Paul Roman, interviewed by Trysh Travis, 16 and 17 Aug 2021, Zoom interview

This transcript of the interview with Paul Roman has been heavily edited from the original interview and some material has been drawn from the initial questionnaire which Dr Roman completed as part of the interview process. The interview was undertaken on two separate occasions and some material was lost.

Trysh Travis (TT):

I'm Trysh Travis, I'm a Professor of Women's Studies at the University of Florida in the United States. I am a cultural and literary historian of substance abuse and recovery cultures and today I am interviewing Paul Roman about the history of industrial alcohol programmes and employee assistance programmes. I am excited to talk to him because when I think of those things, his name is the person I think of and I'm excited to hear how his career developed along these lines and from what I know thus far, it was quite the intellectual journey. Paul, do you want to tell us a little bit about who you are and what your status is now and then we'll get to the real nitty gritty of this interview.

Paul Roman (PR):

I'm Paul Roman, I'm currently semi-retired, still involved at the University of Georgia as a co-investigator on a National Institutes of Health (NIH) study of the treatment of cannabis disorders in a framework of innovation. I've spent, I guess it's a total of 55 years of research related activity in dealing with alcohol and drugs. Citing that number leads me to trying to figure out how things have progressed over that period of time. Right now I'm particularly pessimistic in viewing how leadership in addiction treatment and research has bungled its dealings with the current opioid epidemic.

I got both my bachelor's and PhD at Cornell University, first enrolling in 1960, I bounced around among majors, taking full advantage of Ezra Cornell's 1865 promise to "found an institution where any person can find instruction in any study." As an undergrad, I moved among industrial relations, pre-law, and journalism, finally ending up in rural sociology. The Cornell faculty in rural sociology were incredibly open and friendly, and it was in their offices, at department socials, and in faculty homes that I learned that I wanted to be one of them. I was driven toward academia by a desire to become a teacher/researcher/advisor rather than by a burning pursuit of scientific discovery.

My first field research experiences were 3 intense summer months with a team interviewing farmers all over a remote part of New York State. We were based in a motel on a dairy farm which charged $3 per night. We were focused on farmers' general resistance to adopting what we would now call evidence-based practices in dairy farming. Seeing resistant behaviour that seemed clearly contrary to self-interest was a great way to learn first-hand about the power of culture, institutions and social class. I have never forgotten the old farmhouse door that would not be opened for an interview, behind which an old man's voice shouted, "I'll never talk to you. Cornell invented Daylight Savings Time and made us milk (the cows) in the dark." Otherwise I sat

through long interviews hearing about how certain ”new” farm practices were “dangerous,” “only for the big boys,” or “not God’s way.”

Following graduation I made the decision to stay at Cornell for graduate school, due to a romance with a younger student who ended up dumping me anyway. I started off in rural sociology but quickly found my interests had shifted to deviant behaviour. With great good fortune I received a National Institute of Mental Health traineeship to switch to the Cornell PhD program in child development and family relationships. Almost immediately, Hollingshead and Redlich’s *Social Class and Mental Illness* was an assigned reading, and with exposure to the elegant logic and methods of that study (which should be recognized today as a truly pioneering study in health and healthcare disparities), I felt I had found the Holy Grail. It turned out that I had entered a program that was really skewed toward clinical psychology despite the presence of top flight sociologists Ed Devereux and Margaret Parkman and the pan-theorist, Urie Bronfenbrenner.

Seeing that I was still in the wrong place, I was advised to meet a “different kind of sociologist” who studied alcohol issues in the Cornell School of Industrial and Labor Relations. Hence my first encounter with Harrison Trice and lightning struck. After completing my dissertation on psychiatric disorder in the workplace, Harry and I both accepted positions at the University of Georgia. That did not work out and Harry returned to Cornell after one year.

I spent the next block of my career, 17 years, at Tulane University and had a productive time there and would have probably stayed there had it not been for a new marriage to a fellow academic. My wife did not like New Orleans, so we moved to the State of Georgia, with her settling at Georgia Institute of Technology and myself settling at the University of Georgia. She is Terry Blum and is the former Dean of the Scheller College of Business at Georgia Tech and currently Director of the Centre on Entrepreneurship and Social Innovation She is co-author with me on a great deal of the work I did related to industrial and workplace alcohol and drug misuse. I moved back to the University of Georgia in 1986 and my work was generally facilitated there, they gave me some honours of Distinguished Research Professor and then Regents’ Professor and now my official title is Professor Part-time, so I don’t know what kind of mobility path that is!

TT: (Laughs.)

PR: But anyway I’m honoured to be selected for this series. I would state one thing at the beginning, I feel the study of alcohol and drugs by any behavioural scientist is about the most exciting and open field in terms of research questions that have not been answered, research questions that have only been partially answered and research questions that need to be revisited and if I were the ‘Grand Poobah’ of all graduate schools I would pull massive numbers of PhD students into alcohol and drugs studies. I love this field and going back to an ancient joke, I won’t attempt the accent, but this field has been very, very good to me. I would also add and I think it is pertinent, as a context for people’s work, I am not in recovery, although I’ve been in more contact with the recovery community than most persons who are not in recovery and I regard myself as a great friend of that community. And ageing has given me an interesting and very mixed blessing, I seem to have lost the ability to drink, so I don’t, but I

would if I could! Maybe I should donate some blood or DNA to the National Institute on Alcohol Abuse and Alcoholism (NIAAA) before I finally check out! But I'm currently a non-drinker and so I can appreciate some of the anti-alcohol perspective particularly when you're in social environments and watch what happens to drinkers.

TT: Okay. Thanks for the introduction Paul, so I really appreciate the context of your own position relative to recovery, I think that is an issue that increasingly people are feeling it's relevant to disclose, vis a vis their research. So thanks for putting that out there for anyone who was curious about that as they head into the substance of our conversation. Could you just tell us a little bit more about your intra-disciplinary, or multidisciplinary training as you moved into the field of alcohol and drug research, where you went to school, who you studied with, how that affected the way you looked at issues of alcohol and drug use.

PR: Well sure, I'll be glad to do that. As I said before, my whole formal education was at Cornell University, which is a remarkable institution. Those who know Cornell may appreciate its essence as much as I do, namely that Cornell is an amalgam of private and public supported education. Recently a Cornell professor called this 'a clumsy alliance.' That is certainly true, because you have all these missions combined together, from the level of basic extension work out in the field with people dealing with the deepest problems of science and philosophical concern. But what happens at Cornell is you do get exposed to this ambience of diversity embedded in a natural sense of democracy. It's an amazing place. As I would try to force everybody in alcohol and drugs studies as Grand Poobah, I would probably try to force everybody into Cornell as well, which is not a good plan.

But anyway, I finally ended up with Harry Trice, who became my advisor and life-long friend after that point. And Harry at that point was known for studying alcoholism in industry and was then, with one exception, the only behavioural scientist in the country really doing this. But this did not bring me directly into alcohol studies since Harry initially viewed me as a change agent for his own career. When I linked up with him and this is one of those odd parts of life, I was extremely interested in schizophrenia and the social aspects that was aetiological. So Harry, I recall vividly him saying to me, "well, I have wanted to get this alcohol stuff off my back, so let's write a book on schizophrenia and poverty." We completed that book and conducted some studies on mental illness in the workplace, but we both ended up back with Harry's focus on workplace alcohol issues.

When alcohol took center stage in the United States in the 1970s, Harry and I, even though we had not been working extensively on workplace alcoholism during my period of graduate study, were drafted into the NIAAA circle that was developing. What a place to be! I can vividly remember 1971, which was essentially the first year of NIAAA's existence, the fascinating experience of watching an organisation in its infancy. We think of government as iron clad bureaucracies which they all eventually become. But they all go through a growth process, so we had this first year, actually it was probably more like three years, of super-informal relationships with federal employees who were making up NIAAA, all of whom were in a new place but had all been recruited from different areas of Government. Hardly anybody came to NIAAA out of the private sector. On one occasion which I remember, maybe in 1973, a very large amount of money that had been earmarked for NIAAA but "impounded" by the

Nixon Administration was suddenly released and NIAAA had a tiny window in which to allocate millions of dollars. So they brought together *ad hoc* review committees to go through the accumulated grant applications and recommend what could be funded. Time was so short that this had to be done over weekends when Federal buildings were closed and the committees held at least some of their meetings in the homes of NIAAA staff. I remember a living room floor covered with grant applications – oh I tell you the money got spent.

TT: (Laughs.)

PR: So that was the early years. So I did not have a particular intellectual commitment to alcohol-in-the-workplace issues until NIAAA was founded and we kind of grew together or at least aged together. But anyway, the founding of NIAAA set the course of the first half of my career. It certainly was not the way that scholarly careers are supposed to develop. Looking back, here I was as a young assistant professor who was actually among those who were approached by a new Federal agency which more or less said, 'we've got a social problem here and we have a huge pile of money to combat it and we want to do it right.' As soon as these opportunities were clear, Harry Trice and I each started to work on research proposal ideas and at the same time Harry and I started in 1971 pulling together a book about everything that was known about occupational alcoholism and industrial alcoholism and we managed to get that into print in 1972. I guess this partially fits the mold of the way science is supposed to work.

TT: And the title of that book?

PR: It's called '*Spirits and Demons at Work: Alcohol and Other Drugs on the Job*' which turned out over time to be one of the best sellers of a division of the Cornell University Press called the ILR Press. It really was needed since it was clear that NIAAA was trying to invent a new field of practice but there was no textbook. In the sociology of occupations and professions, one of the things you find is that, while absolutely essential in the case of the professions and very helpful in the case of the "semi-professions," you can't move forward until you have a textbook. This book is a textbook in the sense that it summarizes all of the available data about workplace alcohol programs, but the data base was not that extensive, most of it collected and analysed by Trice.

In the typical course of events, the first textbook is fairly primitive but offers a roadmap for the research that is needed to build the profession. This is a little bit analogous to what you folks in literature call "the canon." Think of medical textbooks, they're all very large, which of course is a wonderful way to assume they are loaded with totally incontestable facts, which they are not. But they literally reek of authority. Having big books, big heavy books is very important in establishing the legitimacy of a profession.

The alcoholism field did not have these volumes in the 1970s. Some appeared quickly and today there are many big, heavy books about alcoholism and addiction but for those who bother to open them, they are loaded with ambiguity. About the only "canonical" book in the alcoholism field is Jellinek's '*The Disease Concept of Alcoholism.'* It is typically used as documentation for the fact that alcoholism (and

addiction) are indeed real diseases. The few who actually read that book today will find that it is loaded with ambiguity and confusion, and shows Jellinek's considerable doubt about the validity of the application of the disease concept.

An anecdote may be of interest here. Long before he was appointed director of NIAAA, Dr. Morris Chafetz co-authored a textbook on alcoholism with a social work professor, Harold Demone. Chafetz and Demone had include in their book a theory of prevention that has shown itself in various forms over the years and always created degrees of outrage. This is the suggestion that the risk of adult alcohol abuse will be reduced if children at an early age are routinely given alcohol at important family meals or gatherings. The "research" underlying this theory is the low rate of adult alcoholism in two cultures that practice this custom, Orthodox Jews and rural Italians. Needless to say, it does not have a good fit with American cultural beliefs and traditions. Chafetz had to repeatedly explain his way out to dissociate himself from this suggestion in various Congressional queries, but this theory kind of stuck to his reputation throughout his career. Fortunately, our little "textbook" was free of controversial theories and suggestions, and for a brief period Trice and Roman were associated with actual written wisdom, albeit highly limited wisdom.

So in those early years of NIAAA, we were all kind of wandering missionaries for the cause of alcoholism, but wandering with knowledge of a giant sack of money in the background, which is a pretty good way to wander. The goal was to convince employers of the "everyone wins" value of workplace-based interventions for alcohol problems. We were wandering in the footsteps of Marty Mann, Selden Bacon, Lefty Henderson and Bunky Jellinek who went out on the circuit to the extent they could, trying to promote the idea of alcoholism as a disease. This same message was at the bottom of everything that NIAAA was trying to do. But these earlier heroes had to struggle to pay their hotel bills and their train tickets while we got $100 per day in consulting fees on top of Federal per diem expense money.

NIAAA put a lot of early emphasis on workplace programming. It ended up developing a model approach called "broad brush" which I think was designed in large part to make its efforts different from what had happened in the past. This model casts a broad net to provide help to a wide range of problem employees and in the process is supposed to identify employees with alcohol problems. This worked for awhile but today there is almost no attention to employee alcohol problems in the descendants of the NIAAA broad brush programs which have been known for a long time as employee assistance programs (EAPs).

NIAAA's workplace intervention campaign initially attacked the Skid Row image of alcoholism in a way that the earlier campaigners avoided. There is no doubt that the early founders of the alcoholism-as-disease movement believed that alcoholism pervaded the social class structure, but they rarely made statements that so strongly "wrote off" the denizens of Skid Row. To confuse things, it has been less than a decade since Congressional had acted on decriminalization legislation that had had a central focus on America's alcoholism problem on skid row.

The goal of that movement had been getting these poor and unusual folks into rehabilitation, instead of jail, and now the new NIAAA model practically said let's forget about these people. It practically implied, we've been making a big mistake

all this time by focusing on them and thinking that they represent America's alcohol problem, because the truth is that the real American alcoholism problem is hidden up and down American socioeconomic strata. But if one looked closely at NIAAA's goals, they included the goal of each state passing "the Uniform Act" which would assure that public inebriates went to treatment instead of jail.

To confuse things further, the new idea was really an old idea, based on evidence for from a 1951 published study from the Yale Center of Alcohol Studies by Selden Bacon and his former doctoral student, Bob Straus (who passed away just a year or so ago). Connecticut had opened at number of treatment centers with encouragement and help from Yale, and a socioeconomic profile of those who entered treatment showed a great many to be employed middle class folks and relatively few were public inebriates.

Well, there are problems with generalising from data like that, but it fit and became translated into a statistic, namely that 5% of the American alcoholism problem is on skid row and 95% is in the "respectable" socioeconomic classes supported by employment. What emerged from NIAAA as the "trademark" of "Project 95" was the well known Interstate Highway marker with a "95."

Another twist to this, which could add some emotion to this, was that American alcoholics could be your next door neighbour, they could be your priest, your auto mechanic, they could be your children's schoolteachers, they could be your spouse, they could be your children, they could be you, hidden. And they could be found via their substandard job performance and admitted to treatment.

We now come to why workplace programs were so critical to the broader design of NIAAA's goals. The treatment programmes which had been supported or expanded in response to the decriminalisation movement were more or less fashioned around the skid row image. Thus NIAAA leadership strongly asserted that new treatment programs were needed that would attract and retain working and middle class people since existing programs were not necessarily appropriate or attractive for the middle and upper social class. Further, treatment that had been developed in response to decriminalization was minimal, so much more was needed. By asserting that the focus had been on the "5 percent," the argument to accommodate the hidden 95 percent supported a greatly expanded, revamped, and upgraded national system of treatment. So not only did we need to change the system, but we needed to build a great big new system.

TT: Hang on, I want to interrupt you and ask you to, before you move forward, to move backwards a little bit.

PR: Great.

TT: One of the things that I've found the most interesting in reading your published work, in preparation for this, is your claim about the way the NIAAA really became a federal agency, focused on advancing a set of ideas and theories that the National Council on Alcoholism had been advancing for a couple of decades prior. Could you walk back a little bit from that moment in 1970, to talk a little

bit about Selden Bacon, the Yale Plan Clinics and sort of alcoholism studies and the National Council on Alcoholism, because I think connecting the dots between the NCA, which today is often seen as sort of a, you know interesting, if a little quirky, advocacy group, whose work kind of ended with the broadening of treatment in the 1970s. I think connecting the dots between NCA and NIAAA would be something that would be really valuable for folks coming to this interview. Can you move back a little bit in time?

PR: My perspective on that starts with an important point that is not widely discussed or emphasized, namely that the addiction field does not have a national voluntary organisation involving lay people to combat either alcohol or drug dependence disorders. Nearly every other "disease"in America has one. Look at the size and the potency of the American Heart Association, the American Cancer Society, Autism Speaks, and on and on. Psychiatric disorder is represented by the weirdly name National Association of Mental Illness, a supposedly powerful organization with deep pockets that are kept filled by Big Pharma. And in the midst of these thriving corporate giants, the slightly re-named descendant of the NCA, the National Council on Alcoholism and Drug Dependence, is dead and gone. It does not exist as a national level. Many of the local "councils" that the NCA established are still in existence, but you'd have to visit each one to find what is going on. Perhaps to add to what might be called the scandal of this disappearance is the lack of any reaction to it!

I should add that I do not at all regard the various organizations of recovered folks as heirs of the NCA mantle. They have a much different purpose, largely mutual support on a large scale, and have no mechanisms for involvement of the general public.

So how do we account for this? It would be easy to say that the establishment of NIAAA and its much bigger younger sister, the National Institute on Drug Abuse, ended the need for voluntary organizations. Observing the existence of NIH Institutes for heart, cancer, Alzheimer's, and so forth undermines that idea.

Maybe it was the people. I mentioned Marty Mann, the founder of NCA, going around the country with Selden Bacon and they would occasionally get Jellinek involved. it was said to be a wonderful dog and pony show. Here they had Marty, I had the opportunity to know her and she was very charismatic, just like Bill W was. Lefty Henderson, a lesser known individual but the world's first industrial alcoholism program consultant, reportedly had the same persuasive abilities. These people could sell bricks to a drowning man. I mean they were good. So Marty would go on with scholarly Selden whose family was evidently present at the founding of Yale and was a descendant of the Bacons going back into the Middle Ages. In manner and appearance, Selden was one of the original patricians and he will not haunt me from saying that, in fact he'd say, 'Paul, say it louder!' Selden was a patrician gentleman as were members of his family. Who else could his namesake son be but the retired headmaster of a private boys' school in New Jersey?

TT: Wow.

PR: So there was a mix here that could hardly be replicated. You had Marty telling her AA story about wrecking her life, getting ready to jump out off tall buildings, overwhelmed by alcohol and struggling through the life in a sanatorium and so forth.

Then she's got her distinguished Yale sociologist sitting next to her and then we have another character who Ron Roizen has studied in depth and that's the absolutely one-of-a-kind Dr Jellinek, the eminent scientist complete with European accent. Jellinek was a sort of self-made genius. Ron Roizen has documented an earlier Jellinek outside Budapest in the Danube River at night in a rowboat, apparently with a sack of money escaping under gunfire from some kind of pyramid scheme that he had created. He ends up in Tegucigalpa, Honduras where he gets himself involved as a biological scientist with the United Fruit banana company. Later Jellinek becomes Dr Jellinek with a doctorate from the University of Tegucigalpa (an institution which seems not to have ever existed). This credential apparently helps him into a position as a biostatistician at Clark University and, being no slouch, he then moves up the ladder to Yale at the Center of Alcohol Studies.

Together and separately, these remarkable people and their synergy promoted the concept of alcoholism as a disease like any other, and must be given major credit for the eventual creation of NIAAA. They were the backbone of NCA and rallied the recovery community into being as what turned out to be a temporary political force. And they did not project or implicitly support the Skid Row image of alcoholism

The middle class respectability image can be traced back to the founding and early years of AA as well. What if Bill W. had never found Mrs. Firestone's mansion or made the connection with Dr. Bob? What if the great 4-hour meeting had been between Bill and Joe Slob who he found on a street corner in Akron ready to give up his daily dose of 4 pints of Richards' Wild Irish Rose Wine? I don't think it would have worked, even if the content of the conversation had been identical.

TT: And they really did make that argument that you know alcoholism happens to everybody, even to the respectable and I just used … That was one of their big arguments and that was Marty Mann's argument in the NCA propagation.

PR: Well it's not an 800 pound elephant, it's probably more like an 8 pound skunk sitting in the room and that is the skid row population during the life of NCA. Its existence was not denied in the way that some supported by NIAAA seemed to claim in the 1970s but Marty and her group tried their best to ignore this population. Importantly, this reflected the realities of their true bedrock partner, AA. Anyone who has worked with any Skid Row or homeless population knows that it doesn't very often work to send a total down-and-outer to AA. If you're down and out, usually your story doesn't work, or you have no story. You know after you've cleaned up your act and gotten a job, then you've got an AA story, but everything that research tells us says the public inebriate doesn't do that. I think it can be argued that there's open hostility in the literature toward the public inebriate, as far as the alcoholism community is concerned. I mean it, they're really the beggars at the feast and they can easily spoil the sweetness of recovery success.

The key player in NCA's middle history is R. Brinkley "Brink" Smithers. He of course was the fiscal patron that Marty Mann said she had dreamed of for years. As a Long Island multi-millionaire, Brink was an icon for the argument that even the most privileged in society could be alcoholic. While Smithers didn't bring the millions that the NIAAA ended up having, he essentially gave Marty a blank cheque book and really supported NCA's central office and the New York City and Long Island

affiliate organizations with tremendous amounts of money. There likely were others involved in paying NCA's bills but Smithers tends to get all the credit. To my knowledge, in his leadership position Smithers never said a word supporting decriminalization and placing Skid Row inebriates in treatment although he was of course an unequivocal advocate of the treatment solution for alcohol problems. Supporting the middle class image of the alcoholic, Smithers was from his earliest NCA days a strong advocate for workplace intervention programs. Another indicator, somewhat out of historical sequence, was the NCA-sponsored "coming out party" at Washington's Shoreham Hotel where some large number of formally dressed men and women of various degrees of fame, led by Smithers, announced their recovery status. I recall no suited-up representative of Skid Row in that group.

As I have said, some of the local affiliates of the former NCA survive, and while no one has aggregated data on what they achieve, their continued presence sustains a voluntary involvement in what might be loosely called an addiction movement.. I think that it would be fair to say that most of the successful local affiliates succeeded by following a pattern not altogether different than the AA General Services Board of Trustees. In my experience, the affiliates' leadership have a good mix of both people in recovery and people who are not in recovery. And so they have unknown influence at the local level, but I would expect it is still based in a very much a middle class kind of orientation.

TT: Very much.

PR: It can be argued that NCA's campaign from 1943 to 1970 culminated in success by the creation of NIAAA. In retrospect, this creation ended up being the doom of NCA, at least in part. From my recollections, NCA leaders were ambivalent about the creation of NIAAA. It took them out of the driver's seat, they were no longer the only kid in town. There may have been some illusion that NIAAA would be a permanent patron of NCA but it would have been a near-delusion to think that NCA could make NIAAA into a wholly owned colony and control its policies and so forth and so on. To some extent, NIAAA's divisions looked a little bit like NCA's divisions, but in my own specialty of workplace programs I would argue that NIAAA probably tried its best to disassociate its programming strategies from those of NCA, perhaps to the point of not giving credit where credit was due.

I think Morrie Chafetz was very much aware of the issues of transition between the two organizations and since he was well-acquainted with the NCA players, he was a good choice as the initial Director of NIAAA. He had been involved in alcoholism at Massachusetts General Hospital and knew the Boston alcoholism scene real well.

TT: Yep and it was ground zero.

PR: While he seemed to try to identify himself primarily with science and with psychiatry, he had a lot of understanding of the politics and a pretty good sense of how to deal with things. Now as you probably know, NIAAA like all of NIH institutes (even though it did not officially become part of NIH until the 1990s, that was its organizational model), had a Council that essentially is supposed to represent both the scientific and lay community affected by an Institute's particular disease

. These offer the promise of public oversight, with no grant to anyone being funded without being approved by the Council of the respective Institute. In reality, almost all of this is rubber stamping, I would say 99% of it is rubber stamping what the Institute's review committees have already evaluated and the Institute staff has prioritized for funding. But the Institutes are also supposed to use these councils as sources of advice and the Institutes are supposed to listen to them. Here you get into the fascinating ways in which organizations protect themselves and their professionals lay claim to authority in final decisions. The bottom line is that from the beginnings of NIAAA and within NIH then and now, the Advisory Councils (which were established by Congressional mandate) don't really exercise a whole lot of power.

Well from the beginning, any question about NCA's importance was confirmed when lo and behold I think it was Chafetz who made sure that Marty Mann (whose NCA title then was I believe Founder and Consultant) was on the first NIAAA Advisory Council. The informality of the early NIAAA is shown in this anecdote. Councils are required to have an open session and a closed session, with only Council members and NIAAA staff permitted in the closed session. Well here I was one day, in probably late 71 or early 72, in the closed session of the council listening to Marty really upset and carrying on about how she had heard that research was being funded that involved giving alcohol to alcoholics in certain experiments. I recall her saying something to the effect that this was never, never what NCA had intended when they fought for the creation of NIAAA, and there was no doubt that such research would kill suffering alcoholics, etc. On the spot Dr. Chafetz announced that NIAAA would have an iron clad policy assuring that this would never happen, that no person who was either an active or recovering alcoholic, would be given alcohol as part of an experimental design and all that research would be vetoed for funding by NIAAA, it would not happen.

What Marty was really shooting at, it seemed, were controlled drinking studies that explored whether alcoholics could be taught to become normal drinkers. This is another huge chapter in the history of NIAAA, one that they would surely like to forget. They had, in 1976, received from Dave Armor who was a sociologist affiliated with Harvard an NIAAA-funded report. It showed from NIAAA treatment center evaluation data that substantial numbers of persons who were alcoholics in treatment at Time 1(a significant minority that could not be ignored) had resumed drinking in what was called a controlled manner at Time 2, maybe 18 months later. In a moment of apparent insanity, NIAAA released this report without thinking and that led to immediate uproar with Marty Mann and NCA leading the pack. To me this was a signal moment defining that NIAAA and NCA could not be a partnership.

TT: Is that the study that Ron Roizen talks about in his article, 'The great controlled drinking controversy?'

PR: Yes, yes absolutely that's it.

TT: Okay.

PR: Ron tells that story beautifully. This remains a taboo topic today even though I see a significant undercurrent of both clinicians and researchers challenging the abstinence criterion as the only measure of treatment success. There has always been a similar

undercurrent about the validity of the disease concept. When NIAAA officials or other people in the alcoholism community are put up against the wall about these things, they literally melt into double talk and just descend into gibberish. and the whole conversation falls apart.

These topics are more or less off limits for funded research. Maybe there should be a warning sign accompanying the availability of alcohol research money, a big sign saying 'purists need not apply.' There's lots of snags and problems and issues and controversies, such as 'how do people recover' – well they stop using – ha, what do you mean, they can't stop using, no they stop using - well wait a minute, you just said they can't, they have this uncontrollable urge – well um, ah, well they overcome that.

TT: So it's not uncontrollable. (Laughs.)

PR: So anyway, researchers in this arena need to live with these rather severe ambiguities, and this is why purists need not apply. One answer to your NCA question is NCA's dead and NIAAA is not. NCA succeeded in getting a lot of money out of NIAAA, not only at the national level but for grants to their local councils. I don't know how widely known this is, but in the realm of occupational programming, NCA got, I think the largest grant the NIAAA had ever given out up to that time, which was the late 70s., for what they called the 'Ten Cities Project,' which was to set up a labour management council in each of ten large cities that would promote the development of joint labour management and alcoholism programmes in these communities. And given the fact that that was the biggest grant ever given out, one would have thought there would have been a major evaluation of what this project accomplished and how it did it. Instead a small consulting contract was given to an NIAAA "insider" who had no background whatsoever in this kind of research. At the time, the word was that NCA would only accept an evaluator who met their approval and promised not to cause trouble. The whole Ten Cities project was a big wash out, for a lot of different reasons. It was overly complicated, it was not adequately conceptualised, it should have been a phased-in effort, (if you're going to launch efforts ten cities, why not do it in sequence over a period of time, so you learn from one city to the next). None of this happened. But some of the projects funded among the local affiliates were quite good.

The problem with demonstration projects in those days and the problem with the same kind of funding that in given out for alcohol and drug projects in much, much larger quantities by the U. S. Substance Abuse and Mental Health Services Administration (SAMHSA) is the absence of outcome evaluations. One would think that would have changed by now, but there is a perfunctory requirement for outcome evaluations for all SAMHSA funded projects, but no one ever sees them. SAMHSA does not even have a mechanism for researchers to find the outcomes of the billions and billions that have been spent, those targeting the current opioid epidemic being a great example. With the US government supposedly committed to evidence-based practices, this is both ridiculous and outrageous. Thus with the opioid epidemic huge intervention projects are almost never properly evaluated and we seem unable to learn what works and what doesn't work and thus make the same mistakes over and over. I am trying to make the point that this problem with Federal intervention programs stretches back at least 50 years and leadership is totally numb about it.

In my opinion, the research that needed to be done about how we'd solve the opioid crisis still hasn't been launched, namely a blitz research and demonstration program to understand how to fully involve all levels of the medical community in dealing with this disaster. Nobody can say that the federal government has given short shrift in the amount of money it has poured into the opioid crisis, relative to what was being spent before, but the huge bulk of funds that go directly to the states is poured into SOS, 'same old "stuff".' There is some innovation here and there, but no real organised effort to diffuse innovations. Most of the money goes to places doing the same old thing, including places that reject the idea of medication assisted treatment.

Going back to the link between NCA and today. I cannot identify NIAAA's message today, and they seem unaware of the piles of data that show that an epidemic of excessive drinking has both preceded and been exacerbated by the COVID pandemic. NIAAA might say that they are engaged in the best quality research that is voluntarily submitted for review and they don't really have any themes, except that they know everything that could possibly be known about college student drinking behaviour. Maybe they are quiet because they got themselves incredibly embarrassed a couple of years ago with a huge study, which was going to look at the cardiac effects of people drinking one drink a day, and supposedly offer the last word in the scientific controversy over whether modest alcohol use has positive cardiac effects. The way the study originated and was funded seemed to break all NIH rules. But to me the study itself was bizarre. Researchers were somehow going to identify an adequately sized and diverse sub-population that drinks one drink a day, not two drinks a day, or not zero drinks a day, but they had to drink that one drink, and evidently couldn't skip a day. I mean that population doesn't even exist, I don't know anybody who drinks one drink a day, I've never seen such a person! Even if you could find such people, how do the researchers control its volume? So anyway, NIAAA got themselves totally embarrassed over a bunch of funding and ethics issues surrounding that project which ended up being deep-sized. I'm sure this episode did not help their status within the NIH community.

So while NIAAA survived and NCA didn't, it is hard to figure out what NIAAA is today.

A final comment on the NCA link to NIAAA. I mentioned earlier that NIAAA may be seen as having continued the workplace alcoholism effort that had been launched decades earlier by NCA. NCA definitely had an industrial occupational programming activity well before NIAAA came along. At the time of NIAAA's creation, NCA had a formal Labor Management Division that was strongly supported by Brink Smithers. While NIAAA created a national network of "occupational program consultants," there can be little doubt that the model was the activity of a Yale-NCA employee in the 40s and 50s, a man in recovery I already mentioned, Ralph "Lefty" Henderson. What I think he would do (it's not recorded, he left no diary and wrote very little) was to use the AA community to tap into somebody who was in recovery in a local company and then use that guy as an entry point as well as leverage to convince the company to start a cost-free effort where this guy would identify alcoholic employees and get them into AA and then back to work as good employees.

The employee in recovery who Henderson picked out was the selling point, and surely he tried to find people whose behaviour and job performance had changed

dramatically after they had affiliated with AA. But this wasn't just a way of planting AA into a workplace….it had a real programmatic thrust. Henderson's emphases was identifying the workers with an alcohol problem (who everyone presumably agreed were out there) and giving them the chance to take a shot at AA recovery. The core message was you are not going to fire him, you are going to let him have a chance and the motivation behind that is what originally was called 'constructive coercion,' namely if you don't take this advice you may be fired.

Without any records, there is no real documentation of what Henderson accomplished although there is a generalized belief that he made a lot of impact in a lot of places. Lots of questions remain, but it seems likely that some good seeds were planted since what he was "selling" was free and simple. Henderson died suddenly and after a hiatus he was replaced within NCA (Henderson had been a Yale Center employee) by Lew Presnall, a former minister who, unlike Henderson, was not in recovery. Lew's work started off in the rough and tumble mining industry and the effort with which he is most often identified is Kennecott Copper's Chino Mine. His original role was industrial chaplain.

TT: That the records are missing is a real shame, because industrial chaplains, we need to know more about that.

PR: Oh they're under the research radar, but they are out there still, in significant numbers. One well-known program that was included among NIAAA's model efforts because of its comprehensive coverage was at R. J. Reynolds Tobacco in North Carolina. It was quite old and had always been staffed by chaplains. Rodney Brown was the program manager and he was one of those recruited to help NIAAA train its consultants. The history of this program reports that in earlier days one of its activities involved getting workers to voluntarily come to work an hour early, before the whistle blew. What do you think would they do?

TT: Pray.

PR: Sing hymns, they'd have hymn singing before they'd go to work. I'm sure there was prayer as well. And this workplace alcoholism programme segued into a broader employee assistance program under Brown's leadership. The role of chaplains in workplace alcoholism history is completely overlooked. Returning to Presnall, the former chaplain…..he is often given credit for inventing the first program that based its interventions on declining job performance rather than on looking for the signs and symptoms of alcoholism. His methodology, which has never been advocated in any of the overviews of "how to do" workplace programming, was to study personnel records for evidence of deteriorating performance and increased or patterned absenteeism. This method couldn't help but uncover employees with all sorts of problems, including alcohol issues.

The broad programme idea may have also flowed from his industrial chaplaincy where employees would bring for any kind of problem to him, not just alcohol problems. I may be wrong about Presnall being Lefty Henderson's direct successor, but the NCA records are either missing or they don't exist. A significant point is the differences in the backgrounds of these two guys. Presnall apparently left in a major huff over something and went to do some kind of workplace programming in a

Midwest insurance company. He was succeeded by Ross Von Weigand who was in recovery, he'd been a real white collar consultant guy, a high level alcoholic employee, who had found recovery and was apparently a workplace success story. His employer had been Perkins Elmer and he became the Division Director of NCA for creating programmes in business and industry. He had two or three assistants most of the time, and I believe he stayed in this job until he died. Rather than doing direct field outreach, I think the *modus operandi* from the national office was largely to provide advice to the local affiliate councils in how to start programmes in their communities. What a treasure trove it would be found in the records of this NCA Division.

TT: There are some papers at the Hay Library at Brown University and they have …

PR: Oh the Chester Kirk collection?

TT: Yeah there are, some of the NCA papers are there and some are in Marty Mann's personal papers at Syracuse University.

PR: Yeah, most of Marty's stuff is at Syracuse. There was a curious indirect connection between NCA and NIAAA through a social worker in Utah, Otto Jones. When NIAAA leadership was trying to formulate its workplace approach in 1971, it somehow found Otto and his Insight Program at Kennecott Copper. From that time forward, for NIAAA, Jones walked on water, or better. Lew Presnall had started his employee alcoholism program in the same company but with the broad approach that included other employee problems in a remote location away from headquarters in Salt Lake City. Jones came on the scene much later, and his program was in Salt Lake. But no one seemed to want to make the connection between the two men, and certainly no one to my knowledge has ever said that Jones followed in Presnall's footsteps. The fact that they were both in the same company does how strongly suggest this, at least to me.

NIAAA regarded Jones' program as an exemplar of the "broad brush" approach that attracted a range of what was for awhile called "troubled employees" and which included employees with alcohol problems. Turning again to backgrounds, Jones was a licensed social worker and to my knowledge was not in recovery. The "tone" of his program, which I had the privilege of visiting for several days in Salt Lake, was an open-door helping effort which had a positive air of trust and I sensed that people believed it was a place where they could really get help for what they needed help for. To me, it did not have any real "flavour" of dealing with alcohol problems, although it definitely did. So you can see, there was a complicated mix of backgrounds and ideas as NIAAA put its plans together.

TT: It sounds like it.

PR: Yeah.

TT: Is he a Mormon?

PR: I honestly don't know, and if he was, it was not part of the identity that he projected. I believe Otto is still with us and retired. He later started one of the first companies that sold EAP services and made a huge fortune.

TT: I couldn't find an obituary……..

But that would be a very different model of industrial chaplain. But he was a social worker, so he came …

PR: No, no, no Jones was a social worker, Presnall was not a Mormon.

TT: No, no, no I'm talking about Otto Jones.

PR: That this work started in Utah is a bit curious. The story of alcohol and drug problems in Utah has got several significant dimensions to it. We often overlook the fact that while Utah, Idaho and Northern Arizona are heavily Mormon, they are not exclusively Mormon. And there are many people who have left the church, or who just rebelled against it. There are non-Mormons among whom I think there are those who enjoy rebelling against the uptight, straight culture, the dominant culture of Utah. So when you turn into an alcoholic in Utah, you tend to really go all the way. The State has always taken the alcoholism problem very seriously, but with the attitude that relatively, well essentially none of the people serviced by its programs are active in the church. They may have been former members or drop outs.

The other curious thing is that there are Mormons who leave the church and get in with a non-Mormon community and become very vehement in their rejection of all things Mormon. They may try to take on as many non-Mormon characteristics as they can. There is evidence that they may be at unusual risk of becoming problem drinkers, not because of rebellion, but because if you are presented with alcohol, you haven't the vaguest idea of what to do with it. If you were brought up in Mormon community life, alcohol is a missing cultural item. It is forbidden, but other than that, it has no meaning. You don't know what alcohol is, you see somebody drinking a beer, a big glass of beer, alright and you go home and say I'd like to try this "alcohol." Well here's some whiskey, alright, I'll pour myself a glass of whiskey, you really don't know the difference as to whether that glass of whiskey should be the same size as the glass of beer. This is very simplistic, but it is clear that when you combine ready access to a substance with a near-total lack of information about its nature and consequences, you are definitely at risk. Similar dynamics may also be true in the Islamic community. All this adds up to saying that alcohol has a peculiar relationship to culture and society in Utah, and while it may be downplayed, it is not a trivial issue.

So Otto Jones was a significant player in the unfolding of the NIAAA workplace programme. He lectured at the training program for the OPCs. His model had elements of both trust and professionalism, which were impressive. I have already stated to you that NIAAA wanted to redefine the target for their alcohol interventions. They wanted to make their institute a respectable operation by aligning it with the middle and upper classes, not inconsistent with the way that local NCA councils would try to load up their boards of directors with non-alcoholic community leaders.

But they couldn't totally ignore the other populations and so there were some support and emphasis on public inebriate programmes.

If we look at the occupational programming emphasis in a different light, it is clear that they thought it would have a great deal of value to their goal of building a treatment system. If they could create mechanisms for identifying middle class and working class alcoholics and get them referred to treatment, they would be dealing with a population more likely to have insurance to cover the cost of the treatment of alcoholism. So in other words if they could generate this population coming out of the work place, they would be able to support their new system of treatment centres. This could fulfil in a way the dream of Marty Mann that alcoholism would be treated as a disease like any other.

TT: Right.

PR: So there's another link between NIAAA and NCA. At the same time I believe that NCA and its affiliates got some NIAAA funding to persuade state legislators to pass legislation that would require group insurance plans sold in that State to require coverage for the treatment of alcoholism. Incidentally, some if not most of those new State laws initially said that only inpatient treatment for alcoholism would be covered. but no coverage should be provided for outpatient treatment.

TT: Wow.

PR: The reason for that seems to be the only game in town in the late 60s and early 70s was inpatient treatment, nearly all of which followed the 28 day Minnesota Model.. So outpatient treatment was an innovation which certainly didn't fit the Minnesota Model except possibly for aftercare. Within the AA vision, outpatient treatment that wasn't AA was perhaps seen as inadequate and just not making any particular sense. Those interests pushing for insurance coverage were ideologically invested in AA and the very complementary Minnesota Model.

TT: But wait a minute, what about the Yale Plan Clinics, that was an outpatient model, why didn't they just say let's adopt that model of the Yale Plan Clinics and have them, have that services be paid for by a third party?

PR: I don't know, I don't know if the Yale Plan Clinics had any organizational descendants left by the 1970s. The Yale Center certainly deemed them as effective in the 1950s, but don't know if that connection was ever made by the 1970s. A historian could dig this out, you'd have to look at a bunch of stuff in the early 70s, but my hypothesis is that outpatient treatment alone was seen as a rare bird, … And there wasn't a lot of inpatient treatment, but what treatment there was, was inpatient.

TT: And based on the Minnesota model.

PR: So in any event that … yes, yes the Minnesota model was seen as sacred.

TT: Right.

PR: The Minnesota model of course that had AA all through it, you know. It was like a quilt with AA fabric sewed in all through it. In retrospect, it was a brilliant blending of professional ideas and the lay ideology of AA. In the early 1970s, it seemed that the NIAAA position shared by the developing alcoholism community was that people in trouble with alcohol could either get better through AA, and if that didn't work, the preference was that 28 days in treatment would be effective people would come out and enter AA immediately upon leaving treatment. If they were bad off, and needed detox, they would be admitted to 28 day treatment as the first step.

Incidentally, I recall people in this second category who would go through 28 day treatment without ever experiencing a community AA meeting. Evidently when these folks would show up at a meeting after their treatment, they tended to talk too much and lack adequate humility, gaining an AA nickname of "28-Day Wonders."

Most of this stuff is moving forward without any data and so that's going to be pertinent in a minute if I …. Okay so here's a system that's being created NIAAA says we've got to recruit these alcoholics in the workplace, we have to find them and bring them to treatment, to fill our new treatment centers. They would be covered by insurance and we will have a system that runs itself. We will literally create a machine with input in one end and output out the other and given the number of people who work, this was a treatment opportunity with a potentially massive caseload.

TT: Maybe what we could do is just go back to that point where we were talking yesterday, you describe people sitting on the floor and living rooms, with piles of paper, trying to figure out how to spend huge pots of money, as a sort of utopian and dystopian moment in the development of these programmes. So out of that moment, which I think you said was 71.

PR: Right ,okay, I'll get back to details about how occupational programming developed. NIAAA moved very fast, probably too fast and that probably accounts for the fact that they really did not start with a solid evidence base for how they should do it. There was almost no direct evidence and no one went searching for basic research studies that might offer guidance. They were under pressure. As you know and this is a bureaucratic fact, it's inevitable, but once government agencies have a budget, are under great time pressure to spend that budget.

TT: Yeah.

P If they show that they can't spend the money, then they don't need the money and they are in terrible shape. So they need to not only spend their money, but show that that it was far less than they really needed. This is just a structural feature of public bureaucracies that have budgets that arrive in 12 month intervals. We have Nixon signing the NIAAA creation bill on News Year Eve, December 31st 1970. In 1971 we have the place getting staffed up and people being brought in, you know without clear job descriptions and without a clear mission statement of what they should be doing. As I understand it, they had 6.5 million dollars for their first fiscal year. So anyway, so they got their act together and tried to figure out what they were going to do. They had multiple missions but the number one mission was probably continuity with NCA's message of treating alcoholism as a disease like any other. NIAAA was the platform for them to create a nationwide treatment system that would give access to

anybody who needed treatment for this recognized disease. The treatment would have to be highly professional, training would be needed to get people who were appropriate to deliver the treatment and insurance would be needed to cover the cost of treatment.

It would be a great challenge for political science theory to articulate how leadership can segue from a dominant private sector voluntary organisation to a government agency having charge over a particular social and health problem. In the case of other diseases, this move did not end up killing the voluntary association as it seems to with the National Council on Alcoholism. Instead the National Cancer Society and the American Heart Association and the Alzheimer's Association seem to thrive along with their respective agencies at NIH. But in our case things got worse and worse and the voluntary involvement, the voluntary agency disappears. So there is a very important question there.

TT: (Laughs.) Little do you know!

PR: So anyway, shifting NIAAA's workplace programming what they had in front of them was the NCA experience of setting up programmes in industry, dedicated solely to alcoholism, heavily dominated by the AA community. While not explicit, they faced a very important organisational issue, how can we make this our own? We cannot just elaborate what NCA has done. No, NIAAA is going to own this. They came up with this plan of sending two people to every State to be their change agents, to be their crusaders, almost reminiscent of the Epistles of Paul. These missionaries will spread the word and convert the public and private sectors into adopting ways of identifying people with alcohol problems and getting them into treatment, through workplace based mechanisms. Instead of picking the missionaries themselves, they gave the states grants and let them pick them. This of course reflects old State Rights issue which were, pervades so much in our society, and which remains a millstone around the neck of the Federal government as it distributes money to deal with alcoholism and addictions.

After these 100+ folks are chosen, NIAAA brought them for a training programme to this extremely elegant and exclusive golfing resort in Pinehurst, North Carolina for 3 weeks in June 1972. They were officially labelled "occupational program consultants (OPCs). At the opening banquet, these guys, about three women and 97 men, are presented with a filet mignon and royal lobster tail. There is kind of a nasty anecdote that some of them didn't know what to do with the lobster tail, they had never seen one before. Will Foster who had been appointed as the head of the occupational programs branch for NIAAA, was this incredibly charismatic guy and he said this is just the first of many meals like this that you will see, we're going top drawer. You people are going to be out there working with the captains of industry. You're going to be persuading them to save alcoholics, to bring them for treatment sooner than they would be brought under the ordinary course of events. Your target is the vast majority of people with alcohol problems in the United States of America who are in the workforce.

As I have already mentioned, the mechanism that Will Foster promoted was the "broad brush" approach where all employees with problems were encouraged to use the program, following somewhat the model of Otto Jones' program in Kennecott.

There is now essentially no organised effort to identify and provide whatever help is needed to employed people with alcohol problems. The deterioration of this outreach mechanism has occurred without any real leadership in government, or the private sector. No one is saying hey we need to do restart this, because we have a huge alcohol problem that is not being addressed.

Related to your interests, Trysh, we have a new and growing alcohol problem where women are achieving parity with men in terms of the equivalency of their alcohol problems, as they "coincidentally" become employed. So there was a halcyon moment in 1972 and it should be a halcyon moment again today.

Okay, NIAAA had two things, they had this network and they had this idea of intervention that had been propagated since 1940s by the National Council on Alcoholism. Okay, so they went out, you know well exercised and bushy tailed from 3 weeks at Pinehurst, going off to their respective States, going in various different directions. You can see that scenario, maybe you can put a sunrise behind it., here they are all moving off to this work and they go to work.

Six months later the band of OPCs go to San Francisco for their next training meeting at the beautiful Sheraton Palace Hotel on Market Street, which if you've never visited, it's just a gorgeous place and you can go see the room where President Harding mysteriously died in that hotel. I was present at these events that I'm describing and oh my gosh the OPCs are in terrible shape. It didn't work. It didn't work, employers do not want to adopt these programs. They are speaking up to their trainers, some of them are angry, they are frustrated. I'm not sure if any of them had quit by this point, but some are on the verge of quitting, it's really this feeling of abandonment. Again I love to use Biblical metaphors, the OPCs were feeling very much like Moses having led them out of Egypt (their former jobs) and here they are in the desert, they have nothing to eat, it isn't working, they are going to starve. So the NIAAA leaders at that point had to move fast. I remember this very clearly, there were the training sessions that were going on and then there were these smoke filled rooms where the NIAAA leadership was meeting with individual OPCs trying to pry out information, what went wrong, hey give us any ideas, etc., etc….

It turned out that very few of them were actually promoting the broad brush program that Foster and other NIAAA leaders had been preaching about at Pinehurst. What the NIAAA leaders had failed to anticipate was that the OPCs may have been all revved up about the broad brush approach when they left Pinehurst, but they all returned to alcoholism agencies whose mandate was to deal with alcoholism. In all likelihood, many of the OPCs became thoroughly confused as to how they should be approaching the selling of programs to workplaces, but Pinehurst had not really equipped them to do this. It was clear that if NIAAA was really committed to this new broad brush approach, it was going to have to really get the OPCs to use it in their diffusion work. So NIAAA backpedalled and came down hard on problems that they had with the occupational alcoholism program model that it seemed was the preference of the state agencies where the OPCs worked.

The first one was a big one, which remains with us today and that is the stigma of alcoholism. Walk in to any workplace today and say, 'Hi, I'm here to talk about alcoholism that you may have among your employees.' Here's an example of a sure

bet, you'll win every time. Bet on the possibility that the company officials will not say, "Oh, welcome, we've been waiting for you to come.' No that is not going to happen. They will try to get rid of you as quickly as possible.

You might as well have come in and said we are here to talk about the incompetence that you've been demonstrating as managers, you evidently have been hiring drunks. Oh, you and if you didn't hire them? Well, you've got them here and you tolerate them and I hope your stockholders don't hear about this, but I can help you fix your incompetence. So then the visitor will be thrown out even faster.

So the OPCs are complaining that workplaces don't want to hear about alcoholism. But they're living off NIAAA money so how can they not talk about alcoholism? Oh um… that is a real challenge. Alright so, assuming you weren't thrown out, then we've got a second problem, The OPC tells the company manager that the problem drinkers will be identified by their supervisors. The response is how can a supervisor do this and the OPCs didn't have very good answers – well they'll know about it, you know everybody knows who the alcoholics are. Anyway this thing just didn't sell, the idea of identifying alcoholic employees by supervisors by looking for alcoholics. But going back to Lewis Presnall and to NCA, what you are going to see with an alcoholic employee is deteriorating job performance. This includes absenteeism that could follow a pattern of occurring especially after weekends, mistakes and poor quality work, bad relationships with co-workers or clients, and something insidious (a concept invented by Harry Trice) called on-the-job absenteeism as early as the 1950s, which means that you are there on the job, but you are really not there at all. This has been reinvented as presenteeism, with no credit whatsoever given to Trice. Opportunities for this vary by the ecology of particular jobs.

The approach of identifying all problems with job performance that supervisors could not otherwise account for had been been described at the Pinehurst training. It did not really sink in, and needed to be further repeated and discussed. It seems that it became the mantra for the OPCs after the San Francisco training: don't try to identify these workers on the basis of the characteristics of their alcoholic behaviour, identify these people on the basis of their job performance problems. And these problems have to be documented in black and white so that the employee cannot con the supervisor, as active alcoholics are very adept at doing.

In a nutshell, the emerging program concept (which would begin to be called an employee assistance program [EAP] over the next year) is to cast out this big net using job performance problems that can be documented: chronic absenteeism, unexcused absenteeism, tardiness, unexplained absences from the work station, poor relationships with co-workers, mood changes during work and arguments or fighting. Lights were coming on all over the place. You take all these possible observations and you urge supervisors to attend to these, and you've got a wonderful tool all of a sudden. Hey that's what supervisors are supposed to do anyway, that's their job, they are supposed to be monitoring job performance, making sure the work gets done, they've got to get the work out.

This kind of supervisory responsibility extends from assembly lines to department heads at colleges and universities. So the OPC has two new tools for encouraging adoption: first, implementing a program does not require introducing new kinds of

skills. Second, every employer has to agree that there are problem employees in the workplace who are not doing their jobs.

This might be seen as really smoothing the way for the adoption of programs, almost like black magic, since the OPC only needs to point to aspects of the workplace that are already present. However, to use an old machine analogy, there are some clinkers in the coal that the stoker automatically feeds into the furnace. A clinker is a rock that gets mixed in the coal and it can bust the stoker, the machine that's feeding coal into the furnace.

The first clinkers are the employees who can't do their job properly, because of various reasons that are inherent in the job; they didn't get the right training, they're assigned to the wrong job, they don't have the right tools, they are bothered by co-workers, they are in a situation where it's freezing cold or boiling hot, or whatever, just a thousand on- the-job reasons, which a supervisor needs to attend to on a day to day basis. So you can identify those, you need to do that as a supervisor. These are reasons why these people's work is not going properly, let's see if we can fix it and it has nothing to do with the occupational intervention program. But in training supervisors, this distinction has to be carefully and emphatically made.

Second is the real problem, the harder rock. This is the target group for a job performance based program where the supervisor says, 'I don't know what is wrong with that guy, why is he coming to work late, in other words, I can't figure out what his problem is. But since we have an employment contract that he has agreed that he's going to do his job as long as he works here, it's up to him to tell me or account for why he's not doing his job. And I'll give him a list of the number of days he's been absent, the number of days she was late, the fights he had had with her co-workers that I know about. and he's got to explain this, we can't tolerate this, you know you've got to do something or I'm gonna have to take action. Then what?'

We started off with an industrial alcoholism program and our model was to turn the employee over to a guy in the medical department who is a recovered alcoholic and who will take this dude to AA to get him straightened out. This won't work here. So it turns out that our new broad brush does require something additional and new, namely a professional who can figure out what ails this employee and what ought to be done about it. Put this in professional jargon, we need to be able to refer the employee to a skilled person who can not only diagnose what is wrong, but make the proper decision on the appropriate next steps. Following what seems to be tradition and having a recovered alcoholic in this position is not going to work unless that recovered alcoholic is a certified professional with credentials to deal with behaviour disorders.

This last requirement was a big one, and in fact a good number of programs that followed the broad brush model had a diagnostic function that was carried out by a recovered alcoholic. Some of them covered their bases by getting advanced training, by using in-house physicians or nurses to help them, or by relying on a diagnostic function that was external to the organization.

Here you can see that we are running off the track in terms of having an occupational alcoholism program indirectly supported by NIAAA. Jumping ahead, what is needed

is this very specialized occupation of a person highly skilled in alcoholism but with overall diagnostic competence, and with the ability to very effectively interface with both the workplace and the treatment place. This was the essential backbone for the program model that was envisioned. And despite some good efforts, this never really happened.

Let's go back to the supervisor talking to the problem employee. 'Well listen we've got a confidential programme here in the ABC Cracker Company, where you can go and you can talk about this problem you're having with your job. We're going to, we are not going to do anything, this is going to be totally confidential, we're not putting it in your personnel record, but we want to keep you, we want to get you back to work. But you are not going to be able to stay here if you keep working at this low level. So if you've got a problem that you need to talk to somebody about, I'm your supervisor, I'm your good friend, I'm not an expert on behavioural problems, or any of that stuff that might be going on in your life, but you can go see Sam Williams, who is in charge of, now we say Employee Assistance Programme.

So that became the model. Am I communicating, is this story making sense? Okay, so what the implications of this are, is that we don't call it Employee Alcoholism Programme anymore, we call them Employee Assistance Programme and the OPCs go into the workplace, not saying we know that 10% of your workforce are actually alcoholics and we need to help you do something about that, but instead saying, we think on the basis of our experience that you've got a bunch of workers in here with performance problems. They are costing the company money and you've not been able to do anything about them, you've tried and this, that, it drives the supervisors crazy and some of the supervisors spend night and day dealing with this. For some of them it's ruined their own job sometimes because they're so frustrated about not knowing the right thing to do. We can take that burden off them.'

And all of a sudden it's found that this works as a selling strategy, because what employer could say I have no problem employees? It also seemed to be work because there did not need to be any real discussion of alcohol problems. I think back to the two decades when I had 20 research assistants working here in my grant operated projects at the University of Georgia, by gosh did I wish I had help of an employee assistance programme for job performance problems, but the University of Georgia didn't have one. So I had to suffer alone. And on more than one occasion I made a real mess of things.

So anyway, the job performance emphasis worked in terms of generating a flow of program adoptions coming out of the work of the OPCs, but NIAAA said the key to making this fit with our overall scheme, you've got to keep your eye on the alcoholism ball, because a company can easily get distracted by other problems that this mechanism brings to the referral process. Perhaps oddly, there was not a lot of discussion about this very obvious problem. The nuance that was important occurred in the supervisory training, which was an absolutely critical part of program implementation. Supervisory training ideally included a lot of talk about alcoholism but emphasized how the purpose could be defeated if alcohol problems were openly discussed or if the supervisor started looking for the signs and symptoms of alcohol problems. At this point in history, supervisors were the key to making the unusual mechanisms of this program model work.

So this was the essence of the Employee Assistance Programme, with an emphasis on alcohol. From 1973 this broad brush model was the watch word for the occupational programmes grants of the NIAAA. They essentially said that their funds will support programmes that identified and assisted people with all sorts of personal problems, because they knew that they're a mechanism which will identify employees with alcohol problems. The emphasis by NIAAA was to make sure programme managers and programme coordinators as they were often called had been trained in a way that they could identify alcohol problems and guide their proper treatment but also were skilled in identifying other kinds of problems, so that people got referred to the right kind of community service.

TT: The programme, I've got a question, the programme coordinator would be on the industry side, so the programme coordinator works for ABC Cracker Company?

PR: That's right, she is an employee of ABC Cracker Company.

TT: Do they get trained?

PR: I say "she", incidentally because at this point lots of women were hired for these positions …

TT: Yes I can totally see this, because how this is a soft skills job, it's an HR job.

PR: Yeah and these women were fantastic, I referred to some of them as occupational program nuns. They were so committed to this work, they would call their clients over the weekend, they'd call them on holidays, they'd bring them home for dinner. They would do everything to make sure their recovery was sustained. And of course there were men in these jobs who would do this too.

TT: So wait, I've got another question. So there would be a person on the industry side, who was identified for this programme coordinator job and then that person would get trained by one of the State level NIAAA funded consultants?

PR: You've hit on a critical point. No, it was not expected that the state OPCs would train the program coordinator. The OPC was supposed to be skilled in launching the workplace program, providing guidance in writing policy and procedures, assuring that the union was on board if there was one, and helping to choose the proper staff. The extent to which a company wanted an outsider to provide this help was highly variable, and since the OPCs were providing services for free, they couldn't very well dictate how the program got put in place, they could just offer advice. This was going to prove to be a major pitfall because a system of selecting and training these internal coordinators never really got developed. Looking backward, the logistics of doing that seem impossible. What was needed was the creation of an occupation of program coordinator or administrator, maybe with something like community college courses that could have been offered in many locations. But that raises the question of who would teach such courses.

It turned out that people assigned to be program coordinators in workplaces that adopted these programs were a diverse lot. Many were folks in recovery who tried diligently to enhance their skill sets to cover these expectations as they understood them. In many instances persons with credentials in social work or counselling took the jobs. And in many settings, union members who were in recovery would become part of a team to coordinate the program.

This highlights an issue that was actually dealt with pretty well in my estimation, namely the involvement of unions. Beginning with the training at Pinehurst, a lot of emphasis, perhaps too much emphasis, was placed on getting union agreement and cooperation so that the program would be supported. , You were not going to succeed with implementing this programme, unless you involve the union.

TT: Right.

PR: There was no question about this from day one and of course this was not a radical invention because unions have of course had welfare programmes of all sorts for their membership. That is one of their mandates and the AFL-CIO was very proud of its own Community Services unit, which was run nationally by a very outspoken social worker, Leo Perlis, who seemed to look at these programs as a bit of a threat to what he had underway and he did not at all like the "open-ended" idea of a broad brush program as compared to a straightforward employee alcoholism program. The involvement of labour in workplace programmes, I mean it was an absolute natural, you know labour would come on board. Why would labour get in the way of a union member's recovery?

Of course it was paramount for the internal programme coordinator to be an absolute neutral and even though her pay cheque was written by the company, she really needed to be absolutely neutral. Here we get into a potential conflict, does she have in mind as her goal, the successful recovery of the individual from his alcoholism, or the successful return to work of an adequately performing employee? Now we would love to think that those two things are perfectly correlated and they are not.

TT: That's right, no.

PR: They are not perfectly correlated and there are people who do return to work and perform according to standards and continue to drink and there are those who succeed in the programme fantastically, but it turns out they were referred to the programme because they are a lousy performer and they come out of the programme as a lousy performer. And AA has a wonderful line on this, I don't know if you've heard, it said, 'one thing about the AA programme, don't let your expectations go wild, because if you see a drunken son of a bitch come in the door for the programme, when he finishes it's very likely you'll see a sober son of a bitch go out.' So you know we don't totally change people and totally revamp them. And I would quickly add that while the AA programme can potentially change people, it's up to the individual as to how far he wants to pursue this.

So anyway you can see that that loyalty issue for the programme coordinator is a bit neutralised by the involvement of labour. In an organised company if the employee who was being referred is a member of the bargaining unit, his, or her shop steward

should be part of the process every step of the way, respecting confidentiality of course. You bring in the individual shop steward to sit with the programme advisor or programme coordinator and the supervisor, depending the confidentiality provisions. The whole idea that this is being done for the good of the employee. Compared to a non-union setting, a member of a union may much more easily understand that if I recover and I still can't do my job, I'm not meeting the conditions of our collective bargaining agreement, I'm going to get my butt kicked out of here.

So anyway, there was a lot of positive stuff in place, although not a perfectly oiled machine, but labour involvement in this programming became very problematic. I can summarise it as a threefold thing. Number one, the labour involvement was pretty unequivocal when it came to dealing with alcohol problems. The idea of this broader employee assistance programme, where you found your union brother is suffering from depression or anxiety disorder, that sounded like dangerous mumbo jumbo. Simply put, you can only have equality in a situation like this if communication is crystal clear and there is trust. Union members generally knew alcoholism and they knew recovery and they would make pains in most companies to find somebody in recovery in their local who would become part of the programme. So to make a long story short, many if not most of the labour people wanted to keep this pretty restricted to alcohol issues and of course the broad brush Employee Assistance model doesn't allow for that.

So that's one kind of clinker that was introduced. Another clinker was why can't we union guys be programme coordinators too? We are in recovery, we know as much as the programme coordinator. Now she may have this fancy pants MSW, but she is in recovery just like I am and we both know the 12 Steps, and everybody that has been a success in this program has gone through AA. I'm just as good as she is, so I should have a job like hers. Why can't I get on this career path too? The answer? Well, um, you don't have the training to deal with these other problems that are going to come up in the broad brush program. That becomes kind of …

TT: But that would never have been a problem in the original model, which was much more centred in the experience of recovering people and …

PR: That's right.

TT: Without the necessity of therapeutic or HR expertise.

PR: There you go, so you've got and what you essentially have is the classic clash between professional and the 'indigenous' expert, I guess would be the best way to put it. This brings up the sticky issues of the role of people in recovery in the whole alcoholism and drug movement, which, I might remind you and I think you've probably written about this, but alcohol and drugs is the only speciality in the world where former patients become the treatment specialists. People who experience severe mental illness rarely if ever return as counsellors or as treatment specialists, or as psychiatrists…you don't hear 'After I was released from the mental hospital, I went to medical school so I could become a psychiatrist.', you know you don't hear that. But you sure hear 'After I came out of the treatment centre I immediately began to plan to go work as an addictions counsellor.' And to make things more complicated, many folks in recovery go on to professional training in social work or counselling.

That's a common story. So we are very unique in having the products of our system as the participants in our system and that has a very subtle effect of pressing for equality.

Now here's another reason why a training programme for broad brush or EAP programme specialists never really developed, namely that the union people really would be at a huge disadvantage in terms of being able to participate in this kind of training. In part, our old friend Social Class is the issue. The union folks were rank and file blue collar people. Many had minimal formal education. They had families, they can't stop working for three years and go to social work school. whereas the other folks, you know the story, I don't need to elaborate on inequality.

The occupational association was originally called ALMACA for the Association of Labor and Management Administrators and Consultants on Alcoholism (later renamed EAPA for the Employee Assistance Professionals Association). It invents for itself an accommodating certification process that has no educational requirement, it's totally experience based. And the requirement for passing the written test is one of those inconvenient truths where you really want everyone to pass. As you can see, with different levels of fluency, this process became potentially traumatic. I'm sure this was one of a number of reasons why almost all of the labor-based members of ALMACA/EAPA quit their membership sometime around 1990. I need to add that this departure did not mean that they turned against these programs, but some of them started their own peer referral programs, which is another story.

There is some complicated ideological stuff here. A lot about this field carries the not-so-subtle cultural stamp of AA as an egalitarian community exemplified by its anonymity. You know you walk in that door and you ain't John D Rockefeller, you're John R and that's all you are going to be in there, you're equal to everybody else. No requirements for membership except wanting to quit drinking. No ranks. No officers. Everyone chooses their own pace of the Steps. From the beginning of ALMACA, an AA atmosphere was pervasive. Essentially anyone who wanted to try was welcome. You didn't leave people out or say that someone's credentials made him better than someone else. You know all this and have embedded all that in your book so please forgive me if I'm being patronising, I'm not intending to.

TT: Not at all.

PR: Okay. So anyway the labour thing is both a blessing and a thorn and it acts to prevent the community from professionalising and creating its niche which was closed off to others, which is what professional associations are supposed to do. You can't accomplish that and still be all-inclusive. Successful professional associations have a clear cut set of boundaries around who is in and who isn't. When the situation demands it, they have to be pretty cut-throat if they want to assure that their members get a particular slice of the pie and hang onto it, or make sure it grows as the pie grows. There are criteria to be 'in' and if you don't meet the criteria you're not going to be in, we don't care how bad it makes us all feel, you are not in, so clear out. So ALMACA/EAPA never really created a niche.

We have this period from 1973 to the mid-1980s where the broad brush/EAP model is being adopted and implemented and is meeting expectations in feeding clients into the

alcoholism treatment system that the NIAAA had created. If you look at the chains of attractive new centers that emerged during the 1970s (and you'll have to look hard, because almost all of them are gone), they were almost all inpatient. Entrepreneurs invested heavily in brick and mortar with every expectation that these "campuses" with their 28 day treatment programmes that would be fully supported by insurance.

All this was working until we get to the early 1980s and here I'm going to talk about the string of crises that contributed a lot to the end of the alcohol emphasis within broad brush workplace programs. President Ronald Reagan is directly responsible for two of these crises. First, in his States' Rights role, he takes away the money that NIAAA had been doling out in program grants to support its chosen interests in such things as workplace programming. His ideology dictates that this money should be split up among the states and let them decide how to spend it. At the same time he also took away this funding authority from the other behavioural health agencies in the federal government that existed at that time, the National Institute on Mental Health and the National Institute on Drug Abuse.

This really shook the whole alcoholism field. NIAAA had funded lots and lots of demonstration projects and from 1972 to 1982, it funded probably 100 demonstration projects in the area of workplace programmes. This involved a lot of activity and a lot of people. They provided a lot of financial support to ALMACA, both directly and indirectly. These demonstration projects were designed to do test out new ideas that could later be used by others, but as I said before, this goal rarely worked out because good research on what they accomplished and how they accomplished it was not done.

I can give you a couple of examples. One of their big innovations successes was a grant that they gave to the Air Line Pilots Association, which was the union representing the majority of commercial airline pilots. Many people don't know this, but airline pilots in recovery may return to work. And this was very complicated, it requiring agreements with the Federal Aviation Administration and involved a very tightly supervised program of recovery over an extended period. This was a union based programme and so that was a demonstration project.

Another demonstration project at the local NCA council in Lincoln, Nebraska dealt with the issue of small employers. You can't fund a programme in a company that has a small number of employees, so a model was developed which was loosely referred to as a consortium. You essentially had floating programme coordinators, who would go from small company to small company and work with the EAP cases, as well as being on call. It was fascinating to see how they built this incredible network in Lincoln, I mean it worked beautifully. Companies paid for it on a per capita basis, but it was run on a not-for-profit basis, so the cost was reasonable.

Several demonstration projects were based in unions largely centered on a program that was within the union and did not involve employers. This is the peer referral model that I mentioned before. Lots of people who are members of unions do not work for employers, they float among employers depending where the work is to be done. Construction workers are the best example, and construction is huge industry, along with transportation and many of the skilled crafts which fit this employment model. Demonstration projects included services for seafarers and longshoremen.

There is a pair of books which really describe the dynamics of how these programs can work. One is called *Working Sober* by my colleague Bill Sonnenstuhl, Professor Emeritus of Organizational Behavior at Cornell, who describes the emergence of a recovery programme in the Tunnel Workers Union, the people who for decades have been continually building the subway system and aqueduct system for the city in New York. The drinking culture is unusual and complex, with tightly linked workers who drink together on and off the job, where drinking on-the-job in truly menacing conditions was very common. And almost simultaneously with Bill's beautifully written academic book, the late New York journalist Jimmy Breslin wrote a book called *Table Money*, which may well be an autobiographical novel of growing up in a drunken tunnel worker's family. Table money is what the dad would throw down from his pay envelope on the kitchen table on Friday night, before he went out to get drunk. That was mum's money to last for the week and mum made sure that he left that at home before he spent the rest of it on drinking. So you read those two together, it's one of the richest alcohol and recovery stories, those two books combined.

There is research other than Bill's book on labour assistance programmes, or peer assistance programmes, almost totally research that Bill and two Cornell colleagues had done awhile back on the success of that model, a discussion that was never sustained in the research literature.

This brings us to the Grand Poobah of effective occupational alcohol and drug programmes which are the physicians assistance programmes, usually weakly disguised under the label of Physicians Health Programs and operating at the state level in the U.S. These efforts report 85% or higher long-term recovery rates and that is not BS, I mean it is backed up by data. If that is not enough, one of the studies reporting these data has both the authorship and thus the *imprimatur* of two addiction gurus, Tom McLellan and Bob DuPont, former Deputy US Drug Tsar and former US Drug Tsar respectively. We need to do a deep dive and try to figure out how to apply what we can learn from this success, something I'm trying to do in the book I'm writing. Note that the programs for labor unions, the airline pilots, and physicians can truly be called occupational alcoholism programs. They are definitely not broad brush or employee assistance programmes, which are based in organisations, not in occupations.

So in 1982 Reagan says that the alcohol, drug and mental health institutes won't be funding these demonstration projects anymore and that they won't be directly funding any treatment services, prevention services, or occupational services. The money for this kind of thing will go directly to each state and it's now up to the states to decide what to do with these rather large bundles of money. NIAAA and the others would continue to exist, strictly as research-funding agencies.

So lots of things disappeared along with the demonstration projects. NIAAA had been paying either directly or indirectly for a lot of the activity related to workplace programs, including paying for conferences to bring people together, paying for training, paying for a national training centre that did some things related to occupational programming and so forth. The whole NIAAA support structure for the workplace field disappeared. So keep in mind here that NIAAA had been promoting the broad brush programs for years through this direct and indirect support, but now

this backbone that encouraged emphasis of alcohol problems within broad brush programs has disappeared.

Since I had always played a research role in this process, I was hopeful that my research on these programs could survive because the research function of NIAAA was still there. But things became very different. Research that myself and others conducted before this had usually been supported by money that was in the occupational program budget, so we had an advantage getting funded. Now our research projects were going to have to compete with everyone else doing alcohol research.

At first this looked promising because Don Godwin, who had been our patron and the Branch Chief for occupational programs, got himself transferred to the NIAAA Research Branch. While it seemed to have the potential for protecting our fledgling group of workplace alcohol researchers, it didn't work. Don had a good sense for research but he had no union card, no PhD. A reorganization had occurred and there was a Prevention Research Branch where Don was appointed. His new boss was a PhD sociologist, Jan Howard, who proudly identified herself as an old time socialist. Her disdain for the workplace intervention concept was immediate. With her orientation and with the mandate for prevention, her vision of the link between the workplace and alcohol was that jobs may drive people to drink. So our program concept could be seen as a band-aid and cover-up over what employers did to their employees through job conditions, overload, stress, you name it. So while NIAAA had to give a fair review to any grants submitted about any aspect of workplace programming, our new socialist research leader did not in any way buy into what we were up to.

TT: (Laughing.)

PR: Conditions of work cause excessive drinking you know, right out of Karl Marx!

TT: That is not what I expect from the Reagan administration, I have to say.

PR: Well yeah, the Reagan administration could not keep its radar focused everywhere, you know, it only had so much radar bandwidth to spare. Oh Jan was fascinating and, a brilliant lady. She didn't come right out and say you EAP researchers can just drop dead, but she essentially said, I'm not going to put my emphasis there. I want to find out, if you want to study the workplace, show me what it is about work that makes people drink and maybe show me what it is about work that prevents people with alcohol problems from achieving recovery. Clearly our work was all about treatment and unless you wanted to really play with words, we had nothing to do with prevention. Jan Howard certainly had a very valid point. Again what I'm saying is that it was her lack of sympathy for these programmes, not active antagonism, and some workplace grants were indeed funded during her leadership. But the interest distinctly diminished and over time it just kind of disappeared.

So research on workplace programs that had been kind of a leg of the stool that was holding things up disappeared. Don Godwin soon left NIAAA for a more practice-oriented job at SAMHSA, but he took us out in a blaze of glory. I had proposed an NIAAA-funded research conference to summarize what we knew and needed to know

about alcohol and the workplace. Don allied with Al Pawlowski, who had been working in NIAAA research since NIAAA was founded and in spring 1988 we had a wonderful 3 day meeting at the posh Jekyll Island Club in Georgia, almost including a surf and turf banquet, but not quite. It was a great conference, recorded for posterity (Roman, 1991)

In addition to losing NIAAA's means of support for workplace alcohol programs, another change that was very, very important and that was the merging of alcohol and drug treatment. Honestly, for the years that I spent from 60s onwards, I never thought of anything being combined with alcoholism treatment. I never conceived the idea that people with addiction would be treated in the same setting. I think what began to change the lay of the land was the reaction to poly-drug abuse. At first it was the issue of what do we do with these people? If somebody comes in with an alcohol problem and they also use heroin, what do we do, sober them up and tell them to continue using heroin? But the issue got complicated, with some leaders asserting that essentially all people needing treatment were using multiple substances.

The merger seemed to occur out of necessity without planning or forethought. I think people today fail to understand how separate the alcohol and drug worlds had been. This was true in terms of both research and treatment. But my crucial point here is how the merger contributed to changing the image of treatment and I think it stigmatised both treatment and alcoholism in ways that have not been appreciated. Bluntly, the severe stigma associated with heroin and cocaine spread over to alcohol and set back decades of progress in destigmatizing alcoholism.

Probably the simplest and biggest driver behind this was money. The last 25 years of my career has been spent on studying the organization of treatment, and I can say without too much hyperbole that people who run treatment centres are running constantly and every 15 seconds looking behind them. I mean it can be a horrible job. It is such a competitive business, it is fraught with difficulties over shifts in funding, harassment by the insurance providers, harassment by Medicaid, problems in being referred patients that don't want to be there at all and who you know are going to be treatment failures and yet you have to take them. You know you've got to keep your beds filled if you want to keep your staff but you have staff turnover anyway because you have no career ladders. Usually the only way your staff can better themselves career-wise is to go to another organisation.

So in this context, the opportunity to merge with or into drug abuse treatment had to do with money. There is a lot more public money for drug treatment than for alcohol even though the problem is smaller and that was very, very attractive. So there was no resistance on the part of the treatment community for the most part in terms of this merging. But it did change the image of treatment. And in terms of employers, it kind of blended alcoholics and drug abusers together, which pulling down the image of alcoholics sharply.

This was totally intertwined with the emergence in the mid-80s of the wonderful war on drugs and this is where our beloved Mr Reagan enters our story for his second cameo appearance. I'll just put it this way, in the world of prejudice, those who hate characterize the objects of their hatred as the worst of all human beings. This is exactly how Reagan framed everything he said about drug abusers, there is no worse

person in the world than a drug abuser. The text that he and his wife Nancy used did not say that people should stop using drugs through whatever means, but rather that drug users should be socially ostracised. If the technology had been available they would have said that drug abusers should be shot into outer space and left there. It is really important to see how their rhetoric did not include means for redemption, it was simply absolutely damning. And it was passionate. Reagan was said to be the son of an alcoholic father, but evidently he was not a cruel alcoholic but mainly an unreliable breadwinner. In my opinion, it's unfortunate that he was able to play out his personal trauma on the national stage.

Reagan definitively states that the workplace has a role to play in the War on Drugs. Its role is to exclude people who are drug users through drug testing from employment altogether by testing all job applicants, For those already employed, use random drug testing, you'll catch them all and get rid of them, get rid of them! A very mealy-mouthed provision was put into the Federal "drug free workplace" legislation that says oh yeah you ought to have an employee assistance program but how it was to be used was vague and perfunctory. And the drug free workplace rules had to be followed by any workplace with any contractual relationship with the Federal government.

Alcohol was barely mentioned if mentioned at all in the War on Drugs, but it certainly was not left out. There was no compelling reason for the public to compartmentalize alcohol abusers from drug abusers, and this added further to stigma.

So the workplace programming model that had been promoted by NIAAA and widely adopted was being undermined by the withdrawal of NIAAA support for the alcohol emphasis within the broad-brush approach, by the squelching of research to back up this strategy, and by double-barrelled stigma from the merger of alcohol and drug treatment and the War on Drugs. If things could not be worse, we also have the managed care arriving on the scene, and it zeroes in on alcoholism treatment.

Managed care presents of course a whole new pile of trouble for all healthcare providers and of course the loudest and the most vocal victims of managed care, are physicians. Oh what it's done to them, my gosh, you know the average annual income of physicians has declined. So, eventually managed care has penetrated nearly everywhere. Managed care has of course turned into a major industry, which two groups absolutely love, first insurance payers, second are employers and, third, the state and federal governments. The need for managed care is complicated and unfortunately describes our health care system as one that is designed to make money. But there are very high stakes. I remember as a kid when our rural family physician would come to our house to treat one of my family is we happened to be laid up in bed. He would drive up in his late model Buick and come up to the bedroom and treat them and give them some kind of medication and as he walked out the door, whoever was not in bed, gave him $3 and that was it. And Dr Barnes lived in a really nice house, you know he had a nice family, a pillar of the little rural town, he had office hours into the night if people were still waiting. He worked extremely hard, seemed to be well off financially and that was medical care. And most of my memories of death were about old people in the community, old people aged 60 or really old people of 65. If you made it past 70 you probably never the left the house again. Medical care does great things today and it costs a lot. I praise God for all blessings

that flow, the medications that I've been able to receive, to make this last phase of my life good quality living. But it has not been a free ride.

Getting back on track, employers had inadvertently ended up paying the rising, rising costs of healthcare. I say inadvertently because they had taken on paying for health care back in the day when costs were very modest. Going back to the occupational program model, one of its drivers was the health insurance that many employed people had. While employees now pay an increasingly large portion of this bill, employers pay plenty and in the 1980s it was beginning to hurt. So managed care is was welcomed with open arms with its promise to cut costs. How? By cutting out unnecessary care while assuring that the patient still gets well.

This will involve outsiders with some knowledge of medicine telling docs what will be the most efficient way to make the patient well. Where does it start? Let's see. brain surgery is really expensive. But what does managed care know about that? Well, let's look at the records about payments for this stuff called behavioural health. Oh here's a case where an employee is an alcoholic and he went for treatment and employer's insurance company paid out $10,000 for treatment. And the guy didn't get his act together and kept on drinking and ended up being fired. The managed care expert thinks, 'Wow, my neighbour goes to AA and he got better, he never went anywhere for treatment.' So he says to his managed care co-worker, 'Hey Joe come over here, I think we've got something where we can really show some cost-cutting.' So alcohol problems and other parts of behavioural health became managed care's first targets for attack. The outcome, which takes a while to settle in, is a literally across-the-board cut in insurance benefits provided for inpatient alcohol treatment.

The federal government added a helping hand to managed care at this time through a very reasonable commissioned study called the Saxe Report after the principal author, Leonard Saxe. Saxe presented what data he could find and there wasn't a whole lot of data but the evidence strongly suggested that inpatient and outpatient treatment for alcoholism showed the same results. (And results of either type of treatment are not great!) So the message was, don't waste your money on inpatient treatment.

So off we go with a whole new outpatient industry with much lower overhead and the inpatient treatment centers start closing fast enough to make your head spin. And while it had made big "hits" in all areas of medical care, managed care really slammed inpatient alcoholism treatment. In the process, a number of workplace programs got bad publicity and lost credibility for their apparent over-use of inpatient treatment and their use of the exact same treatment for every single patient.

Finally, the last ingredient of the death knell for the internal workplace alcohol programs was a major trend toward outsizing of human resource functions in American workplaces. This led to the disappearance of the programme administrators and coordinators who guided referrals by supervisors, who screened out employees for the kind of treatment they needed and were available to follow up with them. "External providers" of workplace programs sprouted up everyone and soon were cannibalizing each other in a competitive struggle.

Simply, top managers were faced with the question of "Am I going to hire an employee to run my Employee Assistance Programme and pay that person a salary

and benefits, or am I going to farm this out?" Contracted services have increasingly become bargains for at least two reasons. First, you have to pay benefits for employees that you don't have to pay for contractors. Second, you usually have greater flexibility in changing whoever you want to carry out these roles.

So anyway this outsourcing not only was a money saver, but the employers generally did not anticipate, or didn't really have a reason to care, that these externalised EAPs were not going to be able to address employee alcohol problems. What was gutted out of the programs was not only the face-to-face availability of the program coordinators, but also the training of supervisors and involvement of unions. The new external programs were almost always a free phone number which employees could call when they wanted to and ask for counselling. The person answering the phone at some remote location decided the nature of their problem over the phone, and set them up with several free counselling sessions. If the free sessions didn't solve the problem, then they moved on to sessions they paid for themselves or which were covered by company insurance.

The structured internal programs also disappeared because there were no in-house advocates, no one to counter the argument for a much cheaper program that could effectively identify and help employees with alcohol problems. As time passed from when these programs had been adopted, turnover occurred in managerial positions so that the original argument which had emphasized salvaging the careers of insipient alcoholics was lost to history. So these external programs are what we have today. In case it's unclear, 95 to 99% of existing EAPs are run the way I described, and they are found in essentially all larger American companies and are available in almost all governmental agencies, including I think the University of Florida.

TT: Oh yeah.

PR: And the University of Georgia, which never had an internal program, has an external EAP. EAPs' utilisation rates vary widely and in many instance hover around 3 to 5% of the workforce, which it really isn't bad, that's pretty impressive and doubtless EAPs are helping people solve some kind of problems that might have been affecting their work. But only 10 percent of Americans who need treatment for alcohol problems get such treatment, and these EAPs are not contributing to that picture. National data shows that the proportion of alcohol treatment clients referred from workplaces has plunged to almost zero.

That is kind of the end of the story of my role in dealing with alcohol in the workplace. I have a wild aspiration that if I can finish a book that I am working on that tells this story, maybe we could go back to realizing the potential of the workplace in identifying and saving the lives and careers of employed people who are developing major alcohol problems.

After the decline and fall of these programs, I shifted my research to studying the organization of treatment for alcohol and drug problems. What I learned in the 25 years of studying the treatment system is that number one, it's not a system. It's a bunch of separate structures that are in the hands of state level political appointees. Legislators and political appointees throughout the United States, not professionals, almost always have the last word to say on alcohol and drug abuse treatment. The

collection of treatment programs that does not comprise a system generally do not interact with each and hence they do not regulate each other. The really excellent programmes get pulled down by the really lousy programmes.

Over the past two decades, a boon to the treatment system has been criminal justice referrals. Despite much fanfare, few of these people are managed through systems like drug courts and often don't want help. They will end up back on the street without jobs and with their substance using buddies. This contributes unfortunately to the low success rate and of course underlines the troubles of the medical model….what other health care system has patients who do not want to "get better"?

In the 25-odd years that I devoted to the study of substance use treatment the most consistent finding was the embeddedness of 12-Step theory and practice. Our findings reached prominence just at the time that NIDA and NIAAA were trumpeting the effectiveness of their efforts to diffuse a number of "evidence-based practices" across the nation, replacing what was understood to be the backward "folk medicine" that had prevailed since the 1950s. Our findings came across a bit like a Bronx cheer.

Those seeing themselves as true "scientists" view continued adherence to 12-step models as a sign of technical backwardness. This completely misses the point. The dimensions of our findings that have not received adequate attention, in my estimation, is that acceptance and use of 12-step ideology within treatment often occurs in a context of highly sophisticated clinical and managerial strategizing. Thus the expected dichotomy of treatment centers into "modern vs. traditional" has far less heuristic value than assumed in the charter for the evidence-based practice movement that was published for NIDA by the Institute of Medicine in 1998.

The collection of organizations providing services for substance use disorders in the US does not yield to simple dichotomy and is far more diverse than what most of the larger addictionology community probably believes. More than many of the field's leaders, treatment providers do have a much better grasp of the fact that 12-step ideology has become deeply embedded into American culture, and this must be taken into thorough consideration in attracting patients to treatment, engaging them in treatment, and effectively marshalling the support of key support networks following treatment.

While in itself, 12-step persistence is a pretty simple survey finding, as a fact it has pretty powerful effects on attitudes and practices related to somewhat novel psychosocial interventions and particularly to medication-assisted treatment (MAT). We found lots of adaptations that often were essential for organizations that operate under constant financial and competitive stress. Studying these diffusion processes was the core of our NIH funding from the mid-90s through 2020. In a nutshell, the diffusion of MAT has shown close resemblance to the patterns of diffusion of evidence-based practices that I studied as a nipped-in-the-bud rural sociologist back in the mid-1960s. Adoption follows a pattern of sequential growth but then seems to hit a brick wall where the rates of new adoption fall to almost zero. And like it or not, many adopters alter and change innovations to best fit their own circumstances, making a bit of a mockery about "fidelity."

Lest this sound hopeless, let me add this. As I moved away from workplace research into substance-linked health services research, new influences emerged. I found this band of researchers, especially several physicians, to be the most hard-working and persistent people I have ever known. As with the workplace specialty, an excellent community of researchers was fostered. Through my study of the NIDA Clinical Trials Network (CTN) and a national survey of therapeutic communities, I became acquainted with a very wide array of practitioners. To me at least, the CTN proved that there is no intelligence or awareness gap between researchers and practitioners in terms of treatment research that is needed or how it should be done.

So where are the "breakthroughs?" Our "new" icons of naltrexone, buprenorphine and naloxone were around in the early 1970s but it took 40 years to connect the dots. Rates of substance use disorders show no decline in any quarter, and of course many new patterns of misuse have blossomed and become embedded before action steps began. The American opioid epidemic has essentially become part of the institutional landscape.

Lots of people use psychoactive substances without creating trouble for themselves and others, but this has been true since the beginning of recorded history. And despite massive growth, stigma abounds and flourishes for those whose substance use disrupts social order, for those with such problems with seek help, for those who try to help them, and for those who study those who try to help them. Despite fanfare and trumpet-blowing reminiscent of the presentation of the Emperor's New Clothes, the acceptance and integration of this specialty into the overall health care complex is largely a delusion.

TT: So okay Paul, I've got to go in like two minutes, but this has been fantastic and I think anybody who has paid attention is seeing the contours of an unbelievable story here. You have mentioned a couple of times that you are working on a book, can you just tell us quickly, how much does it cover and when can we look forward to it in stores?

PR: Oh wow yeah. Well what it covers is just really what I've tried to cover in this conversation. I would like to see the resuscitation of an effort to have mechanisms in place to identify and provide help to people in the workplace with alcohol problems. I've got a fairly good outline, I think I can stick with. So if it's not done in a year, I'm going to be in bad shape.

TT: Wow.

PR: And so you know maybe I can hang in there that long, that would be great. It's been a lot of fun. Thank you for your voluntary time, I really appreciate it.

TT: It's been super instructive and really entertaining to hear this report from the frontlines of what the seventies was, seventies and eighties were like.