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PRESCRIPTIVE PACKAGE

DIVERSION OF THE PUBLIC INEBRIATE FROM THE CRIMINAL JUSTICE SYSTEM

BY

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The points of view expressed in this document are those of the author and do not necessarily represent the official position of the United States Department of Justice.

FOREWORD

This handbook is one of a series of "perspective packages" being sponsored by the National Institute of Law Enforcement and Criminal Justice. The co-sponsor of this report was the Pennsylvania Governor's Justice Commission. The aim of the prescriptive packages is to provide criminal justice administrators and practitioners with both background information and operational guidelines in selected program areas. The guides are based on available research and recent program experiences in various parts of the country. They have been specifically designed for practical application and represent one significant means of effecting technology transfer.

This report presents practical guidelines for diverting the public inebriate from the criminal justice system into community institutions such as health or social service agencies. Public inebriates have traditionally accounted for one-third to one-half of total arrests in municipalities and have long clogged our jails and courts. The intent of this report is to suggest diversionary programs which will not only relieve the burden on law enforcement, but will also enhance the legal, physicial and social well being of this "victimless crime offender."

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CHAPTER I

INTRODUCTION

This paper presents guidelines or "steps" that will aid community leaders interested in the diversion of public inebriates and other residents of Skid Row from the law enforcement system. We view these services as essentially *"diversionary,"* that is, having as one of their primary goals and/or effects the transfer of responsibility for these resourceless men from police, courts, and other law enforcement agencies to other community institutions, such as health or social service agencies. The volume of arrests for public drunkenness dramatizes the need for such diversion. In 1969 a total of 1,390,965 arrests were made for this charge alone throughout the country, or almost 25% of all arrests![1] In 1970, approximately 24% of all arrests were for public drunkenness, making it the largest "crime" resulting in arrest in the nation, and greater than all arrests for property crime and all violent crimes. In 1969, arrests for public drunkenness exceeded the combined total of arrests for all violent and property crimes.[2] In Erie, Pennsylvania, a mid-sized community of 134,000 people, an average of 144 arrests were made monthly in 1969, over 30% of all arrests.[3] In that city, the police chief estimated that every drunkenness arrest required one hour of patrol car and wagon pick-up time. Since there were two men assigned to each patrol car and one man to the wagon, the total task of arresting one man for public drunkenness called for the services of three policemen for three hours, or a total of 432 hours monthly, 5,184 hours annually. Erie police officials estimated that 35-40% of police time was devoted to the resolution of problems dealing with public inebriates.[4] Because the only formal "crime" involved in such cases was being drunk in public, Erie police officials, as well as those in other communities, have sought more effective methods than arrest for resolving the problem. The need for a transfer of responsibility has been documented both for purposes of improving the effectiveness of the law enforcement system and enhancing the legal, physical, and social well-being of this "victimless crime offender." Our case is well presented in *Alcohol Problems: A Report to the Nation,* prepared by Thomas F.A. Plaut for the Cooperative Commission on the Study of Alcoholism.[5]

> "The traditional handling by the police, the court, and jail systems of the very large number of persons found drunk on the streets is inhuman as well as ineffective. There is general agreement that the current 'revolving door' system of repeated arrests and jailings does not alter the drinking behavior of any significant number of problem drinkers, and thus is not effective either as a deterrent or treatment. Many questions have been and are being raised about the constitutionality of treating such persons as criminals. If a man's drunkenness is part of his illness — and thus a non-voluntary act — he should be treated as a sick person and not as a criminal. Clearly it is not a crime to suffer from alcoholism, a characteristic of which is the inability to control one's drinking; thus it seems bizarre, inappropriate, and unconstitutional to punish an individual for being intoxicated.
>
> "In addition, the present handling of public drunkenness offenders is often demoralizing to the police, judicial, and jail personnel. It is an immense economic drain — in terms of men, time and space — on these agencies. Furthermore, it seriously undermines the professional character of the work of policemen, judges, district attorneys, and others, and often makes a mockery of the American judicial system. In most courts the average time spent by the judge in the 'trial' and sentencing of each public drunkenness offender probably is less than three minutes. This system of handling defendants undoubtedly violates the traditional American conception of the 'due process of law'."

In a thorough discussion of this subject, the report adds:

> "There is an immediate need to find substitutes for the current legal handling of public drunkenness. Police, judges, and prison officials generally do not view public drunkenness offenders as criminals, but they are trapped in the present system by the absence of any alternatives. Since the public wants intoxicated persons removed from the streets, other means of accomplishing this are needed."[6]

Spurred on largely by this report and two court decisions, Driver v. Hinnant and Easter v. District of Columbia, as well as the decisions of the U.S. Appellate Courts, which cast doubt on the legality of arresting homeless alcoholics who have committed no other offense than public drunkenness, many and diverse groups throughout the nation have established programs which are essentially diversionary. In the process, tangible evidence became available that police, courts, penal personnel and other law personnel have been to varying degrees relieved of time-consuming, often frustrating chores and given the opportunity of applying themselves to more appropriate law enforcement tasks. For example, in Erie, Pennsylvania, the diversionary program established there (which will be discussed later in this report) resulted in an 85% decrease in arrests from 1971-72, the closing of the "drunk tank," and the discarding of the "paddy wagon."

States which have repealed the legal sanctions against alcoholism, in whole or in part include the District of Columbia, California, Florida, Georgia, Hawaii, Kansas, and North Dakota. In January 1973, the National Advisory Commission on Criminal Justice Standards and Goals recommended "that every State enact legislation which provides authority for civil commitment and court diversion of persons who, because of alcoholism or drug addiction, are in need of treatment and who should be dealt with outside the criminal justice system. Legislation should provide funding for treatment centers where such persons can receive both detoxification and follow-up care."[7]

The lead federal agency in providing both funding and technical assistance for state and local programs to treat alcoholics is the Department of Health, Education and Welfare's National Institute of Alcoholic Abuse and Alcoholism, established in 1970. Appendix A contains guidelines for grants made under NIAAA's Public Inebriate Program. The system of services described below reflects the personal views of the author; however, there are many similarities between this system and the comprehensive program advocated by NIAAA.

Services

We are dealing in the main with five specific types of services which should be viewed separately so as to distinguish the objectives, components, requirements, and other variables of each service.[8] It should be understood that each of these five services is based on a specific, concrete need of the public inebriate, which if not met, will burden law enforcement personnel and diminish the welfare of the skid row resident. We wish to describe each briefly at this point and expand on them later in the report.

The first two are *directly diversionary,* that is, their establishment can have an immediate impact on relieving law enforcement personnel. They deal with specific, short-term needs of the public inebriate and provide substitutions for the community's drunk tank and the police procedure generally used to get them to the drunk tank. These services are the following:

1. Medical Evaluation and Subacute Detoxification (MESAD)

The first service combines a number of functions including emergency pick-up, out-patient medical evaluation, and in-patient treatment.

The public inebriate and the skid row man in general should be viewed primarily as health problems, often including but usually exceeding symptoms of alcohol toxicity. The first step in the diversionary-rehabilitation process is a medical evaluation and subsequent commencement of medical treatment. The medical treatment can be provided on an out-patient basis if appropriate, in an in-patient subacute detoxification center, or through referral to another medical facility such as a detoxification unit or other resource of a hospital. Most symptoms of alcohol withdrawal can be treated in a non-hospital subacute detoxification center, although a great need exists to maintain open channels to hospitals for more serious cases. If after evaluation the client is admitted to the in-patient subacute detoxification center, the stay should approximate seven days with treatment aimed primarily at helping the client in overcoming the physiological effects of acute toxicity and malnutrition. In addition, emphasis should be placed on alcoholism education in a supportive, non-confronting manner and referral.

Although many clients will reach medical evaluation service through self application, MESAD service should operate a 24-hour emergency pick-up service which will largely relieve the police of responsibility for the public inebriate and underscore the medical nature of our concern.

Emergency "pick-up" by a civilian, non-police team will be explored in depth later in this report, but it should be considered as one of the most significant elements of the total program. This civilian team will replace police in "picking up" public inebriates who have committed no other crime, and accompany them back to MESAD or another appropriate resource, but not to jail. From the point of first contact, then, police will be disengaged from the public inebriate who has committed no other crime and will allow non-police personnel to assume responsibility.

2. Shelter

As we use the term, shelter focuses on direct, concrete, and tangible services in a comfortable, pleasant, and supportive environment. This would include a warm bed, sanitary facilities, food, and clothing to the non-acutely ill alcoholic or non-alcoholic resident of skid row. The shelter serves as a resource for any man needing the above services, however, whether he seeks help for a drinking problem or not.[9] While there he should be encouraged to participate in group activities and be encouraged to move on to non-skid row settings.

As suggested above, the shelter should also serve as a residential resource for homeless men who are not alcoholics. To appreciate the importance of a shelter, one must understand the motivation behind the arrests for public drunkenness in the United States. Raymond Nimmer of the American Bar Foundation says,

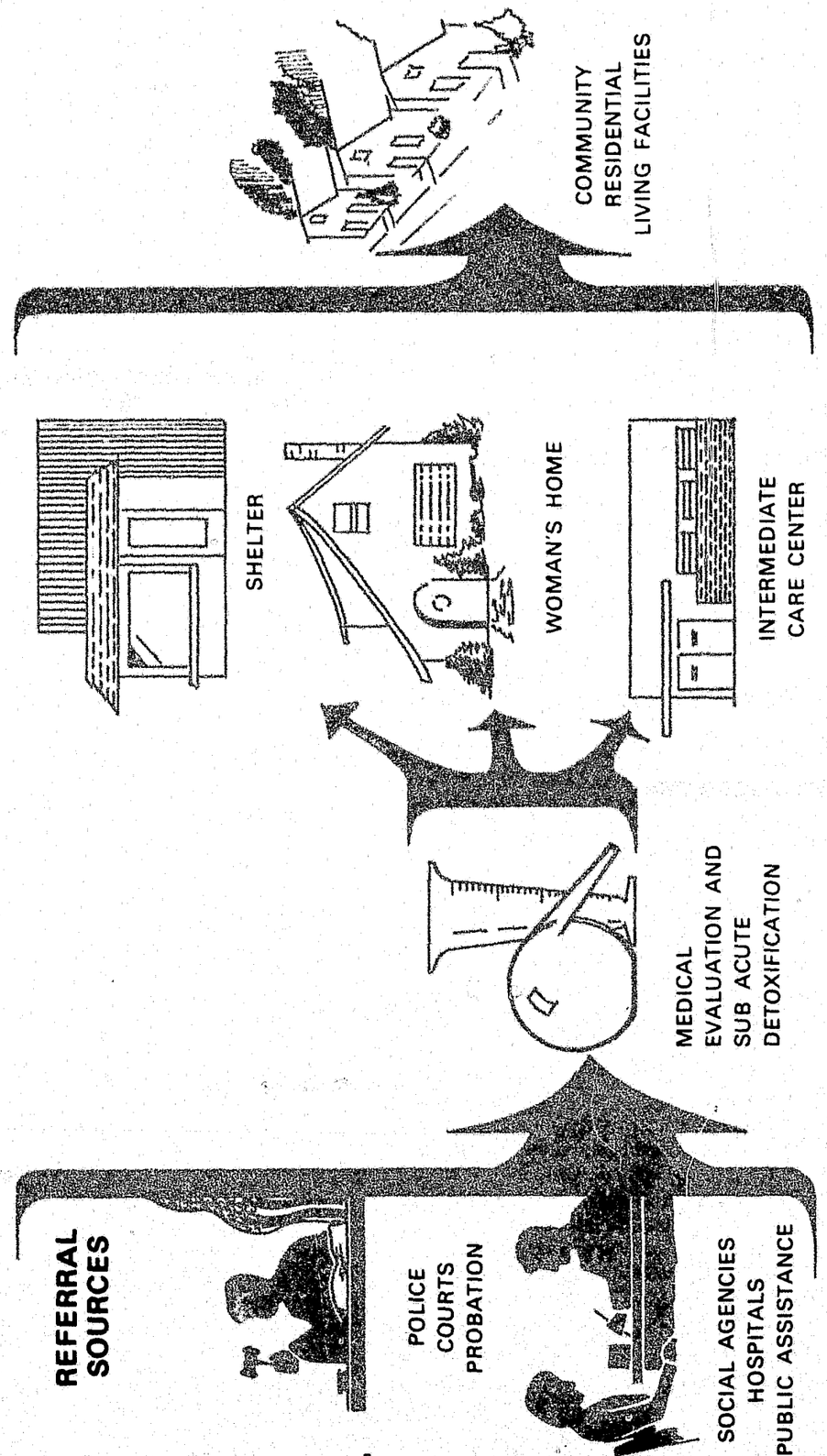
> "Intoxication is never a sufficient cause for arrest but must be accompanied by other conditions . . ."[10]

One of the major conditions would seem to be homelessness. In fact, suggests Nimmer,

> ". . . many intoxicated men are ignored by the arrest process, and sober men are often arrested."[11]

The offense, then, is often homelessness, not drunkenness. By simply providing a place where the homeless man can find shelter, a major factor leading to arrests will be eliminated.

Communities wishing to relieve the immediate burden on the police and the corrections system may wish to begin by providing the above described services or some version thereof. Long-range plans, however, should include the types of services discussed below, which may be



described as *indirectly diversionary*. These include the following:

3. Intermediate Care

The disruptive and insidious course of alcoholism often makes desirable a lengthy period of convalescence following detoxification. During this approximate sixty-day stay, intensive alcoholism education and structured treatment for the chronic stage of alcoholism will be provided, aimed at changing long-term patterns of adjustment. Basically the purpose of the Intermediate Center is to serve as a haven for the public inebriate (or other alcoholic), away from skid-row influences, and provide him with an opportunity to plan a successful return to the community. Alcoholism education and some non-analytic therapy characterize the Intermediate Care Center, necessitating careful and selected placement of clients. Clients participating in Intermediate Care have made some commitment to basic change in their life styles and show some capacity to accept improved opportunities. While the movement away from skid row and subsequent therapy may be helpful to some men, it must be noted that many skid row residents cannot tolerate nor benefit from this type of care. (The more gradual, less confronting half-way house may be more appropriate to motivated clients.)

4. Community Residential Living Facilities

At some time following the detoxification stage, many public inebriates will require not an immediate return to autonomous community living, but rather a semi-protected, home-like setting within the community that will allow the gradual re-entry into community activities while maintaining some varying degree of environmental support. The deleterious effects of alcoholism and/or personality problems characterized by lack of appropriate autonomy necessitate a semi-institutional support service that permits a gradual return to community activities, including employment.[12] These residential facilities can be of several types, depending on the degree of supervision and structured in-house counseling program. Basically, however, there are two types which are closely related:

A. A half-way house (half way between institutionalization and autonomous community living), which is characterized by supervision, rules, and a structured rehabilitation program.

B. A three-quarter-way house (or boarding home), where no in-house organized program exists but access is provided to the half-way house program.

The number of the second type should remain flexible and be dependent on the need. Both should be viewed as long term, unlike previously described detoxification, shelter, and intermediate services. It should also be stressed that three-quarter homes are tied closely to the half-way house.

5. Aftercare Services

For public inebriates who are recovering and have proceeded through Medical Evaluation and/or Subacute Detoxification (No. 1), Shelter (No. 2), Intermediate Care (No. 3), or a Community Living Facility (No. 4), an appropriate Aftercare Service should be provided. This should consist of flexible contacts in one of the previously mentioned facilities or elsewhere in the community (such as Alcoholics Anonymous meetings) where reinforcement of the desire to stop drinking could continue, and support and encouragement would be offered. Medical services may also be necessary. If feasible, clients should choose exactly in which facilities they will follow up, and programs in the facilities should be designed appropriately.

Coordination

The direct diversionary services of MESAD (with all of its essential components) and the Shelter, in addition to the indirect diversionary services of Intermediate Care, Community Residential Living Facilities, and Aftercare comprise the comprehensive diversionary program for public inebriates. Ideally these five services will function under one administration and/or coordination so that uniformity in philosophy and direction of care can occur, and duplication and fragmentation can be avoided. The variety of services comprising the total diversionary program will achieve its full effectiveness as a mutually cooperating, mutually complementing system only when all services are to some degree accountable to one central authority. This central authority will be assisted by a staff, including personnel assigned to research and evaluation and court liaison. Court liaison consists of a specific staff person who serves both as an advocate of skid-row clients involved with the law enforcement system and as a friend of the court and a resource to lessen its burdens.

Much of the balance of this report will examine in detail the essential services and their coordination. Special chapters will deal with providing services for women public inebriates, with research and evaluation, and with coordination, including court liaison.

Presuppositions

It should be noted that we base our writings on four presuppositions:

1. That the sponsoring group for a comprehensive public inebriate program eventually acts as a private, non-governmental, nonprofit body, duly incorporated.
2. That the community under discussion is mid-sized, that is 200,000-300,000 population.
   Where either of the above is not the case, the report may be adapted to apply.
3. That this report is not meant to provide fixed, rigid rules, but is intended to provide guidelines based on extensive experience. Adaptations should be made in response to local conditions. Salaries, for example, will vary considerable with the particular locale.

4. Where existing resources can be used (for example, an on-going alcoholism program) these should be used instead of duplicating efforts and establishing new resources.[13] Moreover, care must be taken to involve agencies that can accept the diversionary-rehabilitation goals of the program. Many existing missions, for example, seem insufficiently flexible to serve as a shelter as we define it.

I

FOOTNOTES

1. "Crime in the United States," *Uniform Crime Reports — 1970,* Department of Justice, Washington, D.C.; U.S. Government Printing Office, 1971, p. vi.
2. See footnote 1.
3. Charles W. Weis, "Alcoholism and Alcohol Abuse in Erie," unpublished manuscript supported by Vocational Administration — H.E.W. grant, 1970; p. 39.
4. See footnote 3.
5. Thomas F.A. Plaut, *Alcohol Problems: A Report to the Nation,* Cooperative Commission on the Study of Alcoholism, N.Y., Oxford University Press, 1967, pp. 110-111. "In one recent decision, Driver v. Hinnant, 356 F. 2d 761, the U.S. Fourth Circuit Court of Appeals ruled that a two-year sentence imposed on Mr. Driver for public drunkenness was 'cruel and unusual punishment.' The court ruled that 'the state cannot stamp an unpretending chronic alcoholic as a criminal if his drunken display is involuntary as the result of disease. However, nothing we have said precludes appropriate detention of him for treatment and rehabilitation so long as he is not marked as a criminal.' In Easter v. District of Columbia, 362 F. 2d 50, another court stated that proof of 'chronic alcoholism' was a defense against a drunkenness charge because the defendant 'has lost the power of self-control in the use of intoxication beverages'."
6. See footnote 5.
7. *Working Papers for the National Conference on Criminal Justice,* January, 1973, Washington, D.C.
8. Systems of services with some similarity to these are described in "Developing Community Services for Alcoholics: Some Beginning Principles," National Institute of Mental Health, 1971, U.S. Government Printing Office, Washington, D.C.; "Guide to Community Control of Alcoholism," Jay N. Cross, American Public Health Association, New York, 1968.
9. "Comprehensive Intoxication and Alcoholism Control Law," Maryland Code (effective July 1, 1968), p. 370.
10. Raymond Nimmer, *Two Million Unnecessary Arrests,* American Bar Foundation, Chicago, Ill., 1970, p. 146.
11. See footnote 8.
12. A thorough study of the personality and environment of skid-row residents is included in *You Owe Yourself a Drunk,* James P. Spradley, Little, Brown, and Company, Boston, 1970. Also see *Alcoholism: Challenge for Social Work Education,* Herman Krimmel, Council on Social Work Education, New York, 1971.
13. See "The Role of Alcoholism Programs in Community Mental Health Planning," Charles Weis, *Proceedings of the Twentieth Annual Meeting of the North American Association of Alcoholism Programs,* NAAAP, 1970. This brief article emphasizes the use of existing community resources in alcoholic programming.

CHAPTER II

BEGINNING THE PROJECT: MOBILIZING COMMUNITY SUPPORT

Thus far we have defined our problem and described the intent of this report, namely the presentation of guidelines to community leaders interested in establishing public inebriate diversionary programs. Having defined the types of services required, we now move toward the actual implementation of the project. To do this, we ask ourselves several questions and attempt to answer them.

1. Who Can Initiate the Programs?

The experiences of existing programs suggest that any interested and invested individual or community group can initiate the steps necessary to implement diversionary programs. Recovered alcoholics, probation officers, clergymen, social workers, attorneys, public health and welfare employees, mental health personnel, foundation associates, redevelopment and law enforcement personnel, and the professional staff of alcoholism agencies have been responsible for *beginning* the implementation process in one or more of the sites visited by the author. Frequently, such groups overlap, that is, the prime movers have been members of two or more of the groups mentioned above, e.g. recovered alcoholics and attorneys, or clergymen and professional alcoholism agency staff. The project staff who probed the histories of diversionary programs discovered many instances of the positive role played by recovered alcoholics. Nevertheless, it is quite clear that the initial mobilization of community and extra-community resources toward the establishment of services that are diversionary in goal or effect can begin with any individual or group sufficiently interested in the problem and sufficiently motivated to pursue the effort. Common denominators of these initiators seemed to be their interest in the program, their vision, and persistence.

The first five footnotes to this chapter describe the beginnings of public inebriate programs in Daytona Beach, Florida; Philadelphia and Erie, Pennsylvania; Cambridge, Maryland; and New York City.

2. Are There "Do's and Don'ts" Which Have Emerged From the Early Implementation Stages of Various Programs?

In answering this question, we summarize the lessons learned from the earliest programs and the mistakes made by those now carrying out diversionary and general alcoholism programs. We are interested at this point only in *early implementation* of the program, not in other concerns which come later.

Suggestion A: Immediate objectives (although not the long-range goals) may have to be limited. Unfortunately, many community needs may be so acute that a planner's goals may include immediate objectives that are impossible to attain. The nature of community's discontent, its willingness and/or capacity to support programs, and a number of other variables may call for the establishment of priorities. "Begin where the community is," a principle that appears sound, will often necessitate a limited beginning and plans for future growth. No rules exist as to exactly which priorities should be established, and various community leaders[6] have differed in their choice of accepted procedure.[7] Because this decision may rest in part on the priorities established in a given state's alcoholism plan, one should contact the state alcoholism program agency named by the governor under Public Law 91-916, Compresehsive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970. (It is unlikely that any federal funding will be granted to a proposed public inebriate program unless the agency and its advisory committee will endorse it.)[8]

Suggestion B: Once a decision is made as to immediate priorities and long-range goals, visit successful programs in communities which have struggled with the problem. (See Appendix B for suggestions.) Specific recommendations for on-site visits include the Diagnostic and Rehabilitation Center, Philadelphia; San Joaquin County Alcoholism Services, French Camp, California; Open Door, Annapolis, Maryland, and Crossroads Center, Erie, Pennsylvania. A well-conceptualized and administered state alcoholism plan, including matters pertaining to the public inebriate, is offered by the State of Maryland and complemented by appropriate state legislation (See Appendix B, On-Site Visits.) Keep in mind that every community is unique and what is applicable to one community may not apply to another.

Suggestion C: Have the program as well defined and conceptualized as possible, and presented in a clear, concisely written manner before seeking community and extra-community support. Such a presentation will require some empirical knowledge of the extent of the problem and some detail as to the proposed solution(s). Salesmen know that an idea is more readily sold when it's illustrated and presented simply and clearly.[9]

Carrying out this step will require a clear understanding of the legalities of establishing programs for public inebriates. In most communities, responsibility for the handling of public inebriates is clearly assigned to the law enforcement system, although a minimum of seven states and the District of Columbia have passed laws which call for alternatives and place restrictions on arresting those who have committed no other crime. Where police are assigned this function through law, however, the matter is easily resolved by having the police simply delegate part of their responsibility to a community agency. This may be done

informally through a "gentlemen's agreement" or formally through a contract. A workable procedure involves the chief of police and other agents of the law enforcement-correction system simply writing to the executive director of a given agency (or the coordinator of a system of agencies such as we are proposing) and requesting assistance in carrying out the task of dealing with citizens with drinking problems who linger in public places. The agency, then, "aids" the police, courts, etc., although, in fact, the role of the latter may be minimized.

Two assumptions are made in the above procedure: that the client accepts the services voluntarily and that he has not commited any other offense. Where either is not the case, the client cannot be considered appropriate for the diversionary program until these matters are resolved.

One's conceptualization of the desired programs should be built, first, on the premise that alcoholism is primarily a health problem; and secondly, that citizens suffering from drinking problems and from homelessness are not the proper concern of the police, no matter how humanitarian the latter's efforts may be. It is strongly recommended that leaders in the community identify with the principles of the *Uniform Alcoholism and Intoxication Treatment Act* and encourage its enactment. Copies of this act can be procured by writing the U.S. Government Printing Office, Washington, D.C., 20852.

Suggestion D: Get the power structure of the community to support your program. Irving Shandler provides the following advice:

> "Virtue and justice are great allies, but if your program has the active support of the key people in the community (city, state, foundation, Community Chest) your chance for success is that much greater. You have to define the 'movers and shakers' in your area. This searching for top level support does not negate the involvement of the 'grass roots' levels of society. It is not an either/or relationship. What happens too often is that support for a new or augmented program does not include the most influential people in the community. There is too much competition for the public's dollar and time not to aim for those few people who make a community go! My own experience in working with the power structure has been a gratifying one. I have been impressed by their willingness to assist and their ability to achieve . . . It is not always easy to measure the value or impact of having 'power structure' support. It can range from definitive action around a specific problem where there has been some delay or block, to the subtle, ongoing awareness that this operation is a prestigious one (prestigious people are associated with!). It is equally important to use the support of the power structure wisely. Their assistance should only be involved when it is absolutely necessary. Don't use cannons to swat flies! It is also essential to keep these people informed without resorting to a lot of jargon and half-truths. People at that level are bright and capable. They may not be experts in alcoholism, but they can quickly spot a phony and they resent being talked down to."[10]

All the programs visited by project staff showed a consistent pattern of finding a large number of people who were willing to assist in the project, providing an effort was made to involve them — that is, someone took the trouble of asking them. Requests for such help should be on a personal, face-to-face basis, rather than through letters or telephone calls. A very significant ground rule in mobilizing community support is giving people the opportunity of participating and contributing at the level at which they can make their contributions comfortably and in a manner that has meaning for them.[11] For example, power people on the Crossroads Center Board of Directors are not asked to address envelopes, but instead, on occasion, are used judiciously to exert inflence on the power structure or to raise funds. On the other hand, there are some who prefer more routine tasks.

Early members of the community implementation group should include those who will give it prestige. Moreover, one or two representatives from the law enforcement system will give the program a special sense of importance and public acceptance. An attorney, a physician, and prominent businessmen will also help. For practical reasons, individuals experienced in grantsmanship (e.g. model cities staff or a development director of a college), alcoholism agency staff, an accountant, a contractor, an advertising specialist, and female and minority representation will facilitate early efforts. Finally, planners should get in touch with the state alcoholism advisory council previously mentioned or any local body recognized by the state council in order to discuss their plans and secure cooperation.

Efforts should be made to avoid having any one community group dominate early planning, (e.g. Alcoholics Anonymous). Alcoholics Anonymous encourages strong feelings and often fierce loyalties. While such feelings can help an alcoholic maintain sobriety, they may also contribute to rigidity, limited horizons, and the inability to appreciate the view of others. One should take care also to avoid political entanglements. Never allow the program to become a "political football" yet give credit where credit is due.

Lastly, one must always remember that requesting community support implies involving others in decision making and listening to their input.

Suggestion E: Gain the support of the service community as early as possible. Says Shandler:

> "The alcoholic does not operate in a vacuum. He will need help from hospitals, public welfare agencies, vocational rehabilitation, state employment, housing, Alcoholics Anonymous, mental health centers, etc. Having the endorsement for and support of these programs is a vital approach to the total treatment needs. The agencies that are involved in accepting your referrals will also be the program that begins to refer clients to you for help and consultation."[12]

Such reaching out should include the police and other agents of the law enforcement system.

Suggestion F: Leaders in the community seeking support for their proposals should include in their approach some activities with emotional power. Occasionally the movers of alcoholism agencies structured emotionalism into their early attempts to seek support; more commonly, however, the emotionalism was spontaneous.[13] Murray G. Ross, in his *Principles of Community Organization* says, "To bind together diverse groups requires common ideas, feelings, and traditions."[14]

Obviously, there are plenty of emotional situations in this problem. One might check local newspapers for deaths in abandoned buildings, police lock-ups, or in more public places. Furthermore, recovering alcoholics who have experienced skid row are often willing to tell their stories. Economic data may also be dramatic: How much do public inebriates cost under present circumstances on the budgets of police, courts, jails, hospitals, public assistance, etc.? How much time do the police devote to public inebriates?

Suggestion G: The founding committee will eventually establish itself as a non-profit, tax-exempt, incorporated body which assumes full responsibility for the programs. To avoid conflicts of interest, no member of the board will also serve as staff.

Suggestion H: In the early implementation stage, the board should employ a coordinator (or executive director) who will take full-time responsibility for the preliminary activities necessary for initiating a program and for directing the program once it is initiated. While exceptions exist, few volunteers can spend the time necessary to implement fully the type of comprehensive, coordinated program with which we are dealing. The coordinator (or executive director) will be accountable to the board. The selection of the coordinator must be considered one of the most important decisions the board will make. Maturity, tact, stability, administrative experience, and some familiarity with alcoholism are some of the criteria to be considered for the coordinator. Qualifications for most of the other positions in the various services include knowledge and understanding of alcoholism, some familiarity with the alcoholic's denial and other mental mechanisms, and the capacity to relate in an accepting, non-judgmental manner. These characteristics however, are generally more present in recovering alcoholics than in the population as a whole. As in other personnel choices, then, the ranks of Alcoholics Anonymous[15] will offer some qualified possibilities. Care must be taken, however, not to allow Alcoholics Anonymous or any other single treatment philosophy to control the program. Finally, at the outset the newly hired coordinator might consider planning a formal training program for non-degreed staff hired to work in the public inebriate programs. Such training might be based on that offered and funded by the Baltimore City Health Department. (See Appendix D.)

Later chapters will deal with significant matters pertaining to implementation, but everything depends on a solid foundation having been established in the "early implementation" stage.

FOOTNOTES

1. *Halifax Alcoholic Court-Oriented Program.* This Daytona Beach, Florida, agency began in April of 1970 as a nonprofit corporation founded by three recovering alcoholics, an attorney, a Protestant clergyman, and a businessman. The businessman eventually assumed the executive director position in the agency which began with no funding save a small amount of private donations and a humble home donated by another recovering alcoholic.

   Through the influence of these respected and established citizens, HACOP eventually interested law enforcement personnel, including city police and the county sheriff's office, in its program and pointed out the advantages of treatment over incarceration. City and county funding followed shortly thereafter, which permitted additional staff. Almost all full-time staff of the agency are recovering alcoholics, and the relationships between HACOP and other community agencies appear strong and cooperative. Present services include court counseling, and male and female half-way houses. HACOP maintains a strong A.A. orientation but provides traditional mental health services as well. The agency now houses fifty clients, in six separate residential facilities, and receives funding from federal, city, and county sources as well as United Fund, general hospital, and other private donations.

2. *The Philadelphia Diagnostic and Rehabilitation Service.* This Philadelphia, Pennsylvania program, recognized as a vanguard facility for skid-row residents, had its origin in the mid-fifties. At that time, Philadelphia had launched a vast center-city urban renewal program which included skid row in its plans. A small but powerful and vital civic organization, the Greater Philadelphia Movement, worked jointly with the Redevelopment Authority and Temple University in studying and planning the most effective means of coping with the skid-row problem. Eventually, they applied for and received funds from the Urban Renewal Administration to conduct an active research program. With actual demolition several years away, this project, known at the time as the Diagnostic and Relocation Service, and headed by a professional social worker, opened officially in May, 1963, offering basic diagnostic and evaluation services. Up until the latter part of 1964, the Diagnostic and Relocation Center was oper-

ated as a demonstration program; but since 1965, under the name of "Diagnostic and Rehabilitation Center" (operated jointly by the Philadelphia Diagnostic and Relocation Service Corporation and the Philadelphia Redevelopment Authority) direct alcoholism services including detoxification, residential facilities, and follow-up, have been provided either by PDRSC or through other community agencies mobilized by PDRSC. Due largely to the influence of powerful community leaders and to the exceptional skill and expertise demonstrated by PDRSC staff, the Center enjoys unusually strong community support and nationwide recognition. Funding has ensued from a variety of federal, state, and local government sources.

3. *Crossroads Center* (Serenity Hall, Inc.). In the early and mid-1960's, citizens of Erie, Pennsylvania, were awakened to the unmet needs of homeless alcoholics by a series of deaths and some violent killings of of chronic alcoholics. As a result, a number of community groups commenced independent efforts to establish more adequate alcoholism services, with an emphasis on residential facilities. These groups included the Junior Chamber of Commerce, National Association of Social Workers, Council on Alcoholism, and a number of recovered alcoholics. Representatives of these groups were brought together by the powerful leadership of a charismatic Catholic clergyman who was also a member of Alcoholics Anonymous. Under his direction, a community movement ensued which sought initial funding from the County and City of Erie for the residential facilities, (a shelter and a half-way house). Subsequent support was sought and secured from the United Fund and federal and state government agencies. A staff consisting largely of recovering alcoholics was hired and the program —an intensive 30-day residential treatment program for employed alcoholics has grown to include an out-reach center, pick-up and transportation, a satellite farm facility, and other services.

4. *Agape, Incorporated.* This Cambridge, Maryland association, designed essentially to carry out shelter and other residential services which at the time of this writing had been funded but not yet established, began largely through the efforts of the State of Maryland probation and parole officers. In 1971, faced with large caseloads, approximately 40% being men known to have long histories of problem drinking, these law enforcement personnel approached Eastern Shore State Hospital staff for help in establishing improved treatment services. With the help of a professional social worker at the state hospital, and the subsequent involvement of the newly hired Dorchester County Health Department Alcoholism Program Coordinator, plans were developed to establish the private program eventually named Agape which would operate a number of alcoholism services. A funding grant was submitted to a federal agency and with the continued involvement of the probation staff and additional support of other community leaders, local financial support was requested and received. Agape will open its first residential center soon.

5. *Manhattan Bowery Project.* A review of the origins of this pioneer Bowery detoxification and aftercare center points out the significant role of the Vera Institute of Justice. The Vera Institute is a private organization committed to reform of the criminal justice system by reaching into the legal apparatus and making it function more fairly in the interests of the defendant and the community. Vera represents a sustained private effort that works within the existing public institutional structure and attempts to develop techniques for promoting changes that are acceptable to an established bureaucracy. Vera is involved in a range of projects that are designed to intervene at various points in the criminal justice system. The Manhattan Bowery Project is just one project of intervention before arrest. Vera generally sought changes in procedures and, perhaps more important, changes in the ways in which accused persons were viewed and treated by the agencies of the system.

   The Vera Institute of Justice first became seriously interested in the possibility of changing this system of handling derelicts when it discovered that nearly all arrests in the New York City precinct chosen to test the Manhattan Summons Project fell into the drunkenness-disorderly conduct category. Encouraged by some success in modifying bail and summons practice, the Vera group felt it might be possible to devise techniques for changes here, too. (Programs in Criminal Justice Reform, Vera Institute of Justice, Ten Year Report 1961-1971.) Two factors combined to give Vera an opportunity to plan just such a project. The first was Mayor John V. Lindsay's pre-inaugural Law Enforcement Task Force which had recommended that a "Skid-Row Project" be undertaken which would test the feasibility of a diversion program for the homeless alcoholic derelict. The second factor was the reasoning in the two court decisions previously mentioned. It seemed likely in 1966 that jails would not be available much longer as the prime, sometimes only, detoxification centers for resourceless alcoholics. In May of 1966, Mayor Lindsay formally invited the Vera Institute of Justice to plan and develop a medically oriented method for removing destitute alcoholics from the criminal justice system. The cost of Vera's planning efforts was financed by a grant from the Ford Foundation.

   Vera eventually established the priority of a detoxification center and with the unusual cooperation of approximately eighteen separate governmental departments and agencies at city, state, and federal levels, the Manhattan Bowery Project's detoxification ward was opened in November, 1967. It is significant to the note the planning and staffing cooperation that Vera received:

   The Social Services Department (Welfare) gave the fourth floor of its Municipal Men's Shelter for the detoxification facility and assigned four caseworkers to the project to handle screening and referral;

   The New York City Police Department assigned four men and two unmarked vehicles to the project for "pickup";

   The Department of Hospitals (City) provided beds and other equipment;

   The Department of Correction assigned four offices for record keeping and reception duties;

   St. Vincent's Hospital agreed to serve as the supporting hospital and provided laboratory service and resident physician time;

   The Mayor's Criminal Justice Coordinating Council endorsed the Vera proposal and provided its supportive services in advising and assisting project operations;

   Funding was initially provided by city, state, and federal agencies.

   Presently the M.B.P. offers a 48-bed detoxification center which basically provides the services previously defined, an out-patient alcoholism clinic, aftercare in orientation, and an emergency medical clinic, all of which are located in the Municipal Men's Shelter.

6. *Example: Manhattan Bowery Project.* During the planning phase, the Vera Institute, after consulting with many health and social service experts, decided to recommend that priority be given to establishment of a short-term service that would provide five days of treatment. The recommendation for a short-term program instead of one seeking long-term rehabilitation was made because it would make possible the handling of large numbers of men and thus provide a genuine alternative to detoxification in the jails. Secondly, it offered periodic detoxification to those men who would be expected to return to the facility repeatedly. Another reason was the availability of long-term care facilities elsewhere to which men could be referred.

7. *Example: Agape, Inc.* In Dorchester County, Maryland, the Agape group concluded that a treatment oriented half-way house would be more appealing to the community and thus stood a greater chance of being supported than a shelter, despite the fact that a shelter appeared to be the greater need. Action has more recently been initiated toward a detoxification center, with the cooperation of the local general hospital.

8. See Appendix F for a complete listing of state alcoholism agencies and their directors.

9. *Example: Crossroads Center.* The Catholic clergyman who effectively mobilized the support of other groups interested in alcoholism services and other community forces as well, distributed a five-page, illustrated "proposal" simply calling for the essential services. While the program changed somewhat from the original proposal, its use proved immediately effective.

   Later, Crossroads applied for and received through the Vocational Administration, Department of Health, Education, and Welfare, a small "Workshop Improvement Grant" which was used to carry on a study of alcohol problems in Erie, Pennsylvania. (Charles W. Weis, *Alcoholism and Alcohol Abuse in Erie: A Study of the Problems in the Erie Area and Effectiveness of Existing Services with Recommendations for Improvement;* 1970). This study contributed in part to future funding awards.

10. Irving Shandler, "Alcoholics of Special Community Concern" *The Williamsburg Papers,* N.I.M.H., 1970, p. 31.

11. Murray G. Ross, *Principles of Community Organization,* New York, Harper and Brothers, 1965, p. 175.

12. Shandler, p. 32.

13. Initial meetings of Crossroads Center organizers included statements of support from community groups, publicized awarding of Bibles for the proposed residential facilities, and the constant message from the clergyman-chairman of the missionary nature of the program.

14. Ross, p. 172.

15. Alcoholics Anonymous is not, of course, an agency or incorporated body, but rather a voluntary fellowship of men and women who achieved sobriety through A.A. and who are ready to help others do the same. Local A.A. groups exist in almost every city, with larger communities housing many such groups. Generally an A.A. answering service is listed in the telephone directory. All of the shelters visited by the project staff had A.A. members in many positions, including that of executive directors or managers.

CHAPTER III

SECURING FINANCIAL RESOURCES

A discussion of financial resources must be included in any serious proposal for the establishment of diversionary programs. The diversity which characterizes the kinds of programs discussed thus far characterizes, too, the means by which diversionary programs are supported. Prior to elaborating on these resources, let us again fall back on the experiences of existing programs and point out that the agencies involved look to more than one financial supporter, often to as many as ten. Most successful programs, especially those operated by autonomous, private agencies, are multi-funded, combining private and government contributions, various levels of government funding, and occasionally using a number of agencies on the same governmental level. Initial funds are often local; on-going funds are generally federal.

In considering this subject, let us begin by elaborating on government (tax-supported) resources, followed by a description of private (non-tax-supported) funding bodies.

1. GOVERNMENT

   A. N.I.A.A.A. — The National Institute on Alcohol Abuse and Alcoholism (formerly the Center for the Prevention of Alcoholism) is a division of the National Institute of Mental Health, a federal government agency which falls under the mammoth Health, Education and Welfare Department (H.E.W.). The N.I.A.A.A. was established by the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (Public Law 91-616), and has the responsibility for formulating and recommending national policy and goals regarding the prevention, control, and treatment of alcohol abuse and alcoholism and for developing and conducting programs and activities aimed at achieving these goals.

   While the programs and services of N.I.A.A.A. are many and varied, our primary concern is the role N.I.A.A.A. plays as a funding resource. In that regard, three funding programs should be noted and understood as prime resources:

   (1) STAFFING GRANTS THROUGH THE COMMUNITY MENTAL HEALTH CENTERS ACT

   These applications can be procured through local community mental health centers and funding may be received if it can be shown that all mandated services, not just some, are to be provided, either directly or through contract.[1] Staffing grant funds are to be used to meet a portion of the costs of compensating professional and technical personnel for the initial operation of community alcoholism services which are new or are to provide a significant increase in the quality of service. Comprehensive programs funded by staffing grants provide a range of alcoholism services, including inpatient, outpatient, intermediate, and emergency care, as well as consultation and education services. Once submitted, the applications often take nine months to a year, sometimes longer, before funding begins.

   (2) PUBLIC INEBRIATE PROJECTS GRANTS OF N.I.A.A.A.

   The purpose of demonstration grants is to demonstrate new or innovative programs and methods not previously used in the field; to adapt to a new geographic area or elements of service, methods used in other localities or in other types of programs; to demonstrate to a particular community some programs or methods it can use to initiate, extend, or improve its delivery system. The original intent of this demonstration section seems to have been somewhat expanded in light of general feeling that community mental health centers have not as a rule accepted responsibility for indigent, skid-row alcoholics. Consequently agencies applying for public inebriate funds, if approved, receive such funds directly, not through community mental health centers or other intermediates. Also unlike community mental health center funding, N.I.A.A.A. provides 100% financial support for approved public inebriate projects. Four communities received such fund-

ing in 1971-1972.[2] As a rule, agencies receiving such funding can expect to continue receipt for three years. Funding covers not only staffing, but monies for renovation, some equipment, and other costs. It should be noted that this program is not encouraging the establishing of autonomous detoxification centers, and may not fund such. (See Chapter IV.) Application guidelines are included in Appendix A and application can be made directly to:

DIRECTOR
PUBLIC INEBRIATE PROGRAM
N.I.A.A.A.— NATIONAL INSTITUTE OF MENTAL HEALTH
Parklawn Building
5600 Fishers Lane
Rockville, Maryland 20852

For an example of an agency awarded this grant, see footnote 3.

(3) STATE FORMULA GRANT FOR ALCOHOLISM PROGRAMS

Public Law 91-616 provides for a formula grant to every state which meets eligibility requirements (establishment of an official state alcoholism program agency, a state alcoholism plan, a representative state advisory council, etc.) The formula is determined by the state's population and economic conditions. N.I.A.A.A. checks eligibility and distributes the formula grant to the authorized state agency which is then responsible for expending the money according to its previously submitted plan. Full information about this potential funding source may be obtained from the state alcoholism agency, the alcoholism consultant to the regional office of the National Institute of Mental Health, or the Community Service Branch of N.I.A.A.A. (See Appendix F.)

B. Veterans Administration — Where programs can show that services are being provided eligibile veterans of the United States Armed Forces, federal V.A. funds can be provided to that program. While this does not appear to be a potentially large resource, it is one that provides approximately $300,000 to the Rehabilitation Center for Alcoholics in Occoquan, Virginia (District of Coumbia — Department of Human Resources). This payment is based on a V.A. per diem/patient payment of $3.50. For such funding no special programming is required, that is, no service above and beyond what is provided non-veteran clients. Further information may be obtained from the State and Community Staff Chief, Medical Administration Services, Veterans Administration Services, Veterans Administration, Room 13G, 810 Vermont Avenue, N.W., Washington, D.C. 20420 (202/389-3679).

C. Miscellaneous City or County Funding—Many of the diversionary programs visited by the staff were partially funded by local governments, especially in the early stages of development. Local government funding is often seed money or matching money. Generally such funding was preceded by personal contact of local officials and the presentation of a strong case detailing advantages for the locality of such programs. Local governments may be especially sensitive to panhandling, transients, or sleeping in public, and therefore appeals are often made on one or more of these bases. Occasionally such local funding is reimbursable; e.g., the County of Erie, Pennsylvania, awards Crossroads Center $20,000 a year, but because such money ensues from the County Mental Health-Mental Retardation budget, $18,000 of that sum is reimbursed by the State of Pennsylvania which offers a 90-10% community mental health matching grant.

Revenue Sharing (State and Local Fiscal Assistance Act of 1972) identifies health and social services for the poor and aged as two of several so-called "priority expenditures." Revenue sharing funds are distributed 2/3 to local governments and 1/3 to states, and while no priorities are suggested on state funding, the local government's implied obligation to spend some of its funds on poor and disabled would theoretically include alcohol problems. Community leaders may appeal to local authorities for a share of these funds, as did Crossroads Center successfully in Erie (Planned Variation funds, a forerunner to Revenue Sharing).

A large potential resource is the "75-25" Social and Rehabilitation Services funds which are distributed through state agencies, generally the Department of Welfare. These funds ensue from Title I of the 1967 Social Security Act and provide 75% funding for general social service needs if 25% matching can be secured from a third-party governmental resource. For a state to secure such funds, a state plan must be prepared, and alcoholism concerns have been stated as priorities. On this funding, contact the local office of the State Department of Public Welfare.

Because the police department becomes one of the primary beneficiaries of diversionary programs, appeals might be made there for assistance. For example, the St. Louis Detoxification Center will receive $30,000 this year from the St. Louis Metropolitan Police Department but has received in the past up to $80,000 per annum.

Irving Shandler suggests other governmental programs as potential funding sources:[4]

D. Titles XVIII (Medicare) and XIX (Medicaid) of the 1967 Social Security Amendments — While the benefits under Title XIX will vary from state to state, this program has been a tremendous aid in Pennsylvania. Inpatient costs are covered up to 60 days at a time and then after 60 days the client is again eligible. This coverage has been a big factor in promoting both detoxification services and moderate-length inpatient care. These monies now can also be used by approved clinics for outpatient programs: individual and group therapy, psychological testing, drugs, etc. Medicare is an important resource for the over 65 group of alcoholics.

E. State Vocational Rehabilitation Agency — This agency, referred to under different names in given states, is usually affiliated in some way with the Bureau of Employment Security and has great flexibility in providing payment for many varied services. It can pay for social-medical evaluations to determine if the patient is an alcoholic. It has paid for extended inpatient care ranging from 28 days to four months. Intermediate care throughout the country is often supported by this agency. Perhaps their most valuable contribution is their ability to help a client with extended periods of education and/or training — a key adjunct to total rehabilitation. The State V.R.A. should be considered a prime resource of financial support to clients and programs.

F. Urban Renewal — There is some evidence that Housing and Urban Development may be willing to assist in partial financing of urban renewal and Model Cities service programs where alcoholism is a principal factor in effective relocation. Skid rows are a key example of this type of problem. The Housing and Urban Development's emphasis is on diagnosis and referral, and they should not be expected to finance fully a total program.

G. L.E.A.A. — The Law Enforcement Assistance Administration of the United States Department of Justice was created by the Omnibus Crime Control and Safe Streets Act of 1968 (Public Law 90-351). As the title suggests, this federal government agency has as its primary purpose the aiding of law enforcement programs, specifically police, courts, and penal institutions. Aid can be frequently rendered by relieving these law enforcement programs and their staffs of responsibilities and duties which may not be appropriate, for example, the victimless crime of public drunkenness (see Introduction). Like N.I.A.A.A., L.E.A.A. functions and activities are numerous and varied, but our primary interest is their funding capabilities.

Program funding by L.E.A.A. of local projects must proceed through, be sponsored by, and/or be approved by the local affiliate of L.E.A.A. (which may be called "The Governor's Justice Planning Commission," or "Mayor's Office on Crime Control," or some such title). The bulk of action funds distributed to states and localities are based on the preparation of comprehensive state law enforcement plans and, therefore, most L.E.A.A. funding proceeds through some government affiliates of L.E.A.A. Further information on such funding can be secured from L.E.A.A. regional offices or state level planning agencies.[5] L.E.A.A.'s role as a funding resource for public inebriate projects may be diminishing, however. (See Appendix E.)

H. Public Assistance — Because the public inebriate is usually eligible for public assistance, the local welfare department may help support a residential program (shelter, etc.) by paying board for the residents, providing clothing, and supplying even home furnishings. The Social Security Amendments of 1972 include a provision that no disabled person would be eligible for benefits if the disability is medically determined to be due solely to drug addiction or alcoholism unless such individual is undergoing appropriate treatment. Furthermore, these payments would be made to third parties only as protective payments.

2. PRIVATE

Private (non tax-supported) resources serve less frequently as supporters of indigent alcoholism programs, but their range is such that they should be explored. In many cases they have provided seed money or funds for limited capital expenditures. Let us examine some of the possibilities:

A. Guest payments — While not a large potential or actual source of income, clients who are receiving public assistance or who have been helped to secure jobs may contribute to the cost of their care. Generally, such money would apply to the shelter service and the community residential living facility. Crossroads Center, for example, received $44,000 from clients in the past fiscal year.

B. Foundations — Literally thousands of foundations exist for a wide number of purposes, and many have goals compatible with the establishment of diversionary-rehabilitation programs. Such is especially the case with "community foundations." The "community foundation" is not a new idea. The concept of using directed, long-term philanthropy for the continuing benefit of the community began in Cleveland in 1914, and today well over 200 foundations exist, and almost all metropolitan areas have one. Crossroads Center received two capital expenditure grants from the Erie Community Foundation (Erie, Pa.) which were devoted to improving

the physical plants of the program. Information on foundations in a given state can usually be secured at a public library. See also the *Foundation Directory*, Russell Sage Foundation, N.Y., 1967.

C. United Fund — No diversionary program visited by project staff was receiving aid from United Fund or a similar agency, although some had received such help in the past. Nevertheless, this resource should not be discounted. Should the United Fund agency not wish to aid the program, consideration might be given to carrying out one's own community fund-raising appeal. The experiences of agencies undertaking this alternative suggest that such should involve the assistance of a professional fund raiser and be conducted only when there is assurance of a sizeable number of volunteers.

D. Community Social Groups — A number of agencies contacted received some financial assistance from community social groups such as the Welcome Wagon or Junior League. A benefit dance, for example, was sponsored in late 1972 by influential well-to-do Bostonians and provided $22,000 to the Pine Street Terrace Shelter.

E. Miscellaneous Private Funding — HACOP in Daytona Beach receives $3,000 a year from the community hospital for removing the pressure from its emergency room. The Home in Alexandria, Virginia, has a Sunday morning Alcoholics Anonymous meeting followed by a collection which is contributed to the facility. The Home also sponsors an annual banquet featuring a speaker, dinner, prizes, and dancing, to which are invited interested citizens, usually A.A. members. Shandler, mentions industrial contracts and health plans.

Note that sources of funding are never static but in a constant state of change. A need exists for constant liaison with all levels of government. Shandler offers this final bit of advice:

> "Perhaps one word of caution concering funding — while raising money is many times difficult, it can be done. But the availability of dollars is neither a guarantee of a successful program nor an inherent right to receive more dollars. Adequate funds produce programs and good programs produce funds."[6]

We have considered thus far the nature of the problem and what this report proposes to do, the steps in early implementation, and a general review of potential funding resources. The following five chapters provide a thorough examination of five essential diversionary services based on seven variables which include:

A. Program
B. Staffing
C. Relation to Other Diversionary and Community Services
D. Location
E. Plant and Equipment
F. Costs
G. Problems to Anticipate

III

FOOTNOTES

1. *Example: Boston's South End Center for Alcoholics.* The South End Center for Alcoholics of Boston, Massachusetts, is a combined outpatient day care, and 28-bed emergency-housing alcoholism program serving primarily Boston's resourceless, indigent alcoholics. The Center is located in the deteriorated south end section of Boston's inner city which falls within the catchment area (geographic area of responsibility) of Boston University Medical Center, Division of Psychiatry. The latter agency sponsors a community mental health center and as part of its functions operates the South End Center. Funding for South End ensues from the Community Mental Health Program through Boston University Medical Center. The South End Center, then, provides some of the five mandated alcoholism services necessary for securing comprehensive alcoholism program funds from the Community Mental Health Center Act.
2. Diagnostic and Rehabilitation Center, Philadelphia $569,952
   Skid Row Community Council, Seattle, Washington $540,500
   East End Hotel, Baltimore, Maryland $500,000
   Office of Economic Opportunity, Milwaukee, Wisconsin .. $500,000
3. *The East End Hotel, Baltimore, Maryland.* This Baltimore facility provides essentially direct, concrete services for a maximum population of fifty resourceless skid-row inhabitants, usually alcoholics. This facility emphasizes residency services (shelter), but its 50-bed capacity is felt to be approximately 450-700 short of those needed to properly house Baltimore's homeless alcoholics as long as they cannot or will not stop drinking. A direct N.I.A.A.A. Public Inebriate Project grant will provide for 50 more beds in a separate plant, a full-time diagnostic and evaluation center, and six boarding homes, one of which is planned as a shelter for alcoholic women who have failed to respond to treatment.
4. Irving Shandler, "Alcoholics of Special Community Concern," *The Williamsburg Papers*, N.I.M.H., 1970, p. 29.
5. *Examples of Agencies Receiving L.E.A.A. Funding:*

   St. Louis Detoxification and Diagnostic Evaluation Center. In October, 1966, this St. Louis, Missouri program received a discretionary grant of $158,700 from L.E.A.A.'s predecessor agency to establish a thirty-bed unit within the facilities of St. Mary's Infirmary. This was the first such detoxification unit sponsored by a police department in the Western Hemisphere, and the program continues today, although without L.E.A.A. funding. The program has since been transferred uptown to the St. Louis State Hospital, a move many felt to be regressive.

   Crossroads Center. Crossroads Center in Erie, Pennsylvania received a discretionary L.E.A.A. grant of approximately $60,000 in 1971 to carry out its "pickup" service which, directly relieves Erie police of this responsibility. Additional L.E.A.A. funding received through the Pennsylvania Governor's Justice Commission of $170,000 for 1972 will fund an expanded system of services under "pickup" as well as an inner-city outreach service.

   HACOP. In Daytona Beach, Florida, the Halifax Alcoholic Court Oriented Program applied for and received an L.E.A.A. discretionary grant of $23,948 to carry out the previously described court-jail counseling program along with supportive residential services.
6. Irving Shandler, p. 31.

CHAPTER IV

MEDICAL EVALUATION AND SUBACUTE DETOXIFICATION

A review of the Introduction will refresh the reader with the scope of the Medical Evaluation (out-patient) and Subacute Detoxification (in-patient) Service (MESAD). As was suggested, MESAD should be seen as the first step in the diversionary-rehabilitation process, a place where any potential medical problem can be determined. Many clients will require admission to the in-patient subacute detoxification unit. Others will be referred to other services such as a community hospital, the shelter, or return for out-patient follow-up. The concept of an autonomous detoxification center is controversial.

Traditionally, two basic alternatives were open to communities interested in detoxification services: sponsorship by an existing hospital, or the establishment of a physically separate, autonomous center. As a rule, only the largest metropolitan centers operate detoxification centers physically separate from general hospitals. These include the Manhattan Bowery Project in New York City, which is located within the Men's Shelter; the Washington, D.C. Detoxification Center, located in its own facility; and the Boston Detoxification Center, Boston, Massachusetts.

Unlike these communities, most "official" detoxification takes place in existing community hospitals, often under contract with an alcoholism or health agency, e.g. County Department of Health. In Maryland, a concept that has similarities and mobilizes the strengths of both autonomous and hospital-unit alternatives is the "quarter-way house." The "quarter-way house" is a hospital affiliated but physically separate detoxification center with little or no medical involvement following admission. An example of such a unit is Baltimore's Tuerk House, a nonprofit, private facility which accepts detoxification referrals only from the emergency room of University Hospital. University Hospital agrees to serve as a back-up for patients where medical needs go beyond the quarter-way house (and less than 1% require referral back to the hospital). "The individual referred to a quarter-way house is one who has been examined by a physician in the emergency room and determined not to need admission to the hospital but to need custody to prevent further drinking and support for his withdrawal syndrome: i.e., not sick enough for a hospital bed, but too sick to be turned out on the street or back to a furnished room or a skid-row dormitory."[1] In the budget for a quarter-way house is a salary for a Nurse Coordinator of Services for Alcoholics on the staff of the general hospital to which the facility is related. The nurse provides active liaison between the hospital and detoxification center. Four quarter-way houses now operate in Baltimore, two for men, one for women, and one for men and women.

The detoxification unit within a general hospital seemingly has obvious advantages, specifically, immediate access to most of the resources needed to carry out any medical task. As was found to be the case by the Montgomery County Department of Health in Maryland, an immediate solution to providing detoxification services was simply to contract with a general hospital, namely the Washington Sanitarium and Hospital. When the hospital is not able to collect payment privately or from a third party, the Health Department pays emergency room and in-patient costs.

More frequently, agreements between a hospital and an alcoholism agency do not include financial commitments on the latter. In Daytona Beach, Florida, and Erie, Pennsylvania, for example, agreements have been reached where local hospitals provide detoxification services that complement other agency programs, but the latter agencies maintain no financial responsibility for patients treated at the hospital. Obviously, most community hospitals have established mechanisms for third-party payments even for indigent patients. Furthermore, using a community hospital rules out the necessity for purchasing a separate building and establishing a separate operation. Irving Shandler and others advised in "Alternatives to Arrest" that in Philadelphia no new detoxification centers be constructed, but rather that the responsibility for detoxification be shared by the hospitals of the city.[2]

However, a general complaint heard in most alcoholism agencies visited by project staff concerned cooperation with the hospital. Admission must usually take place through hospital emergency rooms which are often overburdened. Thus a sick alcoholic might be forced to wait and/or be subjected to harsh treatment by staff with little knowledge of and tolerance for his situation. Furthermore, a general hospital is costly. Costs per day at the previously mentioned Washington Sanitarium and Hospital exceed $100 a patient. On the other hand, detoxification centers, not a part of a community hospital, have reported costs as low as $14.50 a day per patient (Tuerk House, Baltimore) to $30-$40 a day per patient (Manhattan Bowery Project and St. Louis Detoxification and Diagnostic Evaluation Center).[3]

The author recommends a separate unit as described below:

1. PROGRAM OF THE MEDICAL EVALUATION AND SUBACUTE DETOXIFICATION CENTER

   This 24-hour operation will offer the following services to clients suspected of having medical problems:

   A. "Pick-up" when intoxicated or apparently intoxicated in public. A number of communities provide

transportation services for public inebriates which directly relieves police of much of this time-consuming task. The nature of the transportation varies from actual "pick-up" of the public inebriate and transfer to an appropriate resource other than jail, to simple transportation of an incarcerated public inebriate from jail to court for a hearing.

The Ann Arundel County Health Department (Maryland) through its agency, "Open Door," operates two vans equipped with two-way radios and staffed 80 hours weekly with formally trained alcoholism counselors. The vans respond to a wide variety of calls involving alcoholics and other drug abusers, and many of its requests come from police. Acutely ill alcoholics are transported to a detoxification center, others to their home or elsewhere.

A similar service is offered by Crossroads Center in Erie which offers "pick-up" service 24 hours a day. Crossroads has one van especially equipped for transportation of sick alcoholics, and a station wagon is available as well. Most of Crossroads' "pick-ups" are police requested, and the public inebriates are taken either to St. Vincent Hospital or back to Crossroads, depending on the client's condition. No communications equipment is on the Crossroads vehicles, but a special trunk telephone (hot line) was installed to handle police calls. Unlike Ann Arundel County's Open Door, Crossroads does not purchase its vehicles, but rather rents them. They are manned by two "case expediters" not formally trained, but at least one is a recovering alcoholic.[4]

As the author envisions the service, most referrals will come from police and emergency room staff. The police will call by telephone when advised of a man intoxicated in public and, in lieu of incarceration, request a civilian "pick-up." This transfer of responsibility minimizes the necessity of police involvement with the public inebriate and provides opportunity for police involvement in more appropriate crime reduction functions, such as crime detection and in-service training. The men picked up will generally come voluntarily since it is expected that the great majority will prefer the medical approach to incarceration. Where the men refuse to come with the "pick-up" staff (present experiences of Crossroads Center suggest this is rarely the case), they are returned to the custody of the police or left to their recognizance. Word travels, however, and a comfortable, kind, and supportive environment is difficult to refuse.

Emergency Room staff will also refer clients so as to lessen the burden on their facility of any inebriate requiring subacute treatment but not hospitalization. This arrangement offers the MESAD an opportunity for "Quid Pro Quo," and thus to have hospital back-up when necessary. These arrangements with the police and hospital(s) obviously have to be negotiated, but they promise considerable cooperation from influential community institutions. As was suggested previously, the subject of where to provide medical services for alcoholics, including emergency services, is controversial.[5]

B. Physician's examination and commencement of any recommended treatment. In addition to treatment of alcoholic withdrawal, attention will be devoted to common illnesses of the skid-row man such as pneumonia, tuberculosis, fractured and broken bones and cardiac disease.

C. If admission to the subacute detoxification unit is necessary, approximately seven days of medical treatment aimed at countering withdrawal symptoms and malnutrition are required.[6] In addition, some exposure to alcoholism information including Alcoholics Anonymous will take place. Counseling by the staff that is aimed at supportive encouragement to follow through with on-going treatment and an individualized recommendation for recovery after discharge will also be offered. Meals are not prepared in the MESAD but rather are purchased at neighborhood restaurants and brought in.[7]

D. If admission is not required, the client will be treated and referred elsewhere. Data from the Diagnostic and Rehabilitation Center in Philadelphia suggests that a maximum of 30% of the public inebriates seen in MESAD will require referral for admission to a hospital, although a properly equipped subacute detoxification center would seem to lessen that figure considerably.[8] (However, if a referral is to be made to a hospital, it is wise to have previously determined the client's ability to finance hospitalization which usually means his eligibility for medical assistance. Also, the hospital staff should know that the referring agency will accept responsibility for the client following discharge from the hospital.) A client is also likely to be referred to the shelter or other community resources.

E. Whether admitted or referred, the client will receive a brief psycho-social evaluation (see Appendix C) centering on direct, concrete concerns, which serve as the basis of evaluation and treatment planning.

Procedure will operate somewhate as follows: A client will enter via one of several means and be helped by a corpsman-counselor in completing a brief intake form. He is accompanied to the physician who performs a medical examination and with the client arrives at a plan for treatment. If the client is able, a psycho-social history is taken and then the client is either admitted to the subacute detoxification unit or referred elsewhere. If he is admitted to the unit he participates in medical and other treatment and together with his counselor makes plans for post-discharge follow-up. If the client is referred instead to a hospital, the counselor maintains contact and aids the client upon discharge. Follow-up could take place at any one of a number of resources, including the MESAD, but in any case the appropriate aftercare staff person in the coordinator's office is so advised.

2. Staffing the Medical Evaluation and Subacute Detoxification Center

Because the major purposes of the MESAD Center are to provide custody of the acutely intoxicated alcoholic until he is detoxified and to project the concept of alcoholism as an illness from which the client can recover,[9] a majority of the MESAD staff can be recovering alcoholics. Such seems to be the staffing patterns of most non-hospital detoxification and public inebriate programs, although agency directors are quick to indicate that alcoholism recovery is not in and of itself sufficient qualification.

Model Staffing Pattern of the Medical Evaluation and Subacute Detoxification Center[10]

Facility: 25-bed Center (generally appropriate for most communities of 200,000-300,000 population)

Staff:

Manager (resides in the center)	$ 10,000
Physician	30,000
Registered Nurse (2)	8,000
Corpsmen (12)	6,000
Attendants (6)	5,000
Typist	5,000
	$193,000

The typist will handle all correspondence, mail, telephone calls, filing, and general typing.

3. Relation of MESAD Center to Other Diversionary and Community Services

MESAD will serve as the first step for most of the clients coming into the diversionary-rehabilitation program. Those appearing in any of the other services (e.g. the shelter) who are suspected of needing medical evaluation, will be referred to MESAD. MESAD will also act as a referral agent, often to the shelter for clients needing post-detoxification residency but not yet ready for more intensive treatment. Clients deemed ready will be referred from MESAD to Intermediate Care for more intensive therapy, but as a rule will not be referred directly to Community Residential Living Facilities. MESAD will maintain considerable community contacts, especially with the police and other medical facilities.

4. Location

MESAD will be located in or near the skid-row section of the community, allowing easy access for potential clients. It should be near the shelter and, ideally, near a cooperating hospital. (It is not unusual for skid row and a community hospital to be located in close proximity.) Obviously, it must be in an area appropriately zoned.

5. Plant and Equipment

For easy supervision and movement of clients, the MESAD should operate from a one-floor plant of at least 2,500 square feet in a building that meets the local and state health, safety, and fire standards. The dormitory should be open for easy supervision, and, if possible, should include a segregated area for particularly agitated patients and another area for the manager's quarters. The plant should also include possible space for a waiting room, a general office, a manager's office, a clothing room, supply room, a clinic room, a private counseling room, a small lounge, and a lavatory. The lavatory should include a minimum of four sinks, three urinals, three toilets (with partitions), and three showers.

Furnishings should be simple and plain. Each client should have a bed, a locker, and a chair. Goodwill Industries, Salvation Army, and similar resources should be checked. Because state hospital populations are generally declining, these facilities may have surplus furniture. Towels and sheets can be supplied by a commercial laundry. The center should have a supply of folding chairs (for A.A. meetings and other activities), soap and razors, newspapers, television, small table games, appropriate office equipment (including a typewriter), and necessary medical supplies. The latter should include a chest X-Ray machine, a physical examination tray and standard equipment thereof, an examining table, and a locked cabinet for medications. Specific drugs and other medical supplies can be ordered by the physician.

Appropriate janitorial supplies and two rented station wagons will also be necessary. A washer and dryer are essential for cleaning clients' clothing, as is a supply of pajamas and slippers.

6. Cost of the MESAD*

Personnel	
Salaries	$193,000
Fringe Benefits†	23,160
Insurance	1,200
Legal Fees	250
Accounting Fees	1,000
Laundry	800
Food	9,000
Utilities	
Telephone	500
Heat	800
Light	700
Maintenance and Repairs	1,000
Local Travel	400
Sundries (razors, etc.)	300
Rental of Station Wagons	4,000
	$236,110

*Does not include capital costs (improvement or purchases of plant and equipment).
†12% of salaries.

7. Anticipating Problems

The MESAD center will face many of the difficulties of location that the shelter faces. As with the shelter, as little publicity as possible concerning location will be made until operations are underway. This approach is controversial but nearly universally agreed upon in principle. If such a low profile is not feasible, one should attempt to secure as much positive publicity as possible prior to moving in, emphasizing such themes as "the most sober facility in town"; "making the non-productive productive"; etc. Occasionally, it may be helpful to prepare some copy for distribution. Also, one should not hesitate using political pressure. If all else fails and neighborhood resistance develops, it may be necessary to mobilize community and political support. Once the program is established, it may be helpful to reach out to the neighborhood by purchasing needed supplies from local merchants and inviting neighbors to participate through the board or other mechanisms. The East End Hotel in Baltimore, for example, has made friends in its neighborhood by inviting neighbors to A.A. meetings, film showings, parties, etc., and by helping them with clean-up projects.

Center staff will avoid a dependence on excessive medication to accomplish detoxification, but instead use psychotrophic drugs sparingly. When medication is required to inhibit delirium tremens or aid sleep, the choice of drug will fall in the minor tranquilizer range. Hopefully, the patient will be taken off drugs several days prior to discharge to facilitate gradual withdrawal. A policy of not prescribing medication following discharge will be followed religiously in light of the proneness of many alcoholics to addictions in general.

One should expect to encounter not only alcohol use and abuse, but use and abuse of other drugs as well. Sensitivity to such practices and knowledge of treatment are necessary. It is wise to maintain only a minimal supply of medications with types and brands limited. This facilitates good recordkeeping and accountability.

One should maintain a policy of friendly firmness, but with limits. Limit testing will occur. The rule in all facilities for alcoholics should be that if they break laws by stealing, with assaults on person or property, setting fire, etc., they are subject to the same laws and penalties as non-alcoholics. If this rule is firmly and uniformly enforced, problems are greatly reduced.

While most alcoholics are not psychiatric patients, some psychiatrically ill people are alcoholics. The evaluation must include a careful screening to identify those needing appropriate psychiatric care which the MESAD center is unequipped to provide. Some clients may require observation either at MESAD or the shelter.

Many non-hospital detoxification centers across the country suffer from dilapidated physical plants which are untherapeutic to clients and disfunctional from a public relations viewpoint. Maintaining the attractiveness of the building should be a priority, a goal which might be attained through the help of shelter clients or other volunteers. Avoid developing a tolerance for deteriorated buildings.

IV

FOOTNOTES

1. Maryland Division of Alcoholism Control State Plan (See Appendix B for address).
2. Irving Shandler, "Alternatives to Arrest," Philadelphia Diagnostic and Rehabilitation Service, p.27.
3. Many of the problems of hospital detoxification centers would be lessened considerably through the quarter-way house in the opinion of Mrs. Gertrude Nilsson, former Coordinator, Services to Alcoholics, Department of Mental Hygiene for the State of Maryland. "The quarter-way house," she says, "is a Maryland invention, and the four now in operation in Baltimore have clearly proved their value. Through quarter-way we improve detoxification services while reducing the hospital burden caused by the public inebriate, and save money as well."

   Another alternative in providing detoxification services is the use of a state hospital, usually a mental hospital. In Dorchester County, Maryland, detoxification services were provided by Eastern Shore State Hospital. Often, however, this type of arrangement has not been satisfactory. Admission is difficult, commitment procedures hamper voluntary participation, costs run higher than a quarter-way house (usually from $18.42 per patient per day minimum) and hospitalization is considerably longer. Cahn tells us, "Some psychiatric sanitaria treat alcoholics along with patients with other psychosocial disorders. Most are equipped to handle alcohol toxicity. The treatment provided is usually psychotherapy, with a course of treatment anywhere from one week to one month; a few institutions have open-end regimes. This type of care is expensive, costing up to $500 per week." (Sidney Cahn, "Medical Care for Alcoholics," *The Treatment of Alcoholics: An Evaluative Study*, p. 177.)
4. Another type of transportation is provided by Maryland's Montgomery County Health Department's alcoholism program. Using cars from the county pool, general transportation service is provided alcoholics, including transportation to and from detoxification centers, and from treatment centers to the courts. To facilitate such help legally, Montgomery County legislation was amended to permit the appointment of "special duty sheriffs" (the Health Department counselors and other alcoholism program staff). These special duty sheriffs hold office at the pleasure of the sheriff and while doing so have the same power and authority as deputy sheriffs within the area to which they are appointed (i.e., alcoholism concerns). While the legal authority of deputy sheriff there is unclear, the title and accompanying badge serve as effective motivating factors to alcoholics ambivalent about the need for treatment.

   Montgomery County also contracts with the local taxicab company to provide "pick-up" of alcoholics for transport to detoxification centers. This service is used when Health Department cars are not available.

Part of the operation of Philadelphia's Diagnostic and Rehabilitation Center consists of "picking up" and assisting inebriates (some who ordinarily would be police cases) and providing the service called for (i.e., medical treatment at a hospital, transportation home, etc.). "Pick-ups" for the Manhattan Bowery Project's detoxification center represent the primary means of admission. There, four plain clothes New York policemen and civilians, including former M.B.P. clients on the staff of M.B.P., serve as "rescue team" members and drive unmarked police department vehicles and thus assist in bringing men to the facility for treatment. This mechanism of using police for "pick-up" was apparently a pragmatic one in that police had the staff, automobiles, and the willingness to carry out the assignment. ("Pick-up" by police, of course, is not a new function.) The Police Department, then, serves as a funding source as well. In the innovative St. Louis Detoxification Center, police continue to carry out pick-up.

As we define a diversionary program, however, this type of approach would be less diversionary since police are not relieved of this particular function. There may be other disadvantages as well. Nimmer specifically suggests that if pick-ups are employed by an agency (he questions their need), they should be made by specially assigned squads of civilians and not by a portion of the regular patrols of the police. (Raymond Nimmer, *Two Million Unnecessary Arrests*, American Bar Foundation, 1970, p. 150.) However, this approach may provide greater safety and aid police in accepting new ideas toward the problem.

5. Vernelle Fox, M.D., "Recommendations for Detoxification Services," *Proceedings on Alcoholism Emergency Care Services*, National Institute of Mental Health, N.I.A.A.A., 5600 Fishers Lane, Rockville, Md. 20852. Dr. Fox recommends using existing community hospitals for medical services.
6. Medications most frequently found by project staff to be the drug of choice in detoxification centers or units were Librium (Roche — usually 10-25 m.g. three times per day); and Vistaril (Pfizer, usually 100 m.g. three times per day).

   In San Joaquin County, California, the Department of Health supports two detoxification centers, one a 20-bed hospital unit of the San Joaquin General Hospital; the other a 20-bed non-hospital center called "Starting Point," which uses no medical coverage and no medication. Instead, emphasis is placed on abstention, rest, and good food. To operate such a program effectively, a clear and open relationship must exist with a hospital; this does exist between "Starting Point" and the San Joaquin General Hospital.
7. Most public inebriate facilities, including non-hospital subacute detoxification centers, provide food within the plant (e.g. Baltimore's East End Hotel). A simpler method, however, seems to be the issuing of vouchers or meal tickets for meals in neighboring restaurants. This eliminates the expense of installing kitchen equipment and hiring appropriate kitchen personnel. It also has the effect of simplifying building requirements of diversionary programs and improving the business of the neighborhood restaurants and thus public relations. As will be seen, this latter point takes on great significance. However, this arrangement (like many others with which we deal) has both advantages and disadvantages. An in-house kitchen facility may provide job training and jobs for recovering alcoholics who could not qualify as corpsmen-counselors. A kitchen can also provide hot coffee and snacks, 24 hours a day, and dining together may provide an excellent opportunity for personnel to establish closer relations with residents.
8. It must be kept in mind that these figures from the Diagnostic and Rehabilitation Center came from a formal policy of that agency to refer to community hospitals for most detoxification. What they call their subacute detoxification center is not medically equipped and consequently resembles more of what we define as a shelter.
9. Maryland Division of Alcoholism State Plan.
10. This and other model staffing patterns throughout this report imply the assistance of each of the other elements of the comprehensive publice inebriate program. If one or more of the other services are not available, this particular service will assume to some degree additional functions which will necessitate additional staff. This model staffing pattern is presented as a guide, and specific community circumstances may necessitate modifications of the model.
11. This recommendation is based on a program of the East End Hotel where non-professional personnel (non-degreed personnel) are trained at the center as medics and are called medical assistants. This idea might also be incorporated into the formal training program to which the author previously alluded (see Appendix D).
12. Many diversionary programs have secured their physical plants from redevelopment authorities, including the Philadelphia Diagnostic and Rehabilitation Center and Boston's Pine Street Terrace. Abandoned school houses and converted warehouses also house facilities and have been secured frequently at nominal cost to the agency.

CHAPTER V

SHELTER

A review of the introduction will refresh the reader with the scope of the Shelter service and highlight the distinction between this and MESAD. We emphasize that the Shelter serves any homeless man,[1] with or without a drinking problem, but only when acute illness is not present. Services are primarily direct, tangible, and concrete, although efforts are made to relocate the client away from skid row, and in cases of problem drinking (or any other health problem) to secure treatment.

1. Program of the Shelter

The general environment of the Shelter will focus on helpful, supportive, kind assistance. The Shelter offers dormitory style residence for homeless men and supplementary tangible services, such as food (through meal tickets), lavatory and bathing facilities, clothing (donated), sundries, and activities of various types (e.g., meetings of Alcoholics Anonymous: one in-house and one community meeting; two weekly discussion groups, one recreation evening featuring bingo, contests, etc.).

Individual counseling aimed at general problem resolvement will be provided as well as vocational-job help and supportive therapy. The type of work provided should reflect the client's inherent dignity and worth. The residents may be suitable for employment within the comprehensive public inebriate programs as counselors, attendants, corpsmen, etc.

Constant emphasis will be given to discharge planning in a hopeful, supportive manner.[2] While no man will be discharged from the Shelter in a state of homelessness, neither will long-term residency be encouraged.

The Shelter will maintain a sizeable lounge and offer day-care type services during the daylight hours. Reading material, including newspapers, current magazines, and books (donated) ought to be available. A general plan to involve the men in maintenance work, care of others, recreation, exercises, etc. will characterize the program. Accomplishing worthwhile tasks is generally enjoyed by the guests.

Referrals will be considered an essential element in the Shelter's program. Medical problems will be referred to the MESAD (often prior to admission); legal aid will be required as well. A pool of pastoral counselors and potential employers will be maintained. Special emphasis will be given to referral to rehabilitative programs based on the strengths of the client and will include the Community Residential Living Facilities, Intermediate Care, and, in cases of non-problem drinking skid-row men, resocialization centers or any other appropriate resources.

In instances where clients appear at the Shelter with needs extending beyond what the Shelter can meet, referrals will be made elsewhere and clients accompanied to that referral source.

Procedure for the Shelter will function as follows: A client enters the facility and requests a bed. A staff person completes a brief intake form. If no acute symptoms (tremulousness, hallucinations, etc.) are present and detoxification services are not necessary, he welcomes the client to the Shelter. He then accompanies the client to the shower for cleaning and then provides the client with pajamas, slippers, and a bed. The client's clothing is either washed or discarded. If discarded, fresh clothing is provided the client from donations. Upon arising the next day, the client is offered a meal ticket to a neighborhood restaurant and when he returns is offered coffee in the lounge where he will have the opportunity of watching T.V., reading, or making conversation. He will participate in the day's activity, (e.g., Alcoholics Anonymous meeting), and some time that day be approached by an attendant or nurse for an informal discussion centering around his current situation, needs, problems, and goals. A brief history is prepared by the counselor (if one is not already available)[3] and help is offered to the client. This same staff person will meet with the client regularly until and if some disposition is made.

2. Staffing the Shelter

Keeping the objectives and goals of the Shelter limited to those presented in the introduction should rule out the necessity of hiring many degreed staff. As was suggested in Chapter III, recovering alcoholics may comprise the majority of staff. Because of the medical needs of skid-row men, however, and the necessity of appropriate health referrals, one registered nurse will work each shift.

Model Staffing Pattern of the Shelter

Facility: 25-Bed Center (generally appropriate for most communities of 200,000-300,000 population).

Staff:

Manager (resident in the center)	$ 9,000
Registered Nurse (5)	8,000
Attendants (6)	5,000
Typist	5,000
	$84,000

Staff Functions:

The manager will oversee total operations, including professional, administrative, and plant matters. He will be responsible for scheduling of nurses and other staff, the hiring and supervision of staff, the managing of finances, and maintenance of relationships with other diversionary-rehabilitation programs.

The nurse will examine all incoming clients and arrange any necessary referrals. She may complete the intake procedure and assign attendants to assist the clients in bathing and other matters. She will supervise any medications which the guests must take and store such in a locked cabinet. She will also prepare a report on each client (log) and carry out some program and activity, (e.g., a discussion group).

Attendants will assist clients in undressing, bathing, and preparing for bed. They will assume clothing responsibilities, supervise clients generally, occasionally complete intake forms, lead activities, distribute food vouchers, and carry out other miscellaneous functions including the transportation of clients.

The typist will handle all correspondence, mail, telephone calls, filing, and general typing.

3. Relationship of Shelter to Other Diversionary and Community Services

The Shelter will be viewed as one of many services in the total public inebriate program and constantly relate itself to the other services. The Shelter will accept referrals from the MESAD of men not wishing to participate in treatment programs following acute care, as well as men from detoxification units of hospitals. It will also refer men to MESAD when acute symptoms are present in clients, and to Intermediate or Community Residency Care when other clients (probably a small proportion of total clients) wish rehabilitation services.

The Shelter will maintain a close liaison with the "pick-up" service of MESAD and the police who serve as prime sources of referrals. Thus, the Shelter will have a dramatic impact in reducing local police pick-up and lock-up time devoted to the public inebriate by providing police with one of several alternatives to arrest.

The Shelter may also serve as a "way station" for clients who may eventually be transferred to Community Residential Living Facilities but require a period of observation first.

4. Location

The Shelter will be located in the community's skid-row neighborhood in order to provide easy accessibility for potential clients. It should be near MESAD (See MESAD, Location).[4]

5. Plant and Equipment

Plant and equipment will resemble that of MESAD. The Shelter should operate from a one-floor plant of at least 2,500 square feet in a building that meets the local and state health, safety, and fire standards. The dormitory should be open and occupy approximately 50% of the total space available and include a private area for the manager's quarters. (No segregated area for agitated guests will be needed as such clients are inappropriate guests for the Shelter.) The plant should also include a small waiting room, a general office, a manager's office, a clothing room, supply room, a private counseling-clinic room, a sizeable lounge (larger than that of MESAD since clients will stay longer and because a day-care center will operate there), and a lavatory. The lavatory should include a minimum of four sinks, three urinals, three toilets (with partitions), and three showers.

Furnishings should be simple and plain. Each guest should have a bed, locker, and chair. Towels and sheets can be supplied by a commercial laundry. The Shelter must have a supply of folding chairs, soap, and razors, newspapers, current magazines, books, small table games, appropriate office equipment including a typewriter, and a cabinet for medications. A soft drink machine and adequate supplies of coffee and snacks are necessary. So, too, are appropriate janitorial supplies and one rented station wagon. A washer and dryer are essential for cleaning clients' clothing and a supply of pajamas and slippers will be necessary.

6. Costs of the Shelter*

Personnel	
Salaries	$ 84,000
Fringe Benefits†	10,080
Insurance	1,200
Accounting Fees	1,000
Legal Fees	250
Laundry	800
Food	9,000
Utilities	
Telephone	500
Heat	800
Light	700
Maintenance and Repairs	1,000
Sundries (razors, etc.)	300
Rental of Station Wagon	2,000
	$111,630

*Does not include capital costs (improvement or purchases of plant and equipment) or rental fees.

†12% of salaries.

7. Problems to Anticipate

The Shelter will encounter some resistance from those living and/or working in the neighborhood in which it will be located, despite the fact that neighborhood conditions will be improved by the Shelter. Thus, it will be necessary to avoid publicity about the location until after the program has begun. Efforts to discuss the issue with those in the neighborhood prior to moving in usually produce poor results. It will help to do as much purchasing as possible with neighborhood businesses. Other means of reaching out which were discussed in Chapter IV (No. 7) also apply to the Shelter.

It will be necessary to establish regulations for clients (no drinking in the facility, no grouping outside, etc.).

A policy of improving or maintaining the physical ap-

pearance of the interior and exterior of the plant will have many positive effects, including the improvement of neighborhood attitudes and staff morale. As with MESAD, do not learn to tolerate a deteriorated plant.

Avoid idleness on the part of guests and cynicism on the part of staff. The client's tendency to avoid help and his failure to stop drinking may produce cynical, sometimes depressing reactions on the part of staff. Being sensitive to such reactions and allowing time for ventilation at staff meetings or in informal settings will be helpful.

V

FOOTNOTES

1. In Shelters studied by our project staff, the length of stay varied. At the East End Hotel in Baltimore, each resident signs a monthly lease, although there is no limit on the length of stay. If the resident leaves, his room is held for him until the end of the current month. Referrals are accepted only from medically oriented alcoholism programs (state mental hospitals, general hospitals, psychiatric clinics, etc.) in order to avoid admission of residents with communicable diseases, or others who may need medical or psychiatric care that the Shelter cannot provide. In the soon-to-be-revised Terrace House in Buffalo, New York, a client there is officially discharged after one night although he may apply for readmission the next day. At Erie's Crossroads Center, no formal policy seems to exist as to length of stay, but the average client stay in a recent study was shown to be 26.8 continuous days (Weis, "Alcoholism and Alcohol Abuse in Erie," unpublished manuscript).
2. The most helpful form of knowledge will be familiarity with community resources. Through formal training programs or other types of orientation, the staff should learn the names, locations, procedures, and functions of potentially helpful health, welfare, vocational, and other helping agencies. A wide variety of agencies offering specialized, sometimes fragmented, services makes this a difficult task, but most communities have a health and welfare council or some such agency affiliated with the United Fund which publishes a directory of these services.
3. A central record keeping system will be maintained at the coordinator's office. Prior to completing lengthy intake forms, the staff will contact the coordinator's office to learn if such has already been completed.
4. While the author has not recommended such in this paper, a strong case can be presented for combining the MESAD Center and the Shelter. (To some degree, Crossroads Center in Erie, Pennsylvania, has done this.) The same clientele are involved frequently in both, and clients needing shelter often need medical evaluation and sometimes treatment as well. Both facilities should be located in or near skid row and both would have to meet similar zoning, health, and fire regulations. Nevertheless, some distinctions exist as well. MESAD deals with illness and therefore takes on a decidedly medical orientation; Shelter does not. Most MESAD clients will be alcoholics; Shelter clients will include any homeless man.

CHAPTER VI

INTERMEDIATE CARE

For those communities desiring to go beyond just detoxification and shelter care, the following three chapters describe services aimed at longer-range treatment and rehabilitation. The first is the Intermediate Care Service which combines environment manipulation with structured, relatively intensive therapeutic activities of many types to help the public inebriate overcome a primary problem of alcoholism. While many public inebriates may be inappropriate candidates for such care due to the demands of the intensive program, others will prefer this type of treatment and overcome their own mechanisms of defense and denial. This will especially be the case with clients whose underlying personality is relatively intact, that is, those clients who function well when not drinking. Intermediate care emphasizes the therapuetic service, not simply management of clients.

1. Program of Intermediate Care Service

The program at the Intermediate Care Service will combine a non-judgmental, warm, accepting blend of modern mental health treatment therapies, especially the Reality Therapy Model, and the program of Alcoholics Anonymous.[1] Treatment will be primarily of the small group variety with each new guest assigned to one of several groups led by a professional therapist knowledgeable about addictions and skillful in therapeutic confrontation. This group therapist will meet with his group for two two-hour sessions daily and will serve as well as a rotating instructor, along with the nurse, in the evening didactic classes open to the whole guest population and centering around (in part) the philosophy of Alcoholics Anonymous. Films on alcoholism will be included in the didactic classes.

Each guest will also be assigned to a "monitor" (counselor), that is, an individual with experience in alcoholism, who will serve as the primary support giver and provide a liaison between the program and the guest and who will also be responsible for psycho-social history procurement, the coordination of the alcoholic individual with the program, discharge planning, and necessary referrals, (including referrals to specific Alcoholics Anonymous groups, an Aftercare resource, and/or a Community Residential Living Facility, such as the three-quarter-way house). Attempts will be made to plan discharge carefully with special emphasis on job finding.

Each guest will participate in regularly scheduled recreational therapy, some structured, which will include billiards, ping pong, exercises, hiking, and table games. Housekeeping will be mandatory, with each guest assigned a specific task on a weekly basis, in addition to the individual maintenance of his room.

Approximately three Alcoholics Anonymous meetings will be scheduled weekly, to be held alternately with the didactic classes. The treatment day will terminate with a generous snack of sandwiches, condiments, ice cream and nonalcoholic beverages.

Occupational therapy, that is, participation in upkeep of the plant and carrying out of essential chores, is an essential part of the treatment. Generally, guests like being involved.

Medication will not be considered a part of the treatment modality since acute symptoms will have previously been treated, and because the implied goal of the program is to help the individual adjust to anxiety without chemical agents. It may be occasionally necessary, however, to recommend psychotrophic drugs or Antabuse[2] on an outpatient basis following discharge from the Intermediate Care Service.

Professional staff may also carry on family counseling where appropriate and encourage Alanon involvement. Alanon is a supportive program similar to A.A. but oriented to spouses and other members of the families of alcoholics, both recovering and otherwise.

Typical Program Schedule

7:00 - 7:45 a.m.	Breakfast—Lounge
8:00 - 10:00 a.m.	Therapy Group
10:15 - 12:00 Noon	Work Assignments
12:15 - 1:00 p.m.	Lunch - Lounge
1:15 - 3:15 p.m.	Therapy Group
3:30 - 4:45 p.m.	Structured Recreation, Monitor Appointments
5:00 - 6:00 p.m.	Dinner—Lounge
6:15 - 8:15 p.m.	Didactic Class or A.A. Meeting
8:30 - 9:30 p.m.	Unstructured Recreation
9:45 - 10:30 p.m.	Snacks, Informal Discussion—Lounge

2. Staffing the Intermediate Care Service

As is the case in the MESAD and Shelter, an attempt will be made to surround the alcoholic client with as many recovering alcoholics as possible. Unlike the two previously mentioned programs, however, professional therapists will occupy many positions at the I.C.S.

Model Staffing Pattern of the Intermediate Care Service

Facility: 20-Bed Center (generally appropriate for most communities of 200,000-300,000 population).

Staff:

Manager (resides in center)	$ 9,000
Director of Treatment (MSW Social Worker)	15,000

Registered Nurse	8,000
Industrial-Recreational Therapist (non-degreed)	7,000
Counselors — Monitors (4)	7,000
Attendants (4)	6,000
Cook (3)	7,000
Typist	5,000
Psychologist (consulting) 4 hrs./wk.	3,000
	$120,000

Staff Functions:

All staff of the Intermediate Care Service will be ultimately accountable to the manager. The manager will assume responsibility for the general operation of the I.C.S., including staffing functions, financial supervision, and plant upkeep.

The director of treatment assumes responsibility for treatment, including the formation of treatment plans, the carrying out of therapy, and appropriate discharge planning. Aiding in these efforts will be the counselors-monitors who are supervised by the D.O.T. and who, more than any other staff person, will maintain intensive contacts with clients. The nurse is also accountable to the D.O.T. and will provide medical in-put, some therapy, and supervise any medication (non-psychotrophic) which guests must take. The industrial-recreational therapist assumes recreation responsibilities, including provision and maintenance of appropriate supplies, scheduling of organized recreation, and individualization of recreational activities. Furthermore, he will assume responsibility for assigning clients to housekeeping chores including minor repairs. Attendants will perform miscellaneous functions, including night supervision, transportation, and repair. The typist will handle all correspondence, mail, filing, typing, as well as the telephone.

3. Relationship of I.C.S. to Other Diversionary and Community Services

The I.C.S. will be recognized as an intensive treatment center for detoxified public inebriates. Thus it will rarely accept clients unless they have been screened by MESAD or some other screening facility. In no instance will intoxicated alcoholics be admitted, but rather will be referred to MESAD. Most referrals to I.C.S. will come from MESAD or in some cases from the Shelter. Police will maintain minimal contact with I.C.S., but courts coming in contact with public inebriates who have committed no victim-centered crime may wish to suspend sentences in view of the client's sincere request for help with alcoholism and his desire to participate in the I.C.S. (See "Court Counselor," Chapter XI.)

Following treatment at I.C.S. (minimum: 60 days), clients may often be referred to one of the C.R.L.F., or if other residency is available, to some Aftercare resource.

4. Location

The Intermediate Care Service will ideally be located in a semi-rural or rural setting, away from the urban environment, in a tranquil, relaxed setting. The setting will represent one which encourages self reflection and a temporary respite from the overwhelming environmental pressures of the resourceless alcoholic.

5. Plant and Equipment

The I.C.S. will occupy a relatively humble plant, one that will not overwhelm the client but does appear inviting and relaxing. Total square footage will approximate 3,500 with provisions for semi-private bedrooms with no more than three to a room. Grounds will be spacious. The I.C.S. plant will allow for a dining room, a kitchen, and a lounge, plus approximately ten bedrooms. At least two bathrooms with a total of four showers, four toilets, four urinals, and four wash basins are recommended. Offices for the manager, D.O.T., industrial-recreational therapist and space for at least two interviewing rooms and a conference room will be required.

Equipment must include a supply of folding chairs, a movie projector, appropriate kitchen and maintenance utensils, television, reading material, office equipment and supplies, a blackboard, and other equipment described earlier.

6. Costs of the Intermediate Care Service*

Personnel	
Salaries	$120,000
Fringe Benefits†	14,400
Insurance	1,700
Legal Fees	500
Accounting Fees	2,000
Laundry	1,000
Food	20,000
Utilities	
Telephone	1,000
Heat	1,600
Light	1,400
Maintenance and Repair	2,500
Sundries (razors, etc.)	500
Transportation (station wagon)	4,000
Literature — Pamphlets	200
Office Expenses (stationery, postage, etc.)	2,000
	$172,800

*Does not include capital (improvement or purchases of plant and equipment) or rental fees.

†12% of salaries.

7. Anticipating Problems

The treatment program of the I.C.S. would be seriously limited by any consumption of alcoholic beverages or non-prescribed drugs. Consequently, the need for security in this regard is most essential. Visitors must be advised of this restriction, and clients given passes must show to staff

they possess no such beverage or chemicals upon returning. Over-the-counter drugs must also be supervised.

Clear formation of treatment goals and objectives is necessary to avoid carrying out functions of other diversionary programs, (e.g., boarding homes or Shelters). This major concern must characterize all programs in the comprehensive public inebriate plan.

Problems may arise when degreed professionals are accountable to non-degreed professionals, i.e. the manager. This type of problem may be avoided by clearly establishing the necessity for this accountability. The manager must be recognized as a professional although he may not have a degree. Without clear authority and the recognition by the I.C.S. staff that he has the capacity to make all decisions established by board policy and the directives of the coordinator, lack of direction may result.

VI

FOOTNOTES

1. This treatment philosophy is based, to a considerable degree, on the program of Gateway Rehabilitation Center, Aliquippa, Pennsylvania (near Pittsburgh).
2. Antabuse (Ayerst) is a "deterrent" drug to the use of alcoholic beverages. It causes extreme discomfort if the patient drinks alcohol while using such a drug. Its primary advantage is limiting the number of times during one day that the alcoholic must make the decision not to drink. When he chooses to take Antabuse in the morning, he no longer can drink that day. Usual dosage is ¼ to ½ tablet/day.

CHAPTER VII

COMMUNITY RESIDENTIAL LIVING FACILITIES

A review of the scope of Community Residental Living Facilities can be made by referring to the Introduction of this report.[1] As was suggested earlier, the Community Residential Living Facilities differ from the Shelter primarily at the point at which each accepts clients: the Shelter at any time a homeless man requires a roof over his head; the C.R.L.F. only when the potential client suffers from a drinking problem, has achieved through institutionalization (Shelter, Intermediate Care, etc.) a period of sobriety, and indicates an interest in improved social functioning. Nevertheless, such a client requires the support a residential program provides. The Community Residential Living Facilities are home-like; the Shelter is dormitory style. The former is limited to problem drinkers; the latter is open to any man requiring a roof, food, and clothing. While the types of C.R.L.F. may vary in given communities, we have chosen to emphasize two:

(a) Half-Way Houses — where considerable supervision, rules, structure, and program characterize the facility; this may be a rented or purchased facility.

(b) Three-Quarter-Way House(s) — where no in-house organized program exists but instead use is made of the Half-Way House program, Alcoholics Anonymous meetings, or occasionally other community resources. The number of Three-Quarter-Way Houses should remain flexible and be dependent on the need, and as we will describe, this is the least costly and least complex of all facilities. The guests of Three-Quarter-Way Houses pay for their own room and board, and ownership may lie with a private party. The two types of C.R.L.F. should be viewed as long-term. A client may stay for as long as is necessary; he may even reside there permanently if such residence improves his functioning. This is unlike MESAD, Shelter, and Intermediate Care.

1. Program of the Community Residential Living Facilities

The primary therapy in these extended care facilities where length of stay will range from three months to several years, will be that of milieu therapy, That is, the group support will provide encouragement and reinforcement of the desire to avoid drinking. However, the following services will be supplemental:

A. Once weekly in-house meetings of Alcoholics Anonymous, preferably with participation by community A.A. members; and at least one community A.A. meeting.

B. Non-intensive, twice weekly group discussions aimed at reality issues.

C. Individual casework carried out by the social worker, again focused on reality issues. This might involve family members who might also be encouraged to use Alanon.

D. Job placement, perhaps with assistance of community resources. The supportive elements of C.R.L.F. will call for considerable assistance from community agencies to aid the client's adjustment. The help of employment vocational agencies such as the Bureau of Employment Security, Bureau of Vocational Rehabilitation, and private training programs like Opportunities Industrialization Center, will take on some importance.[2] With individuals unable to work in the competitive market, attempts will be made to involve them in productive volunteer efforts. Thus agencies like the Volunteer Coordination Agency will be used.

E. Industrial therapy, that is, the manager will assign to each resident a specific task for house maintenance in addition to maintaing his own room.

F. Limit setting, by enforcing a policy of no drinking as a condition of maintaining residency at C.R.L.F. To aid the resident in this regard, Antabuse may be recommended.[3]

G. Recreation, including one organized recreational program each week.[4]

The procedure will be somewhat as follows: A client who is progressing well in another program, such as Shelter or Intermediate Care, requests and/or is encouraged to seek residency in a supportive, home-like environment. Depending on the stability of his sobriety, a choice is made to place him in one of the two types of facilities. Should he be placed at the Half-Way House, he is accompanied to that facility where he meets the other residents and the staff, who as a group welcome him and discuss the rules he will be expected to follow. Eventually he meets privately with the social worker who explores his needs, and together they arrive at treatment plans. This might include involvement in all house programs, appointments at the employment bureau, and regularly scheduled casework interviews. He is eventually introduced to his recovering alcoholic roommate, to whom he can turn for any help and who — he is told — will serve as his advocate and supervisor.

If all goes well after six months or so, the client may request "graduation" to the Three-Quarter-Way House where more autonomy can be had.

2. Staffing the Community Residential Living Facilities

All paid staff assigned to C.R.L.F. will work from the Half-Way House. An unpaid "monitor" will assume supervisory responsibilities at the Three-Quarter-Way House(s). With the one exception of the social worker, all staff can be non-degreed recovering alcoholics.

Model Staffing Pattern of the Community Residential Living Facilities

Facilities: 15-Bed Half-Way House with Additional Three-Quarter-Way Houses as Needed (generally appropriate for most communities of 200,000-300,000 population, providing both facilities exist).

Staff:

Manager of Half-Way House (resides in)	$10,000
Cook (2—one resides in)	7,000
Social Worker (three-fourths time)	9,000
	$33,000

Staff Functions:

The manager will assume overall responsibility for total plant and program operation, including the maintenance of the plant, rules supervision, scheduling of staff, and handling of finances. The cooks will prepare all meals, with the first serving as primary cook, and the second on weekends and special occasions. The social worker's functions include general supervision of the guests' treatment, assigning of fellow guests for orientation and aiding of clients, leading discussion groups, and casework as needed, both for Half-Way House and Three-Quarter-Way House guests, as well as any Aftercare clients. As was suggested, veteran residents will participate as "therapists" in accompanying new guests to A.A. meetings, serving as friends, etc. One guest in each Three-Quarter-Way House will serve as the monitor of fellow guests in these boarding home-style facilities, and report to the social worker on their progress.

3. Relationship of C.R.L.F. to Other Diversionary and Community Services

Intake to C.R.L.F. is open only to those who have proceeded through an extended period of treatment (at any of the other services mentioned) and have maintained a period of sobriety. It is expected that most referrals will come from the Shelter and the I.C.S. While the relationship between the police and C.R.L.F. will be minimal, the courts may occasionally refer in lieu of sentences, and C.R.L.F. will serve as a resource for motivated alcoholic prison inmates about to be released. Because of the period of observation needed before placement to C.R.L.F., few referrals will be accepted directly from the community at large.

The C.R.L.F. will make considerable use of community resources, however, especially vocational, employment, and legal aids.

4. Location of C.R.L.F.

Both types of facilities will be located in a residential neighborhood, preferably low middle-income or upper low-income so as not to overwhelm the clients.[5] Obvious advantages will exist if the homes are close to each other.

5. Plant and Equipment

An older, brick, multi-floor structure would be ideal for the Half-Way House, offering approximately 2,500 square feet of living area. A minimum of five bedrooms plus one for the manager will be necessary, as will two bathrooms with multiple installation of toilets, basins, and showers. A large kitchen, dining room, and living room-lounge will be necessary, as well as an office for the social worker. The usual furnishings in a private home will be necessary but in greater amounts, and recreational equipment will be needed. (The basement may be finished by guests as occupational therapy and hold ping pong and/or pool tables, checker boards, etc.) A station wagon will also be required for transportation to outside meetings, the purchase of groceries and supplies, the movement of men to other facilities, etc.

6. Costs of the Half-Way House*

Personnel	
Salaries	$33,000
Fringes†	3,960
Insurance	750
Legal Fees	250
Accounting Fees	500
Food	8,000
Utilities	
Telephone	300
Heat	1,000
Light	1,000
Maintenance and Repairs	1,000
Sundries (razors, etc.)	100
Rental of Station Wagon	2,000
	$51,860

*No costs are anticipated for Three-Quarter-Way Houses. They should be rented (partially or completely) and supported by the guests. Does not include capital costs (improvement or purchases of plant and equipment) or rental fees.

†12% of Salaries.

7. Anticipating Problems

Establishment of the residental programs in the neighborhood will result in the same problems as those connected with the Shelter and Detoxification Center, but in a greater degree. Neighbors may develop paranoid-like reactions to the prospect that an "alcoholic home" is being established. The most effective method of dealing with such reactions is not to publicize the program until after it is established, and to maintain pleasant grounds and a home full of sober men. As suggested earlier, it would be wise to invite neighbors in occasionally, perhaps even consider inviting some for Board membership.

Problems may arise if guests do not feel some sense of ownership in the facility, or at least some power to effect policy. Consideration might be given to forming a residents' council, that is, three or four members selected by the guests to suggest policy, to enforce discipline, and to deal with home problems.

VII

FOOTNOTES

1. Many experts feel that the ultimate hope for rehabilitation of skid-row alcoholics lies with the provision of community residential living facilities. This concept is based on the premise that a semi-institutional, supportive care program on a near-permanent basis is necessary for adequate social functioning for the average skid-row man. Several agencies throughout the country, both in the areas of alcoholism and mental health, have provided the simple service of locating available private boarding homes or rentals with vacancies and directing appropriate clients to them. Clients so referred maintain contact with the agency and usually participate in its treatment program.
2. Many prominent members of A.A. may be in managerial or executive positions or own their own businesses, and therefore could serve as excellent resources for employment.
3. Serenity Hall, a half-way house, sponsors one organized recreational program each week. Most events take place in a converted part of the basement set aside for recreational purposes and equipped with pool tables, bowling games, shuffleboard, etc. Practical prizes are always included and involvement is usually quite spontaneous.
4. Excellent examples of appropriate locations and plants of a half-way house are (1) "The Home," a 20-bed largely A.A. oriented facility in Alexandria, Virginia. This residence is being purchased. The residents are expected to stay 90 days and pay their own way after a 10-day orientation period. Following the 90 days, residents must leave. (2) Serenity Hall, a 15-bed facility in Erie, Pennsylvania, is a sister agency of Crossroads Center, and uses a variety of treatment modalities while encouraging long-term stay for the guests.

CHAPTER VIII

AFTERCARE

For clients who have been involved in one or more of the previously described diversionary-rehabilitative services but who returned to autonomous community living, treatment will continue on an Aftercare-out-patient basis. The staff in the coordinator's office will accept responsibility for following such clients and aggressively encouraging Aftercare, but the actual program will take place in one of the services previously discussed. Exactly which service provides the client's aftercare is a decision that rests largely with the client. Presumably, he will return to that facility with which he is most comfortable.

1. Program

Clients will involve themselves in established programs of the particular service or services to which they chose to return. One would expect that most would include Alcoholics Anonymous meetings at particular facilities or in other community locales. The major Aftercare rehabilitative means will be the group support provided by the peers of the client, no matter where he chooses to meet them. It is expected that others will choose group discussion or group therapy, others casework, some may follow-up with the physician, and still others perhaps with Antabuse. Furthermore, Aftercare may be provided in non-alcoholism oriented programs, such as family therapy at a social agency, pastoral counseling, or a mental health resource.

2. Staffing and Costs of Aftercare Services

One staff member working from the coordinator's office will assume "tracking" functions. That is, he will attempt to follow all the clients who have had contact with any service in the comprehensive public inebriate plan and assure that some follow-up is being provided. For clients unwilling to follow-up, records will be kept on their location and regular follow-up visits will be made. The Aftercare worker will receive from the participating services a summary of all client contacts, especially admissions and discharges.

Staff of Aftercare

Aftercare Counselor	$8,000
Fringe Benefits	960
	$8,960*

*Additional costs will be assumed by the coordinator's office (office, typist, transportation, etc.).

Staff Functions

The Aftercare counselor will work from the coordinator's office, which, as we will see, can be located in a separate facility or within a previously described facility, providing space is available. Outside of office supplies and furniture and the occasional use of the coordinator's car, little else is required. The primary criterion of Aftercare success will be the persistence and thoroughness of the Aftercare counselor.

CHAPTER IX

WOMEN'S HOME

The previously discussed services apply to the male public inebriate. This is not inappropriate, since men are most often associated with the panhandling life of the streets and the drinking, filth, and occasional violence that accompanies it. But the female derelict exists as well, and she, too, needs aid and improved opportunities.[1] While all experts agree that the problem of the female public inebriate or skid-row person represents a much less serious concern vis-a-vis the male, nevertheless she is a problem in every locale we visited. Frequently, she may not be literally homeless since she can and often does make a home with any man who will keep her supplied with alcohol. With the exception of homelessness, however, she usually suffers from all the problems of the male inebriate, and occasionally has additional problems, (e.g., jobs are more difficult for her to secure). In New York City, approximately 1,800 women were admitted to the Shelter Care for Women in 1972.[2] In much smaller Erie, Pennsylvania, an average of 35 females were actually arrested for public drunkenness in past years and many more came to the attention of the police but were handled without booking.

The relatively small number of female public inebriates does not justify an equal system of services, however, and because no model exists upon which to base a program,[3] the author suggests one residency or home that combines many of the functions provided by all the services described previously for men. This "Women's Home" will be described, then, using the seven categories which were applied to the various men's services.

1. Program of the Women's Home

Both drinking and non-drinking women will be served by the Women's Home. Medical evaluation, subacute detoxification, shelter, and long-term residency will be provided by this facility. A physician will visit the home as needed, but the Women's Home will maintain close contacts with established medical facilities (either hospital emergency rooms or MESAD) for much of its medical care. If acute symptoms are not present, the client will probably be returned to the Women's Home in a "first nighter's" room where the program will be similar to that of MESAD until physical recovery is attained (see No. 1, Chapter IV). When treatment for withdrawal has been completed and an on-going treatment plan has been formulated, the client will be aided in continuing her rehabilitation. Such might include an invitation to stay at the Women's Home in the status of "guest," whereby all the services provided to clients in the Shelter (see Chapter V) will be accorded her. She will participate in a weekly Alcoholics Anonymous meeting held in the Women's Home, in recreational activities, in therapy run by a social worker, and in all the other activities, including group dining. She may continue drinking, however, but not in the home. Like the Shelter, if she follows house rules while in the Women's Home, all basic needs will be met.

Should the client indicate a desire for rehabilitation, however, and a period of residency in the status of "guest" gives some evidence of this motivation, she may be offered a referral to the Intermediate Care Service (which is integrated—see Chapter VI) or invited to stay at the Women's Home in the status of "resident." The latter would involve her moving to a more attractive room in the home and other rewards as well; e.g., liberty to decorate and arrange her room, employment in the operation of the home, provision of gift certificates (which might be donated) for purchasing her own clothing, and membership in the "residents' club," which could plan outings or possibly special "in-house" activites. As a "resident" her pattern of living would resemble that of a resident in the previously described Half-Way House (see Chapter VII).

The Women's Home as described above would be a unique program offering challenges and problems (see 7 below). Obviously it must prove itself, but the concept has met with considerable approval from some experts with whom the author has met. Mrs. Gertrude Nillsson of the Division of Alcoholism Control, Maryland State Department of Health and Mental Hygiene, adds this comment: "I suspect that the needs of alcoholic women will not be clear to us until a system has been established for men. Only then will we find out the numbers of women and their needs."

3. Staffing the Women's Home

Staff for the Women's Home will be largely female and when possible should involve recovering alcoholics.

Model StaffingPattern of the Women's Home

Facility: 15-Bed Center (based on the estimated need for most communities of 200,000-300,000 population. Includes approximately seven "resident beds," six "guest" beds, and two "first nighter" beds).

Staff:

Manager (resides in the center)	$10,000
Physician (one-quarter time)	7,500
Corpswomen (6)	6,000
Attendants (residents hired as needed)	5,000
Cook (2)	7,000
Social Worker (one-quarter time)	3,000
	$75,500

These positions will resemble those same positions described earlier under part 2 of Chapters IV and VII.

3. Relation of the Women's Home to Other Diversionary and Community Services

The Women's Home will receive many of its referrals from other services of the comprehensive public inebriate program, especially from MESAD through its "pick-up" team. Intermediate Care Service may refer women for community residency to the Women's Home, and a variety of community agencies, especially Public Assistance, will use the facility for female clients. As is true of the male services, the staff of the Women's Home will complement the program by using community resources when client needs make such appropriate. These will include public assistance, legal aid, and various employment programs. It is expected that little direct contact will be had between law enforcement agencies and the Women's Home.

4. Location

The Women's Home will be located in a low-income residential neighborhood within the inner city, ideally near a community hospital.

5. Plant and Equipment

The Women's Home should be a residential building. An older brick home is visualized, somewhat like the Half-Way House (see No. 5, Chapter VII), approximating 2,500 total square feet. Several levels should offer a segregated private area for "residents," a private bedroom for the manager, and three semi-private bedrooms as well as two bathrooms; there should be a large room containing six "guest" beds and nearby two small "first nighter" rooms, along with another bathroom. Like MESAD, a small clinic room with a locked cabinet for drugs will be necessary along with other appropriate medical supplies. The rest of the facility should resemble that of the Half-Way House and include similar equipment. Additions might include a sewing machine, knitting equipment, and other feminine supplies.

6. Costs of the Women's Home*

Personnel	
Salaries	$75,500
Fringes†	9,060
Insurance	750
Legal Fees	250
Accounting Fees	500
Food	8,000
Utilities	
Telephone	300
Heat	1,000
Light	1,000
Maintenance and Repairs	1,000
Sundries	100
Rental of Station Wagon	2,000
	$99,460

*Does not include capital costs (improvement or purchase of plant and equipment) or rental fees.

†12% of Salaries.

7. Anticipating Problems

Because experience with programming for female residents of skid row is minimal, the number of clients is difficult to estimate. Even more than the men's services, it will be necessary to initiate the program conservatively with the option of growing. The availability of such a resource, however, may very well bring hidden female residents of skid row and other female alcoholics out into the open.

Combining recovering alcoholics and unrecovered alcoholics in the same facility may provoke undesired reactions in the former, for the chronic failure may be depressing to the recovering alcoholic. It seems wise, then, to maintain a majority of recovering, stable alcoholics. This will happen if the beds and staff suggested are adopted. Considerable integration of "residents" and other recovering alcoholics is also recommended. (Community Alcoholics Anonymous meetings provide excellent opportunities for such integration, as might combined programs of C.R.L.F. and "residents" of the Women's Home.)

The frustrations recovering alcoholics or non-alcoholics feel in contacts with the still-drinking alcoholic may lead to a punitive reaction in which even basic needs such as shelter, food, and sanitary facilities are refused. This is more likely to occur when the two groups are integrated. It will be necessary to stress "acceptance" of all clients whereby certain services are guaranteed for female clients despite continued drinking. In this respect, the Women's Home resembles the Shelter in which clients are given basic services such as a bed, food, etc. even though they have not accepted the need for abstention. If the number of chronic failures warranted such, consideration might have to be given to separate facilities as we proposed for male public inebriates.

IX
FOOTNOTES

1. "Woman Adrift: She Too Needs a Place to Stay," Judy Klemesrud, *New York Times*, December 5, 1972, p. 56.
2. See footnote 1.
3. A number of communities are considering formal programs for woman public inebriates, including the Open Door in Annapolis, Maryland, and the Diagnostic and Rehabilitation Center in Philadelphia, Pennsylvania. At the time of this writing, however, no formal program existed.

CHAPTER X
EVALUATION AND RESEARCH

An evaluation and research service cannot be considered directly diversionary, that is, its establishment will not have an immediate impact on relieving law enforcement personnel of responsibility for the public inebriate; and therefore, should not be considered a priority. Nevertheless, "Research and evaluation are not dirty words! This field lacks so much information and hard data that we all have a special responsiblity to look at what we are doing and share it with others."[1] Furthermore, effective programming calls for the constant ascertaining of the value of specific services. Such evaluation, if practical and realistic, ". . . becomes the basis for change, re-orientation, and further development of alcoholism services within the total community health and welfare system."[2]

Evaluation of the program should be built into the system of services so as to determine the effectiveness of services and the need for improvements. Needed information dealing with the program's effects on the clients and the community, including its role in diversion, is directly pragmatic in securing additional funding and justifying a program's existence.

> "The effectiveness of services may be assessed when data are available concerning the kinds and the volume of services which are being provided. Services may be related to cost. Information may be gathered which indicates the kinds of patients or clients who are receiving services, referral sources, presenting problems at referral and the relationship of need to availability of services. The effects of individual treatment when treatment goals have been established may indicate the need to develop or modify existing treatment methods."[3]

1. Program of Evaluation and Research

A model of program evaluation is that offered in the final evaluation report of the St. Louis Detoxification Center as submitted to the Law Enforcement Assistance Administration.[4] Basically, this evaluation report focused on two general concerns:

A. *Macroscopic* — To learn what impact the program has made on these criminal justice agencies traditionally assigned with the responsibility for public inebriates, i.e. lock-ups, jails, courts, and probation offices; as well as on other community institutions; e.g. impact on community hospitals, public assistance, etc. This can be translated in dollar terms and improvement in the effectiveness of those community services. It might be carried out on a before-after basis, e.g. comparison of arrests for public drunkenness in a year prior to the establishment of the program with the number of arrests following the establishment of the service.

B. *Microscopic* — To learn what impact the program has made on individuals involved in the program (clients). This can be carried out by randomly selecting a given number of intake forms of the clients (see Appendix C) sixty to ninety days following their admission to a service and attempting a follow-up study with the purpose of assessing the degree of progress or regression. The investigation will include such items as the quantity of drinking, the ability to hold employment, the number of arrests, and other variables that can be measured individually on a before-after basis. Note that the St. Louis study avoided establishing as a criterion of success the rather rigid and unrealistic criterion of sobriety or insobriety, but rather focused on how well, or how much better, the individual client coped with his problems. An assumption is made that the rigors of the scientific approach to evaluation will be adopted.

More general research may focus on many concerns, and indeed it has. A number of government publications available review both published and unpublished research projects focusing on alcoholism concerns and such journals as the *Quarterly Journal on Alcohol Studies* are heavily research oriented. In addition, the National Institute on Alcohol Abuse and Alcoholism will provide valuable findings through its "Current Awareness Service" (N.I.A.A.A. Clearinghouse for Alcohol Information, P. O. Box 2345, Rockville, Maryland 20852). A disciplined review of current research findings is considered a necessary requirement of research staff as ". . . the ideal researcher is one who is familiar with action programs and yet maintains enough objectivity and perspective to conduct studies fairly and realistically."[5]

2. Staffing the Evaluation and Research Service

It was suggested earlier that evaluation and research be built into the service program at its commencement so that needed information is routinely recorded and gathered. In addition, research may be based on planned, short-term studies ". . . which are intended to provide specific answers to specific questions necessary for program planning and assessment."[6] These studies will require the employment of specific staff charged with only evaluation and research functions. We envision a Ph.D. level person with a social science background, trained in research methodology, and assisted by a B.A. or Masters level person with some familiarity with research and some desire to learn more.

Model Staffing Pattern of the Evaluation and Research Component

(To serve all services in the Comprehensive Public Inebriate Program)

Staff:

Director of Research	$20,000
Research Assistant	8,000
	$28,000

Staff Functions:

General responsibilities have been previously described but in addition, such staff will work closely with service managers to develop appropriate intake forms so that essential data is available; with community statisticians such as those in municipal police departments and hospitals to coordinate exchange of data; and with the coordinator to explore specific areas of evaluation and research concern, as well as to aid in completion of grant applications.

3. Miscellaneous

The Evaluation and Research component will maintain constant contacts with all elements of the comprehensive program as well as with those community groups discussed previously. It will be located in the office of the coordinator. Special emphasis will be given to hiring the staff early, not after program has been commenced and patterns established. See Footnote 7 for library references on "Evaluative Research."

X

FOOTNOTES

1. Irving Shandler, "Alcoholics of Special Community Concern," *The Williamsburg Papers*, N.I.M.H., 1970, p. 33.
2. "Developing Community Services for Alcoholics: Some Beginning Principles," National Institute of Mental Health, Rockville, Md., 1971, p. 32.
3. See footnote 2.
4. "L.E.A.A. Project Report: Final Evaluation Report of the St. Louis Detoxification and Diagnostic Evaluation Center," U.S. Government Printing Office, Washington, D.C., 1970.
5. Irving Shandler, "Alcoholics of Special Community Concern," *The Williamsburg Papers*, N.I.M.H., 1970, p. 33.
6. See footnote 2.
7. Excellent texts on evaluative research include Edward A. Suchman, *Evaluative Research*, Russell Sage Foundation, N.Y., 1967; Carol H. Weiss, *Evaluative Research: Methods for Assessing Program Effectiveness*, Prentice Hall, Englewood Cliffs, N.J., 1972; U.S. National Advisory Mental Health Council (H.E.W.) *Evaluation in Mental Health*, Washington, D.C.; 1955.

CHAPTER XI

COORDINATION AND ADMINISTRATION

The variety of services described thus far will achieve their full effectiveness as a mutually cooperating, mutually complementing system only when all services are to some degree accountable to one, central authority. Depending on the particular means a community uses to establish this Comprehensive Public Inebriate Program (e.g. all services sponsored by one agency, or some through contract with other agencies), the coordinator will have varying degrees of authority. But to serve effectively he must maintain direct control over the finances which pay for most program costs. The coordinator, then, will be hired by any agency which serves as primary applicant to N.I.A.A.A. for funding (see Chapter III). We envision, therefore, a community service network that is to a considerable degree administered by one person. If, as was suggested in the presuppositions, all service elements are directly sponsored by one agency, then the coordinator would work for that agency's board and administer all services with service managers directly accountable to him. The illustration on the following page indicates the line of authority envisioned along with additional positions needed to carry out liaison and administrative tasks. If any service elements were to be purchased or otherwise secured under contract with a separate, autonomous agency rather than provided directly, then the heavy lines would be replaced by dotted lines indicating accountability, but also more autonomy by the service units. Should it be that the sponsoring agency is governmental (e.g. a Department of Health, or a general alcoholism or addictions agency), then the only necessary changes would be replacement of the board by the appropriate government agency and changing the coordinator's position to that of an official of that agency.

What is essential is that one authority who has sufficient power to provide direction and to demand accountability be included in the comprehensive diversionary-rehabilitation program. ". . . He needs a streamlined organization where a direct flow of responsibility will make possible a hard hitting and effective program."[1] Too many communities have suffered from diffused authority and uncompromising vested interests. One of the most effective means of securing cooperation and providing meaningful power to effect needed change is money. One of the characteristics of many governmental bodies is the provision of this money to allow such necessary authority. The coordinator, acting on behalf of his board, should be the key dispenser of this money.

1. Program, Staff and Community Liaison of Coordination

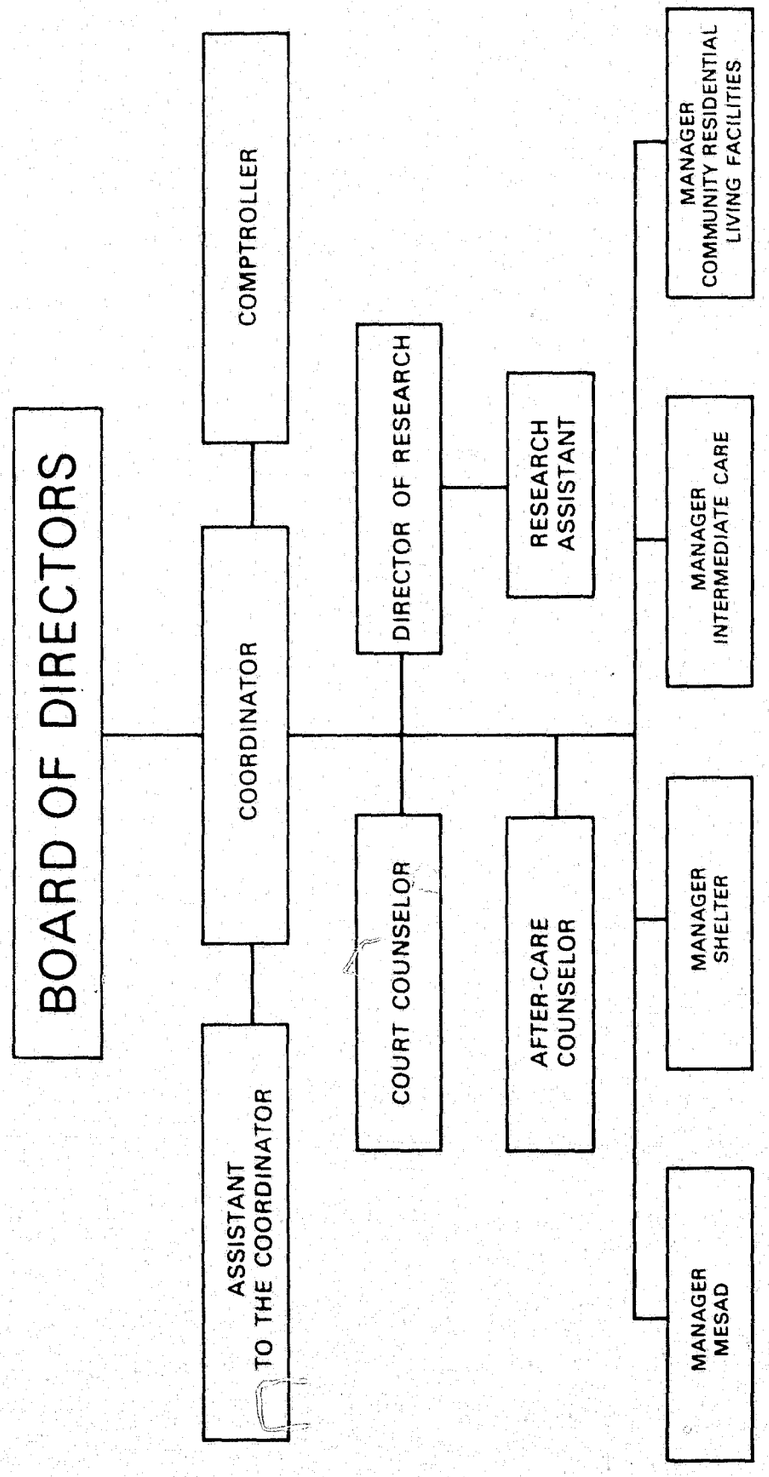
The functions of the coordinator's office vary with the stage of development. For example, in starting programs the demands would include more promotional ability and imagination. But there are at any stage three principal responsibilities which can be listed: (1) "trouble shooting," i.e. responding to crises; (2) providing general supervision to that part of the program which is experiencing no particular difficulty; and (3) promoting future programming (advance planning, anticipation of problems, etc.)[2] Frequent administrative and staff meetings will be necessary to perform these functions. In addition, the coordinator will have primary responsibility for maintaining contact with community groups, either directly or through the delegation to other staff members. Community contacts should be carried out in a planned, systematic manner with goals of improving public relations, assuring cooperation, providing consultation, and educating about the causes of skid row and both macro and micro measures needed to resolve the problems of skid-row men. While considerable assistance can be secured in these areas from board members, the personal qualities of the coordinator and of the staff that assist him will be of utmost importance. Regarding the latter, specific positions are recommended to assist the coordinator in carrying out his functions:

A. *Assistant to the Coordinator* — This staff person will assist the coordinator in carrying out administrative functions, including the preparation of applications for funding and the subsequent paper work; consultation, education, and personnel matters; and any other task deemed appropriate by the Coordinator. To avoid a cumbersome, heavy administrative design, this position is *not* defined as an intermediary between the coordinator and service managers (see illustration).

B. *Comptroller* — This staff person will check all expenditures, manage payroll, keep appropriate books, and prepare financial statements.

C. *Court Counselor* — This person will assist the coordinator in maintaining liaison with court and jail personnel, a primary function in the total diversionary-rehabilitation program. The scope of the court counselor's responsibilites are broad, but basically he is an advocate of skid-row clients involved with the law enforcement system, as well as a friend of the court and a resource to lessen its burdens. The court counselor is seen as a means of entrance for the client into the diversionary-rehabilitation system from the law enforcement system. Defined, court counseling represents the availability of professional alcoholism personnel, either degreed or non-degreed, to the courts for

Coordination and Administration Design



some or all cases where excessive drinking has contributed to the offense.

Court counseling has its greatest diversionary effect on the judges and minor magistrates that are constantly forced to deal with the public inebriate for determination of guilt and sentencing. Furthermore, because court counselers — the term "consultants" more adequately describes their functions — intervene on behalf of alcoholics and use their influence to urge treatment rather than incarceration, penal institutions also benefit from the service.

Most communities with court alcoholism consultants seem to have a relatively informal system in which the rapport between the counselor and the judge determines the program's effectiveness. Such was the case in Dorchester and Montgomery Counties, Maryland. In the latter, Department of Health staff are involved in the main with public inebriates in the courts, but deal as well with non-support, juvenile delinquency, and a wide variety of other cases where alcoholism is known to be a contributing factor to the offense. See footnote 3 for additional elaboration of court counseling.

Staff:

Coordinator	$20,000
Assistant to Coordinator	12,000
Comptroller	12,000
Court Counselor	10,000
Stenographer-Secretary	7,000
Typist	5,000
Custodian	5,000
	$71,000

2. Location, Plant and Costs of Coordination

The coordinator's office can be located in separate quarters or, if room permits, in any one of the service elements. A minimum of six offices will be required, in addition to a reception area, appropriate supply closets and bathrooms. Appropriate office and janitorial supplies as well as an automobile will be required, the latter for use by the coordinator, his assistant, or any other staff working from the coordinator's office.

Costs of Coordination*

Personnel	
Salaries	$71,000
Fringes†	8,520
Utilities	
Telephone	600
Heat	350
Light	350
Maintenance and Repairs	500
Transportation	2,000
Office Expenses (paper, postage, etc.)	2,000
	$85,320

*Does not include capital expenditures (improvement or purchases of plant and equipment) or rental fees.

†12% of Salaries.

3. Anticipating Problems

As suggested earlier, the selection of the Coordinator is one of the most important decisions the board will make. The level of performance of the total program will never rise higher than the capacity of the man in the position of greatest authority. Look for a balanced, strong but empathetic individual with some understanding of alcoholism and much understanding of people, an individual who feels he can be a shaper of policy, not just a passive reactor to forces and events. Take the time necessary to examine thoroughly tentative candidates whose skills include administrative experience. A specific college degree, or any degree, is less important than the above-mentioned qualities.

Many of the coordinator's most serious problems will involve not client or community concerns, but personnel concerns. The aid of a personnel committee will reduce these problems, as will frequent communication with the staff. Look for "team people," not necessarily "individual stars."

XI

FOOTNOTES

1. Marshall E. Dimock, *A Philosophy of Administration*, New York, Harper and Brothers Publishers, 1958, p. 79.
2. See footnote 1, p. 81.
3. A structured, well-established, and comprehensive court counseling program exists in Daytona Beach, Florida. There a senior alcoholism counselor (recovered alcoholic) on the staff of the Halifax Alcoholic Court-Oriented Program (HACOP) makes daily visits to Daytona Beach City Court from 9:00 a.m. to 11:00 a.m. where he serves as a general consultant to the various judges on any offense involving excessive drinking. Frequently, men are released to him on suspended sentences or actually sentenced to HACOP, a 30-day treatment-oriented residential program (much like a half-way house). Many drunk drivers are sentenced to HACOP's Wednesday night "DWI" classes (Driving While Intoxicated) which are based on the successful program sponsored by the City of Phoenix, Arizona. The court consultant also visits incarcerated alcoholics for post release planning both at the city lock-up and at the Volusia County jail.

   One of the most effective large city court counseling programs is offered by the Baltimore City Health Department. There, one counselor is assigned to each of five district courts on a full-time basis. The main function of the counselor is to suggest resources and treatment programs for defendants who appear to have a drinking problem. Much of the individual counselor's time is devoted to establishing relationships with the staff of community based programs, especially

those that serve the geographical area covered by the particular district court. A total of 620 persons were counseled by the court counselors in a nine month period in 1971-72.

Other services were initiated in Polk County, Des Moines, Iowa which are available to criminal alcoholics. The Department of Court Services consists of four operating units: (1) Pre-Trial Release; (2) Community Corrections; (3) Probation; and (4) Ft. Des Moines Residential Corrections Facility. The basic philosophical tenet of the department is recognition of the fact that the overwhelming majority of persons who penetrate to the last step in the criminal justice system, corrections, come from among the "Uneducated, the Unskilled, and the Unrich" portions of our population. In dealing with the criminal justice system it is evident that certain disabilities accrue to the unskilled, the uneducated and the unrich and the principal goal of the department is to assist people to alleviate these disabilities. The concept is that by removing these disabilities the quality of justice is enhanced, and the respect for justice and law and order is taught more effectively by example than by preaching.

Persons charged with simple intoxication and non-indictable traffic offenses are excluded, principally because their cases are disposed of almost immediately. ("A Description of the Functions and Procedures of the Polk County Department of Court Services.")

CONCLUSION

The guidelines presented suggest the means of implementing and maintaining a comprehensive program to divert the resourceless alcoholic and other residents of the skid-row areas of our nation from the criminal justice system. We hold that such programs are immediately practical in reducing the burden on the law enforcement system and thereby allow agents of the law enforcement system to function more efficiently and appropriately. More importantly, such programs also reaffirm an essential and basic belief in the dignity and worth of each individual, including those residing in skid row.

APPENDIX A

U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION
NATIONAL INSTITUTE OF MENTAL HEALTH
NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM

PROGRAM GUIDE
PUBLIC INEBRIATE PROGRAM

COMMUNITY ALCOHOLISM SERVICES —
DEMONSTRATION PROJECTS

Sections 246[1] and 247[2] of the Community Mental Health Centers Act, as amended, provides for grants to support programs for the treatment and rehabilitation of alcoholic persons which will demonstrate new or relatively effective or efficient methods of delivery of services to alcoholic persons. Any public or private nonprofit agency, organization or institution is an eligible applicant.

The purpose of this grant program is the development of comprehensive and integrated services for the public inebriate. Although no public inebriates are excluded from the program, it is intended that the central focus will be upon the most debilitated and chronic alcoholic people known as skid-row men, streetmen, and chronic drunkenness offenders. The clients to be served here are those with severe chronic alcoholism who are poor and often destitute, without normal family relationships, frequently dwelling in skid-row areas, sometimes homeless and sharing superficial social relationships. Any community having a significant population belonging to this subculture, regardless of whether it is known as skid row is an eligible applicant.

The Public Inebriate program should provide a full range of services for those individuals variously acculturated to this human condition. Those belonging to the skid-row way of life are most often in serious need of food, clothing, shelter, medical care, alcoholism treatment services, public assistance services and vocational assistance. Any application should provide or arrange for services to meet these needs. Care ought to be taken that services identified as necessary should be provided at each stage of recovery to the point of independent living outside of a skid-row condition. The applicant may expand the services to provide for special needs of this population in his particular community.

The program must assure continuity of care for each client throughout the duration of treatment and rehabilitation. Close cooperative working agreements should be developed between the program and the currently existing service providers in the community. It is expected that there will be a significant contribution to the program by currently operating community agencies. The Public Inebriate program should coordinate the efforts of existing service providers and new program elements on behalf of the client. Clear arrangements for the overall direction of the program must be developed. To the extent possible, the services should be so integrated as to assure for the program a single visible identity.

The general objective of the Public Inebriate program is the improvement of individuals with a drunkenness problem, particularly those living in the subculture of skid row. For many individuals the goals of improvement will be quite limited. Some will be significantly helped to avoid deterioration and others to improve their level of functioning sufficiently to live outside of that subculture.

As envisioned here, Federal aid will emphasize, but not be restricted to, the following program elements and the services which they connote.

The first of these program elements is a walk-in service, open twenty-four hours a day. This service is to be available to any patient experiencing a need related to alcohol abuse. It should be especially accessible to those most ill, debilitated or decompensated by alcoholism; therefore, the service should be situated in or within walking distance of the skid-row area. The principal functions of this service should be physical care, diagnosis, screening, referral, some direct treatment and outreach services. Its professional outpatient services should also include medical care, psychological testing, social services and counseling. More basically, good warm meals should be provided along with showers and clean clothes. After-care or follow-through is an essential part of the Public Inebriate program. The walk-in service should take major responsibility in providing such care for those individuals leaving any of the treatment services, for those who remain in the skid-row area and for those who have gained independent living.

The second element is a transitional residential treatment program. Many skid-row men need to be provided with a socialized living experience and when they choose, additional alcoholism treatment services. The focus of this program element is upon those individuals who initially do not wish to participate or who initially are unsuitable for participation in the more intensive therapeutic or rehabilitative program elements. A portion of the hard

core, fully acculturated individuals as well as some of the less acculturated would accept participation at this level and could benefit from this approach. Very limited goals should be established for the residents. Although some will exceed such goals, a decent level of living is more realistic for many of these individuals than any idea of full rehabilitation. The residents should be provided housing and meals, including provision for a private room, bed, dresser, clothes, and essential toilet articles. Alcoholism counseling should be made available with some structured counseling contact on the part of the program staff at least once a week for each man. Provision should be made for providing or arranging health, welfare, vocational and legal services at the residence or in the community. Where services are arranged by referral in the community an advocate role function may be required for the men to make use of the services. Alcoholics Anonymous meetings and some recreational activities should also be arranged.

The third program element is an intensive short-term inpatient rehabilitation program. This program should be made available to those individuals who are not yet fully acculturated or integrated into the skid-row subculture. An intensive treatment program should be provided those who have motivation to participate in such a treatment program, who would be physically capable of working after one or two months and who are not chronically psychotic nor highly disruptive to the program. The objective is to prevent their further descending into an integrated skid-row status. For them, a socialized living experience would be provided. The treatment response should include making individualized treatment plans, participation in psychotherapeutic treatment activities, an active social program, receiving medical care, social welfare services and vocational rehabilitation. The psychotherapeutic encounters and other treatment services which are built into this program element should be chosen and developed on the basis of their expected effectiveness with the less acculturated or non-hard core alcoholic people to be served. They would remain in the program for a time not to exceed six months, thereafter, if necessary, follow-through services would continue to be available to them. The intensive inpatient rehabilitation program must be located away from skid row. It should be set in a respectable, if poor, residential area. If at all possible, it should not be isolated from the larger community in order to continue improvement in social functioning.

The fourth program element is a sheltered boarding home. The objective is to provide a more homelike living condition for those individuals who require it and who are unable to arrange it for themselves or are unprepared to be completely independent of the service program. The focus should be on those recovering alcoholic individuals who have established or significantly improved their sobriety for at least six months and who are regularly employed or have a fixed income. The program might be established as a boarding home or be established in foster homes. In either case, the managers of the homes should have been trained to be able to significantly participate and cooperate in the follow-through care which the patients will be receiving.

Generally, limited treatment is already being provided for the public inebriate by the community including emergency medical care, detoxification, and hospitalization. Close working agreement with the service providers and continuation of these services in the community should be secured. Coordination of the efforts on the part of the treatment service agencies and other service agencies is vitally necessary to assure continuity of care throughout the course of the individual's treatment. It is the expectation that there will be maximum utilization of existing community resources as part of the local contribution to the Public Inebriate program. Assurances, however, must be given to each hospital staff that the Public Inebriate program would assume continuing responsibility for the patients after release from the hospital. Where emergency medical care, detoxification service and hospitalization for the treatment of severe medical conditions are not already provided in the community, these program elements should be inaugurated.

The cooperation of the police department in the Public Inebriate program will be essential in those communities where the police and courts continue to be significantly responsible for the public inebriate. Every effort should be made to accept individuals for treatment on referral from the police and courts, to appropriately make services available to acutely intoxicated and other individuals who are in jail, to inform the police and probation officers and other court officials about the services of the Public Inebriate program and to educate them regarding alcoholism as an illness, signs of medic[illegible]mergency and appropriate responses to the behavior of intoxicated individuals.

The cooperation of the public social service agencies must also be secured. The Public Inebriate program should make every effort to enhance the likelihood and ease with which its clients will receive social welfare benefits and social services and should assist those agencies with the clients they have identified on the row.

Recovered skid rowers themselves should be involved in rendering services to those identified as skid-row people. Also, inasmuch as possible, those recovered and recovering from a skid-row condition should be provided the opportunity for meaningful involvement in resolving problems associated with the direction and implementation of the program.

The overall direction of the Public Inebriate program must be clear. A single full-time program director is needed. The lines of his authority over the administration of the several program elements must be defined as well as arrangements for resolving any conflicts which may arise between the program elements and the affiliates. The procedures to be followed for making referrals between program elements and for assuring continuity of care for patients must be specified. The director should collaborate with all participating agencies to formulate a general plan for follow-through care. Affiliation agreements will be required between the Public Inebriate program and every participating agency which is receiving support through the grant or whose services are integral to the program.

Summarily, it is expected that a program plan will identify expected client needs, the services which will be responsive to those needs and then, the system for providing those services. Every system must include the following efforts: case finding, direct service responses, and follow-through care of clients.

Participation in an evaluation study being conducted by the National Institute on Alcohol Abuse and Alcoholism will be required of each Public Inebriate program. Statistical data about patients and staff must be submitted by the applicant as directed by the Special Projects Branch of the National Institute on Alcohol Abuse and Alcoholism.

Ongoing community support is an important aspect of a Public Inebriate program. Criteria for approval of any application will include the extent of a community's contribution to the project.

Federal funds cannot supplant current Federal or non-Federal expenditures.

Programs will not be automatically continued in subsequent years; continuation will be subject to annual staff review. It is expected that, given the availability of funds, Federal support for programs effective in fulfilling their objectives can be continued for up to three years. However, it may be that a change in program direction in particular cases will be necessitated by the subsequent growth in the community of comprehensive alcoholism services.

Description of Program

A detailed narrative description must be prepared on the continuation pages of Form PHS-398. If more pages are needed, use any plain white paper, size 8 ½ x 11 inches. The narrative response should include the information listed below and should be answered in the order indicated with clear references to number 1 through 16.

1. Confirm the need for this project.
2. Enumerate and describe the population of the area to be served. Give the estimated number and percentage of the public inebriates who would benefit from the project.
3. How are needs for services perceived by the community at large, the consumer of services, the professionals and the helping organizations. Identify needs the project will meet in relation to types of clients that will be served.
4. Provide a map or maps of the geographic area which will be served by the project and identify the area by census tract or minor civil districts.

   (Note: The area to be served does not have to conform to any specific census tract or district boundaries. For our information, however, note what census tracts or districts happen to be included in the area you intend to serve.)

   Show the locations on the map or maps of all providers of alcoholism and related services, and the major geographic areas of need. Identify proposed locations of any new service elements.
5. Describe organizational structure of applicant agency — board, executive director, number and types of professional, technical and nonprofessional staff who will provide care and services. (Organizational chart may be used together with a statement of responsibilities of the various positions listed on the application.) Also state the training and experience required for each position. Explain working relationships and define the lines of direction and control of the parts of the program.
6. Where this alcoholism program operates administratively as part of another agency or organization, written assurances must be provided that the following standards will be met:
   a. Separate grant-related financial data and client records must be maintained by the Public Inebriate Program.
   b. The concurrence of the Director of the Public Inebriate Program is required in the expenditure of all direct cost funds provided under this grant.
   c. The concurrence of the Director of the Public Inebriate Program is required in all personnel decisions involving personnel supported by this grant.
7. Describe the proposed program. Included in the description should be the information on the following:
   a. The usual problems of the individuals the program will serve.
   b. A concise statement of the program's philosophy of alcoholism services and treatment.
   c. The services that will be provided.
   d. Person who will be Director of the Public Inebriate Program and responsible for leadership in the program development and coordination. The National Institute on Alcohol Abuse and Alcoholism must concur with the choice of the Director before any funds are made available.
   e. Staff, those to be recruited, the extent of the proposed use of recovered alcoholic persons and indigenous populations, (including the skid-row man, streetmen or the chronic drunkenness offender)

the level of training and experience of personnel, how the initial and continuing training of personnel will be provided, and how the program fosters career advancement for its personnel.

f. Describe the relationship between diagnostic thinking, treatment approach and objectives for individual and family cases.

8. Describe existing alcoholism treatment and rehabilitation programs available to the community. Indicate whether they are an integral part of a comprehensive community alcoholism or mental health program. Show how they will be coordinated with the project.

9. State briefly how services will be delivered (i.e., in central locations, institutional facilities, outreach teams, neighborhood workers and multi-service centers, etc.). Describe the plan for program coordination among community agencies and groups involved in the delivery of services. State your plans to provide for (a) case collaboration, (b) case responsibility and (c) continuity of care.

10. Describe the community welfare situation as it relates to the public inebriate. Note its adequacy and efficiency in providing the social resources and services needed for the public inebriate. Be precise in describing what benefits are available for these individuals.

11. Provide copies of all affiliation agreements with treatment and service programs. Each affiliate receiving any financial support through this grant must show how its present level of effort will be maintained, in addition to providing the proposed services through this grant. Maintenance of effort includes both program activities and dollar expenditures. Federal funds made available through this grant must in no event supplant current State, local and other non-Federal funds. The affiliate must be guided by the same policies as the grantee and have the same responsibilities as the grantee. Each affiliation agreement must be dated and signed by the applicant and the participating agency. The agreement must clearly describe the following:

a. The expected number of clients to be served by the affiliate.

b. The services to be provided by the affiliate.

c. The staff providing the services.

d. The financial support, if any, the affiliate will receive from the grantee.

e. The working relationship between the grantee and the affiliate.

f. Provisions for the sharing of records.

12. Locate and describe all facilities which will be used in the operation of the program. Show how the treatment environment will enhance the likelihood program goals will be met.

13. Show what operational data is to be maintained about the clients, services rendered, and the like; and how evaluation of programs and services will be conducted.

14. Describe in detail what non-Federal support for your programs will be provided. In the case of existing programs, state the dollar amount of the non-Federal portion of the total project costs during the previous twelve-month period, and note what percentage of the total costs was represented by Federal funds. Describe the sources of the local support, the form the contributions will assume, and, in the case of services, who will be contributing services. Include a statement of how the program will generate additional community support to insure the program's continuation beyond the maximum three-year grant period.

15. Indicate how the active and meaningful participation of low-income group representatives, individuals interested in alcoholism, providers of alcoholism services in the community and consumers will be assured in the direction and implementation of the alcoholism program. Generally, a Policy-making Board is necessary.

16. Indicate how the applicant agency has participated in any planning related to the development of comprehensive community alcoholism services, and state the significance of these activities.

ADDITIONAL REQUIREMENTS

1. All proposals shall include an additional separate page listing all sources of revenue for the first twelve-month period including anticipated local, county, State and Federal aid, as well as estimated revenues from patients or clients for services rendered. The revenues should be categorized according to the respective service element for which they are anticipated.

2. If a fee schedule is established for any service this schedule should be included.

3. A breakdown of the DETAILED BUDGET FOR FIRST 12-MONTH PERIOD by each element of service is required. This can be accomplished by including a separate Detailed Budget page for each service, prefaced by a Summary Budget page which shows only the total lump sum amounts for each budget category. (The details would be contained in the appended budge pages for each service; in this sequence, the Summary Budget should be numbered page 3 and the detailed budgets should be numbered 3A, 3B, 3C, etc.).

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[1]Added by Section 304 of P.L. 91-211.

[2]Added by Section 311 of P.L. 91-616.

APPENDIX B

ON-SITE VISITS — CHRONOLOGICALLY

Gateway Rehabilitation Center
R. D. # 2, Box 95
Aliquippa, Pa. 15001 — 412/378-4461

Diagnostic and Rehabilitation Center
304 Arch Street
Philadelphia, Pa. — 215/WA5-3909

Manahattan Bowery Project
8 East 3 Street
New York, N. Y. 10025 — 212/533-8400

Men's Shelter
Department of Social Services
8 East 3 Street
New York, N.Y. 10025 — 212/254-5730

Women's Shelter
350 Lafayette Street
New York, N.Y. 10025 — 212/460-1172

South End Center for Alcoholics
249 East Berkley Street
Boston, Mass. 02118 — 617/542-9242

Pine Street Terrace
8 Pine Street
Boston, Bass. 02111 — 617/482-4944

Boston Detoxification Center
16 James Street
Boston, Mass. 02111 — 617/266-2615

East End Hotel
5 North Exeter Street
Baltimore, Md. 21202 — 301/276-4568

Maryland Division of Alcoholism Control
Department of Health and Mental Hygiene
2305 North Charles Street
Baltimore, Md. 21218 — 301/383-2784

Baltimore Alcoholism Center
2221 St. Paul Street
Baltimore, Md. 21218 — 301/752-2000

Alcoholism Program
Dorchester County Health Department
Eastern Shore State Hospital
Cambridge, Md. 21613 — 301/228-0800

Open Door
Anne Arundel County Department of Health
192 West Street
Annapolis, Md. 21401 — 301/268-4545

Alcoholism Program
Montgomery County Department of Health
12701 Twin Brook Parkway
Rockville, Md. 20852 — 301/279-1631

Halifax Alcoholic Court-Oriented Program (H.A.C.O.P.)
225 Reva Street
Daytona Beach, Fla. 32014 — 904/225-0447

Detoxification Unit
Halifax District Hospital
Clyde Morris Boulevard
Daytona Beach, Fla. 32014 — 904/255-4411

The Alcoholic Detoxification Center
D. C. Department of Human Resources
619 N Street, N.W.
Washington, D.C. 20001 — 202/629-4068

Rehabilitation Center for Alcoholics
D. C. Department of Human Resources
Occoquan, Va. 22125 — 703/836-8410

The Home (Men's Home)
402 East Hume Avenue
Alexandria, Va. — 703/683-3622

Crossroads Center
331 State Street
Erie, Pa. 16507 — 814/521-2151

Serenity Hall
522 East 6 Street
Erie, Pa. 16503 — 814/452-4245

Alcoholism Unit
St. Vincent Hospital Community Mental Health Center
232 West 25 Street
Erie, Pa. 16502 — 814/453-6911

Alcoholism Program
Harford County Department of Health
116 Hayes Street
Bel Air, Md. 21550 — 301/334-2480

National Institute on Alcohol Abuse and Alcoholism
U.S. Department of Health, Education and Welfare
5600 Fishers Lane — Parklawn Building
Rockville, Md. 20852

St. Louis Detoxification Center
St. Louis State Hospital
5400 Arsenal Street
St. Louis, Mo. 63139 — 314/644-5400

Alcoholism Treatment and Rehabilitation Center
St. Louis State Hospital
5400 Arsenal Street
St. Louis, Mo. 63139 — 314/644-5400

San Joaquin County Alcoholism Services
(Project F.A.L.T.H.)
c/o San Joaquin General Hospital
French Camp, Calif. 95231 209/982-1800

Alcoholism Service Corp. of the Salvation Army
1275 Harrison Street
San Francisco, Calif. 94103 415/864-7000

Hough-Norwood Family Health Care Center
1465 East 55 Street
Cleveland, Ohio 44103 216/881-2000

Rosary Hall
St. Vincent Hospital
2351 East 22 Street
Cleveland, Ohio 44115 216/861-6200

APPENDIX C

APPENDIX C - SAMPLE INTAKE FORM

INITIAL INTAKE SHEET AND GUEST AGREEMENT

Date_____

Name_____ S.S. No._____

Legal Residence_____ Length Local Residence_____

Last City (Trans)_____

Age_____ D.O.B._____ Place_____

Weight_____ Height_____ Eyes_____ Hair_____ Race_____

Religion_____ Veteran_____ Type Discharge_____

General Health_____ Handicaps_____

Marital Status_____ Nearest Relative_____

Education_____ Relationship_____

Occupation_____ Address_____

Referring Agency_____ Telephone_____

SUPPLEMENTARY REMARKS

Recent Hospitalization: Place_____ Date_____

Received from Hospital or Institution_____
(If yes, Where?)

Source of Income_____(If D.P.A., Pension, etc., Where mailed?)_____

COMMENTS OF INTAKE WORKER

_____

_____

_____

SIGNED:_____
(INTAKE WORKER)

APPENDIX D

BALTIMORE CITY HEALTH DEPARTMENT
ALCOHOLISM CENTER

TRAINING PROGRAM FOR ALCOHOLISM COUNSELORS

SUPPORTED BY NIMH GRANT # T21 MH11054
IN OPERATION SINCE SEPTEMBER 25, 1967

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BALTIMORE CITY HEALTH DEPARTMENT
ALCOHOLISM CENTER
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BALTIMORE, MARYLAND 21218
AREA CODE—301 752-2000, EXT. 2756

TRAINING PROGRAM FOR ALCOHOLISM COUNSELORS
BALTIMORE CITY HEALTH DEPARTMENT
NATIONAL CENTER FOR PREVENTION AND CONTROL OF ALCOHOLISM
GRANT #5-T21-MH11054

BACKGROUND

The Maryland Commission on Alcoholism, in its report of February 10th, 1961, described the high incidence of alcoholism in Maryland indicated that ". . . according to the best available evidence, Baltimore City contains some 40 percent of the total alcoholic population of Maryland." The report noted the lack of coordination and liaison between agencies treating or serving alcoholics, lack of trained personnel in the field of alcoholism, inadequate follow-up and evaluation of existing therapeutic efforts and the reluctance of the general hospitals to admit or treat the alcoholic patient.

With the endorsement and financial support of the State Departments of Health and Mental Hygiene, the interest and cooperation of the Medical Chirurgical Faculty of the State of Maryland, The Johns Hopkins School of Hygiene and Public Health, and other interested groups, the Baltimore City Health Department established a Clinic to provide, in collaboration with Church Home and Hospital, an inpatient and outpatient program as a means of finding practical and workable solutions to some of the problems highlighted in the Commission's Report. The Clinic accepted its first patients for evaluation and treatment on September 16th, 1963.

One of the major problems encountered in the Clinic is that of patient dropout. This is usually the poorly motivated patient who feels threatened by family, the Welfare Department or the court; it may be the angry, hostile patient who feels that treatment does not move fast enough for him or the one who is looking for a magic formula in one or two visits. In general, the dropout population belongs to a low socio-economic group. The comprise approximately 70 percent of our Clinic admissions.

The trend of satisfying patient needs through a modification of traditional treatment procedures was suggested by Chafetz[1]. Miller and Swanson[2] state: "In clinics which serve patients in both social classes, disproportionate number of blue-collar workers drop out of therapy very early

because of dissatisfaction with the therapeutic procedure . . . . our results indicate the desirability of exploring a variety of new therapuetic techniques."

Frequently patients are lost to the Clinic because of special needs which are poorly identified due to time limitations of staff personnel.

Because of a lack of personnel, it is impossible to conduct anything but the most meager liaison between the Clinic and the state hospitals and certain other agencies, so that many patients are lost after referral to them.

Another problem is the lack of knowledge about the Clinic as a community resource among physicians, social workers and other persons coming into professional contact with alcoholics.

Additionally, patients are frequently sent to the Clinic by the personnel of Emergency Rooms of general hospitals instead of being treated there as a medical emergency. There is no liaison between the two programs.

With the cooperation of the American Academy of General Practice, Baltimore Area Council on Alcoholism, Maryland Psychiatric Society, the Medical and Chirurgical Faculty of the State of Maryland and the State Departments of Health and Mental Hygiene, a series of four seminars for physicians were held in 1964, on the diagnosis and treatment of alcoholism in industry and in private practice.

During the year 1965-1966, a series of seven seminars were conducted for the workers of the Department of Public Welfare, using Clinic personnel as resource persons. This series was sponsored jointly by Baltimore Area Council on Alcoholism, Baltimore City Department of Public Welfare, Baltimore City Health Department and the State Department of Mental Hygiene.

A one-day seminar was conducted by the Clinic staff for 65 clergymen under the sponsorship of the Council of Churches for Maryland and Delaware, the Baltimore Area Council on Alcoholism, the Baltimore City Health Department and the State Department of Mental Hygiene.

A case presentation and conference has been held on alternate weeks throughout 1965-1966 to which have been invited workers from all social agencies and all Schools of Nursing as well as Public Health Nurses and the Instructive Visiting Nurses Association. This valuable didactic program was made possible by a contribution from the Baltimore and Ohio Railroad Company, to cover the cost of service of the medical and psychiatric consultants attending.

Clinic staff has been active in television appearances, radio programs, talks throughout the community to schools and clubs to acquaint people with the problems of alcoholism.

We have established a valuable Community Advisory Board composed of executive representatives of community agencies.

Insofar as possible, the Clinic maintains direct contact with the Department of Public Welfare, the Department of Vocational Rehabilitation, the State Department of Employment Security, Job Counseling Service, Community Action Agency and many others.

The rapidly increasing demands for service for alcoholic patients following recent court decisions (Driver and Easter cases) and the subsequent experience in the District of Columbia Alcoholism Program, plus the Maryland Alcoholism Law of July 1, 1968, highlighted the need for trained personnel in the field of alcoholism.

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[1]Chafetz, M. E. and Demore, H. W.: Alcoholism and Society. Oxford University Press, New York, 1962.

[2]Miller, D. and Swanson, G.: Inner Conflict and Defense. Henry Holt, 1960, p. 397.

TRAINING PROGRAM

A. THE STUDENT BODY

I. *Recruitment of Applicants:* Applicants are accepted from any area of the United States. Locally, applicants are recruited through the Maryland State Employment Service; Civil Service Commissions, both city and state, Vocational Rehabilitation; Classified Municipal Employees Association; Adult Education Section of the Department of Education; State Hospital Attendants — particularly those in Alcoholic Rehabilitation Units; interested clergymen; Alcoholics Anonymous; Baltimore Area Council on Alcoholism as well as the Clinic staff's knowledge of a body of recovered alcoholics.

The program offers to the student:

1. A six months educational program.
2. A stipend of $1,875 over the six months training period, of which $1,800 are tax exempt.
3. A certificate of satisfactory completion.

4. Recommendation for employment: Our graduates are eligible to work on alcoholism programs throughout the United States. Both the Baltimore City and the Maryland State Civil Service Commissions have created a personnel classification of Alcoholism Counselor with specific requirements and job descriptions.

II. Selection of Students

1. *Requirements*
   a. High School education or High School Equivalence. (Proof *must* accompany application)
   b. Emotional maturity as determined by an individual interview with each member of the Admissions Committee.
   c. Evidence of some economic and/or social accomplishment (past or present).
   d. Interest in working with sick alcoholics.
   e. In the case of recovered alcoholics, a period of at least two years of uninterrupted sobriety.
   f. Experience in dealing with sick alcoholics shall be favorably considered but shall not be mandatory.
2. *Method of Selection:*
   a. Selection of Students is made by an Admissions Committee.*
   b. Intelligence quotient and personality tests are administered after the applicant has been accepted. Both are used only as tools of evaluation of the Training Program.

B. Educational Program

I. *Teaching Techniques*

1. Didactic lectures by staff and consultants (resource persons).

   These lectures are designed to provide the student with a working knowledge of each topic under discussion to be supplemented by selected reading material. Professionals who are expert in working in each field are brought in as resource persons and consultants. These didactic sessions are held three hours a day, five days a week for two months, a total of 120 hours. Since the attitude and opinions are basic elements in alcohol education, active participation through discussion and exchange are encouraged.

2. Group discussion periods — Seminars.

   Adequate time is scheduled for the discussion of the material presented in the didactic lectures. The time allotted to the discussion of the varied topics will depend on the nature of the topic and the intended use of the discussion period.

   a. Clarification of the presented material following a didactic lecture of a technical nature.
   b. Digestion and integration of the presented didactic material into the overall picture (relevance of the individual topic).
   c. Demonstration of the didactic material, group dynamics, role playing and practice in group methods.
3. Observation of interviews through one-way mirror.
4. Tape recording of interviews.

   The student body and supervisor observe interviews of patients by staff and students; the tap recordings are used to analyze the content and quality of the interview and to illustrate interview technique.

5. Visual aids (movies, slides, animated cartoons) and discussion.
6. Reading material (textbooks, pamphlets) and discussion.
7. Report and letter writing — supervision and discussion.
8. Attendance and participation in therapeutic groups as observers and recorders; discussion of the group interaction and dynamics.
9. Attendance at appropriate Mental Hygiene Seminars at The Johns Hopkins School of Hygiene and Public Health.
10. Field trips.
11. Home visits to follow-up dropouts.

12. "Each one teach one" case finding. Students are urged to find and bring to the Alcoholism Clinic for treatment one alcoholic who has never been treated in this facility. A complete written report of method involved will be required.

II. Curriculum

A Curriculum Committee* has designed an educational program which adequately prepares the students for the duties they will be expected to perform as Alcoholism Counselors. As a result of feed-back from the student body, faculty and supervisors in the field, the curriculum undergoes periodic changes in terms of teaching and time allotment in various topics, discussion periods, field trips, field placements, etc.

The curriculum includes:

1. Didactic presentations and discussions of topics related to Alcoholism and the Alcoholic Patient.
2. Didactic presentations, discussions and practice of techniques in dealing with the Alcoholic Patient and his Environment.
3. Field trips.
4. Field placement.
5. Evaluation of each student's performance.
6. Written evaluation of the program by each student.

The Curriculum Committee has approved the following list of topics and activities:

*See back cover page.

A) Topics Related to Alcoholism and the Alcoholic Patient

I) Introduction to the problem of alcoholism
) Definitions of alcoholism
   2) Scope and extent of problem in this and other countries

II) Physiology of Alcohol
   1) Metabolism (absorption, distribution in the organism, oxidation, elimination, alcohol blood-level, etc.)
   2) Tolerance; Habituation, Addiction
   3) Effects of alcohol on the body

III) Clinical Manifestations of Excessive Drinking
   1) Acute intoxication, Alcohol hallucinosis
   2) Chronic intoxication, (Hangover, Delirium tremens, Wernicke's Disease, Korsakoff's psychosis, Polyneuritis, etc.)
   3) Organic Complications (CNS, Liver, Heart, Pancreas, etc.)

IV) Why people drink alcohol-beverage
   1) "Normal" drinking
      a) Ritual
      b) Utilitarian
      c) Convivial
   2) "Pathological" drinking
   3) Teenage Drinking—Psychological Implications

V) The Alcoholic Personality
   1) Does it really exist
   2) Common characteristics found in alcoholics

VI) The Non-Alcoholic Spouse (Personality Factors)

VII) Areas of Childhood Development Apparently Related to Alcoholism
   1) Oral phase (infant omnipotence)
   2) Inadequate coping mechanisms of childhood
   3) Psychological deprivation

VIII) Diagnosing the Alcoholic
- 1) Medical aspects
  - a) Recognition of the Alcoholic by the General Practitioner
  - b) Recognition of the Alcoholic by the Psychiatrist
- 2) Psychological Tests
  - a) Personality
  - b) Intelligence
  - c) Organicity
- 3) Social Factors
  - a) Family
  - b) Industry
  - c) Community

IX) Adjustment of the Family to the Crisis of Alcoholism
- 1) Alcoholism in one partner
- 2) Alcoholism in both partners
- 3) Marriage counseling

X) Alcoholism and Industry
- 1) Cost to industry
  - a) Absenteeism
  - b) Poor workmanship (quality and quantity)
  - c) Accident proneness (insurance cost)
  - d) Loss of trainee investment
- 2) Rehabilitation—Alcoholism Programs in Industry

XI) Alcohol in Relation to Crime and Delinquency
- 1) Extent of problem
- 2) Cost in dollars
- 3) Cost in human loss and suffering

XII) Alcoholism and the Law
- 1) Maryland Law concerning alcoholism and drunkenness
  - a) Court Counselors Program
  - b) State Department of Parole and Probation Program
- 2) Admission to State Hospital
  - a) Voluntary request
  - b) Two doctors' certificates
  - c) Court commitment
- 3) Jail sentence vs. Treatment in a Health Facility
  - a) Driver and Easter cases—medico-legal implications
  - b) Treatment program for "first offenders"
  - c) Treatment program for "chronic offenders"
- 4) Definition of Commonly Used Legal Expressions ("assault," "drunk and disorderly," "drunk on a public street," "parole," "probation," etc.)

XIII) Alcoholism and the Department of Public Welfare
- 1) Determination of eligibility
- 2) Programs in Department of Public Welfare
  - a) General Assistance
  - b) Aid to Families with Dependent Children
  - c) Old Age Assistance
  - d) Children's Division
  - e) Protective Services Division
- 3) Applications for Welfare Help
  - a) Emergency Service
  - b) Medical Care Under Age 60
  - c) Medically Indigent

  - d) Medicare Over 65
  - e) Outpatient Medical Clinic Care
  - f) Admissions to Hospitals

XIV) Alcoholism and Health Agencies
- 1) Practicing Physicians
- 2) Emergency Room of General Hospitals
-) General Hospitals
- 4) Alcoholic Rehabilitation Units of State Hospitals
- 5) Alcoholism Clinic

XV) Alcholism and "Self-Help" Organizations
- 1) Baltimore Area Council on Alcoholism
- 2) Alcoholics Anonymous
- 3) Al-Anon
- 4) Alateen

XVI) Alcoholism and Religion
- 1) Pastoral Counseling
- 2) Attitudes toward drinking and intoxication

XVII) Stages of Alcoholism
- 1) Jellinek's classification
- 2) Modified (Consolidated Edison Company)

XVIII) Treatment
- 1) Acute episode
- 2) Chronic alcoholism

B) Topics Related to Techniques of Dealing With the Alcoholic and his Environment

I) Techniques of Interviewing
- 1) Purpose of the interview clearly defined
- 2) Use of material obtained
- 3) Confidentiality of material obtained
- 4) What goes on in any interview
- 5) Learning to listen

II) The First Interview
- 1) Use according to agency setting
- 2) What goes on in the interview
  - a) Interaction between interviewer and patient
  - b) Interaction between patient and family member
  - c) Interaction between family member and interviewer
- 3) Information obtained according to specific needs of agency

III) Verbal and Non-Verbal Communication
- 1) Learning to recognize and identify attitudes of patients and family (Ex. hostiliy, aggression, resistance)

IV) Reciprocal exchange of information with outside agencies
- 1) Obtaining patient's signature for release of information
- 2) Checking with parole and probation officers
- 3) Telephone communications
- 4) Liaison with Alcoholic Rehabilitation Units of State Hospitals
- 5) Maintaining contact with referring agencies

V) Use of group as therapeutic device
- 1) History of group therapy
- 2) Mechanics of conducting a group
  - a) Seating arrangement (purpose)
  - b) Telephone
  - c) Recording devices

3) Types of Groups
   a) Discussion
   b) Psychotherapeutic
   c) Analytical
4) Purpose of particular type of group
5) Use of observers, recorders and co-therapists in groups
6) Clarifying why members have asked for help
7) Importance of group method
   a) To patient
   b) To therapist
8) Advantages of a group
9) Disadvantages of a group
10) Types of patients
11) Considerations in the selection of patients
12) Motivation
13) Signs of resistance
14) Who is resistant
15) How patients react and interact
16) Role of the therapist and/or counselor
17) Patients' expectations
18) Methods of "starting the ball rolling"
19) Winning the confidence of the reluctant patient
20) Use of co-therapists or co-counselors
   a) Reason for use
   b) Advantages and disadvantages
21) Use of observers and/or recorders
   a) As participants
   b) As non-participants
22) Use of time in a group
23) Demonstration and practice of group method in discussion sessions
24) Participation of students in existing groups (Alcoholism Clinic) as observers, recorders, co-therapists/co-counselors throughout the six months program

VI) Special Techniques
1) Case finding
2) Crisis intervention
3) Recognizing and handling a medical emergency
   a) Role of non-medical personnel vs. role of the physician
4) Working with professionals
5) Strengthening care-taking community programs

VII) Home visits for purpose of following up the drop-out

Each student is expected to make three home visits during the course of the program. One will be with the supervisor and two independently. These visits are for the purpose of determining why the patient failed to return to the clinic after the initial interview and attempting to enlist the patient's cooperation in returning. (If the counselor is successful in getting the patient to involve himself in treatment, this case may be used in accordance with # B I 12, page 5, "each one teach one" case finding). A written report of each visit is submitted to the faculty supervisor covering observations in the following areas:

1) Patient's attitude toward visit and visitor
2) Family's attitude toward visit and visitor
3) Family's attitude toward patient
4) Signs of resistance, if any
5) Quality of motivation
6) Housing arrangements
7) Patient's home in relation to the neighborhood

Throughout the training period, stress is placed on personal and interpersonal relationships.

C) Field Trips

These are provided, with an appropriate number of students for each trip, to acquaint the students with the problems of alcoholics in relation to each facility visited and to observe methods in the treatment of alcoholics in other facilities. The following agencies are of special interest in dealing with alcoholics:

I) Alcoholism Clinic, Washington, D.C.
II) Alcoholic Detoxification Unit, Washington, D.C.
III) Melwood Farm, Olney, Maryland
IV) Occoquan Rehabilitation Center for Alcoholics, Lorton, Virginia
V) Saint Elizabeth's Hospital, Washington, D.C.
   (Demonstration of psychodrama in the treatment of alcoholics)
VI) Saint Elizabeth's Hospital, Alcoholic Rehabilitation Unit, Washington, D.C.
VII) Valley-Bridge House
   (A half-way house for alcoholics discharged from a state hospital or from jail)
VIII) The Johns Hopkins Alcoholic Recovery Unit
IX) Tuerk Quarter-Way House, Inc.
X) Provident House

D) Field Placements

During the first two months of the program (didactic lectures) students receive instruction in the operation and procedures of each facility where a field placement is contemplated. At the time of the placement, students have had some indoctrination into the techniques of interviewing and counseling. Each placement facility is expected to provide supervision and to maintain liaison with the faculty supervisor who shall visit the facility at stated intervals to confer with the "field" supervisor regarding students and policy.

All trainees meet at the Alcoholism Center one day each week for individual consultations and a structured program to include:

Case presentation — Each student is expected to present a case; the outline for such a presentation follows conventional patterns with emphasis on description, clarification and evaluations of findings and recommended plan of action.

Brief written assignments— To be discussed in the class, that would enable the trainee to tie in the concepts learned in the classroom to their experiences in the field. This assignment is a practical means of evaluating the trainees' practical application.

I) Alcoholic Rehabilitation Units of State Hospitals

Students are assigned to one of the State Hospital's Alcoholic Rehabilitation Units or a general hospital for a period of two months. The placement facility is expected to provide for the students' experience in reading records, intake interviewing, counseling patients, participation in therapeutic groups, developing and maintaining liaison between Unit and referring agencies, and referring a patient whose discharge is imminent to an agency in his local community for continued service.

The Alcoholic Rehabilitation Unit supervisor provides the Program Director with a written evaluation of each student's performance within one week of termination of his duties in that agency.

II) The Baltimore City Health Department, Alcoholism Clinic

Each student serves in the Alcoholism Clinic for a period of three weeks and is expected to assume, under proper supervision, the duties of a staff member. Appointments are made for him to see Intake cases on a scheduled basis. He deals appropriately with one walk-in case per week. These duties entail taking a social history, explaining the function of the clinic, obtaining signatures for release of information, explaining necessity for a physical examination, arranging for physical examination by clinic physician, scheduling appointments for return visits of patient and spouse during patient's orientation period in order to give the patient emotional support during this transition from drinking to treatment, attending the afternoon

orientation sessions for patients and directing patients scheduled for a physical examination to the physician.

During this period alcoholic-medical emergencies are called to the attention of the student on duty. It is his duty to refer the patient to the Program Director; in the absence of the Director, to accompany the patient to the emergency room or the nearest hospital after first notifying the hospital by telephone of his intent, and to remain with the patient until he is seen by a physician.

When a patient must be sent to an Alcoholic Rehabilitation Unit of a State Hospital, the student shall obtain the necessary information for commitment and inform the Project Director or his medical assistant. If the patient has no transportation, the student shall accompany him to the hospital if his schedule permits, and remain with him until patient is admitted.

During service in the Clinic, the student maintains agency hours including Monday, Tuesday or Thursday evenings from 6:30 p.m. to 8:30 p.m. He attends all regular staff meetings unless specifically excused by the Program Director. At staff meeting he is expected to present and discuss cases he has seen in Intake during the week. While serving in the Clinic, the student is supervised by a Clinic staff member. His records concerning patients are kept in the same manner as the records of other members.

III) Emergency Room of General Hospital

Students whose field placement does not include Emergency Room experience have a rotating field placement in the emergency room of a general hospital for at least four weekends during the program. A weekend is considered to be Saturday and Sunday from 8:00 a.m. until 8:00 p.m. The use of a student in this setting is pre-arranged by the Project Director and the Chief of the Medical Service of the hospital. The student is required to introduce himself to the physician in charge and to the charge nurse upon entering the emergency room and request permission to perform his assigned duties. The student interviews each conscious patient who is requesting treatment for an alcoholic episode and interviews the person accompanying the alcoholic. He obtains information which may be helpful to the attending physician such as:

1) Length of drinking bout
2) Type of material consumed (whether beverage alcohol or other toxic substance such as rubbing alcohol or Sterno, etc.)
3) How much consumed in preceding twenty-four hours
4) Any medication involved such as Antabuse, tranquilizers, etc.
5) Description of any previous episodes.

He submits this information to the attending physician or the charge nurse verbally.

At no time will the student permit his interview to interfere with medical treatment. When treatment is completed, the student explains to the patient and his family the nature of various facilities where the patient may obtain long-term help for his problem and urge the patient to avail himself of this help; this will include private physicians known to be interested in the Treatment of alcoholics, Alcoholics Anonymous meetings, Alcoholism Center, etc. During the ensuing week, the student arranges to follow up the patient in the hospital if he is admitted or at home following his discharge.

In the event a patient is admitted to the emergency room by ambulance or by the police because of an incident involving drinking (such as an automobile accident, a knifing or a shooting), the student follows the above procedure and in addition shall work with the police but shall not in any way interfere with their duties.

The weekend duty in the emergency room of a general hospital is designed to acquaint the student with procedures used by hospital and police in dealing with alcoholics and to coordinate this with what he is learning in didactic courses.

E) Evaluation of Student's Performance

I) Weekly evaluations — tests or summary discussions — are conducted throughout the two-month period of didactic sessions.

II) Written evaluations of each student's performance is furnished by the field work supervisor.

III) A written test is required at the end of the six month course. This test will be devised by a committee composed of full-time and part-time faculty and certain significant resource persons. At the end of the program the faculty supervisor furnishes a written evaluation of each student.

IV) This complete record, in addition to a consideration of emotional and personality factors, determines the student's eligibility for a certificate of completion.

GENERAL SCHEDULE

A. First 8 Weeks of Program (Alcoholism Center — Didactic Program)

9:00-12:00	Monday through Friday	Didactic Lecture
12:00- 1:00	Monday through Friday	Lunch
1:00- 3:00	Monday through Friday	Discussion of Morning Session
3:00- 4:00	Monday through Friday	Library
5:00- 7:00	Monday	Mental Hygiene Seminar, The Johns Hopkins University School of Hygiene and Public Health
7:00- 8:30	Monday through Thursday (one evening mandatory)	Observation and participation in group therapy (Alcoholism Center)
11:00- 1:00	Saturday	Observation and participation in group therapy (Psychiatric Institute, University of Maryland Hospital)

B. Weeks 9 and 10 (Field Trips)

9:00- 4:00	Monday through Friday	Field Trips to facilities dealing with alcoholic patients, followed by extensive interpretation and clarification of policies and procedures of the visited facility
5:00- 7:00	Monday	Mental Hygiene Seminar, The Johns Hopkins University School of Hygiene and Public Health
7:00- 8:30	Monday through Thursday (one evening mandatory)	Observation and participation in group therapy (Alcoholism Center)
11:00- 1:00	Saturday	Observation and participation in group therapy (Psychiatric Institute, University of Maryland Hospital)

C. Weeks 11 Through 25 (Field Placement)

Four Week Days		Schedule as arranged with the individual agency
One Week Day		All trainees meet at the Alcoholism Center at 9:00 a.m. for activities as outlined under "Field Placement"
5:00- 7:00	Monday	Mental Hygiene Seminar, The Johns Hopkins University School of Hygiene and Public Health
7:00- 8:30	Monday through Thursday (one evening mandatory)	Observation and participation in group therapy (Alcoholism Center)
11:00- 1:00	Saturday	Observation and participation in group therapy (Psychiatric Institute, University of Maryland Hospital)

D. Last Week of Program (Examinations and Closing Exercises — Alcoholism Center)

9:00- 4:00	Monday through Friday	1. Written evaluation of the program by each trainee 2. Final test 3. Evaluation of each trainee's performance in individual interview with the trainee 4. Group discussion regarding the overall experience with the program 5. Official Closing Exercises

5:00- 7:00	Monday	Mental Hygiene Seminar, The Johns Hopkins University School of Hygiene and Public Health
7:00- 8:30	Monday through Thursday	Observation and participation in group therapy (Alcoholism Center)
11:00- 1:00	Saturday	Observation and participation in group therapy (Psychiatric Institute, University of Maryland Hospital)

ADMISSIONS COMMITTEE

PAUL V. LEMKAU, M.D., D.P.H., *Professor,* The Johns Hopkins School of Hygiene and Public Health

HARRY E. SHELLEY, TH.B., J.D., *Coordinator of Alcoholism Programs,* Baltimore City Health Department

MISS JULIA SMITH, R.N., *Consultant in Mental Health,* State Department of Health

A. M. SCHNEIDMUHL, M.D., M.P.H., *Project Director*

MRS. GLADYS L. AUGUSTUS, B.S., M.ED., *Project Co-Director*

MRS. NANCY K. WRIGHT, ACSW, *Field Supervisor*

CURRICULUM COMMITTEE

PAUL V. LEMKAU, M.D., D.P.H., *Professor,* The Johns Hopkins School of Hygiene and Public Health

MAXWELL N. WEISMAN, M.D., *Director of Alcoholism Programs and Community Psychiatric Services,* State Department of Mental Hygiene

HARRY E. SHELLEY, TH.B., J.D., *Coordinator of Alcoholism Programs,* Baltimore City Health Department

A. M. SCHEIDMUHL, M.D., M.P.H., *Project Director*

MRS. GLADYS L. AUGUSTUS, B.S., M.ED., *Project Co-Director*

APPENDIX E

STATE LAW ENFORCEMENT PLANNING AGENCIES

ALABAMA
Alabama Law Enforcement Agency
State Capitol
Room 117, Public Safety Building
Montgomery, Alabama 36104
205/269-6665 (FTS 205/263-7521)

ALASKA
Governor's Commission on the Administration of Justice
Goldstein Building, Pouch AJ
Juneau, Alaska 99801
907/586-1112—thur Seattle FTS 206/583-0150

ARIZONA
Arizona State Justice Planning Agency
Continental Plaza Building, Suite M
Phoenix, Arizona 85015
602/271-5467

ARKANSAS
Commission on Crime and Law Enforcement
1009 University Tower Building
12th at University
Little Rock, Arkansas 72204
501/371-1305

CALIFORNIA
California Council on Criminal Justice
1927 13th Street
Sacramento, California 95814
916/445-9156

COLORADO
Division of Criminal Justice
Department of Local Affairs
600 Columbine Building
1845 Sherman Street
Denver, Colorado 80203
303/892-3331 (FTS 303/297-0111)

CONNECTICUT
Governor's Planning Committee on Criminal Administration
75 Elm Street
Hartford, Connecticut 06115
203/566-3020 or 246-2349 (FTS 203/244-2000)

DELAWARE
Delaware Agency to Reduce Crime
1208 King Street
Wilmington, Delaware 19801
302/654-2411

DISTRICT OF COLUMBIA
Office of Criminal Justice Plans and Analysis
Room 1200
711 14th Street N.W.
Washington, D.C. 20005
202/629-5063

FLORIDA
Governor's Council on Criminal Justice
104 S. Calhoun Street
Tallahassee, Florida 32301
904/224-9871 (FTS 904/791-2011)

GEORGIA
Office of Crime and Juvenile Delinquency Prevention
Bureau of State Planning and Community Affairs Office
270 Washington Street S.W.
Atlanta, Georgia 30304
404/656-3825 (FTS 404/526-0111)

GUAM
Office of Comprehensive Law Enforcement Planning
Office of the Governor
Goverment of Guam
P.O. Box 2950
Agana, Guam 96910

HAWAII
State Law Enforcement and Juvenile Delinquency Planning Agency
1010 Richard Street
Kamamalu Building, Room 412
Honolulu, Hawaii 96813
808/584-4572

IDAHO
Law Enforcement Planning Commission
State House, Capitol Annex No. 2
614 W. State Street
Boise, Idaho 83707
208/384-2364

ILLINOIS
Illinois Law Enforcement Commission
Suite 600
150 North Wacker Drive
Chicago, Illinois 60606
312/793-3393

INDIANA
Indiana Criminal Justice Planning Agency
215 N. Senate
Indianapolis, Indiana 46202
317/633-4773

IOWA
Iowa Crime Commission
520 E. 9th Street,
Des Moines, Iowa 50319
515/281-3241

KANSAS
Governor's Committee on Criminal Administration
525 Mills Building
Topeka, Kansas 66603
913/296-3066

KENTUCKY
Commission on Law Enforcement and Crime Prevention
Room 130, Capitol Building
Frankfort, Kentucky 40601
502/564-6710

LOUISIANA
Louisiana Commission on Law Enforcement and
Administration of Criminal Justice
P.O. Box 44337, Capitol Station
Baton Rouge, Louisiana 70804
504/389-5987 (FTS 504/389-2233)

MAINE
Maine Law Enforcement Planning and Assistance Agency
295 Water Street
Augusta, Maine 04330
207/289-3361 (FTS 207/622-6171)

MARYLAND
Governor's Commission on Law Enforcement and
Administration of Justice,
Executive Plaza, One, Suite 302
Cockeysville, Maryland 21030
301/666-9610

MASSACHUSETTS
Committee on Law Enforcement and Administration
of Criminal Justice
Room 1230
80 Bolyston Street
Boston, Massachusetts 02116
617/727-5497 (FTS 617/223-2100)

MICHIGAN
Office of Criminal Justice Programs
Lewis Cass Building—2nd Floor
Lansing, Michigan 48913
617/373-3392

MINNESOTA
Governor's Commission on Crime Prevention and Control
Metro Square Building, Room 222
7th and Roberts Street
St. Paul, Minnesota 55101
612/224-6612

MISSISSIPPI
Division of Law Enforcement Assistance
345 North Mart Plaza
Jackson, Mississippi 39206
601/354-6525 or 6591 (FTS 601/948-2460)

MISSOURI
Missouri Law Enforcement Assistance Council
P.O. Box 1041
Jefferson City, Missouri 65101
314/636-5261 (FTS 816/374-7000)

MONTANA
Governor's Crime Control Commission
1336 Helena Avenue
Helena, Montana 59601
406/449-3604

NEBRASKA
Nebraska Commission on Law Enforcement and
Criminal Justice
State Capitol Building
Lincoln, Nebraska 68509
402/471-2194 (FTS 402/475-2611)

NEVADA
Commission on Crime, Delinquency and Corrections
Suite 41, State Capitol Building
Carson City, Nevada 89701
702/882-7118

NEW HAMPSHIRE
Governor's Commission on Crime and Delinquency
3 Capitol Street
Concord, New Hampshire 03301
603/271-3601 (FTS 603/669-7011)

NEW JERSEY
State Law Enforcement Planning Agency
447 Bellevue Avenue
Trenton, New Jersey 08618
609/292-5800 (FTS 609/599-3511)

NEW MEXICO
Governor's Policy Board for Law Enforcement
P.O. Box 1628
Santa Fe, New Mexico 87501
505/827-2524

NEW YORK
State of New York, Office of Planning Services
Division of Criminal Justice
250 Broadway, 10th Floor
New York, New York 10007
212/488-3880 (FTS 212/460-0100)

NORTH CAROLINA
North Carolina Department of Local Affairs
Law and Order Division
422 North Blount Street
Raleigh, North Carolina 27602
919/829-7974 (FTS 919/755-4020)

NORTH DAKOTA
North Dakota Combined Enforcement Council
State Capitol Building
Bismarck, North Dakota 58501
701/224-2594

OHIO
Ohio Law Enforcement Planning Agency
Department of Urban Affairs
50 West Broad Street, Room 3200
614/469-5295 (FTS 614/369-5295)

OKLAHOMA
Oklahoma Crime Commission
820 N.E. 63rd Street
Oklahoma City, Oklahoma 73105
405/521-3392

OREGON
Executive Department
Law Enforcement Council
306 Public Service Building
Salem, Oregon 97310
503/378-3514

PENNSYLVANIA
Pennsylvania Criminal Justice Planning Board
Federal Square Station
P.O. Box 1167
Harrisburg, Pennsylvania 17108
717/787-2042

PUERTO RICO
Puerto Rico Crime Commission
G.P.O. Box 1256
Hata Rey, Puerto Rico 00936
809/783-0398

RHODE ISLAND
Governor's Committee on Crime, Delinquency, and
Criminal Administration
265 Melrose Street
Providence, Rhode Island 02907
401/277-2620 (FTS 401/528-1000)

SOUTH CAROLINA
Law Enforcement Assistance Program
915 Main Street
Columbia, South Carolina 29201
803/758-3573 (FTS 803/253-8371)

SOUTH DAKOTA
Governor's Planning and Advisory Commission on
Crime and Delinquency
State Capitol Building
Pierre, South Dakota 57501
605/224-3661 (FTS 605/225-0250

TENNESSEE
Tennessee Law Enforcement Planning Agency
Andrew Jackson State Office Building
Suite 1312
Nashville, Tennessee 37219
615/741-3521 (FTS 615/242-8321)

TEXAS
Criminal Justice Council
Executive Department
730 Littlefield Building
Austin, Texas 78701
512/476-7201

UTAH
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Room 304 — State Office Building
Salt Lake City, Utah 84114
802/328-5731 (FTS 801/525-5500)

VERMONT
Governor's Commission on Crime Control and Prevention
43 State Street
Montpelier, Vermont 05602
802/223-8444, Ext. 645 (FTS 802/862-6501)

VIRGINIA
Division of Justice and Crime Prevention
Suite 101, 9th Street Office Building
Richmond, Virginia 23219
703/770-6193

VIRGIN ISLANDS
Virgin Islands Law Enforcement Commission
Box 280, Charlotte Amalie
St. Thomas, Virgin Islands 00801
809/774-6400

WASHINGTON
Law and Justice Planning Office
Planning and Community Affairs Agency
Office of the Governor
Olympia, Washington 98501
206/753-2235

WEST VIRGINIA
Governor's Committee on Crime,
Delinquency and Corrections
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Charleston, West Virginia 25311
304/348-3689 or 348-3692

WISCONSIN
Wisconsin Council on Criminal Justice
State Capitol
Madison, Wisconsin 53702
608/266-3323

WYOMING
Governor's Planning Committee on
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307/777-7716 (FTS 307-778-2220)

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APPENDIX F

STATE ALCOHOLISM AUTHORITIES

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47 Trinity Avenue, S.W.
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Division of Mental Health
Department of Public Health and Social Service
Agana, Guam 96910

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Statehouse
Boise, Idaho 83707

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INDIANA
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MAINE
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Department of Human Resources
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END