POPULAR GOVERNMENT

November / 1971

PUBLISHED BY THE INSTITUTE OF GOVERNMENT
UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL

This month

POPULAR GOVERNMENT / Published by the Institute of Government

Contents

This month's cover shows Benjamin Swalin, director of the North Carolina Symphony, at the chamber music concert given at the Institute on October 10 in honor of Mr. and Mrs. Albert Coates. See the story on page 6. All photos by Carson Graves.

VOLUME 38 NOVEMBER 1971 NUMBER 3

Published monthly except January, July, and August by the Institute of Government, the University of North Carolina at Chapel Hill. Change of Address, editorial business, and advertising address: Box 990, Chapel Hill, N. C. 27514. Subscription: per year, $3.00; single copy, 35 cents. Advertising rates furnished on request. Second-class postage paid at Chapel Hill, N. C.

The Adjourned Session

1971 GENERAL ASSEMBLY ON RESTRUCTURING HIGHER EDUCATION

by Milton S. Heath, Jr.

On Tuesday, October 26, the General Assembly convened at 12 noon in an unusual adourned session, the first in modern legislative annals. In the words of the adjournment resolution that had closed the regular 1971 session on July 21, the Assembly was "to meet again. . . to consider only those matters related to the restructuring of higher education."

Meet again to consider higher education it did, but hardly higher education "only." When the dust of the adjourned session had cleared, 34 bills and resolutions concerning other subjects had been considered. These included, in addition to formal resolutions, five local bills and nine public bills (twelve, counting identical companion bills). In all, fourteen resolutions and ten acts were enacted.

Higher Education

Chief order of business for the adjourned session was, of course, the restructuring of higher education.

The remote origins of the restructuring can be traced through almost two decades of burgeoning competition for funds and prestige among the state-supported institutions of higher learning. In time, the competition generated intense pressures upon the General Assembly and the Governor's office, which erupted in controversy over a number of issues. As controversy deepened, there came to be a growing sense that the pressures were too intense and disruptive to be tolerated indefinitely. The legislative response to these developments took several forms, including:

- The creation of new coordinating machinery (the State Board of Higher Education in 1955), and the modification of that coordinating machinery, as in the expansion of the Board of Higher Education in 1969 to include the Governor and the chairmen of the legislative "money committees" and higher education committees.

- The enactment of legislated priorities, as in the designation of specific functions for each of the campuses in 1957, and in 1963 following the recommendations of the Carlyle Commission.

- The creation or recognition of subgroupings for coordination or administration, as in the addition to the Consolidated University of the Asheville, Charlotte and Wilmington campuses in 1965 and 1969. The latest step in this process was the addition to the Consolidated University of three campuses designated as universities, and the designation of nine other campuses as universities, each with potential doctoral degree-granting programs, and each with the capacity to pursue its own program interests almost unhindered in the General Assembly.

The more recent origins of the restructuring can be traced through developments of the past year, beginning with Governor Scott's appointment of the Warren Committee early in 1971 to study the need for reorganization. Bills were introduced late in the regular 1971 legislative session to implement the recommendations of the Warren Committee for creation of a board of regents with strong coordinating powers, replacing the Consolidated University Board of Trustees and the Board of Higher Education. Alternative proposals embodying the recommendations of a minority of the Warren Committee for strengthening the Board of Higher Education were also intro-

duced as competing bills. Strong legislative sentiment quickly developed for deferring the issue to another legislative session in order to allow time for more orderly and dispassionate study and deliberation. This sentiment carried the day and was reflected in the adjournment resolution of the regular session, which deferred the subject to the adjourned session that is now history.

Between the adjournment on July 21 and the reconvening on October 26, the Senate and House Committees on Higher Education held a series of joint hearings to permit further airing of the higher education issue. These hearings drew recommendations from a number of leaders in higher education who had not previously spoken publicly to the issue. Their testimony lent weight to suggestions for establishing a central governing body (rather than a coordinating agency) with strong budget and appointment powers, with authority to approve all new degree programs and to eliminate or modify unproductive programs, and with some assurance of continuity of leadership during the transition period. All of these ideas were to be reflected in the final product of the adjourned legislative session. If no more, the interim between the regular and adjourned sessions gave an opportunity for these ideas to be expressed and circulated, as well as providing a much needed breathing spell to legislators. When the members returned to their duties on October 26, they were in a better position to act upon higher education as a deliberative body than would have been possible during the frantic waning weeks of the regular session.

On the opening day of the adjourned session, the recommendations of the higher education committees were offered in the form of a committee substitute for S 893 – H 1156, one of the higher education bills that was left pending in committee when the regular session had adjourned. Governor Scott addressed a joint session and threw his support behind the committee proposal. The substitute bill contained the following main features:

● *Three-phase organization.* It contemplated a reorganized University of North Carolina consisting of all of the state institutions of higher learning, to be created in a three-phase process. In phase 1 (during the first half of 1972) present boards of trustees would be continued, but a Planning Committee would begin making plans for implementing restructuring. This Planning Committee would consist of five members chosen by and from the UNC Board of Trustees; two chosen by and from each of the five 5-year regional university boards; one chosen by and from each of the four 4-year regional university boards and the School of the Arts board; and two chosen by and from the State Board of Higher Education. In phase 2 (from July 1, 1972 to July 1, 1973) the members of the Planning Committee would become the initial or interim board of governors of the new university. In phase 3 (beginning July 1, 1973) the permanent board would come into existence, with 32 members serving eight-year staggered terms. It would consist of eight appointees of the Governor and twenty-four persons elected by a joint Senate-House session from a slate of nominees presented by a special nominating committee composed of seven designated legislative leaders and the Lieutenant Governor.

● *Powers.* It gave the proposed governing board authority to determine program and degrees of all of the constituent institutions (including authority to withdraw approval of programs), as well as strong budget and appointment powers. The appointment powers would include selection of a President of the University, and of a chancellor for each constituent institution on nomination of the President from two names recommended by the institutional board of trustees.

● *Representation.* It guaranteed representation on the governing board for minority races and women (at least four members each) and for the principal minority party (at least two members). It also prohibited membership for legislators, other officers or employees of the state or of constituent institutions of the University, or spouses of any of them.

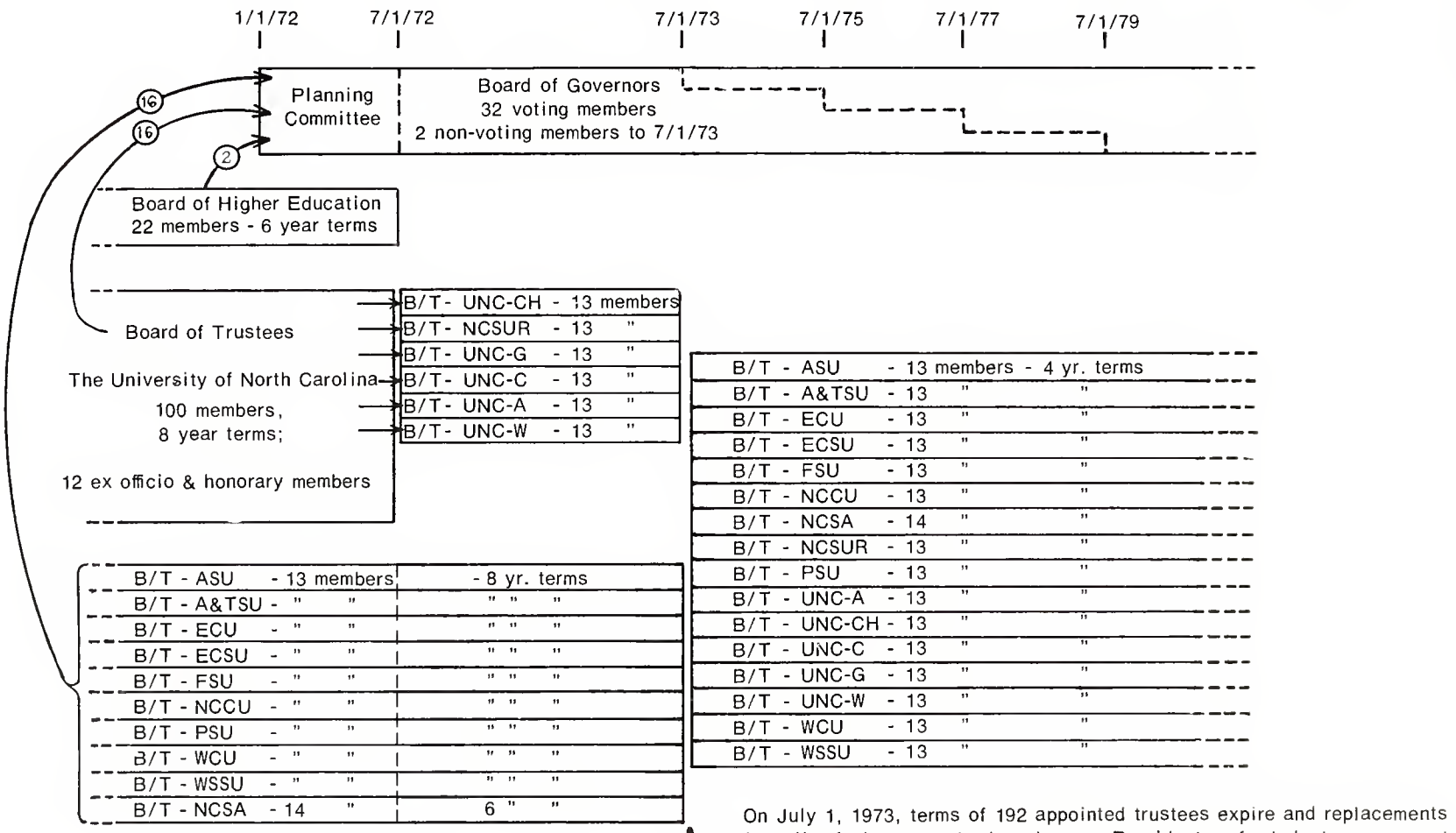
● *Institutional Boards of Trustees.* It provided for each constituent institution to have a board of trustees that would have advisory and promotional functions, together with such other powers as might be delegated to them by the Board of Governors. In each case provision was made for a temporary one-year board of trustees and for permanent boards beginning July 1, 1973.

Much of the content of the committee substitute was to remain undisturbed. The provisions concerning powers of the governing board, representation on the Board, and the powers of the institutional boards of trustees would not be changed materially. But the composition of the Board of Governors, the method of selecting its members, and the transitional provisions of the bill—particularly the provisions bearing upon continuity of leadership—were to be sharply debated and ultimately would be revised in several important respects.

On Wednesday, the second day of the session, there was preliminary skirmishing over the controverted provisions of the bill. An alternate proposal for continuing all existing trustees as the initial governing body, initially about 225 and phasing down to a permanent group of 100, was defeated. In a series of floor amendments, the principle of continuity gained ground, while the provisions for selecting one-fourth of the governing board's members by the Governor and for use of the nominating committee device in the General Assembly lost ground.

On Thursday in the House, a key vote brought adoption of the "Smith Amendment," which assured continuity of leadership on the governing board, pro-

PUBLIC HIGHER EDUCATION BOARDS
Chapter 1244, Session Laws of 1971



On July 1, 1973, terms of 192 appointed trustees expire and replacements for all of them are to be chosen. Presidents of student government continue as members ex officio. Election of successor members of Board of Governors begins, 8 terms expiring each 2 years.

On July 1, 1972, Board of Governors assumes full governing authority and all boards of trustees thenceforth have only powers delegated by Board of Governors. Board of Higher Education expires, terms of all members of Board of Trustees of UNC expire, and at least 78 of its members go on 6 local boards of trustees. Members of other 10 boards of trustees continue in office until July 1, 1973.

vided for all governing board members to be legislatively selected, and assigned half of the membership on the initial governing board to persons chosen from the present University of North Carolina Board of Trustees. The amended House bill was then sent to the Senate, which replaced the Smith Amendment with its own amendments, which differed mainly in that the Senate version did not provide parity of representation for the UNC trustees.

When the Senate version of the bill was returned to the House on Friday, the stage was set for a series of crucial votes that began Friday afternoon and carried over into Saturday. Late Friday afternoon by the close margin of 55 to 51, the House concurred in the Senate's changes in the bill. Under normal assumptions, this would have meant that only the formal steps of enrollment and ratification remained. But this was no normal bill, and overnight the balance of power shifted. On Saturday morning in an atmosphere of high drama the House reversed its Friday actions in a series of cliff-hanger votes: 55–54 (to reconsider the vote by which the House failed on Friday to recall the bill from the Enrolling Office); 56–54 (to recall the bill from the Enrolling Office); 58–52 (to reconsider the vote by which the House had concurred in the Senate version); and finally (unanimously), not to concur in the Senate version. The unpredictability of the ultimate result in the House is indicated by the fact that, during these four votes, a total of twelve House members shifted their alliances in various ways one or more times each.

As a result of the House action, a Senate-House conference committee had to be convened. It went to work late Saturday morning and by mid-afternoon had produced a compromise acceptable to all of its members. In an extraordinary demonstration of consensus, the two houses then approved the conference report by near-unanimous votes (40–0 in the Senate and 106–3 in the House). The act was ratified as chapter 1244 of the Session Laws of 1971.

As finally approved, the restructuring law accepted parity of representation on the initial governing board for members of the present UNC Board of Trustees by giving the UNC board 16 out of a total of 32 voting members and by readjusting some of the terms of the initial members from other boards. In order to carry forward the experience of the State Board of Higher Education, provision was made for two of the current members of this body to serve one-year nonvoting terms on the governing board. Continuity of leadership on the governing board, which had not been ensured by the substitute bill proposed on the opening day of the session, was built into the restructuring law. Selection of the governing board exclusively by the General Assembly was also prescribed. And, finally, the procedure for selecting the governing board was revised in response to objections that had been raised in the House. It was provided that nominations to the board will be made at a joint Senate-House session, with nominees numbering at least twice the number of vacancies to be filled. Thereafter, each House is to elect half the number of persons required to fill the vacancies. A rotation procedure is specified for alternating selection by the respective Houses of the board members representing the minority races, the minority party, and women.

Other Public Bills

The intention to limit the adjourned session to the subject of higher education was announced plainly by the General Assembly in the adjournment resolution of the regular session. After the Assembly had completed the longest regular session in history, legislative leaders doubtless believed that the membership would support their determination to restrict the adjourned meeting to a one-subject session. Developments after the regular session ended, however, put the question of the scope of the adjourned session in a different light.

First, it was discovered that the nonvoted capital bond act enacted during the regular session (Ch. 722) was technically defective. Inadvertently, the bill had not been read on three separate days in the House, as required by the State Constitution for such bond legislation. Believing that the pro forma repassage of this measure would be regarded as a noncontroversial and appropriate expansion of the scope of the adjourned session, the legislative leadership added this item to the agenda for the October session. And, as anticipated, the nonvoted bond act was re-enacted without objection (H 55—Ch. 1240). It was also assumed that no question would be raised regarding the propriety of a legislative resolution paying tribute to the late Senator Frank Patterson, president pro-tem of the Senate in 1971, who died soon after the July adjournment (Res. 129).

As the convening date of the adjourned session neared, more ideas for additions to the legislative agenda began to roll in. Problems arising from the administration of recent laws relating to the costs of nursing-home care and waiver of the right of counsel for indigents were pressed by local and state officials. Revival of the no-fault auto liability insurance proposal (which died in committee during the regular session) was urged by some. Election officials and political leaders pushed for changes in the primary laws to return the date of the spring primary from Tuesday to Saturday and to permit absentee voting in the primary. The need for several local acts was also raised. (See below, "Local Bills".)

House Speaker Godwin, Lieutenant Governor Taylor, and Governor Scott found themselves confronted with the delicate task of balancing the competing values of accommodating reasonable requests for legislation without jeopardizing the prospects for prompt and successful resolution of the higher education issue. The solution arrived at after some deliberation was

to open the session to the more pressing issues which, it was believed, could probably be handled with reasonable dispatch — the nursing-home care spending limit, the indigent counsel waiver, and the local bills. No-fault liability, on the other hand, was regarded as an issue that could greatly lengthen this special session. Although, understandably, no legislative leader wished to be blamed for closing the door to this issue, only perfunctory encouragement was given to its consideration at the adjourned session. The primary election issues were viewed as occupying something of a middle ground between the issues that could, and those that could not, be readily handled; ultimately, because of their urgency they were given the green light.

The limiting language of the adjournment resolution for the regular session ("to consider *only* those matters related to . . . higher education") raised at least a question of mechanics: what procedure should be followed in introducing bills on subjects other than restructuring? In most cases, out of an abundance of caution an authorizing resolution was introduced and passed before such bills were considered at the adjourned session. Senate President Taylor made plain his view, as presiding officer, that no special authorization was required for the Assembly to consider any matters it chose to consider. Most members and observers who made known their views agreed with this position.

Briefly summarized, the public bills that were enacted by the adjourned session (in addition to the restructuring law) were as follows:

● *The Date of the Primary Elections.* Chapter 170 of the Regular 1971 Session had changed the date of the spring primary elections from Saturday to Tuesday, effective July 1, 1971. At the adjourned session, the effective date of this act was delayed until July 1, 1973 (S.L. 1971, Ch. 1241). In effect, this retained the Saturday date for the spring 1972 primary only. By merely delaying this change for another biennium rather than permantly changing the law, the sponsors of this bill avoided directly confronting the primary date issue. This tactic was designed to minimize the risk of a lengthy and possibly divisive contest over this issue during the adjourned session.

● *Absentee Voting in the Primary Elections.* Bills to permit absentee voting in the primary, along with the change in the primary date, were urged at the adjourned session as a means of encouraging and facilitating the new student vote. Competing bills were introduced at the adjourned session to authorize absentee voting in the primary (a) permanently (S 1012—H 1607) or (b) on a temporary basis for the 1972 primary (H 1606). As with the primary date change, the narrower version covering only the 1972 election was pressed for tactical reasons and was enacted (S.L. 1971, Ch. 1247). The new 1972 absentee primary law spells out some of the procedures for absentee voting (e.g., respecting qualifications, delivery of ballots by mail, and form of ballots). In other respects, primary procedures are conformed to general election procedures or are left for coverage by rules of the State Board of Elections.

● *Nursing-Home Care Costs.* The 1971 General Assembly struggled from beginning to end with issues related to the Medicaid program administered through the Department of Social Services. The central issue was the rising costs of this program in state and county funds. A related issue was the respective roles of state and county governments in paying the nonfederal share. These issues were not resolved until the closing hours of the 1971 regular session. The General Assembly reduced the coverage and level of services provided under Medicaid. Allowable costs for skilled nursing-home care was limited to $14 per day. The medically needy were eliminated from coverage by Medicaid for nursing-home care, leaving only categorical public assistance recipients eligible. The amendments to the General Appropriations Act (Ch. 708) split the nonfederal costs between the state and counties on an 85/15 basis (Ch. 934, Ch. 1202).

After adjournment, some urban counties (primarily Mecklenburg) began to complain that the $14 per day limitation would force Medicaid patients out of the nursing homes. Some counties had been paying nursing-home rates greater than $14 per day under the former Medicaid program, which paid operators whatever rates they charged. The problem was brought to the adjourned session by H 1600—S 1005 which would have authorized counties to pay allowable costs greater than the $14 per day limit from county funds. Since federal policy requires statewide uniformity in administering the Medicaid program, enactment of the bill in this form would have created uniformity problems. Thus the bill was amended to set a new limit on allowable daily costs for nursing-home care—$18.50 per day. The bill was enacted in this form (S.L. 1971, Ch. 1242), and it apparently will take care of most of the county-level problems in financing the nonfederal share of nursing-home costs in an 85/15 state-county basis.

● *Waiver of Counsel for Indigents.* A revision of the law on this subject, enacted at the adjourned session in response to a recent North Carolina Supreme Court decision, is described in a memorandum that appears on page 20 of this issue.

Local Bills

The local bills that were introduced this session affected five counties. One of these bills responded to a recent court decision that questioned the constitutionality of the Mecklenburg liquor-by-the-drink act if applied, as intended, to private establishments (S 1011—Ch. 1245). Another sought to remove a techni-

(Continued on page 19)

the North Carolina Symphony Chamber Music Players honor Mr. and Mrs. Albert Coates

ON OCTOBER 10, 1971, the North Carolina Symphony Chamber Music Players, conducted by Dr. Benjamin P. Swalin, played in concert at the Institute of Government auditorium to honor Mr. and Mrs. Albert Coates and the Institute that they founded. Several hundred of the Coateses' friends were present for the occasion.

Ladies and Gentlemen:

It is with gratitude that the North Carolina Symphony presents this performance in honor of Professor and Mrs. Albert Coates and the Institute of Government. We are grateful, indeed, for their outstanding achievements and for the creation of the Institute of Government, which promises to be a landmark in the history of American legal education.

We also appreciate what Professor and Mrs. Coates stand for as individuals who work together with a common objective and high ideals. And so we honor them on this occasion through music, which, indeed, begins where speech leaves off.

Music is a great personal art, for one can say with it what he would scarcely utter unto himself; it is a great religious art . . . an adjunct of God; it can be utilized for enjoyment; and it is particularly significant for the youth, because it evokes the language of the soul of man.

—Benjamin P. Swalin

Dr. Swalin, Members of the Orchestra, Ladies and Gentlemen:

My colleagues in the Institute of Government join me in welcoming you all to this concert in honor of Professor and Mrs. Coates.

At other times, in other places, deserved verbal tribute has been paid to the Coateses for their unselfish labors in the service of their University and their State. I am tempted to do so again here, for the last nine years have given me a special appreciation of the true scale and character of that service.

But the temptation must be foregone, for tonight our tribute is in music and not in words.

The idea for this concert originated with Dr. Swalin. We can only admire the fitness of his proposal and join happily in its execution. Our part has been merely to provide a setting for this event and various supporting arrangements, all of which have been in the charge of Milton Heath, our associate director.

—John L. Sanders

My wife remarked not long ago that the most difficult thing in the world to do was to accept a compliment gracefully. I face that difficulty now.

I have seen men complimented as highly as my wife and I have been complimented here tonight, and I have heard them respond in sheer embarrassment that there was not a word of truth in what had been said. But I am not a natural born liar, and I am not going to say that.

I am going to follow the example of the English philosopher, Samuel Johnson, who was called to the King's library in the city of London for an interview with the King. This was quite a distinction and his friends gave him a dinner to get a report on the interview. Johnson told them the King had complimented him highly on his work, and his friends asked him what he had said in reply. "I took him at his word," was the answer. "Who am I to bandy civilities with my Soverign?"

And who am I to bandy civilities with the leader of the North Carolina Symphony Orchestra and the Director of the Institute of Government? I have listened with exceeding care to every word they have said, and I am satisfied of their correctness to the last detail!

But this occasion calls for more than a quip and a wisecrack from my wife and myself—who are its beneficiaries. And what shall we say in response—to this evening's gracious gesture? To the music of the North Carolina Symphony? And to the words set to that music by men who have been friends and colleagues in former days?

I want to say three things. The first is this. In the middle 1920's, I was in Portsmouth, Virginia, visiting the girl I later married. On a morning drive across the Elizabeth River, a light wind was rippling the water into a thousand facets, with every facet turned into a prism, and every prism reflecting the rays of the morning sun. She remarked: "It looks like a place where bright angels' feet have trod!" That remark endowed a moment in time for me with a lifting power enduring to this day.

The second thing I want to say is this. In the 1930's and the 1940's, during the ups and downs, ins and outs, and despairing moments in the building of the Institute of Government, my wife would over and over again come in with the words from *Romeo and Juliet*: "All these woes shall serve for sweet discourses in our time to come." Our own experience has endowed those words with a lilting power which has lasted to this day.

The third thing I want to say is this. Surely this gracious evening in the 1970's is bringing one of those "sweet discourses in our time to come," with a lifting power of its own.

And here is the response we both would make. It is taken from the words of Marcellus, talking about the Christmas season, in the first scene of *Hamlet*:

> Some say that ever 'gaint that season comes. . . .
> The bird of dawning singeth all night long;
> And then, they say, no spirit can walk abroad;
> The nights are wholesome; then no planets strike,
> No fairy takes, no witch hath power to charm,
> So hallow'd and so gracious is the time.

That is the way my wife and I feel about this particular evening. About those who thought of it. About those who have planned and carried it through. And about all of you who have taken the time to come and share it with us.

—*Albert Coates*

a consideration of the problem

by George M. Teague and
David G. Warren

In 1963, the American Medical Association (AMA) recognized that "the risk of being sued by a patient is one of the facts of life for the physician in active practice. It cannot be ignored or wished away. It must be anticipated and faced."[1] Since then, the incidence of suits and the frequency of claims has greatly increased. Today, even Congress has declared that malpractice litigation is fast becoming a national crisis,[2] and the President has directed the Secretary of Health, Education and Welfare to set up a commission on medical malpractice to begin an "intensive program of research and analysis in this area."[3] What are the causes of this crisis? How is it affecting health care? Are there any solutions to this problem?

This discussion briefly explores the malpractice problem and attempts to provide answers for these questions. While North Carolina is considered one of the states where malpractice is not yet a serious problem, discussion of the national picture at this time seems warranted to provide some perspective about implications for North Carolina citizens.

The Definition of Malpractice

At the outset, it should be noted that the term "medical malpractice" is broadly but improperly used to describe all lawsuits involving physicians' liability. It is a term with quasi-criminal or disreputable connotations and also tends to prejudge the issues in a particular claim or suit. Defined accurately, the term medical malpractice denotes the basis for a civil action brought by a patient-plaintiff against a physician for injuries resulting from his negligence or carelessness. The formula for determining whether the physician will be liable in monetary damages to the patient is commonly phrased in terms of his failure on one of three counts: (a) that he did not "possess the degree of professional learning, skill and ability which others similarly situated ordinarily possess"; (b) that he did not "exercise reasonable care and diligence in the application of his knowledge and skill to the patient's case"; or (c) that he did not "use his best judgment in the treatment and care of his patient."[4]

Negligence is an ordinary tort action that can be brought against innumerable types of defendants (from soft-drink manufacturers to neighbors) but when brought against the medical profession carries special indicia. Among them are especially large damage claims and the rule that doctors ordinarily must be found to testify on behalf of the plaintiff as to the standard of care that the defendant doctor should have observed.

But physicians are sued for more reasons than negligent care, though the public (and many doctors) erroneously connect any legal liability of a medical practitioner with

1. 185 J.A.M.A. 789 (1963).

2. MEDICAL MALPRACTICE: THE PATIENT VERSUS THE PHYSICIAN. Staff of Senate Subcomm. on Executive Reorganization, Comm. on Governmental Operations 1, 91st Cong. 1st Sess. (Comm. Print 1969).

3. See *Suing the Doctor, A Rising Problem*, U.S. NEWS AND WORLD REPORT, Mar. 8, 1971, at 70.

4. Hunt v. Bradshaw, 242 N.C. 517, 521, 88 S.E.2d 762 (1955).

the term "malpractice." The phrase "medical professional liability" has been suggested as a preferable term to describe "all possible civil liability which a physician can incur as a result of his professional acts."[5]

Reasons for the Crisis

The present medical professional liability crisis results from the interaction of several different factors. First, American society has become more mobile, which makes it much more difficult for the physician to establish a good patient physician relationship. The resultant impersonality and absence of trust have made the physician a much more likely target for suit than in the past.[6]

Also, doctors may bring suits upon their professional colleagues inadvertently by loose criticism of another's work. The man who asks his patient "What butcher left that scar?" may have set up another doctor for a malpractice claim.[7]

Furthermore, the public has been made more and more aware of the medical accidents and consequent lawsuits by magazine stories, newspaper articles, and television programs. Much of this has been "bad press," which has distorted and magnified the physician's problem.[8] Beyond this, the physician is seen by the public as a good "target," a deep pocket, for a lawsuit because of his presumed high financial position in the community. This idea is enhanced by the general knowledge that physicians carry substantial malpractice insurance. The well-publicized large money judgments frequently received by plaintiffs in malpractice suits serve only to reinforce this image.[9] Finally, because of the publicity that modern medical "miracles" receive, the public has come to expect one every time. When it does not occur, a patient may sue,[10] particularly when the physician had not adequately discussed the medical situation with him.

Mr. Teague, a Vanderbilt Law School graduate, is a research associate at the Institute. Mr. Warren is an Institute staff member whose field is health law.

Incidence and Effects of Malpractice

These factors have all worked to change American expectations of the medical profession and practice. From 1794, when the first professional liability case was filed against a physician in the United States,[11] until the 1930's, few such cases occurred. However, from 1930 to 1940 the number of claims rose tenfold and rose another tenfold in the next decade.[12] Recent estimates are that the incidence of medical professional liability suits has doubled in the last ten years, such claims increasing at the rate of 10 per cent a year.[13] Probably over 10,000 malpractice claims will be filed this year.[14] A 1964 survey reported that one of every six physicians practicing medicine at that time had at least one professional negligence claim against him.[15]

Jury awards have kept pace with increased litigation. Judgments of $100,000 and over are common,[16] and judgments of $1,000,000 and more are not hard to find. One author cites three such large recoveries: $1,500,000 and $1,400,000 in Florida and California anesthetic mishaps, and $1,250,000 in a New Mexico case involving radiation burns.[17] Within the foreseeable future a jury award of more than $3,000,000 may be granted in a medical-hospital malpractice case.[18] It is estimated that the total figure for settlement and judgments in professional negligence suits now exceeds $1,000,000,000 yearly.[19]

The direct result of the larger number of cases and enlarged judgments in this area is higher cost of medical care to the public. Companies that provide malpractice insurance are increasing the costs of coverage, which are passed on to the patient. In Utah, for example, a rise in premium costs from $294 in 1967 to $3,910 in 1969 (an increase of 13 times!) has been reported.[20] Examples of extremely high premium rates are easy to find: the average 1969 premium paid by ob-gyn solo practitioners in Southern California was $3,452; in New York City, $2,015[21] These high premiums are viewed as a cost of doing business to be spread among the patients. The North Carolina medical profession has experienced an increase of over 80 per cent in premium costs since 1964. Although this is a significant increase, this state continues to have one of the five lowest rate schedules in the nation.[22]

5. C. STETLER & A. MORITZ, DOCTOR AND PATIENT AND THE LAW 305 (4th ed. 1962). Other forms of liability include medical assault and battery (e.g., unauthorized operations), libel and slander, invasion of privacy, mutilation of the body (unauthorized autopsies), false representation, false imprisonment, and wrongful death.

6. Halberstram, *The Doctor's New Dilemma—Will I Be Sued?*, N.Y. TIMES (Magazine), Feb. 14, 1971, at 33, col. 2.

7. Averbach, *Rx for Malpractice*, 19 CLEV. MAR. L. REV. 20, at 22 (1970).

8. *Id.* at 25.

9. Halberstram, *supra* note 6, at 33, col 2.

10. U.S. NEWS AND WORLD REPORT, *supra* note 3, at 70.

11. Cross v. Guthery, 2 Root 90 (Conn. 1794). The physician was held liable for performing a mastectomy (removal of a breast) in the "most unskillful, ignorant, and cruel manner, contrary to all well known rules and principles of practice in such cases."

12 MALPRACTICE AND THE PHYSICIAN, a pamphlet prepared by the A.M.A Committee of Medical-Legal Problems (1951).

13. Halberstram, *supra* note 6, at 9, col 4

14. ARIZONA LEGISLATIVE COUNCIL, INTERIM COMM. REPORT ON MEDICAL MALPRACTICE INSURANCE 2 (1970).

15. *1963 Professional Liability Survey*, 189 J.A.M.A. 859 (1964).

16. Sandor, *The History of Professional Liability Suits in the United States*, 163 J.A.M.A. 459, 464 (1957).

17. *See* Averbach, *supra* note 7.

18. *See* U.S. NEWS AND WORLD REPORT, *supra* note 3.

19. *See* Averbach, *supra* note 7.

20. *See* U.S. NEWS AND WORLD REPORT, *supra* note 3.

21. ARIZONA LEGISLATIVE COUNCIL, *supra* note 14, at 31.

22. In 1964 the base rate for $5000/$15,000 coverage for a class 1 physician (no surgery) was $24. To increase coverage to $100,000/$300,000, that physician had to pay $49 (obtained by multiplying the base rate by 2.06). In 1970 the base rate for $5000/$15,000 coverage for a class 1 physician was $35. To increase coverage to $100,000/$300,000 that physician had to pay $91 (obtained by multiplying the base rate by 2.59—note the increase in both base rate and increase factor). The increased premium cost from $49 to $91 represents an increase of 85 per cent. For class 5 (anesthesiologists, orthopedic surgeons, obstetricians, gynecologists, plastic surgeons, etc.) the increase for $100,000/$300,000 coverage has been $177 (base rate, $86; multiplier 2.06) to $323 (base rate, $175; multiplier 2.59) in the same time period—an 83 per cent increase. While the North Carolina increase factor is now 2.59, nationally the increase factor is 2.99 for class 1 and 3.78 for class 5.

Physicians feel forced to practice "defensive medicine" in an attempt to avoid malpractice claims, sometimes ordering more elaborate and sometimes unnecessary diagnostic procedures. Thereby they further increase the cost of medical care.[23] Today when somethings goes wrong on the operating table, the immediate medical team at fault will answer for it, but the public at large eventually pays for it.

Solving the Malpractice Problem

Physicians have tried to stem the tide of the malpractice cases through the use of their famous "conspiracy of silence"—physicians' refusal to testify against one another in such cases. One commentator suggests, however, that the profession needs to do some "realistic soul searching" about this "conspiracy" before it becomes a national scandal and results in a swing of the courts and public's opinion in favor of injured claimants.[24]

Doctors must use valid professional responses, other than the conspiracy of silence, to help solve this national crisis. One approach has been the establishment of malpractice screening committees to review malpractice claims and settle nonmeritorious claims outside of court. The Los Angeles County medical and bar associations have developed a program to provide a panel of attorneys and physicians to advise threatened physicians before a lawsuit is brought and to provide expert testimony if the action is filed. The county bar association also maintains a list of physicians available to plaintiffs' attorneys.[25]

A different plan, adopted in 1957 in Pima County, Arizona, was also sponsored by the county bar and medical associations. Here a panel of nine physicians, appointed for three-year terms, reviews malpractice claims voluntarily submitted to it before any suit is filed. If its review of the claim indicates any substantial evidence of malpractice and harm to the patient, the panel will support his claim and help him retain expert witnesses.[26] These screening panels provide a mechanism by which valid claims against doctors can be settled without the damage to the profession that the notoriety ensuing from a court-litigated malpractice judgment brings. The patient is properly compensated and the physician is penalized, though "in house."[27]

Educating the profession about the malpractice crisis and its pitfalls would greatly ease the current problems.[28] Simultaneously, the public should be accurately informed of the crisis, for in the long run it is the public whose well-being is threatened with higher medical costs and retardation of medical progress.

But prevention will always be the best defense against the accusation of professional negligence. The best way for the physician to avoid being sued for malpractice is to devote careful, personal attention to the patient. Though he signs a consent form, the patient should also be fully informed, personally by the physician, of the risks involved in the operation or treatment. In this way a good patient physician relationship is fostered and the likelihood of a malpractice claim against the physician greatly reduced.

Inverting the formula for determining professional liability actually indicates a course to follow not only for avoiding legal vulnerability but also for engaging in the practice of good medicine.[29] Each physician should be equipped by training and temperament to practice an increasingly sophisticated level of medicine, and should exercise care and diligence in dealing with each and every patient. He must keep "abreast of the times."[30] He must use his best judgment in making decisions affecting his patients; the decision is not expected to be unfailingly perfect, but it must be arrived at by an honest and good-faith application of all his faculties to each particular circumstance. He should take into account all the available relevant factors. The good physician will consider each patient as a fellow human being in need of genuine concern and special care. The good physician should not have to worry about a damaging lawsuit.

23. This was one of the most dramatic conclusions reached by the Rihicoff Subcommittee report, *supra* note 2.

24. *See* Averbach, *supra* note 7.

25. *See* Archer & West, *Medical Expert Panel for Malpractice Case*, 88 CALIF. MED. 173 (1958); Note, *The California Malpractice Controversy*, 9 STAN L REV. 731 (1957).

26. Lester, *Pima County Screening Plan*, 17 ARIZ. MED. 379 (1960).

27. For a general discussion of medical society screening committees, see C. STETLER & A. MORITZ, *supra* note 5, at 153–54.

28. For an excellent checklist of these areas of malpractice litigation in which the physician should be knowledgeable and preventive tactics which can be used, see *id.* at 439–41.

29. See discussion in the text, *supra* note 4

30 Nash v Royster, 189 N.C. 408, 127 S.E. 356 (1925).

Relationship of State Law to Per Capita Liquor Consumption

by Ben F. Loeb, Jr.

The purposes of this chapter are (1) to examine the alcoholic beverage control laws of several states, with a view toward ascertaining whether any relationship exists between the law of a given jurisdiction and the per capita liquor consumption of the inhabitants of that jurisdiction, and (2) to relate the experience of these states to national trends. For this purpose the liquor control acts of eight states will be surveyed, with all major geographical regions of the country represented. Three of these states have government owned liquor stores (control states) and the other five have privately owned stores licensed by the state (license states). Per capita consumption figures given will be for the year 1970, unless otherwise indicated, and will include the data for distilled spirits (hard liquor) only. Those jurisdictions with a large tourist industry, or having other factors present which might account for an unusually high or low per capita consumption, have been intentionally omitted from consideration. For this reason the District of Columbia, which has an apparent per capita consumption three times the national average, is not included in this study. Nor is Utah, which has a consumption level less than half the national average.

The states to be analyzed, in order of declining per capita consumption, are: Alaska, New Jersey, Illinois, Colorado, Arizona, Oregon, North Carolina, and Iowa. Table I shows the 1969 and 1970 consumption figures for these eight states as well as for all other U.S. territorial jurisdictions.[1] References are to "apparent consumption" because there is no way to take fully into account such factors as purchases by out-of-state residents or illegal purchases of non-taxpaid liquor. Consumption figures are given in terms of "wine gallons," which consists of four quarts each, as with all U.S. standard liquid gallons.

Table II shows the number of retail licenses issued in each state.[2] "On-premises" licenses authorize liquor sales by the drink, and "off-premises" licenses permit sales by the bottle only. Some states issue one license which allows both types of sales on the same premises.

ALASKA

Alaska is a license, as opposed to control, state and has a quite high per capita consumption of liquor. (See Table I.) In this state licenses are issued by an Alcoholic Beverage Control Board. A "beverage dispensary license" may be acquired for on-premises sales of liquor by the drink[3] and a "retail license" for liquor store sales by the bottle for off-premises consumption.[4] A "club license" is available to certain organizations that have been incorporated for at least two years; but sales may be made only to club members and their families.[5] The sale of liquor is on a local-option basis and may be prohibited in a given area altogether.[6]

One interesting provision of the Alaska law concerns the hours for sale. The statutes provide that "no person may consume, sell, or give . . . any liquor

1. ANNUAL STATISTICAL REVIEW OF THE DISTILLED SPIRITS INSTITUTE (1970), 42.

2. RETAIL OUTLETS FOR THE SALE OF DISTILLED SPIRITS, Distilled Spirits Institute (1970).

3. ALASKA (1970) § 04.10.040.

4. ALASKA (1970) § 04.10.100.

5. ALASKA (1970) § 04.10.070.

6. ALASKA (1970) § 04.10.430, .440.

This article will appear as a chapter in a book entitled Law and Drinking Behavior, *edited by John A. Ewing, M.D., which will be published in 1972 by the University of North Carolina Center for Alcohol Studies. Its author is an Institute of Government staff member whose fields include liquor control legislation.*

on any licensed premises between the hours of 5:00 a.m. and 8:00 a.m."[7] Why write into statutory form a law that is effective for only three hours out of twenty-four, particularly when the prohibited period is generally used for sleeping anyway? Except during the hours noted above, liquor may be sold at any time on any day (including Sunday) except on election days—and even then sales may resume after the polls close.

In recent years Alaska has reduced the age requirement for buying and consuming liquor from 21 to 19 years; but a person under 19 is not even allowed on premises holding a liquor license unless accompanied by a parent, guardian, or spouse who has attained that age. The only other category of persons to whom sales are prohibited is those already intoxicated.[8]

Alaska has 3.03 liquor licenses outstanding for each 1,000 inhabitants. (See Table II.) This is by far the highest ratio of licenses to population in the United States, and could be a factor in the state's high per capita consumption level.

Among the other factors that may contribute to Alaska's relative high per capita liquor consumption are the following: (1) *Very long hours of sale.* Not many states allow sales for 21 hours a day. In North Carolina, for example, all alcoholic beverage control stores are required by law to close by 9:00 p.m. and may not reopen until 9:00 a.m. the next morning. (2) *No prohibited days of sale.* In many states liquor stores remain closed on Sundays, and often on a number of holidays as well. (3) *Age requirement.* Reduction of the legal age for purchase and consumption may be a contributing factor. Most states still require that a person be 21 before being eligible to purchase hard liquor.

NEW JERSEY

New Jersey has a per capita liquor consumption of 2.27 gallons per year, which is well above the national average for license states. (See Table I.) Several different types of retail liquor licenses are available in this jurisdiction, including the following:

(1) *Plenary retail consumption license.* The holder of this license is authorized to sell liquor by the drink for consumption on the premises, or by the bottle for consumption off the premises.

(2) *Plenary retail distribution license.* The holder of this license is authorized to sell liquor for off-premises consumption only, and all liquor must be sold in its original container.

(3) *Club license.* This license authorizes only sales by the drink for on-premises consumption; and no sales may be made except to club members and their guests. The New Jersey system, like that of most other states, has local option features. For example, the governing board of any municipality may enact an ordinance prohibiting the issuance within its corporate limits of any one or all types of the retail liquor licenses listed above.[9]

In New Jersey it is a misdemeanor to sell liquor to any person under 21 years of age. For the purpose of establishing age, identification cards are issued by the clerk of each county upon application of anyone 21 years of age or older. This card contains the holder's date of birth, photograph, and signature. Any licensee who mistakenly sells liquor to a minor because of a failure to request proof of age incurs the same criminal liability as one who intentionally sells to a minor.[10]

One rather unusual feature of this state's liquor law concerns days and hours of sale, with these important determinations being left largely to local governments. It is provided by statute that:

> The governing board or body of each municipality may, as regards said municipality, by ordinance or resolution, limit the hours between which the sale of alcoholic beverages at retail may be made, prohibit the retail sale of alcoholic beverages on Sunday. . . .[11]

And, in addition to the authority of the municipal governing board noted above, New Jersey law also provides for municipal referendums on Sunday sales and hours of sale—with the voters in effect taking the decision out of the hands of the governing board.[12]

While permitting local option on various types of retail sales, state law imposes by formula a limit on the number of establishments that may sell liquor by the drink or by the bottle in a given locality. As amended in 1969, the law now provides that no new "retail consumption license" shall be issued in a municipality until the number of such licenses is fewer than one for each 3,000 inhabitants; and no new retail distribution license shall be issued until the number of licenses is fewer than one for each 5,000 inhabitants.[13]

Because of the local-option features of the New Jersey system, it is difficult to categorize its liquor control laws as being either liberal or conservative. New Jersey's structure certainly appears more conservative than that of Alaska, with its 21-hours-per-day legalized sales. Also, the New Jersey requirement that a person be 21 to make purchases is, of course, not exceeded anywhere in the country. However, Table II indicates that there are 1.69 liquor licenses per 1,000

7. ALASKA [19]70 § 04.15.010.
8. ALASKA [19]70 § 04.15.020.
9. N.J. STAT. ANN. § 33: 1–12.
10. N.J. STAT. ANN. § 33: 1–77, –81.2, –81.6.
11. N.J. STAT. ANN. § 33: 1–40.
12. N.J. STAT. ANN. § 33: 1–47, –47.1.
13. N.J. STAT. ANN. § 33: 1–12.14

TABLE I

Apparent Consumption of Distilled Spirits

License States	Rank in Consumption 1970	Rank in Consumption 1969	Consumption in Wine Gallons 1970	Consumption in Wine Gallons 1969	Percentage Increase Decrease	Per Capita 1970	Per Capita 1969
Alaska	47	48	945,370	898,384	5.2	3.13	3.19
Arizona	32	32	2,967,269	2,648,286	12.0	1.67	1.56
Arkansas	39	39	1,865,031	1,783,362	4.6	0.97	0.89
California	1	1	45,070,650	44,013,195	2.4	2.26	2.26
Colorado	25	25	4,254,048	4,147,701	2.6	1.93	1.98
Connecticut	17	17	7,276,811	7,505,861	(— 3.1)	2.40	2.50
Delaware	41	41	1,583,166	1,540,051	2.8	2.89	2.85
Dist. of Columbia	21	19	5,730,253	6,111,564	(— 6.2)	7.57[a]	7.66[a]
Florida	4	6	18,031,618	15,710,834	14.8	2.66	2.47
Georgia	16	18	7,453,253	7,007,387	6.4	1.62	1.51
Illinois	3	3	24,213,606	24,619,182	(— 1.6)	2.18	2.23
Indiana	19	21	6,164,823	5,765,986	6.9	1.19	1.13
Kansas	36	33	2,410,475	2,400,965	0.4	1.07	1.03
Kentucky	24	24	4,450,543	4,336,585	2.6	1.38	1.34
Louisiana	22	22	5,281,620	5,253,429	0.5	1.45	1.40
Maryland	12	12	8,748,466	8,194,173	6.8	2.23	2.18
Massachusetts	10	10	12,732,230	12,767,031	(— 0.3)	2.24	2.34
Minnesota	18	15	7,027,234	7,617,302	(— 7.7)	1.85	2.06
Missouri	13	13	7,724,043	7,631,270	1.2	1.65	1.64
Nebraska	34	35	2,478,081	2,322,900	6.7	1.67	1.60
Nevada	33	34	2,498,767	2,357,709	6.0	5.11	5.16
New Jersey	5	4	16,288,922	16,572,143	(— 1.7)	2.27	2.32
New Mexico	42	42	1,530,291	1,395,915	9.6	1.51	1.40
New York	2	2	43,365,269	41,993,080	3.3	2.38	2.29
North Dakota	45	45	1,031,120	1,044,460	(— 1.3)	1.67	1.70
Oklahoma	28	28	3,568,490	3,355,029	6.4	1.39	1.31
Rhode Island	38	38	1,866,877	1,801,267	3.6	1.97	1.98
South Carolina	23	23	5,187,268	4,863,361	6.7	2.00	1.81
South Dakota	46	46	972,355	1,012,581	(— 4.0)	1.46	1.54
Tennessee	27	26	3,765,694	4,028,396	(— 6.5)	0.96	1.01
Texas	9	9	13,689,637	13,290,390	3.0	1.22	1.19
Wisconsin	11	11	8,867,418	8,452,439	4.9	2.01	2.00
Total License			279,040,698	272,442,218	2.4	1.98	1.96
Control States							
Alabama	26	27	3,862,956	3,749,627	3.0	1.12	1.06
Idaho	49	49	852,600	816,376	4.4	1.20	1.14
Iowa	30	30	3,152,684	3,075,511	2.5	1.12	1.11
Maine	40	40	1,667,559	1,593,230	4.7	1.68	1.63
Michigan	7	7	15,055,823	14,568,480	3.3	1.70	1.66
Mississippi	35	36	2,457,992	2,313,504	6.2	1.11	0.98
Montana	44	44	1,144,966	1,098,296	4.2	1.65	1.58
New Hampshire	29	31	3,370,779	2,879,275	17.1	4.57	4.02
North Carolina	15	16	7,583,955	7,582,980		1.49	1.46
Ohio	8	8	14,045,628	14,434,784	(— 2.7)	1.32	1.34
Oregon	31	29	3,135,465	3,120,181	0.5	1.50	1.54
Pennsylvania	6	5	16,187,669	15,781,625	2.6	1.37	1.34
Utah	48	47	927,278	908,584	2.1	0.88	0.87
Vermont	43	43	1,240,265	1,189,884	4.2	2.79	2.71
Virginia	14	14	7,717,265	7,743,309	(— 0.3)	1.66	1.66
Washington	20	20	6,024,060	5,893,903	2.2	1.77	1.73
West Virginia	37	37	1,996,362	1,897,694	5.2	1.14	1.04
Wyoming	50	50	615,959	592,557	3.9	1.86	1.85
Total Control			91,039,265	89,239,800	2.0	1.47	1.44
Grand Total			370,079,963	361,682,018	2.3	1.83	1.80

population. This compares with a national average of 1.13. The availability of liquor through these numerous outlets may contribute to the high per capita consumption.

ILLINOIS

Illinois is another license state with a per capita liquor intake that is well over the national average. (See Table I.) Retail liquor licenses for on-premises consumption may be obtained from the State Liquor Control Commission for restaurants, hotels, and clubs;[14] and these establishments are defined in a manner to insure so far as possible, that their primary purpose is not the sale of liquor.[15] However, Illinois has no provision, such as exists in Colorado, requiring that liquor be served only with meals.

Local-option provisions allow municipalities with a population of 200,000 or less to vote as a unit on the question of prohibiting the sale of liquor. In cities with a population over 200,000, the vote takes place on a precinct basis; and under this system, a single city could have both wet and dry areas.[16]

Statewide law prohibits sales on election days and on Sunday. Cities and counties may, however, suspend the Sunday-sale law by enacting an ordinance permitting such sales.[17] Hours of sale for on-premise consumption are not set by state law, but are subject to local regulation.

Sales to certain categories of individuals are prohibited. It is unlawful to sell liquor to any (1) person who is under 21 years of age; (2) intoxicated person; (3) known habitual drunkard; (4) spendthrift; or (5) to any other person who is insane, mentally ill or deficient, or who is in need of medical treatment.[18] If the experiences of other states are any indication, then these prohibitions are almost totally ineffective except as they apply to purchases by minors.

Illinois has stringent laws relating to liquor in automobiles. The state vehicle code provides:

> No person shall transport, carry, possess or have any alcoholic liquor in or upon any motor vehicle except in the original package, with the seal unbroken.[19]

The criminal penalty for violating this provision can range up to $500. This type of law, if properly enforced, discourages having an open bottle in an automobile. It would be far wiser, for example, to abandon or leave behind a partially consumed bottle of very expensive whiskey rather than risk such a still fine. The transportation provision is probably intended to discourage drinking only while operating a vehicle, and it is unlikely that it has much effect on over-all consumption.

In Illinois all licenses authorize both on-premises consumption and sales by the bottle for off-premises consumption. The ratio of liquor licenses to inhabitants is high even for a license state—1.90 as compared with an average of 1.21 for other license states. (See Table II.) Per capita liquor consumption declined in this state during 1970 by 1.6 per cent; but there is nothing to indicate that the decrease was caused by any change in the law. Perhaps this decline resulted from nationwide adverse economic conditions.

COLORADO

Colorado is a license state also; but unlike the three previous jurisdictions examined, this state has a per capita consumption level below the national average for license states. Licenses are obtained from the Secretary of State, and retail licenses are of four general types: (1) liquor store; (2) liquor-licensed drugstore; (3) hotel and restaurant; and (4) club.[20]

An establishment licensed as a retail liquor store may sell the beverages in sealed containers only for consumption off the premises. Any drugstore licensed by the state may also secure a liquor license for sales in the original containers for off-premises consumption. Only liquor stores and drugstores are authorized to sell liquor by the bottle.[21]

A "hotel and restaurant license" authorizes sales of liquor by the drink, but drinks may be served only with meals.[22] Club licenses may also be obtained that authorize sales by the drink, but such sales may be made only to members and their guests.[23] Colorado law does not appear to authorize bars where the general public can consume liquor only. In this respect Colorado law is more restrictive than many other states, including Alaska, New Jersey, and Illinois.

The liquor law of this jurisdiction is statewide, but any county or municipality is authorized to prohibit any type or all liquor licenses from being issued within its territorial limits.[24]

Liquor sales are restricted or prohibited altogether on Sundays, election days, and Christmas. On other days sales of liquor by the drink are prohibited from 2:00 a.m. to 7:00 a.m., and sales by the bottle may not be made between midnight and 8:00 a.m.[25] Sales to persons under 21 years of age, habitual drunkards, or anyone who is intoxicated are expressly prohibited.[26]

Colorado has enacted a variety of laws intended to encourage strict compliance with its liquor code. Among these are provisions:

(1) Making it unlawful to possess a container of liquor not bearing excise tax stamps;

(2) Prohibiting the consumption of liquor in any public place, except on premises having a liquor-by-the-drink license;

(3) Prohibiting an open liquor bottle on the premises of a retail liquor store or liquor-licensed drugstore;

14. ILL. ANNOT. STATS. 43 § 115 (d).
15. ILL. ANNOT. STATS. 43 § 95.23, .24, .25.
16. ILL. ANNOT. STATS. 43 § 166.
17. ILL. ANNOT. STATS. 43 § 129.
18. ILL. ANNOT. STATS. 43 § 131.
19. ILL. ANNOT. STATS. 95½ § 11–502.
20. COLO. REV. STAT. § 75–2–16.
21. COLO. REV. STAT. § 75–2–4(12), (13).
22. COLO. REV. STAT. § 75–2–22.
23. COLO. REV. STAT. § 75–2–23.
24. COLO. REV. STAT. § 75–2–30.
25. COLO. REV. STAT. § 75–2–3(3), (4).
26. COLO. REV. STAT. § 75–2–3(2).

TABLE II

Retail Licenses for Sale of Distilled Spirits

State	Number of Licenses				1970 Census (Thousands)	No. of Licenses per 1,000 population			
	On-Premise	Off-Premise	On and Off-Premise	Total Licenses		On-Premise	Off-Premise	On and Off-Premise	Total Licenses
LICENSE STATES									
Alaska	596	319		915	302,000	1.97	1.06		3.03
Arizona	416	1,043	1,260	2,719	1,772,000	0.23	0.59	0.71	1.53
Arkansas	194	604		798	1,923,000	0.10	0.32		0.42
California	12,082	10,498		22,580	19,953,000	0.61	0.53		1.14
Colorado	2,108	1,020		3,128	2,207,000	0.96	0.46		1.42
Connecticut	2,654	2,140		4,794	3,032,000	0.88	0.71		1.59
Delaware	254	278	251	747	548,000	0.46	0.51	0.39	1.36
Dist. of Columbia	663	382		1,045	757,000	0.88	0.50		1.38
Florida	554	534	3,799	4,887	6,789,000	0.08	0.08	0.56	0.72
Georgia	457	1,153		1,610	4,590,000	0.10	0.25		0.35
Hawaii	648	530		1,178	770,000	0.84	0.69		1.53
Illinois			21,127	21,127	11,114,000			1.90	1.90
Indiana	1,187	1,471	2,662	5,320	5,194,000	0.23	0.28	0.51	1.02
Kansas	718	1,080		1,798	2,249,000	0.32	0.48		0.80
Kentucky	857	764	151	1,772	3,219,000	0.26	0.24	0.05	0.55
Louisiana		1,447	5,564	7,011	3,643,000		0.40	1.53	1.93
Maryland	577	1,035	2,633	4,245	3,922,000	0.15	0.26	0.67	1.08
Massachusetts	5,039	2,048		7,087	5,689,000	0.89	0.36		1.25
Minnesota	1,482	625	948	3,055	3,805,000	0.39	0.16	0.25	0.80
Missouri	3,124	2,854		5,978	4,677,000	0.67	0.61		1.28
Nebraska	258	591	1,407	2,256	1,484,000	0.17	0.40	0.95	1.52
Nevada	639	322	411	1,372	489,000	1.31	0.66	0.84	2.81
New Jersey	1,252	2,017	8,874	12,143	7,168,000	0.17	0.28	1.24	1.69
New Mexico	114	123	1,164	1,401	1,016,000	0.11	0.12	1.15	1.38
New York	23,221	5,257		28,478	18,191,000	1.28	0.29		1.57
North Dakota		72	923	995	618,000		0.12	1.49	1.61
Oklahoma		801		801	2,559,000		0.31		0.31
Rhode Island	1,336	338		1,674	950,000	1.41	0.36		1.77
South Carolina		899		899	2,591,000		0.35		0.35
South Dakota	546	560		1,106	666,000	0.82	0.84		1.66
Tennessee	157	471		628	3,924,000	0.04	0.12		0.16
Texas	1,682	3,187		4,869	11,197,000	0.15	0.28		0.43
Wisconsin	11,707	1,173		12,880	4,418,000	2.65	0.27		2.92
TOTAL LICENSE	74,522	45,636	51,138	171,296	141,427,000	0.53	0.32	0.36	1.21
CONTROL STATES									
Alabama	872	105		977	3,444,000	0.25	0.03		0.28
Idaho	658	117		775	713,000	0.92	0.17		1.09
Iowa	3,211	199		3,410	2,825,000	1.14	0.07		1.21
Maine	515	88		603	994,000	0.52	0.09		0.61
Michigan	7,232	2,447		9,679	8,875,000	0.81	0.28		1.09
Mississippi	302	507		809	2,217,000	0.14	0.23		0.37
Montana	1,437	147		1,584	694,000	2.07	0.21		2.28
New Hampshire	650	57		707	738,000	0.88	0.08		0.96
North Carolina		308		308	5,082,000		0.06		0.06
Ohio	11,097	370		11,467	10,652,000	1.04	0.04		1.08
Oregon	1,013	178		1,191	2,091,000	0.48	0.09		0.57
Pennsylvania	20,358	729		21,087	11,794,000	1.73	0.06		1.79
Utah	146	101		247	1,059,000	0.14	0.10		0.24
Vermont	607	57		664	445,000	1.36	0.13		1.49
Virginia	434	237		671	4,648,000	0.09	0.05		0.14
Washington	1,255	273		1,528	3,409,000	0.37	0.08		0.45
West Virginia	818	146		964	1,744,000	0.47	0.08		0.55
Wyoming	131	75	480	686	332,000	0.39	0.23	1.45	2.07
TOTAL CONTROL	50,736	6,141	480	57,357	61,758,000	0.82	0.10	0.01	0.93
GRAND TOTAL	125,258	51,777	51,618	228,653	203,185,000*	0.62	0.26	0.25	1.13

(4) Preventing liquor shipments by wholesalers on New Year's Day, Memorial Day, Independence Day, Labor Day, election day, Thanksgiving, or Christmas.[27]

Over all, Colorado has a somewhat more restrictive liquor law and a lower per capita consumption level than the three states already analyzed. For example: hours during which sales are prohibited are set by state law, rather than being left to local ordinance; a person must be 21 to purchase alcoholic beverages; drinks may not be served except with meals; and the voters in a given political subdivision can prevent sales altogether. These types of restrictions may account, in part, for Colorado's having a per capita liquor consumption level below the national average.

It should be noted, however, that Colorado law has not prevented a proliferation of liquor outlets. This state has 0.96 on-premises licenses per 1,000 population (compared with 0.62 nationally) and 0.46 off-premises licenses per 1,000 population (compared with 0.26 nationally). (See Table II.)

ARIZONA

Arizona is the last of the license states to be analyzed. This jurisdiction has a per capita consumption average of 1.67 gallons, compared with a national average of 1.98 gallons for license states and 1.47 for control states.[28]

In Arizona licenses are issued and revoked by the State Liquor Board, which is a division of the Department of Liquor Licenses and Control. Types of licenses include:

(1) "Restaurant" licenses, which authorize liquor sales solely for consumption on the licensed premises. To qualify as a restaurant, the establishment must be regularly open to serve meals and must have suitable kitchen facilities.[29]

(2) "Hotel-motel" licenses, which authorize sales of liquor by the drink. To qualify for this license, the hotel or motel must have a restaurant in which meals are regularly served.[30]

(3) "Club" licenses, which authorize liquor-by-the-drink sales to members and bona fide guests.[31]

(4) "Off-sale retailer" licenses, which may be acquired by liquor stores for sales of beverages in the original package to be consumed off the licensed premises.[32]

(5) "On-sale retailer" licenses, which authorize both sales in the original container for consumption on or off the licensed premises and sales by the drink for on-premises consumption.[33]

A formula is set out in the statutes to limit the number of "on-sale retailer" and "off-sale retailer" licenses that can be issued in a given county. For on-sale licenses, the ratios are as follows: (a) one license for each 1,000 inhabitants for the first 24,000 inhabitants; (b) one license for each 2,000 inhabitants for 25,000-100,000 inhabitants; and (c) one license for each 2,500 inhabitants over 100,000. A similar formula is provided for "off-sale" or liquor store licenses. These license restrictions based on population do not apply to club, hotel-motel, or restaurant licenses.[34]

Sales are prohibited for both on-premises and off-premises establishments from 1:00 a.m. to 6:00 a.m. on weekdays, and to noon on Sundays. Liquor sales are also prohibited while the polls are open on election days. Consumption on premises licensed for liquor-by-the-drink sales are unlawful after 1:15 a.m.[35]

In Arizona the legal age for purchasing liquor is 21.[36] Thus Arizona's law, in this respect, is more restrictive than that of several states, including Hawaii, Louisiana, Nebraska, New York, and Maine.[37]

The consumption of liquor in public places, except for licensed premises, is expressly prohibited. Sales to intoxicated or disorderly persons are unlawful; and it is a violation for a licensee to allow such a person to remain on the licensed premises.[38] Liquor cannot be purchased on credit, except when served with a meal that is also charged or when included with a hotel or motel bill.[39] There are 1.53 liquor licenses per 1,000 population, which is well above the national average. (See Table II.)

It should be noted at this point that all of the states thus far examined are license states, and all permit liquor-by-the-drink sales in one form or another. The remaining states to be mentioned are "control states" with government-owned liquor stores. It is apparent from Table I that the control jurisdictions, on the average, have a lower per capita consumption level than the states in which stores are licensed. Thus it is no coincidence that the low consumption states in this study are all control states.

OREGON

Oregon has government-owned liquor stores and a per capita liquor consumption level that is well below the national average of 1.83 gallons. (See Table I.)

This state has three types of liquor-by-the-drink licenses. The Class A license may be issued to private clubs, veterans' and fraternal organizations, and commercial establishments where food is cooked and served. Licensees must purchase all liquor from the State Liquor Control Commission, and may resell the same by the glass for consumption on the licensed premises. The Class A license does not allow dancing or any live entertainment on the premises.[40] A Class B license differs from a Class A only in that it allows

27. Colo. Rev. Stat. § 75-2-3.
28. Annual Statistical Review of the Distilled Spirits Institute (1970), 42.
29. Ariz. Rev. Stat. § 4-205.02.
30. Ariz. Rev. Stat. § 4-205.01.
31. Ariz. Rev. Stat. § 4-205.
32. Ariz. Rev. Stat. § 4-101(10).
33. Ariz. Rev. Stat. § 4-101(11).
34. Ariz. Rev. Stat. § 4-206.
35. Summary of State Laws and Regulations Relating to Distilled Spirits, Distilled Spirits Institute (1969), 28.
36. Ariz. Rev. Stat. § 4-241.
37. Summary of State Laws and Regulations Relating to Distilled Spirits, Distilled Spirits Institute (1969).
38. Ariz. Rev. Stat. § 4-244.
39. Ariz. Rev. Stat. § 4-242.
40. Ore. Rev. Stat. § 472.110(2).

dancing and other "proper forms" of entertainment on the licensed premises. A Class C license is issued only for private clubs or for fraternal and veterans' organizations. Oregon law limits the total number of licensed premises to one for each 2,000 inhabitants of the state.[41]

Any county or municipality having a population of 500 or more may conduct a local-option election on the question of liquor-by-the-drink sales. In the event of a negative vote in a given locality, all types of by-the-drink sales by all types of licensees are prohibited.[42] In addition liquor-by-the-drink sales are not allowed anywhere in the state from 2:30 a.m. until 7:00 a.m. and during polling hours on election days.[43]

Sales of hard liquor by the bottle are the exclusive prerogative of the Oregon Liquor Control Commission. The Commission is directed by statute to establish "control stores" and warehouses in such places as are required by public convenience and necessity. One rather interesting provision of law requires the Commission to obtain, upon request of an individual, any particular kind or brand of whiskey that is obtainable anywhere in the United States.[44] By way of comparison, the North Carolina State A.B.C. Board determines what liquor may be sold in control stores, and a disappointed customer's only recourse is to make his purchase outside the state.

Among the restrictions placed on the state-owned A.B.C. system are the following: (1) liquor control stores may be prohibited in any given city or county by local act; (2) advertising of liquor or the control stores is expressly prohibited; (3) all liquor stores are required by state law to remain closed on Sundays, election days, and legal holidays.[45]

In Oregon it is unlawful to sell or serve liquor to a person under 21 years of age. This age restriction is imposed by all of the control states except Maine, which permits sales to persons who have reached the age of 20.[46] Sales to intoxicated persons are also unlawful; and licensees are prohibited from maintaining a noisy, lewd, disorderly, or unsanitary establishment.[47] A violation of the Oregon liquor control law can result in a substantial penalty. A fine of $500 and a jail sentence of six months may be imposed for a first offense, and a $1,000 fine and one-year sentence for a second offense.[48]

Factors that may contribute to Oregon's relatively low per capita consumption include its state-owned distribution system, local-option provisions making it possible for a community to prohibit liquor-by-the-drink establishments, and an age requirement of 21 to purchase alcoholic beverages.

41. ORE. REV. STAT. § 472.110 (3–5).
42. ORE. REV. STAT. § 472.410–.500.
43. SUMMARY OF STATE LAWS AND REGULATIONS RELATING TO DISTILLED SPIRITS, Distilled Spirits Institute (1969), 10–13.
44. ORE. REV. STAT. § 471.750.
45. ORE. REV. STAT. § 471.750.
46. SUMMARY OF STATE LAWS AND REGULATIONS RELATING TO DISTILLED SPIRITS, Distilled Spirits Institute (1969), 2–17.
47. ORE. REV. STAT. § 472.310.
48. ORE. REV. STAT. § 479.990.

NORTH CAROLINA

North Carolina is a control state with an annual per capita consumption level of only 1.49 gallons. In this state the liquor control stores may sell only by the bottle, and as a matter of practice containers of less than one pint are not stocked.[49]

Control stores in North Carolina are established on a local-option basis, and all counties are dry until there is an affirmative vote "for county liquor control stores."[50] The general state law does not provide for municipal liquor store elections because it was originally intended that all referendums on this question be on a county-wide basis. Over the years, however, the legislature has passed many special acts authorizing city-wide referendums; and presently there are about as many city liquor stores as county.

Liquor by the drink, as of this date, is not authorized. The state legislature, however, recently provided for elections on this question in two of North Carolina's 100 counties. These two referendums have not yet been held, and sales are still limited to liquor by the bottle.

As a substitute for by-the-drink purchases, North Carolinians have over the years developed a practice known as "brown-bagging"—which simply means taking one's bottle of liquor with him in a brown bag. This custom has now been written into the statutes, and certain types of establishments may acquire a permit authorizing consumption of hard liquor on the licensed premises. Among the types of places eligible for such a permit are restaurants and private clubs. And, in the case of clubs, a member's liquor may be stored in a locker on the premises.[51]

Liquor control stores, whether city or county, are required to close by 9:00 p.m. and must remain closed until 9:00 a.m. the next day. Also, sales are totally prohibited on Sundays, election days, and a number of holidays.[52] While the state has set rather conservative hours for liquor stores, such is not the case with establishments licensed for on-premises consumption (brown-bagging). There are absolutely no closing hours for these establishments; and liquor may be lawfully consumed on the licensed premises 24 hours per day, 365 days a year. For liberal hours, this tops even Alaska, where establishments are required to close for at least three hours each day.

The liquor license to population ratio in this state is 0.06, which is far below the national average. To state this another way, North Carolina, with a population exceeding 5,000,000, has only 308 liquor stores and no by-the-drink licensees. (See Table II.)

North Carolina, like a number of other states, has tight restrictions relative to the transportation of liquor in a motor vehicle. Only one gallon may be transported in any one vehicle at any time, and all open

49. N.C. GEN. STAT. § 18–45.
50. N.C. GEN. STAT. § 18–61.
51. N.C. GEN. STAT. § 18–51.
52. N.C. GEN. STAT. § 18–45(5) (6).

bottles must be kept outside the passenger area—in others words they must be put in the trunk.[53] Sales to persons under 21 are prohibited; and, theoretically, those convicted of such crimes as public drunkenness and driving under the influence may not purchase liquor either.[54]

North Carolina's low per capita consumption of hard liquor may be attributable to such factors as the absence of privately owned liquor stores, the prohibition of liquor by the drink, the requirement that a purchaser be at least 21 years of age, and a rather tight control over liquor advertisements. As noted above, liquor by the drink may be just around the corner for some areas of the state. In addition, the 1971 General Assembly made other liberalizing changes in the liquor control law. It will be most interesting to see whether these changes are followed by a sharp increase in per capita consumption.

IOWA

Iowa, a control state with a local-option liquor-by-the-drink law, has one of the nation's lowest per capita liquor consumption levels.

The Iowa Liquor Control Commission is empowered to establish state liquor stores and to determine the cities and towns in which these stores are to be located.[55] Unlike some control states, no local-option elections are provided for with respect to the opening and location of these state-owned package stores. Sales by stores are prohibited on Sundays, legal holidays, election days, and on any other days so designated by the Liquor Control Commission.[56]

There are three principal types of liquor-by-the-drink licenses issued in this state. A "Class A" license may be obtained by a club, and authorizes the sale of liquor to members and their guests. A "Class B" license may be issued to a hotel or motel, and a "Class C" license to a commercial establishment.[57] Apparently a commercial establishment would not have to serve food in order to qualify for a liquor license.

Municipalities and counties must expressly approve the issuance of all liquor-by-the-drink licenses, and a local governing board can decline to approve any such license for an establishment located within the territory over which it has jurisdiction. A referendum may be held in a given area to determine voter sentiment on liquor by the drink, but it is advisory only and does not bind the city or county governing board.[58]

Sales by the drink are prohibited between 2:00 a.m. and 7:00 a.m. on weekdays, and from 1:00 a.m. on Sunday until 7:00 a.m. on the following Monday.[59] Sales to persons under the age of 21 are unlawful, but the law allows a minor to drink in his own home with his parents' permision.[60]

Consumption of liquor on a public street or in any other public place (except for licensed premises) is prohibited. Public intoxication is likewise unlawful and conviction can carry a penalty of $100 and 30 days in jail.[61]

The Iowa Liquor Control Act contains one very unusual provision concerning indemnity for one injured by an intoxicated person. Any person who is injured in his person, property, or means of support by one who is intoxicated has a cause of action against any licensee who sold or gave liquor to such person while he was intoxicated. To insure that a licensee can satisfy a judgment obtained pursuant to this provision, Iowa law requires all liquor licensees to furnish proof of financial responsibility. This can be done by a liability policy or by posting a bond.[62]

Liquor licenses are not required for some places and purposes. Thus private social gatherings on premises not open to the public are not subject to Iowa's licensing law. Also, persons attending a convention or other meeting may bring their own liquor rather than making by-the-drink purchases.[63]

Iowa's ratio of off-premises (liquor by the drink) licenses to population is 0.07 per 1,000, compared with a national average of 0.26.

NATIONAL TRENDS

I

Per capita consumption is steadily increasing in the United States and has been ever since the end of prohibition. Table III shows that in 1934 only 28 jurisdictions had legal liquor, and per capita consumption was only 0.65 gallons.[64] Five years later there were 46 wet states, and per capita consumption had risen to 1.08. By 1950, 47 jurisdictions had hard liquor and per capita consumption was up to 1.29. Since 1965 there have been no totally dry states, and per capita consumption continues to increase each year. The liquor intake per person has more than doubled since 1935, and the end is not yet in sight.

II

As noted before, states with government-owned liquor stores on the average have lower per capita consumption levels than states with privately owned stores. This fact is well illustrated by Table I, which shows a national average of 1.83 gallons per person, a license state average of 1.98, and a control state average of 1.47. Thus the license states have an average per capita consumption level approximately 30 per cent higher than control states.

III

Apparently there is also a relationship between the number of retail liquor establishments in a given state and that state's consumption level. Among the

53. N.C. GEN. STAT. § 18-51(1).
54. N.C. GEN. STAT. § 18-46.
55. IOWA CODE ANN. § 123.16(2).
56. IOWA CODE ANN. § 123.25.
57. IOWA CODE ANN. § 123.27(6).
58. IOWA CODE ANN. § 123.27(7).
59. IOWA CODE ANN. § 123.46(2)(b).
60. IOWA CODE ANN. § 123.43.
61. IOWA CODE ANN. § 123.42.
62. IOWA CODE ANN. § 123.95.
63. IOWA CODE ANN. § 123.96.
64. ANNUAL STATISTICAL REVIEW OF THE DISTILLED SPIRITS INSTITUTE (1970), 43.

TABLE III
Apparent Consumption of Distilled Spirits Since Repeal

Year	States			
	Wine Gallons	Number	Population	Per Capita
1934	57,964,788	28	88,706,909	0.65
1935	89,670,446	41	109,041,649	0.82
1936	122,117,965	43	113,235,914	1.08
1937	135,352,692	44	116,716,065	1.16
1938	126,892,827	45	120,711,232	1.05
1939	134,653,694	46	124,554,618	1.08
1940	144,991,927	46	125,662,000	1.15
1941	158,156,921	46	127,019,000	1.25
1942	190,248,257	46	127,736,000	1.49
1943	145,529,454	46	127,657,000	1.14
1944	166,679,635	46	126,779,000	1.31
1945	190,130,760	46	126,338,000	1.50
1946	230,981,503	46	133,988,000	1.72
1947	181,645,635	46	137,397,000	1.32
1948	171,021,257	46	140,082,000	1.22
1949	169,545,152	47	144,353,000	1.17
1950	190,019,680	47	146,823,000	1.29
1951	193,766,629	47	149,007,000	1.30
1952	183,686,737	47	151,385,000	1.21
1953	194,663,221	47	153,983,000	1.26
1954	189,470,688	47	156,873,000	1.21
1955	199,570,748	47	159,959,000	1.25
1956	215,225,286	47	162,832,000	1.32
1957	212,073,384	47	165,875,000	1.28
1958	215,465,819	47	168,788,000	1.28
1959	225,453,345	48	171,904,000	1.31
1960	234,714,557	49	176,512,262	1.33
1961	241,449,065	49	180,082,000	1.34
1962	253,700,966	49	182,879,000	1.39
1963	258,979,291	49	185,687,000	1.39
1964	275,861,906	49	188,365,000	1.46
1965	292,987,572	49	190,785,000	1.54
1966	307,756,120	50	195,139,000	1.58
1967	323,498,937	50	197,124,000	1.64
1968	344,067,256	50	199,082,000	1.73
1969	361,682,018	50	201,130,000	1.80
1970	370,079,963	50	202,415,000	1.83

license states, for example, only Alaska, Nevada, and Wisconsin have a ratio of more than two licensees per 1,000 inhabitants; and each of these jurisdictions has a per capita consumption level considerably above the national average. By way of comparison Arizona, Oklahoma, and Georgia, three license states with a very low license-to-population ratio, also have relatively low per capita consumption levels. (See Tables I and II.)

IV

The data contained in Table II show that only Oklahoma, South Carolina, and North Carolina still totally prohibit by-the-drink sales and statistics contained in Table I show that all three of these states have very low per capita consumption levels. In fact, North Carolina, which is the highest of the three, has a level some 20 per cent below the national average for all states. The argument is often made that allowing liquor to be purchased by the drink, rather than only by the bottle, promotes "moderation." This may be true, but it apparently does not promote low per capita consumption.

CONCLUSIONS

From the foregoing, the following general observations can be made:

(1) As more jurisdictions have legalized liquor, the nationwide per capita consumption level has increased dramatically.

(2) States with privately owned liquor stores tend to have a higher per capita consumption level than those states with government-owned stores.

(3) Per capita consumption tends to be greater in those states with a high ratio of liquor outlets to total population.

(4) States without liquor-by-the-drink establishments tend to have lower consumption levels than those with liquor by the drink.

Besides these trends, there is some evidence of a relationship between high per capita consumption and such factors as late closing hours for liquor outlets and the lowering of the age requirement for the purchase of hard liquor.

It should be noted that the general conclusions outlined above are based on broad trends, to which there are numerous exceptions. Alabama and Iowa, for example, both have liquor by the drink but still have a consumption level below that of North Carolina, which presently permits sales by the bottle only.

Despite these exceptions, however, the conclusion seems inescapable that liberal liquor laws and high per capita consumption levels go hand in hand. What cannot be presently answered is whether enactment of permissive liquor laws is the cause or the result of an increasingly wet American electorate.

the adjourned session

(Continued from page 5)

cal residence requirement for policemen and firemen in Wilmington in order to permit that city to expand its fire and police forces to cope with disorders (S 1002—Ch. 1239). A third dealt with a school board/town board land exchange in Ashe County; a fourth with vacancies on the Winston-Salem board of aldermen (H 1608—Ch. 1246 and H 1609—Ch. 1248). The fifth local bill attempted to set a special ceiling on interest charges for delinquent taxes in Buncombe County (S 1009). All but the Buncombe County bill were enacted.

Some of these local bills, obviously, were not urgent in nature. But more than one dealt with pressing local problems whose early solution must have caused a number of local officials to heave collective sighs of relief. For the affected local officials in these communities, at least, the theoretically restricted but in practice unrestricted adjourned session of 1971 was plainly a blessing.

Memo:

SUBJECT: Indigents' Waiver of Counsel

TO: Officials Concerned with the Administration of Criminal Justice

FROM: C. E. Hinsdale

In 1969 the General Assembly rewrote the law concerning the representation by counsel of indigent persons accused of serious crimes. The new law (G.S. Chapter 7A, Subchapter IX) was based on recommendations of the Courts Commission, which had prepared its draft bill after a painstaking study of the requirements of recent U. S. Supreme Court decisions in this field. G.S. 7A-457, as adopted effective July 1, 1969, permitted an accused indigent to waive his statutory right to counsel in all but capital cases, but the waiver was required to be in writing. This requirement of written waiver was based by the Courts Commission on 1967 recommendations of the American Bar Foundation's Standards Relating to Providing Defense Services, and a substantially identical provision of the Uniform Law Commissioners' Model Defense of Needy Persons Act.

Because the statute required a judge to make a record finding of the voluntariness of the written waiver, some thought the written waiver requirements were applicable only to in-court proceedings. However, in the closing weeks of the 1971 General Assembly, the North Carolina Supreme Court held in State v. Lynch, 279 N.C. 1 (June 10, 1971), that the "in-writing" requirement applied to pretrial proceedings as well as trial proceedings. The court further emphasized that statements made in a pretrial interrogation are inadmissible against an accused who has not made written waiver of the presence of counsel.

The Lynch decision prompted a bill (S 716) late in the 1971 regular session to remove the words "in writing" from G.S. 7A-457(a), thereby permitting oral waivers of counsel in all but capital cases. This proposal passed the Senate without difficulty, but on June 15 failed third reading in the House. The Assembly thereafter adjourned amidst cries from law enforcement people that continuance of the "in writing" waiver requirement would be a serious obstacle to conviction and punishment of many persons accused of felonies.

When the adjourned session of the Assembly met in late October, the district solicitors, the State Bureau of Investigation, and various law enforcement agencies were ready with S 1008, which would (1) make the requirement for written waivers apply only to in-court proceedings, (2) for the first time allow waivers in capital cases, and (3) remove the specific prohibition against guilty pleas by indigents without counsel in capital cases.

The bill generated considerable controversy, much of it apparently based on lack of opportunity for the usual committee action on the bill, a feeling that the sponsoring law enforcement agencies had probably overstated the extent of the "emergency," and a belief that the bill went further than required by the Lynch decision. Thus, in floor action an amendment prohibiting waivers (written or otherwise) in capital cases, was reinserted. Another amendment that was added by the House but later removed in conference would have prohibited the death sentence in capital cases in which the defendant confessed without benefit of counsel if the confession was introduced against him. As amended, the bill was ratified (Chapter 1243) and became effective October 30, 1971.

Still undecided is the fate of a number of persons convicted between July 1, 1969, and October 30, 1971 in violation of the written waiver requirement of G.S. 7A-457; that will have to be decided by the appellate courts. No attempt was made to have Chapter 1243 apply retroactively.

G.S. 7A-457 now reads as follows:

> (a) An indigent person, except one charged with a capital crime, who has been informed of his right to be represented by counsel at any in-court proceeding, may, in writing, waive the right to in-court representation by counsel, if the court finds of record that at the time of waiver the indigent person acted with full awareness of his rights and of the consequences of the waiver. In making such a finding, the court shall consider, among other things, such matters as the person's age, education, familiarity with the English language, mental condition, and the complexity of the crime charged.
>
> (b) If an indigent person waives counsel as provided in subsection (a), and pleads guilty to any offense, the court shall inform him of the nature of the offense and the possible consequences of his plea, and as a condition of accepting the plea of guilty the court shall examine the person and shall ascertain that the plea was freely, understandably and voluntarily made, without undue influence, compulsion or duress, and without promise of leniency.
>
> (c) An indigent person who has been informed of his right to be represented by counsel at any out-of-court proceeding, may, either orally or in writing, waive the right to out-of-court representation by counsel.

where are we going with SOCIAL SERVICES?

by Thomas W. Hogan

The author is the director of social services for Durham County. The article is adapted from his recent talk before a meeting of county social services board members.

The proposal that the federal government assume what has traditionally been social services' responsibility—the administration of programs of income maintenance—provides the opportunity and indeed the mandate for us to rethink and perhaps remold our programs. The assumption of the income-maintenance function by the federal government requires that we rejustify our continuing existence not only to the client and the taxpayer, but to ourselves as well; for certainly we cannot succeed unless we are convinced that our services are needed and that we are delivering them in an appropriate manner. But before we can project where we want to go with our service program, we must understand where we are now. Do our services benefit the client or society? What are these services? How are they structured? In what areas might meaningful change take place?

We need a little historical perspective. Our immediate history goes back to the passage of the Social Security Act of 1935, which, in addition to establishing the social insurance programs, established through a system of federal grants a way for states to provide public assistance programs to certain needy categories of individuals. In this state administering those programs became the major responsibility of what were then county departments of public welfare. But it became increasingly clear that providing money in and of itself would not meet the total needs of people. It also became apparent that what was in 1935 envisioned as a temporary program to fill the gap until the Social Security system's coverage broadened was taking on an air of permanence. These two desires, then—to meet the needs of the poor not amenable to changes in income alone and to help to reduce the number receiving money assistance—fostered the service programs within departments of public welfare. It is extremely important that we recognize the very close relationship the system of social services has had to the administration of the money payment programs of public assistance. In other words, historically our programs of services have been superimposed on a system designed to administer public assistance, not social services. For evidence, merely look at our own county budgets, through which our service programs are funded; or look at the eligibility criteria for those eligible for services. Although many of us boast that our services are available to anyone in the community, we know that to be eligible technically, one needs to be either a former, current, or potential recipient of a money payment. The exceptions to this rule—for example, the child welfare services—prove the theory. Although the child welfare services are available without regard to income, each year county departments of social services count the number of children receiving services in the hope that the nonpublic-assistance recipients of services will not total more

than 15 per cent of the total number, so that the staff providing these services can be counted as public assistance staff.

So this historical interrelationship between services and assistance is extremely important to understanding our present service system. The first influence of this connection is that for the most part eligibility for services has been limited to eligibility for public assistance, with some small latitude recently to provide for services to former and potential clients. Thus, the relationship between services and assistance has dictated the group to be served by our services, with built-in disincentives by the reduction of federal funds if we attempted to expand the group.

This relationship has further dictated the types of services available through the departments of social services. Again, as I have said, one of the compelling reasons—probably the overriding reason—we are in the service business at all has been the hope that these services would reduce the number of people eligible for money payments. Note some of our individual services. Do we puchase day-care services for children out of society's concern for the individual child's development, or out of the expectation that the mother will go to work and thus reduce welfare costs? Do we purchase family planning services for our clients because society recognizes and values the right of families and individuals to limit their family size, or because society hopes we can convince enough people to use these services that the number of children receiving assistance will be reduced? Do we offer attendant care services out of a recognition that enabling the aged or disabled person to remain in his own familar home has value, or because this type of care is cheaper than boarding home or nursing home care?

DO NOT MISUNDERSTAND me—I too believe in the value of being able to escape the welfare check, the value both to the client and to the taxpayer. What I question is the type of service we offer and the approach through which the service is offered. Have they been offered out of a concern for the client and a recognition of his problem, or out of a concern for the taxpayer? While the service may be the same under either approach, the way the service is received may be quite different.

The historic application of assistance and services is at the heart of this matter. It has dictated both the population to be served and the type of services to be offered. A social services system designed out of this historic influence would be and is quite different from one designed so that the total community can meet the basic service needs of that total community.

One other historical influence bears review. For many years the county department of social services, being the only social agency in most counties, has provided a wide array of services for other agencies. These services now include certifying services for various programs like school health funds, providing social history information, in some counties receiving and dispersing support payments made under court order, issuing work permits, and determining family eligibility for work release funds. It seems that in any restructuring of our service programs, these types of activities should be re-evaluated. For example, does it make sense for the Durham County Social Services staff to be called upon to provide a social history for the use of the state mental health agencies—when across the street is a local mental health unit that has its own social work staff, and is indeed charged with following the patient during his experience in the state institution and later in the community? Are departments of social services the only agency in the community that can determine a family's income and apply that income to a scale? I think not.

Thus far, I have noted two historical influences on the development of service programs and service activities—the imposition on services of a structure basically designed to administer programs of public assistance, and the simple availability of county departments of social services, which caused certain functions to be assigned to them. This is our history, and it is still a living fact. But these historical influences alone do not sufficiently describe our present service system. We are in a transition period. Nowhere is change more evident than in the way social services are now structured to deliver service programs.

In Durham County, as elsewhere in the state, service and eligibility functions have been separated for more than two years. We are only now beginning to see the full opportunity this separation provides. One result of this separation is that increasingly we are finding specialization—a specialization that is problem oriented rather than program oriented. That is, for example, we less often provide social services aid for the aged, disabled, and dependent children recipients, and more often to drug addicts, people who need protective services, or placements, or attendants, or training; and staff members necessarily develop expertise in such areas.

The fact that clients are now free, with some exceptions, either to accept or reject our services has emancipated not only the client but the service worker as well. No longer must he visit clients with whom nothing is happening, from whom no concrete service is needed or desirable. Instead he can work with the possible rather than the impossible. And, since the client can reject a service even though we think it desirable for him, we have been brought to the point of recognizing, with the client, that it is he who controls his life, and that our role in relationship to him is to give him the opportunity to choose, not to make the choice for him.

THESE TWO NEW INFLUENCES—separation and the client's freedom to choose our services—

are, I believe, landmarks. They are the basis on which a broader, more meaningful program of services can be built. But other frailties of our services program must be overcome if our service potential is to be fully realized. Among these are:

(1) We have no clear definition of social services.

(2) We have no planning mechanism to identify problems and develop programs to meet them.

(3) We have not yet identified the skills our service staffs need to carry out the service program—nor is training for these skills available when we have identified them.

So what *do* we mean by "social services?" That is not an easy question, for it must be answered in the context of what is meant by social services available through our agencies, and this question opens up the whole question of our role in the community in providing services. Somehow we must define our service role aside from the services we have performed in relation to the eligibility process for money payments. The real question is what are the basic problems present in our community. Once we know that, we can begin to say what we mean by social services.

To identify the problems in the community and design services to meet them, we must add a new dimension to our departments—planning. It is sadly true that we have a lot of information in our files about people and their problems that is inaccessible except on a case-by-case basis and consequently is unused in defining service needs. We have also characteristically implemented programs without consulting those we wanted to help. Advisory committees are changing that, but we still lack the concrete information we need to plan services, and we still have no established way to get it, which makes designing services extremely difficult.

We need to identify the skills necessary to carry out our services programs and teach them to our staff. Despite great effort and considerable success in staff development, we sometimes send our service workers to do a very difficult task with little more than their natural interest and ability and a copy of the manual. They have done a good job—these employees have performed well—but how much better if they were adequately equipped. I am not talking just about social work education and training, but also about specialized knowledge that can be brought to bear on problems—knowledge of the community, of other service programs, of particular areas like home finance or the effects of illness, etc.

I HAVE NOT INTENDED to accentuate the negatives in our service program. I am proud of our accomplishments and the many strengths our programs have. The services now available are basic and must be available if all the citizens of a community are to realize the opportunity for meaningful life.

Before listing some of the types of services currently available through the County Departments of Social Services, I would like to suggest a method by which to catalog the available services. We need to stop viewing our services as separable according to the type of assistance the client receives, and begin seeing them as part of a constellation of techniques that can be brought to bear on certain problems. Some of the stars in this constellation are:

(1) *Information and Referral Services.* People in need of health care are referred to appropriate providers of care, and assistance with cost is provided where necessary and appropriate; people in need of mental health care are referred to the appropriate source; people in need of legal services are referred to the appropriate court official or to Legal Aid, etc. Of necessity, county departments of social services have come to know a lot about the resources their communities have to meet social needs. But we have not advertised this fact or identified it as a service we can provide to the total community.

(2) *Keeping the Old and Disabled Independent.* Services are available to help our elderly and disabled citizens maximize their lives in the settings that provide the minimum necessary outside supports. We attempt to help them continue to live in their own home, whenever possible, while providing a progression of care ranging from homemaker and attendant care to skilled nursing-home care if required.

(3) *Employment and Training.* Clients who need jobs or special training to become employable are helped to obtain employment or training. Again a variety of services are available: referral to sheltered workshops, enrollment in the WIN Program, referral to known job opportunities, provision of day care.

(4) *Child Protection.* Children are protected from the hazards of neglect and abuse through work with the parents, foster-home care, referral to court, or a combination of all three.

(5) *Adoption.* Permanent adoptive homes are found for children who otherwise would not have the opportunity for permanent family life. Through court-ordered investigations, the adequacy of adoptive plans for children in nonagency adoptive homes is evaluated.

(6) *Family Life.* Services are available to enhance the quality of family life—relationship counseling, the provisions of day care to relieve pressure on both the parent and child, family planning services to keep family sizes within the limits desired, homemaker services to provide experience and education in home management, etc.

(Continued on page 32)

Developing Strategies For Coping With DRUG ABUSE

by Gloria A. Grizzle

This report has been prepared at the request of the Charlotte Community Drug Action Committee. Its purposes are threefold:

1) To describe the nature of the drug problem in the nation generally and in Charlotte particularly;
2) To review the findings of drug studies undertaken in Charlotte during the past two years and the action projects now under way in Charlotte;
3) To explore possible strategies for coping with drug abuse and possible action projects that might be carried out within these strategies.

PART I—Nature of the Problem

In grappling with the problem of drug abuse, it has been found helpful to differentiate among abusers according to

. . . their reasons for using drugs;

. . . the types of drug used;

. . . the effect that drug abuse has upon the abuser and the spillover effect upon society.

REASONS FOR USING DRUGS

Among youth, frequency of usage appears to be associated with reason for usage. Those who use a drug once or twice are experimenting because they are curious. Those who use it occasionally or frequently are likely to do so because they want acceptance by their peer group. Those who use drugs regularly depend upon the drug as a means of coping with life. The characteristics of the regular user are likely to be a faulty problem-solving technique, low self-esteem, alienation, and an upsetting family situation.[1]

Although the most publicity has been given to drug abuse by youth, the young have no monopoly upon drug abuse. As youth are thought to abuse hallucinogens and amphetamines, so are other groups thought to abuse particular drugs. It is commonly reported that truckers abuse amphetamines; housewives abuse barbiturates, and alcohol abuse is especially prevalent among the middle aged. Very possibly the association between frequency of usage and reason for usage among adults is similar in many ways to that of youth.

TYPES OF DRUG USED

No one knows how many people are now using each type of drug in Charlotte. The total picture is built up from bits of data provided by various sources. Drug abusers become known when they seek help or

1. John H. Frykman, "A New Connection: An Approach to Persons Involved in Compulsive Drug Use," Mimeographed (San Francisco: C/J Press, 1970), p. 1.

TABLE I

RANK ORDER BY FREQUENCY OF CONTACT

Drug	Doctors (N=185)	Ministers (N=93)	Agencies (N=8)
Marijuana	1	1	2.5
LSD	4	2	1
Heroin	2	5	2.5
Barbiturates	3	6	6
Amphetamines	6	3	5
Multiple use	5	4	4

Source: Health and Hospital Council, "Report of Drug Abuse Treatment Committee," mimeographed (Charlotte, N. C., 1971), Appendix C.

are arrested. Surveys directed to particular target groups, such as students, provide an estimate of the drug-usage patterns for these groups. But drug usage in other groups—housewives, school dropouts, industrial workers, etc.—has not been estimated. What is known about the types of drug used in Charlotte is summarized in the next several paragraphs.

Alcohol is the most commonly abused drug in Charlotte as well as nationally. Arrests for drunkenness and driving while intoxicated far outnumbered arrests for possession or sale of other types of drug (Charlotte Police Monthly Reports).

Two studies recently conducted in Charlotte provide some indication of drugs most commonly used in addition to alcohol. The January 1971 report of the Drug Abuse Treatment Committee to the Health and Hospital Council suggests those types of drug frequently used that result in persons seeking help. This committee sent questionnaires to doctors, ministers, and agencies that might be expected to have contact with drug users. The results in terms of frequency of contact over a twelve-month period are summarized in Table I. It should be noted that the drugs listed are those used by people contacting doctors, ministers, and agencies. The type of drug used may or may not be similar among those who do not make contact and those who do.

The Mecklenburg County Medical Society administered its drug information questionnaire to 31,935 junior and senior high school students in the fall of 1969. The responses to questions about usage are summarized in Table II.

TABLE II

FREQUENCY OF USE	% OF RESPONDENTS USING DRUGS	
	Marijuana	Other
Never	91.1%	92.2%
Once or twice	4.2	3.8
Occasionally	2.3	2.0
Frequently	1.8	1.4

Source: George C. Barrett, M.D., Drug Abuse Committee, Mecklenburg County Medical Society (Personal Interview)

The other drugs mentioned in the questionnaire were acid, speed, and pep pills. Alcohol was not included. In its conclusions, the Society was careful to point out that 2,224 students did not respond to all of the questions and that an additional 4,000 were absent the day of the survey.

EFFECTS OF DRUG ABUSE

Bad effects of drug usage have been the subject of much discussion among the medical, pharmacological, and social science professions. Bad effects may be categorized in terms of harm to the individual user, cost to society to care for the drug-dependent individual, and cost to society because of harm inflicted by drug users upon other individuals.

HARM TO THE INDIVIDUAL. Many drugs, such as barbiturates, amphetamines, and the hallucinogens (e.g., marijuana, LSD, and mescaline), can be harmful to the individual when abused. Because the bad effects have been most extensively studied for heroin and alcohol, these two drugs will be used here to illustrate the harm that can befall the individual who abuses drugs.

For both types of drugs, the user builds up a tolerance, requiring larger amounts of the drug to achieve the desired mind-altering effect. In the case of heroin, building up tolerance and passing the line of addiction occurs fairly rapidly, whereas an alcohol user is more likely to take years to become addicted.[2] Because of the cost and difficulty of acquiring heroin, heroin usage often leads to a destructive life style in which the need for acquiring the drug dominates one's entire life.[3] Alcohol also may become the dominant need in one's life. Both may destroy health, career, and personal relationships.

Whether a drug user becomes addicted to the drug may be conceived as partly a result of his reasons for using the drug and partly a result of the drug's addictive properties. Some drugs—the morphine type (includes heroin), barbiturates, and alcohol—create both physical and psychological dependence. Others—the hallucinogens, amphetamines, and cocaine—create only psychological dependence. About 10 per cent of alcohol users become alcoholics, and the number of alcoholics in the United States is estimated at between six and eight million.[4] While heroin users are far fewer, apparently the rate of addiction among users is substantially higher than for alcohol users.

Another issue raised regarding the bad effects of drug usage is whether marijuana usage leads to using stronger hallucinogens or heroin. Here again, a person's reason for using marijuana appears to be an important factor associated with the likelihood that he will move on to harder drugs. Three types of cannabis (includes marijuana) users have been characterized according to their reasons for using cannabis.[5] The first group includes those who are typically uneducated, unemployed, and poorly motivated and for whom using cannabis is an antisocial activity. The group is considered likely to progress to heroin abuse. In the second group are those who are dissatisfied and in desperate need of finding something different to

2. Abraham S. Levine, "Drug Abuse and Alcoholism: Implications for Rehabilitation and Social Welfare," *Welfare in Review* 9, no. 1 (1971), 8.
3. Frykman, "A New Connection," p. 2.
4. Levine, "Drug Abuse and Alcoholism," p. 7.
5. F. R. Bloomquist, *Marijuana* (Beverly Hills: Glencoe Press, 1968), pp. 45-46.

experience. This group is likely to progress to the use of stronger hallucinogens. The third group consists of curious people who experiment with the drug now and then. They seldom become addicted or move on to other drugs. The last group of cannabis users is felt to be the largest group.[6]

COST TO SOCIETY. Drug abuse by individuals may result in several types of loss to society:

. . . loss of human resources to society;
. . . deaths and injuries in automobile accidents caused by drivers under the influence of drugs;
. . . requirement for medical treatment and rehabilitation of the drug abusers;
. . . theft by drug users to support the drug habit;
. . . other crimes committed by persons under the influence of drugs.

In assuming a destructive life style, the individual eventually drops out from the productive activities of society. This diminishes society's most important resource—people. This resource is further diminished when those injured or killed by automobile accidents or by crimes of physical violence are temporarily or permanently removed from the work force. In addition to loss of economic productivity, there are direct costs borne by society as the result of drug abuse. Society is required to finance medical treatment and rehabilitation of drug abusers and the medical care of those injured by drug abusers. Although treatment of the abuser may be directly financed by the taxpayer while medical costs of the injured are more likely to be paid by health and hospital insurance, the burden in both cases is distributed among society.

Stealing by heroin addicts is a cost generally recognized by society. Perhaps less well known is the association between using alcohol and committing crimes. Urinalyses were performed for 882 persons arrested in Columbus, Ohio, in 1951-53 during or immediately after the commission of a felony. Table III shows the percentages of arrestees having .10 percent urine alcohol or more.

TABLE III

Crime Class	No. of Arrestees	% Having at Least .10% Alcohol Concentration
Rape	42	45%
Felonious assault	64	43
Cutting	40	88
Concealed weapons	48	83
Other assaults	60	78
Murder	30	67
Shooting	33	79
Robbery	85	60
Burglary	181	64
Larceny	141	65
Auto theft	138	59
Forgery	20	60

Source: Lloyd M. Shupe, "Alcohol and Crime: A Study of the Urine Alcohol Concentration Found in 882 Persons Arrested during or Immediately after the Commission of a Felony," *Journal of Criminal Law, Criminology and Police Science*, vol. 44, no. 5 (Jan.-Feb. 1954): 662.

6. *Ibid.*, p. 46.

But these figures include only those who were *caught* committing the crime. Those who commit crimes but do not get arrested may or may not use alcohol. Nor can it be said that most people who use alcohol commit crimes. One cannot say that using alcohol per se causes crime. More likely, using alcohol has an effect similar to that described for cannabis: it "releases inhibitions and impairs judgment with such regular predictability that a user with criminal tendencies will readily commit crimes under the influence."[7]

TABLE IV

Offense	No. Offenders	% Addicted to Heroin
Larceny; theft	32	66%
Drug law violation	23	65
Robbery	25	40
Burglary	14	43
Carry possess weapon	14	36
Assault (other than aggravated)	16	31
Auto theft	8	25
Disorderly conduct: drunkenness	7	14
Receiving stolen property	6	50
Forgery; counterfeiting	6	50

Source: Nicholas J. Kozel, Barry S. Brown, and Robert L. DuPont, "A Study of Narcotics Addicted Offenders at the D.C. Jail," mimeographed (Washington, D.C.: Narcotics Treatment Administration, 1970), Table 29.

A 1969 study focused upon heroin addiction indicated that 15 per cent of 225 inmates of the District of Columbia jail were identified as heroin addicts.[8] Table IV is a breakdown of the 10 most frequent offenses showing the percentages of offenders that are heroin addicts.

CONCLUSION

In coping with the drug problem, one might differentiate among drug abusers according to the person's reason for using drugs in order to (1) estimate the future size of the drug problem, and (2) develop programs that will be effective in preventing drug abuse. In treating drug abusers, one may find it helpful to categorize target groups in terms of types of drug and reason for using. In selecting from among a variety of possible programs, it may be helpful to assess the extent to which each program is likely to reduce the previously described harmful effects to the individual and to the community.

PART II—Strategies and Programs

The drug problem permeates the fabric of society to such an extent that it is probably unrealistic to think about solving it through local effort. Local ef-

7. *Ibid.*, p. 97.

8. Nicholas J. Kozel, Barry S. Brown, and Robert L. DuPont, "A Study of Narcotics Addicted Offenders at the D. C. Jail," mimeographed (Washington, D. C.: Narcotic Treatment Administration, 1970), p. 2.

fort can, however, have some impact upon decreasing the bad effects of drug abuse. In trying to ameliorate the problem, a community must, because of its scarce resources, be selective in funding projects. To maximize the impact of further efforts in Charlotte to cope with drug abuse, specific projects might be assessed in terms of (1) the strategies to which they are most congenial, and (2) their expected results.

STRATEGIES

How one defines a problem channels his thinking about ways of coping with the problem. In dealing with drug abuse, one might conceive the individual who abuses drugs to be the problem. He might be viewed as being either sick or criminal. If he were so considered, then projects aimed at changing his character (as in psychiatry) or in restricting his activity (as in jail) might be considered appropriate ways of dealing with drug abuse. On the other hand, one might view environmental factors as being the problem. Under this conception, projects aimed at cutting off the sources of drugs, providing jobs and adequate housing, and modifying educational programs to fit the needs of the dropout might be considered appropriate.

These two definitions of the problem have been offered merely as examples of how problem definition influences choosing action projects, and they do not imply that one need be used to the exclusion of the other, nor that other definitions would be inappropriate.

Assumptions about cause—e.g., the individual is at fault or society is at fault—are often implicit in action projects suggested for dealing with drug abuse. These assumptions about cause are closely associated with expectations about what impact a given project will have in ameliorating the drug problem. In assessing the expected impact of a proposed project, people may disagree because their causal assumptions differ. For example, those who place primary stress upon heroin addiction as an emotional problem would tend to support a therapeutic project, while those assuming heroin addiction to be a pharmacological problem would tend to support a methodone project.

Since not much careful evaluation of drug projects has been carried out in the past, reliable assessments of the effectiveness of specific projects already implemented in other parts of the country are frequently nonexistent. This suggests that hard data may not be available to resolve differences in estimating the impact of a specific proposed project in Charlotte. In such situations, it would be helpful to make the assumptions about what causes the drug problem explicit so that (1) individuals will understand why they disagree, and (2) a careful evaluation design can be developed for whatever projects are implemented.

In developing a strategy for coping with drug abuse, one might keep in mind four levels of intervention—individual, interactional, organizational, and institutional.[9] At the individual level, emphasis might be placed, for example, upon projects aimed at changing the factors in a child's early development that are believed to lead to drug abuse or upon projects aimed at helping a drug abuser work out intrapsychic conflicts.

The interactional level focuses upon the individual as he comes into contact with his environment—his family, friends, business associates, and other persons whose activities affect him directly. Projects designed to intervene at the interactional level would seek to improve the drug user's relationships with others by reducing the disruptive effects of using drugs and by helping him return to social functioning.

At the organizational level, one is concerned with how well the community has mobilized to provide a comprehensive program for coping with drug abuse. Efforts at the organizational level might be directed toward the gaps existing between services provided by the various public and private agencies and toward relationship among these agencies.

Finally, the institutional level focuses upon modifying societal institutions contributing to drug abuse. Of concern here would be environmental factors, such as society's tolerance of advertising promoting drugs as the solution to all problems[10] and the pressure placed upon children to make good grades in high school and be accepted at the prestige universities.[11] Also of concern would be the community's attitude toward the drug abuser and laws determining how society will deal with the drug user.

EXPECTED IMPACT

No community has the resources available for financing all the projects that have been suggested for coping with drug abuse. In assessing the relative worth of projects for Charlotte, it may be helpful to be explicit about the intervention level toward which each project is directed. It may also be helpful to distinguish among the kinds of impact each project is likely to have. The foregoing description of the nature of the problem suggests several kinds of impact:

. . . prevent drug abuse;
. . . change drug abusers to nonabusers;
. . . reduce bad effects upon drug users;
. . . reduce property loss and personal injury suffered by the victims of drug abusers;
. . . reduce the cost to society for treatment, institutionalization, and rehabilitation of the drug abuser;
. . . reduce the loss to society of human resources.

9. Richard Brotman, "Drug Abuse: The Dilemma of the Criminal-Sick Hypothesis," in *Drugs and the Brain: Papers on the Action, Use, and Abuse of Psychotropic Agents*, ed. Perry Black (Baltimore: Johns Hopkins Press, 1969), pp. 55–57.

10. Charles Dunn (speech by the director of the North Carolina State Bureau of Investigation on drug law enforcement at the state level delivered at the Community Drug Abuse Prevention Conference, Charlotte, N. C., June 16, 1971).

11. Theresa Harwood (speech by the manager of the Drug Evaluation and Methodology Program, Bureau of Narcotics and Dangerous Drugs, on the research and pharmaceutical aspects of the drug problem given at the Community Drug Abuse Prevention Conference, Charlotte, N. C., June 16, 1971).

This list of impacts is merely suggestive. The community may find it useful to develop one in this fashion. Whatever list is developed to help assess the expected impact of specific projects should reflect the community's belief about what kinds of impact are desirable.

PROGRAMS AND PROJECTS

A comprehensive local program for coping with drug abuse might consist of a number of projects already under way in the community supplemented by additional projects designed to fill whatever "gaps" may exist. (What is defined as a gap depends upon the kinds of impact desired and the intervention levels considered appropriate for community action—decisions that must be made by the community.)

Table V lists a number of projects that have been proposed or implemented in Charlotte and elsewhere in the United States. Some attempt has been made to categorize them by intervention level and to point out the kind of impact expected. The author invites suggestions for the table's improvement by those in Charlotte who know more about the drug problem than she.

CONCLUSION

Assumptions about causation, impact, and intervention levels, coupled with the amount of resources available, will shape the drug action program being developed. Projects could be selected for funding without ever consciously considering these assumptions because people are guided by what they believe, whether their beliefs are consciously articulated or not. Even though they were left implicit in the minds of individuals in the community, these assumptions would still influence the choice of specific projects.

The degree to which these assumptions are treated explicitly in developing a comprehensive drug action program is a matter of choice. There are probably both advantages and disadvantages inherent in whatever choice is made. Being explicit about what causes drug abuse and the expected impact of specific projects can provide criteria for choosing projects and make evaluating project results easier. Being explicit about intervention levels can help to focus a community's effort and could result in greater total impact than might decisions made on an ad hoc basis. But being explicit about these assumptions could also lead to disagreement about the nature of the problem and the most appropriate strategy for coping with drug abuse. If such disagreement persisted, it could in turn result in delaying action projects.

Factors that might be considered in deciding how to go about developing a comprehensive drug program include these:

. . . whether the community has people who have been concerned with the drug problem long enough to be articulate about causation, desired impact, and appropriate intervention levels;

. . . whether staff is available that can use explicit assumptions as criteria for estimating project impacts and designing project evaluations;

. . . the likelihood that the community can reach agreement about the nature of the problem and appropriate strategies;

. . . the amount and availability of community, state, and federal resources that can be ploughed into a drug program.

The greater the degree to which these factors are present in a community, the more useful it would seem to consider explicitly what causes drug abuse, what impact the community would like its projects to have, and what intervention levels are appropriate for community action.

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TABLE V

Possible Drug Action Projects

Intervention Level	Possible Project	Expected Impact
Individual	Drug-assisted withdrawal Can be either voluntary or corrective related treatment. Consists of gradually administering smaller dosages of a substitute drug (usually methadone) to withdraw an addict from heroin. Since there is usually no aftercare of the patients, relapse rate is high. Public Health Service Narcotic Hospital Lexington, Kentucky President's Commission on Law Enforcement and Administration of Justice Washington, D.C.	Change the drug abuser to a non abuser
Individual	Therapeutic drug community Private or governmental antiaddiction society using ex-addicts as staff. Voluntary membership with expulsion provided for if the addict does not respond to group pressure to give up drugs. Synanon Foundation, Inc. 1351 Pacific Coast Highway Santa Monica, California Daytop Village, Inc. 450 Bayview Ave. Prince's Bay Staten Island, N Y Exodus House New York City Center for Housing and Environmental Studies, Division of Urban Studies Cornell University [Health and Hospital Council Committee considered a therapeutic community program to be the most urgent need in the community.]	Change the drug abuser to a non abuser
Interaction	Methadone maintenance clinic Experimental medical treatment involving the substitution of methadone (a synthetic opiate) for heroin. Doses are stabilized at a level where it will block the euphoric effects of heroin but allow the patient to function normally. This program is highly controlled and patients are permanently maintained on methadone. Drs. Vincent Dole and Marie Nyswander Bernstein Institute Beth Israel Medical Center New York, New York Dr. R. L. DuPont, Jr. Narcotics Treatment Administration Washington, D. C. United States Senate Committee on the District of Columbia Washington, D.C.	Reduce the bad effects of drug abuse to the abuser Reduce the loss to society of human resources Reduce stealing by addicts to support the habit
Interaction	Vocational rehabilitation Voluntary or parole-oriented treatment program utilizing working therapy, vocational counseling, and in some cases job placement. After undergoing treatment, the patient is released as an outpatient with caseworker supervision and periodic drug tests. California Rehabilitation Center Box 841 Corona, California President's Commission on Law Enforcement and Administration of Justice Washington, D.C.	Change the drug abuser to a non abuser Reduce the loss to society of human resources
Interaction	Supportive services Provide adequate support—either by drug maintenance or counseling and training—to allow the drug abuser to function in the community. Methadone Maintenance Program California Rehabilitation Center	Reduce the loss to society of human resources

Organizational	Community activities Develop organized program for youths during their free time. Co ordinate schools, churches and community centers to provide scheduled activities and after hours access to facilities. YMCA—YWCA Boy-Girl Scouts Local school superintendent	Prevent drug abuse
Organizational	Advertisement campaign Conduct spot announcements, posters and bill board advertisements giving information on organizations providing assistance to drug users and facts on drugs. National Institute of Mental Health 5454 Wisconsin Avenue Chevy Chase, Maryland 20015 Bureau of Narcotics and Dangerous Drugs U.S. Department of Justice Washington, D.C.	Reduce the bad effects of drug abuse to the abuser Change the drug abuser to a non abuser Prevent drug abuse
Organizational	Adult education Develop programs for adult organizations, citizens groups and parent associations on the use and effect of drugs. The programs should also include suggestions on ways these groups can assist in both drug prevention and rehabilitation.	Prevent drug abuse
Organizational	"Drug Analysis Anonymous Program" Distribute kits containing mail-in envelope and specimen card. Sender would telephone-in 7 days later to receive results of specimen analysis anonymously. Primarily for patients suspecting children of using harmful drugs. Reading, Pa. Police Dept.	Prevent drug abuse Change the drug abuser to a non abuser
Organizational	Encourages industries and unions to implement programs to assist drug-dependent employees and members. Wayne County Department of Health Detroit, Michigan (proposed)	Change the abuser to a nonabuser Reduce the loss to society of human resources
Organizational	24-hour telephone service Service can be set up to handle a specific problem area or a multiple area. It is continually in operation and can serve either as a counseling service or an emergency or referral service. Switchboard Chapel Hill, N. C. Contact Telephone Counseling Ministry of Charlotte, Inc. 501 North Tryon Street Charlotte, N. C. 28202	Reduce the bad effects of drug abuse to the abuser
Organizational	Walk-in clinic Providing emergency medical care for drug overdose and general supportive medical care for drug related health needs. Dr. Ben E. Britt Director, Drug Abuse Programs North Carolina Department of Mental Health Raleigh, North Carolina	Reduce bad effects of drug abuse to the abuser
Organizational	24-hour drug center An open facility providing drop-in counseling services, rap sessions and/or referral services. Domiciliary provisions should also be made available to youths needing a temporary place to stay or those undergoing drug treatment. Open House E. Morehead Street Charlotte, N. C.	Reduce bad effects of drug abuse to the abuser
Organizational	Storefront information and referral center To provide an accessible and acceptable setting for communicating	Reduce bad effects of drug abuse to the abuser

	with young drug abusers. Staff to be largely composed of nonprofessional counselors. Health and Hospital Council Drug Abuse Treatment Committee	
Organizational	District Service Centers Aides aggressively seek out the alcoholic and provide hand-to-hand follow-through to insure receipt of services. Wayne County Department of Health Detroit, Michigan (proposed)	Change the drug abuser to a non abuser Reduce loss to society of human resources
Institutional	Comprehensive drug education Education programs directed at various school age groups informing them of the use and abuse of drugs. Special emphasis in counteracting commercial drug advertisements. Resource school systems: New York State Imperial Beach, California Baltimore County, Maryland Great Falls, Montana Rhode Island Flagstaff, Arizona Tacoma, Washington San Francisco, California Curricula available from: National Clearinghouse for Drug Abuse Information 5454 Wisconsin Avenue Chevy Chase, Maryland 20015 United States Senate Committee on the District of Columbia Washington, D.C.	Prevent drug abuse
Institutional	Drop-out program Build a special program around the drop-out problem. Provide vocational training, night school curricula and job counseling.	Prevent drug abuse
Institutional	Dry up drug channels Cut back on the supply of illegal drugs in order to decrease drug abuse. Encourage law enforcement programs aimed at the trafficker rather than the user of drugs.	Prevent drug abuse
Institutional	Develop multiple paths to success Build into the school system ways for the child to experience success in addition to grades and athletics.	Prevent drug abuse
Institutional	Deter experimentation Motivate not using drugs by increasing the probability of punishment for the user through appropriate revision of the laws and additional emphasis upon law enforcement.	Prevent drug abuse

social services *(Continued from page 24)*

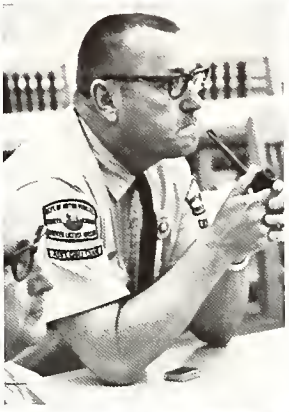
(7) *Adult Protection.* Adults are protected from neglect of themselves when they can no longer make decisions for themselves.

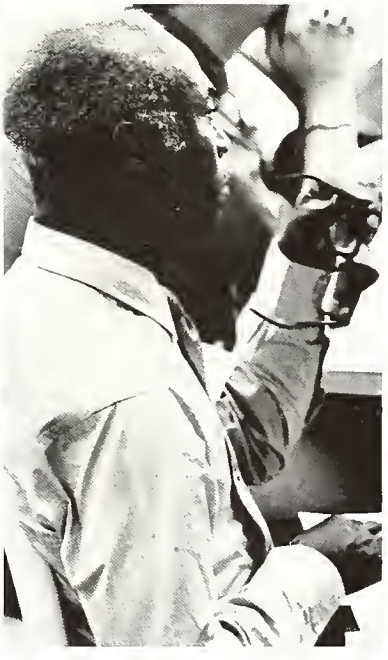
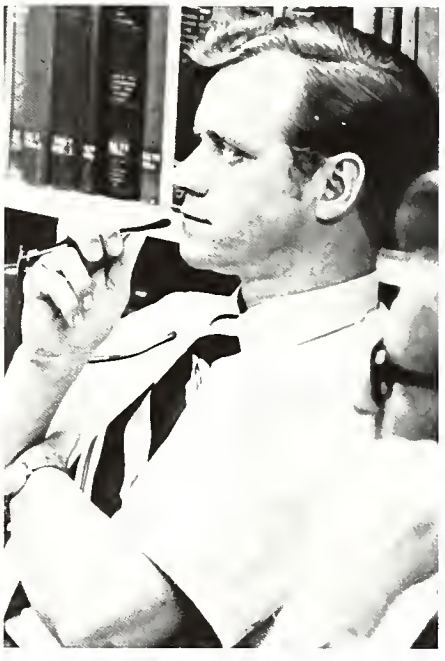
These are but a sample of the services available through county departments of social services. This listing could be extended—for example, transportation services are provided. But the important thing to realize is that though we may lose the income-maintenance function, these kinds of personal needs will not disappear, and consequently the need for our services will not disappear.

Where are we, then, in the development of our service program? We are on the threshold of a program of public social services that could be open to all segments of our community, and this can and should happen regardless of the action of the Congress on HR-I. However, entering this door will not be easy. It will come about only when we have fully informed the public of what we are about, and when we have fully geared the services we offer to the needs of the public. We at the local level must extend our leadership potential and not be content for all the decisions about our future programs to be made in Washington. We are the ones who know our communities—we are the ones who can enlist the community's aid in designing our service system.



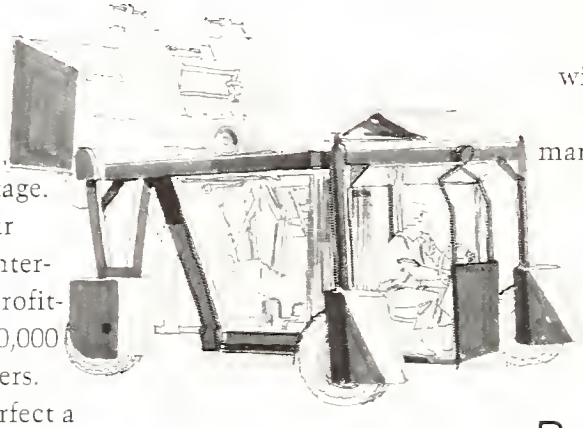




PEOPLE

LAST YEAR, REYNOLDS TOBACCO DEVELOPED A MACHINE TO CURE A HEADACHE.



One of the biggest headaches a tobacco grower has is labor, the cost and the shortage.

Since tobacco is our business, too, we're interested in keeping it a profitable crop for some 120,000 North Carolina farmers.

So we set out to perfect a system that lets them harvest flue-cured, automatically. During the last couple of summers, the prototype harvester was put through its paces in field tests and came out looking good.

This year, a manufacturer will produce the harvester in limited quantities for the market. The latest design may be the answer to one of the grower's biggest labor problems.

We figure anything that helps the grower, helps us.

R.J.Reynolds
Tobacco Company
Winston-Salem, N.C.