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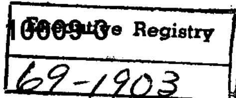

UNITED STATES CIVIL SERVICE COMMISSION

BUREAU OF RETIREMENT AND INSURANCE

WASHINGTON, D.C. 20415

IN REPLY PLEASE REFER TO
DD/S 69-1681

YOUR REFERENCE

March 12, 1969

Mr. L. K. White
Executive Director-Comptroller
Central Intelligence Agency
Washington, D. C. STOP 64

Dear Mr. White:

The new Civil Service Commission pamphlet, The Key Step, presents to Federal agencies a practicable program to deal with problem drinking and alcoholism among employees at little or no cost to the agency. I believe you will find it an interesting publication and a significant stride in this important area of personnel management.

Government probably has a lower rate of alcoholism among employees than does private industry where experts place the rate at 3 to 5 percent but, in absolute numbers, it probably has many more employees with drinking problems than any other single employer. For the most part, Government has lagged behind private industry in realizing, or even examining, the potential savings in dollars and human resources that a good alcoholism program offers. If your agency does not now have an active and formal program to deal with problem drinking, I urge that you instruct your agency's Occupational Health Officer to implement one--either The Key Step's program, or a more comprehensive one. If your agency now is conducting or planning a formal program, I hope you will see that it is re-examined to ensure it contains the essential elements of The Key Step's program.

Combatting problem drinking and alcoholism is only one facet of the Commission's interest and responsibility in leading development of dynamic and substantive occupational health programs for Federal employees. To better accomplish its broader objectives, the Com-

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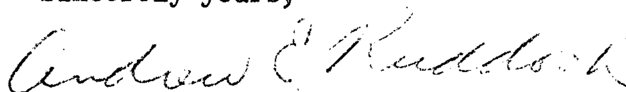
mission has established a new Occupational Health and Safety Division. Its staff soon will be in touch with your agency's occupational health and safety people to help them and their counterparts in other agencies work toward further developing employee health and safety programs as effective management tools.

Sincerely yours,



Andrew E. Ruddock
Director

Enclosure

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Remarks: Bob: This is of course not a new subject but I would like to talk to you and John sometime soon about what we should be doing in 1969 about alcoholism.

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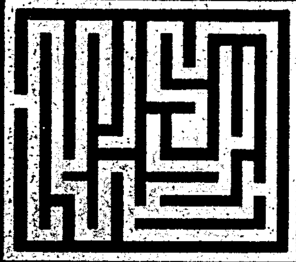

THE KEY STEP

A Model Program To Deal With Drinking Problems Of Employees

UNITED STATES
CIVIL SERVICE
COMMISSION

WASHINGTON,
D.C.

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In April 1968, the Civil Service Commission published *The First Step,* a report of a conference on drinking problems held in late 1967. At that conference representatives from each Federal agency participated in a dialog with experts on alcoholism from industry, medicine, science, education, and organized labor. The thrust of the conference (and of *The First Step*) was directed at exploring the need and means for developing a practicable program to deal with employees who are problem drinkers. Although the emphasis of the conference was on Federal situations, much of the information that was developed is applicable to State and local governments and to private industry.

This *Step,* an extension of *The First,* presents a model program to combat problem drinking among employees which Federal agencies, and perhaps others, may adopt or alter to fit their needs.

Some of the material in this pamphlet has been adapted from presentations at the Conference on Drinking Problems and the publications of others in Government and industry. The Civil Service Commission gratefully acknowledges these contributions.

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a program to

COMBAT PROBLEM DRINKING

AMONG EMPLOYEES

THE KEY STEP

BUREAU OF RETIREMENT, INSURANCE, AND
OCCUPATIONAL HEALTH
UNITED STATES CIVIL SERVICE COMMISSION
WASHINGTON, D.C. 20415

January 1969

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THE EMPLOYER'S CONCERN ABOUT DRINKING PROBLEMS

The Cause for Concern

Alcoholism is a serious and expensive national health problem that annually costs the Nation billions of dollars and causes immeasurable, but vast amounts of human suffering. It is of interest to employers because of their concern with employees as human beings and because of the waste that is generated by employees who are alcoholics. The Federal Government probably has a lower rate of alcoholism among employees than does industry because of its careful selection processes. Because of its size, however, it is probable that, in absolute numbers, there may be thousands of Federal employees who have drinking problems.

Excessive absences, poor decisions, higher accident rates are just some of the results caused by problem drinkers who are ignored or not identified. Government has recognized that it may have some problem drinkers among its employees, and its agencies are now establishing official and pragmatic programs to deal with them.

This publication outlines a program to identify and deal with employees who are problem drinkers. It presents a program that makes few demands on agency resources but which, if vigorously implemented, should yield valuable benefits to the Government and to any of its employees who are problem drinkers. Variations in the model program may be introduced freely to suit the needs and circumstances of a particular agency.

DEFINITIONS

Although there are many variations of them, here are three key definitions:

Alcoholism: a complex illness characterized by repeated and uncontrolled use of alcoholic beverages to an extent that adversely affects an individual's personal, financial, or employment situation.

Alcoholic: an individual who has the illness alcoholism.

Problem drinker: an individual whose drinking habits interfere with his job performance. He may or may not be an alcoholic. Usually, problem drinkers are in an early stage of alcoholism. For our purposes a problem drinker, whether he has or has not lost his ability to control his use of alcohol, does not control it well enough to satisfactorily perform the duties of his job.

The terms problem drinker and alcoholic are used interchangeably hereafter since the same course of action applies in either case.

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ADMINISTRATION OF THE PROGRAM

At the Agency Level

Alcoholism is an illness that affects the occupational health of employees. The most logical and convenient person to administer the program to combat it is the agency's Occupational Health Officer who heads up the agency's occupational health progam.[1] He, better than anyone else, has an overview of the agency's occupational health program. He can see how the agency's efforts to combat problem drinking fit into both its personnel and its medical functions. He also can direct an educational campaign focused on making the agency's employees aware of alcoholism as an illness and of its danger signals. Some sources for pamphlets, films, and educational materials are listed in the appendix.

At the Installation Level

To administer the program at field installations, Occupational Health Officers should designate a Program Administrator at each installation to coordinate the local operations of the program, and to provide supervisors and employees with information about the program. Program Administrators should receive their instructions from the Occupational Health Officer in agency headquarters. Program Administrators may be medical officers, health unit physicians, or personnel officials. There is no special need to seek out recovered alcoholics to assume this role, although some recovered alcoholics may make excellent Program Administrators because they are strongly motivated in this area. If a recovered alcoholic is used as a Program Administrator, he should be familiar with treatment methods other than the one that was successful for him.

At the Supervisory Level

This program must have the support and informed cooperation of supervisors to be successful. Supervisors must understand how it works and why it works.

Before introduction of this program, a supervisor with an employee who was a problem drinker, if he acted formally at all, had only disciplinary procedures at his disposal. He could reprimand, suspend, or start removal proceedings. The alcoholism program provides alternate procedures which allow supervisors to refer problem drinkers to the Program Administrator who in turn arranges for necessary consultation and then refers the employee to a source of rehabilitative assistance in the community. The supervisor no longer is faced with a choice between covering up for a problem drinker or taking disciplinary action. His new alternative makes him a benefactor to the problem drinker.

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[1] Each agency head has designated an Occupational Health Officer to administer all matters pertaining to the Federal Employees Occupational Health Program for his agency.

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Of course, if the employee refuses to admit he has a drinking problem, or if he does not achieve professionally acceptable results from his course of rehabilitation, the usual procedures for dealing with unsatisfactory employees are still available if the supervisor needs them.

Sources of Referral

This program does not contemplate, though it does not prohibit, direct rehabilitative effort by Federal agencies. Most communities have local government or private agencies or organizations that can provide rehabilitative programs. A list of some of these sources is included in the appendix.

Expenses of Rehabilitation

The program does not provide for the Government's paying the costs of rehabilitation. An employee is responsible for the costs of treating his drinking problem just as he is for any other health condition. He may receive some financial help, as with other illnesses, from his Federal Employees Health Benefits plan.

Various types of rehabilitative programs require different financial capabilities. Alcoholics Anonymous, for example, solicits only voluntary contributions; employees who are veterans may be eligible for some assistance from the facilities of the Veterans Administration, etc. These considerations should be explored by the Program Administrator, and should be weighed when offering referral services in individual cases.

THE AGENCY'S POLICY ON ALCOHOLISM

Need for a Policy Statement

A policy statement is one of the most important features of any program to deal constructively with problem drinking among employees.

An official statement issued by top management and endorsed all the way down the supervisory line is necessary so that all employees know that the program has full management support. It is a vital step toward obtaining optimum operation of the program.

Some agencies have expressed a preference for operating their programs in a quiet, unofficial manner. Experience has shown that unless a formal policy is written and publicized, doubts occur about the sincerity of management in operating the program. Employees have a tendency to regard the informal program only as a charitable act rather than as the personnel management tool which it is intended to be. Management need not be embarrassed about facing up to a health problem; indeed, there is more embarrassment inherent in "covering up" or "dealing unofficially" with a problem caused by an illness. Even if a small agency actually is free of any employees with drinking problems—a very unlikely circumstance—a formal and public policy statement is desirable to define what shall be done if, in the future, the agency encounters such a problem. Alcoholism, as a health condition, does not need to be hidden away.

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The following sample policy statement, or a modification of it, should be issued by all agencies.

Sample Policy Statement

Alcoholism is a serious and expensive national health problem. The Federal Government probably has a lower rate of alcoholism among employees than does industry because of its selection processes. Because of the Government's size, however, it is probable that, in absolute numbers, there may be thousands of Federal employees who have drinking problems. Accordingly, this agency recognizes that alcoholism is an illness [1] that may affect, now or at some future time, the health, work performance, and conduct of some of its employees. This statement establishes, within the Occupational Health Program, a policy and program to assist employees whose drinking habits are causing or contributing to job difficulties.

This agency is not concerned with the private decision of an employee to use or not to use beverage alcohol off the job. However, when its use impairs his work performance, attendance, conduct, or reliability, it is the responsibility of management to take action.

The alcoholism program introduces nondisciplinary procedures under which an employee with a drinking problem is offered rehabilitative assistance. If he refuses such assistance, or if the course of rehabilitation fails to achieve professional expectations, regular disciplinary procedures for dealing with problem employees will be used.

This agency will:

—remain neutral on the decision of its employees to use, or not use, beverage alcohol while not on duty;

—implement a formal program to identify and offer rehabilitative guidance to employees whose drinking habits have resulted in job difficulties, including poor attendance and conduct;

—recognize that individuals who suffer from alcoholism are entitled to the same respect, confidentiality of medical treatment, and records handling as employees who suffer from any other health condition that affects job performance;

—conduct all phases of its program on alcoholism in the highest professional manner;

—grant sick leave for employees to participate in approved rehabilitative programs; and

—encourage the use of established community resources and facilities, as available, as sources of rehabilitative care.

[1] This agency accepts the American Medical Association view that alcoholism is a complex, treatable illness. Some authorities regard alcoholism as a manifestation of psychopathology or complication to other physical or mental conditions, but for our purposes the term "illness" may be appropriately applied to alcoholism.

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THE ILLNESS: ALCOHOLISM AND ALCOHOL

The Cause of Alcoholism

Most authorities now believe there may be no single cause of alcoholism, or even one kind of "alcoholism." Theories favoring physiological, psychological, and sociological origins historically have competed for favor and usually just about when one theory reaches a position of general acceptance, another comes into vogue, relegating the first to the sidelines. About all we know positively is that alcohol has a bad effect on the bodies and minds of some people. Sometimes the cause seems to be emotional instability, or the tensions of work or other environments, and sometimes it looks as if alcoholism is an allergy.

Employers generally leave investigations of the cause of alcoholism to professional researchers. They concentrate on preventing those aspects of alcoholism that develop as the illness progresses and which eventually impair the job performance and reliability of some of their valuable employees.

What Alcohol Is

Ethyl alcohol is a common chemical compound that has many uses other than as a beverage. It occurs in nature whenever a grain is allowed to rest with suitable conditions of moisture and warmth. It belongs to a large family of organic chemicals whose members, all alcohols, range from the lightweight methyl alcohol, or methanol, which is used in high powered fuels and explosives, to heavy liquids like ethylene glycol or antifreeze, and solids used in plastics and paints.

Drinking alcohol (ethyl alcohol, or as we will call it, alcohol) is a quick energy food that requires little digestion. It passes rapidly into the bloodstream where it oxidizes through several steps to end-products of carbon dioxide and water. Before it reaches its final oxidation products, it acts as a depressant on the brain's center of intellect and self-control.

Who Uses Alcohol

When used in moderate quantities, alcohol relieves tensions and environmentally induced inhibitions, apparently causing no ill effects on most people who use it. And, most people in our society do use it. No accurate figures are available, but authorities estimate that about 70 percent of adult Americans drink—at least occasionally. The majority of them (estimates say about 90 percent) drink without any significant hazard to themselves, their families, or the community.

What about those others; the alcoholics who bring much misery and expense to themselves and those around them? Again, no reliable statistics are available. Each authority has his own favorite method of estimating the number of active alcoholics in our society. Most come up with a figure that falls between 3 and 5 percent of the total adult population of the United States. If we settle on 4 percent, it means that there are more than 3 million people suffering from the illness in this country.

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These 3 million alcoholics come from every social strata. They are young and old, of every religion and race, and in every vocational pursuit. There are statistical indications that some people have greater chances of becoming alcoholics than others, but most such indicators are not substantial enough to rely on. For example, a person between 35 and 55, a college graduate, earning more than $15,000 per year is a better candidate for alcoholism than a younger or older person who graduated from high school and earns $8,000 per year. However, he is no better candidate than a divorced man earning about $5,000 a year and living in a large city. It is certain that there are too many probabilities to explore here but we can safely say that alcoholism is widespread in all walks of life.

The Stages of Alcoholism

Alcoholism is a disease of stages: only in the fourth and last stage, which involves benders lasting several days, tremors, nameless fears and anxieties, and compulsive bottle hiding and similar abnormalities, do most alcoholics become unemployable. This last chronic stage affects the 3 percent of alcoholics who are on skid row, and in long term custodial-care institutions. The huge majority of alcoholics work in jobs they often have held for many years. They go to church, belong to clubs, and to all appearances live quite ordinary lives—except that they have the illness alcoholism.

The four stages of alcoholism present a description of the progressive nature of the disease and a blueprint of personal destruction. The stages are not clearly delineated, and it is often hard to determine in which stage a person is. However, they are useful for descriptive and analytical purposes:

1. *Early symptom stage.*—From normal drinking a person progresses to a point where no party is fun without a "couple of drinks." In this stage, drinking frequently becomes a crutch to bolster self-confidence and sometimes a person really thinks he "needs" a drink.

Here is where educational programs should come into play. Few people with early symptoms can be identified as problem employees. However, all employees can be made aware that alcoholism is a progressive illness, usually taking several years to develop. They can be told that if a frank self-evaluation indicates they might have some early symptoms, they should watch their drinking carefully.

2. *Problem drinking stage.*—Usually a problem drinker enjoys the full pampering effects of alcohol; he likes the glow he gets, the euphoria, the feeling of unconquerability. He drinks more, or differently, than his friends and associates. He may gulp drinks, get severe hangovers, have some trouble making it to work on Mondays.

Not many people besides the problem drinker's immediate family and closest friends know how heavily he drinks. Problem drinkers are often hard to identify, but most of them can be rehabilitated and kept as good employees. This category presents the toughest problems, yet it is here that good supervisors can make an alcoholism program really pay off both in

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terms of savings to the agency and in helping individuals to recognize and do something about their drinking behavior.

3. *Early alcoholic stage.*—There is seldom any question about persons in this group. These are obvious, confirmed heavy drinkers and their friends and coworkers know it. Early-stagers say they can stop drinking if they want to, but they cannot (by themselves). They are among the world's most ingenious liars. If they devoted the same amount of energy and planning to their work that they do to devising alibis and trying to cover up their condition, they would be excellent employees. They drink alone, they sneak drinks, their work performance is poor. They usually have financial or family problems. They lose friends and they are first-class headaches for supervisors.

If supervisors and coworkers overcome their natural inclination to stop covering up for these early-stagers and try to help, good results from rehabilitative efforts can usually be obtained. More than half of those who are in the early stages of alcoholism can be rehabilitated with professional help. Community resources and other health facilities are useful and essential to good results. One stumbling block is that often the drinker refuses to cooperate. Concepts of a reward-penalty system pay off (see page 8).

4. *Chronic alcoholic stage.*—An agency program cannot offer help with this last stage of alcoholism. Those in it are unemployable. They are already on skid row or otherwise helpless. They are pitiful creatures, beyond the help our program can offer. Their only hope is immediate and successful professional medical care. Most suffer brain damage, but some can still be returned to useful lives with proper care.

THE PROGRAM

Responsibility for the Program

Overall responsibility for the alcoholism program is with the agency's Occupational Health Officer in Washington. The Occupational Health Officer appoints a Program Administrator at each field location to arrange for appropriate diagnostic consultations for employees when necessary and to conduct liaison with sources of rehabilitative assistance in the community. Supervisors will consult with the Program Administrator concerning the program and will refer employees to him for all arrangements under the program.

How the Program Works

Alcoholism is a unique illness in that those who have it seldom seek treatment for it. Industrial and other programs for the rehabilitation of alcoholics usually achieve rehabilitation rates that are well over 50 percent. They do so by creating a situation that forces the alcoholic to face up to his condition. Alcoholics Anonymous (AA) has achieved successes by working with persons who, for the most part, have had a crisis in their lives that caused them to face their condition. AA calls that crisis "hitting bottom."

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"Hitting bottom" does not imply losing everything or sinking to skid row, but merely indicates that point at which an individual realizes that his drinking habits have become intolerable and that he must seek help. Such realization usually comes from a traumatic situation involving family, finances, or job. Something happens in the problem drinker's life to awaken in him a realization that he cannot continue his drinking behavior. That is "hitting bottom." The agency's program is designed to "raise the bottom" for every employee who is a problem drinker.

Why the Program Works

"Raising the bottom," "constructive coercion," whatever label is used, the simple principle of successful alcoholism programs is a reward-penalty technique. The problem drinker is offered a reward—his job and a possible return to a normal life—in return for his successfully pursuing a course of rehabilitation. His refusal, or failure, to cooperate with his treatment program leads to a penalty—loss of his job—that should mean more to him than his drinking.

Employers and supervisors can exert pressure that will usually cause problem drinkers to choose the shelter of their alcoholism programs rather than face the alternative of disciplinary action. Such an approach by an employer most usually proves more effective than the pleas of the employee's family, church, or friends. Many problem drinkers hold only their jobs to be more important than their drinking.

Relationship to Disciplinary Actions

The alcoholism program supplements, but does not replace, existing personnel procedures on problem employees. Its premise is that one type of problem employee is an alcoholic or a problem drinker and that, in the case of this particular type of problem employee, a special situation exists. The employee is a problem because of repeated instances of uncontrolled drinking. The drinking he does is either an illness or a symptom of an illness and, as with other types of illnesses, it is the agency's policy to try to assist him to recover his usefulness as an employee.

In practice, he should be dealt with little differently than other problem employees. A supervisor identifies the aspects of job performance that are not satisfactory. He discusses the unsatisfactory areas with the employee, the possible causes, and points up the need for improvement. If there is no improvement, or inadequate improvement, disciplinary action is taken, as warranted.

Under this program, supervisors must recognize the factor of problem drinking and discuss it with the employee when it appears to contribute to the employee's problem. It is the supervisor's responsibility to identify problem drinkers and to persuade them to accept the assistance offered through the program. Supervisors should understand that a person usually is no more responsible for his alcoholism than another man is for his cancer or heart disease. In fact, in the early stages of the illness the afflicted employee may not even be aware of his condition.

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It should be noted that the program makes the supervisor's life and job easier. Before the advent of this program a supervisor who wanted to take formal action had no alternative to taking disciplinary action when a problem drinker's job performance slipped to an intolerable level. Adoption of nondisciplinary procedures aimed at rehabilitation should eliminate any reason for supervisors to hesitate to deal forthrightly with problem drinkers. Supervisors are no longer being "nice fellows" by shielding problem drinkers, or by doing their work for them. In fact, a supervisor who tolerates poor performance by a problem drinker clearly contributes to the progression of the employee's illness by delaying his entry into a rehabilitative program.

Eligibility for Disability Retirement

This program does not jeopardize the employee's right to disability retirement if his condition warrants it. Eligibility for his retirement is determined by the Civil Service Commission. Either the employee or the agency may apply for it.[1] If alcoholism is involved, the Civil Service Commission determines whether the alcoholism is a symptom of a deeper, underlying physical or psychological condition, in which case the employee would be eligible to retire. In cases where the disability is solely the result of intemperate use of alcohol within the last 5 years, the employee is not eligible for disability retirement under present law.

THE ROLE OF THE SUPERVISOR

Why the Supervisor Is Responsible

Firstline supervision is the logical point of emphasis in this program because the supervisor is in a position to observe his employees' attendance, sick leave, on-the-job attitudes, conduct, and performance. He is responsible for the work his employees do, and if it is unsatisfactory work, the supervisor must redo it or have it redone.

Early Recognition

Alcoholism may be most successfully treated in its early stages. Therefore, if the supervisor can "raise the bottom," by precipitating a crisis as soon as he is justified in doing so, the problem drinker can be referred to sources of rehabilitation comparatively early. That is one of our main objectives—early referral.

To accomplish it, each supervisor must be alert to the possibility that drinking may be a cause of a problem situation. He must identify a problem employee whose difficulty appears to be caused by drinking. He must become expert in recognizing the signs of alcoholism, even among those whose performance is just starting to slip below an acceptable level. Supervisors are not required to diagnose alcoholism. What is expected of them is recognition of, and appropriate action on, reasonable evidence that the employee's drinking habits are hindering the performance of his job.

[1] See FPM Supplement 831–1 for eligibility requirements and filing procedures.

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Supervisors who note a dropoff in the work performance of a previously good employee should consider the possibility of a drinking problem if several indicators are present. The supervisor should, of course, keep in mind that no indicator or group of indicators is unique to alcoholism or problem drinking.

Some Indicators

Possible drinking problems are often signaled by:

- repeated Friday, Monday, or half-day absences;
- frequent reporting of absences by members of the employee's family or persons other than the employee himself;
- unusual excuses for absences;
- lying about inconsequential matters;
- display of an increasing lack of responsibility;
- mood changes in a previously stable employee;
- frequent loud talking or irritability;
- avoidance of the supervisor;
- long lunch periods;
- frequent use of breath purifiers; and
- hand tremors, flushed face, or other commonly recognized physical signs.

In many cases, disclosure that an employee has a drinking problem will occur almost accidentally. Discussions of elements of faulty job performance will often result in the employee's volunteering information that he is developing a drinking problem, or the supervisor may sense it from the employee's bragging about frequent hangovers or blackouts after drinking.

Preparing For Discussion

After identifying an employee who apparently has a drinking problem, the supervisor should plan an approach that, hopefully, will lead to the employee's admission of his problem and subsequent voluntary participation in rehabilitative efforts. Even before discussing the matter with the employee, the supervisor should consult with his installation's Program Administrator who probably has had more experience with similar situations.

The Matter Of Privacy

Supervisors are often reluctant to discuss matters they feel are the employee's own business. They sometimes are not sure of the distinction between the employee's right to privacy and the employer's right to expect a day's work for a day's pay. In the case of problem drinkers, we can differentiate: An employee's decision to drink, or not, is a personal decision and should not interest his employer; however, the instant that personal decision, or its result, affects his job performance, the agency can be legitimately and vitally involved. The employee's drinking problem becomes the supervisor's concern the first day it accompanies the employee to work, or on the first day it prevents the employee from coming to work.

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The first interview should be a discussion with the employee of the areas of job performance that are deficient. These can include an excessive number of absences and habitual tardiness, low production or poor quality, unsatisfactory relations with fellow employees, and any other shortcomings the supervisor thinks pertinent.

The supervisor should speak frankly with the employee about his deficiencies at the first interview. After outlining the problem, the supervisor should indicate that, from the evidence available, alcohol could be a major contributing factor to the employee's difficulties. The employee should be reminded that the agency has a policy on alcoholism and it should be explained to him in detail.

If the employee agrees to use the agency's help, the supervisor should arrange for him to meet with the Program Administrator who will implement the referral and treatment parts of the program. Supervisors should continue to watch the employee closely for improvements or relapses in job performance.

Interview Tactics

If the interview is typical, the employee will dodge artfully from one denial to another. Supervisors should keep in mind that problem drinkers are often ingenious liars. They will use many tactics which, if the supervisor is unprepared, may catch him so far off balance that his efforts are stymied. Some of the tactics frequently used are:

Indignant reaction.—The employee becomes outraged that the supervisor thinks he might be a problem drinker. If the employee takes this tack, the supervisor should explain to him that, in order to perform his job properly, a supervisor must discuss with an employee any deficiencies he has that impair his usefulness to the agency and the possible cause of these deficiencies, including alcohol.

Drinking is a personal matter of no concern to the agency.—The answer to this is: The agency is not interested in whether or not employees drink. It makes no moral judgment on the use of alcohol. As far as the agency is concerned, alcoholism is an illness like heart disease or glaucoma and carries no stigma. Like any other health condition, drinking that adversely affects work performance is more than a personal matter; it is a legitimate concern of the agency.

There is no problem.—The employee may insist he has no problem, but even if he admits he has been drinking too much, he may say he can stop at any time he wants, or that his drinking is a result of home pressures, financial problems, etc., all of which, he says, will soon straighten out. The employee may be sincere. He may believe these statements. He probably uses them to delude himself into thinking he has no problem. Supervisors, except as sympathetic fellow beings, are not interested in their employees' off-work problems. This type of conversation is interesting to them only to the extent it does or does not confirm their opinions about the employee's drinking habits, and the habit's contribution to unsatisfactory job performance.

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Already getting treatment.—The employee may say he is already receiving treatment and that, therefore, he does not need the agency's help. His story may be legitimate or it may be an excuse; e.g., he may be seeing a physician for a condition as remote from problem drinking as flat feet, or he may, as at least one alcoholic has done, be getting "help" from a group composed of his favorite bartender and a half-dozen drinking cronies.

The point is that although a course of legitimate treatment from a recognized source will not be questioned, the vague explanations of a problem drinker that he is "being treated" should be clarified. The problem drinker who says he is under treatment should be asked to explain fully what he is getting and its source. He should be told that, if requested by professionals administering the treatment, the agency will cooperate to the extent that is practicable. He should understand that the agency is not interested in his drinking problem per se; it is concerned about his substandard job performance.

When the First Interview Fails

If the employee refuses to acknowledge that he has a drinking problem or otherwise refuses to cooperate, and does not correct the deficiencies in his job performance, the supervisor should take the disciplinary action that would be appropriate if the employee did not have a drinking problem. Further interviews based on work deficiencies should be held when warranted. In each succeeding interview the supervisor should reiterate the agency's policy on problem drinking and firmly restate his belief that the excessive use of alcohol may be the cause of the employee's difficulties. Additional disciplinary actions, as warranted, for specific instances of on-the-job misconduct or poor performance should be taken just as in cases not involving alcohol problems.

When the Problem Drinker Wants to Cooperate

When an employee admits he needs help, he should be referred to the installation's Program Administrator who will direct the employee to a suitable source of rehabilitative assistance or information in the community. The supervisor should keep the Program Administrator informed of continued deficiencies in job performance or conduct, or improvement in them. The Program Administrator will usually maintain liaison with the source of rehabilitative assistance and should keep the supervisor informed of the progress of the rehabilitative program. Any special medical consultations or other arrangements required before the employee is referred for rehabilitation will be made by the Program Administrator.

REFERRAL

Referral of employees who have been identified as problem drinkers to good sources of rehabilitation is of prime importance to the success of the program. Agencies should use sources of rehabilitation already established in the communities. Referrals may take two general forms. If a diagnosis of

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alcoholism has been made by a physician, the referral may be made to obtain treatment for alcoholism. Otherwise, referrals will be made not to treat "alcoholism," but to assist an employee in overcoming "a drinking problem." While any supervisor may recognize, and an employee may admit, a drinking problem, only a physician is professionally qualified to diagnose the illness alcoholism.

USE OF SICK LEAVE

Probably a request for sick leave, which can be identified as being directly related to problem drinking, would arise only when an employee is away from work to obtain treatment for his condition under an approved course of rehabilitation. Granting sick leave is appropriate for this purpose. Under other circumstances, the granting of sick leave is subject to existing agency policy.

RECORDS

The importance of keeping accurate records of cases handled under the program cannot be overemphasized. Supervisors should document the results of discussions and the actions they take to try to motivate the employee to correct deficiencies in his job performance. They should also record the symptoms of problem drinking in order to assist the rehabilitative experts in charting an appropriate course of treatment for the employee.

The Program Administrator should be the focal point for records relating to the employee's drinking problem and his course of rehabilitation. Program Administrators should release record information only on a strict "need-to-know" basis. Records should be confidential. (Records containing medical information should be handled according to the prescribed procedures for maintaining medical records.) Records created and maintained by the supervisor or Program Administrator should not be filed in the employee's Official Personnel Folder. Official Personnel Folder records should not include mention of an employee's alcohol problems or efforts to rehabilitate him except as they apply to specific charges leading to disciplinary actions; e.g., "Drinking on Duty."

Some statistical records should be maintained, preferably at the level of Program Administrators. Records should include at least the numbers of problem drinkers identified, referred, and rehabilitated. These records should prove useful to the agency's Occupational Health Officer, both in appraising the agencywide impact of the program and in responding to requests for information that the Civil Service Commission from time to time may make. Care should be taken that such records are purely statistical and do not identify individuals.

SOURCES OF REHABILITATIVE ASSISTANCE

Information and treatment sources are being developed so rapidly that a complete listing of them would be out of date by the time it was published.

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Some prime sources of referral are State, county, and city agencies on alcoholism and mental health, committees or chapters affiliated with the National Council on Alcoholism, Alcoholics Anonymous, physicians and psychiatrists, local welfare councils, and church and family service organizations (see Appendix A).

The Program Administrator in each installation should become familiar with sources of rehabilitation in his own local community. He should establish liaison with a variety of sources to meet the varying financial capabilities of employees. Any expense of rehabilitative treatment has to be borne by the referred employee, with possible assistance from his Federal Employees Health Benefit plan if a particular expense item is covered.

FOLLOW THROUGH

After the employee has started on a rehabilitative program, supervisors and Program Administrators should cooperate to the extent that is practicable with the professional personnel involved in his rehabilitation, if asked to do so. Supervisors who deal with employees undergoing rehabilitative treatment should maintain tolerant and impartial attitudes but should be firm in dealing with poor performance or conduct. The employee must realize that he is accountable for the results of his drinking even though he is on a rehabilitative program. Some relapses of employees who are undergoing rehabilitation may occur. These should be reported to the treatment source, and such disciplinary action as is warranted by the offense should be taken.

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APPENDIX A

DIRECTORY OF SOME SOURCES OF REHABILITATIVE ASSISTANCE AND INFORMATION

NOTE: This directory does not include Federal Health Units [1] or local chapters of Alcoholics Anonymous. [2]

Alabama

Birmingham, Jefferson County Committee on Alcoholism, 3600 Eighth Avenue South 35222.

Montgomery, Division of Alcoholism, Alabama Department of Mental Health, 715 State Office Building 36104.

Tuscaloosa, Department of Mental Health, Alabama State Hospital, Station 3 35401.

Alaska

Anchorage, Anchorage Council on Alcoholism, Box 506 99501.

Juneau, Office of Alcoholism, Alaska Department of Health and Welfare, Alaska Office Building 99801.

Arizona

Phoenix, Alcohol and Drug Abuse Section, Arizona Department of Health, 1624 West Adams Street 85007.

Phoenix, Maricopa Council on Alcoholism, Community Service Building, 1515 East Osborn Road 85014.

Sacaton, Alcoholism Prevention and Treatment Program, P.O. Box 427 85247.

Arkansas

Little Rock, Arkansas Board of Health, State Health Building 72201.

Little Rock, Arkansas Commission on Alcoholism, 109 West 12th Street 72202.

Little Rock, Arkansas State Hospital 72201.

California

Acton, Antelope Valley Rehabilitation Center, County of Los Angeles, P.O. Box 25 93500.

[1] See directory of Federal Occupational Health Facilities, U.S. Civil Service Commission.

[2] See local phone directories.

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Berkeley, Division of Alcoholic Rehabilitation, California Department of Public Health, 2152 Berkeley Way 94704.

Berkeley, Berkeley Center for Alcohol Studies, Pacific School of Religion, 1798 Scenic Avenue 94709.

Carmel, Monterey Peninsula Council on Alcoholism, P.O. Box 1058 93921.

Los Angeles, Alcoholism Council of Greater Los Angeles, 1290 Wilshire Boulevard 90017.

Los Angeles, Alcoholic Rehabilitation Clinic, County Health Department, 111 East First 90012.

Oakland, Alameda County Council on Alcoholism, 431 30th Street 94609.

Olive View, Los Angeles County-Olive View Hospital, 14701 Foothill Boulevard 91330.

Pasadena, Pasadena Community Program on Alcoholism, 25 South Euclid Avenue 91101.

Pasadena, Pasadena Council on Alcoholism, 265 South Los Robles Avenue 91106.

Sacramento, California Department of Mental Hygiene, 1500 Fifth Street 94814.

Salinas, Salinas Valley Council on Alcoholism, 984 Lupin Drive 93901.

San Francisco, Department of Health, Education, and Welfare, Regional Office, Federal Office Building, 50 Fulton Street 94102.

San Francisco, Center for Special Problems, 2107 Van Ness Avenue 94109.

San Francisco, Acute Alcoholism Treatment Center, Clay and Webster Streets 94115.

San Francisco, San Francisco Council on Alcoholism, 2340 Clay Street 94115.

San Mateo, San Mateo County Council on Alcoholism, 18 Second Avenue 94401.

Santa Barbara, Santa Barbara Committee on Alcoholism, 804 Santa Barbara Street 93102.

Talmage, Alcoholism and Drug Abuse Services, Mendocino State Hospital 95481.

Colorado

Fort Logan, Alcoholism Division, Fort Logan Mental Health Center, Box 188 80155.

Denver, United States Department of Health, Education, and Welfare, Regional Office, Federal Office Building, 19th and Stout Streets 80202.

Denver, Colorado Department of Institutions, 328 State Services Building 80203.

Denver Mile High Council on Alcoholism, 1375 Delaware Street 80204.

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Denver, Colorado Department of Public Health, Alcoholism Division, 4210 E. 11th Avenue 80220.

Colorado Springs, Pikes Peak Council on Alcoholism, Out West Building, 15 East Pikes Peak Avenue 80902.

Grand Junction, Mesa County Council on Alcoholism, 230 Grand Avenue 81501.

Connecticut

Cos Cob, Greenwich, New Canaan, Stamford Council on Alcoholism—Darien, 521 Post Road 06807.

Hartford, Alcohol and Drug Dependence Division, Connecticut Department of Mental Health, 51 Coventry Street 06112.

Hartford, Connecticut Department of Health, 79 Elm Street 06115.

Hartford, Connecticut Department of Mental Health, 79 Elm Street 06115.

Westport, Fairfield County Council on Alcoholism, 256 East State Street 06880.

Delaware

Dover, Delaware Board of Health, State Health Building 19901.

Wilmington, Delaware Department of Mental Health, 2055 Limestone Road 19808.

District of Columbia

District of Columbia, United States Civil Service Commission, Bureau of Retirement, Insurance, and Occupational Health, 1900 E Street NW. 20415.

District of Columbia, Area Council on Alcoholism, 929 L Street NE. 20001.

District of Columbia, United States Department of Health, Education, and Welfare, 330 Independence Avenue SW. 20201.

District of Columbia, Office of Alcoholism and Drug Addiction Program Development, District of Columbia Department of Public Health 20001.

Maryland, Chevy Chase, National Center for Prevention and Control of Alcoholism, 5454 Wisconsin Avenue 20203.

Florida

Avon Park, Florida Rehabilitation Program, P.O. Box 1147 33825.

Chattahoochee, Division of Mental Health, Florida State Hospital 32324.

Jacksonville, Florida Board of Health, P.O. Box 210 32201.

Miami, City of Miami Alcoholic Rehabilitation Center, 1145 NW. 11th Street 33136.

Georgia

Atlanta, United States Department of Health, Education, and Welfare, Regional Office, 50 Seventh Street NE. 30323.

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Georgia Department of Public Health, 1260 Briarcliff Road NE. 30306.

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Atlanta, Georgia Department of Public Health, 47 Trinity Avenue SW. 30334.

Guam

Agana, Territorial Department of Public Health and Welfare, P.O. Box 2816 96910.

Hawaii

Honolulu, Hawaii Committee on Alcoholism, Aloha Tower 96813.

Honolulu, Alcoholism Branch, Hawaii Department of Health, Kinau Hale, P.O. Box 3378 96891.

Idaho

Boise, Idaho Commission on Alcoholism, Statehouse 83701.

Boise, Idaho Department of Health, Statehouse 83701.

Illinois

Alton, Alcoholism Treatment Program, Alton State Hospital 62004.

Anna, Alcoholism Treatment Program, Anna State Hospital 62906.

Aurora, Alcoholism Information and Referral Center Family Counseling Service, P.O. Box 769 60507.

Chicago, Illinois Department of Mental Health, 160 North La Salle Street 60601.

Chicago, Chicago Council on Alcoholism, 6 North Michigan Avenue 60602.

Chicago, Warren Clinic, Stone Brandel Center, 1439 South Michigan Avenue 60605.

Chicago, United States Department of Health, Education, and Welfare, Regional Office, New Post Office Building, 433 West Van Buren Street 60607.

Chicago, Chicago's Alcoholic Treatment Center, 3026 South California Avenue 60608.

Elgin, Community Concern for Alcoholism, 20 North Grove Avenue 62002.

Glen Ellyn, Alcoholism Council of DuPage County, P.O. Box 526 60137.

Jackson, Alcoholism Treatment Program, Jackson State Hospital 62650.

Kankakee, Alcoholism Treatment Program, Kankakee State Hospital 60901.

Manteno, Alcoholism Treatment Program, Manteno State Hospital 60950.

Moline, Rock Island County Council on Alcoholism, 1630 Fifth Avenue 61265.

Murphysboro, Southern Illinois Committee on Alcoholic Concern, P.O. Box 511 62966.

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Peoria, Association of Alcoholism [illegible], 410 Fayette Street 61602.

Peoria, Alcoholism Treatment Program, Peoria State Hospital 61607.

Peoria, Peoria Area Council on Alcoholism Information Center, 410 Fayette Street 61602.

Rockford, Alcoholism Treatment Unit, Illinois Department of Mental Health, 4402 Main Street 61103.

Rockford, Northern Illinois Council on Alcoholism, 425 East State Street 61104.

Springfield, Division of Alcoholism, Illinois Department of Mental Health, 401 South Spring Street 62706.

Springfield, Division of Vocational Rehabilitation, 623 East Adams Street 61101.

Springfield, Illinois Department of Public Health, 400 South Spring Street 62706.

Indiana

Indianapolis, Division on Alcoholism, State Department of Mental Health, 3000 West Washington Street 46222.

Indianapolis, Indiana Board of Health, 1330 West Michigan Street 46207.

Indianapolis, Indiana Department of Mental Health, 1315 West 10th Street 46207.

Iowa

Des Moines, Des Moines Council on Alcoholism, Bankers' Trust Building, 406 Sixth Avenue 50309.

Des Moines, Harrison Treatment and Rehabilitation Center, 75 Sixth Avenue 50309.

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

Iowa City, Iowa Mental Health Authority, Psychopathic Hospital, 500 Newton Road 52240.

Oakdale, University of Iowa, Alcoholism Treatment Unit 52319.

Kansas

Topeka, Alcoholism Services, Kansas Department of Social Welfare, State Office Building 66612.

Topeka, Kansas Council on Alcoholism, 2044 Fillmore 66604.

Topeka, Kansas Department of Health, Topeka Avenue at 10th 66612.

Topeka, Veterans' Administration Hospital, 2200 Gage Boulevard 66622.

Kentucky

Frankfort, Alcoholism Program, Kentucky Department of Mental Health, P.O. Box 678 40601.

Frankfort, Kentucky Department of Health, 275 East Main Street 40601.

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Louisiana

Baton Rouge, Baton Rouge Area Council on Alcoholism, Fidelity National Bank Building, 3875 Florida Building 70806.

Baton Rouge, Louisiana Department of Hospitals, 655 North Fifth Street 70804.

Lafayette, Acadiana Council on Alcoholism, P.O. Box 2364 70501.

New Orleans, Committee on Alcoholism for Greater New Orleans, 410 Chartres Street 70130.

New Orleans, Louisiana Board of Health, Civic Center 70160.

Monroe, Twin Cities Council on Alcoholism, P.O. Box 332 71201.

Shreveport, Caddo-Bossier Council on Alcoholism, 9 Commercial Building, 509 Market Street 71101.

Maine

Augusta, Division of Alcoholism Services, Maine Department of Health and Welfare, Statehouse 04330.

Augusta, Maine Department of Mental Health and Corrections, State Capitol 04330.

Maryland

Baltimore, Baltimore Area Council on Alcoholism, 22 East 25th Street 21218.

Baltimore, Maryland Department of Health, 301 West Preston Street 21201.

Baltimore, Services to Alcoholics, Maryland Department of Mental Hygiene, 301 West Preston Street 21201.

Cambridge, Eastern Shore Council on Alcoholism, P.O. Box 286 21613.

Chevy Chase, National Center for Prevention and Control of Alcoholism, 5454 Wisconsin Avenue 20203.

Chevy Chase, National Institute of Mental Health, 5454 Wisconsin Avenue 20203.

Hagerstown, Washington County Council on Alcoholism, Professional Arts Building 21740.

Silver Spring, U.S. Public Health Service, 7915 Eastern Avenue 20910.

Massachusetts

Boston, United States Department of Health, Education, and Welfare, Regional Office, J.F.K. Federal Building 02203.

Boston, Division of Alcoholism, Massachusetts Department of Public Health, 755 Boylston Street 02116.

Boston, Greater Boston Council on Alcoholism, 419 Boylston Street 02116.

Boston, Massachusetts Department of Mental Health, 15 Ashburton Place 02108.

Boston, Massachusetts Department of Public Health, Statehouse 02133.

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Ipswich, Central Essex Council on Alcoholism, Appleton Professional Centre, 2 North Main Street 01938.

Jamaica Plain (Boston), Washington Hospital, Medical and Psychiatric Treatment Center for Alcoholism, 41 Morton Street 02130.

Salem, North Shore Committee on Alcoholism, 5 Broad Street, Health Center 01970.

Worcester, Worcester County Council on Alcoholism, 253 Belmont Street, Middle Building 01605.

Michigan

Detroit, Greater Detroit Council on Alcoholism, 10 Peterboro Street 48201.

Flint, Flint Committee on Alcoholism, 304 Metropolitan Building 48502.

Flint, Greater Flint Council on Alcoholism, 202 East Boulevard Drive 48503.

Lansing, Greater Lansing Council on Alcoholism, 223 North Pine Street 48933.

Lansing, Michigan Department of Mental Health, Lewis Cass Building 48913.

Lansing, Michigan Board of Alcoholism, 212 South Grand Avenue 48913.

Lansing, Alcoholism Program, Michigan Department of Public Health, 3500 North Logan 48914.

Muskegon, Muskegon County Council on Alcoholism, 980 Third Street 49440.

Saginaw, Saginaw County Information Center on Alcoholism, 1320 South Washington 48601.

Minnesota

Minneapolis, Minnesota Department of Health, University Campus 55440.

St. Paul, Commission on Alcohol Problems, State Office Building 55101.

St. Paul, Minnesota Department of Public Welfare, Centennial Office Building 55101.

Willmar, Alcohol and Drug Addiction Unit, Willmar State Hospital 56201.

Mississippi

Jackson, Mississippi Board of Health, Board of Health Building 39205.

Missouri

Jefferson City, Division of Health, Missouri Department of Public Health and Welfare, 221 West High Street 65101.

Jefferson City, Division of Mental Diseases, Missouri Department of Public Health and Welfare, 722 Jefferson Street 65102.

Jefferson City, Missouri Alcoholism Program, 722 Jefferson Street 65101.

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Kansas City, Kansas City Council on Alcoholism 2 West 40th Street 64111.

St. Louis, Alcoholism Treatment and Research Center, Bliss Mental Health Center, 1420 Grattan Street 63104.

St. Louis, Greater St. Louis Council on Alcoholism, 1210 Locust Street 63103.

St. Louis, St. Louis Detoxification Center, 1536 Papin Street 63103.

St. Louis, Social Science Institute, Washington University 63130.

Montana

Helena, Montana Board of Health, Cagswell Building 59601.

Warm Springs, Montana Alcoholism Services Center, Montana State Hospital 59756.

Nebraska

Ingleside, Alcoholic Unit, Hastings State Hospital 68953.

Lincoln, Lincoln Council on Alcoholism, Lincoln Center for Community Services, 215 South 15th Street 68509.

Lincoln, State Department of Public Institutions, Division of Alcoholism 68509.

Lincoln, Nebraska Department of Health, Statehouse Station, Box 94757 68509.

Omaha, Nebraska Department of Health, Psychiatric Institute 68100.

Nevada

Carson City, Division of Health, Nevada Department of Health, Welfare, and Rehabilitation, 201 South Fall Street 89701.

Carson City, Nevada Alcoholism Division, Department of Health and Welfare, State Capitol 89701.

New Hampshire

Concord, New Hampshire Department of Health and Welfare, 61 South Spring Street 03301.

Concord, Program on Alcoholism, New Hampshire Department of Health and Welfare, 105 Pleasant Street 03301.

New Jersey

Montclair, North Jersey Council on Alcoholism, Council of Social Agencies Building, 60 South Fullerton Avenue 07042.

New Brunswick, Center of Alcoholic Studies, Rutgers—The State University 08903.

Red Bank, Alcoholism Council of Monmouth County, 54 Broad Street 07701.

Trenton, Alcoholic Control Programs, New Jersey Department of Health, 66 South Warren Street 08625.

Trenton, New Jersey Department of Institutions, 135 West Hanover Street 08608.

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New Mexico

Albuquerque, Albuquerque Area Council on Alcoholism, 229-B Truman Street NE. 87108.

Albuquerque, New Mexico Commission on Alcoholism, P.O. Box 1731 87103.

Santa Fe, New Mexico Department of Public Health, 408 Galisteo Street 87501.

New York

Albany, Bureau of Alcoholism, New York Department of Mental Hygiene, 44 Holland Avenue 12208.

Albany, New York Department of Health, 88 Holland Avenue 12208.

Albany, New York Department of Mental Hygiene, 119 Washington 12225.

Binghamton, Broome County Commitee on Alcoholism, 25 Park Avenue 13901.

Brooklyn, Alcoholic Clinic, Downstate Medical Center, State University of New York, 600 Albany Avenue 11203.

Buffalo, Buffalo Area on Alcoholism, 1 West Genesee Street, 722 Genessee Building 14202.

Corning, Corning Area Council on Alcoholism, Corning Hospital, 163 East First Street 14830.

Elmira, Chemung County Council on Alcoholism, 100 East Gray Street, 240 Elmira Theater Building 14901.

Garden City, Long Island Council on Alcoholism, 350 Old Country Road 11530.

Ithaca, Alcoholism Council of Tompkins County, 223 Fayette Street 14850.

Hornell, Hornell Council on Alcoholism, P.O. Box 221 14843.

New York, United States Department of Health, Education, and Welfare, Regional Office, 26 Federal Plaza 10007.

New York, National Council on Alcoholism, 2 East 103d Street 10029.

Rochester, National Council on Alcoholism, 973 East Avenue 14607.

Syracuse, Onondaga Council on Alcoholism, 405 Community Building 107 James Street 13202.

Utica, Oneida County Council on Alcoholism, Information and Referral Center, 205 Paul Building 13501.

White Plains, Westchester Council on Alcoholism, 120 Grand Street 10601.

North Carolina

Asheville, Education Division, Board of Alcoholic Control, Parkway Office 28801.

Burlington, Alamance County Council on Alcoholism, National Bank Building 27215.

Charlotte, Charlotte Council on Alcoholism, 1125 East Morehead Street 28204.

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Durham, Durham Council on Alcoholism, 606 Snow Building 27701.

Elizabeth City, Alcoholism Information and Service Center, Medical Building, Box 645 27909.

Greensboro, Greensboro Council on Alcoholism, 216 West Market Street 27401.

Jamestown, Alcoholism Education Center, P.O. Box 348 27282.

Raleigh, Department of Mental Health, 2100–C Hillsboro Street 27607.

Raleigh, Division of Alcoholism, North Carolina Department of Mental Health, P.O. Box 9494 27603.

Raleigh, North Carolina Board of Health, 225 North McDowell Street 27602.

Wilson, Wilson County Council on Alcoholism, 116 South Goldsboro Street 27893.

Winston-Salem, Alcoholism Program of Forsyth County, 105 West Fourth Street 27201.

North Dakota

Bismarck, Commission on Alcoholism, North Dakota Department of Health, State Capitol 58501.

Fort Yates, Standing Rock Commission on Alcoholism, Standing Rock Indian Agency 58538.

Jamestown, Alcoholism Program, North Dakota State Hospital 58401.

Ohio

Akron, Akron Department of Public Health, Municipal Building 44308.

Cincinnati, Council on Alcoholism of the Greater Cincinnati Area, P.O. Box 101 45012.

Cleveland, Cleveland Center on Alcoholism, 2071 East 102d Street 44106.

Columbus, Columbus Alcoholism Program, Ohio Department of Health, 450 East Town Street 43215.

Columbus, Ohio Department of Mental Hygiene and Corrections, Ohio Department Building 43216.

Hamilton, Butler County Council on Alcoholism, P.O. Box 101 45012.

Oklahoma

Oklahoma City, Oklahoma City Council on Alcoholism, 312 Park Avenue 73102.

Oklahoma City, Oklahoma Department of Health, 3400 North Eastern 73105.

Oklahoma City, Oklahoma Department of Mental Health, State Capitol Building 73105.

Tulsa, Tulsa Council on Alcoholism, 2121 South Columbia Avenue, Parkland Plaza Building 74114.

Oregon

Grants Pass, Josephine County Council on Alcoholism, 203 NE. Steiger Street 97526.

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Portland, Alcohol Studies and Rehabilitation Section, Oregon Mental Health Division, 10 NW. 10th Avenue 97209.

Portland, Alcoholic Rehabilitation Association, 915 SE. Hawthorne 97214.

Portland, Alcohol and Drug Section, State Mental Health Division, 309 SW. Fourth Avenue 97204.

Portland, Oregon Board of Health, 1400 SW. Fifth Avenue 97201.

Salem, Division of Mental Health, Oregon Board of Control, 20 State Capitol Building 97301.

Pennsylvania

Allentown, Lehigh County Council on Alcoholism, 34 North Fifth Street 18101.

Bethlehem, Bethlehem Council on Alcoholism, Community Chest Building, 520 East Broad Street 18018.

Eagleville, Eagleville Hospital and Rehabilitation Center, P.O. Box 45 19408.

Harrisburg, Alcohol Studies and Rehabilitation Program, Pennsylvania Department of Mental Health 17108.

Harrisburg, Bureau of Special Services, State Department of Health, 10 NW. 10th Avenue 17120.

Harrisburg, Division of Alcoholism Studies and Rehabilitation, State Department of Health, P.O. Box 90 17120.

Harrisburg, Office of Mental Health, Health and Welfare Building, 17120.

Haverford, Haverford State Hospital 19041.

Lancaster, Lancaster County Council on Alcoholism, 630 Janet Avenue 17601.

Pittsburgh, Allegheny County Council on Alcoholism, 4026 Jenkins Arcade 15222.

Philadelphia, Delaware Valley Council on Alcoholism, 1006 Social Service Building, 311 South Juniper Street 19107.

Reading, Berks County Council on Alcoholism, 300 North 25th Street 19601.

Robesonia, Chit Chat Foundation, P.O. Box 418 19551.

Scranton, Northeastern Pennsylvania Council on Alcoholism, Chamber of Commerce Building 18503.

Washington, Washington County Council on Alcoholism, 18 West Wheeling 15301.

Puerto Rico

San Juan, Department of Health, Ponce de Leon Avenue 00908.

Rhode Island

Providence, Division of Alcoholism, Rhode Island Department of Social Welfare, 333 Grotto Avenue 02905.

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Providence, Rhode Island Department of Health, State Office Building 02903.

Providence, Rhode Island Department of Social Welfare, 1 Washington Avenue 02905.

South Carolina

Columbia, Commission on Alcoholism, 1429 Senate Street 29201.

Columbia, South Carolina Department of Mental Health, 2214 Bull Street 29201.

Columbia, State Board of Health, J. Marion Sims Building 29201.

South Dakota

Pierre, Commission of Mental Health and Mental Retardation, State Capitol 57501.

Pierre, South Dakota Department of Health, State Capitol 57501.

Tennessee

Chattanooga, Chattanooga Area Council on Alcoholism, 867 McCallie Avenue 37403.

Jackson, Jackson Area Council on Alcoholism, The Lawyer's Building, 201 Shannon Street, P.O. Box 1031 38301.

Memphis, Memphis Area Council on Alcoholism, 310 McCall Building 38117.

Nashville, Division of Alcoholism, Department of Mental Health, 300 Cordell Hull Building 37219.

Nashville Division of Alcoholism, Tennessee Department of Mental Health, Sixth Avenue N. 37219.

Nashville, Nashville Area Council on Alcoholism, Nashville Gas Company Building, 814 Church Street 37203.

Texas

Austin, Austin Council on Alcoholism, 411 Littlefield Building 78701.

Austin, Texas Commission on Alcoholism, 808 Sam Houston Building 78701.

Austin, Texas Department of Mental Health and Mental Retardation, 4500 Lamar Street 78711.

Austin, Texas Department of Health, 1100 West 49th Street 78756.

Dallas, United States Department of Health, Education, and Welfare, Regional Office, 1114 Commerce Street 75202.

Fort Worth, Tarrant County Council on Alcoholism, 1602 Medical Arts Building 76102.

Houston, Houston Council on Alcoholism, 601 Medical Towers 77025.

Longview, East Texas Council on Alcoholism, 621 North Fourth 75601.

Midland, Midland Council on Alcoholism, 500 West Illinois 79701.

Orange, Orange County Council on Alcoholism, P.O. Box 635 77630.

San Antonio, San Antonio Area Council on Alcoholism, 220 Life Building, 118 Broadway 78205.

Temple, Be
Building,

Utah

Salt Lake C
84111.
Salt Lake C
Drive 841
Salt Lake
Temple 8

Vermont

Burlington,
Burlington,
Avenue 0
Burlington,
05402.
Montpelier,
05602.

Virginia

Charlottesvi
Welfare,
Norfolk, N
23510.
Richmond,
Health D
Richmond,
Streets 23
Richmond,
23214.

Washington

Olympia, A
Health, 3
Olympia, W
98501.
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Seattle, Kin
ing 98101.
Seattle, Pion
Seattle, Sea
Building, 1
Vancouver,
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Wenatchee,
221 98801

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Temple, Bell County Council on Alcoholism, 816 First National Bank Building, Temple 76501.

Utah

Salt Lake City, Utah Alcoholism Foundation, 770 East South Temple 84111.

Salt Lake City, Utah Department of Health and Welfare, 44 Medical Drive 84113.

Salt Lake City, Utah State Board on Alcoholism, 770 East South Temple 84111.

Vermont

Burlington, Alcoholic Rehabilitation Board, 59–63 Pearl Street 05401.

Burlington, Vermont Alcoholic Rehabilitation Board, 34 Elmwood Avenue 05401.

Burlington, Vermont Department of Health, 115 Colchester Avenue 05402.

Montpelier, State Department of Mental Health, State Office Building 05602.

Virginia

Charlottesville, United States Department of Health, Education, and Welfare, Regional Office, 50 Seventh Street NE. 22901.

Norfolk, Norfolk Council on Alcoholism, Professional Arts Building 23510.

Richmond, Division of Alcoholic Studies and Rehabilitation, Virginia Health Department, 1314 East Grace Street 23219.

Richmond, Virginia Department of Health, Banks and Governor Streets 23219.

Richmond, Virginia Department of Mental Hygiene and Hospitals 23214.

Washington

Olympia, Alcoholism Section, Washington Department of Public Health, 320 Public Health Building 98502.

Olympia, Washington Department of Health, Public Health Building 98501.

Olympia, Washington Department of Institutions, P.O. Box 867 98501.

Seattle, King County Commission on Alcoholism, 1012 Seaboard Building 98101.

Seattle, Pioneer Fellowship House, 1102 East Spruce Street 98122.

Seattle, Seattle-King County Council on Alcoholism, 3109 Arcade Building, 1319 Second Avenue 98101.

Vancouver, Clark County Citizens' Committee on Alcoholism, 207 Central Building, 1206½ Main Street 98660.

Wenatchee, Greater Wenatchee Committee on Alcoholism, P.O. Box 221 98801.

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Yakima, Yakima Valley Council on Alcoholism, 202 Miller Building 98901.

West Virginia

Beckley, Raleigh County Mental Health Commission, P.O. Box 1759 25801.

Charleston, Alcoholism Information Center of Kanawha County, 410 Kanawha Boulevard East 25301.

Charleston, Division of Alcoholism, West Virginia Department of Mental Health, State Capitol 25305.

Charleston, West Virginia Department of Health, 1800 East Washington Street 25305.

Clarksburg, Alcoholism Information Center, 917 West Pike Street 26301.

Elkins, Alcoholism Information Office, Appalachian Mental Health Center, 201 Henry Avenue 26241.

Huntington, Alcoholism Information Center of Cabell County, 821 Sixth Avenue 25701.

Huntington, Alcoholic Treatment Unit, Huntington State Hospital 25709.

Lewisburg, Alcoholism Information Center, 106 South Court Street 24901.

Princeton, Alcoholism Information Center, Mercer County Mental Health Clinic, Court House 24701.

Spencer, Alcoholic Treatment Unit, Spencer State Hospital 25276.

Weston, Alcoholic Treatment Unit, Weston State Hospital 26452.

Wheeling, Alcoholism Information Center, McLain Building, 40 12th Street 26003.

Wheeling, Alcoholism Information Center, Peterson Place and Homestead Avenue 26003.

Wisconsin

Madison, Alcoholism Services, Division of Mental Hygiene, Wisconsin Department of Health and Social Services, 1 West Wilson Street 53702.

Madison, Dane County Alcoholic Information and Referral Center, 210 Monona Avenue 53709.

Madison, Wisconsin Board of Health, P.O. Box 309 53700.

Milwaukee, Milwaukee Council on Alcoholism, 1012 Majestic Building, 231 West Wisconsin Avenue 53203.

Racine, Racine Council on Alcoholism, 523 Main Street 53403.

Weyerhauser, WNOT Alcoholism Treatment Center, Rehabilitation Foundation, Route 1 54895.

Wyoming

Cheyenne, Division of Mental Health and Mental Retardation, Wyoming Department of Public Health, State Office Building 82001.

Evanston, Department of Alcoholic Rehabilitation, Wyoming State Hospital 82930.

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APPENDIX B

SOME SOURCES OF EDUCATIONAL MATERIALS

Some sources of information about available books, films, lectures, posters, and other educational aids are:

1. National Center for Prevention and Control of Alcoholism, National Institute of Mental Health, U.S. Public Health Service, 5454 Wisconsin Avenue, Chevy Chase, Md. 20203.
2. National Council on Alcoholism, 2 East 103 Street, New York, N.Y. 10029.
3. Center of Alcohol Studies, Rutgers University, New Brunswick, N.J. 08903.
4. Alcoholics Anonymous, Box 459, Grand Central Station, New York, N.Y. 10017.
5. United States Civil Service Commission, Bureau of Retirement, Insurance, and Occupational Health, 1900 E Street NW., Washington, D.C. 20415.

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