ALCOHOLISM IN NEVADA

BULLETIN NO. 31

Nevada Legislative
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Carson City, Nevada

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ALCOHOLISM IN NEVADA

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FOREWORD

The Nevada Legislative Counsel Bureau is a fact-finding organization designed to assist legislators, State officers, and citizens in obtaining the facts concerning the government of the State, proposed legislation, and matters vital to the welfare of the people. The staff will always be non-partisan, and non-political; it will not deal in propaganda, take part in any political campaign, nor endorse or oppose any candidates for public office.

The primary purpose of the Counsel Bureau is to assist citizens and officials in obtaining effective State government at a reasonable cost. The plan is to search out facts about government and to render unbiased interpretations of them. Its aim is to cooperate with public officials and to be helpful rather than critical. Your suggestions, comments, and criticisms will greatly aid in accomplishing the object for which we are all working--the promotion of the welfare of the State of Nevada.

PREFACE

During the 1957 Session of the Nevada Legislature, the Senate adopted Senate Resolution No. 16, which memorialized the Legislative Counsel Bureau to study alcoholism and related problems in the State of Nevada, and to present a report to the 1959 Session of the Nevada Legislature for study and consideration.

The 1955 Session of the Nevada Legislature introduced Assembly Bill No. 342, which would have created a state board on alcoholism. This measure died in the Assembly Committee on Ways and Means.

The Legislative Counsel Bureau presents this study in an effort to explain the alcoholic problem in general, and to indicate the extent of the problem in Nevada.

A series of extensive tables shows the nature of the programs in other states and the methods employed toward a solution of the alcoholic problem. Since the Legislature may wish to reconsider alcoholic legislation, and may wish to establish a state board on alcoholism, there is contained, as a part of this report, a chapter on suggested provisions for such legislation.

This study was undertaken and completed by Arthur J. Palmer, Jr., Senior Research Assistant for the Nevada Legislative Counsel Bureau. Mr. Palmer and the Legislative Counsel Bureau gratefully acknowledge the valuable assistance and materials furnished for the study by: Dr. Marvin Block, Chairman, Committee on Alcoholism of the American Medical Association; Mr. Ken Bovard, Executive Director, Western Nevada Committee on Alcoholism; Mr. Harry Chambers, Secretary, Nevada Peace Officers Association; Dr. E. T. Demars, Dean, School of Alcoholic Studies of the University of Utah; Dr. Charles E. Fleming, Jr., Chairman, Committee on Alcoholism of the Nevada State Medical Association; Mr. Clyde W. Gooderham, Executive Director of the Utah State Board on Alcoholism; Mr. Grover Hillygus, Chief, Liquor and Cigarette Tax Division, Nevada State Tax Commission; Dr. D. J. Hurley, Nevada State Health Officer; Mr. Mark Keller, Editor of the Publications Division of the Yale Center of Alcoholic Studies; Dr. Irving Lazar, Clinical Psychologist at Las Vegas, Nevada State Department of Health; Dr. Martin S. Levine, Chief, Mental Health Services, Nevada State Department of Health; Mr. Russell McDonald, Director, Statute Revision Commission, Carson City, Nevada; Rev. Welles Miller, Executive Secretary, Southern Nevada Committee on Alcoholism; Mr. Ed Nance, a Director of the Alcoholics Rehabilitation Association of Washoe County, Nevada; Mr. Nelson B. Neff, Executive Secretary, Nevada State Medical Association; Dr. Henry Stewart, Carson City, Nevada; Dr. Sidney J. Tillim, Superintendent, Nevada State Hospital; Annals of the American Academy of Political and Social Sciences; California Alcoholic Rehabilitation Commission; California Department of Public Health, Division of Alcoholic Rehabilitation; Institute of Scientific Studies, Loma Linda, California; Licensed Beverage Industries, Inc.; National Council on Alcoholism, Inc.; Nevada State Library, Carson City, Nevada; North Dakota Commission on Alcoholism; Quarterly Journal of Studies on Alcohol, Yale University.

Copies of this study may be obtained without cost from the Nevada Legislative Counsel Bureau, Carson City, Nevada.

J. E. Springmeyer
Legislative Counsel

1957 SESSION, NEVADA LEGISLATURE

SENATE RESOLUTION NO. 16

Memorializing the Legislative Counsel Bureau to study alcoholism in the State of Nevada, and problems incidental thereto.

WHEREAS, Alcoholism is an ever-increasing problem in the nation and in the State of Nevada; and

WHEREAS, An alcoholic or compulsive drinker is a sick person whose nio-chemical and emotional nature makes it impossible for him or her to partake of alcoholic beverages in moderation, and alcoholism is a disease calling for medical psychiatric and social help; and

WHEREAS, The great majority of alcoholics are not visible "skid-row" type of alcoholics found in court line-ups, in the jails, and in the hospitals, but are to be found in the homes, offices and communities of Nevada; and

WHEREAS, Present methods of dealing with alcoholics are costing our communities large sums of money each year; and

WHEREAS, Wage losses through absenteeism in business due to excessive drinking are costing large sums each year; and

WHEREAS, The number of hospital beds and other facilities for dealing with this public health problem is recognized to be inadequate; and

WHEREAS, Alcoholism is a public health problem, and thereby a community responsibility; and

WHEREAS, A public health program on alcoholism needs careful planning, knowledge of local situations, cooperation of courts, social agencies, physicians and hospitals, and support from all sections of the communities; and

WHEREAS, Rehabilitation, education, and community service are the greatest forces operating today for the control and prevention of alcholism in the home, the job, and the community; and

WHEREAS, it appears desirable that a study be made of the needs, and problems of alcoholics in the State of Nevada; now, therefore, be it

RESOLVED BY THE SENATE OF THE STATE OF NEVADA, That the Legislative Counsel Bureau be memorialized to study alcoholism in the State of Nevada, and the problems incidental thereto; and be it further

RESOLVED, That a report relative thereto be presented to the 1959 Session of the Nevada Legislature for study and consideration.

ALCOHOLISM IN NEVADA

CHAPTER I

THE PROBLEM

In the preparation of this study, it was desirable to survey other states and investigate what was being done at the state level as a solution of the problem of alcoholism. While other studies become a mechanical classification of data, from which obvious conclusions can be drawn, the area of alcoholism is intangible.

It is generally agreed that it is difficult to assign precise definitions to the various aspects of the alcoholic problem. However, in the absence of areas not thoroughly defined, there has been a large measure of rehabilitation progress under some programs.

It is only in recent years that any attempt has been made to fully understand alcoholism, so we find some disagreement on a definition. The existence of numerous types of alcoholics precludes simplification. The following definitions point out the variations and includes those which encompass the problem with broad terminology.

The following material is an excerpt from the 1957 Interim Report of the California State Alcoholic Rehabilitation Commission. Alcoholism is defined in a number of ways. Such terms as "addiction," "compulsion," "dependence" are used to identify the symptoms of alcoholism, and "loss of control over drinking," "maladjustment," "interference with normal living habits," "disregard of responsibilities," to describe the consequences associated with these symptoms. The problem is marked by the consumption of alcohol to such an extent that the drinker repeatedly or usually is unable or unwilling to meet responsibility, is heedless of the rights of others, and ignores generally accepted social customs and values. But alcoholism is not mere drunkenness. In alcoholism there is a pathological quality, a compelling force, stemming from psychological or physiological conditions, or both, depriving a person of the power to control himself in consumption of alcohol.

Dr. Oskar Diethelm, Professor of Psychiatry, Cornell University, and Psychiatrist-in-Chief of the New York Hospital, distinguishes between alcoholism and excessive drinking in the following way.

"A patient suffers from chronic alcoholism if he uses alcohol to such an extent that it interferes with a successful life (including physical, personality, and social aspects), and he is either not able to recognize this effect, or is not able to control his alcohol consumption although he knows its disastrous results. An excessive drinker is an individual who uses alcohol frequently and in large quantities and may even behave pathologically when under the influence of alcohol. He is, however, capable of overcoming the habit when he becomes aware of the necessity for it."

Another definition frequently used is: "Alcoholism is a chronic illness, psychic or somatic or psychosomatic, which manifests itself as a disorder of behavior. It is characterized by the repeated drinking of alcoholic beverages, to an extent that exceeds customary dietary use of compliance with the social customs of the community and that interferes with the drinker's health or his social or economic functioning. Many special categories of alcoholics have been identified, including 'alcohol addicts,' who cannot control their drinking, and 'alcoholics with complications.' The latter are those whose excessive drinking has led to recognizable physical or mental sequels."

There are no objective mental or physical conditions that can be called diagnostic criteria of alcoholism, although there are various illnesses and injuries that often are found in persons with a history of excessive drinking. It is not known whether these illnesses and injuries are caused by alcohol itself or by physical conditions, such as malnutrition, which often accompany heavy drinking.

The psychological dynamics by which the compulsion develops have not been identified clearly or explained. In some cases, a precipitating incident may be responsible; in others, long habituation may lead gradually to compulsion. The processes by which the final end is reached are presently as obscure as the grip of the compulsion is real.

The following material is an excerpt from "The Role of Alcohol in Society" prepared by the North Dakota Commission on Alcoholism.

Who is an alcoholic? At times it may be difficult to distinguish an alcoholic from a heavy drinker from outward appearances. This is especially true in the earlier stages. Whether or not a person is an alcoholic cannot be determined on the basis of the amount consumed or how often it is used, but rather on the basis of motivation and the reaction of the individual to alcohol.

First of all, an alcoholic is characterized by a peculiar inability to control the amount he is going to drink after he has taken the first drink. This peculiar physical intolerance to alcohol is one of the earliest and perhaps most pronounced symptoms of potential alcoholism. There is no known cure for this condition. An alcoholic can never hope to become a controlled drinker again, not matter how long he has been without it.

There is a similarity between this condition and that of diabetes. It is difficult to explain just why some people become diabetics; yet, we know that sugar and certain starchy foods must be eliminated from their diet. Now, we would hardly say that these particular elements were the causes of diabetes. Yet, it is reasonable to assume that had they never been used the individual would never have become a diabetic.

The same is true with alcoholism. It is difficult to explain why some people react as they do to alcohol or what is the cause. We do know that the first drink sets up a chain reaction which invariably results in a "bender" and, unless alcohol is eliminated from the diet of the alcoholic, the condition will become progressively worse.

Unlike the diabetic, however, the alcoholic generally neglects or refuses to go on a diet. He continues to drink in spite of the fact that he invariably drinks more than he intends to. Here the alcoholic is characterized by the fact that he continues to drink even though his drinking interferes with his normal way of life.

Whenever drinking has reached the stage where it creates problems, disrupts home life, threatens job or position and interferes with social functions and he still continues, it is reasonable to assume that it has gone beyond controlled drinking, that is has become psychological rather than social.

Why does an alcoholic drink? The age-old question still remains unanswered for many people. Why can't he control his drinking? If you were to ask the alcoholic why he drinks, he would undoubtedly have many excuses to offer - an unhappy domestic situation, physical pain, social conflicts, adverse or unpleasant working conditions or other forms of adversity and, yet it is doubtful if he would be able to give you the real reason. It may be any one or a combination of many of these.

The real problem lies in his inability to face reality, to cope with the problems and conflicts of daily living, his inability to accept responsibility and assume an adult role in life. Alcohol becomes a means of escape from painful reality - a reality that, in turn, becomes even more painful as his drinking progresses.

What causes alcoholism? To find the real cause would require an analysis of each individual case. Quite often the real cause may seem insignificant and may sometimes be completely obscured by the condition and problems that result from drinking and often it is hard to distinguish between cause and effect.

There are certain characteristics common to most alcoholics. Most alcoholics are emotionally immature, sensitive and selfconscious. The alcoholic is never satisfied with himself and is very sensitive to criticism. Problems and responsibilities that are common to all become exaggerated and magnified to him and life becomes unbearably painful.

The progressive symptoms of alcoholism may not always follow in the same order. However, you will always be able to note a very definite pattern of drinking behavior. According to a chart prepared by the Yale Center of Alcohol Studies, the symptoms most commonly manifested by the alcoholic are listed in order as follows:

1. Gross Drinking Behavior
2. Blackouts
3. Gulping and sneaking drinks
4. Hangover
5. Loss of Control
6. Alibi System
7. Eye Openers
8. Changing the Pattern
9. Anti-Social Behavior, Solitary Drinking.
10. Loss of Friends-Jobs
11. Medical aid
12. Benders
13. Tremors "Shakes"
14. Protecting Supply
15. Unreasonable Resentments
16. Nameless Fears and Anxieties
17. Collapse of alibi system, admission to self that drinking is beyond control
18. Surrender Process.

The first step is that of gross drinking behavior. He begins to drink more heavily than his companions. He may not drink very often, but when he does he invariably drinks to excess. He usually becomes very bold and aggressive and quite often his behavior is a source of embarrassment to his wife and friends.

He begins to experience black-outs. He can't remember what happened the night before. These black-outs are not a result of passing out but a sort of amnesia. Not all alcoholics will experience black-outs at this stage. However, whenever they do, they are a source of fear and anxiety.

He begins to realize that his drinking is frowned upon by his friends, that it is not socially accepted, and this leads to the next stage of gulping and sneaking drinks. Now, he is going to fool everyone. He takes a few drinks before going to a party. If he is at home he may sneak a few extra drinks when no one is looking. If he is away from home, he will arrange to have access to a bottle from time to time and will find numerous excuses to get off by himself so that he can "toss off a quick one."

As time goes on, the morning-after becomes increasingly painful. He begins to experience painful hangovers together with feelings of guilt and remorse for his behavior. Up until this time, the individual has established no real serious dependence on alcohol - there is no urge or compulsion to drink, no obvious symptoms of impending danger except during the time of drinking. If he could recognize the danger at this point, it would be comparatively simple for him to stop drinking entirely.

Unless he stops, he will soon develop the symptoms of early stage alcoholism - the loss of control. So far, he may have been able to control the occasion, to determine when to drink and when not to drink. At times he may even have had some control over the amount he would drink; but from now on, he finds himself drinking more frequently and for more reasons, and when he has once started, his drinking is completely out of control. A single drink is likely to start a chain reaction and he will end up completely intoxicated.

This behavior demands an alibi, so he sets up an alibi system. This is done to pacify his family, his friends, and to reassure himself. He begins to rationalize.

He can alwyas find a good reason why he drank too much last time - he drank on an empty stomach, it was the wrong mixture, the wrong crowd, or the wrong bar. The occasion, too, can be rationalized in the same manner. He met an old friend, he was nervous, tense or tired, he had a severe pain, or perhaps someone said or did something he didn't like, but next time is going to be different.

He develops a unique talent for reassuring and convincing himself and others, but the situation is becoming serious. His bouts become longer and more frequent, his hangovers increasing painful and now, he has reached the stage where he needs an eye-opener. This morning drink helps to relieve the physical pain of his hangover and also eases the horrible new feelings of guilt and remorse; he cannot face the new day without it.

By now, drinking has begun to cause him trouble. There is increased pressure on the part of family, friends and employer to stop drinking, or at least to drink less and there may even be threats. He tries to change his drinking pattern. He goes on the proverbial "water wagon." At times he rides high and dry for weeks, perhaps even months, but sooner or later he falls off. He tries drinking only beer or wine, but the result is always the same.

He begins to realize that his drinking is making him unpopular, old friends begin to avoid him. He suspects he is being criticized, so he develops an anti-social behavior. He begins drinking alone. He avoids bars and early drinking companions. He becomes very critical of others, in order to justify himself. He blames others for his drinking and constantly brooks over imaginary wrongs.

His drinking behavior results in loss of jobs and friends and this leads to more drinking. Physical disorders and physical pain begin to develop andhe may begin to seek medical aid. He seldom receives any permanent benefit because drinking is responsible in any way for his condition. Rather, it is the physical discomfort that is the cause of his drinking. He has now advanced to the later stages of his addiction. Alcohol has become a constant necessity. He must drink. He has no choice. He goes on periodic benders and drinks himself into complete oblivion. It becomes increasingly hard for him to face the reality his drinking behavior has created. He becomes careless of his physical appearance and less concerned about his family, job and friends.

His benders are followed by violent tremors. Alcoholic diseases often begin in this period with vitamin deficiency ailments and the DTs. After each of these attacks he usually swears off, but he can't stay away from alcohol long. Having a supply of alcohol available becomes the most important thing in his life. He begins to protect his supply very carefully. He will hide bottles in convenient and safe places. He will beg, borrow, sell or trade and even steal in-order to have an adequate supply. He develops unreasonable resentments toward almost everyone. He feels rejected and abused and indulges in endless self-pity. Nameless fears and anxieties become his constant companions. There is an increasing load of regret and remorse for the past and constant fear and apprehension for the future. Life without alcohol has become utterly unbearable. Finally his alibi system collapses. He is no longer able to excuse himself or put the blame on others. He begins to awaken to the realization that he is licked, that his drinking is beyond his ability to control. His only hope for recovery at this point is an unconditional surrender. He must accept the fact that he will never be able to drink again and be willing to make the necessary adjustments to live without alcohol.

Problems Associated With Excessive Consumption of Alcohol and Alcoholism.

The following material is an excerpt from the 1957 Interim Report of the California State Alcoholic Rehabilitation Commission.

If the boundaries that define an alcoholic and separate a social, habitual, or heavy drinker from an alcoholic are elusive, the problems that stem from excessive drinking and alcoholism are not. They are conspicuous and critical, affecting the individual, society and governments.

Excessive drinking in the individual, particularly when prolonged, often is associated with physical afflictions: liver disease, delerium tremens, malnutrition, psychosis, brain damage, etc. Sacrifice of abilities and waste of talent are frequent effects.

The effect at the social level, alcoholism and excess drinking account for major problems of law enforcement, traffic safety, provisions of care and treatment facilities, welfare aid for dependents of alcohol and others.

At the governmental level, alcoholism and excessive drinking account for major problems of law enforcement, traffic safety, provision of care and treatment facilities, welfare aid for dependents of alcoholics, and others.

The following material is an excerpt from "The Role of Alcohol in Society" prepared by the North Dakota Commission on Alcoholism.

No matter what our attitudes or opinions might be in regard to the use of alcoholic beverages, we must be realistic and accept the fact that alcoholism presents a major problem in our society.

Alcoholism is today recognized as our nation's 4th greatest public health problem. It is by no means a new problem. On the contrary, it is perhaps one of the oldest problems known to man and today it is, without question, the most insidious and complex socio-economic and health problem facing our nation.

Because of the stigma that has always been associated with alcoholism, it has not been exposed to the public eye as has been the case with polio, cancer, and other illnesses that have aroused public concern. Consequently, few people are aware of the extent, nor do they understand the nature of the problem.

Alcoholism is a contributing factor in a large percentage of the many tragic situations that exist today. There are more people afflicted with alcoholism than with cancer, tuberculosis or infantile paralysis. It is estimated that we have over 4-1/2 million alcoholics in our nation. This includes people in the various stages of addiction. While it has been generally accepted that our alcoholic population includes one female for every six males, recent studies have revealed that the ratio between male and female alcoholics is much less than this. Some even go so far as to claim that there are as many female alcoholics as male.

Alcoholism an Economic Problem.

It is estimated that alcoholism costs our nation over $1,000,000,000 annually. This includes an estimated $432,000,000 in potential wage loss. The National Safety Council claims that alcoholism contributes to the cost of preventable accidents to the tune of $120,000,000 annually. Other costs to which alcoholism is the major contributing factor are in the area of crime, medical, hospital and institutional care and maintenance of alcoholics in county and local jails.

Although no accurate data are available for Nevada, the following report from Utah is significant. This material is an excerpt from "Alcoholism in Utah" the fifth Biennial Report of the Utah State Board on Alcoholism.

A sizeable portion of Utah's law enforcement problem can be attributed to arrest for drunkenness. Since 1952, Utah has conducted a special survey of the arrests for drunkenness to determine the number of repeaters and their frequency of arrest. The survey was made by sampling the arrests for drunkenness in urban, rural and farm areas representing more than fifty percent of the State's population. The sample included not only the total arrests for drunkenness, but also the number of individuals arrested one time only, and the number of individuals arrested two or more times in a single year. By application of the sample percentages to the total arrests for drunkenness reported by all counties and municipalities of Utah, it was determined that over the past five year period, repeaters represented thirty percent of the total number of individuals arrested, and accounted for seventy percent of the total arrests for drunkenness made. It should also be pointed out that repeaters averaged being arrested four or more times each year. Being arrested for drunkenness does not necessarily indicate that an individual is an alcoholic. However, being arrested repeatedly for drunkenness is a good indication that the individual is compulsively motivated to the use of alcoholic beverages, and that considerable problems are being created in his life through its use. It is quite possible that such individuals are alcoholic. Continuous jailing of alcoholics is not the answer to the problem.

Law enforcement agents estimate that arrests for drunkenness represents more than SEVENTY PERCENT OF UTAH'S TOTAL LAW ENFORCEMENT PROBLEM. Assuming these estimates are reasonably accurate, it can be easily reckoned that repeaters account for more than fifty percent of Utah's total law enforcement problem.

Some indication of the cumulative cost to governments for just one alcoholic can be obtained from the following typical police record: (U.S. News & World Report) April 19, 1957

Subject: A man 54 years old who has been jailed 285 times in the last 32 years and is in jail now. He studied accounting as a youth, has worked intermittently as a clerk, printer, cook, carpenter, driver, plumber, painter, laborer.

Cost to city to date:	
Police and court costs at $60 per sentence	$ 17,100.00
Jail keep, at $2.86 per day	26,873.00
Hospital care, during 140 days' treatment of delirium tremens, other ailments	1,400.00
Total	$ 45,373.00
Less 52 fines paid by subject	510.00
Net cost To Date	44,863.00

Alcoholism is a Complex Problem.

The following material is an excerpt from "The Role of Alcohol in Society" prepared by the North Dakota Commission on Alcoholism.

Until we learn to recognize and accept alcoholism as a public health problem and a public responsibility, we will continue to pay this overwhelming price, not only in dollars and cents, but in the loss of human lives, broken homes, and warped personalities, and alcoholism will continue to exert its insidious influence in our society.

Accepting the concept of alcoholism as an illness requires an understanding of some of the basic facts about alcoholism, the causation, effects, and results. Too often, any reference to alcoholism conveys a mental picture of the chronic court offender, physically

and morally deteriorated. Too often, alcoholism is defined simply as a self-inflicted condition resulting from an excessive intake of alcohol - alcohol being considered the primary causation factor. Any approach to the problem based on these assumptions will be certain to fail.

The most common approach in dealing with this problem in the past has been through punitive action. Substituting punishment for treatment is an injustice that can only intensify the condition that prevails.

Contrary to popular opinion, alcohol cannot be considered the only factor, or even the primary factor, as a cause of alcoholism. When we consider the fact that it is only 6 or 7 percent of those who use alcohol who develop this illness, it is obvious that alcohol is not the only factor. If it were, then why don't all people who drink become alcoholics? And when we consider the moral, social, and intellectual caliber of most of those who are afflicted, it certainly the premise that alcoholism is due to ignorance or a lack of moral stamina. Alcoholics represent a cross section of our American Society, from the top to the bottom or our social scale. Within our alcoholic population may be found men and women from every walk of life. The majority of these are above average in ability and intelligence

Alcoholism is a complex, progressive illness with phsyiological as well as psychological manifistations. This concept of alcoholism as an illness is based on the belief that alcoholism is a symptom complex as defined by one authority as a "reaction syndrome related to deeper problems of the individual personality, his emotional maturity, psychological and physiological functioning and his interaction with other persons."

Alcoholism does not result from a lack of willpower. Will-power cannot prevent or cure alcoholism any more than it can cure diabetes or tuberculosis. Alcoholism is not inherited; although, it is recognized that a large percentage of alcoholics come from families who have a tendency to be high strung or nervous and who are often emotionally immature individuals and it is, of course, possible to inherit some of these characteristics. There is no known cure for alcoholism. It can be arrested, however, and with the proper attitude and treatment, the alcoholic can learn to live a normal useful life without alcohol.

CHAPTER II

AREAS TO BE EXPLORED

Individual, social, and governmental inability to cope with excessive drinking and alcoholism stems from lack of knowledge and awareness.

The knowledge needed to enable society to cope more effectively with alcoholism is indicated in the following review. (This material is based primarily on a Current Research on Problems of Alcoholism *** report of a research institute on problems of alcoholism, Madison, Wisconsin, October 1954. Quarterly Journal of Studies on Alcohol, Vol. 16, No. 3, September 1955.)

Alcohol in the Body.

What are the effects of alcohol on the body and what happens to it in the body? Recently, there has been much interest in establishing the relationship of nutrition to alcoholism. Some investigators have looked for the basic cause of alcoholism in vitamin deficiency. The converse relationship of the influence of alcohol in causing malnutrition has been explored extensively. But at this time, the character of these relationships is not fully understood.

Further investigation is needed on the sopoforic effects of alcohol. Although it is known that alcohol slows down activity in the nerve cells, interfering with utilization of oxygen and energy production in the cells, the mechanism by which this is accomplished has not been defined satisfactorily.

The physiological and biochemical characteristics of the "hangover" and the so-called withdrawal stage also need further exploration.

Important discoveries have been made recently on the vital role played by the endocrine glands and their hormonal secretions in maintaining bodily health. In relation to alcoholism, further inquiry is needed to determine whether disturbances in endocrine functioning may account for alcoholism and what effects alcohol has on the endocrine glands.

Alcoholic drinks contain many substances in addition to ethyl alcohol, some highly toxic. The possibility that such substances play a role in the development of alcoholism needs more study.

Permanent damage in body tissue sometimes is found in the chronic alcoholic. Study is needed to ascertain whether milder but permanent damage in tissue also occurs in earlier stages of alcoholism.

Psychological Steps to Alcoholism.

The psychological processes in the genesis of alcoholism require study. Reliance on alcohol may relieve an individual of the need for employing resources of personality and character that would ordinarily be called upon in times of stress. There may be a progressive development of the tendency to substitute the synthetic relief of sense of ease obtainable from alcohol for resources of character and personality that would ordinarily be called upon in situations of stress, fatigue, or tension. This hypothesis needs more systematic examination than has yet been accomplished. The part alcohol may play in accentuating stress also calls for more inquiry.

A favorite topic for research has been the personality characteristics of the alcoholic. Many attempts have been made to find a pattern of traits typical of the alcoholic, so far without success. If a pattern of personality traits common to all alcoholics ultimately is established, the value will be great, particularly in relation to preventive programs.

More progress has been made in describing behavioral stage in the evolution of alcoholism. Knowledge on behavioral stages has furnished the basis for questionnaires and similar devices by which a person often can ascertain with some reliability if he is exhibiting alcoholic tendencies. But refinement of such devices and more comprehensive description of the development of alcoholism are needed.

There is also the question of the connection between alcoholism and psychopathology. How frequent is the occurrence of mental illness among the alcoholics? What is the incidence of alcoholism among psychotics? Is the alcoholic always a neurotic?

Social Factors.

A third general area for investigation concerns the ways alcohol is used in society and the extent of its use. We have only rough measurements of the prevalence of alcoholism. The most widely used estimates are based on the Jellinek Formula. This formula, actually a crude yardstick but considered the most reliable oneavailable for general application, provides a way of estimating the number of alcoholics with complications, i.e., persons with definitely alcoholic - associated mental or bodily infirmities.

Ratios generalized for large population groups (e.g. the entire U.S. population) are applied to these figures, numbers of alcoholics with complications, to obtain estimates of total numbers of alcoholics of all kinds and degrees. (For the U.S., the assumed ratio is three alcoholics without complications to each alcoholic with complications.)

Improvements in methods of alcoholic census-taking are needed to assess the problem accurately and to evaluate progress made in dealing with it in a particular population.

From the viewpoint of causation of alcoholism, particularly the relationship of various environmental factors to causation, it is important to obtain breakdowns of prevalence figures for various population subgroups; social, cultural, ethnic, religious, and others. This information also would be essential for sound planning of control and prevention programs.

Another subject of fundamental importance is the relationship of drinking customs and habits to excessive drinking and alcoholism. Are there particular kinds of social usage of alcohol, or particular kinds of attitudes toward drinking of alcoholic beverages that are conducive to alcoholism? What are the practices, values, attitudes toward other objects, e.g., food or entertainment that are correlated with patterns of excessive drinking or alcoholism. Questions also arise on the relationship of the use of alcohol to family life, marital relations, and the interaction of children and parents.

Treatment and Rehabilitation.

A fourth major area in which more knowledge is needed is treatment and rehabilitation. It is, in a sense, the ultimate one since it is here that new insight and information gained in the other areas will be applied. Medical treatment of alcoholism today is aimed initially at the manifestation, not the cause; getting the patient to refrain from drinking rather than removing the compulsion that drives him to drink. Any combination of available measures that seem to offer promise with a particular individual is employed to achieve this. The procedure often is effective, but the processes taking place are obscure. They must be clarified before more certainty can be hoped for in treatment methods.

Rehabilitation of the alcoholic may involve every phase of the individual's life. It is often just as important for rehabilitation therapy to be directed to his wife and family as to the alcoholic himself. The concept of total therapy requires further development and the application of the concept must be worked out more fully.

More should be learned about the use of drugs in treatment of alcoholics. Tranquilizing drugs have given some encouraging results but further evaluation is needed. The use of chlorpromazine, reserpine, radioactive iodine, and other medicaments is still in the experimental stage.

Alcoholism is a disease for which the birthrate of treatment methods is extraordinarily high and the mortality rate almost as high. The turnover rate may decline when more knowledge of what the various methods actually do is obtained. Administration of hormones to correct metabolic and endocrinological dysfunctions thought to have some relationship to alcoholism is in vogue, but further controlled trial is needed.

More research is required, not only to improve the use of psychotherapy in treatment of alcoholics but also to find out to what extent psychotherapeutic techniques can be applied safely and effectively by persons without extensive training in use of these techniques. This is important because psychiatrists and psychiatric social workers with professional training are few in number in relation to needs for treatment of mental illness alone, without regard to additional needs for alcoholism.

Research in community organization is also needed. It is necessary to develop methods of having skilled therapists work with alcoholics found on welfare rolls, in hospitals, jails and work farms, half-way houses, etc. This may necessitate a pilot program in which administrative relationships can be clarified and sharpened and a coordinated community control program developed. In part, the first steps are already taken in community alcoholic rehabilitation clinics, but the extension of services out of clinics and into other community agencies and institutions has not developed.

Evaluation of any comprehensive treatment of alcoholics cannot be complete without consideration of long-term effects. The decisive question, "Has treatment succeeded?" can only be answered on the basis of 19 g-term assessment of changes in the ability of the individual to function productively and to develop and maintain a constructive social adjustment.

Prevention.

A fifth area of study pertains to prevention of alcoholism. Other than generalized pleas for moderation and warnings of possible consequences of excess use, there is little being done in this area. More specific preventive methods may evolve as knowledge is accumulated on the psychological and physiological components of alcoholism, its extent and distribution in the population, and modes of treatment.

CHAPTER III

NEVADA'S PROBLEM

The Jellinek Formula

The standard formula for estimating the existence of alcoholism in any community, state, or nation has been referred to as the Jellinek formula. This formula was developed by Dr. E. M. Jellinek, the world's leading authority on problems of alcohol and alcoholism. Since there has been no nation-wide census of alcoholics, the formula is of utmost significance. The principle of the formula expressed in detail rests on Jellinek's determination of the constant relationship between the percentages of alcoholics (separately for men and women) who die of cirrhosis of the liver and the proportion of all death from cirrhosis attributable to alcoholism. Once the number of alcoholics with complications is thus calculated, another constant is required to allow the addition of alcoholics without complications. This latter constant varies from country to country. In the United States and Canada, according to Jellinek, it is 4; that is, there are 3 alcoholics without for every alcoholic with complications, hence the number with complications must be multiplied by 4 to obtain the total number of alcoholics. A highly critical analysis of the formula nevertheless concluded that Jellinek formula estimates of the prevalence of alcoholism in Canada and the United States, bases on data reported in recent years, would probably provide reasonably reliable indications of the magnitude of the problem.

This is in agreement with an earlier opinion, based on a comparison of Jellinek formula estimates with results of several local surveys carried out by a variety of methods, that the various empirical confirmations justify substantial confidence in the Jellinek estimation formula. We therefore consider estimates of the prevalence of alcoholism based on this formula to give at least a satisfactory approximation of the magnitude of this problem in the United States.

Estimated by the Jellinek formula, in 1955, there were 4,712,000 alcoholics in the United States--4,002,000 men and 710,000 women. A far more meaningful datum, of course, is the rate of alcoholism. Based on adults (aged 20 and over), the rate per hundred thousand population of same sex is 7,550 in males and 1,290 in females. The rate in both sexes combined is 4,360. The sex ratio is 5.6 to 1. The rate of alcoholism varies greatly by geographic region, by states and by cities, as well as among ethnocultural groups. Only a small part of the alcoholic population will be found on Skid Row. Alcoholics may be discovered in every stratum of the population, and it has been estimated that more than 1,650,000 are employed in business and industry.

TABLE 1

Estimated Rates of Alcoholism in the United States per 100,000 Adults (20 Years or Over), 1940-1955 by Sex.

Year	Male	Female	Both Sexes	Male:Female Ratio
1940	5,230	870	3,050	6.0
1941	5,340	940	3,140	5.7
1942	5,700	980	3,180	5.5
1943	5,040	980	3,180	5.5
1944	5,350	920	3,070	5.3
1945	5,290	950	3,090	5.5
1946	5,790	970	3,330	5.7
1947	6,200	1,100	3,600	5.5
1948	6,850	1,150	3,930	5.7
1949	6,850	1,160	3,930	5.7

TABLE 1 (Cont.)
Estimated Rates of Alcoholism in the United States per 100,000 Adults (20 Years or Over), 1940-1955 by Sex.

Year	Male	Female	Both Sexes	Male:Female Ratio
1950	6,710	1,180	3,890	5.5
1951	7,180	1,260	4,160	5.5
1952	7,680	1,280	4,380	5.8
1953	7,590	1,320	4,390	5.5
1954	7,860	1,320	4,530	5.7
1955	7,550	1,290	4,360	5.6

National rates for alcoholism are not overly significant to the Nevada Legislature as it is recognized the rate fluctuates widely from state to state. By adopting the Jellinek formula to other basic Nevada statistics, some very definite data are supplied on the rate of alcoholism in Nevada. Alcoholism rates for the states has been published twice since the Jellinek formula received widespread acceptance. In 1940, Nevada ranked in first place in the Nation. When the formula was employed at the state level again in 1953, Nevada's position was modified to third position among the states. This information points to a higher than average prevalence of the "problem" in the State of Nevada.

TABLE 3
Estimated Numbers of Alcoholics and Rates of Alcoholism, U. S. A. 1953, by States and by Sex[1]

	Males		Females		Total		Rank
	Number	Rate	Number	Rate	Number[2]	Rate	Order
Alabama	33,300	3,680	6,700	740	40,000	2,210	47
Arizona	19,550	7,140	3,500	1,280	23,050	4,200	19
Arkansas	27,500	5,000	4,600	840	32,100	2,920	32
California	494,850	11,780	97,900	2,330	592,750	7,060	2
Colorado	27,850	5,860	6,200	1,300	34,100	3,580	22
Connecticut	83,600	9,890	14,300	1,860	97,950	6,380	3
Delaware	13,400	11,210	1,000	840	14,400	6,020	5
District of Columbia	42,000	13,250	7,450	2,350	49,450	7,800	1
Florida	79,300	7,220	15,550	1,420	94,850	4,320	17
Georgia	48,500	4,540	6,200	580	54,750	2,560	38
Idaho	5,050	2,780	1,350	740	6,450	1,770	49
Illinois	291,400	9,180	42,050	1,330	333,450	5,250	9
Indiana	104,600	7,530	15,900	1,140	120,550	4,340	16
Iowa	32,600	3,820	6,450	760	39,050	2,290	46
Kansas	27,150	4,070	4,250	630	31,400	2,350	45
Kentucky	50,700	5,690	8,200	920	58,900	3,310	27
Louisiana	58,300	6,820	6,950	810	65,250	3,820	20
Maine	16,300	5,680	2,100	730	18,400	3,210	29
Maryland	70,600	8,250	12,700	1,480	83,300	4,860	10
Massachusetts	155,300	9,100	34,100	2,000	189,400	5,550	8
Michigan	171,600	7,600	31,100	1,380	202,700	4,490	15
Minnesota	53,200	5,330	10,550	1,060	63,800	3,200	30
Mississippi	25,000	4,070	4,350	710	29,350	2,390	42
Missouri	110,400	7,980	17,150	1,240	127,600	4,610	13

TABLE 3 (Cont.)
Estimates Numbers of Alcoholics and Rates of Alcoholism, U. S. A. 1953, by States and by Sex[1]

	Males		Females		Total		Rank
	Number	Rate	Number	Rate	Number[2]	Rate	Order
Montana	12,300	6,200	2,000	1,010	14,300	3,600	21
Nebraska	22,100	4,900	2,500	550	24,550	2,720	35
Nevada	6,500	9,560	1,850	2,720	8,400	6,160	4
New Hampshire	14,500	8,150	2,600	1,460	17,100	4,800	11
New Jersey	171,950	9,370	33,100	1,800	205,050	5,590	7
New Mexico	12,650	5,900	2,350	1,100	15,050	3,500	24
New York	529,250	9,730	105,750	1,940	635,000	5,840	6
North Carolina	52,150	4,400	7,200	610	59,350	2,500	40
North Dakota	8,700	5,060	1,000	580	9,700	2,820	34
Ohio	235,300	8,180	39,200	1,360	274,500	4,770	12
Oklahoma	29,300	4,170	5,700	810	35,050	2,490	41
Oregon	25,350	4,630	5,700	940	31,050	2,840	33
Pennsylvania	280,200	7,710	53,250	1,470	333,450	4,590	14
Rhode Island	20,650	7,150	4,100	1,420	24,750	4,280	18
South Carolina	21,350	3,310	5,100	790	26,450	2,050	48
South Dakota	8,700	4,290	850	420	9,550	2,350	44
Tennessee	45,600	4,510	7,600	750	53,200	2,630	37
Texas	129,950	4,910	25,150	950	155,100	2,930	31
Utah	8,700	4,040	1,500	700	10,200	2,360	43
Vermont	5,050	4,210	1,000	830	6,050	2,530	39
Virginia	51,750	4,610	7,600	680	59,350	2,650	36
Washington	42,000	5,310	9,700	730	51,700	3,270	28
West Virginia	32,950	5,700	9,700	990	38,650	3,350	26
Wisconsin	69,150	5,900	13,050	1,110	82,200	3,510	23
Wyoming	5,800	5,800	1,000	1,000	6,800	3,400	25
U. S. A.	3,884,000	7,590	705,000	1,320	4,589,000	4,390	

Rather than rest Nevada's alcoholic caseload entirely on a formula, it was considered wise to employ a survey to determine the known number of alcoholics. At the request of the Legislative Counsel Bureau, one of the Alcoholic Anonymous groups in Nevada conducted a survey to determine the number of known alcoholics in Nevada. This group sent a questionnaire to the other Nevada groups and the results are tabulated below. The questionnaire asked that the alcoholics be classified into the three categories listed in the tabulation. It must be remembered that the results of the survey do not indicate the total number of alcoholics in Nevada. The results indicate the number of known alcoholics in those areas which reported back to the survey group. Obviously, there are many more representing non-reporting groups and those not known to groups which did report. Included in the tabulation are selected data for four of Nevada's counties, the two large counties, and two medium-sized counties. Reports were not complete enough to warrant the inclusion of all seventeen counties in a separate tabulation. However, the counties listed point out the depth of the problem in those counties, which may be employed as a measure of the problem in others.

[1] Alcoholics with and without complications; rates based on adult population (aged 20 and over). Calculated by Jellinek estimation formula from preliminary data kindly supplied by the National Office of Vital Statistics.

[2] Total number does not always equal the sum of males and females because of rounding off effect.

Alcoholics	State Totals	Churchill	Clark	Humboldt*	Washoe
Alcoholics who have called on AA groups for help in past year	1,655	48	---	175	860
Hidden alcoholics, known to have a problem but not reached by AA	1,205	58	250	170	315
Alcoholics who don't realize their problem, drink in public, and are not concerned about assistance	1,251	--	250	305	362
TOTALS	4,111	106	500	650	1,537

* An unusually complete report from groups in the county

A tabulation of Alcoholic Anonymous groups in the state was made by the Bureau to establish the strength and coverage of the fellowship in Nevada. This count was made subsequent to the official report of the General Service Conference of Alcoholics Anonymous because of the very rapid growth of the fellowship in Nevada. The official tabulation is given below as of January 1, 1958. The Bureau tabulation as of October 1, 1958, shows a substantial growth and is presented by cities and towns. All of the additional groups tabulated by the Bureau have not necessarily been formally registered by the General Service Conference.

General Service Conference Tabulation as of January 1, 1958

Total AA Membership	443
Number of Local Groups . . . (Registered Groups Only)	17
Number of Hospital Groups .	1
Lone Members (Small Towns)	2

Tabulation made by the Legislative Counsel Bureau as of October 1, 1958

Total AA Membership	625
Number of Local Groups (Registered and Non-Registered)	32

Tabulation of AA groups by cities and towns

Boulder City. . 1	Fernley. 1	Pioche. 1
Carson City . . 2	Hawthorne . . . 1	Reno. 9
Elko. 1	Henderson . . . 1	Sparks. 4
Ely 1	Las Vegas. . . . 4	Lake Tahoe . . 1
Fallon. 1	Lovelock 1	Winnemucca . 2
	No. Las Vegas . 1	

Lone members are found in the following towns

Battle Mountain	Eureka	Pioche
Beatty	Fernley	Tonopah
Carlin	Gardnerville	Wells

Families tend to hide an alcoholic condition, and the alcoholics are often successful in concealing their problem. When further consideration is given to the difficulty in drawing a line between a heavy drinker and an alcoholic, census-taking becomes most difficult. However, the extent of the problem in Nevada is indicated by the data presented in this Chapter, by an estimate and actual count. It is obvious the problem exists in Nevada, what measures are to be taken, rest with the Legislature.

The present treatment facilities which are available for alcoholics are inadequate. The usual pattern which follows a long period of compulsive drinking by an alcoholic often leads to arrest and confinement until sober. This cannot be considered constructive treatment that will eventually lead to sobriety for the alcoholic. Only a few cases of alcoholism are entered in the hospitals of the State. Those reaching the hospitals as public charges are released immediately after a short period necessary to "dry them out". Section 433.250, Nevada Revised Statutes, provides that persons defined as inebriates can be committed to the Nevada State Hospital for treatment of an alcoholic condition. The nature of the treatment available at the Nevada State Hospital is commendable. However, the facilities are limited and it is suggested that the majority of alcoholics do not require specialized treatment. The stigma attached to commitment to the Nevada State Hospital is difficult to overcome when the alcoholic returns to society. Undoubtedly, a rehabilitation method which does not place a strain on limited state-owned facilities, and accomplishes results through support of private centers, would be preferred. Such a rehabilitation plan is presented in Chapter V.

CHAPTER IV

STATE PROGRAMS ON ALCOHOLISM IN THE UNITED STATES

The following tables are included in this report to show the programs in operation in the other states, appropriations made for them, how the funds are spent, and the types of treatment facilities employed.

A. State Programs on Alcoholism in the United States in 1957

At the close of 1957, a total of 38 states and the District of Columbia had taken official action to establish a public medical care program for alcoholism.

With the exception of 3 states, programs were created by enactment of enabling legislation. Programs in these 3 states are set up as a unit in the State Department of Health.

Included in these totals were 7 new programs in the process of being organized, several of which were operating on a limited scale. Programs in Wisconsin and Kansas had suspended operations as the legislatures had not appropriated funds.

One additional state-Iowa-continued to operate a study commission to review the problems on alcoholism and to recommend a course of action to the State Legislature.

Twenty-five of the 39 programs have been set up as integral units in state health or welfare departments, 14 have been set up as special commissions or independent agencies.

Of the 34 programs for which sources of funds have been established, 25 receive their support from the State General Fund; only 9 have been made dependent on the yield of special taxes of funds for their support.

And, as will be noted in the accompanying table, the scope of activities of these state health programs concerned with alcoholism has, in general, been made broad enough to encompass the fields of research and education, as well as treatment and rehabilitation.

In general, then, the trend has been toward the development of a broad based alcoholism program, operating within the existing public health framework and financed by appropriations from the general revenues of the state.

TABLE 1

Activities of State Programs Concerned with Alcoholism

State	Year Prog. Estab.	Name of Agency	ACTIVITIES OF AGENCY		
			Education	Treatment and rehabilitation	Research
		1. SPECIAL INDEPENDENT COMMISSIONS			
Alabama[a]	1957	Commission on Alcoholism	X	X	X
Arkansas[b]	1955	Commission on Alcoholism	-	X	X
Colorado	1949	Commission on Alcoholism	X	X	X
Connecticut	1945	Commission on Alcoholism	X	X	X
Georgia	1951	Commission on Alcoholism	X	X	X
Kansas[c]	1953	Commission on Alcoholism	-	-	-
Kentucky[d]	1956	Commission on Alcoholism	X	X	X
Michigan	1951	State Board of Alcoholism	X	X	X
New Mexico	1949	Commission on Alcoholism	X	X	-
North Dakota	1951	Commission on Alcoholism	X	X	-
Oregon	1943	Alcohol Education Committee	X	X	-
So. Carolina[e]	1957	State Alcohol Rehabilitation Center	X	X	X
Utah	1947	State Board on Alcoholism	X	X	X
Vermont	1951	Alcoholic Rehabilitation Commission	X	X	X

II. STATE PROGRAMS OPERATED AS INTEGRAL PART OF EXISTING HEALTH, MENTAL HEALTH, OR WELFARE AGENCIES

State	Year Prog. Estab.	Name of Agency	ACTIVITIES OF AGENCY		
			Education	Treatment and Rehabilitation	Research
California	1954	Div. of Alcoholic Rehabilitation, State Department of Public Health	X	X	X
Delaware*	1948	Alcoholic Rehabilitation Center, Governor Bacon Health Center	-	X	X
D. of C.	1947	Alcoholic Rehabilitation Div., D. of C. Department of Public Health	X	X	X
Florida	1953	Alcoholic Rehabilitation Program 1	X	X	X
Illinois[f]	1957	Division of Alcoholism, Department of Public Welfare	X	X	X
Indiana	1953	Section on Alcoholism, Division of Mental Health	X	X	-
Louisiana[g]	1956	Alcoholism Section, Mental Health Div., State Dept. of Hospitals	X	X	X
Maine	1953	Div. of Alcoholic Rehabilitation, Dept. of Health and Welfare	X	X	X
Maryland*	1951	Section on Alcohol Studies, State Department of Health	X	X	X
Massachusetts	1950	Div. of Alcoholism, State Dept. of Public Health	X	X	X
	1956	Office of the Commission on Alcoholism	X	X	X
Minnesota[h]	1953	State Department of Health	X	X	X
Montana*	1949	Narcotic and Alcohol Program, State Board of Health	X	X	X
New Hampshire	1947	Division of Alcoholism, Department of Health	X	X	X
New Jersey	1948	Bureau of Alcoholic Control, Div. of Chronic Illness Control, Dept. of Health	X	X	X
New York[i]	1951	Interdepartmental Health Resources Board	X	X	X
North Carolina	1949	Alcoholic Rehabilitation Program	X	X	X
Ohio[j]	1957	Research Program on Alcoholism	-	-	X
Pennsylvania	1953	Section of Alcoholic Studies and Rehabilitation, Department of Health	X	X	X
Rhode Island	1951	Division of Alcoholism, Department of Social Welfare	X	X	X
Tennessee	1955	Alcoholism Commission	X	X	X
Texas[k]	1954	Commission on Alcoholism	X	X	X
Virginia	1948	Division of Alcohol Studies and Rehabilitation, State Department of Health	X	X	X
Washington[l]	1957	Division of Alcoholism, State Department of Institutions	X	X	X
West Virginia[m]	1957	State Department of Mental Health	-	-	-
Wisconsin[n]	1947	Bureau of Alcohol Studies, Division of Mental Hygiene, Dept. of Public Welfare	-	-	-

III. STUDY COMMISSIONS

Iowa	1955	University of Iowa Alcoholism Studies	-	-	-

B. Public Funds Received by Alcoholism Agencies from State Governments for Operating Purposes, 1957, and Since Inception of Programs

Support of 30 reporting operating public medical care programs and one study group from public funds appropriated by state governments totalled $4,704,956 in 1957.

In 1957 funds made available to these operating programs ranged from $12,500 to $704,800.

Funds made available to 30 operating programs in 1956 ranged from $10,440 to $374,400 and totalled $3,808,100; in 1955 those made available to 30 operating programs came to $3,082,698 and ranged from $7,500 to $330,533.

In a few states some funds were received from the collection of fees from patients, grants or donations; and where the programs were integrated in existing health departments, additional money was available to support the activities of programs in those states.

TABLE II

PUBLIC FUNDS RECEIVED BY ALCOHOLIC AGENCIES FROM STATE GOVERNMENTS

State	Year in Which Program Established	1957 Appropriations Fiscal or Calendar	Other Income	Total Income Reported from Inception of Program through 1957	1958 Appropriations Fiscal or Calendar
Alabama	1945	NFA	none	$ 99,880	$ 150,000[1]
Arkansas	1955	NFA	C 3,500	8,500	15,000
California[2]	1954	$ 704,800	none	960,263	704,800
Colorado	1949	24,020	none	73,922	31,002
Connecticut	1945	395,769	B 1,875	2,901,598	440,502
Delaware[3]	1948	74,910	A 9,357	261,177	INA
D. of C	1947	73,072	1,449	744,823	72,065
Florida	1953	468,213	NA	2,604,563	588,016
Georgia	1951	234,935	AG 35,097	901,783	280,000
Illinois	1957	-	-	-	150,000
Indiana	1953	171,535	none	551,450	195,920
Iowa[4]	1955	15,000	-	15,000	14,000
Kansas[5]	1953	NFA	-	126,456	NFA
Kentucky	1956	NFA	-	none	none
Louisiana[6]	1948	35,000	-	480,000	25,000
Maine	1953	17,500	none	53,000	35,857
Maryland	1951	23,615	none	156,975	37,788
Massachusetts[7]	1950	208,845	none	776,785	348,870
Massachusetts[8]	1956	25,000	none	25,000	55,142
Michigan	1951	136,750	none	802,739	203,062
Minnesota[9]	1953	312,152	-	650,588	313,132
Montana	1949	INA	-	45,302	INA
New Hampshire	1947	81,563	D 315	504,126	80,271
New Jersey	1948	71,000	none	393,000	99,000
New Mexico	1949	182,171[10]	A 29,595	1,035,385	173,250
New York	1952	172,280	none	786,095	168,000
N. Carolina	1949	175,436	-	1,343,166	191,277
North Dakota	1951	12,500	-	90,000	17,500
Ohio	1957	NFA	none	none	INA
Oregon	1943	99,111	none	723,585	109,145
Pennsylvania	1953	250,000	none	1,124,426	250,000
Rhode Island	1951	75,149[11]	none	450,774	86,416

State	Year in Which Program Established	1957 Appropriations Fiscal or Calendar	Other Income	Total Income Reported from Inception of Program through 1957	1958 Appropriations Fiscal or Calendar
South Carolina	1957	NFA	none	none	$ 95,000
Tennessee	1955	$ 75,000	none	$ 225,000	100,000
Texas	1950	119,220[12]	-	189,330	119,330
Utah[13]	1947	25,000	-	275,000	INA
Vermont	1951	61,195	A1,957	224,502	57,328
Virginia	1948	259,105	A58,226	1,236,381	312,715
Washington	1957	125,000	-	125,000	125,000
West Virginia	1957	14	-	-	-
Wisconsin	1947	NFA	none	425,896	INA
Total 40 Programs		$4,704,956	$141,371	$21,406,470	$5,644,388

C. Allocation of Public Funds to Various Purposes by State Alcoholism Programs

Only 21 of the 35 operating programs supplied complete data on the portion of funds allocated for education, treatment, research or other purposes during 1957.

Reports from these 21 states show that the major portion of funds continues to be assigned to treatment purposes.

Of a total outlay of nearly $4,700,000, about 56 percent of available funds are being allocated to treatment and rehabilitation.

A little less than 13 percent of funds is being used for research activities; about 8 percent is going to educational activity; a bit over 17 percent for administrative purposes, and the balance to physical facilities, improvements, and unclassifiable types of overhead.

TABLE III

ALLOCATION OF PUBLIC FUNDS TO VARIOUS PURPOSES BY STATE ALCOHOLISM PROGRAMS

(As Reported by State Agencies)

Note: Unless otherwise indicated data are for fiscal or calendar 1957.

States	Total Public Funds Allocated Latest Year	Treatment	Education	Research	Administration	Other
Arkansas	$ 15,000*	-	-	$ 9,000	-	$ 6,000
California	704,800	$ 369,900	$ 1,500	240,000	$ 95,400	-
Connecticut	440,503	232,615	13,200	18,000	52,188	125,500*
D. of C.	67,697	32,969	8,462	2,843	23,425	-
Florida	588,016	396,384	27,709	-	46,750	117,173*
Georgia	319,674	269,382	-	4,100	46,192	-
Illinois	120,000	60,000	45,000	22,450	22,550	-
Maine	35,857	2,885	6,579	-	26,393	-
Maryland	37,788	-	4,000	10,300	15,688	7,800[1]
Michigan	156,230	51,550	34,793	35,361	34,526	-
Minnesota	312,152	300,000	12,152	-	-	-
New Hampshire	81,340	65,000	3,000	3,000	9,000	-
New Jersey	99,000	65,000	4,000	-	30,000	n.a.
New York	168,000	24,025	2,300	139,675	2,000	-
Oregon	218,289	109,826	76,671	-	31,792	-
Pennsylvania	500,000[3]	220,000	92,000	74,000	114,000	-
Rhode Island	108,405	21,906*	-	-	86,499	-
Tennessee	100,000	65,000*	25,000	10,000	-	-

States	Total Public Funds Allocated Latest Year	Treatment	Education	Research	Administration	Other
Texas	$ 269,330	$ 150,000	-	-	$ 119,330	-
Vermont	75,954	15,541	$ 5,896	-	30,535	$ 23,981*
Virginia	198,260	158,260	1,500	$ 21,500	13,500	3,500*
Total 21 reporting states	$4,646,295	$2,610,243	$ 363,762	$ 590,229	$ 798,768	$ 283,954
Percent of total allocated to each purpose		56.2	7.8	12.7	17.2	6.1

D. Types of Treatment Facilities Operated Or Supported by State Alcoholism Programs and Other Agencies.

Twenty-three state alcoholism programs reported operating or supporting 203 treatment facilities in 1957. Of these, 18 facilities provided "in-patient" care only, 64 facilities provided "out-patient" care only, and 20 facilities provided both "in" and "out-patient" care.

And, in 22 states, other treatment facilities provided by other state agencies totaled 75, almost all of which were for in-patient care exclusively.

TABLE IV

TYPES OF TREATMENT FACILITIES OPERATED OR SUPPORTED BY STATE ALCOHOLISM COMMISSIONS AND OTHER AGENCIES

States in which Alcoholism Programs Operate or Support Treatment Facilities	In-Patient Only	Out-Patient Only	In and Out Patient
California	-	8	-
Connecticut	2	5	-
Delaware	-	-	1
District of Columbia	1	-	1
Florida	1	4	-
Georgia	1	2	-
Indiana	1	1	-
Maine	-	5	-
Maryland	-	7	1
Massachusetts	-	-	10
Michigan	1	4	1
New Hampshire	-	1	1
New Jersey	-	7	-
New Mexico	2	-	-
New York	-	4	1
North Carolina	1	5	-
Oregon	2	1	-
Pennsylvania	1	5	2
Rhode Island	-	2	-
Tennessee	1	1	-
Vermont	2	2	2
Virginia	-	2	2
Utah	2	-	-
	18	64	20

States in Which Other Agencies Provide Treatment Facilities	NUMBER OF FACILITIES		
	In-Patient Only	Out-Patient Only	In and Out Patient
Arkansas	1	-	-
California	9	-	-
Colorado	1	1	-
Florida	1	-	-
Illinois	12	-	-
Indiana	7	-	-
Iowa	4	-	-
Louisiana	4	-	-
Maine	1	-	-
Maryland	1	-	-
Michigan	6	-	-
Minnesota	2	-	-
Montana	1	-	-
New Hampshire	1	-	-
New Jersey	1	-	-
North Carolina	1	-	-
North Dakota	1	-	-
Oregon	2	-	-
Rhode Island	1	-	-
Tennessee	1	-	-
Texas	6	-	-
Vermont	11	-	-
	75	1	0

Footnotes - Table I

a Alabama - Prior to 1957 activities of program established in 1945 were limited to educational activities.

b Arkansas - Limited activity - first appropriation 1958 - program in process of organization - has been functioning on donations.

c Kansas - Program not operating since 1956.

d Kentucky - Program in process or organization - no funds appropriated.

e South Carolina - First appropriation 1958 - program in process of organization.

f Illinois - Program in process or organization - limited activity.

g Louisiana - Commission established in 1954 transferred in 1956 to State Department of Health.

h Minnesota - State hospitals provide treatment.

i New York -Under Mental Health Commission until 1956.

j Ohio - No funds appropriated - program in process of organization.

k Texas - First appropriation September 1957 - works closely with State Hospital Board.

l Washington - First appropriation July 1957 - in process of organization.

m West Virginia - In process of organization.

n Wisconsin - No funds appropriated since 1955.

* No legislation - operated as unit of State Department of Health (Delaware, Maryland and Montana).

Footnotes - Table II

1 Alabama - October 1, 1957 through September 30, 1958.

2 California - Alcoholic Rehabilitant on Commission abolished September 11, 1957, and responsibilities of program assigned to Department of Public Health.

3 Delaware - Estimated.

4 Iowa - Study programs.

5 Kansas - State Board of Health in its general health and community mental health educational programs gives due consideration to this problem. State hospitals accept alcoholics for treatment.

6 Louisiana - Data not available on funds allocated for treatment by state hospitals.

7 Massachusetts - Department of Public Health

8 Massachusetts - Commissioner on Alcoholism.

9 Minnesota - State Hospital allocates estimated $300,000 for treatment; $12,152 to alcoholism program.

10 New Mexico - Actual.

11 Rhode Island - Spent.

12 Texas -No funds appropriated to Alcoholism Commission until September 1, 1957; prior to that State Hospitals allocated monies from their regular funds.

13 Utah - Estimated.

14 West Virginia - Treatment provided through regular services of state hospitals and clinics of Department of Mental Health.

A Fees collected.

B Grant.

C Donation

D Sale of literature.

E Hospital Board spends from their funds for care and treatment of alcoholics.

F Miscellaneous.

NFA - No Funds Allocated.

INA - Information Not Available.

Footnotes - Table III

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1 Casework counseling demonstration.

2 Appropriations have not been allocated in these categories.

3 June 1, 1957 to May 31, 1959.

4 Hospital Boards spends from their funds for care and treatment of alcoholics.

* Rhode Island - $21,906 covers treatment, education and research.

* Arkansas - $30,000 from July 1, 1957 to July 1, 1959.

* Connecticut - General Services $24,148; Food Service $34,579; Equipment $2,172; Care of Chronic Polic Court Drunkenness $64,601.

* Florida - For Buildings and Physical Improvements.

* Vermont - Miscellaneous and Overhead Expenses.

* Tennessee - $65,000 covers Treatment and Research; $10,000 in research column is additional research.

* Virginia - Capital outlay.

n.a. Not available.

CHAPTER V

A REHABILITATION PROGRAM

Solutions to Alleviation of the Alcoholic Problem.

Various states consider the problem of alcoholism with different programs. Because of environmental conditions, a program that may be feasible in one state will not necessarily apply in another. The amount of money appropriated to support an alcoholic program determines how far, and into what fields, it may extend.

Some basic and fundamental principles have emerged from the experience of other states. While it is true that sufficient financing is important, the method used in initiating and carrying out a program is of even greater importance. Unfortunately, a well-financed program of research, education, and hospitalization is not always successful.

A program which requires the cooperation of alcoholics, and provides for the fellowhip found in the organization known as Alcoholics Anonymous, has the best results. This unusual result pattern is proved by the high rate of success of the "AA"program, which is a plan providing for close association with individuals receiving rehabilitation treatment.

In considering the overall program of the alcoholic problem, four general areas can be set forth. Thesefour do not include administrative considerations which are attendant upon any program which might include any or all of the following:

(1) The nature of the rehabilitation treatment for the alcoholic. This is the most tangible part of the program and usually a basic part of any initiated program.

(2) Dissemination of information as part of the educational curriculum in secondary schools, to the general public, and to alcoholics. This aspect of the program is aimed at relieving the stigma attached to alcoholics and affords an opportunity to bring more cases to light.

(3) Facilities for basic research in the field of alcohlism. This part of the program is generally restricted to states with adequate financing and proper facilities.

(4) Measures for the prevention of alcohlism. Unfortunately, the field of prevention has received little consideration. In any other illness this would be a primary consideration.

The expenditures in these areas are shown in section (C) of Chapter 4 by the several states, which reported the breakdown of their programs into these categories. Education, in a broad sense, is a preventive action and could cover part of a prevention program. Other than this aspect, there is no indication of a broad program of prevention in the several states. A full prevention program would be directed at proper education, restricted outdoor advertising, and possibly some radio and television controls for the liquor industry. New Hampshire, North Carolina, Oregon and the Federal Government have either passed or considered such legislation.

The neighboring state of Utah has a program for alcoholics which has received national attention in the past few years. Since Utah's environment is similar to Nevada, and the rate of rehabilitation success has been outstanding, an examination of the Utah plan is desirable.

The rehabilitation program employed by Utah forms much of the foundation for the suggested provisions which are presented in Chapter VI. Specific recommendations concerning membership of the advisory board on alcoholism, administration of the division of alcoholism, and selection of a director, are original suggestions of the Legislative Counsel Bureau.

The Rehabilitation Program in Utah.

The State of Utah, in an attempt to solve the problem of alcoholism, established the Utah State Board of Alcoholism in 1947. The Utah plan is recognized as one of the most successful programs, although it has been in operation for only 10 years. The Utah School of Alcoholic Studies is part of this program. The only other school of this kind in the United States is at Yale University.

This report does not suggest the adoption of all facets of the Utah program. The report does recommend those portions of the Utah plan which relate to rehabilitation and which could be readily adapted to Nevada in the initial stages. Other phases of the Utah program could be added as the rehabilitation program became well established in Nevada.

It should be emphasized that the rehabilitation phase of the program is not expensive and does not require special medical facilities and trained medical personnel. The fellowship of Alcoholics Anonymous can readily administer its rehabilitation therapy in the environment created in the rehabilitation centers.

The following description of the rehabilitation phase of the Utah plan is copied from the Fifth Biennial Report of the Utah State Board on Alcoholism, 1954-1956 and in an address given by the Director, Mr. Clyde Gooderham.

The Board's rehabilitation activities during the Fifth Biennium are briefly described as follows:

1. Maintained a statewide information center at 221 David Keith Building, Salt Lake City, which handled numerous inquires, personal interviews and referrals to Alcoholics Anonymous, rehabilitation centers, hospitals, medical doctors and therapists.

2. Provided assistance in the form of training, literature and guide manuals to information centers elsewhere in the State.

3. Assisted in the development of new facilities for the House of Hope for women alcoholics at Salt Lake City.

4. Assisted in the procurement of supplies and equipment such as beds, springs, mattresses, floor coverings, furniture, etc. from organizations and institutions to supply the needs of the centers.

5. Served as recipient agent for procurement of government surplus foods such as, cheese, butter, dried milk, and other items for the centers. This service included determining the needs of the centers, processing procurement orders, receiving, storing, distributing and maintaining accountability of the food items. Handling and storage costs of the food program were paid by the Board.

6. Encouraged civic organizations and churches to sponsor projects for special needs such as remodeling and other improvements at the centers.

7. Provided literature, books, films and other such items used by the centers in rehabilitation education.

8. Assisted with emergency needs of the centers procuring such items with Board funds.

9. Assisted with commitment of alcoholics to the State Hospital and Veteran's Hospitals.

10. Provided monthly financial assistance to the centers through approved legal contractual arrangement. The amount of assistance paid to the centers was July 1, 1954 to June 30, 1955, $5,045.00, July 1, 1955 to June 30, 1956, $4,980.00.

11. Assisted in developing and carrying out a full scale rehabilitation program for alcoholic inmates of the Utah State Prison. Continuing assistance has provided this program in the form of lectures, literature, films, therapeutic services, referrals and program coordination.

Utah's Three Rehabilitation Centers For Alcoholics.

Utah has three rehabilitation centers; The Alcoholic Rehabilitation Center at Salt Lake City, for men, The House of Hope, Salt Lake City, for women, and The Ogden Rehabilitation Center, Ogden, for men. The centers not only fill a definite need in the communities in which they are located, but also serve the state as a whole. The centers are not operated as hospitals or clinics, as they are only equipped to handle people whose main difficulty through alcoholism is need of rest, food and some attention while getting over the shakes. The sick alcoholic having no place to go, no money for food or lodging, but who sincerely wants to stop drinking, finds full acceptance at these centers. Acute cases, or those in critical condition, sent to the centers are referred to hospitals, if need be, otherwise a physician is called in or consulted. When physical health is regained, work and dress clothing are provided if needed. When progress indicates, counsel and help are given toward obtaining employment. As soon as employment is procured individuals are expected to pay the established fee of $14.00 per week for the full period of their stay at the center. Length of stay varies from one week to three months, depending upon individual attitude and progress.

Although not required to join Alcoholics Anonymous, all individuals entering and remaining at the centers are exposed to this therapy. A. A. meetings are held two to three times weekly at each of the centers.

A record is kept of each resident but finances do not warrant sufficient help to maintain extensive follow-up. Individuals experiencing trouble with alcohol after leaving the centers are permitted to return a second time, and in some instances a third admittance is allowed. Only on rare occasions are individuals permitted to re-enter more than a third time. Experience indicates that individuals not capable of maintaining sobriety after a thrid admittance, are in need of additional help or therapy which is beyond the scope and means of these facilities. Referral is made to the psychiatric division of the County Hospital or the State Hospital.

Each center operates as an individual, non-profit corporation and has its own board of trustees who hire management and maintain the policies of the center. Financial assistance for the centers is given partly by the Utah State Board on Alcoholism, by way of assistance contract. The men's center at Salt Lake receives $150.00 per month. The men's center at Ogden $125.00 and the House of Hope for women at Salt Lake, $140.00 per month. The Board's assistance contract is on a cooperative basis with the cities and counties in which they are located. For example, Salt Lake City lends $150.00 per month assistance to the men's center and $100.00 per month to the women's House of Hope. Salt Lake County also provides $150.00 for the men's center and $100.00 for the women's house. The Welfare Department assists in all cases that are declared medical.

The Utah Alcoholism Foundation, Utah State Board on Alcoholism, L.D.S. Church, Catholic Charieties and other organizations assist with food, clothing and finances.

TABLE XII

ALCOHOLIC REHABILITATION CENTERS

Report for Fiscal Years 1955-1956

Center	Number Admissions	Number Needing Medical Service	Sober 6 Months or longer	Drinking After 60 Days	Sobriety Not Known
Alcoholic Rehab. Center Salt Lake (Men)	597	209	245	135	217
Alcoholic Rehab. Center Ogden (Men)	243	97	120	20	93
Total Men	840	306	365	155	310
House of Hope Salt Lake (Women)	191	103	87	48	56
Total Men & Women	1031	409	452	203	366

The close cooperation of the Alcoholics Anonymous fellowship and the Utah Alcoholism Foundation with the Utah State Board on Alcoholism, suggests that an explanation of their personnel and function be set forth in this report.

THE UTAH ALCOHOLISM FOUNDATION

The Utah Alcoholism Foundation was originally organized as the Utah Committee on Alcoholism and came into being in 1946. The organization has grown until it is now statewide. In most counties or districts of the State, membership has been formed into District Chapters in order to deal more effectively with the problems of alcoholism within the area. Membership of the organization consists of individuals from every county and most communities throughout the State, with a broad representation of agencies, organizations and institutions. The objectives of the Foundation are: 1. To promote training and education on alcoholism; 2. To increase public understanding of alcoholism; 3. To promote help and understanding of the alcoholic; and 4. To work for the accomplishment of treatment facilities for alcoholics. The Foundation has no paid officers or workers. Its projects and programs are carried out through the efforts of its members. Financial needs of the projects and programs developed have been met through unsolicited contributions and membership dues.

The organization has consistently worked toward fulfillment of its objectives and has sought to coordinate the efforts of social, law enforcement, and medical groups, having various interests in the total problem. The foundation has rendered a continuous and valuable service to the State through its cooperation with the Board and other programs developed and carried out.

THE SOCIETY OF ALCOHOLICS ANONYMOUS

WHAT IS ALCOHOLICS ANONYMOUS? "Alcoholics Anonymous is a fellowship of men and women who share their experience, strength and hope with each other that they may solve their common problem and help others to recover from alcoholism.

"The only requirement for membership is an honest desire to stop drinking. A.A. has no dues or fees. It is not allied with any sect, denomination, politics, organization or institution; does not wish to engage in any controversy, neither endorses nor opposes any causes. Our primary purpose is to stay sober and help other alcoholics to achieve sobriety."

HISTORY AND PROGRESS OF ALCOHOLICS ANONYMOUS.

The society of Alcoholics Anonymous had its birth in June of 1935 when two men, one a New York stock broker, and the other a physician of Akron, Ohio, both victims of alcoholism met at Akron. The former had managed to stay sober for several months prior to this through the application of certain basic spiritual principles.

From this time on, both of these men remained sober. The society of Alcoholics Anonymous was born and a new ray of hope appeared on the horizon for alcoholics everywhere. By 1939 the membership in A.A. had grown to about 100 men and women and by the end of 1939 it was estimated that about 800 alcoholics were on the way to recovery. At the end of 1941, A.A. had become a national institution with an estimated membership of 8,000.

Today there are some 5,000 groups in the United States with a membership of approximately 150,000. Groups may be found in every state and some 50 foreign countries and United States' possessions. Besides these there are over 200 hospital groups and 290 prison groups in the United States.

The first edition of the book, "Alcoholics Anonymous," was published in 1939. By 1955, over 300,000 copies had been sold. A revised edition was published in 1955. Other A.A. publications include a 190-page book, "Twelve Steps and Twelve Traditions," and a variety of some 15 pamphlets as well as a monthly magazine, "the A.A. Grapevine," a monthly "A.A. Exchange Bulletin," and a World Directory. A number of these pamphlets are published in several languages.

The General Service Headquarters located in New York City offers special services to hospital, prison and foreign groups in addition to the general services offered to all other A.A. groups and lone members.

In 1951, the Lasker Award was given Alcoholics Anonymous. The citation reads in part as follows: "The American Public Health Association presents a Lasker Group Award for 1951 to Alcoholics Anonymous in recognition of its unique and highly successful approach to that age-old public health and social problem, alcoholism...In emphasizing alcoholism as an illness, the social stigma associated with this condition is being blotted out...Historians may one day recognize Alcoholics Anonymous to have been a great venture in social pioneering which forged a new instrument for social action;a new therapy based on the kinship of common suffering;one having a vast potential for the myriad other ills of mankind "

In addition to the regular Alcoholics Anonymous groups there are some 700 active Al-Anon Family Groups. "The Al-Anon Family Groups are a fellowship of the wives, husbands, relatives and friends of members of Alcoholics Anonymous and of problem drinkers generally, who are banded together to solve their common problems of fear, insecurity, lack of understanding of the alcoholic, and of the warped personal lives resulting from alcoholism. The primary purpose of the Al-Anon Family Groups is to carry their helpful experience in gaining greater happiness to the non-alcoholic who seeks personal understanding of the problem of alcoholism and how to cope with its consequences.

The message of the Al-Anon Family Groups is a simple story of hope. It is the story of men and women who once felt hopelessly alone and powerless to deal with the alcoholism of their loved ones. Today these men and women no longer feel lost or lonely. They have learned that there are simple things that they can do to help themselves and their alcoholic partners.

Many who are now in Family Groups have already seen their loved ones achieve sobriety through A.A.; they know that life with a sober alcoholic can present special problems, too. Others still have active problem drinkers in their homes. All members share the friendly bond of men and women who have turned from defeat and frustration to a new way of life in which positive, constructive thinking is the keynote."

---THE AL-ANON FAMILY GROUPS

STRUCTURE OF ALCOHOLICS ANONYMOUS.

A.A. is not an organization in the usual sense of the word. There are no membership fees or dues, no membership cards are issued, no one is asked to make any promises or to sign any pledges. In fact it is actually impossible to join A.A.

Anyone who has a sincere desire to attain and maintain sobriety is as much a part of this fellowship as one who has been sober and associated with A.A. for many years. There is no rank or seniority in A.A. A.A. has no officers or executives. It has no "government." The absence of authority as well as the absence of rules and regulations is one of the unique features of A.A.

At the national and international level a General Service Board functions as the custodian of A.A. traditions and over-all services and assumes responsibility for the integrity and service standards of A.A.'s General Service Headquarters in New York. This board functions as a clearing house for all groups, produces and distributes literature and periodic publications and offers guidance and information to the general public as well as to the ever-increasing number of groups and individuals throughout the world.

The General Service Headquarters with all its functions is financed by voluntary contributions from local groups and individuals. Each local group functions independently as stated in one of the A.A. Traditions: "For our group purpose, there is but one ultimate authority, a loving God as He may express Himself in our group conscience. Our leaders are but trusted servants. They do not govern."

The A.A. Traditions are not binding on any group. They are suggestions, not rules. The Twelve Traditions are offered as helpful guards to sound public relations for local groups. They suggest clearly how a group may relate itself to a community, cooperating but never affiliating with other agencies or organizations.

Each group chooses its own leaders. These generally consist of a chairman, a secretary and a treasurer. A.A. groups generally meet once each week. As a group grows, it is often divided into squads who generally meet in the same place on alternate nights.

Membership in A.A. is in no way contingent upon financial support. The inability to contribute does not in any way bar anyone from A.A. Most groups have a "kitty" or pass a hat at meetings to defray the cost of the functions of the group. Each group is entirely self-supporting. No outside contributions are accepted.

THE TWELVE TRADITIONS.

1. Our common welfare should come first; personal recovery depends upon A.A. unity.

2. For our group purpose there is but one ultimate authority...a loving God as He may express Himself in our group conscience. Our leaders are but trusted servants...they do not govern.

3. The only requirement for AA membership is a desire to stop drinking.

4. Each group should be autonomous except in matters affecting other groups or AA as a whole.

5. Each group has but one primary purpose...to carry its message to the alcoholic who still suffers.

6. An AA group ought never endorse, finance or lend the AA name to any related facility or outside enterprise, lest problems of money, property and prestige divert us from our primary purpose.

7. Every AA group ought to be fully self-supporting, declining outside contributions.

8. Alcoholics Anonymous should remain forever non-professional, but our service centers may employ special workers.

9. AA, as such, ought never be organized; but we may create service boards or committees directly responsible to those they serve.

10. Alcoholics Anonymous has no opinion on outside issues, hence the AA name ought never be drawn into public controversy.

11. Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio and films.

12. Anonymity is the spiritual foundation of all our Traditions, ever reminding us to place principles before personalities.

PHILOSOPHY OF ALCOHOLICS ANONYMOUS.

Those who are associated with AA are men and women who recognize and have accepted the fact that they are alcoholics and that they can never drink again. They also realize that they are never more than one drink away from another drunk and that because of their emotional sensitivity they must ever be on guard; eternal vigilance is the price they must pay for continued sobriety.

In order to maintain sobriety it is necessary to maintain a certain degree of serenity, happiness and peace of mind. This is possible only through the fellowship and companionship of others who have suffered in the same way, are fighting the same battle and who understand one another and applying the principles of AA in their everyday living. AA is a way of life. The AA program of recovery is contained in twelve suggested steps for daily living.

THE TWELVE STEPS.

1. We admitted we were powerless over alcohol...that our lives had become unmanageable.

2. Came to believe that a Power greater than ourselves could restore us to sanity.

3. Made a decision to turn our will and our lives over to the care of God as we understood Him.

4. Made a searching and fearless moral inventory of ourselves.

5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.

6. Were entirely ready to have God remove all these defects of character.

7. Humbly asked Him to remove our shortcomings.

8. Made a list of all persons we had harmed and became willing to make amends to them all.

9. Made direct amends to such people wherever possible, except when to do so would injure them or others.

10. Continued to take personal inventory and when we were wrong promptly admitted it.

11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.

12. Having had a spititual awakening as the result of these Steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

THE IMPORTANCE OF AA FOR CONTINUED SOBRIETY.

AA works only for those who want help and who are sincere in their application and practice of the AA principles. AA does not make anyone stop drinking nor does AA make it impossible for anyone to drink or make it possible to become a social drinker.

To those who sincerely apply the principles of the AA program of recovery, life takes on a new perspective, they develop new motivations, new objectives, and find a new outlet for their emotions. As a result, the necessity to drink is removed and it becomes possible to face reality and to cope with the problems and conflicts of life without alcohol.

ALCOHOLICS ANONYMOUS AND RELIGION.

Alcoholics Anonymous is not a religious society. It has no doctrine or creed and is not allied with any religious organization, sect, or denomination.

The AA program of recovery is basically spiritual, based on the acceptance of certain spiritual valaes. These, however, do not conflict with any religious faiths or beliefs and are accepted and approved by most religious leaders. Within the ranks of AA may be found men and women from every walk of life and every religious denomination.

ALCOHOLICS ANONYMOUS AND TREATMENT.

Many people have questioned the need of AA where the individual has been exposed to some type of formal treatment. Others question the need of any type of treatment as long as AA is available.

No treatment program is a substitute for AA. With few exceptions, people who are engaged in the treatment of alcoholics, professional or otherwise, recognize the value and the need of AA for continued sobriety. It is a recognized fact that it is a small percentage of alcoholics, no matter what type of treatment they may have been exposed to, who maintain continued sobriety unless they become actively associated with an AA group.

At the same time, we must also recognize that many alcoholics are in need of some preliminary treatment prior to coming into AA. This may be only a short period of hospitalization for physical recovery or it may require a longer period of institutional care where the individual can receive help in making a thorough self-analysis and in making the necessary adjustments. Without the help of AA treatment would be of little value.

The many activities and achievements of Alcoholics Anonymous account for the important position it holds in Utah's program of rehabilitation. It would not be possible to fully describe all of the activities or fully evaluate the great contribution of service Alcoholics Anonymous is rendering to the State.

Alcoholics Anonymous has experienced a continual growth in Utah since its beginning in 1945 and now has active groups in most communities throughout the State. Ten new groups have been added since 1954 bringing the total number of groups in Utah to 61. Survey made of the groups throughout the State indicates an active estimated membership of 2,300 members. It is also estimated that there are more than 500 inactive members who after two or three years attendance at A.A. meetings, have returned to normal living and are remaining sober. The total of the two estimates indicates that more than 2,800 men and women have been rehabilitated through this program.

In addition to serving the sick alcoholic, A.A. has also cooperated with the Utah State Board on Alcoholism, The Utah Alcoholism Foundation and many other organizations and institutions in programs of prevention and rehabilitation. The Fellowship provides speakers for humdreds of meetings in churches, civic clubs and also accepts numerous assignments for lectures in secondary schools and schools of higher education. In addition to these activities, A.A. groups throughout the State have held hundreds of open public meetings which have contributed much to the over-all educational program being carried on. In addition to regular group meetings, meetings are also conducted by the Fellowship in the Rehabilitation Centers, State Hospital, Veteran's Hospitals, the Utah State Prison, and may other similar institutions throughout the State. The Board is indeed most grateful to Alcoholics Anonymous for the wonderful cooperation it has always given to its program. The citizens of Utah are indebted to this Fellowship for the human lives, families and monies it has saved through the humble service it is rendering.

In short, the rehabilitation aspect of the Utah plan emphasizes the establishment of private centers which are partially supported by the Utah State Board on Alcoholism. These centers provide the alcoholic with clean dormitory and kitchen facilities, where he can escape from the former environment which is associated with his drinking. The centers act as direct contact establishments where Alcoholics Anonymous can work to best advantage and arrest alcoholism at the most opportune time. Severe cases receive medical attention in close cooperation with medical practices. There is no attempt to provide "hospital facilities" at the centers.

CHAPTER VI

SUGGESTED PROVISIONS FOR LEGISLATION IN NEVADA

It is the conclusion of this Bureau, after examination of the programs at other state levels, that portions of the present program in effect in Utah meets the requirements of Nevada's alcoholic problem for the following reasons:

(a) The Utah rehabilitation program has accomplished results which indicates the methods employed are highly successful.

(b) With a large part of the program self-supporting, the cost of operating the program is relatively low.

(c) The Utah rehabilitation program is well adapted to Nevada's geographic conditions, where a very few centers would service a high percentage of the population.

(d) Alcoholics Anonymous has an excellent opportunity for direct contacts with alcoholics under the Utah program.

SPECIFIC PROVISIONS WHICH SHOULD BE CONSIDERED AS A BASIS FOR AN ALCOHOLIC PROGRAM AND LEGISLATION FOR THE STATE OF NEVADA

1. A division of alcoholism would be established within the framework of the Department of Health.

   Comment: To place the alcoholic problem in the Department of Health follows the modern concept that alcoholism is an illness or sickness. This is in contrast to its former treatment as a law enforcement problem alone.

   Comment: The establishment of a separate division within the Department of Health is recommended because of the unique problem of alcoholism.

2. The alcoholic division established in the Department of Health would have a separate advisory board. This board might be called the Advisory Board on Alcoholism. The board would be appointed by the Governor and serve at the pleasure of the Governor.

   Comment: It is interesting to note the remarks of Mr. Austin F. MacDonald, eminent authority in the field of public administration, relative to the functions of boards in State Government. In his recent volume, "American State Government and Administration," Fourth Edition, Thomas Y. Crowell Company, New York,(1950), Mr. MacDonald remarks as follows:

Whenever a state undertakes a new function, it must decide whether the task of administering that function would be entrusted to a single individual or to a group of individuals who exercise authority jointly. The singleheaded department or bureau has certain obvious advantages. To put control in the hands of one person is usually to get action. Moreover, responsibility is more easily fixed. If the work of a singleheaded department is improperly done, everyone knows where to place the blame. There is no possibility of evasion. And, conversely, the credit for good work can readily be fixed and rewarded.

When a board or commission assumes control, however, everything is changed. Responsibility is no longer centered in one person, but is diffused among five, six, or a dozen--as many persons as the commission has members. It is impossible to determine who is to blame for maladministration.

Another good reason for preferring individuals to boards is that the singleheaded department plan is more likely to lead to the performance of administrative duties by technical experts. Even though a board is composed of laymen who admittedly have no understanding or appreciation of the problems involved and must therefore hire a trained administrator to carry on the day-to-day routine, there is seldom a disposition to give the administrator a free hand in the performance of the work for which he has been employed. Members of the board, forgetful or careless of their ignorance, are likely to interfere with every detail. They may, and often do, insist upon examining the persons whom the administrator has selected as subordinates--or worse still, appointing their friends and followers to the important positions. This is not just a theoretical danger; long and bitter experience has shown that it is a common trend in the field of American public administration. ***

Although reference is made to boards and commissions versus singleheaded departments, it must not be assumed that these separate types of administrative organization are mutually exclusive. It is not at all necessary, or even desirable, for a State to depend entirely on individual department heads or to put its trust completely in boards and commissions. Concerning any one function of government, a choice between an individual and a board or commission may be necessary; but when the manifold activities of State government are considered, it may seem best to entrust some of them to boards and commissions and others to departments presided over by individuals.

In every instance the test lies in the nature of the agency's work. Its task may be quasi-legislative--that is, resembling the work of the legislature. In other words, it may find itself concerned chiefly with the determination of policies, in the form of rules and regulations that do not differ greatly from the statutes enacted by the legislature at every session. Therefore, it should be organized for deliberation rather than for action; its work should be entrusted to several persons instead of to one.

Another agency of the State government may perform quasi-judicial functions--functions that resemble those of a court. It may sit as a court, hear witnesses, take testimony, and render decisions. A workmen's compensation board of a public utility commission answers this description perfectly. True, the findings of such a board or commission are subject to review by the courts, but this fact does not alter the judicial character of its work. The decisions of courts of first instance are also subject to review. Now, an administrative agency that is performing quasi-judicial functions also lends itself readily to the commission type of organization; impartial justice can best be secured by the meeting of trained minds. That the majority of State agencies are not concerned chiefly with the performance of quasi-legislative or quasi-judicial duties. Their most important task--often their only task--is to execute the policies that they receive readymade. Obviously they should not be hampered by the needless discussions and delays that characterizes board administration. Action is their primary need, and they should be organized to produce results promptly. That is simply a way of saying that individuals, rather than boards or commission, should be placed in control.

Few States have made any serious attempt to apply the general principle that a board or commission should be used for deliberation and a singleheaded department for action. Usually they have accepted a very different premise: "When in doubt, establish a board or commission." The result has been a veritable epidemic of multiple-headed agencies--an epidemic that is spread from coast to coast and has not yet been brought under control by the advocates of sound administrative organization. The disease has assumed a more malignant form in some States than in others, of course, but nearly every State has placed under board control some activity that could be better administered by the singleheaded department.

Strangely enough, however, there are relatively few instances of departments with individual heads administering functions that ought properly to be assigned to boards or commissions. The States have pinned their faith to the board idea. Time after time that faith has been rudely shaken. Government has stood still while some board deliberated, or merely waited for a quorum; it has suffered from the mistakes of board members who did not understand their role as amateurs. But always the faith in boards has risen triumphant above the lessons of experience. For the people of the United States, despite their oft-repeated boast that they have practical men and women, find it extremely difficult to change their theories of government. * * *

3. The advisory board would consist of (7) members and the membership would be specifically designed to represent areas effected by alcoholism.

4. The composition of the membership of the advisory board would be as follows:

(a) One member to be a doctor of medicine who has been licensed and who has been engaged in the practice of medicine in the state for not less than (2) years immediately prior to his appointment. At the time of his appointment he would also be a member of the staff of a hospital in the state which is accredited by the Joint Commission on Accreditation of Hospitals.

(b) One member to be a psychiatrist who has been licensed and who has been engaged in such practice in the state for not less than (2) years immediately prior to his appointment. At the time of his appointment he would also be a member of the staff of a hospital in the state which is accredited by the Joint Commission on Accreditation of Hospitals. He would also have had training and experience which would qualify him to take the examination of the American Board of Psychiatry and Neurology.

These two medical appointments to be taken from lists submitted to the Governor by the Nevada State Medical Association. There would be a minimum of three names submitted for each of the two medical positions on the advisory board.

Comment: It is suggested that the medical appointees be doctors who are familiar with the problem at the hospital level and familiar with hospital methods of alcoholic treatment.

Comment: A prior experience of (2) rather than (5) years has been suggested. Although (5) years is employed in the other membership provisions, it is felt this would be too restrictive with medical men for the following reasons. There are currently only five accredited hospitals in the entire state. With the provision that a doctor must have had five years experience in Nevada, the restriction would eliminate specialists who might render very necessary assistance to the advisory board.

(c) One member would be from the fellowship of Alcoholics Anonymous. This member would be selected from a list of three submitted to the Governor by the General Service Representatives of the Nevada Alcoholics Anonymous fellowship.

Comment: Since the Alcoholics Anonymous fellowship will be carrying the burden of a large share of the rehabilitation program, it is suggested that they be represented on the advisory board.

(d) One member would be a professional welfare worker who has been engaged in welfare work in the state for not less than (5) years immediately prior to his

appointment. At the times of his appointment he would also be a member of the staff of a state or county welfare department. This member would be selected from a list of three submitted to the Governor by the State Welfare Board.

(e) One member would be a law enforcement officer who has been engaged in law enforcement work in this state for not less than (5) years immediately prior to his appointment. At the time of his appointment he would also be a member of a state, county, or municipal law enforcement agency in the state. This member would be selected from a list of three submitted to the Governor by the Nevada Peace Officers Association.

Comment: Since law enforcement and welfare departments are concerned indirectly with the problem of alcoholism and its results, representatives of these two groups are recommended for membership on the advisory board.

(f) One member would be a full-time personnel director employed by a private company in this state and who has been engaged in that capacity for not less than (5) years immediately prior to his appointment. At the time of his appointment he would also be a personnel director for a company which employs a minimum of (500) employees in the state.

Comment: It is suggested that industry have representation on the advisory board since the alcoholic problem directly effects the efficiency of their employees. Selection from a company employing a minimum of (500) would direct the appointment to be made from the state's largest employers. This figure has been supplied by the Employment Security Department as representing the first twelve to fifteen largest employers.

(g) One member would be a professional educator who has been engaged in educational administration or instruction in this state for not less than (5) years immediately prior to his appointment. This member would have a minimum of a Master's Degree and be a member of the staff of the University of Nevada, or a county school system of this state, at the time of his appointment.

Comment: It is suggested that education be represented on the advisory board since the scope of the alcoholic program is directed ultimately toward preventive methods. These are introduced through proper education at the seconday and college level of instruction.

5. Member of the advisory board would serve without salary or compensation except reimbersement as provided by law, for travel and per diem, while performing official duties.

The advisory board would hold meetings at such times and places as they deem necessary, but not less than four times a year.

At the first meeting subsequent to the appointment of any new member, the board would elect one of its members as chairman. The board would prescribe rules and regulations for its own management and government, and it would have only such powers and duties as authorized by law. Four members of the board would constitute a quorum, and such quorum would exercise all the power and authority conferred on the board.

6. A director for the Division of Alcoholism would be appointed by the State Health Officer. The director would be in the classified service of the State Department of Personnel and would be required to pass a written qualifying examination. A specific qualification for the director would be his active membership in the fellowship of Alcoholics Anonymous as a recovered alcoholic.

Comment: The recommendation that the director be a member of Alcoholics Anonymous follows the success such membership has shown in the development of other state programs. Such a qualification is necessary for the most efficient co-operation of Alcoholics Anonymous in the key area of rehabilitation.

7. The Division of Alcoholism would be authorized to function in the following areas, and offer the following assistance:

(a) To make recommendations to the Department of Health, Governor and the Legislature.

(b) To promote or operate programs for rehabilitation and care of alcoholics. To cooperate with and assist associations and committees directly associated with either Alcoholics Anonymous or the National Council on Alcoholism, Incorporated, by providing them with essential materials for furthering programs of prevention and rehabilitation of alcoholics. To enter into contracts with these groups for the partial underwriting of the expenses of operating rehabilitation centers.

Comment: An important function of the division is to assist groups already established, with the financing of their rehabilitation programs and centers. This method removes the state from the necessity of establishing costly facilities, equipment and personnel.

(c) To assist in the procurement of supplies and equipment and to act as recipient agent for procurement of government surplus from the State Department of Purchasing, for centers established by these recognized groups.

Comment: Alcoholics Anonymous cannot accept donations as an organization. However, an incorporated organization composed of members of the fellowship may receive assistance and an underwriting of part of their rehabilitation center expenses.

(d) To concern itself with and promote, through established private centers, a system which will result in the employment of arrested alcoholic cases.

Comment: This follow-up is of extreme significance. There is little value in providing centers for rehabilitation if the alcoholic must eventually face the monumental problem of securing employment on his own. This service should be provided by the rehabilitation center.

Comment: The private centers would have a paid supervisor from the fellowship of Alcoholics Anonymous. Other employees would include a night man and a cook. Salaries would be kept at a minimum and consideration given to room and board where applicable. The supervisor would act as a liasion officer with the Nevada State Employment Service in the interests of maintaining close contact for the placement of arrested cases of alcoholism. The ordinary employment facilities available to the alcoholics are not equipped to provide the extra measure of assistance necessary to place an alcoholic. Each alcoholic is an individual case and the efforts necessary to educate the public on the value of an arrested case, as an employee, are difficult.

(e) To cooperate with and assist political subdivisions of the state, educational institutions, religious organizations, and other organized groups working with problems associated with alcoholism.

(f) To promote or conduct educational training, and preventive programs on alcoholism, and conduct research necessary to the further development of the alcoholic program in the state.

Comment: Basic research on the problem of alcoholism is not intended to be a part of a program for Nevada. However, certain statistics, particularly in the area of "Follow-up" information on cases, may have a distinct value to the further development of a program.

(g) To promote or establish cooperative relations with courts, hospitals and clinics, medical and social agencies, public health authorities, law enforcement agencies, education and research organizations, and other related groups; to promote the establishment and operation of public clinics and other public alcoholism facilities in local communities of the state; to provide consultation and other assistance to public and private agencies and groups; and to contract for the services of individuals and public and private agencies.

Comment: Although many of the authorizations given in this section indicate a very broad program, they are suggested as a part of initial legislation so that the alcoholic program may not be restricted in any aspect the Division might deem wise to develop. Should specific authority be lacking in the legislation, expansion of the program might rest upon broad and indefinite authorizations which could be questioned. It is not intended that the program be immediately developed to the extent authorized by these provisions.

8. The Division of Alcoholism would establish and assess fees for rehabilitation services and would have the power to accept in the name of and in behalf of the state, donations, gifts, devices or bequests of real or personal property or of services. Such fees, donations, gifts, devices or bequests would be used by the Division in the performance of its powers and duties. Any money so obtained would be deposited with the State Treasurer and placed to the credit of the Division of Alcoholism. Any unexpended monies so obtained would not revert to the general fund at the close of the biennium.

Comment: It is anticipated that much assistance will be forthcoming from church groups, and interested persons. In Utah, a major part of the food and clothing for the centers is contributed directly by churches. Also, a large percentage of the patients who are residents of, or who have been residents of, the rehabilitation centers, make payments toward their board and room.

Comment: Municipal and county governments contribute financial support to the rehabilitation centers in Utah. This support could eventually become a part of a Nevada rehabilitation program initiated at the state level.

9. The Division of Alcoholism would establish agreements with hospitals and doctors of the state for the temporary treatment of severe alcoholic cases prior to the acceptance of cases by rehabilitation centers.

Comment: There are a few cases of alcoholism which will require medical attention prior to the treatment available at a rehabilitation center. This number usually runs between 1% and 5% of the cases.

10. An appropriation would be made by the legislature to carry out the rehabilitation program suggested and to initiate action in other areas which may be possible. Primary consideration should be given to the salary for a director, office space, travel and operating expenses, and the funds necessary for the partial underwriting of rehabilitation centers. A center in Las Vegas and one in Reno should be a minimum consideration for rehabilitation work.

Such an appropriation to operate the alcoholic program suggested for Nevada should be large enough to cover the following anticipated costs for the year.

The following amounts, brokendown by budget category, are suggested for an annual appropriation:

Salaries		
Division Director	$ 5,110.00	
Senior Clerk Stenographer	3,792.00	$ 8,902.00
Travel		
Travel for Division Director.	1,000.00	
Travel for Advisory Board.	1,000.00	2,000.00
Operating		
Rent at $100 per month	1,200.00	
Utilities, heat, janitoral services	720.00	
Freight and Express	50.00	
Postage	100.00	
Printing	100.00	
Telephone and Telegraph	282.00	
Industrial Insurance	36.00	
Retirement	295.00	
Personnel Administration Assessment	63.00	
Repairs.	10.00	
Office Supplies	300.00	
Equipment		3,156.00
Manual typewriter	235.00	
Executive desk	150.00	
Typewriter-well desk	175.00	
Executive chair	95.00	
Typist chair	60.00	
Storage cabinet	70.00	
File case	102.00	887.00
Underwriting (2) centers		
Rent, utilities, food at $1,400 per month for two centers	16,800.00	
Managers, $200 per month at each center	4,800.00	
Cooks, $120 per month at each center	2,880.00	
Night man, $150 per month at each center	3,600.00	
Total	$28,080.00	
Cost of two centers at 65% self-supporting		9,828.00
TOTAL APPROPRIATION		$24,773.00

Comment: The administrative costs are recognized as a large percentage of the suggested appropriation. In relation to the funds which would be used to underwrite two centers, the following must be realized. As previously pointed out in the study, the alcoholic program is concered with a large number of other activites in addition to the support of the rehabilitation center. These are as follows:

1. Procurement of supplies and equipment for rehabilitation centers
2. Employment and placement of arrested alcoholic cases
3. Educational and preventive programs on alcoholism
4. Research necessary for further development of the alcoholic program
5. Assisting governmental and private organizations with problems associated with alcoholism
6. Cooperative relations with courts, medical facilities, and the police. Especially hospital treatment for severe alcoholic cases.
7. Promoting the operation of public alcoholic clinics
8. Providing consulatation and assistance to public and private agencies
9. Contracting for services necessary to carry out the programs
10. Acting as recipient and distributor for donations and gifts.

11. The Legislative Auditor would be authorized and directed to audit any rehabilitation centers or other organizations with which the alcoholic division may contract for services. Such audits would include an audit of all of the funds of the organization at least once a year and as often as deemed necessary.

Comment: This provision is necessary to protect state funds which will be employed to partially underwrite the expenses of rehabilitation centers. An audit of all of the funds of the centers will be necessary to guarantee that the alcoholic division is contracting with an organization that is properly managed.