. Mental health centers, where 212 cases were referred, were the most popular referral destination. Following the centers in popularity was AA where 193 cases were referred. This was followed by physicians, hospitals, and clergy with about 100 referrals each.

Alcoholics Anonymous. Questionnaires were sent to the eighty AA groups in the state. The forty-seven who responded reported a total of 1, 152 members; that is, persons who usually attend at least one meeting per month. In addition, they reported 165 "new members, " that is, persons who had entered the group since December 1, 1963, and who attended at least two of the four to six weekly meetings held since December 1. During this same time period, 143 persons had dropped out of the forty-seven groups for any and all reasons--death, "slips, " changes of address, etc. Thus, during this particular time period of four to six weeks the new members appear to have exceeded the dropouts by about twenty-two. The forty-seven groups also reported that a total of 837 members, old and new, attended the meeting at which the questionnaire was filled out and that 884 had attended the previous meeting which, in most cases, was held the previous week. The membership of the thirty-three groups failing to answer the questionnaire can be esti-

mated from the 1963 AA World Directory to number 630. Since the group membership reported in the directory is usually quite conservative, we can estimate that there were at least 1, 467 AA members in the state, but probably not over 2, 000. We can also estimate that something less than 1, 000 attended meetings during the week that was studied.

Summary. The findings of this section suggest that if few alcoholics receive any type of medical service, even fewer of them receive medical treatment for alcoholism. Presumably, the medical services do provide physical examinations and whatever physical repair is indicated. However, in the vast majority of cases, treatment for alcoholism is largely a matter of referral. Even psychiatrists reported treating alcoholism in only one-third of the alcoholics and problem drinkers that came to them, and other physicians treated only 17 per cent of such cases coming to them. The police and courts, of course, "treat" the alcoholic with punishment. Employers, if they attend to the alcoholic worker at all, merely discharge him or threaten discharge if he doesn't "go somewhere and do something about his drinking."

Obviously, the disease concept of alcoholism has not reached a point where society, as a matter of course, channels the alcoholic to medical services for treatment. Although there are notable exceptions, the most that can be expected by the alcoholics who do reach a medical service is physical repair and referral.

Referrals and Cross-Referrals

The finding that referral is a major part of the management of alcoholics by the agencies studied, raises questions regarding the pattern of cross-referrals. Who refers to whom, and is there any one agency or professional service where the pattern seems to terminate? That is, is there one agency that receives the bulk of referrals and does not pass them on; and does the referral pattern tend to concentrate alcoholics in the medical services? Answers to such questions will further illuminate the current management of alcoholics in Iowa.

Tables 9, 10, 11, and 12 summarize the findings regarding referrals and cross-referrals. Except for hospitals, no effort was made to discover whether referrals followed or replaced attempts to give direct help to the alcoholic. Hospitals were asked about referrals in lieu of admission, but most of them failed to answer the question.

Table 9

REPORTED SOURCE OF ALCOHOLIC PATIENTS SEEN BY IOWA MEDICAL SERVICES
Mailed Questionnaire Survey, Iowa 1963

Source of Referrals

Type of service		Self Referral		Police		Friends & Relatives		A.A.		Physicians		Other	
	N	N	%	N	%	N	%	N	%	N	%	N	%
Physicians	(97)	1465	41	1172	34	682	19	103	3	90	3	26	1
Psychiatrists	(24)	568	47	94	8	333	28	27	2	146	12	42	4
Gen. Hospitals	(44)	42	5	112	13	93	10	--	-	609	68	38	4
Mental Hosps.	(5)	231	26	199	23	388	44	--	-	45	5	13	2
M.H. Centers	(9)	26	18	15	11	65	46	--	-	30	21	6	4
Totals	(179)	2332	35	1592	24	1561	23	130	3	920	14	125	2

Source of alcoholic patients. The medical services studied--the physicians, psychiatrists, hospitals, and mental health centers--were asked the source of their alcoholic patients.

Table 9 shows that of the total alcoholic case load of the five types of medical services, 35 per cent were reported to be self-referrals while 23 per cent were referred by friends and relatives. Thus, it would appear that more than one-half of the alcoholics seeking medical help came "voluntarily" or at the urging of friends and relatives, 24 per cent were referred by police, 14 per cent by other physicians and 3 per cent by AA. All other sources of referral accounted for only 2 per cent of the cases. If the facts were known, they probably would show that some combination of relatives, friends, police, and perhaps the employer, family physician, and clergyman play a role in motivating many of the self and relative referrals.

There are interesting variations in sources of referral for the different medical services. Whereas nearly one-half of the referrals reported by physicians and psychiatrists were self-referrals, mental hospitals and mental health centers reported that nearly half of their cases were referred by friends and relatives. About two-thirds of the alcoholics admitted to general hospitals were referred there by physicians.

Who refers to whom? It can be calculated from Table 9 that when self-referrals and referrals by relatives are excluded, the medical services reported that 58 per cent of their remaining cases come from the police, 33 per cent from other physicians, and only 10 per cent from all other sources. Thus, the several medical services report relatively few referrals from nonmedical sources other than police.

Table 10 excludes self-referrals and referrals by relatives and compares the number of cases which the several medical services referred elsewhere. With the exception of general hospitals, all of the medical agencies listed in Table 10 referred more cases to other agencies than other agencies referred to them. Of course, the difference is made up by self-referrals and relative referrals. The significant finding revealed by this table is that none of these medical services is a terminal point for all alcoholics.

This is brought into sharper focus in Table 11 (which includes self-referrals and relative referrals) where it is revealed that over half (56 per cent) of all professionals and agencies studied referred more than half (58 per cent) of all their contacts with alcoholics. Generally speaking, a majority of each type of agency refers a majority of their cases to another agency. General hospitals may be

Table 10

A COMPARISON OF NUMBER OF CONTACTS A MEDICAL SERVICE REPORTED REFERRED TO IT WITH NUMBER REFERRED BY THAT SERVICE
(Self and relative referrals excluded)
Mailed Questionnaire Survey, Iowa 1963

Type of Service	Number Referred to	Number Referred by	Ratio Referred to/ Referred by
Physicians	1391	1939	1.39
Psychiatrists	309	871	2.82
General Hospitals	759	123	.16
Mental Hospitals	257	654	2.54
Mental Health Centers	51	52	1.02

Table 11

NUMBER AND PER CENT OF AGENCIES AND PROFESSIONALS REPORTING REFERRALS AND NUMBER AND PER CENT OF REFERRALS MADE
Mailed Questionnaire Survey, Iowa 1963

Agency or Professional	Make Referrals		Do Not Refer		No Answer		Total N Contacted*	Number Referred	N Referred per 100 Contacts
	N	%	N	%	N	%			
Physicians	103	64	51	32	6	4	3634	1939	53
Psychiatrists	24	83	5	17	--	--	1317	871	66
Gen. Hosps.	25	37	33	49	10	15	824	123	15
Mental Hosps.	4	67	1	17	1	17	902	739	82
M. H. Centers	9	64	3	21	2	14	130	52	40
Clergy	53	47	59	52	1	1	533	453	85
Welfare Offices	56	70	21	26	3	4	1516	936	62
Employers	40	51	35	44	4	5	230	117	51
Totals	314	56	219	39	27	5	9086	5292	58

*This refers to the number of alcoholics and problem drinkers contacted by those answering the question "do you make referrals?" These contacts include self-referrals and relative referrals.

Table 12

DISTRIBUTION OF REFERRALS, IN PER CENT
Mailed Questionnaire Survey, Iowa 1963

Referred by:	Agency or Professional Referred To:										
	Physicians	Psychia.	Hospitals	M.H. Centers	AA	Sal. Army	Clergy	Pri. San.	Welfare	Other	Total Referred
Physicians	1%	20%	22%	19%	34%	--%	2%	2%	--%	--%	1939
Psychiatrists	10	2	11	15	49	--	5	6	1	1	871
Gen. Hosps.	4	3	58	11	9	--	--	4	4	7	123
Mental Hosps.	16	10	5	5	37	--	17	5	5	--	739
M.H. Centers	19	12	14	--	52	--	2	2	--	--	52
Clergy	12	13	3	10	30	--	6	8	6	14	453
Welfare Offices	12	8	12	23	21	4	10	--	5	6	936
Employers	23	5	6	9	43	--	13	--	--	2	117
Totals	8	12	15	16	34	1	7	3	2	2	5230

an exception. Only one-third of the hospitals reported referrals, and referred only 15 per cent of their contacts. However, probably hospital patient referrals are, in most instances, actually made by the attending physician. Over one-half (56 per cent) of the clergymen made referrals, and they referred 85 per cent of all their contacts.

Table 12 presents yet another view of the cross-referral pattern and shows considerable variation in who refers to whom. It was noted in Table 11 that 58 out of every 100 contacts with an excessive drinker end in referral to another agency. We see in Table 12 that one in three (34 per cent) of all referrals were made to AA, making it the most popular single referral destination. The proportion of referrals to AA ranged from about one-fifth of the welfare office referrals to about one-half of the referrals made by mental health centers and psychiatrists. (Hospitals are included in the table for the sake of completeness, but will be given little attention because, presumably, the attending physician makes most referrals.)

By totaling the percentages in the first four columns of Table 12 we can compare referrals to medical services with referrals to nonmedical services. Overall, one-half of all referrals were to medical services and one-half to nonmedical agencies. Physicians other than psychiatrists are inclined to keep referrals within the medical community. About 62 per cent of the referrals made by physicians were to other medical services. Nearly all of the balance of their referrals were to AA. On the other hand, among the remaining medical services only 38 per cent of the referrals made by psychiatrists, 36 per cent of those made by the mental hospitals, and 44 per cent of the mental health centers' referrals were made to other medical services. Clergymen sent about the same proportion (37 per cent) of their referrals to medical service, as did psychiatrists. And 55 per cent of the welfare referrals and 43 per cent of the employers' referrals were to medical services.

A closer look at referrals. Since information was obtained from all mental health centers, it is possible to give more detailed analysis to the movement of alcoholics from other agencies and professionals to the centers. The several agencies and professionals participating in the study reported referring a total of 811 cases to mental health centers. Yet, the centers reported contact with only 130 cases. Disregarding the fact that 18 per cent of these were self-referrals (see Table 9), these 130 contacts equal only 16 per cent of the cases reported referred to the centers by other agencies participating in the study. Considering self-referrals, these findings

DOCTOR

POLICE

CLERGY

MENTAL HEALTH
CENTER

THE REFERRAL MERRY-GO-ROUND

indicate nearly 90 per cent loss of cases between referring agency and the centers. Yet, the loss is even greater than these data indicate. Undoubtedly, additional referrals made to the centers by the agencies and professionals who did not participate in this study more than equalled referrals by those who did participate. A very rough guess is that a total of about 2, 000 alcoholics were referred to the centers by all agencies and professionals of the state. When it is recalled that the centers diagnosed as alcoholic only 20 of the 130 contacts with persons who had a drinking problem, only 13 of whom were treated and 10 of these withdrew from treatment, it appears that, at best, only 1 or 2 alcoholics out of every 1, 000 referred to the centers by other agencies actually arrived there and received treatment for their alcoholism.

These findings regarding referrals cannot be adequately interpreted without further research, but it seems clear that for all the agencies and professionals studied except AA, referral is a large part of the procedure for handling alcoholics. The inadvertant failure to inquire about referrals made by AA is an embarrassing omission. However, it was noted in Table 9 that the medical services reported receiving very few cases from AA. It is also clear that none of the agencies or professional services studied is a terminal point for many alcoholics. It is no less apparent that a great many of the alcoholics who are referred do not follow through. We can only suspect, until further study, that in most instances if the alcoholic did follow through, it would only lead to another referral. It would not require many referrals before an alcoholic began to feel he was receiving the "run around." Certainly he is not likely to go on after a number of referrals have proved futile. Considering the alcoholic's impatience and the fact that his motivation for help is often fleeting, at best, it is not surprising that many of them lose their motivation between referral points and terminate their "treatment" in a bar along the way.

The large number of referrals suggests that there may be considerable duplication in the contacts reported by these agencies. But offsetting this is the failure of referrals to reach their destination. There is need for a great deal more study of the actual movement of alcoholics among the several community services that encounter them and of how much help each service renders the alcoholic. Assuming that each service is doing all it can for the alcoholic, it is obvious none of them is very successful.

The pattern of referrals revealed here suggests the need for a community program to coordinate the work of the agencies

and professionals who encounter the alcoholic. The information regarding cross-referrals presented in Table 12 and the information regarding contacts presented in Table 8 strongly indicate that none of the agencies studied can be omitted from a comprehensive community attack on the alcoholism problem.

Costs

The data collected do not yield an estimate of financial costs attributable to alcoholics. However, most of the agencies--the physicians, clergy, mental health centers, welfare officers, and hospitals--were asked to estimate the amount of time and effort they devoted to alcoholics. Table 13 shows the proportion of each type of agency reporting different proportions of time devoted to such cases. Hospitals are not shown. Their responses can be disposed of by noting that virtually all general hospitals devote only a fraction of 1 per cent to alcoholics. The mental hospitals estimated 10 to 15 per cent of their time and effort was given to alcoholics.

Nearly two out of three of all reporting agencies and professionals spend less than 4 per cent of their time with alcoholics, another 19 per cent spend between 4 and 6 per cent, and 12 per cent devote more than 10 per cent of their time to such cases. As a group, psychiatrists devote a relatively large proportion of their time to patients with a drinking problem. One in eight psychiatrists devotes over 15 per cent of his time to alcoholics. On the other hand, one in five psychiatrists gives less than 3 per cent of his time. Some 5 per cent of the welfare offices devote more than 15 per cent of their time, and 1 per cent of the clergy likewise give this much time to alcoholics. On the other hand, a large majority of the clergy and an even larger proportion of the physicians spend less than 4 per cent of their time with the excessive drinker.

Further evidence of cost is seen in the finding that arrests for drunkenness and OMVI account for nearly one-half of all police arrests in Des Moines, 29 per cent in the six next largest cities, and 10 per cent in cities under 50,000. Since one-fourth to one-half of all drunkenness arrests are accounted for by relatively few chronic offenders, alcoholics occupy more than their proportionate share of police time and resources.

Additionally, it can be estimated that the welfare agencies participating in the study distributed an average of $685.91 to each of the 996 families containing an alcoholic. The fifty business firms aware of any alcoholics in their company estimated that about 1 per cent of their workers were alcoholic, that the alcoholic loses an

Table 13

PER CENT OF TIME DEVOTED TO ALCOHOLICS AND PROBLEM DRINKERS
Mailed Questionnaire Survey, Iowa, 1963

Agency or Professional	Per Cent of Time Devoted						
	N*	0-3%	4-6%	7-10%	11-15%	Over 15%	Total
Physicians	89	87	10	4	--	--	100
Psychiatrists	24	21	38	29	--	13	100
Clergy	75	73	12	12	1	1	100
M. H. Centers	8	38	38	25	--	--	100
Welfare Offices	59	41	32	12	10	5	100

*Number answering the question.

average of sixteen days work annually, and that a total of 9, 059 man-days of absence was due to excessive drinking.

Yet, another indication of costs is seen in the finding that 70 per cent of the 119 police chiefs who responded reported that alcoholics arrested by their department serve jail sentences. The length of sentence varies from three to thirty days; while one-fourth of the sentences are from three to four days, about 20 per cent of them varied from twenty-two to thirty days. It is impossible to arrive at a summary measure of all these costs, but it is obvious from the above illustrations that the costs are substantial.

Professional Attitudes Toward the Alcoholic

The distribution of alcoholic contacts among medical and nonmedical agencies and the procedures for handling alcoholics--especially the referral patterns--indicate that the agencies and professionals who encounter the alcoholic are hardly imbued with the idea that alcoholism is a disease or that alcoholics deserve to be treated as other sick persons. However, in order to obtain a more direct expression of attitudes toward the alcoholic, respondents were asked the same question that had been asked of the general public. That is, whether they viewed the alcoholic as criminal, a sick person, morally weak, weak willed, some combination of these, or held some other view. Table 14 compares the definitions of the alcoholic reported by the agencies and professionals participating in this study with those of the general population (28, 32). Overall, there is little difference. Only 29 per cent of all respondents accepted the sickness view; 23 per cent rejected it, and 48 per cent defined the alcoholic as both sick and weak. However, there was considerable variation among the several types of community services studied. At the one extreme, only 10 per cent of the police chiefs accepted the illness view, and at the other extreme all but one of the seven mental hospitals' administrators accepted it. While 79 per cent of the psychiatrists and 66 per cent of the general hospitals' administrators see the alcoholic as sick, the remaining medical services are less inclined toward this view. Only 45 per cent of the physicians and 58 per cent of the mental health centers see the alcoholic strictly in medical terms. The police were most inclined to reject the illness view. Some 34 per cent of them defined the alcoholic as morally weak and in this respect did not differ from the general population. Police were followed by physicians (20 per cent) and welfare directors (17 per cent) in the proportion defining the alcoholic only in moral terms. Psychiatrists (7 per cent), mental

Table 14

DEFINITION OF THE ALCOHOLIC BY TYPE OF AGENCY, OR PROFESSIONAL IN PER CENT
Mailed Questionnaire Survey, Iowa 1963

Study Population	Sick Person	Sick & Weak	Morally Weak Weak Willed*
General Pop. of Ia.	24%	41%	34%
Physicians	45	35	20
Psychiatrists	79	7	7
Police Chiefs	10	56	34
General Hospitals	66	24	10
Mental Hospitals	83	--	--
Employers	54	37	10
Clergy	29	62	9
Mental Health Centers	58	--	8
Welfare Offices	51	42	17
All Agencies or Professionals	29	48	23%

*Since the "criminal" response amounted to less than 3% it is combined with "morally weak and weak willed."

health centers (8 per cent) and, interestingly enough, clergy (9 per cent) were least inclined to define the alcoholic only in moral terms. These expressed definitions of the alcoholic are no more consistent with the notion that alcoholism is a medical disease than were the findings regarding contacts and referrals.

Finally, it is remarkable that whereas 55 per cent of the physicians either define alcoholics only in moral terms or as having a moral component, they made only 17 per cent of their referrals to clergymen. And whereas 91 per cent of the clergymen either defined the alcoholic only as sick or as sick and weak, still only 37 per cent of their referrals were to a medical service.

Chapter V

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Existing knowledge regarding the alcoholism problem in Iowa may be summarized as follows:

1) Alcoholic beverages have been used in this state since the time of the first European settlers. There is no evidence of radical or abrupt changes in drinking practices. While indications are that the population has always been rather evenly divided between abstainers and drinkers, little is known about the extent of individual consumption prior to 1958. Total consumption of alcohol has not varied greatly during recent decades, and we suspect that the vast majority of drinkers have always been light or moderate consumers. The proportion of extreme deviant drinkers--alcoholics--probably was about the same in the past as it is today--about 5 per cent.

   While the abusers of alcohol are relatively few in number, their ubiquitousness and the social consequences of their deviant drinking have always been such that society has not ignored them. In the absence of adequate informal controls, laws have been passed which were intended to control the number of drinkers and the extent of individual consumption through police action. What conditions would have been without such laws can never be known. But it is known that the laws were widely violated and did not attain their purpose entirely. Throughout the history of the state, control efforts have alternated between licensing and prohibition until 1934, when the state assumed a monopoly on the sale of liquor. During the past decade, Iowa has followed a nationwide trend which emphasizes the treatment of existing alcoholics as diseased and the prevention of excessive drinking through education rather than relying entirely upon legal controls of liquor sales and distribution.

2) Today Iowa has something over 1,000,000 drinkers, the large majority of whom are light or moderate consumers. Approximately 50,000, or 5 per cent of them, use alcohol to an extent which adversely affects their life--their personal relations, job performance, and health. These drinkers are generally called "alcoholics."

3) While the financial costs of alcoholics to the taxpayers of the state may approximate the state's revenue from the sale of beverage alcohol (2), the alcoholics probably account for nearly one-half

of the state's liquor profits. The social costs cannot be measured. We may note, however, that each alcoholic wrecks havoc on the lives of a number of other persons, and a large portion of the population is directly or indirectly affected.

4) Alcoholics vary in their needs, their motivation for help, their personal resources, and the type of treatment to which they will respond.
5) Alcoholics are presently recognized, labeled, treated, and understood mainly on the basis of their drinking and related behavior.
6) Alcoholism as a disease is poorly understood. Its causes, treatment, and prevention remain a mystery. Although there is no specific treatment for alcoholism, still a great variety of therapeutic procedures can claim "recovery" rates of 20 to 50 per cent, and even higher for certain company programs for alcoholic employees. We can expect that almost any kind of special attention given to alcoholics will benefit one out of three or four of them.
7) Certain agencies and professionals--the police, physicians, clergymen, welfare officers, hospitals, employers, mental health centers, and Alcoholics Anonymous--encounter a large portion of the state's alcoholics each year. Only a handful of these agencies and professionals have the interest, motivation, knowledge, and ability to deal effectively with the cases they encounter. With rare exceptions, the management of alcoholics by most of these agencies and professionals consists of little more than referral. The alcoholic, poorly motivated to seek help in the first place, is even less inclined to follow through with a referral. All too often his "treatment" terminates somewhere (probably in a bar) between referral points.
8) Since most alcoholics are employed, the employer is in a strategic position to detect and motivate them to seek assistance. However, most employers do not attend to the alcoholic worker. They are inclined to ignore or deny his existence in their own company.

Recommendations

From a broader perspective, the alcoholism problem consists of two parts: first, there is the problem of rehabilitating the current population of alcoholics; secondly, there is the problem of preventing or reducing the incidence of alcoholic drinking. Moreover, rehabilitation is a double task. The alcoholic must be motivated to seek help, and those who might render help must be motivated and prepared to do so. The following suggestions are made in

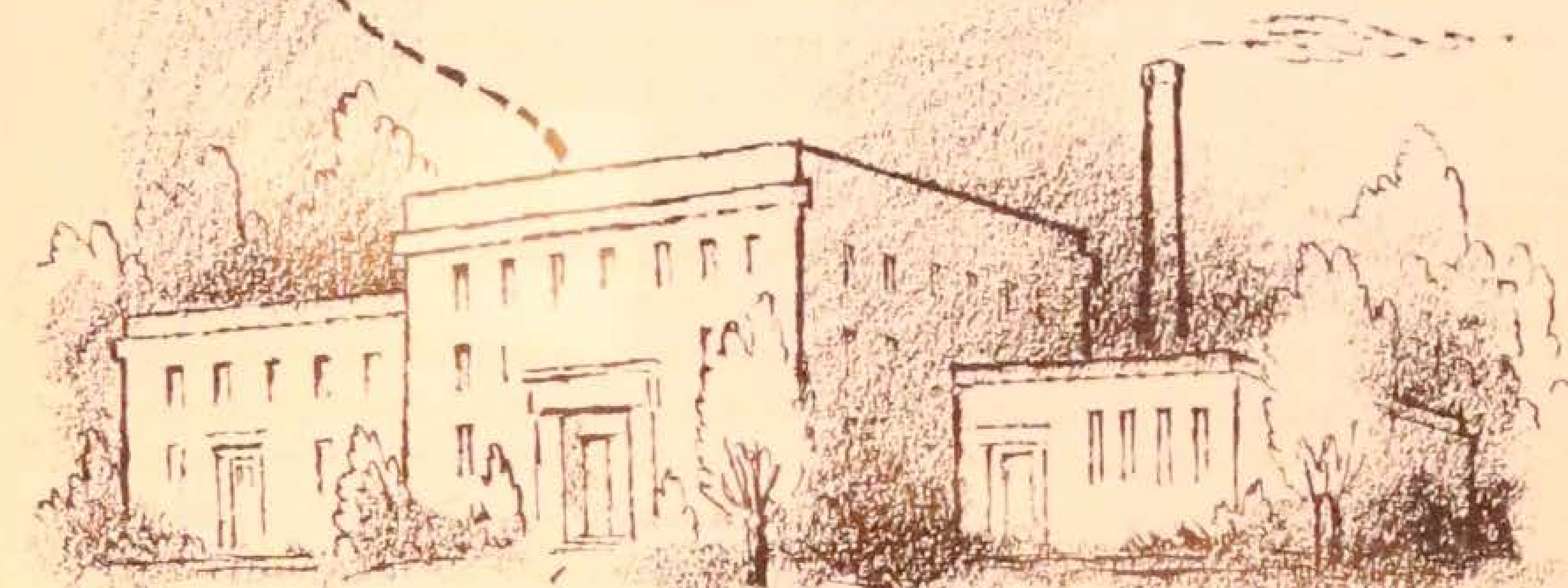
the hope that they will contribute to an improved program of rehabilitation and prevention.

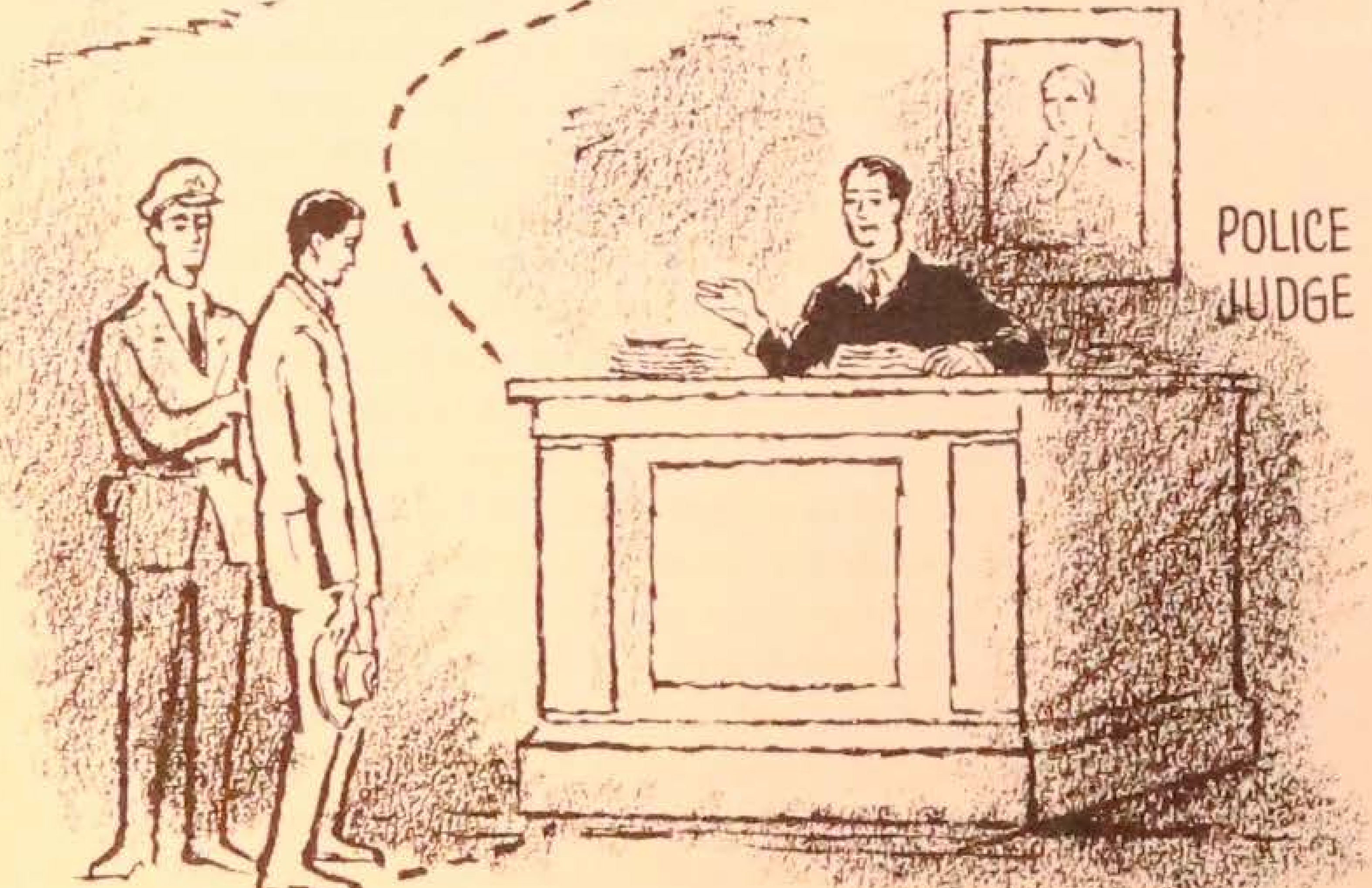
Chronic police offenders. Iowa's chronic drunkenness offenders, numbering some 2,000 to 3,000, have two immediate needs that could be met--physical repair and motivation to do something about their drinking. Most of these alcoholics are well advanced in their alcoholic drinking careers. Most of them are homeless, jobless, and physically deteriorated from prolonged, excessive drinking. These very poorly motivated alcoholics often are under the authority of the police and the courts; instead of being sentenced to jail, they should be committed to an institution where they will be repaired physically and will be exposed to a variety of rehabilitation procedures.

It has been more than adequately demonstrated that, as yet, there is no specific cure for alcoholism. With exceptions all too rare, alcoholics cannot simply enter an institution, receive treatment, and emerge as rehabilitated, useful citizens. Still, the exceptions are a hopeful sign, as are the reports showing that a great variety of therapeutic approaches enjoy some success. In fact, this author is aware of no report of a treatment approach that was a complete failure. Apparently a certain small proportion of alcoholics will respond favorably to almost any type of special attention. Moreover, no existing therapeutic approach can justifiably claim any great superiority. Possible exceptions to this are certain industrial company programs for alcoholics which seem to enjoy unusually high recovery rates (56, 57). However, their greater success probably is due more to the motivation provided by threat of job loss than to the specific type of treatment employed.

The half-way house. In the trial-and-error search for a more effective means of managing alcoholics, the half-way house concept appears promising (58-60). The usual institutional philosophy is that something is done to the alcoholic. The half-way house, by contrast, attempts to do something for the alcoholic--or, more accurately, it attempts to help the alcoholic do something for himself. It aims to provide the employable alcoholic with physical, psychological, and social support, usually for a period of some months, while he gradually makes the transition from skid row and the jail back to steady employment and useful citizenship. The half-way house is not practical if it is not located in the alcoholic's home community, where the rehabilitation process can draw on any family or other respectable social connections which may remain to the alcoholic. Moreover, when the alcoholic is treated in a half-way house in his

RETURNED TO USEFUL CITIZENSHIP





THE CHRONIC POLICE OFFENDER

home community, his employment and other social connections, such as with AA or his clergyman, would not have to be interrupted when he left the shelter of the institution.

As a practical matter, only Des Moines and perhaps a few of the other larger cities of the state have enough chronic alcoholic cases to warrant the construction of a special institution for alcoholics. Hence, a community should consider the alternative of using the county home as a half-way house. However, this possibility should be carefully studied beforehand. What are the current conditions in the county home? What is the attitude of the staff toward alcoholics? If close cooperation between the county home and the employers, physicians, the community mental health center, and other community agencies and professionals appears unlikely, then the home could hardly serve as a half-way house.

It may be necessary for the community to form a local council on alcoholism to establish and administer its half-way house and to take the lead in coordinating it with other community resources. Here, the community alcoholism counselor, to be discussed presently, could play an important role. Existing community resources could meet the needs of the alcoholic if they were properly motivated and mobilized.

Regarding the matter of staffing the half-way house, or otherwise employing personnel to work with alcoholics, it must be borne in mind that, any claims to the contrary notwithstanding, no professional or lay group has demonstrated that it has the answer to alcoholism. Even claims of superiority are based more on personal opinion than on solid evidence. On the other hand, individuals from many professions--psychiatrists, general practitioners, psychologists, social workers, sociologists, educators, clergymen, and others--have demonstrated unusual success in helping alcoholics, as have many persons with no professional training at all.

The question of who is qualified to treat the alcoholic is currently being discussed in a series of papers by authors representing different disciplines and contrary opinions (61). Frederick Lemere and R. A. Moore are two psychiatrists--both with long experience treating and studying alcoholism--who believe that treatment of the alcoholic should not be the sole responsibility of any one professional group, including their own, and that persons with no professional background can, through experience and training, develop into competent therapists for alcoholics. Dr. Moore (61, p. 716) reminds us that the recommendations of the Joint Commission on Mental Health (62) include broadening our criteria for determining

who will be allowed to treat the mentally ill, though specifying careful preparation as mandatory.

Dr. Lemere (63) expresses the opinion that the magnitude of the alcoholism problem and the pressing need for attack on it requires as wide and diversified an approach as possible and also that "... 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." He feels that without these qualities, professional training will not make one a successful therapist for alcoholics. It is undoubtedly true that some nonprofessional counselors may do some alcoholics and their families more harm than good, but Dr. Lemere states that it has been his experience that this is also true of some highly trained psychiatrists. If the truth were known, probably the same could be said about AA. This unfortunate state of affairs will undoubtedly persist so long as alcoholism remains as poorly understood as it is today. Meanwhile, neither psychiatrists nor AA nor anyone else who can help alcoholics should be discouraged from doing so. On the contrary, they should be encouraged. Dr. Moore suggests (61, p. 716) that psychiatrists might help train other professionals and nonprofessionals to counsel alcoholics.

We should not deceive ourselves by expecting a high recovery rate from the half-way house. If one-half or even one-fourth of the cases showed substantial improvement, the program would have to be considered a success. But even the lowest recovery rate would exceed that now found in the jails.

An alternative to a community half-way house for the chronic offender would be a state farm or special institution. While commitment of the alcoholic to a special state institution would be far better than sentencing him to jail, it would be second best to a community half-way house. There are not enough chronic offenders to justify more than one, or at most two, state farms, which means that most of the alcoholics committed there would be removed some distance from their local community. If the state's chronic alcoholics were thus concentrated in one locality, the operation of the institution as a half-way house would soon exhaust job opportunities which would tend to defeat the half-way house concept. In addition, any family connections or other home-environment resources would be less readily available to the alcoholic in a state institution. Moreover, the rehabilitation process would be interrupted when the alcoholic was released from such an institution to return to his community. He would be faced with the problem of finding employment

and establishing contact with AA or his clergyman or other sources of long-term psychological support. In short, it probably would prove impractical to apply half-way house principles to a state farm. If the farm could not operate as a half-way house or could not provide long-term out-patient treatment, it would be offering little to the alcoholic that is not now available (or could be made available) in existing state mental hospitals.

Most alcoholics have little need for institutionalization. The balance of the alcoholic population, probably exceeding 45,000 in number, have less need for institutionalization. However, one in four may suffer physical complications requiring a period of hospitalization. These alcoholics are no more motivated than the chronic police offender, but unlike the chronic offender, they seldom are under the authority of the police and courts, and it is therefore more difficult to commit them. Usually they have jobs, family, finances, and other personal rehabilitation resources to draw on. The major need here, and a primary goal of these recommendations, is to bring the alcoholic together with local community agencies and professionals who are prepared to render assistance.

Considering first the problem of motivation, it will be recalled that most alcoholics (other than chronic police cases) are on someone's payroll. Hence, employers are in a strategic position to detect alcoholic employees, and through threat of job loss, motivate them to take action in their own behalf (56, 57). A company personnel manager who understands alcoholics can soon detect them, motivate them to do something about their drinking, and help them decide what to do--whether to employ the services of a physician or psychiatrist, seek the counsel of a clergyman or AA, or go to a mental health center or private hospital or seek some other type of help; or perhaps no more help will be needed than can be provided by the personnel manager himself. Of course, this assumes the existence of community services that are willing to work with the alcoholic and are able to render effective assistance. All too often, this assumption is not valid.

It will be recalled that most community agencies and professionals have some contact with alcoholics, and, together, they have contact with a large number of cases. If there could be added to these cases all the alcoholic workers that might be detected and motivated by employers, there would then be a large segment of the alcoholic population seeking help. But it will also be recalled that as matters now stand, alcoholics seeking help are most likely to find only referral. The following idea is offered as a means of getting

EMPLOYERS CAN DETECT AND MOTIVATE THEIR ALCOHOLIC EMPLOYEES

the alcoholic off the referral merry-go-round, not at the nearest bar, but at an exit point where expert assistance is available.

A community alcoholism consultant. Assuming that most community services encounter alcoholics in their daily work but do not know what to do with them, and considering also that in many communities there are persons who have demonstrated success in helping alcoholics, then the local community should hire such a person to be on call as a consultant to the clergymen, physicians, employers, AA groups, or others who encounter alcoholics and wonder how best to manage them. While such a consultant should be well prepared by experience, understanding, tolerance, and common sense, if not by professional training, to give direct counseling to alcoholics, he would refuse to see a case except through one of the agencies or professional persons in the community. And then he would counsel the alcoholic directly only after it was decided, in consultation with the agency or professional, that this was the most appropriate course for this particular case.

Ideally, the consultant would be drawn from, and would be well acquainted with, the local community and its potential resources for helping alcoholics. Such a consultant should have long experience and demonstrated ability to work effectively with alcoholics. He should be able to work with the agencies and professionals of the community and not attempt to dictate to them or relieve them of responsibility for their alcoholic cases. Instead, his task is to aid and encourage the community services to do all they can for such cases. He should approach his task with the attitude that he is on call to help the community help itself. To keep abreast of the latest advances in the field, these consultants should attend the Rutgers Summer School of Alcohol Studies, and The University of Iowa should conduct short seminars and workshops for them.

To begin with, this consultant service should be established on a two-year experimental basis. It should be carefully studied and evaluated. The community should make a "before-and-after" study. Before the consultant begins his work, it should be determined as closely as possible how many alcoholics are in the community, how many are being seen by the several agencies and professionals, what is currently being done with them, and what is the current state of the referral system for alcoholics. At the same time, a matched control community, without the services of such a consultant, should be studied and comparisons made. A year or two later, the effectiveness of the procedures could be evaluated. Answers would then be sought for such questions as: Are more alcoholics being seen now

A COMMUNITY ALCOHOLISM CONSULTANT ON CALL TO AID THE VARIOUS AGENCIES IN MANAGING THEIR ALCOHOLIC CASES.

than before the experiment began? Have the attitudes of the professionals and agencies changed? Are alcoholics being managed any more effectively? Of course, the evaluation may show the whole project has been a complete waste of time, but the possibility of failure is all the more reason for careful evaluation.

Hopefully, the evaluation would show some of these results: Employers will have made progress in uncovering their alcoholic employees and many such workers will have returned to work as "recovered alcoholics." The community agencies and professionals will be seeing more alcoholics and boasting more recoveries. Referrals will have declined and cases being referred will be passing smoothly through a coordinated cross-referral system and reaching their destination. Hopefully, the county home could be integrated into the system as a half-way house for the chronic alcoholics.

Considering that alcoholics account for a large portion of the state's profits from liquor sales, it would be most appropriate if the consultant services (and any other local alcoholism programs) were financed from Liquor Control Commission profits. The money which municipalities now annually receive from the Liquor Control Commission, amounting to about $1.29 per resident, might be increased and used to finance the consultant services being recommended; or the one-half of the retail license fees which now go to the state should be returned to local governments to be used for local alcoholism programs.

Finally, a word of caution is in order. There is no pretense or hope that the half-way house or the consultant service is the ultimate answer to the alcoholism problem. It is offered only as an improvement over existing procedures for managing alcoholics. If one-half of the alcoholics dealt with were benefited, it would have to be considered a tremendous success.

Prevention. Another recommendation concerns the prevention of the deviant drinking usually called "alcoholism." Even the discovery of an organic cause and a specific cure for alcoholism would be a solution second to the prevention of new cases. Considering that certain cultures have evolved public attitudes toward alcohol that make for controlled drinking, and if, as we suppose, the definitions of alcohol currently prevailing in our own society discourage uncontrolled drinking among women, then there is hope that we can reduce the alcoholism rate by modifying attitudes toward alcohol use. A change in drinking attitudes and practices is the only real solution to the alcoholism problem now discernable on the horizon.

The difficulty is that so far this possible means of prevention rests more on theory, hope, and faith than on solid evidence. In recent years, a great deal of effort has gone into alcohol education programs. Unfortunately, the success of these efforts has received little careful study. We would venture the guess that their efficiency is something less than 5 per cent.

We have seen that very little progress has been made promoting the disease concept of alcoholism in the general public or among the professionals. We have also seen that education aimed at the drinking driver has not eliminated such driving. Moreover, the educational efforts of the prohibition forces, even with the backing of state laws and a federal constitutional amendment, did not bring about prohibition. In short, so far as can be determined, the results of past educational endeavors in this area are not encouraging.

Still, it is not known what the situation would have been without these educational efforts. It seems reasonable to assume that some progress has been, and is being, made in redefining the alcoholic in medical terms and in reducing the amount of drunk driving; and the prohibitionist forces may even have tempered public use of alcohol.

In any case, it is recommended that alcohol educational programs be continued, but that they be conducted on an experimental basis and that much more attention be given to the scientific evaluation of such programs. It bears repeating that an effective, efficient educational program to modify attitudes cannot be intelligently designed in the absence of knowledge about existing attitudes. And the results must be assessed by measuring changes in drinking attitudes and practices, not by counting the pieces of literature distributed or the number of speeches made.

A final specific recommendation is that all physicians, clergymen, police chiefs, welfare directors, employers, hospital administrators, and anyone else who is faced with the necessity of coping with an alcoholic, contact the local chapter of Alcoholics Anonymous, seek an invitation to attend a meeting, learn about its program, and establish a working relationship with the group. Because it is the only organization in the state (other than the State Commission on Alcoholism) that exists solely to serve the alcoholic, it is ideally adapted to provide the long-term supportive therapy necessary for the rehabilitation of the alcoholic.

It also bears repeating that we have only recently begun to apply scientific methods to the understanding of the alcoholism problem. Many more years of painstaking study will be needed.

Meanwhile, action is unavoidable and desirable. While, certainly, an action program should be founded upon the latest and most valid information available, yet action should not await all the answers to a problem, because "all the answers" are never in.

Addendum

Are You an Alcoholic?

If you repeatedly drink in an uncontrolled fashion to an extent that interferes with normal living, then you should suspect that you are an alcoholic. The following tests will help you determine the question. Can you make these statements about your own drinking? Be honest with yourself.

The Iowa Scale of Preoccupation with Alcohol

1. I stay intoxicated for several days at a time.	Yes	No
2. I worry about not being able to get a drink when I need one.	Yes	No
3. I sneak drinks when no one is looking.	Yes	No
4. Once I start drinking it is difficult for me to stop before I become completely intoxicated.	Yes	No
5. I get intoxicated on work days.	Yes	No
6. I take a few drinks the first thing when I get up in the morning.	Yes	No
7. I awaken next day not being able to remember some of the things I had done while I was drinking.	Yes	No
8. I take a few quick ones before going to a party to make sure I have enough.	Yes	No
9. I neglect my regular meals when I am drinking.	Yes	No

If you answered yes to any two of these items you should give serious thought to the possibility that you are an alcoholic and should do something about your drinking.

Another Test

The Iowa Scale of Trouble Due to Drinking

1. Has an employer ever fired you or threatened to fire you if you did not cut down or quit drinking? Yes No
2. Has your husband or wife ever left you or threatened to leave you if you did not do something about your drinking? Yes No
3. Has your husband, wife, or other family member ever complained that you spend too much money for alcoholic beverages? Yes No
4. Have you ever been picked up or arrested by the police for intoxication or other charges involving alcoholic beverages? Yes No
5. Has a physician ever told you that drinking was injuring your health? Yes No

If you have encountered any of these troubles because of your drinking, you should consider the possibility that you are an alcoholic.

If, in addition to the above tests, you try but fail to quit drinking or to reduce consumption to a more normal level, this is further evidence that you are an alcoholic. As a guide to "a more normal level" of consumption the reader will recall that 85 per cent of Iowa's drinkers drink no more than two drinks, no more often than once a week.

The above tests cannot rule out the possibility that you are an alcoholic, but if the tests indicate that you are preoccupied with alcohol or are having trouble because of drinking, and if in addition you find it difficult to quit drinking or reduce consumption, there is a strong likelihood that you are an alcoholic and you should not be ashamed or hesitate to seek expert assistance.

Where to Go for Help

The following is a list of resources where the alcoholic might seek help:

Iowa State Commission on Alcoholism
State Office Building
Des Moines, Iowa 50319

Alcoholics Anonymous Groups

Other than the State Commission on Alcoholism, AA is the only organization in the state that exists solely to serve alcoholics. AA groups are distributed throughout the state. All the larger cities have one or more groups. AA groups may be found in the following cities. Most groups have a telephone listing.

Algona
Anamosa
Belle Plaine
Boone
Burlington
Carroll
Cedar Falls
Cedar Rapids
Charles City
Clarion
Clinton
Council Bluffs
Cresco
Davenport
Decorah
Denison
Des Moines
Dubuque
Eagle Grove
Eddyville
Emmetsburg
Estherville
Everly
Fairfield
Fort Dodge
Grundy Center
Harlan
Ida Grove
Independence
Iowa City
Le Mars
Manchester
Marengo
Marion
Marshalltown
Mt. Pleasant
Muscatine
New Hampton
Newton
Oelwein
Ottumwa
Osage
Oskaloosa
Red Oak
Rockford
Sioux City
Storm Lake
Traer
Vinton
Waterloo
Waukon
Waverly
Webster City

State Mental Health Institutes. These four state hospitals are located at:

Clarinda
Mt. Pleasant
Cherokee
Independence

Alcoholics may enter these hospitals voluntarily or may be committed by County Boards of Hospitalization.

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Community Mental Health Centers. These centers are located in the following communities:

Black Hawk Co. MHC
1028 Headford Ave.
Waterloo

Cedar Valley MHC
Lutheran Children's Home
Waverly

Central Iowa MHC
223 1/2 Main St.
Ames

Jasper Co. MHC
2009 1st Ave. East
Newton

Lee Co. MHC
110 North 8th St.
Keokuk

Linn Co. MHC
Room 233 Guarantee Bank Bldg.
Cedar Rapids

Marshall-Hardin Co. MHC
One North Fourth Ave.
Marshalltown

Mental Health Center of N. Iowa
215 Adams St.
Mason City

North Central Iowa MHC
Ft. Dodge

Northeast Iowa MHC
130 1/2 West Water Street
Decorah

Northwest Iowa MHC
19 East 8th St.
Spencer

Pottawattamie Co. MHC
704 Bennett Bldg.
Council Bluffs

Scott Co. MHC
57 Schmidt Bldg.
Davenport

Southeastern Iowa MHC
522 North Third St.
Burlington

The State Psychopathic Hospital
500 Newton Road
Iowa City, Iowa

Iowa Association for Mental Health
306 Flynn Bldg.
Des Moines, Iowa

An alcoholic should not hesitate to contact any of the above or to seek help from his family physician, clergyman, or local hospital.

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