



on of Alcoholism and Alcohol Abuse



STATE OF NEW YORK DIVISION OF ALCOHOLISM AND ALCOHOL ABUSE

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December 29, 1989

The Honorable Mario M. Cuomo Governor The State of New York Executive Chamber Albany, New York 12224

Dear Governor Cuomo:

I am pleased to submit to you and the Legislature the 1990 Update to the Five-Year Comprehensive Plan for Alcoholism Services in New York State. This Update satisfies the requirement of Section 5.07(b) of the Mental Hygiene Law in that it is based on the local services plans developed by local governments in compliance with the law and includes revisions based on comments received at seven public hearings held throughout the state during the month of September, and numerous submitted testimonies from individuals who were unable to attend the scheduled hearings.

The Update addresses many of the issues identified in the Division's 1989-1994 Five-Year Plan which was developed with a great deal of input and assistance from the alcoholism field. It is the Division's intention to continue to seek the advice of these dedicated professionals whose insight and concern for those in need are a credit to the state.

The plan update contains three chapters. Chapter I focuses on the concept of the alcohol connection to a host of health and human service problems. The Division has been engaged in a number of cooperative initiatives with other state agencies over the past year and this concept has been well-received at the local level. Chapter II describes internal Division activities, which have been undertaken during the past year in prevention and intervention, treatment and rehabilitation, professional development, and research. A key concept presented in this section is the notion of alcohol as the "gateway drug" to other drug use by young people. The final chapter focuses on planning and policy issues of long-standing concern to the Division and the field including financial accessibility to care and rural alcoholism service development.

I hope you find the document informative, and I look forward to your continued support in addressing the consequences of alcoholism and alcohol abuse. This support becomes ever more critical as we join forces with all New Yorkers to fight the pervasive debilitating effects of alcohol and other drug abuse.

Sincerely

Marquerite T. Saunders

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U.S. Department of Justice National Institute of Justice

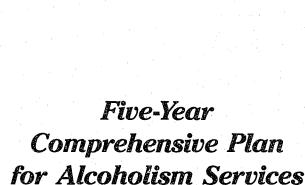
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1990 Update

in New York State

Submitted to Governor Mario M. Cuomo and to the Legislature in Accordance with Mental Hygiene Law, Section 5.07 (b) October 1, 1989 Following Public Comment and Revision



STATE OF NEW YORK Mario M. Cuomo, Governor

Division of Alcoholism and Alcohol Abuse 194 Washington Avenue, Albany, New York 12210 Marguerite T. Saunders, Director

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DICTIONARY OF ACRONYMS

State Agencies/Federal Agencies/State-Sponsored Entities

ADAC Anti-Drug Abuse Council

ADAMHA Alcohol, Drug Abuse and Mental Health Administration

CCF Council on Children and Families

DAAA Division of Alcoholism and Alcohol Abuse

DCJS Division of Criminal Justice Services

DFW Division for Women

DFY Division for Youth

DHCR Division of Housing and Community Renewal

DOCS Department of Correctional Services

DOH Department of Health

DOL Department of Labor

DOP Division of Parole

DPCA Division of Probation and Correctional Alternatives

DSAS Division of Substance Abuse Services

DSS Department of Social Services

DVA Division of Veterans' Affairs

HFMCFFA Housing Finance and Medical Care Facilities Finance Agency

IOCC Inter-Office Coordinating Council

NIAAA National Institute of Alcohol Abuse and Alcoholism

NIDA National Institute of Drug Abuse

NYC HRA New York City Human Resources Administration

OMH Office of Mental Health

OMRDD Office of Mental Retardation and Developmental Disabilities

SED State Education Department

SOFA State Office for the Aging

TFIP Task Force on Integrated Projects

Other Acronyms

ACIS alcohol client information system

ATC alcoholism treatment center

CAC credentialled alcoholism counselor

CDS client disposition survey

CIP client information profile

CON certificate of need

EAP employee assistance program

HSA health systems agency

LGU local governmental unit

LS-2C Monthly Statistical Report for Unit

LSP local services plan

MICA mentally ill chemical abuser

NDATUS National Drug and Alcohol Treatment Utilization Survey

RIA Research Institute on Alcoholism (Buffalo, NY)

SOAS state operated alcoholism services

INTRODUCTION

This is the first update to the Division's third generation Five-Year Plan (1989-1994) and describes the progress that has been made over the past year in addressing a number of the major issues facing the alcoholism field. The topics included in this update represent those areas which the Division has substantially addressed during the past year. It is the Division's intention to continue to use the action plan presented in the five-year plan as a short-term guide for policy making and program development activities. Other issues and areas identified in the five-year plan, and not covered in this update, will be addressed in subsequent updates.

This update concentrates on three systemwide principles for implementing the Division's three-year action plan:

- o to prevent the onset of alcohol abuse and alcohol dependence;
- o to reduce the incidence of alcohol-related problems; and
- o to provide effective treatment and recovery of alcoholic persons and their families.

Over the past year, the Division has engaged in a number of activities consistent with these principles. In the area of preventing alcohol dependence and alcohol abuse, the Division has further specified a continuum of prevention and intervention services and has stressed the concept of alcohol as the gateway drug to illicit drug use. In addition, the Division has disseminated the recent survey finding that the younger a person is when he/she begins using alcohol, the more likely they are to be a heavy drinker when they are older. Division prevention efforts have and will continue to target specific groups where needed and will stress a "no use" message to underage youth.

In response to reducing the incidence of alcohol-related problems, the Division has been engaged in a number of alcohol connection activities across the full continuum of alcoholism services — prevention, intervention, and treatment. The involvement of alcohol in a variety of social, family, and personal problems is, and will continue to be, a major theme of the Division. A number of cooperative and collaborative efforts undertaken by the Division at the statewide level are discussed in this update, and alcohol connection activities at the state and local program levels will be an ongoing focus of Division planning and program development efforts.

In providing for the effective treatment of alcoholic persons and their families, alcoholism program efforts over the past year have targeted specific subgroups in need of alcoholism services, as well as specific system issues such as availability of services to all those in need. In this update, activities related to the delivery of treatment services include alcoholism services for women, youth, families, and mentally ill chemical abusers. In addition, this update also examines the financial accessibility

of services for those unable to pay the full cost of care, rural alcoholism service development, and Division efforts to further streamline the program development process. In this year's local services plan guidelines, and also included in this update, the Division articulated a core continuum of alcoholism services which should be available within each county and a program development hierarchy to assist local alcoholism planners in prioritizing their program needs. The Division is committed to the establishment of a core continuum of quality alcoholism services in every county of the state. Refined and targeted services or programs should be developed in areas where there is a sufficient concentration of populations in need of these specialized services.

During this past year, the Division concentrated its program development efforts primarily on upgrading existing programs and implementing pilot demonstration projects such as hospital intervention services which had a specific appropriation. While new program development was limited, planning and policy development activities were expanded in order to place the Division and the alcoholism field in an advantageous position for those monies that were available, as well as for monies that may become available in the future. These activities included a revised local services planning process, promotion of the alcohol connection concept, and a number of internal work groups designed to identify problems related to specific issues and to examine potential solutions. These work groups were based on issues identified during the five-year plan development process.

The convening of internal work groups is the second phase of a functional process to resolve major issues facing the field. The first phase of this process is the identification of major issues and related potential strategies in conjunction with the alcoholism field. This was accomplished during the pre-plan work sessions (Spring 1988) for the five-year plan. first phase is followed by an internal work group which examines an issue indepth, doing background research, as necessary, and develops a draft proposal, policy, position paper, action plan, and/or set of recommendations for addressing the issue. This draft product is cleared internally and then the third phase of the process, which includes the involvement of interested individuals outside the Division, is implemented. This phase produces a final draft proposal which is submitted to the director of the Division. proposal is then reviewed by the director who determines whether further input is needed or that the proposal can be initiated. It is the Division's intention to continue to rely heavily on input from the alcoholism field through the use of external work groups and the local services and long-range planning processes in both identifying and resolving issues.

RELATIONSHIP BETWEEN LONG-RANGE AND LOCAL SERVICES PLANNING

Over the years the Division has sought to coordinate its statewide long-range planning efforts with the planning for, and development of alcoholism services at the local level. This coordination has enabled the Division, in conjunction with LGUs and the alcoholism field, to define a continuum of alcoholism services which are needed to address the problems of alcohol dependence and alcohol abuse in New York State. Once defined, the Division

has worked in partnership with local governmental units and local alcoholism providers to develop and implement a system of services designed to address the alcohol-related problems within each county of the state. This combined state-local effort has enabled the alcoholism service delivery system to develop in a flexible cost-efficient manner designed to meet the differing needs of the various counties throughout the state as well as to meet changing needs over time.

The Division utilizes the five-year plan and annual updates to introduce broad policies and directions which the Division intends to pursue over the course of the next few years. These documents are also used to provide more detailed information on specific initiatives to be undertaken by the Division during the following year. The broad policies and specific initiatives are developed by a variety of means including input from the field, gubernatorial or legislative initiatives, research findings and studies, and analyses by Division staff. The policies and initiatives presented in the plans and updates are also subject to public review. A draft of the plan or update is produced and distributed in August of each year. Public hearings are held during September throughout the state, and the testimony from these hearings provides feedback which is used to revise the draft document. The final version of the plan or update is submitted to the Governor and Legislature on or about October 1, including the changes based on presented testimony.

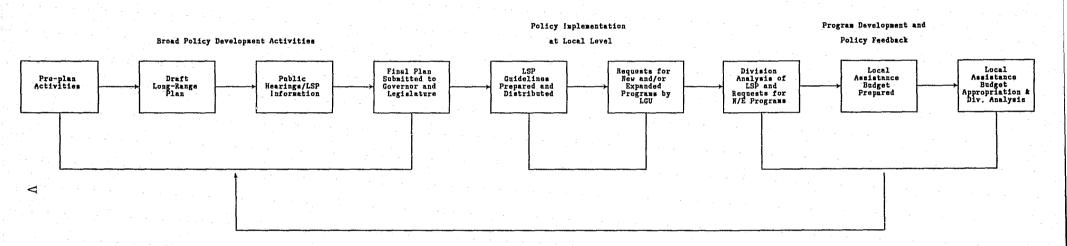
Following submission of the long-range planning document, the Division prepares the LSP Guidelines which are distributed by mid-February to all LGUs and local alcoholism providers. The LSP is utilized by the Division for four main purposes. First, the LSP generates the Division's local assistance budget request for new and expanded programs. Second, the LSP provides input for the development of the Division's long-rang plan. Third, the LSP helps implement policies and initiatives contained in the long-range plan. Fourth, the local plan provides information on the functioning of the alcoholism services delivery system which is not otherwise available. Through the LSP process, local governments generate proposals for new and expanded programs, some of which are later approved for inclusion in the Division's local assistance budget request. This information along with other data contained in the local plans is also utilized to help formulate broad planning and policy directions which may be articulated in statewide plan documents and then reviewed and commented on by the field. These broad directions are often in turn, included in the funding priorities and other sections of the local services plan guidelines to assist counties in their local annual alcoholism planning. This coordinated local/state planning process provides the state with information on local needs which can then be used to develop and implement policies which will enhance the development of alcoholism programming.

The 1990 Local Services Plan Guidelines introduced a number of new planning concepts designed to enhance local planning across the full range of alcoholism services, enable counties and the Division to develop more realistic annual budget requests and annual implementation plans, and reduce the annual effort to generate new/expanded program proposals. The principal change contained in the guidelines was the introduction of a three-year planning window for new and expanded program proposals. This approach

requested counties to separate the total pool of new and expansion proposals received from agencies and endorsed by the LGU into three, one-year priority listings based on the county's analysis of local needs. To assist local governments in this planning effort, the Division developed a hierarchy of program development which is presented later in this chapter. The major components of this hierarchy are developing core alcoholism services, correcting deficiencies in existing programs, and targeting services to special populations.

This overall process allows for input from the field during the policy development phase as well as feedback during the program development stage. The Division's analyses of LSPs and proposals for new and expanded programs provide information on the current functioning of the alcoholism service delivery system as well as what programs local governments and providers view as most critical. These analyses, coupled with the outcome of the budget request, allows the Division to determine how well program development policies worked and whether further modifications to existing policies or new policies are needed. This information is then incorporated into subsequent long-range planning activities. This process is presented schematically in the Figure on the following page.

RELATIONSHIP BETWEEN LONG-RANGE AND LOCAL SERVICES PLANNING



CHAPTER SUMMARIES

Chapter I: The Alcohol Connection

Chapter I focuses on the concept of the alcohol connection. This concept has two components: 1) alcohol is a factor in a wide range of social, family, and personal problems; and 2) linkages and collaborative efforts with other health and social service providers are essential in order to maximize prevention, intervention, and treatment efforts.

Chapter I contains a sample of efforts involving the Division and other agencies. These include membership in the Anti-Drug Abuse Council and the Task Force on Integrated Projects; collaborative efforts with various state and local criminal justice agencies, the Departments of Health, and social services; and initiatives directed at meeting the needs of the homeless, the elderly, Vietnam Veterans, and people with AIDS.

Chapter II: Intra-agency Initiatives

This chapter focuses on internal Division initiatives which have occurred during the past year in the areas of prevention and intervention, treatment and rehabilitation, professional development, and research. This chapter provides: information on alcohol as a gateway and norm setting drug; the newly revised program guidelines for EAPs; discussions of treatment services for women, families, youth, and MICAs; a discussion of the new CAC examination; and an annotated list of research projects currently underway at RIA.

Chapter III: Planning and Policy Development

This chapter focuses on planning and policy development issues of long-standing concern to the Division and proposes, suggests, and/or recommends future Division efforts. The issues discussed in this chapter include: financial accessibility to services; revision of the CON regulations; rural alcoholism service development; funding for local alcoholism services; the integrated need methodology; and the new alcohol information system.

PUBLIC HEARINGS

During August and September, the Division distributed approximately 3,000 copies of the draft 1990 Update to alcoholism providers, allied health professionals, local governments, policy makers and planners, the state legislature, state agencies, and interested citizens. Following this distribution, the Division conducted seven public hearings across the state during the month of September in order to receive comment and input on the draft document. The Division also continued to receive mailed testimony throughout September from individuals who were unable to attend the hearings.

Changes in the draft document have been made based on testimony received by the Division. The changes are highliqued by a vertical line in the margin of the page next to the revised text.

Following is the schedule and attendance for the public hearings:

Location	<u>Date</u>	<u>Testifiers</u>	<u>Attendance</u>
Buffalo	9/11/89	20	31
Rochester	9/12/89	8	24
Syracuse	9/13/89	13	34
Albany	9/14/89	7	19
Long Island	9/20/89	17	52
New York City	9/21/89	9	22
White Plains	9/22/89	15	22

CHAPTER I

THE ALCOHOL CONNECTION

INTRODUCTION

The Division introduced the concept of the alcohol connection in the Five-Year Plan (1989-1994). The concept has two components. First, alcohol has been identified as a factor in a wide range of social, family, and personal problems. Second, given the range of negative consequences associated with alcohol abuse and the limited resources of the Division, it is essential that linkages and cooperative efforts with other health and human service providers be established in order to maximize alcoholism prevention, intervention, and treatment efforts.

The need for such efforts was further indicated in an analysis of long-range goals and objectives developed in 1988 by local governmental units as part of their local plan for alcoholism services. This analysis indicated that certain issues and concerns, which could be addressed through cooperative linkages with other major systems, were shared by a number of counties throughout the state. These concerns involved each of the major portions of the alcoholism service delivery system, that is, prevention, intervention, and treatment, other major health and human service systems, and the criminal justice system. Many counties also suggested target populations, such as women, elderly, youth, ethnic minorities, and multi-disabled which might be identified through these other service systems.

As a result of the stated goals and objectives in the 1988 local services plans, and the Division's promotion of such activities at the state and local levels, the LGU's were asked in the 1990 Plan guidelines to identify existing and planned efforts to address the alcohol connection. The ways in which planned efforts were identified were varied and incomplete, and therefore are not described here.

The LGU's were asked to select from six development status options to describe current arrangements with seven separate human service systems. The statewide summary of responses is shown in Table I-1. It should be noted that a positive response to an option only indicates that there is at least one program in the county with such an arrangement. The responses in no way measure the extent to which these arrangements exist to cover all clients within a given service system.

Table I-1
Current Alcohol Connection Arrangements
Percent of Counties Responding By System Type

Current Alcohol Connection Arrangement

			Prevention and	Informal Referral	Training to Professionals	Formal Referral/	Provision of Alcoholism
	Counties	None	Education	Network or	in that	Screening	Treatment
System Type	Responding	Exist	Services	Arrangements	System	Procedures	Services
Health Care	60	11.7%	20.0%	48.3%	26.7%	31.7%	23.3%
Mental Health	59	0.0%	20.3%	37.3%	33.9%	45.8%	44.1%
Criminal Justice	60	1.7%	16.7%	30.0%	35.0%	55.0%	45.0%
Juvenile Justice	59	3.4%	15.3%	35.6%	23.7%	52.5%	33.9%
Social Services	59	0.0%	15.3%	55.9%	25.4%	40.7%	30.5%
Employment	59	15.3%	22.0%	40.7%	13.6%	42.4%	25.4%
School/Youth Progs.	59	1.7%	47.5%	49.2%	27.1%	37.3%	39.0%

Hospitals and other health care facilities often encounter individuals with alcoholism or alcohol dependence as an underlying or contributing factor. Approximately 12% of the counties completing Table 1B of the 1990 Plan guidelines, however, indicated that there are currently no arrangements in place to effectively deal with such encounters. An arrangement for some form of referral and/or screening procedure, however, was reported 73% of responding counties, primarily on an informal basis. This particular service area is addressed by the Division's hospital and health care intervention efforts described in Chapter II.

The historically close relationship between the alcoholism and mental health systems is reflected by the existence of some form of alcohol connection efforts reported by all responding counties. Furthermore, these arrangements tend to be more formalized and structured than with the health care system, as nearly twice as many counties indicated current arrangements for the provision of treatment services to clients within the mental health system.

Linkages with the criminal and juvenile justice systems tend to have more formal referral or screening procedures and often lead to the provision of treatment services for adults. This pattern of arrangements is undoubtedly heavily influenced by the convicted drinking driving population. Additionally, more counties reported arrangements for training of professionals and the provision of treatment services within the criminal justice system than any other system.

Current alcohol connection efforts with the social services system are primarily in the area of intervention and referral, with 88% of responding counties indicating some form of referral arrangement in place. A relatively low percentage of counties reported arrangements for the provision of prevention and education services in this area where such services may be particularly needed and appropriate.

Nine LGU's reported having no service linkage with employers within their respective counties. Of the 50 LGU's reporting linkages, however, 86% indicated having some form of referral mechanism in place, the highest percentage of such arrangements among the various systems.

Alcohol connection efforts with schools and other youth programs obviously focus on prevention and education services and on more informal referral arrangements, with 64% of the counties reporting either or both of these efforts. That figure goes to 78% when formal screening and referral is included.

An analysis of alcohol connection efforts by size of county showed that the least populous counties of the state (less than 100,000 population) reported more arrangements to provide prevention and education services to clients in other systems. The more populous counties, on the other hand, indicated a greater degree of training of professionals in other systems, formal screening and referral arrangements, and the provision of alcoholism treatment services to clients in other systems.

The Division has become involved in a number of alcohol connection activities over the past year. In some cases the Division has initiated or taken a leadership role in establishing or encouraging connections, while in other cases the Division has been receptive to initiatives from other agencies. At the state level, the Division is establishing linkages with a number of other state agencies to discuss possible collaborative efforts including innovative program models and funding mechanisms. The following alcohol connection activities are a sample of efforts involving the Division and other state agencies. These activities demonstrate the varied aspects of the alcohol connection, as well as the interest from other state agencies in the relationship of alcohol to other problems.

ANTI-DRUG ABUSE COUNCIL

In January 1989 Governor Mario M. Cuomo issued an executive order establishing a statewide Anti-Drug Abuse Council (ADAC). The directors of the Division of Alcoholism and Alcohol Abuse, the Division of Criminal Justice Services, and the Division of Substance Abuse Services, and the commissioners of the Department of Health and the State Education Department were named as members of ADAC. The council is chaired by Lieutenant Governor Stan Lundine.

The executive order establishing the council cites the unprecedented growth of drug abuse throughout the state and the need to develop and maintain extraordinary efforts to combat its consequences. ADAC's members have been charged with developing a coordinated effort in the areas of enforcement, education, prevention, and treatment to reduce the demand for drugs, including alcohol. The council's efforts are to be designed to enhance the state's existing anti-drug initiatives, as well as to recommend a comprehensive strategy to develop new measures to combat the growth of the drug epidemic. Measures are to include prevention and treatment, as well as approaches to decrease drug trafficking and drug use through vigorous law enforcement and education efforts.

The Division views its participation as an ADAC member as an opportunity to both contribute its expertise and to continue its own efforts to heighten awareness of alcohol as the gateway drug in the progression toward abuse of illicit drugs. Similar opportunities exist with regard to the Division's recent efforts to deal with the emerging trend of poly-substance abuse among youth and chemical dependency treatment approaches designed specifically for youth. Division-sponsored interdisciplinary programs, such as those developed through the Task Force on Integrated Projects, residential chemical dependency treatment programs for youth, and alcoholism services for methadone maintenance clients, are being reviewed by ADAC as potential models for replication.

As part of its agenda, ADAC co-sponsored "Substance Abuse '89," a four-day conference held in June in Rye, New York. The conference brought together participants involved in anti-drug abuse from both the public and private sectors. The Division contributed to this effort by hosting a number of alcoholism-specific workshop presentations and an anti-drug abuse roundtable which included representatives from the alcoholism field. The Division's director also participated as a member of a panel consisting of the five ADAC agency heads.

ADAC was also charged with preparing an anti-drug abuse strategy report to be submitted to the Governor by October 1, 1989. The Division contributed to the preparation of this report through its experience with local planning, and identification of existing local alcoholism resources and alcoholism issues related to anti-drug abuse efforts. This report, entitled "State of New York Anti-Drug Abuse Strategy Report" has been completed and proposes a three-prong approach utilizing enhanced prevention, treatment, and enforcement to combat alcohol and drug abuse.

THE DEPARTMENT OF HEALTH

Major system which offers opportunities for developing linkages to identify and intervene with persons with alcohol problems is the general health care system. A specific pilot project which the Division has developed for hospitals and which includes routine screening for all admissions for alcohol dependence problems is the hospital intervention program, which is discussed in Chapter II. The Division intends to demonstrate in this pilot the cost-effectiveness of such an approach in order to promote making these services an integral part of all general hospitals, as well as other health care settings. Research has shown that:

- o alcoholic persons and their families are high consumers of health care costs;
- o treatment of alcohol dependence results in decreased utilization of health care services by both the alcoholic person and family members;
- o failure to treat alcohol dependence will result in escalating health care and other costs.

In addition to hospital and other health care intervention opportunities, there are also numerous opportunities for integrating alcoholism treatment programs into health care settings. Currently, hospital and other health care settings account for 44 percent of all alcoholism outpatient visits. Many hospitals also provide medical alcoholism detoxification services and hospitals account for 17.5 percent of alcoholism inpatient rehabilitation beds. A more thorough discussion of sponsorship of alcoholism services is contained in the treatment and rehabilitation section of Chapter II.

Opportunities for addressing specific alcohol-related problems within the health care system also exist. For example, prevention and intervention programs targeted at women can be developed within health care programs, thereby taking advantage of women's tendencies to utilize these programs in obtaining care for themselves and their children. Such programs can address fetal alcohol syndrome, as well as the general health consequences of alcohol abuse. The state's extensive community public health network, which includes county health departments, public health nursing services, and maternal and infant care programs, may also be utilized in the prevention and intervention of alcohol problems.

Specific activities being conducted at the state level include:

- o the initial stages of preparing an interagency plan between DOH and the Division, which will utilize the Division's alcohol-specific expertise and DOH's extensive public health network;
- o collaborative efforts to develop materials to distribute to the community public health network; and
- o efforts, utilizing the local health care network, to inform at-risk groups, such as pregnant women, COAs, and so forth, about the dangers of alcohol consumption.

THE DEPARTMENT OF SOCIAL SERVICES

A key component of the alcohol connection concept involves linkages between the Division and DSS. The connections with DSS are viewed as particularly important since they often involve families and can serve as intervention opportunities for women who, as a group, are currently underrepresented in the alcoholism treatment system. The literature and experience of providers indicate that one barrier to treatment for women in need of alcoholism services is a lack of effective women-oriented intervention programs, and that alcoholism intervention for women needs to be promoted in family service agencies and health care settings.

The family nature of many DSS services is also important since alcohol dependence is considered a family disease with consequences not only for the alcoholic person but for the family members as well. In those instances where families receiving public assistance are also affected by alcohol dependence or alcohol abuse, it is important to address these latter problems and their consequences for all family members in addition to providing for their social service needs. Cooperative programming with DSS can assist in the development of effective identification and intervention programs particularly for families and women affected by alcohol dependence or alcohol abuse. In addition to intervention and referral, other areas of potential collaboration include cross-training, prevention, and education.

DSS may also provide valuable assistance to alcoholism treatment efforts through Medicaid eligibility and housing programs. With regards to Medicaid eligibility, certain alcoholism programs have expressed the need for cooperative efforts to expedite client eligibility procedures particularly in cases where clients living in one county are receiving services in another county. Other testimony called for DAAA and DSS to work cooperatively to develop alcohol— and drug—free supportive living environments. Through its participation in the Homeless Singles Task Force (DSS lead), the Division along with other key state agencies has developed a major 1990 initiative to begin to address the short— and long—term residential needs of homeless single alcoholic persons. The initiative includes increasing the availability of crisis center and community residences, developing innovative residential models and establishing independent permanent housing for persons with special needs.

Child Protective and Preventive Services

Effective September 2, 1988, Chapter 707 of the New York State Social Services Law was amended to provide greater state reimbursement for child protective and preventive services. Local social services districts which choose to pursue this increased level of state funding can receive it for qualifying expenditures on or after October 1, 1989. In order to qualify for this higher reimbursement level, the local social services district must implement enhanced performance standards for investigative activities and other child protective services, and develop a community services assessment and plan. This plan is to ensure the availability of a number of services to families receiving child protective and preventive services, including treatment for alcoholism. The legislation stipulates various requirements of this assessment and plan including:

- o an assessment of services to families and children involved in child abuse and maltreatment reports;
- o a projection of the number of child protective and preventive clients to be served, the types of services needed, and the methods to be used to provide such services; and
- o the use of a community child protective services assessment and planning committee to assist in the development of the community services assessment and plan.

The legislation further requires that those portions of the community services assessment and plan related to the provision of alcoholism services also be included in the annual implementation plans and budgets of the local services plan for alcoholism. In addition, the plans must include an estimate of the funds to be made available by the social services district for the provision or purchase of these services.

This legislation provides an excellent opportunity for the local alcoholism service system to develop linkages with local social services departments. The specific identification of alcoholism treatment as a service which must be included in the community services assessment and plan will help ensure that such needed services for child protective and preventive clients will be addressed. Due to the detailed planning stipulations of the legislation, LGUs and local alcoholism providers should be prepared to respond to possible requests for assistance from those local social services departments which choose to participate in the implementation of this legislation.

CRIMINAL JUSTICE ALCOHOLISM SERVICES INITIATIVES AND ACTION PLAN

Position Statement

The Division's initiatives in the criminal justice area are based on the premise that alcohol dependence and alcohol abuse play a significant role in the state's criminal justice problem. The criminal justice system is a major source of referrals to the alcoholism service delivery system. These referrals are increasing, and the trend is expected to continue. The Division is committed to the development and implementation of a series of coordinated, cooperative efforts that address the alcoholism treatment needs of criminal justice clients.

While the exact nature and extent of the association between alcohol and crime are not currently known, a 1988 joint report from the U.S. Department of Health and Human Services and the Federal Bureau of Investigation offers the following statistics regarding the involvement of alcohol in crime.

Alcohol is involved in:

- o seventy percent of all murders
- o forty-one percent of assaults
- o fifty percent of rapes
- o sixty percent of sex crimes against children
- o sixty percent of child abuse
- o fifty-six percent of fights and assaults in homes
- o thirty-seven percent of suicides
- o fifty-five percent of all arrests

These statistics support the Division's position that:

- o Alcohol dependence/alcohol abuse is a problem exhibited by a significant number of criminal justice clients.
- o Alcohol dependence/alcohol abuse has been identified in a significant portion of criminal justice problems.
- o Alcohol dependence/alcohol abuse has a negative impact on the spouses/partners, children, and friends of many criminal justice clients.
- o Failure to address alcohol dependence/alcohol abuse among criminal justice clients diminishes the potential for successful rehabilitation.

Therefore, the Division strongly encourages the alcoholism provider community to work closely with the criminal justice system to establish a continuum of services that can be integrated and coordinated with the sanctions and rehabilitation services offered by the criminal justice system. Alcohol dependence and alcohol abuse prevention, identification, intervention, and treatment services can play a vital role in crime prevention efforts and in the management and rehabilitation of many criminal justice clients. Joint programming efforts between alcoholism and criminal justice services have tremendous potential for identifying persons in the

early stages of alcohol dependence and alcohol abuse, and also for reducing the criminal justice costs associated with crime, arrest, supervision, and rearrest.

Actions and Activities

In the spring of 1988, a series of five two-day work sessions were conducted in order to obtain input from a broad spectrum of professionals in the field of alcoholism. Although each of these work sessions focused on a specific subject area, such as professional development, prevention and intervention, treatment, planning and policy development, research, and alcoholism and criminal justice issues were identified within each area.

In the Five-Year Plan (1989-1994), the Division indicated a desire to develop a plan to implement a series of coordinated, cooperative efforts to begin to address alcoholism service needs of criminal justice clients. Subsequent to the five-year plan, Division staff have engaged in a number of internal meetings involving central and regional office staff. The purpose of these meetings has been to examine the impact of criminal justice clients on the current alcoholism service delivery system, determine the capacity and capability of the current service delivery system to assimilate an influx of criminal justice clients, and identify potential, cooperative efforts between the Division and the criminal justice system.

Following the planning work sessions and internal meetings, Division executive staff met with executive staff from DCJS, the Commission of Correction, DPCA, DOCS, DOP, and DFY. An outcome of these meetings was a clear message from each of the criminal justice agency heads regarding 1) a recognition that alcohol dependence and alcohol abuse were major problems among their client populations, and 2) a willingness to explore the potential for cooperative efforts with the alcoholism community. As a result of these meetings, the Division's director was invited to participate as a member of the Governor's Criminal Justice Subcabinet.

Alcoholism Services for Criminal Justice Clients

The Division has conceptualized three program areas for potential collaborative efforts with the criminal justice system. These areas are:

- o <u>the state-operated adult criminal justice system</u> consisting of services for clients under the jurisdiction of DOCS and DOP;
- o the locally-operated adult criminal justice system consisting of services for clients involved in court procedures, probation programs, and local jails; and
- o <u>the juvenile justice system</u> consisting of services for clients involved in family court, diversion, local probation, county youth, and state-operated DFY programs.

This breakdown provides a conceptual model for both planning and funding cooperative programs with criminal justice agencies. From a planning perspective, the model defines the actors to be involved and clearly identifies specific criminal justice target populations. From a funding

perspective, the model defines options for funding cooperative programs. For example, for the state-operated adult criminal justice system and the state-operated portion of the juvenile justice system (DFY), the Division would consider programs jointly sponsored with another state agency and/or multiple state agencies. For the locally-operated adult or juvenile justice system, the Division would consider demonstration or regular local assistance funding. Priority would be given to programs that can demonstrate a commitment to shared funding by the local criminal justice system.

The Division views the transition points of entry and exit from criminal justice program areas as critical opportunities for alcoholism services intervention. Transition opportunities for joint programming in the state-operated adult criminal justice system can occur when the client moves from incarceration to parole, while in the locally-operated adult criminal justice system, entry into the system is a critical point for identifying clients. Opportunities exist on the front-end of the system to develop diversion programs and other alternatives to incarceration programs that would prove less costly than incarceration. Opportunities also exist to develop alcoholism treatment transitional services upon exit from the adult incarceration system to assist persons returning to the community and reduce the potential for recidivism.

Many program opportunities exist to address the needs of clients in the locally-operated adult criminal justice system. Specific examples of joint programming efforts include assessment services for probation and county jail clients; the development of alternatives to incarceration programs; the development of county-jail transitional services; the development of training programs for court, probation, and county jail personnel; and the development of comprehensive assessment and case management services for criminal justice clients who are multiply disabled. For example, comprehensive services are needed for mentally ill or developmentally disabled persons who are alcohol dependent and under criminal justice supervision.

The entry and exit from the juvenile justice system are critical points for intervening with both youth and family members with histories of alcohol-related problems. Joint programming efforts might include diversion programs that provide alcoholism education and treatment services; client assessment, linkage, and referral programs for juvenile justice offenders; and transitional services for youth returning to the community from DFY facilities.

Current Program Models

The Division is currently involved in a number of initiatives that have been favorably received by the criminal justice system. The Access Project is one such initiative. This is an interagency assessment, linkage, and referral program for parolees with histories of alcohol and/or other drug-related problems who are returning to New York City. Teams of alcohol and substance abuse counselors are located in the Manhattan and Brooklyn parole offices and work closely with parole staff. The Access counselors also provide services to inmates of the Lincoln Correctional Facility Pre-Release Program. Funds supporting the Division's participation in this effort have been received from DOP.

Another initiative in the early implementation stage is the Drug and Alcohol Self-Help (D.A.S.H.) Volunteer Network. The D.A.S.H. program is an effort to connect newly released inmates with community self-help groups. The majority of persons returning home from correctional facilities have no contact person in the community to assist them in establishing linkages with self-help groups such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). The purpose of the D.A.S.H. Volunteer Network is to provide support to parolees motivated to seek help for their alcohol problems. The primary role of the volunteer community contact person is to engage the released inmate in a self-help program within the first 24-48 hours following release.

It is anticipated that the D.A.S.H. program will become operational in the New York metropolitan area in 1989. If it proves successful, efforts will be made to expand the program statewide. The goal of this initiative is to have in place in each county of the state a contact person who would have available a roster of volunteers in the county who have indicated a willingness to help newly released inmates establish contact with a self-help group. This will ensure that all inmates seeking assistance in establishing contact with community self-help groups have the name of an individual to call upon for assistance. Once the program is fully operational, it is anticipated that it will be staffed primarily by volunteers. (Note: This program could be duplicated at the county level to provide similar services to inmates released from county correctional facilities.)

The Alcoholism Juvenile Justice Project is a third initiative, and it is expected to become operational during 1989. This is a federally funded project, developed in close cooperation with DFY, that will allow DAAA to hire an alcoholism counselor who will integrate community alcoholism services with the supervision services provided by community care workers in the four-county Capital District area. The counselor will provide alcoholism assessment, linkage, and referral services to youth returning to community living from DFY facilities. This project was initiated in recognition that many DFY clients have alcohol abuse problems and/or are from families with histories of alcohol-related problems. The goal of the project is to demonstrate that an integrated and coordinated approach between community alcoholism services and DFY community supervision services can result in fewer youngsters experiencing alcohol and criminal justice problems upon their return to community living.

The fourth initiative involves an agreement between DOP and the Division's St. Lawrence Alcoholism Treatment Center. Over a twelve-month period approximately 20 to 24 inmates will be released under parole supervision and integrated into the client population of the residential treatment program at the St. Lawrence facility. Following their participation in the residential treatment phase of the program, the parolees will be transitioned to community alcoholism treatment programs. Their participation in the residential and outpatient alcoholism treatment programs will be closely supervised by Parole. Anticipated outcomes from this jointly developed program between Parole and the Division are: 1) a successful treatment outcome for a significant portion of the program participants, 2) a reduction in rearrest and subsequent incarceration, 3) a cost savings to the state by reducing incarceration time, and 4) the development of funding mechanisms and other resources to implement proven models in other parts of the state.

A fifth Division initiative will involve the development of a program to address the needs of criminal justice clients who are alcohol dependent and developmentally disabled. The Division, in coordination with DSAS, has received federal funding from the New York State Developmental Disabilities Planning Council to conduct a statewide assessment of service needs and current service availability for criminal justice clients with alcohol problems and developmental disabilities. Anticipated outcomes of this effort will be the identification of successful program models and the potential to fund pilot projects targeting this special population.

Potential Program Development

In addition to the models described above, many other opportunities exist for collaborative program development involving the alcoholism community and the criminal justice system. In designing these programs, it is important to recognize that between 40 and 65 percent of individuals sentenced to state prisons and county jails in New York State were drinking when they committed their crime. It is also generally recognized that approximately 50 percent of the individuals under criminal justice supervision at either the county or state level have histories of alcohol-related problems.

Given these statistics and the results of the Division's deliberations with the criminal justice agencies, the following is a partial listing of program opportunities that warrant further exploration.

Within the state-operated adult criminal justice system, programs designed to address both criminal justice and alcoholism service needs should be considered. An example of a coordinated effort is the shock incarceration approach. This approach recognizes that alcohol and other drug problems are directly related to the person's crime, and that incarceration alone will accomplish little for the individual who has an alcohol and/or substance abuse problem. Incentives can be built into the program whereby the criminal justice client agrees to participate in an alcohol treatment program while incarcerated and following release from prison. This approach stresses a continuum of sanctions and services that provides the criminal justice client with the opportunity to assume responsibility in both rehabilitation from criminal activity and recovery from alcohol dependence. This coordinated effort has the potential to limit incarceration time and to ensure that an inmate receives alcoholism treatment services while in the prison setting and at the community level.

There are other opportunities for collaborative programming that can serve as alternatives to incarceration. One such program is the establishment of transitional living centers. These are centers in the community that function as short-term transitional residences. Persons are released to transitional living centers with the understanding that staff at the center will provide assessment, case management, and referral services. Staff at the center engage the client in those community services best able to help the client with housing, employment, vocational, social, and alcoholism outpatient treatment needs. This model parallels the Division's current community residential program models in the alcoholism service delivery system. One approach to establishing transitional living centers could be to develop alcoholism community residences for criminal justice

clients.

An alcoholism assessment, linkage, and referral service is needed in all major metropolitan areas of the state for newly released inmates. This service would work closely with parole offices to ensure that parolees with alcohol problems are identified and linked with appropriate community alcoholism services. These programs would provide a brokering service between the parole system and community alcoholism treatment services and would also ensure that there is a continuum which includes alcoholism services and criminal justice sanctions for the released individual.

There is also the need to develop a comprehensive assessment and case management service for special criminal justice populations. These populations would include the criminal justice client with a history of mental illness and chemical abuse, or developmental disabilities and chemical abuse. Both services and program models that effectively treat these special populations are currently limited and need to be developed.

Another option to consider is the establishment of an alternatives to incarceration alcoholism treatment program for parole violators. Parolees who would be eligible for this residential program are persons who have alcohol-related parole violations and, because of their alcohol dependence or alcohol abuse, are unable to meet the conditions of their parole.

Many of the concepts highlighted in the state-operated adult criminal justice system are also appropriate for application in the <u>locally-operated</u> adult criminal justice system. Most county courts, probation departments, and jails are being taxed beyond their capabilities. Again, the Division's recommendation is that emphasis be placed on jointly developed programs that provide diversion or alternatives to incarceration. One such approach is the honor court program. This model utilizes alcoholism treatment services as a sentencing option to be used in conjunction with other sanctions and/or as a plea bargaining condition in "adjournment in contemplation of dismissal." The honor court program is a case finding, case management, and treatment resource that can be used to identify and help individuals whose legal problems are inter-related with alcohol dependency or alcohol abuse.

Collaborative efforts between the local alcoholism community and the county criminal justice system could result in a comprehensive program to ensure that all individuals identified as having alcohol problems entering the county jail system receive an alcoholism evaluation and treatment plan, if necessary. Incentives could be built into this program to encourage participation in alcoholism treatment programs while in jail and/or following release. Jail time could be reduced for inmates who agree to the conditions of the treatment plan. This has the potential to reduce jail overcrowding and may reduce the chances of rearrest and incarceration for some persons.

The Division supports the concept that an intensive alcohol and substance abuse education program needs to be developed for use as a court sentencing option. It is envisioned that a 13 week, 26 hour program could be developed for individuals who do not need treatment services but clearly have problems with alcohol and are in need of a better understanding of how alcohol and other drugs are negatively impacting their lives. It is believed that many courts would utilize this community education resource as a sentencing and/or

adjournment in contemplation of dismissal option. It would be possible to structure this program to include a pre- and post-knowledge and attitude survey that could be used as a feedback mechanism to the courts. This program could be standardized and structured to ensure that it was user-funded.

The transitional living center concept is also a viable option for county alcoholism authorities to consider. These programs would provide needed services for county criminal justice clients with histories of both alcohol-related problems and unstable home environments.

The Division applauds the initiative by many county probation departments to establish probation alcoholism treatment programs. These programs should represent a coordinated effort between county probation personnel and alcoholism treatment providers. The Division plans to work with DPCA to develop guidelines for the operation and linkage of these programs to the alcoholism service delivery system.

The juvenile justice system has great potential for the early identification and treatment of persons with alcohol problems. These individuals if undiagnosed and untreated may eventually enter the adult criminal justice system. Alcoholism treatment providers have the opportunity to become involved in joint planning and program initiatives that could result in the provision of assessment and treatment programs for persons presenting themselves before family court judges and/or involved in PINS (Persons In Need of Supervision) diversion programs. LGUs and local alcoholism providers are also encouraged to explore joint program development opportunities with county youth or social services programs, including prevention and education, cross-training, intervention, and treatment efforts.

The Omnibus Criminal Justice Bill

Late in the 1989 legislative session, following the completion of the draft update, the Omnibus Criminal Justice Bill was passed by the legislature and signed into law by Governor Cuomo. Upon signing the legislation, Governor Cuomo said: "It provides the prison capacity to accommodate every sentenced offender who merits a term in state prison, and an intelligent and equally ambitious program of initiatives to address the problem of alcohol and drug dependency. Most importantly, this law is a forceful response to the problem of addiction that afflicts three out of every four offenders in our system. To reduce crime in the long run, we must break the vicious cycle of drug-related crime."

The legislation has a great deal of significance for the alcoholism community. One key component of the legislation calls for the construction of one, 750-bed alcohol and substance abuse treatment facility in the town of Romulus, Seneca County. In addition, construction of six, 200-bed alcohol and substance abuse treatment annexes will occur in the following areas: Town of Portland, Chautauqua County; Town of Brasher, St. Lawrence County; Town of Johnstown, Fulton County; Town of Chateaugay, Franklin County; Town of Butler, Wayne County; and Town of Marcy, Oneida County. The legislation states that outside contractors will be solicited by DOCS to provide alcohol and drug treatment for inmates who are within two years of parole eligibility

and are eligible for temporary release programs. Providers would have to guarantee participating inmates post release treatment services. A seventh annex site is pending, subject to legislative authorization.

The DOCS has requested input from this Division and DSAS concerning program recommendations for the alcohol and substance abuse treatment annex programs. It is the Division's position that the opportunity exists to implement various program models in the annexes. Alcoholism treatment providers are encouraged to respond to a request for proposals which will likely be issued in late 1989.

In addition, the new law makes available approximately \$7,000,000 to DPCA for payment of state aid to counties and the City of New York for local alternatives to incarceration programs. The legislation requires that the County Executive appoint to the Advisory Board for alternatives to incarceration or existing Criminal Justice Coordinating Council, the Director of Community Services and an individual within the county who provides a state certified alcohol and/or substance abuse treatment program or service. To be eligible for these additional funds, the county will be requested to develop a plan that includes an analysis of the relationship between alcohol, drugs, and crime, including the impact of alcohol and substance abuse on the jail, probation and alternatives to incarceration populations within the local criminal justice system.

The DPCA has requested consultation from the Division. The Division encourages county and city alcoholism providers to meet with members of the Advisory Board and/or Criminal Justice Coordinating Council to foster the development of alternatives to incarceration for alcoholic individuals within the local criminal justice population.

The legislation also makes available \$3,400,000 to DOP for the provision of alcohol and substance abuse services to parolees and conditional releasees. The DOP has requested Division assistance in expanding alcoholism services for the parole population.

The Division is pleased that the criminal justice agencies responsible for the implementation of the Omnibus Criminal Justice Bill are soliciting input and cooperation form the alcoholism community. This legislation provides a valuable opportunity for the alcoholism treatment community to work with the criminal justice system to develop a continuum of services and sanctions that hopefully will serve to break the cycle of alcohol and drug-related crime.

SERVICES TO THE HOMELESS

The alcoholism treatment system in New York State is continuing its long-standing tradition of serving homeless people with acute and chronic alcohol-related problems. Alcoholism services to homeless and runaway youth and to homeless families are growing, as are the more traditional services to homeless single adult individuals.

The Division is one of twelve state agencies providing services to homeless people. In 1987, a formal Interagency Workgroup on Homelessness, chaired by DSS, was established by the executive chamber to guide program development for the homeless. DSS is New York State's designated liaison for coordination of homeless services through the Comprehensive Homeless Assistance Plan (CHAP), which is required by the federal government in order for a state to receive McKinney Act homeless funds. The twelve participating state agencies include human service agencies, housing agencies, and advocacy agencies: DAAA, SED, DOH, DHCR, HFA, DOL, OMH, DSAS, DSS, Department of State, DVA, and DFY.

In addition to the interagency workgroup, the Division is actively involved in a number of specific interagency homeless program efforts for adult singles, homeless families, and runaway/homeless youth.

- Adult Singles The Division is exploring a number of treatment program models for addressing the various needs of homeless adult singles, including persons with multi-substance dependence and concurrent psychiatric disorders. service needs include emergency care, inpatient and outpatient long-term residential treatment, and alternatives. Consideration is being given to approaches which provide multiple services at the same location. This approach is particularly relevant for homeless persons who are mentally ill chemical abusers. The Division, in conjunction with other members of the interagency workgroup, is exploring this and other models.
- Homeless Families - During 1988-1989 the Division instrumental in the development of an outpatient treatment model for chemically dependent families living in Tier II family shelters. An interagency workgroup chaired by DSS, and involving DAAA, DSAS, and DOH, is now following through to bring the concept into operation. An RFA (Request for Applications) was sent to alcoholism, substance abuse, and family shelter providers in June 1989, with contracts projected for October. Two service options could be developed: 1) a single voluntary agency could provide both the core Tier II shelter for 24-40 chemically dependent families and the outpatient alcoholism and substance abuse services; or voluntary agency could operate a core Tier II shelter and contract with another voluntary agency to operate the dually-certified alcoholism and substance abuse clinics.
- o Runaway/Homeless Youth For the past three years, the Division has been an active member of DFY's Runaway/Homeless Youth

Advisory Council, sharing technical knowledge concerning transitional residence models and participating in local plan reviews. A number of potential services linkages are being explored between alcoholism clinics that provide youth and family treatment services and DFY's youth transitional residences. Starting in February 1989, utilizing TFIP funding, the Cumberland Alcoholism Clinic in Brooklyn opened a full day treatment program for multi-problem, chemically dependent This treatment service includes two full-time teachers youth. and offers services in Spanish as well as English. homeless youth shelter and transitional living facilities in Fort Green and adjacent neighborhoods are a major referral source. This pilot program provides the opportunity to develop specific techniques and procedures for providing alcoholism treatment to homeless youth, and has the potential for replication elsewhere in the state.

The interagency homeless efforts which have been described above have had to rely almost exclusively on state and local commitment. The Division, in concert with the other state agencies involved in providing services to the homeless, is seeking to attract increased federal support for New York State through the McKinney Act.

TASK FORCE ON INTEGRATED PROJECTS FOR YOUTH AND CHEMICAL DEPENDENCY

The Task Force on Integrated Projects for Youth and Chemical Dependency (TFIP) was created by Chapter 812 of the Laws of 1987 to ensure an integrated approach among state agencies responsible for prevention, education, and treatment services to high-risk chemically dependent youth and multi-disabled persons. The new law named the director of DSAS (also designated as chairperson of TFIP), the director of DAAA, and the commissioners of OMH and SED as members of the task force. The law created a mechanism to develop and fund pilot, innovative, community-based programs designed to address needs of at-risk youth and multi-disabled persons. The task force was established on July 1, 1987, with an expiration date of October 1, 1989.

To date, two rounds of funding have been completed, the first in October 1987, and the second in June 1988. A total of 98 applications for treatment projects were submitted, and twenty-one were funded for a total of \$4.8 million. Thirteen of these programs serve persons under 21 years of age, while eight programs focus on services to dually-diagnosed young adults. The Division has lead or co-lead responsibility for ten of the twenty-one programs, funded at approximately \$1.7 million. Of these ten programs, seven are youth treatment services, and nine of the ten are expansions of existing alcoholism treatment programs.

A total of 410 prevention program applications were submitted, 62 of which were funded, at a total of \$6.3 million. The Division was designated as lead agency for 28 of these programs, totaling 2 million in prevention dollars. All programs, both treatment and prevention, have significant replication potential if proven effective and represent innovative approaches in the organization and delivery of services. Annotated descriptions of the treatment and prevention programs for which the Division has the lead or co-lead responsibility are contained in Appendix A.

During the summer of this year, following the completion of the draft 1990 Update, legislation was passed to amend Chapter 812 of the Laws of 1987 which established the Task Force on Integrated Projects. The new law (Chapter 711 of the Laws of 1989) contains a number of significant changes:

- o mentally ill chemical abusers are specifically identified as a target group;
- o new language enabling the task force to make administrative rules and regulations to facilitate the review of funding applications for pilot projects;
- o new language calling for local planning coordination of alcoholism and drug abuse prevention and education efforts funded through TFIP and specifying certain program content;
- o new language calling for reports from funded projects;
- o new language specifying licensing requirements for applicants; and
- o extension of the TFIP legislation until October 1, 1992.

The new law also identifies an appropriation of two million dollars in Chapter 53 of the Laws of 1989 for the purpose of establishing school and community-based drug and alcohol abuse prevention and education programs under TFIP.

The Division intends to continue to support the concept of the TFIP for the rapid development and implementation of new and cooperative programs to address the needs of the multi-disabled and at-risk, chemically dependent youth and mentally ill chemical abusers. The Division is in favor of including an evaluation mechanism in the TFIP approach to determine which program models are most effective and should be prioritized for integration into member agencies' budgets and operations.

AGING

Another area of concern for the Division which offers the potential for cooperative linkages is alcoholism services for the elderly. The Division has identified the elderly as a group which experiences access problems within the alcoholism service delivery system, and may require services tailored to address their specific needs. Population-based surveys historically indicated that alcohol consumption rates were significantly lower for the elderly (60+) than for middle-age adults (40-59). In the Division's recent report Alcohol Use and Abuse Among Adults in New York State, which utilized data from a 1986 adult household survey, it was somewhat surprising to note that rates for heavier drinking among the elderly were as high as those for middle-age adults. In addition to this finding, other specific concerns of the Division in planning for services for this growing population are the etiology and correlates of problem drinking among the elderly, as well as an over-all need for more research on drinking among the elderly.

The Division, through the Research Institute on Alcoholism, and in cooperation with SOFA, has developed a research plan to obtain reliable and valid information about alcohol use among New York's elderly citizens and the prevalence of specific alcohol problems in this group. The research plan includes mechanisms for the dissemination of findings to relevant governmental agencies, voluntary organizations, legislative authorities, service agencies, and individuals. The findings will also serve to aid the SOFA and the Division in the development of specific strategies and programs targeted to affected segments of New York's elderly population. The research protocol submitted to the Administration on Aging of the U.S. Department of Health and Human Services was approved for two years of funding and began operation on September of this year.

The research proposes to utilize a telephone survey of 2,400 New York residents 60 years of age or older, with oversampling of heavy drinkers, and plans to investigate a number of possible correlates of problem drinking among the elderly. Prevalence rates for problem drinkers, non-problem drinkers, and abstainers will be established. Problem drinkers will be further subdivided into those with recent onset of alcohol problems and those with continuation of problems that began earlier in life. The role of life events common to the elderly, such as retirement and bereavement, in recent onset of problem drinking are a particular area of interest, especially among older persons whose coping mechanisms or social supports are inadequate. The research will also explore suggestions that heavier drinking among the elderly may be related to an active/leisure lifestyle. Decreased drinking, which is characteristic of the elderly, may be related to illness, lower tolerance, less active lifestyle, or health-oriented lifestyle, and each of these factors is included in the research. Finally, the area of drug-alcohol interactions is especially critical among the elderly because of the high use of prescribed and over-the-counter medications. This important issue will also be studied in the research.

The dissemination and utilization of findings will be a collaboration between DAAA and SOFA, involving a multiple level approach. The first level of dissemination will be national and statewide groups and organizations interested in alcoholism or aging. The second level will be state, regional,

and community planners and administrators for alcoholism and aging services. The third level of dissemination will be local providers of alcoholism and aging services. This third level consists of local agencies, including private-proprietary, nonprofit, and hospital-based programs funded and/or certified to provide alcoholism or aging services. The fourth level of dissemination consists of the elderly consumers who receive or are in need of alcoholism and aging services.

The Division plans to continue to pursue cooperative efforts with SOFA, and to continue to encourage these efforts on the local level. In the upcoming year, the Division will be proposing a collaborative effort with SOFA to develop a joint action plan on alcoholism services for the elderly. Consideration will be given to joint statements and/or releases from the Division and SOFA on alcohol dependence and alcohol abuse among the elderly in conjunction with the state planning process in 1990 to develop a state agenda for the White House Conference on Aging, which takes place in 1991. The Division believes that alcohol problems among the elderly should be included as an agenda item at both the state and national level.

ALCOHOLISM SERVICES FOR VIETNAM VETERANS

Introduction

For years, the majority of persons believed that most veterans with alcohol problems were being treated in the Veterans' Administration (VA) hospitals. However, increasingly we find more and more veterans are turning to state-funded and certified alcoholism programs for treatment. In 1986, a one-week survey found that veterans represented about one in four of the male treatment population. This is a very significant sub-population, and likely to increase if federal services are cut. Services to veterans, particularly Vietnam veterans, have been identified as a high priority by the Division.

Alcoholism prevalence among veterans in general is between 10-12 percent, slightly higher than for the population as a whole. In addition, a number of studies conclude that in-country Vietnam veterans (Vietnam veterans who actually served in Vietnam, Cambodia, and Laos) experience a higher level of problem drinking than either Vietnam era veterans (those veterans who served in active duty between January 1, 1963, and May 7, 1975, at other than Vietnam, Cambodia, Laos, or the larger southeast Asia theatre) or non-veterans. This is particularly significant as Brinson and Treanor point out in a recent article in the Alcoholism Treatment Quarterly, "It should further be noted that the average age of Vietnam veterans is about forty years old, just the age when physical tolerance to alcohol generally breaks down, and the overt symptoms of progressive alcoholism most insidiously begin to manifest themselves."

During the next decade, it is anticipated that many more veterans will seek help for alcoholism problems. The issue of accessibility to alcoholism services for Vietnam veterans may become critical if access to the federal Veterans' Administration system is limited for either of the following reasons:

- 1) Due to federal budget constraints, the Veterans' Administration has considered the closure of wards in many VA Medical Centers and New York State may be affected by this situation. If closure of medical center wards occurs in the near future, particularly those with alcohol and drug programs, this could mean a large influx of patients into the state-funded and certified alcoholism service delivery system;
- Since receiving services within the VA system is based on a priority system largely determined by category of discharge and/or disability, access to care in VA Medical Centers is often limited for those Vietnam veterans most in need. For example, Vietnam veterans suffering from Post Traumatic Stress Disorder (PTSD) and/or chemical dependency who are most in need of services, may have received an "undesirable" or "bad conduct" discharge placing them on a lower priority or making them ineligible for services.

Based on Division need estimates, utilizing age/sex problem drinking rates only and not accounting for in-country status, it is estimated that 14.5 percent or 63,724 Vietnam era veterans are problem drinkers. Using this

same approach, it is conservatively estimated that of this group there are 19,496 Vietnam in-country veterans who are problem drinkers. It is also estimated that there are approximately 1,400 women Vietnam era veteran problem drinkers. Furthermore, based on the 1986 Patient Characteristics Survey the following estimates for Vietnam veterans admitted to the alcoholism service delivery system in 1988 have been derived:

- o alcohol crisis centers 2,598;
- o acute care 1,197;
- o outpatient clinics 2,968 males;
- o outpatient rehabilitation 284;
- o inpatient rehabilitation 772; and
- o community residences 177.

In its efforts to increase access to alcoholism services by Vietnam veterans, the Division has identified a number of issues which must be addressed, including the following:

- o Access to treatment by sub-groups of Vietnam veterans, for example, women, Blacks, Hispanics, and Native Americans, may intensify already difficult access problems.
- Outreach by alcoholism clinics to the Veteran Centers operated by the VA can effectively improve access to treatment.
- Many men who served in Vietnam or other Southeast Asian countries during the conflict did so when they were eighteen or nineteen years of age. For many, their war experiences and subsequent difficult readjustment experiences in the United States have resulted in a high level of social isolation.
- o Veterans and their families often require assistance and support from more than one service system.
- o There is a high correlation between alcoholism and PTSD. Estimates of alcoholism rates among those who suffer from PTSD range from 60 85 percent.
- Concurrent treatment for both conditions is essential. If either the alcoholism or the PTSD is left untreated, the person remains under extreme pressure. Treatment within an alcoholism program should focus on the establishment of a small supplementary group for Vietnam veterans to deal with common problems, in addition to including the veterans in other groups and activities with other alcoholic patients. Flexible availability of individual counseling and psychiatric consultation is also key, however, psychoactive medication over long-term periods has proven to be contra-indicated.

- o Family treatment, and the treatment of individual family members, must be conducted with the understandit that a combination of alcoholism and PTSD in a family creates additional problems.
- o Most alcoholism treatment programs are unfamiliar with PTSD associated with alcohol problems and training of alcoholism staff is needed. The major issue for training the alcoholism service provider is to ensure an understanding of the Vietnam experience and PTSD. Training on PTSD should be required for alcoholism professionals who expect to work with Vietnam veterans. Alcoholism programs which choose to develop specialized services for Vietnam veterans should ensure that clinicians have a comprehensive training in PTSD and related treatment issues.
- o Vietnam veterans represent ten percent of all male admissions to local alcoholism treatment programs and state-operated ATCs. Therefore, the programmatic need for in-service training and the creation of additional groups and services is most critical.

Strategy

In response to Vietnam veterans access issues, the Division convened an internal work group to identify major barriers and to explore proposed strategies. This group will develop a draft policy statement with recommendations and an action plan which will be circulated to representatives from outside the Division and then submitted as a final draft to the director of the Division.

The Division also expects to collect military status and Vietnam Veteran status as part of the new alcohol client information system. This information may also include the "in-country/not in-country" distinction. The coding scheme would also include currently serving, reserves/national guard, Vietnam veteran, other veteran, and those who never served. The final coding scheme will be determined after an extended review of the pilot process. While this system will not be fully implemented in all programs until June 1991, some preliminary information will be available prior to that date. The Division has also engaged in a number of specific activities related to Vietnam veterans:

- o In its 1990 LSP guidelines (issued 2/89), the Division identified Vietnam veterans as a special population which has experienced unique access problems within the alcoholism service delivery system.
- o In the 1989 Program Guidelines, the Division presented a model for alcoholism outreach and intervention services within a Veteran Outreach Center. This model specifically references Vietnam veterans and their families, and the need to address specific issues such as PTSD.

- o The Division worked with the Division of Veterans' Affairs to establish linkages between their counselors and local alcoholism providers.
- o The Division also worked with the Office of Vocational Rehabilitation to obtain a re-examination of their six-month sobriety requirement before admission to a training program.
- o The Division assisted the Department of Labor in obtaining alcoholism training for over 200 Job Service Veterans' staff within its own system.
- o The Division conducted a program in conjunction with the Camp LaGuardia Residence for the Homeless, where 50 percent are estimated to be veterans; and established a referral program to ensure access to the Division's state-operated ATC.

A second major emphasis of the Division has been in response to the issue that Vietnam veteran problem drinkers and their families often require services from more than one service delivery system. Therefore, the Division will promote interagency coordination, for this population, at the state and local levels. In order to meet the goal of coordinating services for Vietnam veterans, the Division will focus its efforts in the following areas:

- o work with the Department of Social Services in the areas of housing for homeless veteran alcoholics;
- continue work with DOL in training of Job Service Veterans' staff in the areas of alcoholism education, identification, and referral;
- o work with OMH to train mental health staff to ensure that Vietram veterans suffering from PTSD who also need treatment for alcoholism are referred propriately;
- o promote coordination through joint policy development; the review of mandates and regulations which may create barriers to access; and, where appropriate, develop interagency agreements to ensure service delivery to Vietnam veterans;
- o promote outreach services from alcoholism clinics and Veteran Centers utilizing Credentialed Alcoholism Counselors (CACs) through visits to a range of veteran agencies and programs;
- o develop a pilot training program for recovering Vietnam veterans in conjunction with DOL to become CACs using the SOAS for training sites; and
- o review Division regulations for any constraints or barriers which limit access for Vietnam veterans.

AIDS - ACQUIRED IMMUNE DEFICIENCY SYNDROME

ATDS is readily acknowledged as a major public health issue and one that has had widespread impact on the alcoholism treatment system. As indicated in the Five-Year Plan (1989-1994), many people now entering the alcoholism treatment system have used drugs intravenously and have shared needles within the last ten years. They may also have engaged in high-risk sexual behavior. Their needle-sharing and sexual behaviors have placed these individuals and their sex partners at risk for HIV infection. Depending on geographic location, the Division estimates that 5% to 30% or more of those in alcoholism treatment may be infected or at risk of infection. The Division considers the need for accurate information on the prevalence of AIDS within the alcoholism service delivery system to be a priority and is making plans for the collection of the information.

Conversely, alcohol may play a role in the development of HIV infection and the progression of the disease due to the adverse effects of alcohol use on the immune system. Alcohol's possible role as a co-factor in the development of AIDS is currently being researched.

Alcohol use/abuse has two additional consequences related to AIDS that have been documented. First, chronic alcohol use causes liver damage, and AZT, one of the few drugs available for treating AIDS, is contraindicated for people with liver damage. Second, isoniazid (INH), the drug used to prevent (and treat) tuberculosis, cannot be used in conjunction with alcohol. Unfortunately, an increased incidence of TB among HIV-infected IV drug users, many of whom abuse alcohol, has been documented.

The use of alcohol is also implicated as a factor in behavior that results in infection, either through the increased likelihood of IV drug use or the decreased likelihood that individuals will practice safer sex. Because of alcohol's disinhibiting effects, people may engage in behavior they would have avoided if sober. We know, for example, that gay men in San Francisco, probably the best educated and most aware group in the country in regard to the need to utilize safer sex practices, tend to engage in unsafe behaviors when sex is preceded by alcohol use. For women, whose efforts to negotiate safer sex are often complicated by cultural, social, ethnic, racial, and religious factors, alcohol use may undermine the most determined intentions to reduce risk.

Other studies indicate that alcohol abuse is common among methadone maintenance patients and current or former cocaine users. Alcohol use by these individuals may trigger a relapse to illicit drug use, thereby increasing their risk of HIV infection.

The Division recognizes the importance of the AIDS-alcohol connection and has been actively involved in numerous interagency, AIDS-related initiatives. The primary areas of involvement include the collaborative responsibilities delineated in the Governor's Five-Year AIDS Plan, co-sponsorship of the Women and AIDS Project, preparation of HIV-related regulations, and creation of AIDS coordinator positions in some NYC alcoholism clinics.

Five-Year AIDS Plan

The Division is a member of the Governor's Interagency Task Force on AIDS, which oversees the implementation of state-agency collaborative initiatives, and Division staff participate in the task force's four committees (Prevention/Education, Housing, Criminal Justice, Strategic Planning).

The Division's interagency responsibilities under the Five-Year AIDS Plan include development and implementation of the initiatives listed in the following table:

Recommendations	Involved Agencies
A pilot intervention program to educate gay and bisexual men about the related issues of drug and alcohol use and AIDS prevention.	DAAA DOH DSAS
Primary prevention of alcohol and other drug use through programs targeted to school age youth and public information campaigns to increase awareness of the relationship between alcohol and other drug use and HIV infection.	DAAA DSAS
A task force to identify existing programs for reaching women at risk of HIV infection.	DAAA DOH DSS DSAS DFW CCF
A youth council on AIDS and adolescents to help plan and develop HIV-related education, consultation, and assistance to staff of youth programs, group homes, and residential facilities serving troubled youth.	DAAA DOH DSS DSAS DFY
Curricula and HIV training for state licensed and funded health, human service, and chemical dependency treatment programs serving at-risk adolescents.	DAAA DOH DSS DFY DSAS

	Involved
Recommendations	<u>Agencies</u>
A continuum of residential options for HIV	DAAA
infected people.	DSS
	DOH
	DSAS
	HFMCFFA
	NYC HRA
Substance abuse treatment and health programs in	DAAA
correctional settings.	DOCS
	DOP
	DSAS
	DOH
Models for alcohol and substance abuse treatment	DAAA
in work release facilities.	DSAS
	DOCS
A plan for continuing treatment begun in prison	DAAA
for people under the supervision of parole.	DOP
	DSAS
Regional AIDS planning.	DAAA
	HSAs
	State Agencies
	Local Agencies

Women and AIDS Project

The Division also co-sponsors, with DFW, the Women and AIDS Project. The project provides monthly educational/informational seminars in Albany and New York City on issues relating to women and AIDS. The project also produces a quarterly newsletter and recently published the proceedings of its public hearing on the impact of AIDS on women, children, and families.

Participants in the project include staff from state and local governmental agencies, service providers, advocates, educators, representatives from various religious organizations, state legislative staff, caregivers, and volunteers for various HIV-related organizations. Of the over 1,400 members, approximately 800 are located in New York City, over are in the Capital District, 50 are in Rochester and Syracuse 200 respectively, and 300 are located throughout the United States and other countries. As a direct consequence, interagency barriers have been lowered and interagency coordination and cooperation have improved. Furthermore, service providers and advocates have gained access to government officials, and government staff have been provided with valuable advice and feedback from those directly affected by governmental policies.

Through additional funding from the AIDS Institute, a full-time project coordinator was recently hired. During the 1989-1990 FY the coordinator will establish additional project chapters on Long Island and in Rochester. Other project responsibilities, as delineated in the Governor's Five-Year AIDS Plan, include development of regional service directories for HIV-infected women, creation of support groups for caregivers, and sponsorship of a statewide conference or a series of smaller neighborhood forums.

HIV-Related Regulations

Public Health Law Section 2786(1), as added by Chapter 584 of the Laws of 1988, required each agency authorized to obtain confidential HIV-related information to promulgate rules and regulations to implement new Article 27-F of the Public Health Law. In fulfillment of this requirement, the Division issued an emergency rule in May 1989. Following a period for public comment, the rule was adopted on a permanent basis. It amended 14-NYCRR by adding Part 309 and revising Parts 305, 372, 374, 375, 380, 381, and 382.

The proposed regulations, as required by Article 27-F of the Public Health Law, establish:

- o requirements for informed consent to an HIV-related test;
- o restrictions on disclosure and release of confidential HIVrelated information;
- o authorization for contact notification by physicians in certain circumstances; and
- o definition of significant risk.

In addition, Division regulations:

- o prohibit discrimination in the provision of alcoholism services based on actual or perceived HIV-related condition or willingness to be tested or to disclose test results;
- o require facilities to develop policies and procedures relating to treatment of protected persons and training of staff on HIVrelated requirements and practices; and
- o reconcile the federal regulations on confidentiality of alcoholism patient information with the requirements of Article 27-F.

The Division worked closely with DOH on the development of the new regulations and the HIV-specific release of information form to ensure compliance with both the state law and the federal confidentiality requirements. In addition, the Division and DSAS consulted with one another before issuing their respective regulations to ensure interagency compatibility of HIV-related regulations, particularly in regard to chemical dependency for youth programs.

AIDS Coordinators

In cooperation with the New York City Department of Mental Hygiene, Mental Retardation, and Alcoholism Services, AIDS coordinators have been placed in nine NYC alcoholism clinics. The clinics are located in NYC Health and Hospitals Corporation hospitals that are, or have applied to be, designated AIDS care facilities and voluntary hospitals. The coordinators provide alcoholism evaluation and referral services and act as a linkage between the alcoholism clinic and other needed services.

Specifically the AIDS coordinators:

- o provide comprehensive education and training for alcoholism clinic staff, patients, and family members/significant others;
- o refer HIV-infected alcoholic patients and their families to appropriate health, mental health, and social services;
- evaluate those people with AIDS who utilize hospital services and who may need alcoholism treatment, and refer them to appropriate alcoholism services;
- o act as a liaison and advocate with other service providers; and
- o provide information and education on the relationship between alcohol use and HIV infection to hospital staff and patients.

During the 1989-1990 fiscal year, the Division plans to create six additional AIDS coordinator positions, one for each of the regions outside of New York City. These coordinators will be located in the regional, AIDS Institute-funded community service programs (CSPs), thereby broadening the spectrum of services the CSPs can provide the HIV-infected people and their families.

CHAPTER II

INTRA-AGENCY INITIATIVES

This chapter presents highlights of intra-agency initiatives which have occurred over the past year in the areas of prevention and intervention, treatment and rehabilitation, professional development, and research. majority of these initiatives and associated activities represent follow-ups to major issues identified in last year's plan. In seeking final resolution of the various issues, it is the Division's intention to continue to solicit and utilize the input of the field. The general process, which the Division will employ when identifying and resolving issues, is: input from the field is obtained to identify issues, needs, and so forth (pre-plan work sessions, Spring 1988); Division conducts background work, holds internal deliberations, and develops a product, for example, a position paper, proposed recommendations, and so forth; a variety of mechanisms are utilized to gather input and feedback from the field, for example, advisory groups, work groups, task forces, meetings, and editorial boards; the product is revised accordingly; recommendations are presented to the Director; and policy is implemented in a variety of ways, such as regulatory changes, administrative bulletins, and revisions in program models and funding priorities. While much of the work over the past year represents the internal work phase, it should be evident that much of the work in the upcoming year will involve the alcoholism field and its input and recommendations to Division proposals.

PREVENTION AND INTERVENTION

INTRODUCTION

In the Five-Year Plan (1989-1994) the Division identified a number of issues related to the delivery of alcoholism prevention and intervention services. Many of these issues were raised by representatives of the alcoholism field at the pre-plan work session and a major need articulated was for a clear definition of the role, function, and philosophy of prevention and intervention within the alcoholism service delivery system. As a first step in addressing this need, the five-year plan presented a preliminary conceptual framework which included a continuum of alcohol use:

Non-Use ----> Use ----> Abuse ----> Alcoholism

This continuum, the setting, and the target population were identified as critical components in specifying any alcoholism prevention or intervention effort.

As was stated in last year's plan, the Division views prevention/education and intervention/referral as integral components of the alcoholism service delivery system. In this year's local services plan guidelines, the Division identified a general community-based prevention and education program and a general community-based intervention and referral program as elements of the core continuum of alcoholism programs, which should be available within each county. As part of the local services plan, each county was requested to determine the availability of these prevention and intervention services, as well as treatment programs which were defined as a core continuum. If core services were not currently available, the development of these services were suggested to be a priority for development. Once the core continuum of services is in place, counties could then direct their efforts to targeting services to specific populations.

This plan boilds on the conceptualization presented in last year's plan, and further defines the alcoholism prevention and intervention system. The alcohol use continuum has been slightly revised to include an experimentation stage. This addition is particularly important when youth are the target group since experimentation characterizes initial alcohol use and alcohol is usually the gateway drug to illicit drug use. Alcohol use does not automatically lead to illicit substance use, although research indicates that almost all substance abusers used alcohol prior to substance use, and continue to use alcohol after initiating substance use. The experimentation stage thus becomes an important determinant of program and message content when targeting youth.

Non-Use --> Experimentation --> Non-Experimental Use --> Abuse --> Alcoholism

The continuum provides a useful tool for conceptualizing where aggregate population groups may fall in the progression of alcohol use, but does not imply that every individual follows a specific pattern or progression of alcohol use.

The Division has also further defined settings and target populations for prevention and intervention efforts. The following table identifies the settings and target populations for prevention/education and intervention/referral alcoholism programs.

<u>Setting</u>	Services	Target Population
Community	Prevention and Education	General Population
		Targeted Groups: such as Youth, Minorities, Women, COAs
	Intervention and Referral	General Population
		Targeted Groups: such as Youth, Women, Minorities, Vietnam veterans
School	Prevention and Education	Elementary (K-6), Jr. High (7-8), Sr. High, College, COAs
	Intervention and Referral	Jr. High, Sr. High, College
Worksite	ion/Employee Assistance Programs)	
Criminal Justice System	(See Chapter I, Criminal Justice Alcoho	olism Services)
Social Services System	Prevention and Education	DSS Clients: Home Relief, ADC, Child Protective, Adult Services
	Intervention and Referral	DSS Clients: (Same as Above) (Also see chapter II, Social Services)
Health Care System	Prevention and Education	General Population, Pregnant Women, Women, Elderly (Also see this chapter, Fetal Alcohol Syndrome)
	Intervention and Referral	General Population, Pregnant Women, Women, Elderly (Also see this chapter, Hospital Intervention Services)

The next step in further identifying prevention and intervention services will be to specify the program and message content of each setting/service/target population. During the next year, the Division will engage in three major activities to accomplish this task. First, a Programs of Excellence process will be initiated to identify outstanding prevention and intervention approaches in operation in New York State. This process will provide exposure for exemplary programs and allow them to serve as a resource in assisting other communities as they plan and develop services to meet the needs of their population. Any currently operating prevention/intervention program within New York State will be eligible for self-nomination or nomination by LGUs, other programs, schools, community groups, or business and labor organizations. The process will be initiated in December 1989, at

which time additional information will be available from the Division's central and regional offices.

The second component in specifying program and message content for prevention/intervention programs will be a process which will include input and feedback from the alcoholism field and other health and human service systems. This process will utilize alcoholism and other health and human services prevention and intervention specialists from across the state to assist the Division in identifying the primary message contents and core program components which are necessary for effective programming. This activity will be undertaken in the latter half of 1989, and results will be proposed for implementation in subsequent local plan cycles.

A third source of information on alcoholism prevention and intervention programming, which will be utilized by the Division, is this year's local services plans. As part of their resource assessment, counties were asked to identify both targeted and core prevention and intervention programs currently operating and to indicate planned targeted intervention programs. These analyses will assist the Division in its prevention/intervention planning efforts and will be utilized in specifying a continuum of these services.

SAFE SUMMER INITIATIVE

The Division recognizes that the summer months present a special risk for young people becoming involved with alcohol. Since summer is the time when most young people are out of school and have minimal external controls, the months betweent he close of school and its re-opening after labor Day, represent a period when the likelihood of exposure to alcohol and experimentation is greatest. Moreover, since much prevention programming is conducted through the schools, the summer months require special attention.

For these reasons, in 1989 DAAA has inaugurated a "Safe Summer" theme. Under this broad umbrella, the Division plans to annually promote development of local, targeted activities that will support the Safe Summer goal.

It is the Division's intention to encourage local councils on alcoholism, as well as other grassroots organizations to develop targeted activities that will promote the theme of a safe, health, and alcohol-free summer.

ALCOHOL: THE GATEWAY DRUG

The Division has continued to regard alcohol use by youth as a serious problem, and a particular concern is the tendency of youth to use alcohol in combination with other drugs. This tendency has resulted in the adoption of a chemical dependency approach to residential treatment programs for youth jointly certified by this Division and DSAS. In order to gain a better understanding of youth substance use, and to develop effective prevention and intervention strategies targeting youth, the Division has examined the etiology of substance use by youth and the relationship between alcohol use and other drug use. This examination has centered on the gateway theory of substance use by youth.

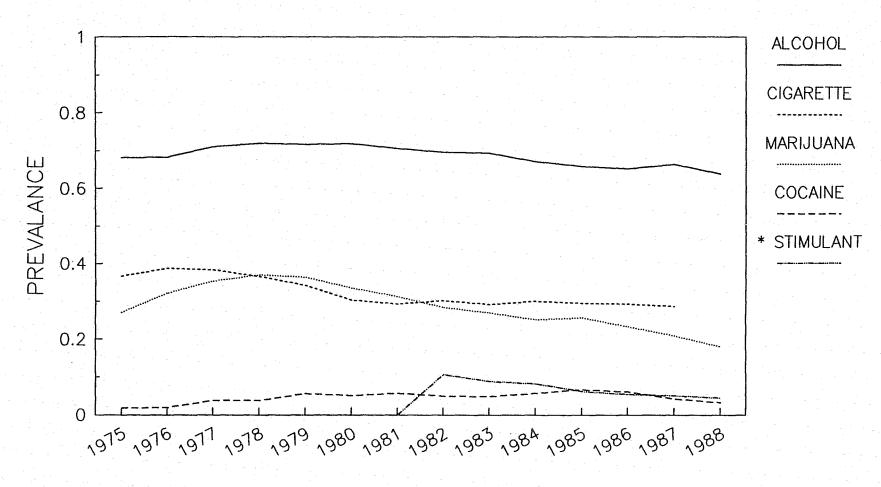
Related to this theory is the recognition that alcohol is also seen as the "norm setting drug." This refers to the relative societal approval and acceptance of drug use in the form of alcohol consumption as compared to illicit drug use. This is a particular concern for youth below the legal purchase age where alcohol use can be seen as a "rite of passage" or as "preferable" to illicit drug use. For example, many parents, when their child experiences difficulty with the law, will indicate relief in learning that "only alcohol" and not illicit drugs was involved.

The condoning of alcohol use creates mixed messages for youth who will very likely be faced with a similar choice of use or non-use of illicit drugs. As long as use of alcohol is portrayed as less harmful than, or preferable to, illicit drug use, we are perpetuating a mixed message.

Figure II-1 charts the national trends over 14 years in the use of certain drugs by high school seniors during the 30 days prior to the National High School Survey sponsored by the National Institute for Drug Abuse. Nationally, use of cocaine (including crack) rose to a peak in 1985, and has since declined: in 1985, 6.7% of high school seniors had used cocaine in the last 30 days, while in 1988 only 3.4% had used the drug in the same time period. Stimulant use in the last 30 days, at the national level, has declined steadily since 1982 and similar use of marijuana peaked about 1978 and has, with the exception of one year, declined steadily. Cigarette use during the last 30 days among high school seniors was at a high in 1976. It declined until 1981; however, since then it has changed little: about 30% of high school seniors used cigarettes in the 30 days prior to the surveys.

Use of alcohol during the 30 days prior to the surveys, reached a peak in 1978. Beginning in 1984, alcohol use began to decline slightly; however, it remains the most prevalent drug used by high school seniors: in 1988, 64% of high school seniors reported using alcohol in the last 30 days. Next in prevalence was tobacco at 29%, followed by marijuana at 18%. Cocaine and stimulants were used in the last 30 days by 3.4% and 4.6% respectively.

Use of a substance in the last 30 days, the 30-day prevalence, is a relevant indicator when we are concerned with experimentation and initial use of substances since it represents the extensiveness of drug use in the population. Alcohol is extensively used by high school seniors, and is thus widely available for experimentation.



* Survey item was adjusted in 1982. Comparable data is not available prior to 1982.

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Table II-1 compares the changes in 30-day prevalence for nine substances based on the National High School Survey. Except for inhalants, use of all drugs have decreased in recent years. In general, the decrease has been quite dramatic. However, changes in alcohol and cigarette use have been minimal. Thus, while prevention efforts on a national scale may have had some affect on the use of certain drug use among students in high school, they have had little or no affect on alcohol or cigarette use. It is important to point out that these data from a school-based survey do not account for youth who have dropped out of school and who may be most at-risk for alcohol and substance abuse.

Table II-1

National Trends in 30-Day Prevalence of Selected

Drug for High School Seniors

	Percent Who Used in Last Thirty Days			Percent Change			
	1975	1982	1985	1988	75-88	82-88	85-88
Approx. N =	(9400)	(17700)	(16000)	(16300)			
Alcohol	68.2	69.7	65.6	63.9	-6%	-8%	-3%
Cigarettes	36.7	30.0	30.1	28.7	-22%	-4%	-5%
Marijuana	27.1	28.5	25.7	18.0	-34%	-37%	-30%
Cocaine	1.9	5.0	6.7	3.4	79%	-32%	-49%
Stimulants**		10.7	6.8	4.6		-57%	-32%
Sedatives	5.4	3.4	2.4	1.4	-74%	-59%	-42%
Heroin	0.4	0.2	0.3	0.2	-50%	0%	-33%
 Hallucinogens	**	4.1	3.8	2.3		-44%	-39%
Inhalants**	• • • • • • • • • • • • • • • • • • •	2.5	2.2	3.0	•	20%	36%

^{** &}quot;Adjusted" Survey Item Data Not Available in 1975

Source: National High School Survey, National Institute on Drug Abuse.

The gateway theory of drug use evolved in the 1960s during debates on the legalization of marijuana. The Federal Bureau of Narcotics (1965) publicized the notion that marijuana use was a dangerous first step to heroin addiction, and that most heroin addicts started their progression of drug use by first smoking marijuana. Subsequent work clarified the issue by noting that most

marijuana users did not go on to become heroin addicts (Johnson, 1973).

Kandel's seminal work in 1975, using New York State high school samples, included alcohol use as a necessary stage in the sequence of drug use. Alcohol use was shown to be a stepping stone between non-use of substances and marijuana use. Almost no adolescents shifted directly from no use of any substances, including alcohol, to illicit drugs other than alcohol (Kandel & Faust, 1975).

These same findings are confirmed and extended in studies at the Research Institute on Alcoholism using data from the 1983 secondary school survey sponsored jointly by DAAA and DSAS. Welte and Barnes (1985) found that alcohol is the gateway drug for New York State teenagers. Unless alcohol is used first, there is very little use of any other drug, including cigarettes and over-the-counter drugs. New York State youth of every age and sex combination--as well as Blacks, Hispanics and whites--follow a definite pattern of progression from alcohol to marijuana to other illicit drug use. A recent paper by Windle, Barnes and Welte (1989) of the Research Institute, using sophisticated causal modeling techniques, confirmed that the best model of substance use, for both males and females, is a progression from alcohol use to marijuana use to other illicit drug use (see Figure II-2).

Figure II-2

Model of the Progression of Substance Use



Other studies by the Division using a household survey of 3,000 New Yorkers age 16 - 24, also provide information about the relationship between alcohol and other drug use. Relevant findings showed that respondents who drank alcohol were six times more likely to use marijuana than those who did not drink.

Cumulative scientific evidence conclusively demonstrates that alcohol use is the gateway to the use of other drugs. Research done at the Division's Research Institute on Alcoholism and elsewhere has shown that alcohol use precedes the use of illicit substances. While all drinkers do not necessarily go on to use illicit substances, nearly all extensive users of other illicit drugs used alcohol before initiating their drug use. Figures II-3, II-4, and II-5, based on data from the jointly sponsored school survey, illustrate the role alcohol use has in relation to other drug use.

An important component of the gateway theory is the delay of onset of alcohol use. The recent household study from the Division's Research Institute indicated that "the younger that New Yorkers start drinking alcohol or become intoxicated on alcohol, the more likely they are to be classified as current heavy drinkers, regardless of age." This finding, along with the research supporting the gateway nature of alcohol use, has major significance for prevention strategies. The Division's position is that there should be a "no use" message for all underaged persons, which should be delivered at very young ages before experimentation with alcohol occurs.

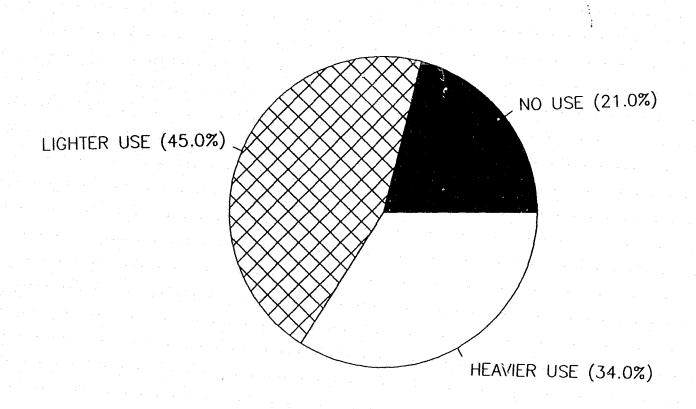
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Strategy

Policy and program implications from these findings suggest that prevention efforts and programs must understand the role that alcohol plays in other drug use. We know that early alcohol use increases the risk for our children's later development of alcohol problems. We also know that alcohol use by our youth greatly increases the risk that these youngsters will use other drugs, and that alcohol use greatly increases the risk for a range of problem behaviors.

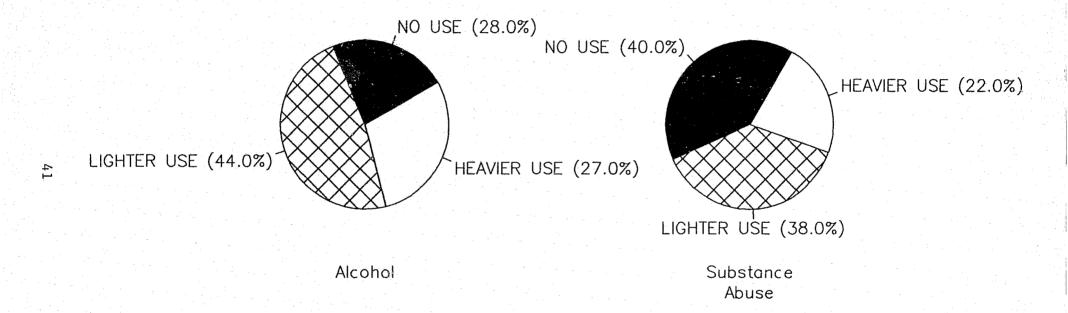
PERCENT ALCOHOL AND/OR SUBSTANCE USE BY LEVEL OF USE FOR THE 1,542,000 STUDENTS IN GRADES 7-12



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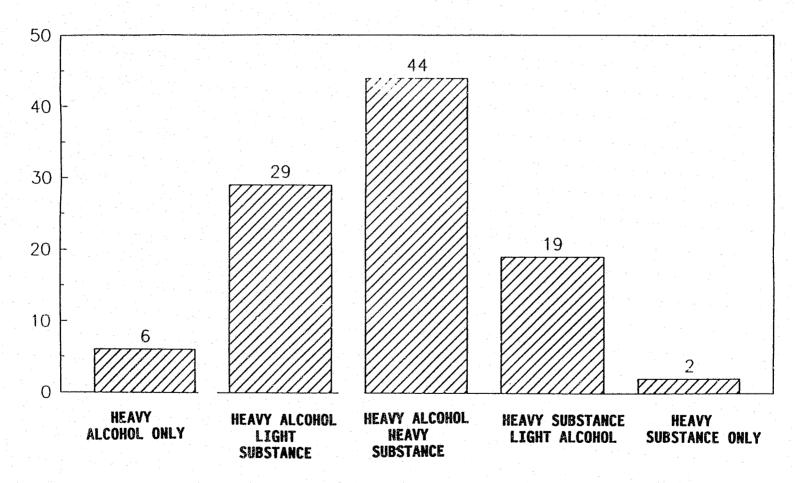
Source: Joint report by DAAA and DSAS, A Double Danger: Relationships Between Alcohol Use and Substance Use among Secondary School Students in New York State, Fall, 1985.

PERCENT ALCOHOL AND SUBSTANCE USE BY LEVEL OF USE FOR THE 1,542,000 STUDENTS IN GRADES 7 - 12



Source: Joint report by DAAA and DSAS, A Double Danger: Relationships Between Alcohol Use and Substance Use among Secondary School Students in New York State, Fall, 1985.

7 - 12



Source: Joint report by DAAA and DSAS, A Double Danger: Relationship Between Alcohol Use and Substance among Secondary School Students in New York State, Fall 1985.

A primary concern to the Division is the continuation and enhancement of efforts to recognize alcohol as the "gateway drug" that leads to other drug involvement. The Division stresses the importance of early childhood alcohol prevention and education efforts that prevent and delay the onset of alcohol use. Prevention programs for all young people, but especially those targeted at adolescents must give a no-use message. Prevention programs must assist all elements of a community, including educators, parents, religious leaders, and business organizations, to communicate a consistent message to young people that alcohol use by under-age youth is unacceptable.

Currently, school-based prevention and intervention efforts related to alcohol and other drug use are divided among DSAS, DAAA, and SED. Because of the Division's concern for alcohol as the "gateway drug," and the tendency for youth to concurrently use alcohol and other drugs, the Division supports efforts that utilize the school environment as a focal point for mounting effective education, intervention, and prevention aimed at youth. The Division views the involvement of family as an important component of effective programming. A pool of highly skilled personnel is needed to develop and staff these efforts.

Programs in grades K - 6 should stress the prevention and education efforts that deter the use of any substance. These programs should also consider the identification of high-risk youth, for example, Children of Alcoholics and Children of Substance Abusers. At the junior high level, school-based programs should continue with prevention and education efforts and need to add intervention services for youth who have begun a pattern of use and abuse. The Division endorses a student assistance program model, which has been successfully demonstrated in a number of communities throughout the state. Programs targeting senior high students need to include all these previous components, plus a treatment component designed to provide group and individual counseling in the school setting. Such programs should have the capacity to include family members, where appropriate.

A related issue to providing school-based alcoholism treatment services is the need to explore the necessity for designating alcohol dependence/abuse, chemical dependency, and/or substance dependence/abuse as a handicapping condition within the education system. The Division is currently exploring this issue with DSAS and SED. Such a designation would allow youth attending school to have an individualized education plan that would permit them to receive counseling and treatment services for their alcohol dependence or abuse.

A primary component in the Division's strategy is the newly revised and updated alcohol curriculum, developed in conjunction with SED for grades K-12. SED reviewed the curriculum in June and limited field review is expected to occur during the summer. The curriculum is expected to be disseminated to all schools by January 1990, with administrative and then in-service teacher training to follow.

FETAL ALCOHOL SYNDROME

Fetal Alcohol Syndrome (FAS) is now recognized as the leading known cause of mental retardation in the Western World, and the only one that is totally preventable. In addition to the human costs and suffering, it is estimated that New Yorkers spend an estimated \$43,680 per FAS victim per year, for a lifetime cost of \$2,620,000 per child. In a 1986 Division survey, only 12.3% of women of childbearing age (18 to 44 years old) statewide mentioned pregnant women as a group at increased risk of illness or other problems as a result of drinking. In New York City where there is an ordinance requiring an FAS warning to be posted in establishments selling alcoholic beverages, women were twice as likely to be aware of risks than upstate women; however, only 18% of the New York City women mentioned these risks. (NYSDAAA, Youth Alcohol Survey, 1982-1986.)

In addition to the risks associated with drinking during pregnancy, recent research has also identified dangers for the nursing baby whose mother consumes alcohol. As with FAS associated with drinking during pregnancy, it is unclear how much alcohol, at what period of time is needed to inflict damage during breast feeding. For this reason the Division supports the recommendation that pregnant women and breastfeeding mothers should abstain from the use of all alcoholic beverages.

The Division is also concerned about this tragic and preventable condition because teen pregnancy rates and teen alcohol/drug use rates are continuing at unacceptable levels. This combination of sexual activity and substance use among youth who are likely to be uninformed about the associated risks, and if they become pregnant, about pre-natal care, is particularly relevant to FAS.

In order to address this situation, during the week of May 14-20, 1989, the Division reissued an updated and revised FAS awareness campaign. This multi-media initiative, with support from the local county councils on alcoholism, provided educational presentations and disseminated print materials statewide. This renewed education and prevention effort, while continuing to address all women ages 15-44, as well as the general public and health care professionals, has $\underline{\text{targeted}}$ the adolescent and the pre-adolescent population.

The Division has the support and cooperation of the eight New York State chapters of the National Perinatal Association and the Healthy Mothers/Healthy Babies Coalition in this effort. These health professionals, all volunteers, will work with the council on alcoholism in their region to broaden outreach to the targeted youth population.

The heightened awareness of the medical and public health community around the damage done to the fetus by the mother's alcohol and other drug use during pregnancy, coupled with the media coverage of several trials blaming alcohol for damage done to the fetus, reinforces the need for a sustained state effort to alert and inform the public about the dangers of FAS. The Division plans to continue to disseminate materials related to FAS and to encourage local efforts to address FAS prevention and education for all women, particularly for teenagers. The Division supports the recommendation that pregnant women should abstain from the use of all alcohol

during the entire course of pregnancy.

Recent Congressional action supports efforts to educate the public. As of November 18, 1989, all alcoholic beverage containers sold in the United States must carry warning labels. The labels, approved by Congress in 1988, state:

- o According to the Surgeon General, women should not drink alcoholic beverages during pregnancy because of the risk of birth defects, or
- o Consumption of alcoholic beverages impairs your ability to drive a car or operate machinery, and may cause health problems.

The Division has responded to the proposed regulations governing the position, type size, font, and visibility of the labels; and has recommended to the Federal Bureau of Alcohol, Tobacco and Firearms that the intent of the original legislation be more accurately reflected in the final regulations by specifying parameters to make the label clearly identifiable.

The Division has also supported statewide legislation requiring establishments with liquor licenses to display FAS warning posters. In the absence of such legislation, the Division supports the passage of similar local and municipal ordinances.

PREVENTION MATERIALS DEVELOPMENT

1988 - 1989 witnessed a major expansion in the Division's efforts to develop and distribute alcoholism education materials. New publications included a series of three youth-targeted brochures and a special resource packet for teachers, as well as the revised and redesigned FAS materials.

Targeted mailings have proven successful, and the expansion of distribution outlets will continue to play a key role in prevention and education efforts. The Division targeted school administrators in all of the state's school districts for the teacher packet. In the six months since the initial mailing, the Division has distributed over 20,000 pieces of information to 3,500+ teachers from 621 schools and BOCES in 31% of the state's school districts. Schools for special populations, and those operated by the state's DFY and OMH, were also included in this targeted mailing.

Cooperative efforts with other organizations in targeting distribution also have generated positive responses and will continue. These efforts have included the statewide PTA, which joined in a mailing of youth materials to over 2,000 local PTA chapters, the NYS Hospital Association, and the NYS United Teachers. Distribution was similarly targeted for the new FAS materials, with groups such as the NYS Perinatal Association, Physician's Assistants, and others helping to increase exposure and utilization of Division materials.

Other cooperative efforts include the development of relevant materials which highlight the alcohol connection to other health and social problems in conjunction with various state agencies. For example, in 1989, the Division will produce a brochure for the State Division of Parole to distribute to the families of parolees.

The Division's primary messages for materials development continue to focus on non-use of alcohol by high-risk groups and in high-risk situations; discouraging alcohol consumption in quantities sufficient to produce intoxication, and at levels above two standard drinks per day; and on reducing the stigma associated with alcoholism and promoting understanding of alcoholism as a treatable disease.

Delaying the onset of alcohol use by youth will remain an important thrust of the Division's public education endeavors. The Division also plans to highlight the alcohol connection in materials that identify alcohol's involvement in an array of health, family, and social problems.

Based on data from the 1988 NYS Research Institute on Alcoholism report, Alcohol Use and Abuse Among Adults in New York State, which reported a large percentage of heavy drinking by college students and an increasing number of college women reporting heavy drinking patterns, the Division has maintained and expanded its college program. The Division's college manual, Alcohol Problems Prevention/Intervention Programs; Guidelines for College Campuses, has been revised. In subsequent revisions, the Division will strongly consider the inclusion of a section on self-help groups such as Alcoholics Anonymous and Narcotics Anonymous, and groups for children, spouses and adult children of alcoholics.

Our newest initiative for colleges is the development of targeted resource material for college administrators. <u>Comprehensive Alcohol Programs</u>, A <u>Guide for College Administrators</u>, is a resource packet sent to approximately 200 college presidents statewide to increase their awareness of campus alcohol-related problems and the need for administrative support for the success of campus alcohol programming.

In addition to the development of resource materials for colleges, the Division has provided technical assistance in the development and expansion of regional college alcohol consortia. During the past six months two new consortia have been established bringing the statewide total to seven. The Division also assisted the five longer-standing consortia in applying for grants from the U.S. Department of Education's Fund for the Improvement of Post-Secondary Education to gain operational money for alcohol and other drug prevention and intervention activities. All five grant applications were successful and the Division plans to assist the two more recently established consortia in their applications for similar grants in the Spring of 1990.

WORKPLACE INTERVENTION/EMPLOYEE ASSISTANCE PROGRAMS (EAP)

During 1989 the Division convened a workgroup of EAP practitioners from local companies, provider agencies, and statewide organizations to assist the Division in establishing an agenda of activities and to provide feedback in carrying out these activities. The workgroup identified areas of EAP concern, provided input on EAP service delivery and program quality, and participated in activities related to the development of a statewide EAP inventory and new program guidelines for workplace intervention/EAPs. The Division gratefully acknowledges the assistance of all those who participated in the workgroup (see Appendix B). Major Division efforts related to EAPs were workgroup related initiatives, the development of new program guidelines for workplace intervention/EAPs, and implementation of Chapter 449 of the Laws of 1988, which provides for the development of EAP consortia for smaller, unserved work organizations.

Workgroup-Related Initiatives

One recommendation which resulted from the meetings with the EAP workgroup was the promotion of EAP as part of the alcohol connection in the workplace. New promotional materials for newspaper, magazine, and TV ads are being planned for both employers and labor organizations. As part of this effort, the Division is approaching other state agencies, including SED and DOL to obtain their involvement in statewide EAP promotion. As part of its own ongoing EAP promotion, the Division has distributed 40,000 copies of the Division pamphlet, Alcohol and Drugs on the Job, largely in response to the many requests related to the Drug Free Workplace Act of 1988. A new brochure, Small Business and EAP, is being developed, printed, and distributed in conjunction with the implementation of Chapter 449 of the Laws of 1988.

With the assistance of the workgroup and the many local EAP directors and providers, the Division has completed a New York State Inventory of EAP services, the single largest survey and report on the nature of EAPs operating throughout the state. The findings from the inventory will provide important information on the functioning of EAPs and will be utilized in planning and other EAP-related activities.

Two other areas which were identified by the workgroup for further consideration were the need for a code of ethics for EAP service providers and the need to specifically target small unions in economically distressed industries for EAP services. The Division plans to continue to explore both these concerns over the next year.

EAP and Law Enforcement Initiative

A major area of concern of the Governor's Task Force on Alcoholism Treatment in Criminal Justice and its final report, was the need to address alcohol-related problems among the criminal justice work force. In order to help address these needs, the Division has developed a Memorandum of Understanding with DCJS and implemented three law enforcement EAP initiatives to increase the level of EAP services for police and other law enforcement officials.

DCJS and DAAA held six executive development training seminars throughout NYS from November 1988 through January 1989. A police/EAP panel was formed to discuss and make recommendations regarding the pending police/EAP desk reference manual. The first draft of this manual was due in June 1989, and completion is expected in early spring 1990.

Future funding sources for the promotion of, and training in the use of the desk reference manual, will be explored as part of the panel discussions, as well as funding for two local pilot projects (one upstate and one downstate) aimed at smaller police agencies.

As a result of this EAP/law enforcement model, networking with a significant number of other agencies, such as the Police Conference of New York, the associations of Police Chiefs and Sheriffs, and OMH has occurred, providing further promotion and support for EAP in law enforcement agencies.

EAP PROGRAM GUIDELINES

The newly revised program guidelines for workplace intervention/EAPs were prepared with input from the workgroup, and careful study of other recently developed EAP guidelines of national organizations. These guidelines reflect the various models of EAP service delivery and describe the common goals, objectives, and program elements consistent across the models.

Introduction:

During the past decade, there has been an increase in the number of employee assistance program services to work organizations. As these programs expanded, their initial intent was sometimes modified, and today many different services are offered under the EAP label. Some of these services fall outside the parameters of appropriate employee assistance services and, in some instances, the provision of such services requires licensing or certification.

Employee assistance programs were established primarily as a system to enable early identification of, and intervention with, employees whose problems with the use of alcohol and/or other substances interferes with their ability to function on the job effectively, efficiently, and safely. These programs rely heavily on the concept of constructive intervention which utilizes job performance as the primary criteria for identifying employees who may need program services. At the same time, these programs endeavor to meet the specific needs of the unique demographic and cultural composition of a particular work force. EAP services also deal with a number of other employee problems, including marital, financial, legal, and family problems. These problems are often associated with alcoholism and/or other substance Thus, offering assistance to employees with such problems frequently results in earlier identification and intervention with alcoholism and/or other substance abuse. Many EAPs expanded their assistance to employees with a broad range of personal problems that can interfere with the ability of function on the job. In today's EAPs, services can be obtained by voluntarily seeking program assistance, through a referral by a colleague or peer, and/or through the constructive intervention process.

Some EAPs provide other services (for example, counseling), that fall outside the range of employee assistance programming. In order to conduct appropriate EAP services which maintain the organization's ability to constructively deal with alcoholism, substance abuse and other serious problems of their employees, any other services should be provided in addition to, not in lieu of, basic EAP elements. Appropriate license or certification should be obtained as indicated by the services provided.

Employee assistance programs are not designed to provide that ment services. Rather, these programs endeavor to refer employees to resources that can best meet their needs. To accomplish an appropriate referral, EAP staff must conduct an assessment. EAP staff must also overcome the denial of many employees as to their need for assistance. Therefore, a key function of EAP staff is motivation of employees to accept a referral. Workplace assessment and motivation functions typically require three sessions, but may be accomplished in as few as one, or as many as five sessions.

Once an employee has been referred by the EAP, he/she enters the treatment system. It is the responsibility of the EAP staff to maintain a link between the work organization and the treatment system in order to ensure compliance with treatment recommendations and to facilitate the employee's return to work.

EAP program costs are borne by the work organization served by the program. These costs are offset by savings that result from effective programs and are not covered by insurance. In conjunction with appropriate EAPs, efforts should be made to ensure that coverage available to employees includes the treatment services to which they may be referred by the EAP.

The following glossary of terms defines concepts integral to EAP functions. This section concludes with a description of the activities and standards deemed appropriate in the provision of employee assistance programs and will assist work organizations and EAP practitioners in planning and conducting appropriate EAP services.

Glossary of Terms:

Prevention - a series of activities designed to help employees recognize and reduce the incidence of a variety of health concerns, including alcoholism and substance abuse; promote healthy lifestyles; and where necessary, assist in changing behavior prior to the onset of a serious problem. Prevention occurs through information dissemination and/or direct interaction with EAP staff, and emphasizes the safety and other workplace factors associated with different health problems. Prevention also identifies risk factors at the workplace that may be associated with alcoholism and substance abuse.

Identification - a process whereby a supervisor, shop steward, fellow employee, family member, or the employee him/herself determines that the services of the EAP may be appropriate. Identification is frequently based on observation of problems with job performance or work behavior.

Intervention - the interaction between a supervisor, shop steward, fellow employee and/or family member, and the employee which encourages and

motivates the employee to seek EAP assistance. The need for intervention is based on job performance and work behavior problems. Intervention also occurs when EAP staff and the referred employee review the nature and extent of the employee's problem, the job-related consequences, and the need for outside assistance.

Workplace Assessment - an interview process that elicits and reviews data to determine the timely and appropriate response to the needs of the EAP participant. Information on job performance, work behavior and personal history and concerns leads to an initial determination of the nature and extent of the problem and the employee's motivation to resolve it.

Motivation to Treatment - working with the referred employee following workplace assessment to recognize the identified problem and the need for help. Where denial is present, the job performance factors and potential consequences are raised to assist the employee in making a commitment to take the action recommended by the EAP.

Referral - the link between workplace assessment and treatment, where an initial determination of the most appropriate response to the employee's needs is made. Specific referral options, including self-help groups, are identified and discussed with the employee, and a timely referral is made. The referral resource confirms the EAP's initial problem determination through evaluation and diagnosis, and the appropriateness of admission. If necessary, the referral resource arranges referral to another provider of service, and notifies the EAP.

Follow-up - ongoing activities following referral to determine whether the referral appointment was kept, the employee's progress in treatment and the need for additional care. Follow-up occurs only with the written consent of the employee. Follow-up also takes place while the employee is on the job to offer support, to monitor the employee's progress, and to determine the need for further assistance. This process also identifies special concerns regarding an employee's return to work following a referral and treatment.

Program Description:

The employee assistance program is a confidential service that acts as a resource for work organizations and their employees. These programs operate as an integral part of an organization to assist employees with problems that can interfere with the ability to function on the job effectively, efficiently, and safely. These may typically include but are not limited to: alcoholism; substance abuse; and emotional, marital, family, and other personal problems that affect job performance. These programs serve organizations and occupational groups by providing prevention, identification, intervention, assessment, motivation to treatment, referral, and follow-up of employees.

Program Goals

 Establish a system within the work organization for prevention, early identification, and follow-up of employees with alcoholism, substance abuse, other dependencies, and other problems that are adversely affecting job performance.

- 2) Establish a system whose services can be provided either within the work organization, or at a location external to it, for assessment, referral, and follow-up of employees whose personal problems may adversely affect job performance.
- 3) Sensitize and educate labor, management, peers, and other personnel where appropriate, about the role of EAPs within work organizations.
- 4) Ensure program understanding and support at all levels.
- 5) Minimize workplace disruption caused by employees, or family members, with alcoholism, substance abuse, and/or other problems such as eating disorders, gambling, financial, legal, or marital problems.
- 6) Assist program participants in returning to acceptable levels of job performance and to restoration and maintenance of health, through referrals to appropriate community resources when necessary and through follow-up monitoring.

Program Objectives

- 1) Develop and implement written EAP policies and procedures that are compatible with the structure and function of the organization which they serve.
- 2) Establish a process within the organization for the prevention, identification, intervention, motivation, and referral of individuals who may need EAP services.
- 3) Develop a system whereby the employee assistance professional provides assessment, referral, and follow-up for program participants.
- 4) Establish guidelines to ensure that confidentiality of information is maintained.
- 5) Provide expert consultation to management, labor, peers, and other personnel on the process of intervening with employees whose personal problems affect job performance.
- 6) Develop and implement education, information, and/or training programs for labor, management, peers and other representatives about the program and its uses.
- 7) Collect data for program evaluation and utilize the information to increase its efficiency and effectiveness.

Program Elements

No two work settings are alike; each is culturally different. The development and operation of EAPs must consider the definition, characteristics, and services deemed necessary by the organization served by the EAP. A fully functioning EAP requires cooperation and participation at all levels of the organization. The following elements are needed for

effective and efficient EAP operation.

- 1) Program Director manages and provides for the delivery of appropriate EAP services; ensures that program elements are implemented and maintained.
- 2) Policy Statement defines the program, its scope, activities, and commitment to confidentiality; states that alcoholism and other substance abuse are treatable diseases.
 - Written policies of the EAP should be reviewed and updated periodically to remain current and meaningful. Each new update be communicated to all levels of the organization.
- 3) Procedures describe the processes for program participation, including a variety of constructive intervention strategies that are appropriate for the work organization or occupational group served by the program. Such strategies include peer intervention, supervisory intervention, and intervention by occupational health personnel. At the same time, employees are encouraged to voluntarily seek help for their personal problems before these problems adversely affect job performance.

There should be written procedures describing the process for program participation and for communications concerning referrals, which is periodically distributed to all employees.

- 4) Assessment, Referral and Follow-up provide assessment of problem(s) underlying work performance difficulties, determine appropriate resource for referral, follow-up with individuals who have been referred for services, ensure compliance with recommendations, and provide additional referrals for assistance, as needed.
- 5) Education and Training prepare and present information and written materials on a regular basis to management, supervisory personnel, labor representatives, and co-workers, regarding their respective roles in program participation.
- 6) Consultation provide management and union leaders with consultation that reflects the specific needs of the organization. In addition to training, such consultation includes prevention issues, the identification and referral of employees to the EAP, the management of follow-up procedures including issues pertaining to employees' return to work following an EAP referral, and identification and amelioration of risk factors that may contribute to alcoholism and/or other drug abuse.
- 7) Resources maintain current information and appropriate liaison with treatment providers and other resources.
- 8) Insurance review periodically insurance coverage for disabilities covered by the EAP assessment and referral process, and make recommendations for revision as needed.
- 9) Committee of Concern composed of equal representation of decision makers from management and labor, meets regularly to assist in the

program's internal promotion and evaluation.

10) Ethics - expects EAP professionals to adhere to codes of ethics of the organization which they serve as well as to codes of ethics espoused by their professional organization, licensing and certification bodies, and federal, state and county laws.

Any conflict of interest, actual or perceived, among EAP professionals and service providers should be avoided.

11) Data Collection and Evaluation - evaluates the appropriateness, effectiveness, and efficiency of its operations. At a minimum, the EAP should periodically assess its program implementation, staff performance, program activities, program utilization, and the ability to identify, intervene, assess, refer, and follow up with employees who experience problems with their use of alcohol and/or other substances, as well as other problems covered by the EAP.

Evaluation requires measurable objectives and mechanisms for data collection. The procedures for achieving each objective should be reviewed to assure that the objectives are attainable. The data that measure the objectives should be gathered routinely and analyzed at least annually to evaluate progress toward meeting each objective.

Reports covering progress on each objective should be written at intervals consistent with program needs. These reports should discuss why some objectives were met or exceeded and why others were not. This report should also recommend changes in program structure, staffing, and/or procedures based on the evaluation. For effective data collection and evaluation, the best available technology should be used.

Program Design and Implementation

The successful EAP meets the specific needs of the unique demographic and cultural composition of its workforce. A needs assessment prior to program development should identify relevant management/union concerns and special work considerations that must be integrated into the development of the organization's EAP. In addition to guiding the implementation and operation of the program, such objectives contribute significantly to the development of an accurate, comprehensive description of the EAP for distribution to all employees and their families.

Staffing - EAP staff size and staffing patterns vary according to the type of program and the range of services provided. Whether internal or external, staff should have the necessary background and qualifications needed to carry out all program functions as defined in the program elements section. The CEAP (Certified Employee Assistance Professional) is the credential that indicates a mastery of EAP competencies.

EAP staff responsibilities include program management; supervisory and staff education and training on an ongoing basis; and the assessment, referral, and follow-up of program participants. Within this role, a thorough understanding of alcoholism and substance abuse enables the staff to appropriately carry out its duties.

EAPs with no internal staff should have at least one liaison person responsible for coordination with external program providers. This liaison function includes monitoring the appropriateness of EAP service delivery to the work organization served by the program.

Program Promotion - The EAP operates at an optimal level when it is fully integrated with other organizational activities. To maximize program effectiveness, the EAP should be positioned at the highest possible level in the organization. Working relationships should be established with a variety of internal departments and committees. Visibility is critical to overall program effectiveness, and promotional activities should be ongoing. An overall strategy for program promotion should be developed; it should encompass all levels of the organization and should include regular briefings for management and union representatives.

Program Models:

Internal Programs

1) Internal Program Based within the Work Organization

This program is established as a discrete entity within a work organization and serves its employees. Frequently, program services are also available to members of employees' families. Program services include:

- o Development, implementation, review, and revision of EAP policies and procedures;
- o Training for supervisors and labor representatives about the program and its uses;
- o Orientation and education for employees;
- o Assistance to supervisors in program utilization and in making referrals to the program;
- o Assessment, referral, and follow-up of eligible individuals who voluntarily seek program services and of those who are referred to the program;
- o Internal program promotion;
- o Data collection regarding program utilization;
- o Evaluation and appropriate modification of program activities;
- o Implementation and maintenance of program elements as defined in these guidelines.

2) Internal Program Based in a Union

This program is established in a union facility and serves union members who may work in various locations covered by the union. Program services

include:

- o Development, implementation, review, and revision of EAP policies and procedures;
- o Development and implementation of activities designed to encourage program utilization by union members and their families;
- o Training and education for labor representatives and business agents regarding program participation;
- o Promotion of program concepts to "shops" where union employees work;
- o Assessment, referral, and follow-up of eligible individuals who seek program services or who are referred to the program;
- o Review of insurance benefits and recommendations for revision as needed;
- o Identification of appropriate referral resources;
- o Data collection and evaluation regarding effective and efficient program activities and program utilization;
- o Implementation and maintenance of program elements as defined in these quidelines.

Shared Service Programs

Note: These programs are sometimes called external programs. This term may be misleading since no program is ever external to the work organization which it serves. However, program services may be furnished by providers in a location that is outside the organization.

Designated liaison individuals in each work organization served by a shared service program function as contacts with the provider. These individuals generally perform this function on a release-time basis.

1) Contract Program Services

In this model, an EAP organization provides program services on a contractual basis to several work organizations. This contractual arrangement may consist of selling services to individual work organizations or contracting with a group of organizations (e.g., through a Chamber of Commerce) to provide services which include:

- o Promoting the EAP concept and encouraging the local industrial and labor communities to establish and maintain programs;
- o Marketing the EAP services to targeted work organizations and operating under formal service contracts;

- o Conducting needs assessments to determine appropriate EAP services for each organization where an EAP is to be established;
- o Consulting to contract organizations regarding the formulation and implementation of EAP policies and procedures;
- o Implementing and ensuring the maintenance of program elements as defined in these guidelines.

2) Consortium

This model is suitable for small organizations that wish to share the costs of establishing and operating an EAP.

In this model, program services are the same as those described for an internal program. The EAP provider unit may be based in one of the participating organizations or in a separate location that is accessible and available to all consortium participants.

EAP Consortiums for Small Work Organizations

New York State's first EAP legislation, Chapter 449 of the Laws of 1988, specifies that the Division create EAP consortia for smaller, unserved work organizations. A special appropriation will permit the expansion of EAP services to a very large but underserved group of work organizations, those with fewer than 750 employees.

Assisted by an EAP Advisory Board (see Appendix C) and working in consultantion with DSAS and the Department of Economic Development, the Division and the EAP field will obtain valuable information about the issues and successful approaches to reaching small work organizations, and retaining their involvement. Specific areas of interest include:

- o differences in interest, operation, and results across different sponsoring organizations, such as professional and trade associations, chambers of commerce, central labor councils, EAP providers, and insurance carriers;
- o the timeframe for, and response to, the required regulations and the RFP process itself;
- o the ability of new program sponsors to achieve the first year's required funding match;
- o the impact of new regulations which clearly describe the appropriate functions of EAP on both funded services and EAP operations in general; and
- o the relevance of a professional promotion/education campaign on new program development.

In reference to the timeframe for implementation of the legislation, draft regulations will be prepared for comment during the summer months. The regulations will be based upon the Division's newly revised program guidelines for Workplace Intervention/Employee Assistance Programs. At the same time, a Request for Proposal (RFP) process will be instituted and disseminated to a very broad audience of potential applicants, inviting new and unique approaches to serving smaller work organizations. Information on the regulations and RFP process is available from the Division's Bureau of Workplace and Institutional Intervention Services.

HOSPITAL INTERVENTION SERVICES

The findings of the U.S. Department of Health and Human Services indicate that as many as 50% of patients in certain general hospitals may have been admitted for a condition either precipitated by or exaggerated by alcoholism. In addition to the above findings, the New York Business Group on Health conducted a survey of acute care hospitals in the NYC metropolitan area. This survey found that the great majority of cases of alcoholism among hospital admissions remained undiagnosed, and that only three percent (two out of 62) of participating hospitals had a fully functioning system to routinely detect and refer for treatment patients with an alcoholism problem. In recognition of the alcohol connection to general hospital admissions, the rising health care costs, and the lack of routine hospital screening for alcoholism the Division established the Hospital Intervention Demonstration Project in 1988. This statewide pilot program will demonstrate and measure the efficacy of this formal proactive model in the early identification, intervention, and referral to treatment of alcoholic persons within the general hospital population. A related issue raised at the public hearings is the need to ensure that adequate alcoholism treatment services for elderly clients are available for those hospital intervention programs identifying large numbers of elderly alcoholics.

A modified RFP process was implemented in the selection of eleven hospital project sites, including sites from all the Division's regions. The hospitals range in size from 127 to 600 beds and include rural, suburban, and urban locations with diverse patient populations. Funding has been made available to these hospitals for a minimum of eighteen months to cover the costs of initiation. In return, the hospitals will provide statistical and other reports for a period of five years.

An evaluation process has been developed which will include site visits. These visits will be used to evaluate the hospitals' implementation of a model which calls for the active screening of all patients using the normal admissions process. Other areas to be evaluated include the statistical results of each hospital's intervention program, the variations in different settings for the intervention service, and the project's efficiency in delivering that service.

The results of the evaluation will be used, in part, to determine whether the proposed 18-month demonstration period provides adequate time for the development of the HIS projects, education of staff, working through resistance, implementation, and evaluation. A continuation of the Division's financial support for this initiative, including implementation within other general hospitals and non-hospital health facilities, and extension of funding to some or all of the original projects is expected.

The findings of the evaluative process will be collated and used in the generation of a procedural manual which describes the process of development and implementation of a hospital intervention service. The manual will include a curriculum and a listing of educational materials for the training of hospital and HIS staff, patients, and the community.

Contacts will be made with hospital-related organizations that may have an interest and offer support for the HIS model. Discussions will also be

held with DOH to consider the incorporation of HIS within the overall quality assurance and rate setting mechanisms of the hospital. It is anticipated that the Division's pilot projects will demonstrate the efficacy and cost efficiency of the HIS model so that these programs will eventually be supported as on-going services of all hospitals in the state.

Since the publication of the draft Update, the New York Business Group on Health completed and released <u>Screening for Alcohol Problems: A Guide for Hospitals</u>, <u>Clinics and Other Health Care Facilities</u>. The guide which was supported by a contract with DAAA, is designed to assist facilities where health care is provided in developing screening programs that would be best suited to their needs and most acceptable to their medical staffs.

TREATMENT AND REHABILITATION

In the area of treatment and rehabilitation, the Five-Year Plan (1989-1994) identified a number of issues related to the development and delivery of alcoholism treatment services. These issues included the geographic accessibility of services, particularly for rural counties; the need to target services to special populations; the need to address alcoholism service needs of criminal justice clients, mentally ill chemical abusers, and youth; financial access to care; the role of family services within the alcoholism treatment system; and the overall development of quality alcoholism services in each county of the state. A related initiative to be carried out over a three-year period as outlined in the Five-Year Plan is the development of position papers to address the specific service needs of rural populations, Blacks, Hispanics, youth, elderly, and the multi-disabled. It continues to be the Division's intention to address the alcoholism service needs of each of these groups, as well as all other groups experiencing access problems. For example, the Division plans to initiate the process for the Black and Hispanic position papers in the latter part of 1990, however ongoing discussions and initiatives will continue to address the alcoholism service needs of these and other special populations. Division will continue to recognize special populations in its alcohol connection activities and the need for culturally sensitive services and training where appropriate.

This plan update addresses a number of these treatment issues, and relevant discussions are contained in other sections of the document. For example, many alcohol connection activities described in Chapter I involve the delivery of services to specific populations and Chapter III discusses financial accessibility of services and rural alcoholism programming. This section of the update will examine overall treatment system development and highlight efforts related to four groups: youth, families, women, and mentally ill chemical abusers. It is anticipated that subsequent updates will address other special populations and treatment issues.

OVERALL TREATMENT SYSTEM DEVELOPMENT

The following four figures present various aspects of overall development of the alcoholism treatment system. As can be seen in Figure II-6, the total number of alcoholism treatment programs has grown steadily between 1978 and 1988 with some of the more dramatic increases occurring in the mid-1980s. It should be noted that the growth in programs from 1988 to 1989 is largely due to a change in certification procedures necessitated by the new outpatient regulations which became effective January 1988. These new regulations required existing programs to be in substantial compliance by July 1, 1989. Based on the new regulations, previously uncertified locations (satellites to clinics), had to be certified as additional sites and any new additional locations had to be approved and certified. Of the 33 new programs, as of May 1989, 28 were outpatient programs and the majority of these were previously operating satellites which were recertified as additional locations under the new outpatient regulations. The other five new programs involved one inpatient rehabilitation program and four new community residences.

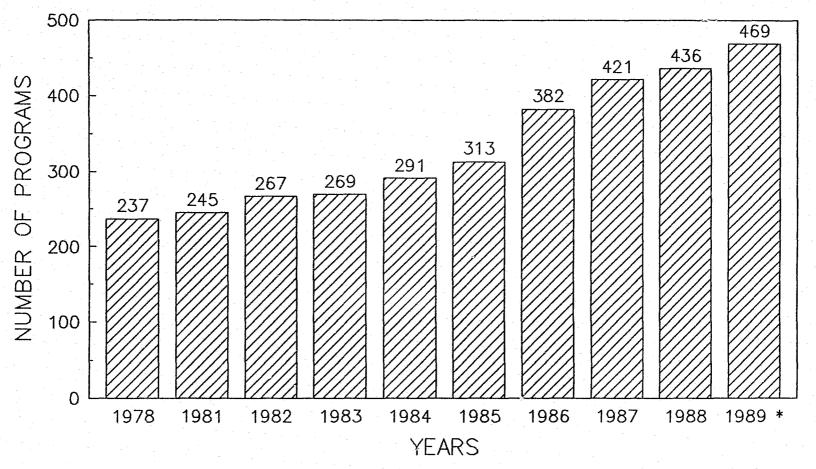
Figure II-7 displays the total need for each program category for 1995 based on the new integrated need methodology presented in the Five-Year Plan (1989-1994). The figure also illustrates the portion of need which is currently being met. As can be seen, the largest category of need being currently met is in inpatient rehabilitation, while the caegory where the least amount of need being met is community residence beds. For outpatient visits, 37 percent of total need is currently accounted for, while for emergency services 47 percent of acute care and 38 percent of primary care needs are currently being met.

Figure II-8 displays the distribution of alcoholism programs by category for 1978, 1988, and 1989 (as of May). As can be seen, outpatient programs have become a relatively larger portion of the alcoholism treatment system from 1978 to 1988. While they also increased from 1988 to 1989, the same caution should be applied to this data as for the data in Figure II-6 since the increase in outpatient programs is partly an artifact of the change in outpatient regulations. Nevertheless, this figure demonstrates the Division's reliance on an outpatient system of services. Compared to the category, community residences and inpatient rehabilitation outpatient programs have increased but at a slower rate than outpatient, and they continue to be about 10 percent of the treatment programs. Emergency care programs, that is, acute care and primary care, which includes crisis centers (formerly called sobering up stations), have actually decreased steadily as a percentage of alcoholism programs. Residential chemical dependency programs for youth were added as a category in 1988.

visits Figure II-9 presents outpatient clinic and inpatient rehabilitation beds by sponsorship. As can be seen, outpatient visits, which are based on 1988 LS-2C reporting, are 12.2 percent proprietary, 44.1 percent municipal and voluntary hospital, and 43.6 percent free-standing voluntary. This compares with 1987 figures of 10 percent proprietary, 38.7 percent municipal and voluntary hospital, and 51.3 percent free-standing voluntary. For inpatient beds, which are based on the most current certification data, 37.3 percent are proprietary, 32.5 percent are state-operated, 17.5 percent are municipal or voluntary hospital based, and 12.7 percent are free-standing A similar analysis performed earlier this year showed the following distribution for inpatient beds: 35 percent proprietary, 32.8 percent state operated, 22.9 percent municipal and voluntary hospital, and 9.2 percent free-standing voluntary.

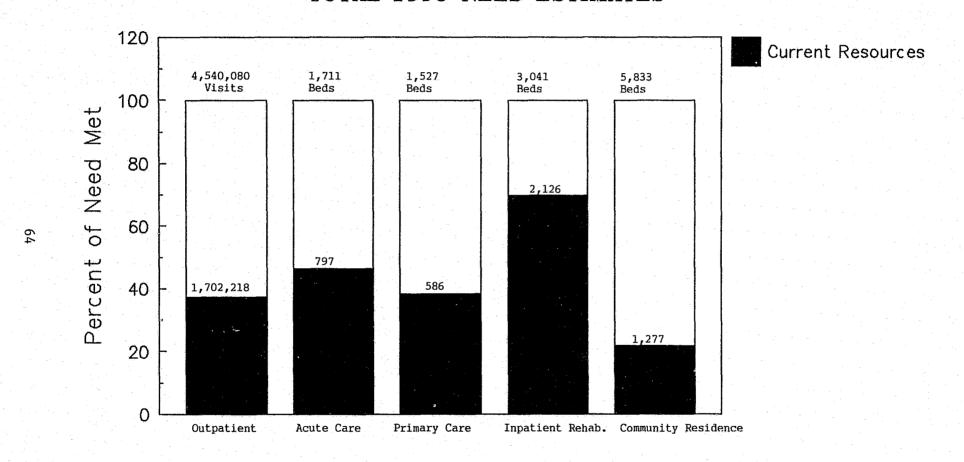
Thus, in both outpatient visits and inpatient rehabilitation beds, proprietary sponsorship is growing and voluntary sponsorship is decreasing. Together, hospital and free-standing voluntary sponsored clinics comprise 87.7 percent of all outpatient services; whereas for inpatient rehabilitation beds, hospital and free-standing voluntary sponsors comprise 30.2 percent of available resources. For inpatient beds, the number that are state-operated is remaining constant; however, this translates into a relative decrease as the other sectors grow.

NUMBER OF ALCOHOLISM TREATMENT PROGRAMS (1978 TO 1989)



* Includes total operating treatment programs as of May 1989.

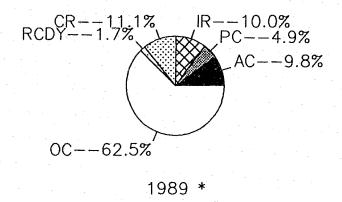
ESTIMATES OF NEED AND CURRENT RESOURCES FOR ALCOHOLISM SERVICES IN NEW YORK STATE TOTAL 1995 NEED ESTIMATES



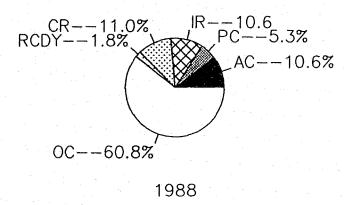
TYPE OF SERVICE

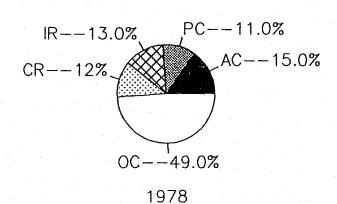
Source: Need Estimates Based on Division's Integrated Need Methodology Described in Five-Year Plan (1989-1994) and Current Resources from the 1988 LS-2C (Visits) and current Certification Files (Beds).

DISTRIBUTION OF ALCOHOLISM PROGRAMS BY CATEGORY



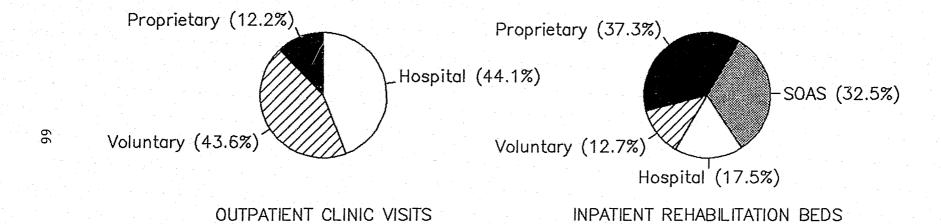
6





* Includes total operating programs as of May 89 AC — Acute Care; PC — Primary Care; IR — Inpatient Rehabilitation; CR — Community Residence; RCDY — Residential Chemical Dependency for Youth; OC — Outpatient

DISTRIBUTION OF ALCOHOLISM SERVICES BY SPONSORSHIP



^{*} Visits are from the Division's 1988 LS—2C reporting system and beds are from the Division's certification files as of May 1989.

WOMEN

Each year the Division develops a women's report in compliance with Mental Hygiene Law, which requests a summarization of initiatives targeting women. The women's reports of recent years have provided a status of alcoholism programming for women, as well as highlights of accomplishments. This approach has been valuable since it provided an opportunity to establish and monitor a baseline of services for women; however, it has also demonstrated that alcoholic women continue to be underrepresented in the alcoholism treatment system. This underrepresentation has persisted despite a number of efforts undertaken by the Division (see 1987 and 1988 Reports on Special Programming for Women). During 1988, in preparation for the Five-Year Plan (1989-1994), the Division conducted a series of pre-plan work sessions with representatives from the field and asked LGUs to identify their long-range goals and objectives in the areas of prevention, intervention, and treatment. In both efforts, services to women were identified as major issues continuing to face the alcoholism field.

As a result of this situation, the Division identified women as primary alcoholics to be the subject of a position paper to be completed for the 1990 Women's Report. This position paper will utilize a participatory process and its principal objective will be to identify and recommend for implementation of effective alcoholism treatment and intervention models for women. In addition to the position paper, the Division also plans to provide accompanying comprehensive annotated bibliography on women, alcohol and drugs.

In anticipation of this effort, the 1989 Women's Report examined, among other things, barriers to treatment. The ability of program models to address one or more of these barriers will serve as one of the criteria for evaluating and recommending specific models in the position paper. The list of barriers are presented below and the Division is particularly interested in any barriers which may have been overlooked.

Based on a review of existing literature and activities conducted by the Division and other organizations concerned with women's alcoholism treatment issues, a number of barriers to treatment for women are consistently be divided into three categories: identified. These barriers can pre-dispositional, intervention-related, and treatment-related. categories correspond to factors within women or society which impact on behavior, knowledge, or attitudes toward female drinking or women seeking treatment for problem drinking (pre-dispositional); factors within the traditional alcoholism outreach and intervention system; and factors within traditional alcoholism treatment programs.

Pre-dispositional factors may include:

- o societal norms which tend to minimize and devalue the role of women as homemakers and wage earners;
- o societal norms which associate women who drink or who frequent drinking establishments with sexual promiscuity;
- o societal norms which place the responsibility for child

nurturance on women;

- o greater societal stigma for women who drink, and particularly for women who drink heavily, as a result of the above norms;
- o poor self-esteem and feelings of guilt among women who drink;
- o lack of awareness among women, family members, and significant others about women-specific drinking patterns, etiology of problem drinking, and effects of alcohol, all of which often differ significantly from males;
- o tendency for women to drink alone or surreptitiously;
- o greater tendency for personal and family/significant other denial and/or lack of awareness of a woman's drinking problem;
- o less motivation for treatment since the woman is usually not the primary "bread winner";
- o for women with children, fear of losing custody;
- o tendencies for women problem drinkers to have accompanying prescription drug use/abuse which complicates accurate diagnosis and appropriate choice of treatment;
- o less likelihood of women having the means to pay for treatment; and
- o for women who are single parents, homeless, members of non-dominant racial and ethnic cultures, or who have non-traditional sexual orientations, additional stigma and increased barriers to treatment may be experienced.

Intervention- and treatment-related barriers for women are linked to many of the pre-dispositional factors mentioned above, as well as the historical development of alcoholism services. Intervention-related barriers may include:

- o lack of active outreach and intervention efforts targeting women;
- o lack of networking with services oriented to women's problems, which are likely to have female problem drinkers within their caseloads;
- o lack of effective, women-specific screening techniques and a lack of awareness of effective techniques that do exist;
- o lack of gatekeepers knowledgeable about the etiology and characteristics of women problem drinkers; and

Treatment-related barriers include not only those circumstances that diminish the likelihood of women entering treatment, but also those

circumstances that contribute to women not successfully completing treatment or receiving inappropriate levels of care. These barriers include:

- o lack of women-specific treatment programs throughout the alcoholism service continuum;
- o lack of female counselors and female administrators (directors) in alcoholism treatment programs;
- o lack of awareness or sensitivity to women-specific treatment issues;
- o failure to provide discrete services in a setting comfortable for women;
- o failure to adequately address women-specific treatment issues such as sexual abuse, incest, sexual dysfunction, and accompanying prescription drug use or depression;
- o a shortage of women-oriented self-help options;
- o lack of networking to provide ancillary services to meet the full range of needs of women in treatment, for example, housing, medical, and public assistance; and
- o lack of accompanying child care options for women in treatment.

FAMILY SERVICES

Overview of Issues

The treatment of family members/significant others has become a major focus in the alcoholism field in recent years. The majority of services delivered to family members/significant others of alcoholic persons in New York State are provided in outpatient programs. In 1988, over 7,600 family members were seen in outpatient programs in the alcoholism service delivery system (see Table II-2). Over 75 percent of those seen were significant others over the age of 18, of which 81 percent were women. The remaining 25 percent were children (under the age of 18) of alcoholic parents. Services currently being provided to family members/significant others in outpatient programs include family education, multi-family groups, family therapy, and ACOA- and COA-specific treatment programs. Some alcohol inpatient programs include weekend family education programs and week-long residential family programs.

Five primary issues related to the delivery of family services were identified in the Five-Year Plan (1989-1994), including:

- o the need to define what is meant by services to families/ significant others;
- o the need to identify currently available resources and service gaps;
- o the role of the alcoholism service delivery system in the treatment of the family;
- o the need for increased training and research; and
- o the need for treatment service components to care for young children of alcoholic persons in treatment while the parents are in treatment.

Analysis of Issues

In response, the Division convened an internal work group consisting of administrative, clinical, and training staff. The purpose of this work group is to further define issues and develop preliminary recommendations in regard to family programming. The discussion includes, but is not limited to, the scope of services to be provided to families, minimum qualifications for those providing family services, and types of services to be provided at each level of care within the alcoholism service delivery system. Once this task is completed, individuals from outside the agency will be invited to participate in additional discussions and dialogue.

The internal work group members, which included upstate and downstate representatives, used as their basic premise the concept that alcoholism is a family illness in which persons closely associated with an alcohol abusing or alcohol dependent person are affected. Services to family members/significant others enhance the chances of recovery for the alcoholic person, and improve the health and functioning of affected family members/significant

others, thereby interrupting the intergenerational cycle of alcoholism within the family system.

TABLE II-2

ADMISSIONS OF SIGNIFICANT OTHERS TO OUTPATIENT ALCOHOLISM CLINICS WITHIN REGIONS OF NEW YORK STATE JANUARY - DECEMBER, 1988

							1		
.	Significant Others Under Age 18				Significant Ot Age 18 and Abo				
 			Tatal					Total Family &	o/
kegion	<u>Male</u>	<u>Female</u>	<u>Total</u>	<u>Male</u>	<u>Female</u>	<u>Total</u>		Youth Ad.	<u>%</u>
Statewide	849	958	1,787	1,081	4,741	5,822	·	7,609	100
							. 1		
New York City	62	80	142	45	332	377		519	7.8
ا Nassau-Suffolk	206	234	440	173	833	1,006		1,446	18.5
i									
I Mid-Hudson	194	187	381	179	728	907		1,288	17.8
politica de la proposición dela proposición de la proposición de la proposición dela proposición de la proposición de la proposición dela proposición dela proposición de la p									
 Northeastern	111	158	269	197	890	1,087		1,350	18.8
						N			
Central	116	113	229	111	621	732		961	13.1
ا Finger Lakes	40	34	74	198	587	785	 	859	9.5
 Western	120	132	252	178	750	928	<u> </u>	1,180	14.6
i					·				<u> </u>

^{1.} Includes outpatient alcoholism clinics and comprehensive alcoholism clinics.

Related Division Activities

The care of children whose parent(s) is(are) in treatment is one of long-standing concern. The absence of viable options, especially for women who fear they will lose their children permanently if the children are placed in foster care, often means that the parent refuses to enter treatment. The Division is currently exploring a model that will address this issue, utilizing multi-agency funding streams and relying heavily on inter-agency collaboration.

The Division is convening a three day focused Discussion on Family Treatment Issues within the alcoholism service delivery system during November 1-3 of this year. This discussion is designed to bring together individuals from the alcoholism field and Division staff to develop proposed recommendations related to the major issues. These recommendations along with other information including feedback from the public hearings and the results of the internal family workgroups will be presented to the Director and used to develop an overall agency strategy to address family issues.

The Research Institute on Alcoholism (RIA) in Buffalo has received grants for two projects that directly involve the study of family systems (see Chapter II - Research). The first project involves detailed research on alcoholic families. The second is a study of domestic violence. The research results will prove valuable in shaping and streamlining services to family members in the alcoholism service delivery system in the coming years.

The Division would like to officially acknowledge the large number of comments received during the public hearing process addressing the need for family services within the alcoholism service delivery system. The Division has continued to conceptualize alcoholism as a family disease and has identified family-oriented outpatient clinics as a core component of local alcoholism service systems. The comments and level of interest related to family issues are testimony not only to the need for such services but also to the need for a carefully thought-out plan or strategy which will ensure the delivery of needed services to both alcoholic persons and family members.

SERVICES FOR YOUTH

Alcoholism services for youth have been a growing concern of the Division, LGUs, and providers, particularly over the past few years. These concerns have involved prevention, intervention, and treatment services and the overall need to specify a continuum of services and program models to address alcohol and chemical dependency problems among youth. As was discussed earlier in Chapter II, alcohol can be considered the norm-setting drug and the gateway drug to later illicit drug use. Based on data from the joint DAAA and DSAS secondary school survey, it was also found that youth tended to use more than one substance, and among heavier users, the predominant category was combined heavy alcohol and heavy substance use. As a result of these findings, the Division identified a continuum of schoolbased prevention and intervention services for K - 12 and noted that a school-based treatment component should be available to senior high students. Further specification of message and program content for these services will be undertaken over the next year. Still remaining is the need to further develop the non-residential treatment portion of the youth continuum of services, including non-school-based youth components.

In the Five-year Plan (1989-1994), the Division presented an interim need methodology for determining the need for youth <u>alcoholism</u> programming, including the need for residential chemical dependency programs for youth based on the estimated prevalence of alcohol dependency within the state's youth population. The Division estimates that approximately 27 percent of the state's 1.5 million secondary school aged youth (12 - 17 years old) can be classified as heavier consumers of alcohol. Of this heavier alcohol using population, the Division estimates that there are betwen 21 percent and 27 percent who are also alcohol dependent and in need of treatment services. Of this group in need of services, it is estimated that 10 percent are in need of residential treatment, while the remainder are in need of outpatient treatment. Utilizing 1990 population projections from the NYS Department of Economic Development, it is estimated that among the state's 12 - 17 year olds:

- o 382,328 will be heavier alcohol users in need of at least education and intervention services designed to reverse or halt their pattern of use;
- between 82,130 and 103,370 will be alcohol dependent and in need of treatment services; and
- o between 8,213 and 10,337 will be in need of inpatient treatment.

Current Services

In an attempt to address a portion of the youth substance abuse problem, the Division and DSAS have developed joint regulations to support two models of residential chemical dependency programs for youth, a short-term and a long-term program model. There are currently nine of these residential programs in operation, eight short-term and one long-term accounting for 236 beds. An additional 379 beds are in various stages of development. During 1988, there were 688 admissions to these programs. The Division anticipates

having a thorough client-based analysis of admissions to these programs for the final plan update since all of these programs were included in the pilot test, conducted earlier this year, of a client-based information form. While these programs have been in operation only a short time, a number of issues have become evident:

- o lack or inadequacy of inpatient insurance coverage;
- o lack of youth-oriented aftercare settings;
- o need to further explore the possibility of locating and operating these programs in cooperation with other residential youth service agencies, such as DFY and DSS;
- o provision of, and reimbursement for, educational services within these settings; and
- o establishing linkages and referrals to self-help groups for youth returning to their home community from the program.

The Division's current adult outpatient program model allows for the provision of youth-specific treatment through the addition of chemical dependency youth counselors or the development of youth-oriented treatment components. For example, in 1986 the Division supported an initiative to place chemical dependency counselors in outpatient clinics. The following table provides data on the number of admissions of alcoholic persons under 18 to outpatient alcoholism programs in 1988. As can be seen, there was a total of 2,453 admissions, 69 percent of which were males. Youth admissions make up less than 3 percent of the total outpatient admissions, while they are an estimated 7 percent of the population in need of services.

Admissions of Alcoholic Persons Under 18 to Outpatient Alcoholism Clinics* by Region (1988)

Region	# of Alcoholism Clinics	Alcoholic Persons <u>Under Age 18</u>					
Statewide	247	<u>Male Female Total</u> 1,704 749 2,453					
New York City	59	87 28 115					
Nassau-Suffolk	49	132 62 194					
Mid-Hudson	26	126 71 197					
Northeastern	30	388 182 570					
Central	27	252 133 385					
Finger Lakes	30	457 174 631					
Western	26	262 99 361					

* Includes comprehensive alcoholism clinics.

In planning and developing outpatient services for youth, the following issues and concerns have been identified:

- o the reluctance of many youth to utilize outpatient services within the adult outpatient programs;
- o the existence of barriers that reduce access for youth to adult outpatient programs;
- o the need to integrate after-school and weekend programming in youth outpatient services;
- o the need for a range of youth outpatient services, for example, intensive outpatient as an alternative to residential;
- o the importance of active outreach in schools and community youth programs;
- o the need to consider locating youth treatment within youth settings, for example, schools and community youth programs;
- o the importance of involving families in the treatment process; and
- o the importance of networking with other professionals and systems to address other concurrent problems, such as mental illness, learning disabilities, and juvenile justice involvement.

Strategy

In response to these concerns over youth alcoholism and chemical dependency treatment, the Division has engaged in a number of activities during the past year. While continuing to support the development of residential chemical dependency for youth programs, the Division has turned its attention to less costly alternatives which will effectively address the needs of chemically dependent youth. The second major focus which the Division has been addressing is the need to develop discrete youth treatment models which utilize youth settings for both outreach and identification, as well as for the delivery of treatment services. These models would be heavily reliant on school and community youth settings.

Specific activities which the Division has undertaken include:

- o the establishment of an internal work group to identify youth services issues, which will be followed by convening a group with representatives from outside the Division and developing a position paper;
- o submitted legislation to allow for 100 percent state aid for the net operating costs of outpatient chemical dependency

programs for youth;

- o the development of a discrete youth chemical dependency program within a DSS residential setting through the TFIP; and
- o the development of a training package (to be released this fall), which will address chemically dependent youth and their families.

Profile of Clients Served in Short-Term Residential Chemical Dependency Programs for Youth

In February 1989 the Division conducted a pilot test of a Client Information Profile (CIP) form at 62 of the 450 alcoholism program units across the state including all six short-term residential chemical dependency for youth programs (RCDYs) which were operating at the time of the pilot.

The RCDYs were asked to report on all persons served during February 1989. During this period, one person was assessed, but not admitted; this person has been excluded from the analysis. A total of 143 clients were reported by five programs for which data was available for analysis. The preliminary analysis below is based on data from five RCDYs and due to the relatively short time of operation of some of the programs and the relatively recent development of the program model, caution should be exercised in interpreting and generalizing the results.

Demographic Characteristics:

Twenty-seven percent of the youth served were female. The age at admission ranged from 13 to 19 years with twenty-two percent of the sample aged 18 or older. While 28 percent of males were 18 or older, only 8 percent of females were this old. About half of the clients were between 16 and 17 years old.

Eighty percent of the clients were white while 15 percent were Black and 5 percent were of Hispanic origin. No other racial/ethnic group was represented. The racial-ethnic composition was similar for males and females.

Living Situation Upon Discharge:

All residential programs were asked to indicate with whom and in what type of residence clients would be living upon discharge. In response to the former, eighty-two percent of the RCDY clients served were expected to live with their parents upon discharge. Among males, the percentage was 86 percent while among females it was 71 percent. Four percent would be living with foster parents and 6 percent would be living "with others," such as in a group home. Females were more likely to be living with foster parents and in group homes.

In response to the type of residence clients would be living in upon discharge, 94 percent were expected to live in a house, apartment or mobile home. Two clients were homeless and expected to live in a family shelter or hotel and one client expected to live in an SRO (single room occupancy).

Four were expected to live in an institution or other group quarters.

Education and Employment:

Programs were asked to indicate the highest grade completed, current school status, and current employment status for all clients served during the month. At the time of admission, 62 percent of the clients served were going to junior or senior high school full time. For males the percentage was 55 percent while for females it was 82 percent. Some of this difference is due to age as males were older and therefore less likely to be in school. Fifty clients (35%) were not enrolled in an educational program. Of these, 84 percent (42/50) were "drop-outs" in that they had not completed the twelfth grade. Four clients from the sample were going to school part-time or enrolled in a vocational program.

As would be expected, only a few clients (5%) were working or unemployed, looking for work. Twenty-seven percent were under age 16 and, for purposes of this analysis, considered not in the labor force by virtue of age. An additional twenty-nine percent were reported as not being in the labor force because of their student status. Twenty-five percent were reported as "not in the labor force, other," meaning that the client was age 16 or older, however s/he was also not in school, a homemaker, disabled or retired. For 13 percent of the clients, employment status was reported as "not applicable or unknown." Since the clients' employment status should have been known to the programs, this large percentage may have resulted from misinterpretation of the "not applicable" category.

Access to Care:

Access to care was examined based on county of residence of the client, referral source, mandated referral status, and principal payment source. Only 7 percent of the clients served were from New York City. Two percent were from the Nassau-Suffolk health service area and 2 percent were from the NY-Penn health service area. No short-term RCDYs were located in these areas. Eight percent of the clients came from another state. The remaining clients were distributed as follows: 31 percent -- Hudson Valley, 10 percent -- Northeastern, 20 percent -- Central, and 16 percent -- NY-Penn.

Referrals into the RCDYs came from many different sources. percent were from other alcoholism and substance abuse treatment programs. Eleven percent came through formal intervention programs, such as community prevention programs, youth intervention programs in the community, school-based intervention programs, hospital-based intervention programs and employee assistance programs. Five percent of the referrals were drinking driver-related. Referrals from the mental health system, the health care system and the social services system represented 3, 5, and 8 percent, respectively. Family court provided 9 percent of referrals while criminal justice sources (primarily probation) provided an additional 10%. Eight percent of clients were referred by family or friends while self-referrals and other less-structured sources accounted for 13 percent. Females were more likely to be referred from treatment agencies and the social services system while males were more likely to be referred from criminal justice sources.

"Mandated referral" was defined as a referral in which an agency, court or employer referred the client and, if the client does not comply with the conditions of the referral, the agency, court or employer is likely to take some action against the client, such as denying home relief payments, revoking the driver's license, incarceration, firing or demotion, suspension or expulsion from school. Thirty-one percent of the clients served had been admitted under a mandate. Most of the mandated referrals were from the criminal justice system, 24% of the clients served. The percentage among males was 30 percent and among females 8 percent. The social services system was responsible for mandating 5 percent of the clients served. Thirteen percent of females were mandated through social services while only 2 percent of males received social services mandates. No mandates were attributable to drinking driver referrals or employers. One mandate was provided by a school and two were attributable to "other".

An analysis of principal payment source showed that for 48 percent of the clients, private insurance was expected to pay most of the charge for treatment and Medicaid was the principal payment source for 41 percent. Statewide, health maintenance organizations were the primary payor for 9 percent of the clients. Medicare and other third party payers were not represented. There was one case of "self-pay" and one case of "no charge" for services.

Clinical Indicators:

Clinical indicators such as COA status, a significant other treatment component, and as many as four diagnostic codes were requested for each client served. Two-thirds (65%) of the clients served were identified as children of alcoholics (COAs). Females were more likely to be COAs (76%) than were males (61%). While over half the clients served had alcoholic fathers, in 20 percent of the cases both parents were alcoholic. Thirty-nine percent of the clients being served had a treatment component to address problems related to being a significant other in addition to receiving treatment for chemical dependence. Interestingly, in this sample, males were more likely to have a significant other treatment component (41%) than females (34%).

As would be expected, no clients were diagnosed with conditions of alcohol or drug psychosis or intoxication. Such conditions would be unusual in a young population and/or would have been resolved prior to admission. All clients were diagnosed with conditions of chemical dependence or abuse. One program diagnosed all clients as abusers and none of them as "dependent." Apparently this program used the DSM-III diagnostic schema rather than the DSM-III-R (revised). (Under DSM-III the definition of dependence requires withdrawal symptoms or tolerance to a substance. These conditions are typically difficult to demonstrate in a young population appropriate for treatment, despite their dependence on alcohol or drugs.) Because of this apparent definitional inconsistency, abuse cannot be distinguished from dependence across programs and therefore separate statistics for dependence and abuse are not presented.

Eighty-three percent were diagnosed under alcohol dependence or abuse while 91 percent were dependent on or abused one or more other drugs. Seventy-three percent were dependent on or abused cannabis. Cocaine was the

substance of dependence or abuse for 45 percent of the clients served while 15 percent were dependent on or abusing hallucinogens. Amphetamines, sedatives, opioids and polysubstance abuse account for only a small fraction of the clients diagnosed.

Only 17 percent of the clients served were not diagnosed under alcohol dependence or abuse, but abused or were dependent upon some other substance. While 9 percent of the clients received only an alcohol diagnosis, 73 percent received a diagnosis of dependence or abuse for a drug (other than alcohol) in addition to an alcohol diagnosis.

Sixty-two percent of the clients received both alcohol and cannabis diagnoses while only 11 percent received an cannabis diagnosis without a concurrent alcohol diagnosis. Thirty-six percent of the clients received both an alcohol and cocaine diagnosis while only 8 percent received a cocaine diagnosis without a concurrent alcohol diagnosis. Fourteen percent received an alcohol and hallucinogen diagnosis while only 1 percent received a hallucinogen diagnosis without a concurrent alcohol diagnosis.

As noted above, 65 percent of the clients were found to be children of alcoholics (COAs). This proportion applied generally regardless of the diagnosis. Among those with a cannabis diagnosis, 65 percent were COAs while 58 percent of those with a cocaine diagnosis and 64 percent of those with a hallucinogen diagnosis were COAs.

MENTALLY ILL CHEMICAL ABUSERS (MICA)

In the Five-Year Plan (1989-1994) a number of issues related to services to MICAs were identified and the Division proposed to develop a position paper on services to the multi-disabled, including MICAs. In subsequent plan hearing testimony, many of these concerns and issues were again emphasized by persons presenting testimony from throughout the state.

In the 1989-1990 local plan cycle, New York City and most major urban counties (Westchester, Suffolk, Erie, Monroe, and the capital district counties), as well as some smaller counties, submitted goals and action steps to address alcoholism treatment initiatives for patients with alcoholism and/or substance dependence and concurrent psychiatric disorders. Almost all these local plans focused on expanded outpatient efforts and some identified connections with mental health community residences.

The major issues concerning services to MICAs are the overall lack of services and the need to develop viable treatment models staffed with appropriately trained personnel to address the unique needs of this group. An additional concern of the Division is that given our relatively small base of services, which is inadequate to handle alcoholic persons and their families, there is a definite limit as to how much of an influx the current alcoholism service delivery system can absorb. Therefore, as part of its position paper, the Division will identify which MICA clients can reasonably be treated within the alcoholism system. The position paper will also include an action plan for addressing those MICA clients to be treated within the alcoholism service delivery system, as well as for providing technical assistance and training to other systems serving MICA clients.

The following considerations are proposed for possible inclusion in the development of the Division's position paper on alcoholism services to MICAs.

- The Division will determine which mental disorders with an accompanying alcohol problem can be treated within the alcoholism service delivery system given appropriate staffing.
- o The Division will rely on model programs developed through the Task Force on Integrated Projects and pilot demonstration programs to explore and evaluate approaches to providing alcoholism services to MICAs.
- o In developing services for MICA clients, the Division will rely primarily on expanding existing alcoholism programs.
- o In developing outpatient services for MICAs the Division will employ the strategies of adding specialized staff, such as psychiatrists, psychiatric nurses, and psychiatric social workers to existing programs and developing specialized discrete program components, such as day treatment and outpatient rehabilitation.
- o Alcoholism outpatient programs located in larger general hospitals with psychiatric units and staff, will receive a high

level of consideration for providing services to MICAs.

- o Sub-groups of MICA clients, such as the homeless and Vietnam veterans suffering from alcoholism and PTSD will be considered for specialized services.
- o Approaches stressing linkages between service systems will be considered more favorably.

The Division is particularly interested in input from the field on what services should be developed within the alcoholism system for MICA clients and what types of MICA clients can be treated within alcoholism programs.

PROFESSIONAL DEVELOPMENT

COUNSELOR CREDENTIALLING

In 1989 the Division of Alcoholism and Alcohol Abuse marks a decade of issuing credentials to alcoholism counselors. As the Division prepares to begin its second decade, more than 4,000 credentials have been issued.

The credentialling process and the credential itself have achieved more than early advocates foresaw. The credential has become valued as an indicator of alcoholism expertise and credentialled counselors have become an integral part of interdisciplinary teams. Growing numbers of clinical supervisors and program administrators have the credentialled alcoholism counselor (CAC). Employers in the alcoholism field and in other health, human service, and criminal justice systems all actively recruit CACs for their staff, resulting in significant competition for the pool of CACs in the state.

The increased recognition of the CAC has come as the Division has worked to standardize and improve its credentialling procedures. Relying heavily on the 15-member New York State Alcoholism Counselor Credentials Board for advice, it has examined virtually every facet of the credentialling process. The Division made a decision to delay any pursuit of an advanced credential until the current CAC credentialling process and procedures have been firmly resolved and promulgated as regulations. In instituting changes, the Division has been guided by the following premise: the improvements must assure equity and fairness to all candidates while expediting processes and eliminating fragmentation.

One of the major steps the Division took was to issue a briefing on work and experience requirements, which informs applicants of what needs to be documented for credentialling purposes. Criteria used to judge work settings which are outside certified alcoholism programs have been described. These criteria assure that experience gained in these programs will be equivalent to that obtained in certified alcoholism programs. The alcoholism counseling work experience is considered one of the most critical factors in developing competence in the practice of alcoholism counseling skills.

As the Division faces the next decade of credentialling of alcoholism counselors, the Division will have implemented a new credentialling examination. This examination, which represents the third major change in the examination's history, is a response to many of the suggestions and to the constructive criticism the Division has received by those examined and those CACs who have acted as examiners.

In 1989 the Division contracted with Psychological Services Inc. (PSI) of Washington, D.C. and Los Angeles, California to review the credentialling examination, recommend changes, and work with subject matter experts who were CACs to develop a new examination. The first revised, streamlined examination was delivered statewide in April and May to 368 examinees.

In the process of examination development, CACs reviewed the core knowledge and skills that were identified in the national Birch and Davis

study. CACs not only identified the core knowledge, skills, and tasks as relevant to New York alcoholism counseling practice but identified the competency area under which they should fall. The seven competency areas were then weighted, based on their importance, and the examination was designed to reflect the professionals' judgments. Competency areas include: communication; knowledge of alcohol use, abuse and alcoholism; evaluation and assessment; planning; information and referral; counseling and treatment; and principles of professional conduct. All the content of the Division's examination has been developed by CACs from across the state, representing diverse interests and experience. Because the examination requires application of knowledge that is relevant to the work of an alcoholism counselor, the subject matter experts' contribution to the content was particularly critical.

The examination for credentialling is competency based and consists of two parts: a written multiple choice examination and an oxal examination with a treatment plan and two work situations in which examinees are asked questions. The oral examination process continues to allow preparation time for examinees to familiarize themselves with the material and questions. Three CACs serve on a panel conducting each of the oral examinations for candidates. The administration of the examination is handled by the New York Federation of Alcoholism Counselors, Inc. (NYFAC) with which the Division has a contract.

The examination process is unique in that it involves CACs volunteering their time (and being paid only for travel expenses) to ensure that CAC candidates are examined by their CAC peers in the regions in which they work. NYFAC, as the contractor, recruits the volunteers for the process.

The response to the first delivery of the examination, which is delivered twice a year in the spring and fall, has been overwhelmingly positive. Examinees queried on their experience praised the examination for fairness and job relevance. The CACs who served as proctors and oral panelists praised the new examination not only for being more job related but being vastly improved for administering and scoring, allowing professional judgment of the candidate while preserving objectivity. CACs worked with the Division and Psychological Services Inc. in developing the format and the rating scales. Because of the positive results of this process, the Division will continue periodically to convene CACs as subject matter experts to develop examinations for future delivery.

The final revision of Part 395 Regulation governing credentialling was delayed to allow for changes that might be recommended by PSI experts as they reviewed the process and developed the new examination. Hearings on the final draft of Part 395 will be held in Albany and New York City late in 1989.

The Division sought legislation in 1988 and 1989 to protect the CAC as a title that can be used only by credentialled alcoholism counselors. Such protection of title exists for other health professionals.

WORK FORCE ISSUES

The Division's 1989-1994 Five-Year Plan identified work force issues as an area of critical concern to the alcoholism service delivery system in New York State. Since little data currently exist on the alcoholism work force, the Division collected certain baseline data at the agency and program level through the 1990 Local Services Plan. The information collected through the Plan submissions is essential in clearly defining the work force problems in New York State. The information will also help regional work force planning groups in their efforts to address local work force issues and problems.

During September of this year, a more detailed alcoholism work force survey was distributed to all professional staff members of certified programs. Through this survey, the Division has collected such information as professional licenses and certifications held, continuing education and training being received, certain supervisory responsibilities and caseloads, and other demographic information. The survey results, when analyzed over the coming months, will add to the developing profile of the alcoholism work force and contribute to the efforts to address the work force issues still being defined.

The Professional Staff Profile from the local services plans was completed by 234 agencies statewide, covering 374 prevention, intervention and treatment programs. The form was completed for approximately 79% of all residential, and 92% of all non-residential treatment programs. Since most agencies operating more than one program type could not complete the profile at the program level, they were asked to complete it for the entire agency staff. Many agencies that could separate program staffs, however, did so. In all, 202 professional staff profiles were completed for single programs and 63 were completed for multiple programs.

The profile survey asked for information concerning the current staff, including professional licenses and/or certifications held, and current and recent vacancies by staff category. Tables II-3 and II-4 show the statewide summary of responses by staff category.

Table II-3
Statewide Professional Staff Profile
Current Staff - Filled Positions

			Total Current	Damasant	
Staff Category	Male	Female	FTE	Percent CAC	
Physician	285	70	150.1	0.3%	
Psychologist	71	45	69.1	8.6%	
Nurse	60	619	598.8	10.2%	
Social Worker	174	395	494.5	29.8%	
Alcoholism Counselor	789	934	1531.3	45.3%	
Rehabilitation Specialist	32	44	68.3	31.6%	
Recreation Specialist	35	47	68.4	2.4%	
Occupational Therapist	2	14	10.6	25.0%	
Prevention/Intervention Staff	72	127	163.3	16.6%	
Other	267	282	446.1	7.5%	

Professional staffs within New York State's alcoholism service delivery system tend to be primarily female. Of the 4364 individuals reported on the survey form, 59% were females, including minorities in eight of the ten staff categories shown. The staff category "other" covers a wide range of including Program and Administrative Directors, various positions, "assistants", EMT's, House Managers, etc. Among alcoholism counselors, approximately 54% are females. The percentages are virtually identical across agency type, whether private proprietary, voluntary non-profit, publicly operated, or general hospital. While outpatient clinics and prevention and intervention programs each show female majorities of 62%, residential treatment programs show a 51% male majority. On a regional basis, male alcoholism counselors are the majority in New York City and in the Northeastern Region, while females predominate in the rest of the state.

The total current full-time equivalent (FTE) represents the professional staff on the basis of an agency's normal full-time work week. For each staff category, the total FTE is calculated by dividing the total number of staff hours worked per week by the hours in a normal full-time work week. The total FTE may provide a more accurate picture of the state of affairs within the system than the total number of individuals on staff. It better reflects the actual work force strength and may be a more valuable statistic in work force planning from a budgetary standpoint.

Approximately 26% of the professionals working within the service delivery system are reported to be Credentialed Alcoholism Counselors, with better than two-thirds of them identified, functionally, as alcoholism counselors. Among the alcoholism counselors, there appears to be little variation in the percentage who are CAC from one program type to another. When agency type is considered, however, general hospitals reported 59% of their alcoholism counselors to be credentialed, compared to 47% at publicly operated programs, and 43% and 42% at private proprietary and voluntary non-profit programs, respectively.

Table II-4
Statewide Professional Staff Profile Responses
Current and Recent Vacancies

	Vac	cancies		Average Time it Takes to Fill Vacancies					
Staff Category	Current	Within Past Year	N	< 30 Days	1 - 3 Months	3 - 6 Months	6 - 12 Months	> 12 Months	
Physician	24	56	88	15.9%	22.7%	35.2%	14.8%	11.4%	
Psychologist	6	14	27	11.1%	33.3%	33.3%	14.8%	7.4%	
Nurse	79	141	87	14.9%	43.7%	27.6%	10.3%	3.4%	
Social Worker	91	167	122	8.2%	36.9%	32.8%	15.6%	6.6%	
Alcoholism Counselor	185	437	180	15.6%	42.2%	26.1%	12.8%	3.3%	
Rehabilitation Specialist	10	20	19	10.5%	31.6%	42.1%	5.3%	10.5%	
Recreation Specialist	7	20	27	7.4%	55.6%	18.5%	14.8%	3.7%	
Occupational Therapist	. 3	4	7	14.3%	28.6%	28.6%	14.3%	14.3%	
Prevention/Intervention Staff	24	67	39	20.5%	51.3%	25.6%	0.0%	2.6%	
Other	37	98	53	17.0%	41.5%	32.1%	7.5%	1.9%	

The Division's Five Year Plan identified recruitment, staff training, and career advancement as three major problem areas facing the alcoholism work force in New York State. A consequence of these problems is a high rate of turnover and difficulty filling the vacancies with qualified personnel. Eighty percent of the agencies responding to the survey reported vacancies on their professional staffs within the past year, with 55% reporting current vacancies. The current vacancies represent 46% of all those reported within the past year, perhaps an indication of the difficulty agencies are having replacing staff.

Agencies reported that 83% of the vacancies in all staff categories are filled within six months, though one in twenty positions remain unfilled after a year. From the survey responses, however, vacancies in no single staff category appear to be the most difficult to fill. Total current vacancies reported for all staff categories represent approximately 10% of the entire alcoholism work force.

The problem of alcoholism counselor vacancies shows some variations by agency type and region. Proprietary agencies appear to have the greatest success filling vacancies, as 78% are filled within three months, compared to 60% for voluntary non-profit programs, 50% for general hospitals, and only 40% for publicly operated programs.

In the Mid-Hudson region, current vacancies represent 725 of the total vacancies within the past year, compared to a low of 295 in the Northeastern region. All other regions of the state are either near or at the statewide average of 42%. Variations between program types are not as dramatic, though residential treatment programs show 69% of vacancies within the past year

being current. That variation seems to be supported by the responses given to the length of time it takes to fill vacancies, as only 45% of residential programs reported filling vacancies within three months while 61% of all other program types reported filling their vacancies within the same time period.

The Division has initiated discussion with regional groups representing alcoholism providers to determine the optimum structure for a work group that will assist the Division in addressing problems and issues over which the Division, the LGUs, or alcoholism providers, have control. Generally, there is consensus on the need for increased salaries for alcoholism staff, better working conditions, and opportunities for traineeships with stipends, but the current economic climate mandates a long-range strategy for achieving these goals. There also is consensus that credentialling of sufficient numbers of alcoholism counselors is a work force concern, but that it cannot dominate any work force group's agenda. While not ignoring any of these issues, the group will work toward effecting changes that are feasible in the shorter term.

Initially, regional work force groups will be convened to assure that relevant regional work force issues are addressed. It is anticipated that a statewide group, consisting of regional representatives, will then be convened to share information and recommended strategies and to determine the substance of a work force report due in 1990. Groups will include representatives from the field.

Concurrently, the Division, through its Bureau of Professional Development, will develop additional in-service training modules and will facilitate efforts to make training more accessible.

As a measure of support for those who work in the alcoholism field, Governor Mario Cuomo proclaimed March 21 as Alcoholism Counselor Appreciation Day, setting the stage for annual recognition of the work and commitment of alcoholism counselors. In 1990, the Division looks forward to expanded efforts to recognize the alcoholism counselor as key in providing quality care to alcoholic persons and their families. A day of recognition is intended to focus on the alcoholism professional rather than agencies, systems, or the community.

The Division has also worked with academic institutions and professional associations to include more alcoholism specific content in curricula and to foster certificate alcoholism programs, when appropriate. In two regions of the state, academic institutions and alcoholism providers joined in a promotional effort to alert college graduates to the opportunities in the alcoholism field.

AIDS TRAINING INITIATIVE

The Bureau of Professional Development initiated the alcoholism/AIDS training project for alcoholism service providers throughout New York State in October 1988.

Three separate curriculum modules have been developed as part of the project and direct training has been provided in each of the seven regions of the state.

The modules are:

Alcoholism and AIDS Overview - This 12 hour experiential training offers alcoholism program staff an overview of AIDS and human immunodeficiency virus (HIV) illness including: current material on testing, transmission, infection control, and treatment approaches. This training considers the issues and problems relevant to alcoholism treatment services as well as providing an overview of the elements of prevention models.

Alcoholism/AIDS Training for Administrators - This six hour training offers alcoholism program administrators an opportunity to consider implementation issues that arise from policy and regulations regarding HIV and AIDS in alcoholism treatment systems. This training addresses legal, confidentiality, liability, and administration issues in relation to supervisors' responsibilities.

Alcoholism/AIDS Clinical Issues in Treatment - This 12 hour training leads to the development of an awareness of the range of issues related to HIV illness/AIDS and their impact on providing alcoholism treatment services. The experiential nature of the training allows participants to process factors that must be addressed in the provision of treatment to alcoholic persons and their families. The training also addresses steps clinicians can take to avoid becoming overly stressed by working with clients who have multiple needs and require more extensive counseling and referrals. Additionally, this training addresses clinical concerns in working with family members or significant others.

The Alcoholism/AIDS training project will ultimately result in the training of community-based trainers to deliver this curriculum to local alcoholism services and the production and distribution of resource materials for local training efforts. The project will also enable the Division to meet many of its objectives as delineated in the Five-Year AIDS Plan for New York. The training is designed to incorporate new content when it becomes relevant and also to support a growing network of community-based trainers who can identify the changing needs of alcoholism services staff. It is recognized that one-time deliveries of training are inadequate; furthermore, Division regulations require on-going training to assure clients the best possible treatment.

RESEARCH

Over the years, the Division's Research Institute on Alcoholism (RIA) has attempted to increase its communication with the alcoholism field in order to be more responsive to research needs and to provide the field with relevant research findings for practical application. There are numerous RIA research projects currently under way or proposed which focus on several priority themes identified by the Division. Support for these projects comes from a mix of state and federal funding, with the federal share coming primarily from NIAAA.

The alcohol connection has been identified in a wide variety of social, family, and personal problems resulting in the need to develop appropriate linkages between state and local human service agencies. Research by RIA is attempting to address, and enable an effective response to, the many consequences of alcoholism and alcohol abuse on the lives of individuals involved in other human service systems.

Special populations continue to receive priority focus in the Division's policy development and program planning activities. Much of the research under way at RIA focuses on one or more special populations in an effort to better understand their unique problems and circumstances so that appropriate and effective prevention, intervention, and treatment strategies may be developed and targeted.

A number of projects specifically address goals relating to youth. Continued research at RIA involves the study of alcohol as the gateway drug. These projects also serve to track the current trends in the use and abuse of alcohol, particularly among school-aged children. Two other research projects specifically address children of alcoholics.

Finally, a number of projects focus on the evaluation of clinical assessment and early detection techniques and on the effectiveness of intervention and treatment approaches. The results from these studies will help identify effective approaches for practical application at the program level.

Few research projects currently under way at RIA focus on any single area described above. For example, the alcohol connection or effective assessment and early detection may be studied in relation to the unique characteristics of a specific population. The following summary of active projects identifies research efforts which should be of interest to the alcoholism field. For further information on these projects, the reader should contact the Research Institute on Alcoholism.

- o Restraint and Attribution: Risk Factors in Alcohol Abuse (NIAAA-funded) A series of related correlational and laboratory investigations examining how preoccupation with controlling one's drinking, and pessimistic views of the causes of one's drinking, affect progression from social to pathological drinking. Subjects include young men and women. Findings will have early assessment strategy implications.
- o Impact of Family Violence on Women's Alcohol Problems (NIAAA-

- funded) Examines violence by parents and partners in relation to the development of alcohol abuse and dependence in women.
- O <u>Vulnerability Factors and Adolescent Drinking</u> (NIAAA-funded) Examines how vulnerability/risk factors influence alcohol use and drinking problems among adolescents. Subjects are 600 10th and 11th grade boys and girls and their parents. Risk factors include family history of alcoholism, parental depression, life stress, and peer and family conflict.
- o <u>Children of Alcoholics: A Comprehensive Bibliography</u> (state-supported) Updating of the 1984 children of alcoholics research, treatment, and prevention bibliography developed by the Division.
- o <u>Children of Alcoholics: Critical Review of the Literature</u> An edited book with chapters by experts within and outside RIA. Publication due 1990. Will serve as foundation for future studies.
- o <u>Initial Drinking experiences Among Alcoholics, Problem Drinkers, and Non-Problem Drinkers</u> (state-supported) Examined first drunk experience in 420 individuals and found that alcoholics and problem drinkers drank more and had a second drinking experience sooner even though they reported more negative effects than non-problem drinkers.
- o <u>Alcoholism and Depression</u> (state-supported) A collaborative project with SUNY at Buffalo Department of Psychiatry examining the biological connection between alcoholism and depression by examining cortisol levels and MHPG among alcoholics in treatment and depressives in treatment.
- o <u>Family Factors and Adolescent Alcohol Use</u> (NIAAA-supported) The first longitudinal study of alcohol and hypertension in relation to stress. Studies general population household samples of Black (1,050) and white (884) men and women, and also permits examination of children of alcoholic subjects.
- o <u>Drinking and Alcoholism in Young Men: A National Study</u> (NIAAA-supported) Examined rates of alcohol abuse and alcohol dependence in a national sample of young men (900 heavy and 300 social drinkers) in relation to risk for alcoholism, including parental alcoholism, anti-social behavior, expectations about alcohol effects, and personality variables.
- o <u>Problem Drinker Driver Project</u> (state-supported) Examines DWI offenders to identify risk factors that predict different types of problem drinkers within the general DWI population. The results have implications for assessment, secondary intervention, and differential programming for DWIs.
- o New York State Survey of Adult Alcohol Use (state-supported) A survey of 6,364 adults in New York State about drinking

practices, with oversampling of the homeless and ethnic minorities. The database, developed by DSAS, permits further study of alcohol as the gateway drug.

- o <u>Adolescent Drinking Survey</u> (state-supported) A 1983 survey, conducted by DSAS in collaboration with DAAA, of 27,000 high school students. Many reports, including <u>Double Danger</u>, continue to result from the survey. A repeat survey is scheduled for Fall 1989, or Spring 1990, dependent on state funding.
- New York State Continuous Alcohol Survey (state-funded) The project tracks drinking trends in New York State by collecting data over time using consistent questions, sampling, and interviewing methodology.
- The Role of Spouses in Rolapse Prevention for Smokers (NIDA-funded) Examined the role of social support (spouses) on relapses, particularly the nation that the more shared and structured the support of spouses, the fewer the relapses. The findings have implications for alcoholism treatment and for smoking interventions.
- o <u>Treatment Setting and Aftercare Duration for Alcoholics</u> (NIAAA-funded) Compares relative efficacy of inpatient and outpatient treatment for alcoholics, evaluating overall treatment outcome and relapse rates for various combinations of treatment setting and aftercare duration.
- o <u>Preventing Substance Misuse Among the Mentally Retarded</u> (NIDA-funded) Compares the effects of two preventive education programs on reduction of substance misuse in non-institutionalized, moderately handicapped, mentally retarded men and women. Results will add to our knowledge of alcohol and other substance misuse in this group and will provide tested preventive methods.
- o Aging and Musculo-Motor Consequences of Alcohol Abuse (NIAAA-funded) Investigates the effects and reversibility of alcoholism and aging on muscular and psychomotor functions. Findings will provide information essential to the assessment and rehabilitation of muscle functions in alcoholics in clinical settings.
- o Frequent Heavy Drinking and Marital Violence in Newlyweds (NIAAA-funded) Investigates the relationship between heavy drinking and marital violence over time in a sample of newlyweds. Results will be used to develop assessment and prevention/intervention strategies to reduce marital dysfunction due to heavy alcohol consumption.
- o <u>Long-Term Effects of Alcohol/Benzodiazephine</u> (NIAAA-funded) Investigates the long-term effects in mice of the combined use of alcohol and benzodiazepines, as well as how these drugs

interact during chronic intake. Findings will increase understanding of combined use and cross-addiction between these substances.

- O Intra- and Inter-Generational Aspects of Serious Domestic Violence and Alcohol/Drugs (National Institute of Justice-funded) Investigated violence in the families of parolees, including parents, spouse, and children. Findings indicate that alcohol and drug abuse characterize families and mediate domestic violence. The findings also have implications for policy formation and program development in the criminal justice system.
- o <u>Interferon System in Chronic Alcoholics</u> (NIAAA-funded) Preliminary investigation of interferon parameters in alcoholics in relation to behavioral indices before and after treatment. Findings may result in the development of a joint application between RIA and Roswell Park Memorial Institute (RPMI) for a larger projects.

In addition to these active projects, RIA has a number of proposed studies pending funding. These projects cover many of the same issue areas as those described above, including the relationship between alcohol use and stress, delinquency, use of other substances, and marital aggression; drinking patterns of selected special populations; and studies designed to improve existing techniques for classifying alcohol drinkers and preventing alcohol problems in specific populations.

CHAPTER III

PLANNING AND POLICY DEVELOPMENT

FINANCIAL ACCESSIBILITY TO SERVICES

Introduction

Access to the full range of programs for all those in need of alcoholism services has been a long-standing concern of the Division, particularly with regard to those unable to pay the full cost of care. This issue was discussed in the 1988 Update: Focus on Treatment and Rehabilitation, and was identified as a major planning issue in last year's Five-Year Plan (1989-1994). This issue has become particularly critical in recent years as the rate of proprietary growth within alcoholism services, especially inpatient rehabilitation programs, has increased; the ceiling on inpatient and outpatient services needs is approached; publicly funded programs become more crowded and have longer waiting lists; charges for all care but especially inpatient, continue to rise; and not all providers demonstrate a willingness to accept and treat a share of the uninsured, the medically indigent and those unable to pay the full cost of care.

The five-year plan also identified a number of proposed alternatives to address the issues related to financial accessibility of services.

- o Establish a program whereby the Division could purchase services for a reasonable rate from inpatient providers for persons unable to pay the full cost of care.
- o Refine the Division's need methodology to reserve a percentage of inpatient and outpatient capacity for future development of services by providers of service to medically indigent clients.
- o Establish a suggested minimum percentage of Medicaid and medically indigent services that inpatient and outpatient freestanding providers should provide based on regional data about the size of the medically indigent population.
- o Examine the legality that as a condition of Division licensure, all providers of services must become Medicaid eligible.
- o Mandatory inpatient alcoholism treatment coverage in group health insurance policies.

During the past year, the Division has examined a number of these alternatives and these efforts are described below.

Estimated Uninsured or Medicaid Eligible Problem Drinkers in New York State

The Division has attempted to estimate the number of adults between the ages 18 and 64 who are problem drinkers and either have no health insurance or are eligible for Medicaid coverage. Because there is little information currently available regarding the number of uninsured adults in New York

State, a number of assumptions were applied to certain known data to arrive at the estimates shown in table III-1.

In a November 1987 report prepared by Signalhealth, estimates of the 1985 New York State population without health insurance were presented. These age-based estimates were given for larger metropolitan areas of the state, and for the rest of the state which included all counties not located in one of these larger metropolitan areas. The uninsured percentage given for each metropolitan area was applied to each county within that area, and the uninsured percentage given for the rest of the state was applied to all other counties not located in a metropolitan area. Those percentages were then applied to the 1985 population estimates for 18 to 64 year olds provided by the NYS Department of Economic Development to determine the estimated number of uninsured by county for 1985.

The average monthly number of Medicaid eligible residents between the ages 21 and 64 was provided by the Division of Medical Assistance, New York State Department of Social Services for the period of October 1, 1986 to September 30, 1987. The ratio of this number to the population, age 21 to 64, was applied to the 1985 estimated 18 to 64 population to determine the number of Medicaid eligibles ages 18 to 64.

The percentage of the 18 - 64 population identified as uninsured or Medicaid eligible was applied to the Division's 1985 estimates of 18 to 64 year old problem drinkers for each county to determine how many problem drinkers in New York State may be uninsured or eligible for Medicaid coverage. This methodology assumes that the rate of uninsured or Medicaid-eligible is the same for the general population and the alcoholic population. This assumption is considered conservative since later-stage alcoholism often results in loss of employment and family supports resulting in a greater percentage of uninsured among the alcoholic population than the general population.

These figures are also considered to be conservative for the following reasons: they do not include estimates of the underinsured population, that is, persons covered by minimal health insurance which does not include alcoholism treatment; or estimates of under 18 year olds and over 65 year olds with alcohol problems who do not have adequate public or private coverage.

The Division estimates that there are between 82,000 and 103,000 problem drinkers between the ages 12 and 17. While comparable uninsured and Medicaid eligible data for this population were not available for this analysis, Signalheath reports that approximately 17 percent of the 0 to 17 population was uninsured in 1985, and the Division of Medical Assistance reports that approximately 20 percent of the 0 to 20 population are eligible for Medicaid coverage.

The Division further estimates that there are approximately 117,000 problem drinkers in New York State at least 65 years of age. While most individuals in this age group have health insurance cover: e through the federal Medicare program, outpatient alcoholism treatment or erage is only available through the optional Part B policy. While Medicare figures were not available for this analysis, the Division of Medical Assistance reports

that approximately 14 percent of the 65 and over population are eligible for Medicaid coverage. The Division therefore recognizes that, while comparatively few in numbers, these individuals must also be ensured access to alcoholism treatment services.

Table III-1 indicates that 25 percent of the 18 - 64 year old New York State population are estimated to be uninsured or Medicaid eligible which translates into 293,885 problem drinkers who are unable to pay the full cost of care.

Access to Care

In addition to attempts to quantify the number of problem drinkers who were uninsured or Medicaid eligible, the Division also examined attempts by other health care systems to ensure access to care for those unable to pay the full cost for services.

After studies revealed that Medicaid eligible persons needing residential health care services are often passed over for admission in favor of private paying patients, the NYS Public Health Council requested that DOH staff develop regulations requiring residential health care facilities (RHCFs) to accept a certain percentage of Medicaid patients. The regulations were controversial from the start, taking almost two years because of revisions to promulgate, and they have recently been successfully challenged in Federal Court. The Department of Health has also proposed legislation (A.6591 Gottfried) to accomplish the same purpose. Since the language of the Department of Health's statute for certifying health care facilities is the same as that of the Division's, the ultimate determination of validity of the DOH regulation is important to the Division.

The original regulation required that RHCF accept a percentage of Medicaid patients based upon the total Medicaid admissions in an RHCF's service area. The requirement would be imposed when establishment, incorporation, or change in ownership of a facility was reviewed by the Public Health Council.

Following numerous objections from RHCF operators, nursing home organizations, and other groups, the regulation was amended to require that all RHCFs undergoing establishment review, whether or not Public Health Council review was required, accept a "reasonable percentage" of Medicaid patients. Reasonable was defined as 75 percent of the annual percentage of all RHCF Medicaid admissions within the long-term care planning area to be served, not counting stays under 30 days. The modification was in response to objections that the first draft of the regulations unfairly affected only those RHCFs undergoing Public Health Council review. This revised regulation also required facilities to develop access plans for meeting the percentage requirements.

Objections were again raised, particularly that 1) the regulation was still discriminatory because it impacted facilities undergoing Public Health Council review, more often than the proprietary sector and 2) reduced program revenue would result because Medicaid rates are lower than those charged private paying patients.

The Office of Business Permits and Regulatory Review issued a Notice of Noncompliance objecting to the regulation because, among other things, some provisions were not within the statutory authority of the Public Health Council. This objection was also raised at public hearings, claiming that access was a major public policy issue that should be left to the Legislature. The Public Health Council disagreed, stating in response that Article 28 authorized it to ensure that applicants for establishment approval provide reasonable access to Medicaid patients.

Other legal objections were that the regulation improperly mandated participation in the Medicaid program, that the Public Health Council could not impose a requirement on facilities whose applications did not come before it for review, and that the regulation improperly attempted to impose quotas on applicants.

After public hearing and issuance of a report, the Public Health Council adopted the regulation with two changes. It would not be applied to facilities whose applications did not require Public Health Council review and would clearly state that a facility is not required to participate in the Medicaid program. This regulation was adopted and is now under court challenge.

The proposed legislation (A.6591 Gottfried) would prohibit residential health care facilities who participate in the Medicaid program from discriminating in admission, retention, or care on the basis that the person is or will be eligible for Medicaid or because Medicaid reimbursement is less than the facility charges other patients. The bill has no Senate sponsor at the time of this writing. It might be noted that during the time the controversial regulation was being considered, some legislators expressed opposition to it. One basis for this opposition was information that the Public Health Council has imposed access requirements on applicants even before the regulation was adopted and this was regarded as impermissible and beyond the Council's authority.

Despite the controversy surrounding the Health Department's regulation, it seems clear that regulations establishing criteria for determining need may include factors such as current and future population characteristics and socioeconomic conditions in the service area of an applicant. DOH has such criteria and in <u>Matter of Chambery et al v. Axelrod</u> was upheld by the Appellate Division, First Department in denying an application for expansion because approval was given to another applicant from the same service area that had no admission limitations regarding Medicaid eligible patients. The court found that this method of promoting access was a logical and reasonable method for determining need.

Two other cases will affect the final determination of the validity of the regulation now under challenge. The <u>Chambery</u> decision stated it is well settled that participation by a provider of health services in the Medicaid program is purely voluntary, citing <u>Matter of Sigety v. Ingraham</u>, a New York Court of Appeals decision. <u>Chambery</u> also cited <u>Matter of Blue v. Whalen</u>, an Appellate Division case, as support for power of the commissioner to prohibit discrimination in admitting or retaining Medicaid eligible patients <u>if</u> Medicaid reimbursement rates are not lower than fees charged to other patients. There are, of course, other legal issues that will be raised in

the challenge. The resolution of those issues can provide guidance to the Division as it seeks to ensure access to alcoholism care to all those in need regardless of their ability to pay for the cost of care.

TABLE III-1 1985 ESTIMATED UNINSURED AND MEDICAID ELIGIBLE POPULATIONS AND ESTIMATED NUMBER WHO ARE PROBLEM DRINKERS AGED 18 TO 64

	18-64	UNIN	ISURED	MED]	CAID SIBLE	UNINSUF MEDICAID	RED OR ELIGIBLE	UNINSUREI OR MEDICAL ELIGIBLE
County/Region	Population	Number	Percent	Number	Percent	Number	Percent	PROBLEM DRINKERS
New York City Region	4,475,308	919,711	20.6%	612,813	13.7%	1,532,524	34.2%	161,457
Naosau	868,614	137,429	15.8%	17,189	2.0%	154,618	17.8%	16,282
Suffolk	850,125	138,064	16.2%	26,139	3.1%	164,203	19.3%	17,457
Nassau/Suffolk Region	1,718,739	275,493	16.0%	43,328	2.5%	318,821	18.5%	33,740
Dutchess	163,773	17,752	10.8%	4,304	2.6%	22,056	13.5%	2,376
Orange	168,698	18,443	10.97	8,031	4.8%	26,474	15.7%	2,852
Putnam	52,422	4,849	9.2%	641	1.2%	5,490	10.5%	588
Rockland	174,271	15,638	9.0%	5,872	3.4%	21,510	12.37	2,279
Sullivan	41,521	6,099	14.7%	2,457	5.9%	8,556	20.6%	927
Ulster	103,358	15,256		4,640	4.5%	19,896		2,135
Westchester	555,924	48,304	8.7%	27,285	4.9%	75,589		7,947
Mid-Hudson Region	1,259,967	126,341	10.0%	53,230	4.2%	179,571	14.3%	19,105
415	170 100	06.005	1. 7.			00.107	10 5#	
Albany Clinton	179,100 52,594	26,325 8,034	14.7% 15.3%	6,869 3,605	3.8% 6.9%	33,194 11,639	18.5% 22.1%	3,555 1,277
Columbia	37,322	5,459	14.6%	1,615	4.3%	7,074	19.0%	752
Delaware	27,474	3,999	14.6%	1,494	5.4%		20.0%	592
Essex	22,470	3,304	14.7%	1,609	7.2%	4,913	21.9%	521
Franklin	25,744	3,814	14.7%	2,669	10.4%	6,483	25.2%	693
Fulton	32,880	4,842	14.7%	2,290		7,132	21.7%	753
Graene		-						
Hamilton	24,435 3,006	3,583 431	14.7%	1,074 144	4.4%	4,657 575		496 61
Herkimer								860
	39,516	5,829	14.8%	2,258	5.7%	8,087		
Montgomery	30,642	4,520	14.8%	1,749	5.7%	6,269	20.5%	662
Otsego	36,148	5,301	14.7%	1,863	5.2%	7,164	19.8%	776
Rensselaer	92,904	13,670	14.7%	4,500	4.8%	18,170	19.6%	1,959
Saratoga	102,504	15,173	14.8%	2,768	2.7%	17,941	17.5%	1,923
Schenectady	91,626	13,468	14.7%	4,398	4.87	17,866	19.5%	1,891
Schoharia	18,605	2,693	14.5%	1,135	6.1%	3,828		424
Warren	33,457	4,955	14.8%	1,423	4.37	6,378	19.1%	674
Washington	33,949	5,034	14.8%	1,651	4.9%	6,685	19.7%	716
Northeastern Region	884,376	130,434	14.7%	43,114	4.9%	173,548	19.6%	18,587
Broome	131,479	19,292	14.7%	7,284	5.5%	26,576	20.2%	2,835
Cayuga	47,472	7,074	14.9%	3,247	6.8%	10,321	21.7%	1,108
Chenango	30,097	4,469	14.87	1,553	5.27	6,022	20.0%	639
Cortland	29,228	4,354	14.9%	2,191	7.5%	6,545	22.4%	708
Jefferson	52,282	7,785	14.9%	4,199	8.07	11,984	22.9%	1,266
Lewis	14,650	2,206		1,105	7.5%	3,311	22.6%	355
Madison	40,211	5,037	12.5%	1,595	4.0%	6,632	16.5%	722
Oneida	151,242	22,244	14.7%	12,150	8.0%	34,394	22.7%	3,651
Onondaga	287,319	36,580	12.7%	16,092	5.6%	52,672	18.3%	5,599
Oswago	73,310	9,490	12.9%	4,898	6.7%			1,558
St. Lawrence	68,687	10,160	14.8%	•	10.0%	17,029		1,866
Tiogs	30,811	4,572		1,611	5.2%			657
Tompkins	59,826	9,030		2,497	J. 27	11,527	19.3%	1,302
Sentral Region	1,016,614	142,293		65,291		207,584		
Chemung	57,779	8,518	14.7%	5,078	8.8%	13,596		1,448
Livingston	36,323	3,755	10.3%	1,468	4.0%	5,223 75,675	14.47	563
Monroe	450,330	46,297		29,378		/5,6/5	16.8%	8,082
Ontario	57,155	5,819		2,264	4.0%	8,083	14.1%	873
Schuyler		1,560		655	6.2%	2,215		235
Seneca	19,502	2,891		663	3.4%	3,554		381
Stauban	58,025	8,562	14.8%	4,874	8.4%	13,436	23.2%	1,425
Wayne	53,583		10.3%	2,388	4.5%	7,882		842
Yates	12,758	1,883	14.8%	740	5.8%	2,623	20.6%	276
inger Lakes Region			11.2%	47,508	6.3%	132,287	17.5%	14,125
Allegany	30,267	4,477	14.8%	3,222	10.6%	7,699	25.4%	855
Cattaraugus	50.952	7.561	14.87	3,982	7.8%			1,230
Chautauqua	86,527	12,802	14.8%	7,744	8.9%			2,192
Eria	618,942	90,736	14.7%			145,339		15,389
Genesee		5,317		1,451	4.0%	6,768		720
		19,586		11,224	8.4%	30,810		3,269
Orleans					7.0%	4,034		432
	23,520 24,879	2,37/	15 19	1,637 988	4.0%	4,735	10 07	518
Wyoming Western Region	1,003,941	3,747	15.1%	84,851		921 474	17.UA	24,605
						231,474		
tatewide Totals	11,114,960		16.4%		8.5%			293,885

Other Related Efforts

With passage of Chapter 595 of the Laws of 1983, which mandated outpatient alcoholism coverage for group health insurers in New York State, the Division's Advisory Council on Alcoholism Services was created, replacing the former Advisory Council on Alcoholism and Alcohol Abuse. Among its duties is the responsibility and authority to review and provide recommendations to the director of the Division on CON applications. Since 1983, the alcoholism service delivery system has experienced considerable growth. In the area of inpatient rehabilitation beds, much of this growth has been by providers reluctant to accept Medicaid clients. This has led to a concern over the accessibility of services to Medicaid clients, as well as those unable to pay the full cost of care. The Advisory Council, in reviewing applications, has noted the following:

- o an escalation in the fees charged for alcoholism services;
- o a lack of sliding fee scales; and
- o a reluctance to become Medicaid eligible.

In order to fully consider these concerns, the chairperson of the Advisory Council appointed a committee to review issues around financial accessibility of services. The committee was charged with exploring the following options related to the financial accessibility of care:

- Require All Sponsors to Accept Medicaid Clients Explore whether DAAA can legally withhold approval of a CON if an applicant fails to agree to provide care to the medically indigent. Explore the possibility of including a criteria to be used in the review of CON applications, which would assess the degree to which applicants address how they will serve the Medicaid population.
- o Explore Alternatives to Charge-Based Payments Consider a move toward establishing a reimbursement methodology that is not strictly charge-based. Initiate efforts to control charges and move away from an uncontrolled situation of charging what the market will bear. Explore alternatives such as cost-based payment systems, sliding fee scales, free care, and so forth.
- o Enhancements to the Division's Need Methodology The Division needs to examine possible enhancements to its need methodology to reflect the needs of the uninsured, the Medicaid population, and those unable to pay the full cost of care.
- Batch Competing Applications The Division should explore the possibility and practicality of instituting a batching system for competing applications which would result in the ability to compare applications based on how well they proposed to serve the uninsured, the Medicaid population, and those unable to pay the full cost of care.

Following deliberations of these issues, the committee developed the

following recommendations to be submitted to the full Advisory Council.

- 1. The committee concluded, based upon legal precedents, that the Division could not require applicants to particiate in the Medicaid program. The committee did recommend that the Advisory Council adopt a resolution to be included in communications from the Division or in a direct communication from the Advisory Council to proposed sponsors. The resolution would state that "the Advisory Council will review each application to ensure responsiveness of service development to the medically indigent and encourages a positive approach to providing services to this population by all applicants."
- 2. In response to alternatives to a charge-based payment system, the subcommittee concluded that facilities have varying charges, and the Division should begin to explore the collection of cost-based data from all certified providers, and concurrently develop a set of guiding principles for proposing changes in how alcoholism treatment services are paid for.
- 3. With regard to modifying the Division's need methodology, the subcommittee recommended that the Division refine its need methodology to ensure an integrated approach which balances need for the medically indigent and other underserved populations within specific service areas.
- 4. The committee concluded that "batching" could have the unintended effect of slowing down program development and, therefore, this approach is not recommended at this time.

The full Advisory Council is not scheduled to review these recommendations until after the final document is sent to the printer. These recommendations along with the great deal of testimony presented at the public hearings and further deliberations or discussions convened by the Division will be utilized in developing a final strategy.

PROGRAM DEVELOPMENT

Introduction

Part 51 of Title XIV(A) of the Codes, Rules, and Regulations of New York State, are the regulations which currently govern the Division's certificate of need (CON) review process. These regulations were initially promulgated in 1977, immediately prior to the reorganization of the Department of Mental Hygiene into the separate mental hygiene agencies of OMH, OMRDD, DAAA, and DSAS. Part 51 governed the CON processes of OMH, OMRDD, and DAAA; however, DSAS was not covered by these regulations. In 1987 and 1988, respectively, OMH and OMRDD promulgated their own CON regulations, thus leaving the Division as the only agency covered by Part 51. The Division also intends to promulgate its own CON regulations now that development work on the new integrated need methodology is coming to a close.

There are many trends which have occurred in the alcoholism field in the last decade which have indicated the need for the Division to revise its current CON regulations. Foremost is the 1983 law (Chapter 595 of the Laws of 1983), which mandated outpatient alcoholism coverage for group health insurers, and which created the Advisory Council on Alcoholism Services and required it to review and provide recommendations on CON applications, after LGUs and HSAs submitted their recommendations to the Division. This change became significant because it forced the Division to alter its process and timetable for making decisions on applications. Other trends which have affected CON review include the following:

- o Between 1980 and 1987, the Division either developed or revised all of its treatment program regulations including those for outpatient facilities, community residences, inpatient facilities, and residential chemical dependency for youth programs.
- O During the 1980s, as alcoholism treatment expanded and the service delivery system became more sophisticated, other trends have emerged, which include the following:
 - competing applications for similar programs in the same region or county, but with different sponsorship, that is, by voluntary or county-sponsored applicants requesting Division deficit funds for operations, and applications by voluntary and proprietary applicants who are not requesting or currently receiving Division net deficit funding;
 - an increase in the number of applications for changes in governing authority of existing programs;
 - a greater number of requests for relocations and expansions of existing programs through the establishment of additional locations.

To address the above trends in a CON context, the Division has an internal workgroup drafting new CON regulations to replace Part 51, and to be

inserted as a new Part 366. The timetable to complete this draft is this September, with the goal of conducting hearings and promulgating into regulation by the end of the year. The proposed contents of Part 366 are:

- o the criteria for conducting full CON reviews;
- o the criteria for conducting administrative CON reviews;
- o changes in existing programs which do not require CON review;
- o the process for both full and administrative reviews;
- o the standards for approval of both full and administrative reviews;
- o the review process for approval of construction projects; and
- o incorporation of the Division's integrated need methodology, which was outlined in detail in last year's five-year plan.

Other related areas which will have a bearing on the development of the CON regulations include the following:

- o mandated environmental reviews;
- o Division approval of construction or major renovation projects involving use of Division capital funds; and
- o Division approval of incorporation papers involving not-for-profit and business corporations.

RURAL ALCOHOLISM SERVICE DEVELOPMENT

Over 2 million New Yorkers live in 37 counties of the state with populations under 100,000 persons. Twenty-four of these counties have fewer than 60,000 residents. Low population density, small tax bases, competing priorities for scarce resources, and a lack of voluntary contributions create programmatic and fiscal challenges for all health and human service development. While most rural counties now have outpatient clinics and councils on alcoholism, these are often limited in the intensity and range of services they are able to offer. Alcohol crisis centers, acute care alcoholism programs, inpatient rehabilitation programs, and community residences are often nonexistent or are insufficient to meet local needs.

Furthermore, people living in rural areas are not homogeneous. As is true in other more populous areas, rural counties have special populations, each with its own particular needs. These populations include:

- o DWI offenders, who constitute a major problem in rural areas, in part because more people own cars and drive longer distances.
- Other criminal justice offenders, particularly those involved in domestic violence.
- o Women, who are especially affected by transportation problems, the lack of child care, and the particularly strong stigma against alcoholic women in rural areas.
- o The homeless, a growing number of whom live in rural areas where it is difficult to obtain public assistance, as well as other services.
- o Migrant farm workers, who exhibit a very high rate of alcoholism but are often neither county nor state residents; hence, they are often ineligible for public assistance and may have difficulty accessing other services.

Staffing shortages exacerbate the problem of providing rural services. While shortages in alcoholism and other human service professionals are reported in all parts of the state, the combination of a smaller labor pool and lower salaries has created particularly severe workforce problems in rural areas. Those recruited often require extensive training which is difficult due to lack of resources, travel logistics, and release time. Training is generally informal, on-the-job training provided by the administrator or clinical supervisor. The only real incentive to become a credentialled alcoholism counselor is to leave for a higher paying job, often in an urban or suburban area, thus leading to high turnover.

Because of the scarcity of fiscal and human resources, it is vital that effective linkages be forged between rural alcoholism programs and other human service systems. During the 1989 local services planning process, the development of these linkages was identified as an objective by a number of rural counties. In most counties, linkages with the criminal justice system exist through DWI programs, and local councils on alcoholism work with the

local school systems. More work needs to be done in the areas of health services, social services, other criminal justice agencies, mental health, transportation, local employers, and other indigenous systems.

Division Strategy

To encourage program development, a commitment was made in 1984 - 1985 to provide 100 percent funding to new and expanded outpatient clinics and councils on alcoholism in rural areas. Under this initiative, nine new councils on alcoholism serving 14 counties and ten alcoholism outpatient programs serving 12 counties were established.

In 1988, legislation was passed authorizing the Division to provide 100 percent net operating cost funding for the development of non-residential alcoholism services in rural counties of 100,000 or less, providing these services are determined to be necessary to serve the public interest by the director of the Division. (See FUNDING FOR LOCAL ALCOHOLISM SERVICES for further information.) At the same time, Division administration identified rural services provision as an area requiring in-depth policy attention and the development of an action plan.

The Division has now convened an internal workgroup to identify barriers to services in rural areas, develop a policy for providing additional services in rural areas, and recommend possible strategies and action steps for implementation.

The agency has also escalated its efforts to develop relationships with other agencies having an interest in rural issues. The following are current interagency activities:

- Department of Health DOH has a Rural Health Council which addresses the problems of rural hospitals. As a result of interagency discussions, rural hospitals have been identified as potential sites for alcoholism programs, particularly hospital intervention, inpatient rehabilitation, and acute care alcoholism programs. In addition to using an indigenous institution to deliver needed services, alcoholism programs can help rural hospitals ensure their fiscal viability. Rural Health Care Service Diversification Grants and the Rural Health Care Development Grants, administered by DOH, may be resources for the establishment of such programs.
- Department of Transportation The Rural Transportation Coordination Assistance Program administers federal funds to plan and implement local programs to pool transportation resources into a single operation. At present, nine New York State counties are participating in the program. The Division has ensured that community service directors are included in the planning and implementation of the Rural Transportation Coordination Assistance Program.
- o Legislative Commission on Rural Resources This commission develops and monitors legislation affecting rural communities. It has proven to be a valuable resource in identifying other

resources and agencies addressing rural issues. The Division is working with this commission to provide technical assistance in programmatic areas of pending legislation and will also work to develop legislation regarding the needs of migrant farm workers.

o Rural Schools - The Division is exploring the possibility of using a telecommunications network to provide alcoholism training for program staff and teleconferences for PTAs and other parent groups promoting alcohol prevention for youth.

Future Efforts

The following activities are being considered for inclusion in a proposed action plan, pending the full report of the rural initiatives workgroup. Activities requiring fiscal resources will be contingent upon annual appropriations.

- o Include participants from outside the agency in the policy recommendation process.
- o Sponsor a conference in 1990 1991, preferably in conjunction with other agencies, on rural alcoholism services.
- o Re-examine the definition of rural.
- o Expand program models geared to the special needs of rural communities.
 - Consider a joint acute care/inpatient rehabilitation model for rural hospitals.
 - Encourage rural programs to enter cooperative agreements with programs in other counties for the sharing of specialized services.
- o Develop a comprehensive strategy for the recruitment and training of the rural alcoholism workforce.
 - Develop a variety of in-service training and monitoring programs to encourage the use of CACs.
 - Explore the possibility of using grants from sources such as the Job Training Partnership Act (JTPA) and the Appalachian Regional Commission for those eligible counties to fund these programs.
- o Identify and encourage linkages among systems at the local level.

FUNDING FOR LOCAL ALCOHOLISM SERVICES

Broad Financing Guidelines

The Division is committed to the geographic, financial, and cultural accessibility, and the availability of high-quality community alcoholism services for the people of New York State. It is the Division's expectation that local governments will assure the delivery of alcoholism services on a non-discriminatory basis to all New Yorkers. The Division has identified a number of historically underserved groups including: special populations such as minorities, women, youth, elderly, multi-disabled, physically and developmentally handicapped, Vietnam Era veterans, and gays/lesbians; and populations with access problems such as the poor, medically indigent, homeless, persons living in rural areas, and criminal justice clients. Minorities refer to specific racial and ethnic populations and include, but are not limited to, Blacks, Hispanics, and Native Americans. The Division further recognizes that there may be differences within specific racial or ethnic groups which need to be accounted for in the delivery of alcoholism services. Where it is determined that these groups are not being adequately served, funding will be approved to correct the problems of inaccessibility. Otherwise, funds will be made available to provide for general increases and improvement in specified alcoholism services available to all populations. Funding of all programs is contingent upon the level of appropriations.

Many alcoholism programs can be operated in compliance with Division regulations without deficit support. The Division has two principal sources of funding, regular state aid and demonstration, to initiate programs. Programs requesting support from the Division should initially seek funding under the regular state aid formula. Due to limited demonstration funds available from the Division, these funds should be requested when a high priority program cannot be initiated under the regular state aid formula. When deficit support (regular state aid or demonstration) is requested from the Division, demonstration of efforts to maximize sources of financing such as client and third-party payments is required. The Division is not supportive, however, of arrangements involving Division-funded alcoholism providers who enter into agreements with third-party payers such as HMOs and PPOs to provide alcoholism services to health care plan enrolless at a cost below the gross unit of service cost reported by the alcoholism provider.

During the 1988 legislative session, the Division was granted statutory authority in the Mental Hygiene Law for 100 percent state aid funding for certain alcoholism services. The services eligible for 100 percent funding under the new law are alcohol crisis centers, residential chemical dependency programs for youth, and "non-residential services determined to be necessary to serve the public interest by the Director of the Division of Alcoholism and Alcohol Abuse provided by local governments having a population of 100,000 or less... or by voluntary agencies pursuant to contracts with such local governments or through direct contract with the Division." In the case of alcohol crisis centers and residential chemical dependency programs for youth, the Division has authority to fund newly developed programs at 100 percent state aid, as well as to transition already established programs on local assistance to 100 percent funding. For practical purposes, this transition to 100 percent funding only applies to crisis centers since all existing residential chemical dependency for youth programs are relatively

new and are supported by 100 percent demonstration funds. Residential chemical dependency for youth programs will, however, be eligible for 100 percent state aid. It is important to note that in relation to alcohol crisis centers, the Division has maintained, in the past, that where local costs for existing programs are displaced with 100 percent state aid there would need to be a local plan providing for a maintenance of local effort to be offset by an expedited conversion of other alcoholism programs to shared state and local support. For non-residential services in rural counties of 100,000 or less, the Division's 100 percent funding authority under the new legislation allows for support of newly developed programs only, and does not include the Division's assumption of local share for programs currently funded with regular local assistance.

As a follow-up to the enabling legislation for 100 percent funding of non-residential services in rural counties, the Division has promulgated a regulation for the purposes of outlining a procedure for granting this funding. This regulation which is the administrative equivalent of the statute provides definitions, eligibility requirements, criteria for determining the "public interest" of the proposed service, and application procedures. Further information related to this funding will be provided in the local services plan guidelines to be released in February 1990.

Another bill passed by the legislature, and signed into law by the Governor during the 1988 legislative session, relates to the Division's funding of employee assistance programs (EAPs). This law provides the Division with the authority to prepare guidelines, appoint an advisory board, and to establish consortiums to offer EAPs to small businesses and other organizations (less than 750 employees) which are not large enough to make individual EAPs feasible. The law stipulates maximum funding levels of 70 percent of non-capital expenditures of the program's first year of operations, 50 percent in the second year, 40 percent in the third year, and 30 percent in the fourth year. The law states that no program shall receive financial aid under this act after completion of the fourth year of operation. Implementation of eligible programs under this legislation will be subject to the availability of funds.

It is the Division's policy to encourage all localities to develop a core continuum of quality alcoholism programs. This core of programs includes prevention, intervention, and treatment services which are aimed at the general population within the local governmental service area, and may be delivered by a variety of sponsors including local governments, voluntary agencies, hospital-based programs, and private/proprietary providers. It is the Division's policy that public funding to support the development of these core services should be directed to those persons most in need with the least The core continuum of programs consists of: a general ability to pay. community-based prevention and education effort; a general community-based intervention and referral effort; a capacity to provide emergency care services in at least one of the following ways--an acute care alcoholism program operated by general hospitals or psychiatric hospitals, primary care alcoholism program operated by a free-standing rehabilitation facility, free-standing alcoholism crisis center, rural alcoholism emergency care services, scatter bed detoxification in general hospitals, or LGU designation of emergency rooms of general hospitals; a comprehensive family-oriented outpatient clinic treatment program reflective of the population

characteristics of the service area where it is located; at least planned community residential settings in those counties with sufficient need to support a program, and arrangements for shared services in counties that do not meet minimum need requirements; and at least access to inpatient treatment and rehabilitation services. Treatment and rehabilitation services identified in the core continuum are expected to operate in compliance with Division regulations. The 1990 Local Services Plan Guidelines requested that LGUs complete Table 1A, Program Inventory and Identification of Core Programs, which is arranged to catalogue the programs according to elements which the Division feels should be available to persons in need within each The Division's Program Guidelines contain sample descriptions for prevention and intervention programs which provide localities and potential providers with models endorsed by the Division. The Program Guidelines also contain descriptions and guidance on how treatment and rehabilitation services can be organized, delivered, and funded in a variety of settings consistent with regulations.

The analysis of LGU responses to Table 1A of the 1990 Plan submissions showed 19 counties currently reporting a gap in one or more core program areas. Several counties indicated that one or more of the existing core programs provided only minimal services.

Prevention and intervention services in New York State are provided primarily by local Councils on Alcoholism. Currently, 37 councils are expected to be operational during the current plan year, leaving nine counties indicating that prevention and intervention services are being provided by clinics (usually on a limited or infrequent basis) or not at all.

The second core program area the LGU's were asked to identify was the capacity to provide emergency care alcoholism services within the county. Currently, 26 counties have a certified acute care or primary care alcoholism program providing services to county residents. An additional 22 counties indicated that emergency services are provided through hospital scatter-bed detoxification and/or emergency room detoxification. The remaining 14 counties indicated that emergency services are not available within the county.

Currently, about 290 outpatient alcoholism clinics are located in 60 of the state's 62 counties. The two remaining counties each have an arrangement for residents to receive services at an outpatient clinic in a neighboring county.

The core continuum includes an arrangement for community residence services. For purposes of defining the core continuum of services, this may include the existence of a community residence within the county, arrangements to share a community residence with a neighboring county, or plans for the development of a community residence by means of a CON application being filed or a Schedule B being submitted with a county's Local Services Plan. Currently, community residences are located in 27 counties with arrangements to serve residents of 30 counties. Of the remaining 32 counties, 18 have either filed a Certificate of Need application or submitted a Schedule B for the establishment of a community residence in their county. Fourteen counties indicated that no formal planning process has begun for the provision of community residence services.

Finally, all LGU's should provide their residents with access to inpatient treatment and rehabilitation services. In addition to the State Operated Alcoholism Treatment Center utilized by residents in each county, the LGU's were asked to identify programs located within the county and programs located elsewhere that are utilized by county residents. In all, 28 counties identified an inpatient rehabilitation program located within the county. An additional 29 counties identified one or more programs outside the county to which residents are referred for inpatient services. The remaining five counties indicated sole reliance on the ATC.

Once localities have planned for a core of programs that are consistent with minimum standards established by Division regulations, localities should address the issues of overall availability of alcoholism services for all those in need and the accessibility of services to all segments of the population in need. Planning and program development activities, at this point, should address targeted populations, additional core services to address unmet need, and expanding the core continuum of programs to provide additional levels of care and services of greater intensity. Targeted efforts include prevention, intervention, and treatment approaches which target specific populations, particularly underserved populations, and which may be delivered as components within the core continuum of services or within discrete program models. Expansions of services to meet targeted needs or general unmet need may include adding different modules to the outpatient clinic, or developing additional emergency care or community residential program models.

In summary, the Division will utilize the following hierarchy to evaluate local planning efforts and to guide program development and funding decisions:

- o establishing core services and programs where none exist;
- o improving existing core treatment and rehabilitation programs to bring them into compliance with Division regulations;
- o upgrading existing core prevention and intervention services to meet goals and objectives for these programs as outlined in annual local and state planning documents;
- o establishing targeted services and increasing levels of core services to address unmet need through the expansion of existing programs;
- o establishing targeted services and increasing levels of core services to address unmet need through the establishment of new programs.

Due to the wide variation in demographic characteristics and historical differences in program development activities among the state's LGUs, the application of this hierarchy will be heavily dependent on current local circumstances as well as the availability of funds in any given year. Localities are expected to differ in their levels of development of core services, their need for targeted services/programs, their concentrations of

traditionally underserved populations, their tax base, and their ability to meet minimum size requirements in program regulations. Therefore, LGUs are expected to factor these local circumstances, as well as the hierarchy presented above into planning efforts for new and expanded program proposals. It is the Division's expectation that to accomplish the development of a comprehensive system of alcoholism services, a multi-year planning effort will be required.

Targeted Initiatives

During this three year local services planning cycle, the Division is emphasizing a number of targeted initiatives for counties which have developed or planned where appropriate, a full complement of core services. addition to ongoing efforts to target services for historically underserved populations within the service area, other initiatives reflect, in part, the Division's alcohol connection approach to current statewide needs and priorities. These initiatives include school-based prevention efforts targeting elementary, junior high, and senior high youth; schoolbased intervention efforts; residential chemical dependency services for youth jointly certified by this Division and DSAS; targeted prevention, intervention, training, and treatment services for criminal and juvenile justice clients; and targeted services directed at the workplace, hospital, and health care facilities, and family/social service providers. As is the case with applying the above hierarchy, the Division expects localities to differ in their needs for these specific targeted services. Over the next three years, the Division will be further defining program models related to the provision of these services, and will be funding a limited number of innovative pilot projects. The Division is encouraging agencies and counties to develop proposals for pilot projects in these areas which may be funded by the Division or through current alternative funding streams such as the Task Force on Integrated Projects or through future funding which may become available over the next three years. The Division is also currently engaged in a number of cooperative planning efforts with other state agencies, criminal justice and children/youth service programs, in particularly attempts to develop collaborative programming and funding approaches. Therefore, counties and agencies should be planning at the local level for innovative programming for youth and adults involving cooperative approaches with other health, human service, and criminal justice agencies. Local Services Plan requested the LGUs to complete Table 1B which proves an inventory of existing and planned linkages to address the alcohol connection. Alcohol connection efforts cover a range of activities which include prevention and education, intervention and referral cross-training, and the provision of treatment services within traditional alcoholism service models or through innovative joint treatment efforts.

Funding Priorities for Education, Prevention, and Intervention Services

The Division's funding priorities for education, prevention, and intervention programming will be focused on the promotion of public education, early identification, and intervention strategies. These strategies will seek to identify individuals with alcohol-related problems as early as possible and to make appropriate referrals to alcoholism-specific services when necessary in order to prevent lasting disability from

alcoholism. Funding will continue to be approved to support the establishment of student assistance programs, EAPs, hospital and health care intervention programs, intervention programs with other major human service systems such as criminal justice and social services, community-based primary prevention and intervention programs, and for the establishment of councils on alcoholism in those communities which do not have such organizations.

1. Public Education and Intervention and Referral Programs

- o The Division considers the local council on alcoholism to be the cornerstone of local prevention and intervention efforts. Program expansion or establishment is eligible for demonstration and ongoing state aid support from the Division. In counties with populations, less than 100,000, the Division may support up to 100 percent of net costs of operations of newly established councils whose operations are consistent with the Division's program quidelines.
- o The Division will provide demonstration support for local public education/information and referral programs where these are not operated by a council on alcoholism. The Division will provide ongoing state aid to programs in those areas where no council exists or where access to such services would be targeted to a particular population group which has been historically underserved.

2. Youth Intervention Programs

The Division will consider youth intervention programs, both school- and community-based, for demonstration support if other funds are not available. Resources for school-based youth intervention programs should first be sought from the education system, the School-Based Alcohol and Substance Abuse Prevention and Education Program administered by DSAS, or the Task Force for Integrated Projects. This latter funding source should also be initially considered for community-based youth intervention programs.

3. Employee Assistance/Workplace Intervention

- The Division will support the development of the consortium model and occupational program consultation approaches to meet the workplace intervention needs of employed persons. Programs are expected to become fully self-sufficient through support from user fees at the end of two years. A third year of demonstration funds for employee assistance programs will be considered only on an exceptional basis.
- o The recently enacted EAP legislation, Chapter 449 of the Laws of 1988, provides an alternate funding formula for EAP consortiums, which serve two or more employee units. These units are defined as an employer with less than 750

employees, or a labor organization, a professional organization or a community organization which applies for financial aid. Projects consistent with rules established by the Division under this act can receive up to four years of funding for net deficit non-capital operating expenditures at the rate of 70 percent in year one, 50 percent in year two, 40 percent in year three, and 30 percent in year four. The law further states that no program shall receive financial aid under this act after completion of the fourth year of operation.

- 4. Hospital and Other Health Care Facility-Based Intervention Programs
 - o The Division will provide hospitals and other health care facilities with demonstration funds for up to 18 months to cover the costs of initiating hospital and other health care facility-based intervention programs consistent with the Division's program guidelines. During this 18-month time period, programs should integrate these services into their overall cost structure so that these services can become reimbursable by the end of the demonstration period. Where documented, extensions for demonstration support may be granted for a pre-determined period of time on an exceptional basis where programs require additional time to complete the process of enabling these services to be reimbursed. The Division would require an agreement to provide statistical reporting on the activities of the program for three to five years.

Funding Priorities for the Range of Outpatient Services

- o Outpatient alcoholism programs must make every effort to maximize revenue for alcoholism services through client fees, Medicaid, and private insurance. Increased revenues from insurance reimbursement should be used to support needed expansions of services, with maintenance of state and local net support.
- o In counties with populations of less than 100,000, the Division may support the full net costs of operation of newly established clinics which are consistent with the Division's regulations.
- o Agency fee schedules, including agreements with third-party payers, should be approved by the LGU. Division review must be requested for any such agreement to charge payers less than the gross unit of service cost if the program is funded by the Division.
- o Demonstration funds and state aid will be approved for outpatient alcoholism clinics to allow expansion of services to offer a full range and intensity of services to alcoholic people and to develop the capacity to serve families as a unit,

young and elderly alcoholic persons, spouses, significant others, children of alcoholic persons, and the multi-disabled (consistent with the IOCC policy on the multi-disabled). Demonstration funds will be approved for staffing expansions in response to increased criminal justice system referrals resulting from improved cooperation and provider participation in local alternative-to-incarceration programs and DWI efforts, as well as anticipated increased referrals from probation and parole sources.

- o The Division will provide demonstration funding for a limited number of pilot alcoholism services managed care programs involving LGUs and publicly-funded outpatient alcoholism clinic with involvement of appropriate state-operated alcoholism treatment centers. Upon successful completion of the demonstration period, it is expected that the managed care module will be included within the sponsoring agency's ongoing clinic operations.
- o Demonstration funds and state aid will be approved for mental health clinics and community mental health centers only for the purpose of establishing separately certified alcoholism clinics.
- o Demonstration funds and state aid will be approved for alcoholism clinics to provide outreach/consultation services to the criminal justice and social services system, and other underserved target populations. The establishment of these services from an existing licensed program may be an acceptable alternative to the establishment of new services, in order to meet the needs of such populations.
- o The Division will provide time-limited demonstration funding for a limited number of pilot alcoholism treatment/criminal or juvenile justice programs involving cooperative arrangements between local alcoholism programs and local criminal or juvenile justice agencies designed to address the alcoholism treatment and/or intervention needs of criminal or juvenile justice clients. Priority will be given to programs that can demonstrate a commitment to continued funding beyond the demonstration period of funding.
- o Demonstration funds and state aid will be approved for outpatient rehabilitation services. Funding should be requested to assure programs are able to meet the staffing and operational requirements to provide a full range of outpatient clinic services (including evaluation, treatment planning, and case management), unless the program is to be operated in affiliation with a separate, certified clinic program.
- o Certain vocational rehabilitation programs may be supported by the Division with demonstration funds only. Programs using the model of the employment program for recovering alcoholics may be provided up to three years of demonstration support, or

until other resources can be identified, whichever occurs first. New proposals will be approved only in those cases where prior agreements have been made for other funding, assuring a fee for service contract adequate to fund the cost of care after the demonstration period.

o Clinic expansions needed to meet the needs of mandated drinking-driver referrals should be financed with STOP-DWI fine revenues or other local assistance and Division state aid. In selected cases, exceptions to this policy may be made through the use of demonstration funds for a time-limited period.

Funding Priorities for Residential Services

Given the significant unmet need for residential programming for alcoholic people, the Division will place an urgent priority on the establishment of new alcoholism community residences. The Division will also approve the development of freestanding alcoholism treatment centers financed through demonstration funding, third-party and client fees, and state aid as an alternative to an expansion of the state operated alcoholism service system.

- o Agency fee schedules, including agreements with third-party payers should be approved by the LGU. Division review must be requested for any such agreement to charge payers less than the gross unit of service cost if the program is funded by the Division.
- o New alcohol crisis centers will be approved for 100 percent state aid. The Division will approve up to 100 percent funding to support, where necessary, the acquisition, development, and renovation of alcohol crisis centers, the pre-operational costs of these programs, and up to 100 percent of the approved net operating costs. The Division will fund and certify hospital-based alcohol crisis centers under Article 31 as an alternative when no other site is available.
- o Hospital-based inpatient programs will not be approved for state aid funding. Time-limited demonstration funding may be considered on an exceptional basis for hospital-based inpatient programs where no other site or sponsor is available.
- o Demonstration funding and state aid will be approved for freestanding inpatient rehabilitation programs established in the public and voluntary sector.
- o The Division may provide demonstration funds for development costs for community residences, including supportive living facilities. Operating costs of supportive living facilities will not be approved for state aid, and will be financed only through client fees and congregate care level II public assistance payments. In addition, up to 50 percent of gross operating costs of new community residences will be approved for state aid as provided by Section 41.33 of the Mental

Hygiene Law. This funding mechanism will support recovery homes and halfway houses. The Division's 1988-1989 appropriation language allows for 100 percent reimbursement for the development and associated net operating costs for newly developed alcoholism community residential beds. The Legislature is currently considering legislation to make this funding a permanent part of Mental Hygiene Law.

- o The Division will approve 100 percent net deficit financing for residential chemical dependency for youth programs.
- o The Division will approve up to 100 percent of net operating costs for a period of up to three years for hospital affiliated, rural alcohol emergency care programs. The Division will continue to pursue 100 percent state aid for these programs. General hospitals operating these programs should explore submission of a rate increase request to the Department of Health so that the additional staff and operating costs can be reflected in the hospital's rate structure.

INTEGRATED NEED METHODOLOGY

The Division indicated in the Five-Year Plan, 1989-1994 (published in October of 1988) that for upcoming planning cycles it would be developing and implementing an integrated need methodology to replace the separate interim need methodologies which had been used for program planning and certificate of need purposes since the early eighties. The integrated methodology presented in the five-year plan was well-received and county-specific service needs computed with the new methodology were included in the 1990 local services plan guidelines (published in February of 1989) to assist local governmental units in planning for future alcoholism programs. The plan guidelines also provided an opportunity for feedback on the methodology from local governmental units.

Based on comments from the Division's planning process a number of issues have been identified that must be resolved in order to finalize the integrated need methodology. These include:

- o the historical patient origin adjustment of allocating New York City region inpatient rehabilitation beds to the Mid-Hudson and Long Island regions;
- o need estimates for primary care beds;
- o an adjustment to account for the provision of outpatient services to family members/significant others; and
- o the need to address the increasing demand for alcoholism services for criminal justice clients.

Under the current interim need methodologies, the Division allocates 47% of the New York City inpatient bed need to the Nassau-Suffolk (16%) and Mid-Hudson (31%) regions. This adjustment was based on a patient origin study done in 1985 utilizing a three-year average of clients seen in inpatient rehabilitation facilities as reported on the 1981-1983 Patient Characteristics Surveys. The new integrated need methodology generates a small increase in the need for inpatient rehabilitation beds based on annual In order to encourage the development of alcoholism utilization data. services located within the community of those in need the Division is in agreement with the New York City Department of Mental Health, Mental Retardation and Alcoholism Services that inpatient bed need should be maintained in New York City. Therefore the additional inpatient bed need generated by the integrated methodology over and above the need estimate from the interim methodology, will not be allocated to regions outside New York This will allow cooperative planning between the State and City for the development and eventual locations of these additional beds to serve residents of New York City.

The second area which needs to be addressed in finalizing the integrated methodology is the estimate of primary care beds which were a sub-category of crisis center beds in the interim methodology. The integrated need methodology has not to this point, separately addressed the need for primary care beds which are operated predominately by non-funded freestanding inpatient rehabilitation programs. Primary care beds which are operated by

non-funded providers function as close observation beds that almost always result in an inpatient rehabilitation admission. In order to account for the current existence of these beds and their additional future development, primary care bed need will be estimated based on the ratio between existing non-funded inpatient rehabilitation-based primary care beds and existing non-funded inpatient rehabilitation beds. This ratio will be applied to the integrated need estimate for inpatient rehabilitation beds minus the one-third set aside for general hospitals and the current number of SOAS beds, since neither of these types of facilities currently operate primary care beds. For need methodology purposes, this primary care bed need estimate will be added to the inpatient rehabilitation programs category. The Division will continue to maintain primary care as a separate reporting category in order to be able to monitor its development and utilization patterns.

The third issue concerns the need to account for the provision of outpatient services to significant others and families. Both the interim and integrated need methodologies estimate the number of outpatient visits needed by alcoholic persons only. The number of visits provided by existing programs i.e., current supply of outpatient visits, is collected from the Division's LS-2C reporting system. However, reported visits are not tabulated by patient status so the total count includes services to alcoholic persons including the multi-disabled, significant others/family members, and those with non-alcohol problems. This inflates the current supply and thus reduces unmet need since the outpatient need estimate does not include services to significant others or persons with non-alcohol problems. approach would be to increase the need to reflect services to significant others and families. The Division is in the process of addressing a number of issues surrounding services to families and significant others and has just recently convened a three-day discussion group to explore strategies to address these issues. In order to not conflict with this effort the Division will not utilize the above approach at this time.

A second approach would be to adjust the current supply of visits by subtracting visits provided to other than alcoholic persons in order to make the current supply consistent with the need estimate. This second approach will be incorporated in the finalization of the integrated need methodology. Utilizing information from the 1985 LS-2C reporting system which was the last full year for which visits by patient status was available, the visits by admission status from 1985 will be applied to the admissions by patient status for 1988 to estimate visits by patient status for that year. Only the number of visits by alcoholic/chemically dependent and multi-disabled persons will be used to compute the unmet need for outpatient services.

Counties will be able to continue to estimate needed services for significant others/family members by utilizing the methodology which was included in last year's, 1990 local services plan guidelines.

Throughout 1989 there was a growing trend to develop programs to provide services to the criminal justice population. A major impetus for this trend was the passage of the Omnibus Criminal Justice Bill discussed in the "Alcohol Connection" chapter of this update. Due to the much higher prevalence rate of alcoholism and alcohol abuse among criminal justice clients compared to the general population and the unique access to service

problems these clients present, the Division feels the integrated need methodology should be adjusted to ensure the availability of services to both criminal justice and non-criminal justice persons in need. In finalizing the integrated need methodology, the Division will undertake a two-step adjustment to estimate needed alcoholism services for criminal justice clients.

The first step is to obtain a point-in-time estimate of the criminal justice population by the age and sex cohorts similar to the cohorts used in the Division's prevalence estimating methodology. The criminal justice populations involved are inmates in DOCS, parolee caseloads from DOP, probation caseloads from DPCA, and inmates in county jails penitentiaries. Once these populations have been estimated, the general population prevalence factors are applied and the result is subtracted from the current adult prevalence estimate. The second step to the criminal justice adjustment is to estimate the prevalence of problem drinking in each of the above criminal justice populations. These percents will be applied to the appropriate population to produce a prevalence estimate which then can be used to estimate needed alcoholism services for criminal justice clients. For local planning purposes, the DOCS clients will not be included in estimating need for services since these clients are the responsibility of DOCS while they are incarcerated and upon release will be included in the parolee population or become part of the general population.

The Division will also continue the practice of excluding certain beds from the current inpatient rehabilitation supply for purposes of calculating unmet need. These "specialty" beds are targeted to specific groups and provide specialized services. Currently excluded are beds for the hearing impaired, beds located on Indian Reservations, beds dedicated for research purposes, and beds targeted exclusively for criminal justice clients. Additional "speciality" inpatient beds as well as other "speciality" services may be considered for exclusion from the supply for need methodology purposes in the future as determined through the Division's planning process.

ALCOHOL CLIENT INFORMATION SYSTEM (ACIS)

Introduction

Since 1980, the Division has been involved in collecting data on both programs and clients served within the alcoholism service delivery system. In 1980 the Division implemented an aggregate program reporting system and from 1981 to 1986 the Division conducted one-week surveys of individuals served by all alcoholism and alcohol abuse programs. In 1986, the Division expanded its aggregate program reporting system (LS-2C) to include aggregate data on client characteristics and discontinued its one-week surveys. While aggregate client data have been useful, the limitations of such data have since become apparent. Detailed client-based data are needed for policy analysis, planning, and program development at the state and county levels, as well as to respond to requests for information from the Legislature, the governor, the Division of the Budget, and third-party payers. Client-based data are also critical for enhancing the Division's evaluation capabilities in light of an increased emphasis on accountability. In order to address these critical needs, over the past two years the Division has undertaken a process to re-evaluate all its information needs including both aggregate program-level and client-specific data.

As a component of the Division's reassessment of its information needs, in the summer of 1988 the Division established a Client Information Advisory Group composed of fifteen members representing treatment providers and LGUs from across the state. The mandate of the advisory group is to make recommendations to the director of the Division regarding what client information should be collected, how it should be collected, and what reports and analyses should be produced from the client data. The group is also expected to develop recommendations on the structure and content of the overall information system, including the current LS-2C. Appendix D lists the advisory group members.

In the fall of 1988, the Division convened the advisory group, and at their meetings it was agreed that the Division and the local alcoholism service delivery system needed a client-based information system. In consultation with the advisory group, an admission-based profile of client information and a 62-program pilot test were designed. In February 1989 the pilot test was conducted and the data are currently being analyzed.

The Division expected to reinstitute sampling of client characteristics in the last quarter of 1989 either on all admissions during limited time periods or continuously on a small proportion of admissions depending on the outcome of the pilot test. However, in March the Division was informed of new federal requirements mandating that state alcoholism and drug abuse agencies collect a client-specific "minimum data set" on all admissions to treatment as a condition of continued federal block grant funding. The Division advocated for the option to submit data based on a sampling of admissions, but could not obtain support for the option from any other state. These requirements have radically altered the Division's plans for client-based data collection.

Federal Client-Specific Minimum Data Set

Under the Comprehensive Alcohol Abuse, Drug Abuse and Mental Health Amendments of 1988 (Public Law 100-690, Title II, Chapter 2, Section 2052), ADAMHA is authorized to implement data collection activities to ensure the availability of statistical information on the care and treatment of persons with alcohol and substance abuse problems. This law adds a new section (Section 509D) to the Public Health Service Act which requires ADAMHA to collect various kinds of information regarding alcohol and drug abuse treatment programs, including:

- o the number of individuals seeking treatment in alcohol and substance abuse programs, the number and demographic characteristics of individuals receiving such treatment, the percentage of individuals who complete such programs, and with respect to individuals receiving such treatment, the length of time between the individual's request for treatment and the commencement of treatment;
- o the number of such individuals who return for treatment after completion of prior treatment and the method of treatment utilized during the prior treatment;
- o the number of individuals receiving public assistance for treatment programs.
- o the costs of the different types of treatment modalities for drug and alcohol abuse and the aggregate relative costs of each such treatment modality provided; and
- o to the extent of available information, the number of individuals receiving treatment who have private insurance coverage for the costs of treatment.

As part of ADAMHA's response to the mandate of Section 509D, NIAAA and NIDA are 1) implementing a national, client-specific information system on clients admitted for treatment, and 2) continuing the National Drug and Alcohol Treatment Utilization Survey (NDATUS). Participation by states in these two activities will be a condition of continued block grant funding to the state for alcohol and drug abuse programming. Current NIAAA and NIDA plans call for the client data system to be based on a national standard minimum data set developed in consultation with state alcoholism and drug abuse authorities. Initially, data will only be collected at admission; however, there will be an option at a later date for collecting data at discharge at a later date.

The federal standards for the minimum data set require that client identifiers must be unique within each provider agency. Client data are to be collected for all admissions to programs receiving federal or state funding. A state may also report data for admissions to privately supported programs. The specific content of the federal minimum data set is expected to be finalized in the fall of 1989, and NIAAA and NIDA expect states to begin routine reporting of the minimum data set to the federal contractor by June 1991. The following items are expected to be required:

- Client Identifier
- Patient Type (e.g. significant other)
- Program Type/Setting (i.e., facility and unit codes)
- Admission Date
- Date of Birth
- Sex
- Race/Ethnicity
- Highest Grade Completed
- Employment Status
- Referral Source
- Substances Abused (for up to three substances)
- Route of Administration (for up to three substances)

Response to Federal Mandate

The Division certifies and regulates over 475 treatment program units in the following program categories: alcoholism crisis centers, acute care, outpatient clinics, outpatient rehabilitation, inpatient rehabilitation, community residences, and residential chemical dependency programs for youth (jointly certified with DSAS). These units admit over 160,000 patients a year. Thus, not only does implementing a client-based data system represent a primarily new effort, it also represents a very large effort not only for the Division, but also for many alcoholism providers and county governments.

In order to meet the federal data requirements, the Division has specified the basic structure for implementation of a client-based system, while maintaining as much flexibility as possible in order to respond to the needs of all parties involved. As mentioned above, the Division has already established a Client Information Advisory Group which has primary responsibility for reviewing and making recommendations regarding the Division's plans for implementing the client-based data system. The Division also receives input on proposed initiatives from the Alcoholism Liaison Committee of the Conference of Local Mental Hygiene Directors.

Understanding that collection of a uniform minimum data set is a condition of continued funding under the federal block grant program, the Division has specified two major components to be part of the NYS ACIS: the Client Information Profile (CIP) and the Client Disposition Survey (CDS). The CDS, while providing critical information, would not be implemented until the CIP was fully operational.

The CIP will record all admission and discharge transactions, and corresponding client characteristics for patients admitted or discharged from any treatment program unit in the alcoholism services delivery system. This will be called the "NYS minimum data set" and will include the required federal minimum data. In addition to admission characteristics, the CIP will obtain status and referral at discharge. The CIP will replace the LS-2C, the Division's current aggregate program reporting system.

The CDS will obtain information at discharge on a <u>small sample</u> of clients admitted. Information collected for outpatient programs and inpatient rehabilitation programs will include severity of illness (case mix), the nature and extent of services received, achievement of treatment plan goals,

participation in self-help groups, and placement based on discharge referral.

In the long term, the Division intends to collect outcome information on a sub-sample of clients admitted to treatment services. Outcome is viewed as a logical component of a client-based information system, and the design would need to be based on a prior analysis of client disposition data.

Content of ACIS

The NYS minimum data set to be collected on the CIP will contain all federal minimum data set items as well as additional items judged to be crucial by the Client Information Advisory Group and approved by the director. Certain items must be included to maintain the continuity of information while transitioning from the current client aggregate reporting format to client-based reporting. A necessary step in the implementation of the CIP is elimination of the LS-2C reporting requirements. The LS-2C form includes aggregate client characteristic data based on admissions and discharges. When these same client characteristics are collected in a disaggregated fashion on the CIP, reporting of the corresponding information on the LS-2C is redundant and unnecessary.

In order to maintain the continuity of information during this reporting transition, the following are necessary:

- 1. the CIP must include discharge transactions;
- the CIP must contain all relevant client data items that were aggregated on the LS-2C;
- 3. other currently collected information such as aggregate units of service and waiting list levels will have to be collected as part of the CIP or by some other means. A new reporting system for prevention programming must be developed.

Thus, the following items will have to be added to the federal minimum data set:

- o county of residence/homeless indicator;
- o expected payment source;
- o discharge type; and
- o discharge referral.

These, and any other additional items to be included in the New York State minimum data set, will be discussed with the advisory group.

Development and Implementation of ACIS

A pilot test of a CIP form to collect the anticipated NYS minimum data set (federal minimum plus New York items) was designed in consultation with the Client Information Advisory Group. The Client Information Advisory Group will review the results of the pilot test, testimony at plan hearings, the final version of the federal minimum data set, and other materials. In November 1989, after reviewing the various implementation strategies, the advisory group will make its recommendations to the director. This will

permit the Division to publish the NYS minimum data set specifications and implementation plans in December 1989.

In January 1990 staff will conduct previews of the ACIS at regional locations for program directors and county officials. These presentations will also serve to identify the needs of these target groups for information products that can be produced by ACIS. During January and February of 1990, forms and manuals will be printed.

Beginning in February 1990 project staff will provide training to program staff designated by provider agencies at regional locations. Programs will begin reporting as soon as possible based on their individual circumstances. The first possible reporting month will be April 1990. Training will be provided in an ongoing, as needed basis through September 1990. From October through December 1990, efforts will focus on bringing the remaining non-reporting programs into compliance. The Division will have issued appropriate directives and/or regulations in support of the ACIS. Beginning July 1990 program specific reports will be generated for programs reporting CIP data.

By January 1991 all programs will be required to begin reporting CIP data on a monthly basis. The Division will begin reporting data to the NIAAA/NIDA contractor for the June 1991 reporting month. Reports will be produced for higher aggregate units such as counties and program types. The data will begin to be used in policy analyses and the planning activities of the Division.

During the last half of 1990 a CDS will be pilot tested. Various items, formats, and data collection procedures will be tried since different content will be required for different types of programs. A reliable sampling methodology must be developed, preferably one that does not identify clients prior to discharge. During the first half of 1991 the CDS will be implemented for selected program types, initially outpatient programs and inpatient rehabilitation.



APPENDIX A

TASK FORCE ON INTEGRATED PROJECTS¹

YOUTH TREATMENT PROGRAMS

- o The <u>Berkshire Farm Center</u> program is essentially a short-term residential chemical dependency program for youth in facility certified by DSS, SED, and DFY. This utilizes a separate cottage on the Berkshire campus for a six-week intensive program for youth with alcohol and drug problems. The Division and DSAS share lead responsibility for oversight of this program.
- o The <u>Columbia County Alcoholism Center</u> coordinated a joint county-wide effort to provide youth consultation and outpatient clinic services to multi-disabled young people and their families. Schools and social service agencies serve as host sites for three additional staff. This rural model also provides coordinated planning efforts and educational programs focusing on chemical dependency.
- o The <u>Cumberland Neighborhood Family Center</u> in Brooklyn has targeted intensive outpatient services for adolescents and their families, and offers programming in both Spanish and English. Linkages with Woodhull Medical and Mental Health Center facilitate case finding, and the NYC Board of Education provides teachers. Significant Medicaid reimbursement will ensure this program's ongoing operation.
- o The <u>Delaware County Community Service</u> program provides intensive outpatient services to young people ages 12 to 21 and their families. A twelve-week intensive outpatient model with 26 weeks of aftercare services, this program offers services to all disability groups and has long-standing linkages with a variety of agencies including BOCES, DSS, and Probation. This concept, highly replicable in rural counties with county-operated services, includes a family component and the possibility of accessing DSS foster care beds for back-up residential needs.
- o The <u>Dutchess County Department of Mental Hygiene</u> program offers an intensive outpatient/day-treatment-plus-school model for chemically dependent youth. This urban/suburban model is highly replicable in counties with BOCES and county-coordinated services.
- o The St. John's Episcopal Hospital in Queens expands an existing alcoholism treatment program to treat multi-disabled youth. Located in Far Rockaway, the program operates after-school services and an "evening hospital" four days a week. Serving a largely minority population, this intensive program includes an emphasis on family treatment. It is now serving adult MICAs as well, and has linkages with adult homes.

^{1.} This annotated list of TFIP funded projects includes only those projects for which the Division is the lead or co-lead agency. For a complete listing of TFIP funded projects, contact the Division.

- o The St. Luke's/Roosevelt Hospital in Manhattan has established a comprehensive outpatient treatment program for MICA youth ages 12 to 21. It has a strong emphasis on family therapy and outreach to minority youth. Vocational/educational upgrading is provided in addition to the usual youth clinic services.
- o The <u>Weekend Center</u> in Northern Westchester operates a youth outpatient clinic with an emphasis on family treatment. It is an easily replicable suburban model.

MICA TREATMENT PROGRAMS

- o The <u>Rochester Mental Health Center</u> provides enriched outpatient clinic services, intensive case management, and hospital consultation for MICA clients ages 21 to 30. As part of the community mental health center, the program emphasizes family treatment and deals with those who are severely mentally ill.
- The <u>Salamanca Hospital</u> in Cattaraugus County provides the full continuum of care to young adult MICA clients. Emergency services, detoxification services, inpatient rehabilitation, and outpatient/day treatment are available to residents of a four-county service area, with consultation services provided as needed. This model offers excellent potential for replication utilizing rural general hospitals as key providers.

YOUTH PREVENTION PROGRAMS

- o The <u>Brooklyn U.S.A. Jackie Robinson Center for Physical Culture</u> is a community center that provides a comprehensive, holistic alternatives approach to drug prevention and education. The center represents a consortium of community groups which have implemented an after-school program for in-school youth ages 10 through 18 residing in central Brooklyn.
- The <u>Cattaraugus Council on Alcoholism and Substance Abuse</u> has developed a program to address the special needs of identified "at risk" adolescents through student support groups, a one-week summer residential camp, and alcohol and drug in-service training for teachers and parents. Special emphasis is placed on establishing linkages to community agencies to facilitate referrals for students requiring treatment services.
- o The <u>Cazenovia College</u> (Madison County) has developed a flexible teaching module for promoting self-esteem in girls, since low self-esteem has been identified as the single most important common denominator of young people at greatest risk for alcohol/substance abuse, teen pregnancy, sexual abuse, dropping out of school, suicide, and other problems.
- o The <u>Center for Youth Services</u>, <u>Inc.</u> (Monroe County) provides a comprehensive approach to alcohol and drug prevention for at-risk unserved/underserved youth. The focus of the TFIP-funded component is outreach to minority youth in areas where they congregate and the provision of workshops, training, and group counseling. The target

populations are school-age youth grades 4 through 12, out-of-school youth, parents, and professionals. Youth and families have access to the Center's counseling, intervention, and emergency shelter services as well as social service and treatment programs with which the Center is linked.

- The <u>Chautauqua County Council on Alcoholism</u> links the council's Awareness Theatre Project with the Jamestown Boys and Girls Club to expand its innovative approach to alcohol and drug prevention education through the use of drama and audience participation and to reach out to at-risk youth.
- c The <u>College at Old Westbury</u> (Suffolk County) has implemented a comprehensive community outreach effort directed at regional high schools and presents awareness workshops for the parents of youth at high risk.
- o The <u>Colleges of the Seneca</u> (Ontario County), using the knowledge gained from their comprehensive approach to substance abuse prevention, education, and intervention among college-level youth has involved student leadership in providing accurate information about use and abuse of alcohol and other drugs and has integrated drug education into the broader context of health promotion activities. College students serve as role models for secondary school students who are brought to the campus for two one-day conferences. Local agencies have been involved in the planning and have made a commitment to assist in the implementation.
- o The <u>Dutchess County Council on Alcoholism</u> and <u>Chemical Dependency, Inc.</u> has implemented the Westchester Student Assistance Program (SAP) model in six rural school districts serving at-risk youth and targeting COAs and COSAs.
- o The EPIC Effective Parenting Information for Children is an established prevention model that has been implemented in many New York schools. It is a grade K through 12 curriculum model that focuses on development of decision-making skills, sclf/esteem enhancement, and problem solving. The TFIP-funded program focuses on very high-risk youth and their families in a Buffalo Alternative High School.
- o The <u>Greater Buffalo Council on Alcoholism and Substance Abuse</u> has developed a project that is primarily directed at youth within the juvenile criminal justice system to identify those youth under 21 who are at risk of developing alcohol and other drug dependency problems. Training is provided to the juvenile criminal justice system to enable staff to recognize the connection between anti-social/delinquent criminal behavior and alcohol/other drug abuse, thereby leading to early intervention and referral of youth to appropriate levels of treatment.
- o The <u>Leaf Council on Alcoholism</u>, <u>Inc.</u> (Otsego County) has established a school-based alcohol and other drug prevention education program for 7-to-12 year old students. Participatory teaching techniques of demonstrated effectiveness with this age group are emphasized. An important innovative feature of the program is the use of puppets.
- o The <u>Lesbian and Gay Community Services Center, Inc.</u> (NYC) has developed a drug and alcohol abuse prevention project which is designed to respond to

the unique needs of high-risk lesbian and gay youth through a community-based comprehensive education and prevention service. It is responsive to the needs, exacerbated by the connection of alcohol/drug abuse to AIDS, of lesbian and gay youth, who have been historically unserved.

- The <u>Madison County Council on Alcoholism and Substance Abuse</u>, <u>Inc.</u> has established relationships with the county schools where no alcohol and other drug education, prevention, or intervention services are provided. Teacher training for 30 teachers in three school districts is provided to assure on-going services to all youth and to assist teachers in identifying and referring high-risk COAs and COSAs for appropriate services. The Council is also establishing an alcohol and other drug resource library for the county.
- o The Middletown Community Health Center, Inc. (Orange County) provides a 6-week course on alcohol/drug education as part of prenatal services to adolescent youth under 21 years. Social workers provide assessment and referrals to treatment when indicated. Training for peer educators is provided to those successfully completing the 6-week course. They, in turn, do outreach to their unserved peers and refer them to the program. Training is provided for the county obstetricians to assist them in identifying alcohol and drug using patients and referring them to the center for the 6-week education course.
- o <u>Montefiore Medical Center Rikers Island Health Services</u> provides an alcohol and other drug prevention, education, and diversion program for incarcerated youth, many of whom are COAs/COSAs. These prevention/education services provide placement in treatment centers, housing, training programs, and jobs.
- o The Narcotic and Drug Research, Inc., Training Institute has implemented an intervention and prevention training program for DFY staff who work with youth at high risk of chemical dependency or abuse. The DFY staff work at 12 facilities located in a variety of non-community based settings. Mobile mental health team staff who serve these DFY facilities also participate in the training.
- o The Nassau County Coalition Against Domestic Violence has implemented a prevention education program for high-risk children of alcohol and other drug abusers who are also primary or secondary victims of domestic violence. A range of preventive treatment and educational services is utilized, including group and individual counseling for children and adults, parenting groups, family interaction sessions, and alcohol and drug education.
- o The Nassau County Department of Drugs and Alcohol program addresses the needs of those professionals who come into daily contact with young COAs and COSAs through the distribution of a film "The Mystery of the Disappearing Parents" with an accompanying discussion guide. One hundred elementary schools in Nassau County initially received the film.
- The <u>National Committee for the Furtherance of Jewish Education, Inc.</u> has developed a program designed to reduce alcohol and other drug abuse among at-risk youths through the replication of the Westchester SAP model and

through networking with Black and Hispanic community leaders to reduce tension in a multi-ethnic community in Brooklyn.

- o The New York State Association for Human Services/NYS Youth Council has sponsored a statewide program consisting of a series of regional youth speakouts on alcohol and drug abuse in which people testified on a broad range of issues related to drug and alcohol abuse. Through this project, state and community policy makers and service providers gained input from the target groups they are trying to serve.
- The <u>Onondaga Council on Alcoholism/Addictions</u> has expanded four successful initiatives directed at the prevention of alcoholism and chemical dependency in youth at risk. These integrated program models include Chemical People, training for human service agency professionals, teen institutes, and Talking With Your Kids About Alcohol (TWYKAA).
- o The Research Foundation SUNY Buffalo developed a program model specifically designed to address the needs of the Native American after a long and detailed research project identified gaps in services and reasons for past failures. This project focuses on high-risk youth in schools and substance abusing parents from two reservations.
- The <u>Ridgewood Bushwick Senior Citizens Council</u>, <u>Inc.</u> provides a comprehensive, educational substance abuse program directed at children in local public and private schools through a mobile outreach team. Team staff work with teachers and counselors to identify high-risk children, and conduct educational workshops with participants in the School to Employment Program, the Structured Educational Support Program, and the Summer Youth Employment Program. Referrals for youth and their families are made to agencies providing employment programs and after-school and evening recreational and social programs. A counseling component addresses stress reduction and promotes positive alternatives to substance abuse with referrals to long-term counseling programs provided as needed. This agency serves a high-risk minority population.
- o The Schuyler Hospital Alcohol Outpatient Clinic has identified the need for an on-site alcohol and other drug education, counseling, intervention, and referral program directed at adolescents and children whose parents abuse alcohol or other drugs. The program provides classroom services and in-school counseling for "at-risk" 4th-12th grade students and a trained counselor to work with PINS through the PINS Diversion Committee.
- o The <u>Single Parent Resource Center</u>, <u>Inc.</u> (NYC) is a community-based prevention program focusing on homeless children between the ages of 6 and 14 who are living with their families in mid-town hotels adjacent to the center. It has created a safe, stress-free, clean, and spacious place where homeless children and their parent(s) can take part in educational and recreational activities.
- o The <u>Sullivan County Council on Alcoholism and Drug Abuse, Inc.</u> uses Kids Klub, a community-based prevention/early intervention program for children 5 to 12 years of age who have been identified as children at risk. The program coordinator also provides educational in-service

training to school and agency personnel.

- o The <u>United Way of Buffalo and Erie County WNY United Against Alcohol</u>
 and <u>Drug Abuse</u> is a broad-based community alcohol/drug awareness program
 that includes media campaigns, print materials, development, and outreach
 to all segments of the community. The program has established referral
 linkages with appropriate provider agencies.
- o The Yonkers Community Action Program, Inc. has developed The Coalition for a Drug Free Yonkers, a citywide coordinated policy regarding the importation, sale, and use of alcohol and illegal substances. The target population, high-risk multi-disabled youth, receives alcohol/drug education, group seminars and counseling, and support services.

APPENDIX B

EAP QUALITY REVIEW WORKGROUP

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APPENDIX D

CLIENT INFORMATION ADVISORY GROUP MEMBERS

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TABLE E-1 ADMISSIONS BY REGION

LOCAL ALCOHOLISM PROGRAMS AND LOCAL MENTAL HEALTH PROGRAMS SERVING ALCOHOLIC PERSONS NEW YORK STATE – 1988

		NEW YORK	NASSAU-	MID-	NORTH-		FINGER	
PROGRAM CATEGORY	TOTAL	CITY	SUFFOLK	HUDSON	EASTERN	CENTRAL	LAKES	WESTERN
TOTAL	161,306	46,885	23,206	24,392	18,278	18,027	14,848	15,670
LOCAL ALCOHOLISM SERVICES	160,475	46,848	22,448	24,392	18,244	18,027	14,848	15,670
Prevention and Intervention*	_	.		· -	·		. en 🚉	
Inpatient Facilities	83,704	31,592	11,376	13,416	7,316	8,848	5,275	5,881
Acute Care**	38,574	19,555	6,389	6,079	2,977	1,164	1,075	1,335
Inpatient Rehabilitation**	17,719	2,585	2,846	4,711	1,660	1,732	1,953	2,232
Crisis Centers	26,747	9,452	2,141	2,391	2,559	5,875	2,134	2,195
Residential Facility (CDY)			,	_,			_,	
(Short-Term)	664	_	_	235	120	77	113	119
Community Residential Facilities	2,282	516	189	269	352	355	410	191
Recovery Home	21	_	_	_	21	_	-	-
Halfway House	2,188	516	189	269	327	342	354	191
Supportive Living	49	_	=0	-	4	13	32	-
Residential Facility (CDY)	0	1						
(Long-Term)	24	-	_	-	-	-	24	_
Outpatient Facilities	74,489	14,740	10,881	10,707	10,576	8,824	9,163	9,598
Outpatient Clinic	70,642	14,528	10,480	8,822	10,020	8,230	9,163	9,399
Outpatient Rehabilitation	3,544	_	310	1,885	556	594	_	199
Day Activity***	303	212	91		_	_	_	-
		·				* .		
LOCAL MENTAL HEALTH PROGRAMS								
SERVING ALCOHOLICS	831	37	760	-	34	_	· · · · · ·	
Clinic Treatment M. H.	831	37	760	_	34	_		· -

SOURCE: 1988 LS-2C

^{*} PROGRAMS THAT GENERALLY SERVE COMMUNITIES, AGENCIES, GROUPS, OR ORGANIZATIONS.

^{**} DOES NOT INCLUDE THE FULL RANGE OF SELF-SUPPORTING DETOXIFICATION OR INPATIENT REHABILITATION SERVICES.

^{***} PROGRAM CATEGORY DISCONTINUED AS OF 7/1/86, UNLESS EXCEPTION GRANTED.

TABLE E-2 SERVICE UNITS BY REGION LOCAL ALCOHOLISM PROGRAMS AND LOCAL MENTAL HEALTH PROGRAMS SERVING ALCOHOLIC PERSONS NEW YORK STATE - 1988

		NEW YORK	NASSAU-	MID-	NORTH-	t i	FINGER	
PROGRAM CATEGORY	TOTAL	CITY	SUFFOLK	HUDSON	EASTERN	CENTRAL	LAKES	WESTERN
								r P
LOCAL ALCOHOLISM SERVICES								1
Prevention and Intervention*	_	-	_		-	-	. -	-
Inpatient Facilities	898,009	236,411	139,271	184,857	85,718	93,118	78,844	79,790
Acute Care**	208,446	112,024	32,080	27,406	16,161	8,025	6,240	6,530
Inpatient Rehabilitation**	529,263	81,526	90,207	135,647	49,942	55,121	59,415	57,405
Crisis Centers	137,501	42,861	17,004	12,642	15,417	27,618	10,122	11,837
Residential Facility (CDY)								
(Short-Term)	22,799	-	_	9,162	4,198	2,354	3,067	4,018
Community Residential Facilities	286,131	69,728	18,584	23,346	51,683	40,561	49,057	33,172
Recovery Home	4,519	_	_	_	4,519	- ,	-	-
Halfway House	265,229	69,728	18,584	23,346	46,900	35,489	38,010	33,172
Supportive Living	12,872	-	-	-	264	5,072	7,536	_
Residential Facility (CDY)	0				100			
(Long-Term)	3,511	- ,	-	_	-	_	3,511	
Outpatient Facilities	1,792,338	602,994	234,938	194,310	202,160	149,325	213,723	194,888
Outpatient Clinic	1,659,177	597,277	219,370	127,100	181,322	133,095	213,723	187,290
Outpatient Rehabilitation	124,969		13,093	67,210	20,838	16,230		7,598
Day Activity***	8,192	5,717	2,475	_	_	_	· -	·
								V**
			100		1			
LOCAL MENTAL HEALTH PROGRAMS			r .					
SERVING ALCOHOLICS								· -
Clinic Treatment M. H.	13,719	1,254	12,213		252	_	_	.

SOURCE: 1988 LS-2C

- * PROGRAMS THAT GENERALLY SERVE COMMUNITIES, AGENCIES, GROUPS, OR ORGANIZATIONS.
- ** DOES NOT INCLUDE THE FULL RANGE OF SELF-SUPPORTING DETOXIFICATION OR INPATIENT REHABILITATION SERVICES.
- *** PROGRAM CATEGORY DISCONTINUED AS OF 7/1/86, UNLESS EXCEPTION GRANTED.

TABLE E-3

NUMBER OF ALCOHOLISM PROGRAMS BY TYPE

TYPE OF PROGRAM	1981	1982	1983	1984	1985	1986	1987	1988	1989
ACUTE CARE	36	41	38	41	40	41	41	46	46
CRISIS CENTER	26	24	24	24	23	23	25	23	23
INPATIENT REHABILITATION	30	31	33	35	40	44	45	46	47
COMMUNITY RESIDENCE	32	38	36	39	40	42	46	48	52
CHEMICAL DEPENDENCY FOR YOUTH	_	-	-	_	***	-	4	8	8
OUTPATIENT	121	133	138	152	170	232	260	265	293
TOTAL	245	267	269	291	313	382	421	436	469

SOURCE: DATA BASED ON THE DIVISION'S LS-2C INFORMATION SYSTEM ON LOCAL AND STATE-OPERATED ALCOHOLISM SERVICES.

TABLE E-4
SERVICE VOLUME

	ADMISSIONS BY YEAR									
TYPE OF PROGRAM	1982	1983	1984	1985	1986	1987	1988			
EMERGENCY SERVICES *	58,911	63,802	63,195	67,677	67,496	64,427	65,321			
INPATIENT REHABILITATION	10,113	11,573	12,359	14,705	16,509	17,041	17,719			
COMMUNITY RESIDENCE	1,690	1,794	1,788	1,928	1,777	2,217	2,258			
CHEMICAL DEPENDENCY FOR YOUTH	·	, .	· · · · · · -	- · · · · · · · · · · · · · · · · · · ·	-	195	688			
OUTPATIENT	42,339	44,889	51,194	59,102	69,080	73,696	75,320			
TOTAL	113,053	122,058	128,536	143,412	154,862	157,576	161,306			

UNITS OF SERVICE BY YEAR

TYPE OF PROGRAM	1982	1983	1984	1985	1986	1987	1988
EMERGENCY SERVICES *	307,528	307,958	309,434	317,570	316,967	337,768	345,947
INPATIENT REHABILITATION	303,311	348,662	362,079	452,276	500,340	518,144	529,263
COMMUNITY RESIDENCE	184,686	188,093	208,720	208,065	219,273	254,398	282,620
CHEMICAL DEPENDENCY FOR YOUTH	-		-	-		8,533	26,310
OUTPATIENT	855,907	947,308	1,031,103	1,182,517	1,388,736	1,634,531	1,806,057
TOTAL	1,651,432	1,792,021	1,911,336	2,160,428	2,425,316	2,753,374	2,990,197

^{*} INCLUDES ACUTE CARE AND CRISIS CENTER PROGRAMS

SOURCE: DATA BASED ON THE DIVISION'S LS-2C INFORMATION SYSTEM ON LOCAL AND STATE OPERATED ALCOHOLISM SERVICES.

PERSONS ON ROLLS FOR ALL REPORTING DAMA CERTIFIED PROGRAMS AS OF JUNE 30 OF EACH YEAR

TABLE E-5

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8	539 :	25,417	26,324	205	26,529	27,686		27,686	30,502		30,502	32,069		32,069	37,935	_	37,935	42,142	-	42,142	41,916		41,916
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SOURCE: DATA BASED ON THE DIVISION'S LS-2C INFORMATION SYSTEM ON LOCAL AND STATE-OPERATED ALCOHOLISM SERVICES.

NOTE: THE STATE-OPERATED ALCOHOLISM SERVICES (SOAS) DISCONTINUED PROVIDING INPATIENT DETOXIFICATION SERVICES DURING 1984 AND OUTPATIENT SERVICES DURING 1983.

^{*} DATA NOT AVAILABLE DUE TO CHANGE IN REPORTING PROGRAM CATEGORY.

TABLE E-6 (PUBLICLY SUPPORTED) LOCAL ALCOHOLISM SERVICES NEW YORK STATE - 1989 (PRELIMINARY) (IN THOUSANDS)

		NEW YORK	NASSAU-	MID-	NORTH-		FINGER	
PROGRAM CATEGORY	TOTAL	CITY	SUFFOLK	HUDSON	EASTERN	CENTRAL	LAKES	WESTERN
OCAL ALCOHOLISM SERVICES	\$51,702	\$15,996	\$7,414	\$7,717	\$5,485	\$5,241	\$4,843	\$5,006
Prevention and Intervention*	6,924	1,748	357	1,523	1,061	952	798	485
Inpatient Facilities	12,361	4,298	2,054	857	600	2,002	1,271	1,279
Acute Care**	_	_		_	-		· _ :	-
Inpatient Rehabilitation**	1,163	-	385	_	59	250	276	193
Crisis Centers	11,102	4,298	1,669	857	541	1,656	995	1,086
Residential Facility (CDY)			100	,				
(Short-Term)	96	-	-	-	-	96	-	-
					·			
Community Residential Facilities	8,102	1,620	555	714	1,306	730	1,873	1,304
Recovery Home	233	_		_	99	-	_	134
Halfway House	6,136	1,470	555	714	558	730	1,052	1,057
Supportive Living	64	-	_	_	-	· -	64	-
Residential Facility (CDY)	113	1,		,				113
(Long-Term)	1,556	150	-	-	649	-	757	-
								4
Outpatient Facilities	24,315	8,330	4,448	4,623	2,518	1,557	901	1,938
Outpatient Clinic	22,296	8,067	3,762	3,785	2,389	1,529	901	1,863
Outpatient Rehabilitation	1,650		580	838	129	28	-	75
Day Activity***	369	263	106	_	-		. -	-
				. *				
			· · · · · ·					

SOURCE: 1989 STATE AID FUNDING AUTHORIZATIONS

- * PROGRAMS THAT GENERALLY SERVE COMMUNITIES, AGENCIES, GROUPS, OR ORGANIZATIONS.
- ** DOES NOT INCLUDE THE FULL RANGE OF SELF-SUPPORTING DETOXIFICATION OR INPATIENT REHABILITATION SERVICES.
- *** PROGRAM CATEGORY DISCONTINUED AS OF 7/1/86, UNLESS EXCEPTION GRANTED.

