CSTAA

COUNCIL OF STATE AND TERRITORIAL ALCOHOLISM AUTHORITIES, INC.
1101 15th Street, NW, Suite 206, Washington, DC 20005

REPORT ON THE IMPACT STUDY OF THE UNIFORM ALCOHOLISM AND INTOXICATION TREATMENT ACT

VOL. 1 EXECUTIVE SUMMARY
AND
STATE ALCOHOLISM AUTHORITIES' RECOMMENDATIONS AND SUGGESTIONS

VOL. 2 GUIDANCE MANUAL FOR
THE IMPLEMENTATION OF THE
UNIFORM ALCOHOLISM AND INTOXICATION
TREATMENT ACT

TWO VOLUMES BOUND IN ONE $17.00

GUIDANCE MANUAL
FOR
IMPLEMENTATION OF THE
UNIFORM ALCOHOLISM AND INTOXICATION
TREATMENT ACT

EXECUTIVE SUMMARY

November 30, 1976

Prepared for

Council of State and Territorial
Alcoholism Authorities, Inc.
1101 15th Street, N.W., Suite 206
Washington, D.C. 20005

INSTITUTE FOR RESEARCH IN PUBLIC SAFETY
School of Public and Environmental Affairs
Indiana University
400 East Seventh Street
Bloomington, Indiana 47401

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School of Public and Environmental Affairs
Indiana University
400 East Seventh Street
Bloomington, Indiana 47401

Authors

Gary J. Scrimgeour, Ph.D.
Professional Studies Associates
P.O. Box 464
Bloomington, Indiana 47401

James A. Palmer, J.D.
Institute for Research in Public Safety

Research Staff

James A. Palmer, J.D., Project Director
Gary J. Scrimgeour, Ph.D.
Barbara J. Hill, R.N.
Lynn W. Buttorff, M.Div.
Grace L. Moser, M.L.S.

ACKNOWLEDGMENT

The Guidance Manual is the product of the initiative, insight, and effort of many individuals. The major contributors, however, were the administrators and staff of the state alcoholism agencies in states which have adopted some form of the Uniform Alcoholism and Intoxication Treatment Act. Five of these state agencies agreed to on-site visits during the summer, 1976, by the research staff to view the Uniform Act in operation and to interview participants involved in the implementation of the Uniform Act: state and local alcohol program representatives, legislators, consumers, criminal justice personnel, governmental managers, and many others. Their contribution was critical; those involved in the day-to-day process of making the Uniform Act work were considered best situated to relate the problems and successes of this major health-legal program.

In September, 1976, twenty state alcoholism agency directors and representatives met in New Orleans, Louisiana, to review the draft Guidance Manual. Assisting in this review process were representatives of the National Association of Counties and the U.S. Conference of Mayors, two national organizations concerned about alcohol abuse and the role of government in its control and treatment. The constructive comment from this conference was invaluable in determining the orientation and content of the final Manual.

Special thanks are due to W. Claude Reeder and Lois Whitley of the National Institute on Alcohol Abuse and Alcoholism for their support in promoting the development of this Guidance Manual.

Finally, the Council of State and Territorial Alcoholism Authorities, a service organization for the state alcoholism agencies, saw this study and the resulting Manual as a service desperately needed by states considering enactment and implementation of the Uniform Act. Thomas E. Price, Ph.D., Executive Director of CSTAA and his staff, Gary F. Jensen and Lynn W. Buttorff, aided the study team throughout in the development of the Manual. The authors and remainder of the study team are pleased to be able to present the resultant Guidance Manual, comprised of an Executive Summary and a Technical Report, to CSTAA for the use and benefit of the CSTAA constituency---the states and communities seeking an eventual resolution of our national alcohol problem.

Gary J. Scrimgeour, Ph.D.
James A. Palmer, J.D.

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NOTE: The references to terms such as "all states," "some states," and "no states" in this text mean "among those responding to the study's questionnaire." Twenty states which have enacted laws significantly similar in policy to the Uniform Alcoholism and Intoxication Treatment Act were questioned. Some of those states did not answer all questions.

SECTION 1: INTRODUCTION

This document summarizes a larger volume entitled a Guidance Manual for Implementation of the Uniform Alcoholism and Intoxication Treatment Act, which is the first attempt since the Act was promulgated in 1971 to analyze--for the benefit of states still facing enactment--the experience of states which have implemented it. (The Uniform Act is not a federal statute, but recommended uniform legislation developed by the National Conference of Commissioners on Uniform State Laws.)

The Uniform Act

The Uniform Act has proven very popular; more than half the states and territories have enacted versions of it, many others are about to follow suit, and Congress has authorized special incentive funds. The best known of the Act's provisions is the decriminalization of public drunkenness. Other provisions, however, may prove in the long run just as significant; the Act represents a major shift in the attitudes and resources which states direct toward the treatment of alcoholism as well as of intoxication.

The major policy intentions of the Act are as follows:

- A non-criminal, voluntary, treatment-oriented approach to the control and care of alcoholics and intoxicated persons is desirable and required of the state.
- Treatment programs must be fostered by a state alcoholism agency with necessary authority and broad responsibility.
- The quality of alcoholism treatment services must be assured by enforcing minimum program standards.
- States must undertake to establish a statewide comprehensive and coordinated structure of alcoholism treatment services.
- Services and procedures for the immediate care and limited control of alcohol-impaired persons must be provided.
- Services and procedures for long-term and/or involuntary care of dangerous and/or incapacitated persons with continuing severe alcohol impairment must be provided.

The Guidance Manual

The Guidance Manual intends to enable both national and state policymakers to determine whether these policy intentions are embodied in present or planned operations. It consists of sets of questions, accompanied by commentary. The questions are for use by anyone wishing to analyze the Uniform Act's operations at either state or community level. The commentary was created by asking these and other questions of managers and operational personnel in communities which have implemented the Uniform Act. Credit for the detailed information in both questions and commentary belongs to such personnel, especially to the staff and directors of the state alcoholism authorities in all Uniform Act states. The Manual was created at the request of the Council of State and Territorial Alcoholism Authorities. Some of the more general conclusions (appropriately indicated) are, however, the responsibility of the study team alone and do not necessarily reflect the beliefs of CSTAA or the state alcoholism authorities.

The Executive Summary

To create this Summary, materials from the Manual's commentary (but no questions) have been extracted. Some have been moved from their surrounding detailed explanations, and others have been taken out of context. The study team advises against quotation from the Summary without accompanying scrutiny of the Manual text and questions. In both Manual and Summary, the study team intentionally avoided collecting statistics, believing that existing data are inadequate to provide a picture of the Act's impact nationwide. Local statistics could be misleading, though individual states and communities have made many good statistical studies. The study team also avoided naming individual states or programs. They visited at least four communities in each of five states and interviewed the state alcoholism agencies in all decriminalized states.

General Conclusions of the Study Team

Having heard (since 1971) rumors in many states of the "failure" of decriminalization to satisfy the intentions of the Uniform Act, the study team began work prepared for bad news. By the end of the study, however, they were convinced that the Uniform Alcoholism and Intoxication Treatment Act is one of the more successful pieces of uniform legislation promulgated in recent years.

It has been widely enacted, and almost as widely implemented. Many states remain reluctant to enact the Uniform Act.

A few remain even more reluctant to fund it. Some "Uniform Act states" have enacted legislation which departs too far from the original model. There are many problems with implementation, and, as the study team anticipated, nobody is as yet satisfied that we have fulfilled the complete range of the Act's intentions. But despite all this, the Act has had major and beneficial effects in every state or territory which has enacted it.

The Act's most publicized intention was to move public inebriates out of the criminal justice system and into the health care system. In general, this intention is being met, though more money, more time, more knowledge, and more training are all necessary before it becomes a reality everywhere and in all cases. The criminal justice system (especially the police) is still involved with public inebriates, but to a much lesser degree than before and under circumstances more generally agreeable to all involved. There have been considerable savings of police time and resources, and there are excellent prospects for more.

The health care system is not seeing as many public inebriates as did the criminal justice system, but it is seeing more than ever before. Some health care agencies are reporting "success" with their programs: improved health care, greater humanitarianism, and rates of "improvement" among elements of the public inebriate population higher than were expected. Some alcoholism program managers complain that too many resources are going to the least productive group of alcoholics at the expense of other groups. Some complain that alcoholism treatment funds are being expended inappropriately on functions of public order, public safety, and public convenience. But all interviewed program managers endorsed the intentions and the current operations of the Uniform Act as a whole.

The Act was everywhere regarded as having produced the following benefits:

- a marked expansion of alcoholism services;
- greater coordination of alcoholism services statewide;
- better coordination at the community level;
- more interagency cooperation within state and local governments; and,
- the creation of services previously inadequate or non-existent.

This is a singularly heavy vote of confidence. Coupled with the dramatic decline in numbers of inebriates handled by the criminal justice system, it indicates that the Uniform Act is causing substantial changes in the delivery of health care services.

There are two major remaining problems. Most often cited was the inadequacy of funds for treatment, especially for public inebriates. Programs are often too small to handle demand. Community managers often complained about increased costs, though state agencies are paying the major share. However, the programs visited by the study team were all economical, and none seemed to be either wasting money or seeking luxury. Second most often cited as a problem was the Act's unrelenting emphasis on "voluntariness." Under the Act, government is required to provide treatment services, but alcoholics and inebriates are not required to accept them. This issue deserves much greater analysis at the levels of both theory and operations.

There are many other problems, lesser or less frequent. They are indicated in the text of the Manual, and some appear in this Summary. None seems insoluble. All had been solved in at least one jurisdiction, and the study team therefore strongly encourages the Council of State and Territorial Alcoholism Authorities to continue its efforts to disseminate information from state to state and program to program. Such efforts are desperately desired at the community level and would be highly beneficial in terms of costs and equity.

SECTION 2: THE UNIFORM ACT'S IMPACT--ATTITUDES AND RESOURCES

Successful implementation of the Uniform Act depends on the resources a state is willing to devote to its provisions, and these depend on a state's attitudes toward alcoholism and treatment. Negative attitudes will result in inadequate appropriations. The second major factor is decriminalization. Seen as a potential savings of criminal justice resources, decriminalization is popular, and it is probably the single strongest factor encouraging enactment and implementation.

Enactment of the Uniform Act

Most states passed Uniform Act legislation easily and with little prior planning or even discussion. States currently contemplating enactment are more cautious because of new information about costs.

Decriminalization of public drunkenness is a popular concept, and legislatures tend to regard it as the major reason for the Act.

Many states passed the Act without analysis of costs. Several made no appropriations, but all but two have since provided both cost-studies and funds. There have been many underestimates and overestimates of both the costs and savings of the Act's provisions.

Reactions after Enactment

No state has repealed its Act. Moves to recriminalize have been small and temporary but still exist. Amendments are common, usually at the instigation of a state alcoholism agency.

Initial public reaction to decriminalization was often unfavorable. The presence of more "drunks" on the street disturbs police, merchants, and sometimes the public. These negative reactions have proven neither major nor enduring, and in fact often stirred legislatures to provide treatment funds. No responding state reported widespread public dislike for decriminalization, and police and public in most states generally favor it.

City and county managers have tended to develop new negative attitudes toward decriminalization as the costs of services became clear, and as disillusionment set in after high and false expectations about the purpose of treatment and the probability of treatment success. However, there is an extreme range of favorable and unfavorable attitudes in different communities.

The major source of complaint is inadequate funding for pick-up and transportation service, and for treatment centers or overnight shelter. A second developing problem stems from the Act's emphasis on voluntariness. Many people thought decriminalization would mandate treatment in lieu of jail, and they expected "cures." Some people resent the greater degree of freedom now permitted public inebriates--especially the small group of chronic repeaters--and blame them for "littering the streets."

There is much gossip to the effect that "decriminalization is not working." Expert opinion, however, concludes only that decriminalization has not everywhere been accompanied with enough funds to meet the expectations which many people originally (and perhaps incorrectly) held.

Some critics believe that decriminalization is replacing court supervision with police-dispensed justice, since it increases the degree of police discretion. Other critics believe that those communities providing the better services will attract more public inebriates. A few communities report experiencing one or other of these developments.

Most people report a belief that decriminalization has resulted in more humane treatment of inebriates. Exceptions occur in states which have not funded treatment programs, where public inebriates are much worse off than before.

Introducing public inebriates into the health care system has, in many communities, helped alcoholism professionals improve the attitudes and knowledge of hospital staff about alcoholism, though many hospitals are refusing cooperation.

Many communities report earlier identification; many public inebriates brought to treatment have had no prior drinking-related contact with police or alcoholism agencies.

Situations Seen as Program Problems

The process of implementation is still in its early stages almost everywhere, and it is still plagued with problems.

Almost everyone sees treatment facilities as overloaded: handling increased numbers of repeaters with poor results. They blamed the following: inadequate funds; the subgroup of chronic repeaters; the voluntariness mandated by the Act; the quality or appropriateness of treatment programs.

Almost all states report continuing geographical inequities, i.e., differences in attitude and comprehensiveness of programs from one jurisdiction to another. No state as yet has a complete treatment structure in place, though almost all have made dramatic progress. They blame inadequate funding, lack of time since decriminalization, and resistance from local government toward funding treatment services.

All states and many communities can document the overload in receiving centers, detoxification centers, and halfway houses. There are not enough facilities for the population, especially in large cities. Many inebriates are now either ignored, taken to jail, or released from treatment prematurely.

Most states report weakness in the referral process. Many public inebriates referred to outpatient treatment fail to appear. Follow-up is everywhere inadequate. Program personnel are not satisfied with the effectiveness of their immediate services in leading to ongoing treatment.

Most people report belief that the Uniform Act is clearly succeeding in achieving more humane treatment for most public inebriates; in strengthening the authority of the state alcoholism agency; in extending and strengthening treatment programs; in removing public drunkenness from the register of crimes; and in affecting attitudes and behavior of persons delivering all kinds of government services to alcoholics and intoxicated persons.

Partial decriminalization is more common than is realized. In either statute, ordinance, or practice, many states which have nominally decriminalized allow for more coercion than envisaged by the Uniform Act. The coercive thrust is often supported by alcoholism program personnel.

Confusion in terminology from group to group, jurisdiction to jurisdiction, and state to state is great and harmful. Such terms as detoxification, inpatient treatment, residential care, withdrawal, emergency services, and medical screening mean very different things to different people, and their misuse causes drastically inaccurate communication.

There are not enough nationwide statistics to indicate how real these perceived problems may be. Sample studies indicate they are real and widespread.

Attitudes, Resources, and Costs

Many states report anxiety that public inebriate programs will not survive without some federal funds. Some states (reflecting community attitudes) believe that too high a proportion of their funds is going to public inebriates.

State-funded agencies are presently the major strength of local alcoholism programs, but communities are contributing funds almost everywhere, even to public inebriate programs.

Most states follow the Uniform Act's advice to exploit existing structures rather than create a new network. Many alcoholism programs economically piggyback their services on existing mental health or public health structures. Independent and non-governmental service agencies remain a major source of strength at the local level, though some such programs are reluctant to deal with skid-row and homeless inebriates. Many communities incorporate existing police and jail services into the treatment structure--to a degree greater than intended by the Act. Support from hospitals is generally much weaker than the Act intended.

Police, courts, jails, and prisons sometimes save money and always save time as a result of decriminalization. Almost all other concerned agencies experience increased costs. All provisions of the Act cause some increase in costs. The most expensive provision is for a comprehensive and coordinated treatment program statewide.

We cannot yet prove that the provisions of the Act cost more than the criminal justice system in terms of absolute dollars. Every interviewed jurisdiction, however, reported savings in the criminal justice system, increased costs in the health care system, and no transfer of funds from one system to the other.

Enacting Uniform Act legislation without appropriating funds does not fulfill the intentions of the Act. States which have not provided appropriations reported such problems as dislike among police officers for decriminalization; anxiety about survival of treatment programs; total inadequacy of existing programs to population needs; decline in overall services to public inebriates; decline in the health and well-being of the public inebriate population.

Both state and community managers ask: "How much more will we have to spend on alcoholism treatment than we did before, especially for public inebriates?" No state alcoholism agency could answer that question with complete confidence. Many believe a direct answer would be misleading. Community managers often understand the more sophisticated cost/benefit answer given, but, under severe financial pressure, they do not generally want to make a powerless, homeless, and non-voting population a high fiscal priority.

There is widespread expectation that money allocated for alcoholism treatment should pay for all costs resulting from the Uniform Act and from decriminalization, whether or not those costs are related to alcoholism treatment. Alcoholism among public inebriates is seen as different from other public health and public safety problems, so that other agencies do not expect to allocate portions of their regular budget to its control once the law is seen as having removed it from their domain.

The Act tried to avoid creating extra costs. A methodology for measuring the costs of decriminalization as compared with the arrest-and-jail system urgently requires development.

Attitudes within the Alcoholism Profession

The major question here is whether the profession believes that alcoholism funds are being allocated inappropriately to the unproductive subgroup of public inebriates.

All states reported a greater total of alcoholism funds available as a result of the Uniform Act. Public inebriates represent at most 25% of the alcoholic population according to most states, and more likely less than 10%. About half the states report expenditures appropriate to the proportion of public inebriates, but about half also report spending a disproportionate 50% or more of their funds on public inebriates. Most professionals believe the disproportion is justified on a catch-up basis, but a vociferous minority believes that public inebriates are depriving other subgroups of needed treatment funds.

Most interviewed alcoholism professionals indicated their belief that the government now is spending too little or just right amounts of money on public inebriates, and a heavy majority believes that the expenditure is worthwhile. Significant minorities dissented, reporting that the government is spending too much, and/or that the expenditures are not worthwhile. No state had asked the public inebriates what they think. Consumer satisfaction is not yet a factor in this field.

Most states indicated that the federal incentive funds to aid implementation are important, especially since the recent increase in amounts. Although most states said they would have the same priorities with or without incentive funds, a significant minority indicated there would be a sharp decline in their public inebriate programs without them, and in two states there would be no special programs without them. All

states indicated that the incentive funds were supporting crucial elements of the implementation process. The impression of the study team was that states are using the federal incentive funds as leverage where state funding is difficult or impossible, especially during the first stages of implementation. This is the intent of Congress.

The alcoholism profession is anxious about its role as regards the skid-row population (many of whom are not alcoholics). Chronic repeaters are a special source of worry. Treatment agencies do not want reputations as failures (revolving doors), yet the voluntariness of the Act guarantees that reputation for their immediate services, especially for their detoxification centers. The profession is under pressure to help "break up" skid row, which they correctly do not see as their function or as an intention of the Uniform Act. As a generalization, the profession believes that the Act calls upon them to leave alone whatever proportion of the skid-row population wants to be left alone, but merchants, police, and local government often have very different expectations.

Summary of Attitudes

Decriminalization coupled with voluntary treatment is strongly endorsed by almost everyone--as long as it is accompanied by adequate treatment resources. Almost everyone, including police, is opposed to a return to the old arrest-and-jail system, even if that system were bolstered by better treatment resources and deprived of criminal penalties. The Act's intentions in this area thus receive the strongest possible endorsement.

There is hesitation about the degree of voluntariness which the Act demands. Though no interviewed person supported involuntary incarceration and mandated treatment, many preferred a quasi-diversionary system using the threat of criminal sanctions to induce cooperation with treatment. This system exists in some states both with and without Uniform Act legislation, and it has been well publicized by the success of the Alcohol Safety Action Program for drinking drivers.

But support for moving inebriates from the criminal justice system and into the health care system remains very, very strong. Support is also widespread for the Act's other major intentions: strengthening the state alcoholism agency, and creating a comprehensive and coordinated treatment program. Most people from all sectors believe the basic philosophy and major provisions of the Uniform Act are proving operationally to have been right on target.

SECTION 3: THE NEW SYSTEM IN OPERATION--DECRIMINALIZATION, VOLUNTARINESS, AND TREATMENT

Complete decriminalization has not occurred, even in all those states which have adopted versions of the Uniform Act. In many states, voluntariness is not as extensive as the Act recommends. By no means all states have funded comprehensive treatment programs.

Some state statutes and municipal ordinances do not contain the specific elements of decriminalization outlined in the Uniform Act. More decriminalized systems are based on police and jails than the Act envisaged. Circumvention of full decriminalization--either in statute, ordinance, or practice--is great enough nationwide to warrant special study from the national level.

Though "public drunkenness" is no longer an offense in any decriminalized state, a majority of decriminalized states still have statutes naming such offenses as "drunk and disorderly," "disorderly intoxication," "drunk in public," and "drinking from an open container." Thus, while all states have seen sharp decreases in arrests for public drunkenness or similar charges, no state has seen such charges totally vanish.

Some states' Attorney General may have certified that their legislation is in compliance with the Uniform Act without sufficient study of either the Act or their own statutes. Some state alcoholism agencies seem unaware that their legislation departs from the Act's provisions.

The use of substitute charges by the police has not proven a major problem. Although most states show increases in the number of substitute charges, nowhere does the increase approach the decrease in public drunkenness charges. However, the situation demands monitoring because police feel a strong need to have a misdemeanor charge available for controlling the street population.

Both states and communities are confused about "protective custody" as recommended in the Act. A few states indicate that it is used as a substitute charge, though most believe not. Some communities are undoubtedly using it to circumvent decriminalization on a selective basis, thus placing inebriates in jeopardy from police-dispensed justice.

However, there is no evidence of massive or widespread or substantial police evasion of correct decriminalization procedures. Most police in most areas are willing to comply with decriminalized procedures--as they understand them--though some are uneasy as to their legal vulnerability under the protective custody situation, and some have been misled by local prosecutor opinions.

There is a widespread lack of clear guidelines for the police. Some published guidelines are clearly in error. There is a need to disseminate accurate guidance from the national level. It would be welcomed by the police.

Decriminalization has the strong support of most police officers interviewed, and they have adopted readily the concept of alcoholism as a disease. They do, however, worry because of the removal of their power to "defuse" some street and family situations by a simple drunkenness arrest.

In most states many public inebriates are still going to jail, though less often or easily than before, either because detoxification centers are overloaded, or because communications between centers and police are poor, or because centers are located in jails. States report decreases of between 35% and 85% in the numbers of inebriates entering jails. Small towns and rural counties still use jails extensively, though some have developed non-jail detoxification centers. Rough estimates from the states indicate that better studies of the jail population are needed. Chronic repeaters seem to be going to jail more often than other intoxicated persons. In at least two states they are still going to prison.

The Act does not specify whether the use of jails as detoxification centers is or is not desirable. Jails seem likely to continue their contact with some inebriates, and therefore alcoholism authorities should pay close attention to the amount and quality of jail-based treatment, and to the training of jail staff.

In some communities, local government managers have encouraged police and jailer dislike for decriminalization, mainly because of costs. In other communities, jails are overly proud of their health care systems. Most states have developed techniques for overcoming these problems, which do not seem widespread.

Services to Consumers

Is the health care system doing better by public inebriates than did the criminal justice system? Police and jails provided vital services and health care to some public inebriates. Are treatment programs doing worse or better?

There have been many rumors that "regulars" have died from neglect as a result of decriminalization, especially in cold climates. Some rumors seem true, but other more generalized reports are demonstrably false, or at least unprovable.

Nobody knows whether the health of the public inebriate population is better or worse since decriminalization. Nobody is investigating the beliefs of that population. This ignorance should be tackled from the national and the state level.

Most people believe that more and better services are now available to inebriates as a result of decriminalization. Most programs think their communities offer better shelter and health-care services. (The notable exceptions are those states which did not appropriate funds to accompany decriminalization.) However, many inebriates may now choose to be ignored, and many are brain-damaged, retarded, emotionally disturbed, or consistently drunk. Their situation calls for further study.

Criminal Justice Savings

Savings in criminal justice time and resources may not have resulted in savings of money. For example, courts now see few or no public inebriates, who now cost the courts nothing--but they never cost them very much. Police time and resources are allocated elsewhere, and while all interviewed police agencies reported pleasure with their savings in time and resources, none reported financial savings. Some agencies (e.g., county sheriffs) reported increased costs due to the need to transport inebriates to a distant health facility.

Jails and prisons report fiscal savings. Decriminalization has allowed the closing of some jails and many drunk tanks. However, drunk tanks still exist in most large urban areas, and detoxification centers still exist in many jails. Further, some jails and prisons lament the loss of free public inebriate labor. Jail and prison savings, therefore, may not be as great as expected.

Since some states support decriminalization because of anticipated criminal justice savings, the subject deserves further study and proper emphasis on the precise nature of such savings (i.e., time and resources).

Opinions about Decriminalization

The courts and jails are content to have less contact with public inebriates. Most police report pleasure at "getting out of the drunk business," but many also feel they now lack control mechanisms which they need. Some police feel that decriminalization has increased their discretion, others that it has decreased their discretion and power. There is, in other words, no clear police consensus either for or against decriminalization can be predicted within an individual jurisdiction.

City and county managers are now more knowledgeable, concerned, and irritated about public inebriates, mostly because of funding issues. Some counties, both urban and rural, are fighting state statutes which mandate them to pay some or all treatment costs.

Nobody knows how the majority of the public inebriates feel about decriminalization, though those interviewed like it and regard the detoxification centers as an additional resource.

The alcoholism profession is enthusiastic and is fast learning how to deal with a skid-row population of which it was mostly ignorant until now. Frustrations exist, but these stem from overload or soluble problems.

Respondents from all sectors believe that more alcohol abusers are now receiving treatment. A substantial body of opinion believes that public inebriates are now receiving more attention than they merit.

Voluntariness

Almost everyone supports the general concept of voluntariness advanced by the Act because they find the alternatives intolerable, but many people have in mind certain subgroups which they think should be handled involuntarily. The problem is when and how to define those subgroups.

The Act intends society to have less legal control over inebriates, and almost all components are uneasy about their own loss of control. The uneasiness was nowhere predominant, except concerning the subgroup of long-term chronic repeaters.

The Act expressed the belief that a "vast majority" of alcoholics would enter and stay in treatment voluntarily. Present experience does not support this belief. Volunteer clients are more usual at outpatient centers than at detoxification centers, and even at the latter it seems that some 25 to 50% of clients enter voluntarily, but this is not the "vast majority" contemplated by the Act.

Voluntary clients seem generally to get better treatment than involuntary clients.

Long-term control remains a major unresolved problem, especially for the subgroup of chronic repeaters. It deserves detailed study at both the national and state level. Half of the interviewed states reported that certain subgroups should receive long-term involuntary treatment.

The concept of the "wet hotel" is emerging as an alternative to long-term hospitalization, since the Act does not mandate alcoholics to accept treatment, get cured, or even stop drinking. A large minority of interviewees thought that such persons ought to be offered a government-sponsored "protected living situation," as an alternative to private flophouses. "Government-sponsored" need not mean "government-paid," since many existing flophouses operate at a profit.

Conclusions

The important theoretical problem is what to do about those public inebriates who do not respond to the Act's standard pattern of decriminalization, voluntariness, and treatment. Are the police and treatment agencies obligated to provide them with whatever care they want? And reciprocally, must we weaken voluntariness in order to make custody, treatment, and confinement mandatory for some public inebriates?

Most states (including some decriminalized states) retain some police powers and some treatment methods by means of which community control may continue to be asserted. Compromise with the Act's intentions is in other words already frequent, and clearly the easier route. Unless policy is clarified nationwide, the intentions of the Act in this area will be diluted operationally.

SECTION 4: STATE AGENCY RESPONSIBILITY AND PROGRAM STANDARDS

Many experts believe that the Uniform Act's assignment of clear powers and duties to a state alcoholism agency may prove in the long run more important than decriminalization.

Some states believe their state alcoholism agency would not have been created without the Uniform Act, at least along present lines, and several states attribute the entire reorganization of their alcoholism efforts to the Act. Most states, however, were already moving in this direction. Most state alcoholism agencies believe that their role as regards other state departments and local treatment programs has been strengthened by the Act.

Agency Powers and Duties

"Powers" signifies areas where an agency may act if it so chooses. "Duties" signifies areas where it is required to act by law.

Many legislatures diminished the list of powers and duties laid out by the Uniform Act. Thus the Act is now better called "model" than "uniform." Amendment of the original legislation is also frequent. Many state alcoholism agencies have not yet had time or resources to attend to all their new duties, let alone to exercise their powers.

Administrative duties have preoccupied most state alcoholism agencies so far. The least exercised powers are in the areas of research, records, and statistics. No state agency reports itself yet satisfied with its exercise of either powers or duties. Some states are far ahead of the majority and very activist.

Special problems arise because of overly swift changes in policy and interest at the national level as reflected in the duration and subject-matter of categorical grants. Such changes are reported as impeding the progress of Uniform Act implementation at the local level. Other problem areas arise in relationships with other state agencies, and in relationships with local treatment programs.

Weak relationships exist generally between state alcoholism agencies and state criminal justice agencies, though a few states have moved far ahead of the federal government in this area because of joint recognition of mutual problems. Spasmodic or token relationships exist with state highway safety agencies, though again a few states are far ahead. Most states believe that greater cooperation between relevant Federal agencies, e.g., DHEW, DOJ, and DOT, would be highly beneficial to them.

Most states report unsatisfactory relationships with the medical profession at the local level, though decriminalization is creating positive changes in some hospital staff. Local alcoholism treatment programs are uneasy with the state agency's new duties to establish and monitor standards, to approve programs, to inspect and ensure compliance, and to collect data. Other state or local agencies may also be uneasy, but the patterns are unpredictable.

Various state agencies reported difficulty with the following powers and duties:

- commitment laws;
- clients committed to state agency custody;
- mandatory medical powers possessed by agency;
- agency mandated but not funded to provide treatment;
- licensing/regulation of treatment facilities;
- preference for voluntary services;
- emphasis on outpatient services;
- program standards (monitoring and evaluation); and,
- local accountability to state agency.

Many states have caused difficulties with implementing their legislation by failing to provide new staff to the state alcoholism agency. The pattern of understaffing was clear--especially in a lack of field personnel to work with local programs, and of data experts. Agencies desired small numbers of extra staff, and their needs seem real if they are to implement all the powers and duties assigned to them by the Act.

Citizen's Advisory Council

All interviewed states had created the required Citizen's Advisory Council. Most found it useful, for a large variety of purposes. Contrary to the Act's recommendation, there was a general lack of researchers on such Councils.

Interdepartmental Coordinating Committee

The Act calls for creating a committee of representatives from public health, mental health, education, public welfare,

corrections, highway safety, public safety, vocational rehabilitation, and other appropriate state government agencies.

Many states have found these agencies coy, and only a small majority of states have an operational Committee, though a large majority thought it "worth the effort." Despite skepticism from a minority, most states want better coordination of state departments and of federal departments and programs.

Program Standards

The Act calls upon states to set standards for treatment programs. Activity in this area is not particularly high; half the interviewed states reported large gaps. Many have either no guidelines and standards, or token standards only. Confusion and caution are the cause, not neglect. Most states indicated that national-level assistance could help here, especially by promoting the exchange of standards and guidelines from state to state.

Program standards within a state are not always those envisaged by the Uniform Act, even in the case of minimum standards. Moreover, many local treatment programs are not yet meeting state standards, and there are clear operational difficulties in the Act's standards concerning the preference for voluntary treatment; no denial of treatment because of withdrawal or relapses; individual treatment plans; and continuum of treatment services.

States disagree as to whether there should as yet be strict evaluation of compliance, which might be premature, demoralizing, and beyond the capability of fledgling local programs. There should be better promulgation of existing standards, since many local personnel did not know or had forgotten they existed.

The one area of non-compliance which raised strong feelings involved hospitals, where cooperation is generally weak. Almost all states had experienced truculence from hospitals, which had been lessened in some cases by education or special funds. In other cases, the state alcoholism agencies are ready to have DHEW take action under P.L. 93-282 and P.L. 94-371 to threaten hospitals with the loss of all federal funds if they continue to refuse to obey the law.

The general issue of enforcing standards creates uneasiness in most state alcoholism agencies. They see great opportunity to seek improved quality in a profession where people have long merely been content that anything at all was being done, but they do not want a Big Brother role.

SECTION 5: COMPREHENSIVE AND COORDINATED TREATMENT

All states agree that the Uniform Act's requirement for "a comprehensive and coordinated program for the treatment of alcoholics and intoxicated persons" is at least as important as its call for decriminalization. The issue is whether any state has approached achievement of that ambitious goal as yet.

Effects of the Act

Though many states were previously moving toward creation of a statewide comprehensive and coordinated treatment program, the Act itself was widely credited with having had a major impact on state plans. Further, almost all states indicated that the Act had had special influence on state plans for public inebriates. Only those states where legislation was not accompanied by appropriations indicated little or no effect from the Act.

Asked where the strengths and weaknesses of their comprehensive and coordinated programs lie, all states indicated some weaknesses. Strength is more frequent among emergency medical services, detoxification centers, in-patient and residential care, outpatient care, and variety of facilities. Weaknesses lie mostly in prevention, follow-up, sleep-off, and transportation, only one of which (follow-up) is named as a high priority by the Act. However, there is no universal pattern.

Asked about their responses to the various avenues by which an alcoholic may enter treatment, most states were satisfied with their systems for handling voluntary clients, those in crisis, and those committed involuntarily (though there were weaknesses even here). States were generally less happy with their response to those in protective custody or under emergency commitment, and almost all states were dissatisfied with their response to those who need long-term care.

A majority of states indicated that the subgroup of habitual public inebriates is getting services at the expense of other alcoholics who need or deserve them more, but this means they believe not that the public inebriates are receiving too many funds but that other groups are receiving too few. The Act itself is <u>not</u> seen by a majority as having created any inequities (though a minority believes that it has).

In sum, the Act has valuably stimulated activities in a few specific elements of the treatment continuum, especially detoxification centers, and to a lesser extent outpatient services. Disappointingly few states indicated that the Act had strengthened such elements as emergency civilian patrol, transportation, sleep-off, follow-up and referral, and prevention.

Treatment Requirements and Recommendations

The Uniform Act's single most contentious subject is its call for affiliation between detoxification centers and the "medical service of a general hospital," particularly when coupled with examination by a licensed physician. The Act does not seem to have intended exclusive endorsement of this medical model, though many states have so interpreted it.

This study did not investigate costs, but many states have fiscal studies showing the medical model as much more expensive than non-hospital care with medical triage and back-up. Only one state reported the medical model as economical, though several states are attempting to follow it. Several states reported that mandatory medicalization would end their state programs because of increased costs.

All states agreed with the Act's recommendation to keep treatment programs community-based. Most states also support the Act's recommendation for intrastate regionalization, especially for administrative convenience. The most popular basis for determining program organization was a combination of general population size and political jurisdiction. No alcoholism agency recommended organization according to the size of an area's public inebriate population, though many local planners emphasized such a need.

Government and Non-Government Programs

The Uniform Act creates a major governmental intrusion into the skid rows where only police and urban renewal have previously represented the governmental presence. Traditionally, non-government sources have provided many public inebriates with most services. The Act does not recommend dissolving or replacing existing non-government services. What then has been the Act's impact on them?

In most states there has been some cooperation between government and non-government services. There has been no widespread competition, and no general decline in non-government services. The two groups seem to provide different services, often to different kinds of population. Interviews with inebriates showed that consumers seem largely more familiar with and trusting in non-government services.

However, a significant number of communities reported a decline in non-government programs, and a greater number thought there will be a decline in the future. There is a need to examine this question much more deeply, since skid rows all over the country are changing swiftly because of many factors. Rigidity of government programs could prove their eventual downfall.

Services for Skid-Row Inebriates

The Uniform Act does not require sobriety but does mandate government to provide treatment. Does this mean that the government may or should provide other than treatment services to skid-row inebriates? Should it provide services unrelated to alcoholism treatment but of the kind which this population of alcoholics needs?

For instance, most cities report the existence of Salvation Army or mission shelters, labor marts, and charity-supplied food; and some kind of shelter is available if a skid-row inebriate has a little money. However, most skid-row inebriates used to rely partly on police and jails to provide them with important and basic services: food, shelter, cleansing, medical services, etc. These are no longer generally available via the police. Further, the skid-row population has no way of protecting their money, persons, or possessions. They are prey. Is storage of personal items a legitimate government concern? banking? check-cashing? job referrals? Few program managers had previously considered the idea of protective and preventive services of this nature, but all agreed that at least the government should seek to stimulate private services in this area.

A basic issue is whether the Uniform Act encourages some alcoholics to maintain undesirable lifestyles. Treatment personnel tend to regard anything which permits someone to continue his drinking as counterproductive, but the Uniform Act does not seem to exclude lifestyle maintenance as an element of a genuinely comprehensive program, and thus even the concept of a government-sponsored "wet hotel" received support from local program managers with humanitarian and public safety ambitions for their activities.

Another important area of services lacking to public inebriates is protection of their general civil rights. In no community or state did the study team find an independent or disinterested party, either government or private, charged with this duty.

Decriminalization makes the population of public inebriates vulnerable in some new ways. There is widespread confusion as to whether the treatment provided by alcoholism

programs is the kind of treatment which the inebriates need or want, or whether it is the kind envisaged by the Uniform Act. The Act's humanitarianism could be undermined because of our continuing failure to see public inebriates as citizens with full and equal rights.

Many program managers see themselves as providing "only" a revolving door. (This may be all the Act calls upon them to provide.) On the other hand, by far the majority of program managers remain very optimistic about the probable success of their treatment programs, even on the basis of their present experience with inexperienced and underfunded programs. Asked whether the public inebriate population receiving treatment would or would not show substantial improvement, most program managers judged that a third to a half of them would, and a third to a half of them would not. Asked if the inebriates would do better if greater treatment funds were available, most program managers remained pessimistic about only 25% or less of them--a proportion much smaller than traditional expectations in the alcoholism profession.

Most program managers felt that their referral processes and long-term treatment programs were causing unnecessary "failures," and at present only a few programs manage to keep "many" public inebriates in long-term counseling programs either inpatient or outpatient.

The Uniform Act's preference for outpatient counseling may be inappropriate for a large number of public inebriates. There is an evident need to develop treatment modalities appropriate to different elements of the public inebriate population (e.g., on one hand the derelicts, on the other regular inebriates with families and possessions; or inebriates in small towns and those in large urban areas; or those who stay in one community and those who travel).

Evaluation of the success of public inebriate treatment programs is premature. Already, however, some demonstration projects are showing improvement rates much higher than expectations.

Summary

The Act's requirement that a state establish a comprehensive and coordinated treatment program seems reasonable. Most states reported success in establishing such programs (even for public inebriates) as long as funds were available. Most but not all states indicated a need for more funds. Most states indicated a lack of appropriately trained personnel, and

many reported a lack of concern at the community level. Most states reported that the burden of implementation--taking the initiative--would rest on the state alcoholism agency, and that leaving things to local option was not satisfactory.

SECTION 6: IMMEDIATE SERVICES

Transportation

Pick-up and transportation of public inebriates was previously the responsibility of police. Decriminalization changes the process profoundly, altering the nature and reducing the number of contacts between police and inebriates. General disengagement on the whole satisfies both sides, but major problems remain.

The police remain the major social agents for identifying and transporting inebriates in need of care. Though there is a widespread preference for using an emergency civilian patrol, most people freely recognize the value of police performance in this area. Both ambulance and contract taxi service are widely regarded as too expensive, though used economically in a scattering of jurisdictions and worthy of closer scrutiny. The Uniform Act's preference for an emergency service patrol is seen as difficult to fund.

Police have saved a lot of time by transporting fewer inebriates. Some patrolmen resent having to take inebriates home ("free taxi service"), while others prefer this to jail. In some decriminalized communities, "drunk wagons" still pick up inebriates on schedule, transporting them to a treatment center. In some communities, even incapacitated inebriates are ignored by some patrolmen.

County sheriffs report and resent increased transportation needs and costs when a detoxification center is much more distant than a local jail. Decriminalization is working poorly in such cases; transport to the local jail remains usual.

The entire issue of transportation problems and solutions merits study from the national level.

Police Discretion

Decriminalization increases the number of choices available to an officer encountering an inebriate, in particular by distinguishing between an intoxicated person and an incapacitated person. In this area, there is no standard national policy viable at the level of street operations, and some local policies clearly circumvent the intentions of the Uniform Act. Many enforcement agency guidelines and district attorney guidelines are clearly erroneous. Police are confused, and inebriates receive different handling in neighboring jurisdictions. There are inherent conflicts between the Uniform Act's intention to provide voluntary treatment and the police need to maintain public order.

There is, however, very little distrust of present police operations. In most jurisdictions the police are glad to provide treatment rather than jail where processing is comparatively simple. There are a few complaints about police abusers of their discretion, but no substantial anxiety.

Police/Treatment Relationships

Contrary to earlier expectations, the police endorse the idea of treatment for inebriates and are glad to "get out of the drunk business." Some officers everywhere still believe that arrests and jails are better, but only occasional police agencies oppose decriminalization in theory. There are however many problems at the operational level.

Detoxification centers do not usually process persons as quickly as do jails, (though more quickly than hospitals), and unlike jails they may refuse someone brought in by an officer. Improvements in procedures and in the capacity of detoxification centers are needed in most urban areas. This subject deserves national attention.

Detoxification centers and hospitals continue to rely on police help when an inebriate is disorderly, thus using the time of patrol officers to perform functions previously belonging to jailers. The common alternate solution to disorderliness is the use of sedative drugs, though most program personnel believe that training in verbal counseling is medically safer and as effective. There is a clear need for more such training at the local level.

Medical Screening

Most program managers find that only about 5% of their public inebriates require emergency medical response, but the Act calls for medical screening of all persons. Examination by a licensed physician is regarded as neither necessary nor possible nor desirable as a universal policy by most program managers (though a minority disagrees). Most program managers want a medical triage decision, which could be made by any appropriately trained personnel.

Program managers are concerned about the emergency medical responses given at hospitals. Many emergency room staff do not have training which is alcoholism-specific, and they are thus ignorant of the special medical and medication needs of alcoholics.

Medical screening still often occurs within jails, under varying circumstances. Drunk tanks still exist in many communities (though handling smaller numbers). Though they

usually offer some medical screening, their medical response is rarely alcoholism-specific. (A few jails possess model programs.) Horror stories of alcoholics dying or suiciding in jail continue to circulate. Large jails tend to have nursing staff, medical back-up, or medically trained jailers, but they do not claim adequacy for their treatment services.

Many jails are used as the locus for detoxification centers. Although alcoholism program managers want to dissociate detoxification centers from jails, many communties will not provide funds for a separate facility. Thus alcoholism program personnel, cooperating with jails because they have to, try to bolster them by insisting on medical scrutiny before admission or requiring medical back-up or training jailers in alcoholism as well as emergency medical services. Some jails rely on or employ alcoholism-oriented staff.

However, the relationship between jail and detoxification remains unclear and uneasy. Jail-based detoxification centers do not provide more than immediate medical services and so cannot achieve a treatment spectrum. Referrals are very rare. Release is rapid. Further, whereas alcoholism personnel see detoxification centers as merely the locus where treatment begins, both police and community managers see them primarily as alternatives to jail. Each attitude demands a different set of procedures and philosophy. The area needs further analysis from both state and national authorities.

Hospitals

Hospitals are not as heavily involved in providing emergency services to public inebriates as the Uniform Act envisaged, though they have become more involved than before and in some areas are the mainstay of the system. Cooperation has often been reluctant and depends on the policy of individual hospitals more than the Act contemplated. Many problems remain in many jurisdictions.

The major problem is payment for treatment. Most hospitals are reported as refusing indigent intoxicated persons treatment, and all involved hospitals report increased costs.

Crowding of emergency rooms and increased disorderliness also discourage cooperation, as does pessimism about treatment success. Alcoholism professionals report that special alcoholism training is essential for hospital staff. Creation of a special receiving station separate from the regular emergency room is also a frequent solution.

There is much anxiety that the special symptoms of alcoholism withdrawal, and the interrelationships between alcohol-addiction, other medical problems, and medication, are not familiar to most hospital staff, including physicians.

With notable exceptions, hospitals nationwide have not yet decided to cooperate fully or professionally with the special medical needs of public inebriates and do not yet respond to that population's needs or to the desires of the Uniform Act. In reaction, many alcoholism programs are abandoning cooperation with hospitals, or contemplating enforcement of federal statutes against them, though most programs are still ready to try education and negotiation.

Detoxification Centers

There has been a mushrooming of independent detoxification centers throughout the country. They seem to be increasing in professionalism and autonomy.

Their major strength is their low cost--almost as cheap as jails, much cheaper than hospitals. Their major weakness is the quality of alcoholism treatment they provide, and many have gained reputations as revolving doors.

Most detoxification centers have a strong medical orientation, based on the use of nursing staff, triage, and back-up from physicians or hospitals. All report this "quasi-medical" structure to be successful and economical. There are great variations in the degree of their medical orientation (e.g., some dispense no drugs, others dispense drugs to all clients; some have physicians examine all clients, others none).

Attitudes of detoxification center staff toward their clientele, and toward the objective of their programs, also vary widely. They differ over preference for self-referrals or police-referrals. They often show skepticism about their clients' motivation in coming to them. But they tend to be optimistic about the probability of their client's achieving sobriety (currently estimating that more than half of their clients will do so). Their morale is usually high.

On the whole they are cooperating appropriately with both hospitals and police. But a major problem is lack of capacity, causing many centers to turn away clients and thus disillusion either the clients or the police. There are problems with centers refusing admission to clients who have previously received treatment, contrary to the policy of the Act.

The nature and purpose of the "treatment" provided by detoxification centers varies widely. They all do everything that the jails did, and more, and their clients stay much longer than they did in jails. After that, however, goals for treatment vary, drastically affected by (a) capacity, and (b) success in convincing clients to stay. There is no universal philosophy as to what detoxification centers ought to be doing, and the issue requires attention from both state and national agencies.

It cannot yet be said that detoxification centers are usually serving as either complete alternatives to jail or as successful intake and referral centers, but success in both capacities seems probable in the future.

The degree of comfort provided by detoxification centers is much superior to that of jails, but it is certainly not luxurious. Only food and drink; beds; bed-sheets; and pajamas, gowns, and slippers were identified as essential equipment. The centers' needs and wishes for their clients are very modest, and they show a legitimate desire to create a new health care alternative at reasonable cost. This they are doing.

Another problem is the degree of voluntariness emphasized by the Act. Since clients can leave when they wish, police and center staff both complain about the revolving door, and the centers need ingenious ways of persuading clients to stay voluntarily. Most people believe that a client should stay about 72 hours, and average lengths of stay tend to be in that vicinity.

Special Populations

Weaknesses exist in the immediate services offered to certain subgroups of the public inebriate population. There are special difficulties in communities with nearby populations of Native Americans. These problems deserve attention because costs of providing services to non-residents discourage counties from fully operating programs. They require solution at the federal, state, and local levels.

Other problem subgroups are females and juveniles, who require different patterns of response from the majority of public inebriates and who are not getting parallel services in most communities.

The most difficult subgroup is that of the chronic repeaters. Their emergence as a subgroup with different dynamics and needs from the majority of public inebriates is perhaps one of the most significant effects of decriminalization.

Their number is not large (perhaps some 10 to 25% of the public inebriate population), but they place a disproportionate burden on all services. There is some evidence that they may eventually be screened out of the system. Alternatively, their needs may unduly distort the programs and philosophy of the overall decriminalization effort. Special studies of this subgroup and possible responses to their nature and needs should be undertaken.

There is an essential and urgent need to create a nationwide population profile of the public inebriate population if treatment programs are to be made suitable to that population, which is more diverse than expected.

SECTION 7: CONTINUING INVOLUNTARY CARE

The Uniform Act softens its requirement for voluntariness only in cases of protective custody for incapacitated individuals; emergency medical attention longer than the brief period of protective custody; and long-term custody of certain carefully demarcated subgroups. The latter two subjects--emergency commitment and involuntary commitment--are two of the least "uniform" of the Act's provisions as embodied in state legislation. Some states have accepted the Act's commitment provisions verbatim. Others have modified them to suit local needs. Many rely on preexisting mental health commitment procedures.

The Uniform Act shows full concern for the "due process" clause of the 14th Amendment to the U.S. Constitution. Substantive due process precludes involuntary control of an alcoholic's life by the government unless there is a compelling state interest (e.g., assisting those unable to help themselves; protecting the public from threats of harm). Procedural due process demands that certain procedures protect an individual from unjust confinement against his will. There is also emerging law on the right to adequate and appropriate treatment of persons so committed. The current thrust is clearly to protect the rights of alcoholics from deprivation of liberty except under narrowly prescribed circumstances.

Most questioned states did not know how often their commitment laws and procedures are being used for alcoholics. Some states reported rare or infrequent use, while a few reported extensive use. Some states, even when officially decriminalized, still base a considerable number of commitments on police-initiated charges for alcohol-related offenses.

Emergency Commitment

In the Uniform Act, dangerousness and incapacitation due to alcoholism are the only grounds for emergency commitment. Most responding states agreed with these grounds, though there was considerable sentiment for adding "danger to self" (rather than only "danger to others") as a legitimate extension. States often also chose "severely impaired judgment" as a basis for incapacitation leading to possible emergency commitment.

Procedurally, the Act recognizes the need to allow for fast action in emergency commitments, and therefore allows the administrator of an approved public treatment facility to make an emergency commitment decision upon written application by any responsible person and accompanied by a supporting physician's certificate.

Half the responding states make their emergency commitment decisions in this way, while in most of the remainder the decision goes to a court and in at least one state it is made by a physician. Court-oriented states reflect a traditional trust in the court's power to protect patient rights as more important than a speedy response through an administrator.

The Uniform Act places a five-day limit on emergency commitment, and most states choose that limit or less and also agree that it is appropriate.

However, state and local personnel are generally very ill-informed about their statute's provisions for emergency commitment. Persons therefore often grow disgusted that inebriates are released "too quickly" or "not confined at all." Program managers agree with the need to educate the public, merchants, police, and others concerning the narrow limitations on emergency commitment in order to lower the level of irritation, and state alcoholism agencies agree that program administrators need better education as to their powers, responsibilities, and limitations.

Although all states report general satisfaction with their emergency commitment procedures, they all also report dissenting groups in their states; for instance, committing judges, police, state alcoholism agency, treatment agencies to which commitments are made, and the alcoholic population. Most complaints found either the procedures too cumbersome or the duration too brief. There was some dissatisfaction with the quality or behavior of the agencies treating committed persons, and some states indicated their present procedures are "unworkable." In comparison with state variants, the Uniform Act's provisions stand up extremely well, solving almost all objections to the variants.

There were three other areas of concern. Many state alcoholism agencies had had inordinate trouble in revising their emergency commitment statutes, finding the process of working with the legal profession very time-consuming. Other states expressed the belief that emergency commitment could be used to circumvent decriminalization, though no state reported this as occurring. Finally, there was general agreement that the state alcoholism agency should ensure that patient rights are safeguarded both in general and in individual cases, by continuing to monitor the commitment process.

Involuntary Commitment

The Uniform Act allows for the long-term involuntary commitment of persons who are both alcoholics and likely to inflict physical harm on others or who are incapacitated by alcohol. That is, only alcoholics who are dangerous or incapacitated may be committed involuntarily.

Respondents agreed with these grounds for involuntary commitment, but they also added two others not included specifically in the Uniform Act. "Danger to self" was widely regarded as a justified ground, and may be implied by the Act under "incapacitation." The second popular addition, however, is not envisaged by the Act: "repeated conviction for alcohol-related offenses" and "number of contacts with police, jail or detoxification center." Such criteria for involuntary commitment show an orientation toward the "habitual offender" approach specifically not endorsed by the Act, and states which use number of convictions, contacts, or arrests as a basis for involuntary commitment are not complying with the spirit of the Act.

Under the Uniform Act, only a judge can order involuntary commitment after a timely hearing, for determinate periods of time up to an eventual maximum of 210 days. The only element of this pattern apparent in all states was formal involvement of the court. Periods of commitment varied widely from state to state (though none exceeded 210 days). Further, state program directors differed as to what they considered desirable periods of commitment. Thus there is no consensus or theory pervasive through all states, and there is opportunity here for thoughtful legal/medical research. Nor does it fit the intentions of the Act that a person should be subject to different periods of involuntary control according to one's place of residence. The uniformity of the Act needs strengthening here, for the sake of equity.

The same groups are dissatisfied with involuntary commitment as are dissatisfied with emergency commitment, especially the judiciary. The main cause is the cumbersomeness of procedures, a quality which may lessen usage as time passes. The police, the state alcoholism agencies, and the alcoholic population were also reported as dissatisfied with present policies or procedures.

The Act specifies a long list of patient rights under involuntary commitment. Almost all (but not all) state program directors indicated that their statutes are in compliance. However, scrutiny of such statutes from the national level

seems desirable, and at the state level the alcoholism agencies might appropriately work with legal counsel to disseminate accurate guidelines and other information.

Involuntary commitment was not reported as being used to circumvent decriminalization. However, in some states it can be tied to arrest or conviction for alcohol-related charges, which does not conform to the spirit of the Act. There was also some sentiment among interviewees that involuntary commitment was either (a) being used to warehouse recalcitrant alcoholics, or (b) serving as a means for coercing treatment. Some local treatment personnel, some judges, and many police strongly supported the idea of using involuntary commitment as a method for coercing treatment. The degree to which commitment is being so used, and the strength of sentiment concerning it, was not measured by the study.

The major problem worrying almost everyone is what to do with the chronic repeaters. Most state program directors reported that the state mental health hospital is their ultimate back-up facility for such persons, though many states now rely on the local alcoholism facility, whether inpatient or outpatient. Asked whether there should be somewhere for the involuntary residential and/or custodial care of habitual drinkers who do not give up drinking, a majority of program directors (both state and local) uneasily favored the idea. They would prefer voluntariness. But they almost all want some form of domiciliary control. This is a major area for national policy attention.

SECTION 8: ADVICE ABOUT IMPLEMENTATION

Enactment to Implementation

Responses from state alcoholism agencies in states which have Uniform Act legislation indicate that the slowest provision to implement is creation of a coordinated and comprehensive treatment program, at both state and local levels. Many states are also having trouble with state regulation of treatment facilities, examination by a licensed physician, and commitment procedures. Individual states have problems in other areas.

Many states have as yet failed to implement three provisions:

- Interdepartmental Coordinating Committee;
- regionalization (an option chosen by only half the states); and,
- emergency service patrol.

Most states reported that creation of the state alcoholism agency, the Interdepartmental Coordinating Committee, and the Citizen's Advisory Council can be accomplished speedily, and that at the other extreme creation of the coordinated and comprehensive treatment program takes more than two years. All other provisions of the Act were judged as taking anywhere from "no time" to "longer than two years," so clearly there has been a wide variety of state experience and priority.

All states recommended a period of advance planning between enactment and implementation, and if possible prior to enactment. Many states advocated implementing as many changes as possible by administrative action prior to enactment.

In sum, a state alcoholism agency can count on spending two years of intensive effort implementing the Uniform Act, at the end of which period it will still have problems, especially in establishing the continuum of treatment services.

Asked which of the Act's provisions were not worth the required level of effort, only one was singled out. Fewer than half the responding states thought the effort at ensuring examination by a licensed physician of all inebriates was worth the trouble it took.

All states recommended that the state alcoholism agency be deeply involved in the process of enacting the original legislation. Disagreement occurred, however, over the best strategy to follow at this time.

Most states advocated passage of the entire Uniform Act at one time and with only minor amendments, and they recommended unanimously against the piecemeal process which had occurred in several states. Their strong advice was to stick to the Uniform Act as a package. However, many states disagreed about what to do concerning decriminalization. Most states recommended a formal delay for decriminalization to be included in the original legislation. They reason that formal enactment coupled with formal delay forces and enables everyone to face up to the situations brought about by decriminalization. But a significant number of states felt that faster and better solutions would appear if decriminalization was implemented immediately after enactment, because of public reaction.

Asked what role state alcoholism agencies should play after enactment, all states recommended swift attention to the issuance and monitoring of guidelines and standards. Most states favored then concentrating efforts on special target groups among the population statewide, and they advised against instead concentrating on selected high-population areas first.

Most state alcoholism agencies recommended providing selected treatment components statewide, especially detoxification centers, as a first move in the treatment field, and they recommended the use of state funds for this move.

Almost all state alcoholism agencies advised against attempting to take a passive role. The initiative, they felt, must come from the state alcoholism agency rather than the community at first, and important areas for original activity were input into the legislative process and conduct of a widespread public education campaign about decriminalization.

Advance planning emerges as a major virtue in the eyes of those states which have decriminalized. Most believe that they did not do enough, and they tended to recommend one to two years of planning before implementation, especially for creating the comprehensive and coordinated program.

As to the long-term structure of treatment services, all states recommended bolstering existing local agencies with government funds, and all recommended against separating public inebriate programs from other local treatment programs. There were many other suggested strategies dealing with long-term structure, but no national consensus.

States which have decriminalized saw three main obstacles to implementing the Act's provisions:

- inadequate funding;
- inadequate treatment programs or facilities; and,
- lack of advance planning.

Funding Problems

Almost all states recommended that at the time of enactment the legislature should be provided with accurate fiscal projections of the cost of implementation, based on the need for services, and including analysis of the cost of the present arrest-based system. Some legislatures have refused decriminalization as a result of these projections, but the state alcoholism agencies firmly believe that honesty is the best policy nonetheless.

A large number of states also favored enacting the legislation even without funds, believing that they would later become available. They also recommended strongly in favor of separating costs associated with public inebriates from other costs of the Act. In almost half the decriminalized states, legislatures had failed to appropriate funds at the time of enactment, but in all but two of these states funds had since been voted. This occurred largely because the spectacle of unfunded decriminalization creates pressure of public opinion which the alcoholism lobby then uses to work on the legislature with the help of key executive and legislative personnel.

Lack or inadequacy of appropriations is the sole stumbling-block to enactment of decriminalization in several non-decriminalized states. Most decriminalized states recommend against enactment without funding. (A quarter of them, however, advise going ahead regardless.) The role of federal incentive funds in this situation merits careful study.

After enactment, the group most likely by far to have difficulty with the costs of decriminalization is "local government leaders." Most communities expect to save money through decreased criminal justice system costs and are reluctant to provide treatment funds for the public inebriate population. Legislatures and state executives are also apparently increasingly wary of the costs of decriminalization.

Cost data of any kind are very difficult to find in this area, though some local communities have greatly advanced the

state-of-the-art. Opinion nationwide indicates rough estimates that with the Uniform Act criminal justice system costs decrease, existing health care costs remain stable, and only the new services cause increased costs.

Since new state-legislated services require the majority of new costs, in most states the communities expect the state to fund the new services. Local government is reported in most states as bearing less than 10% of the costs of new public inebriate programs, and in only one state is the proportion higher than 25%.

Local funds have traditionally paid for almost all social services to public inebriates (e.g., police, jail, medical treatment). All states agree that this should continue to be so, that federal funds should be limited to initial costs, and that established programs should be a mixed state/local responsibility. Public inebriate programs have become so quickly established that almost all decriminalized states envisage incorporation of the programs into the regular expenditures of state and local government, and most states anticipate increases in long-term state funding, and even in local government funding. Local government leaders disagree.

There is also a widespread and growing support for a special "user tax" on liquor as the best and perhaps only long-term solution to the funding of treatment programs.

There needs to be much deeper exploration for funding sources other than alcoholism treatment funds. Many program personnel point out that as a result of decriminalization, alcoholism moneys are expected to fund services which have more to do with public order, public safety, and public convenience than with alcoholism treatment.

Alternative sources are not everywhere being thoroughly investigated. For instance, some states find that many public inebriates are far from impoverished and can in fact reimburse alcoholism programs as they reimburse other medical programs, but most communities seem unaware of their population's financial potential (especially from various governmental sources).

There was much sentiment that some criminal justice funds should be allocated to public inebriate care. Alcoholism funds are now paying for services previously paid from the criminal justice budget, and some believe that the savings should be transferred. Asked for examples of communities where criminal justice funds had been thus reallocated, not one state could come up with a single example, although

all states report that small sums of federal and state criminal justice funds are going to some public inebriate programs. Clearly there is a disjunction between national and local policy in this area, and it would seem profitable for federal, state, and local planners to examine the subject further.

RECOMMENDATIONS AND SUGGESTIONS OF STATE ALCOHOLISM AUTHORITIES RESULTING FROM THE IMPACT STUDY OF THE UNIFORM ALCOHOLISM AND INTOXICATION ACT

RECOMMENDATIONS AND SUGGESTIONS OF STATE ALCOHOLISM AUTHORITIES RESULTING FROM THE IMPACT STUDY OF THE UNIFORM ALCOHOLISM AND INTOXICATION ACT

The purpose of this document is to provide recommendations and suggestions which indicate SAA priorities concerning future activities related to the Uniform Alcoholism and Intoxication Treatment Act (Uniform Act) to legislators, federal and state; SAA colleagues; the National Institute on Alcohol Abuse and Alcoholism (NIAAA); other federal, state, and local policy makers; and the Council of State and Territorial Alcoholism Authorities, Inc. (CSTAA) staff. It is the product of a Task Force of State Alcoholism Authority (SAA) directors. The Task Force includes states in varying stages of enactment and implementation of the Uniform Act.

The observations, recommendations, and suggestions that follow are based upon the findings of the impact study reported in the Guidance Manual for Implementation of the Uniform Alcoholism and Intoxication Treatment Act and the Executive Summary. The Task Force met twice to review these documents and concluded that the study was so well done and these two documents so well written that we want to ensure the effort has not been in vain. We are determined that this effort will not result in just another report to be praised and put on the shelf to gather dust.

In the following pages are the general observations, recommendations, and suggestions of the Task Force. Wherever possible, we have indicated the specific targets of the recommendations and suggestions. By general observation, recommendation, and suggestion we mean:

- General Observations

  While the Executive Summary addresses the many observations and conclusions drawn from the impact study there are some which are of more immediate concern to SAAs at this point in time. These are lifted here for presentation. The general observations will be followed by appropriate recommendations and/or suggestions.

- Recommendations

  The recommendations proferred are intended to be strong requests for immediate or near future action by the group(s) to which they are addressed. Usually they deal with policy issues which need resolution or program concepts for implementation.

- Suggestions

  These are suggestions to colleagues from ones who "have been over the road" and noted "bumpy places and muddy spots" which should be avoided if possible.

I. GENERAL OBSERVATIONS

Incentive funds are not available until all the provisions of the Uniform Act are in place, including decriminalization. In practice, it is necessary that the treatment system be planned and in place before decriminalization can take place. It would be helpful to states if the incentive grants could be authorized to assist in the build-up period.

Recommendations

1. It is recommended that the 95th Congress consider an amendment to Section 304 of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970, which would authorize the National Institute on Alcohol Abuse and Alcoholism to make Special Grants for Implementation of the Uniform Alcoholism and Intoxication Treatment Act (Incentive Grants) to those states where the intent of the Uniform Act has been met by all the required legislation excepting the implementation of the decriminalization provision

[Sec. 304(b)(1)] and where that implementation date is set in the legislation not more than one (1) year in advance of the date of approval for such incentive grant.

2. NIAAA should support the request by the states for "front-end" funding with the incentive grant monies through DHEW.

Suggestions

1. CSTAA should poll the states not now implementing the Uniform Act to determine the probable impact of such a change in the legislation: would the change, if enacted by Congress, result in how many more states passing and implementing the Uniform Act.

2. Staff should prepare relevant material to be made available to appropriate committees and witnesses.

II. GENERAL OBSERVATIONS

While there is general support for the Uniform Act there are several areas of confusion as indicated in the impact study reports (Guidance Manual and Executive Summary). The areas of confusion seem to be state specific and issue particular rather than the Act in general. Therefore, there is a need for a national coordinating group to work through the individual problems with the states affected.

Recommendations

1. NIAAA should work through CSTAA as the natural forum and vehicle for the coordination of state activities in relation to the Uniform Act. To this end, NIAAA should consider funding staff requirements to provide coordination and technical assistance to states in matters relative to the Uniform Act.

2. CSTAA should build on the present in-house capabilities to expand their capabilities to provide specific technical assistance to states contemplating enacting the Uniform Act and/or experiencing implementation problems with the Act.

3. CSTAA should develop alternative funding sources to continue its ability to provide Uniform Act technical assistance beyond the level of NIAAA funding (e.g., state technical assistance contracts for feasibility studies, etc.).

4. CSTAA should begin immediately to establish mechanisms for interagency cooperation among SAAs and State Criminal Justice Authorities (SCJA) by:

- Identifying common problems
- Developing model cooperative standards for SAAs and SCJAs

Suggestions

1. States planning legislation and/or experiencing implementation problems ought to seek assistance first from CSTAA.

III. GENERAL OBSERVATIONS

When the Uniform Act is fully implemented the treatment community is faced with the problem of providing transportation for the public inebriate. Prior to decrimilization the program's clients provided their own transportation. Public inebriates, especially the chronic public inebriates, typically have no personal means to get the the place of treatment. Since they are no longer the responsibility of the police department they often must be transported by the treatment program or other SAA sponsored provider.

Recommendations

1. CSTAA should conduct studies to:

- Determine what is being done by states to provide transportation to public inebriates.
- Identify the police department's role in transportation of public inebriates.

2. CSTAA should work with a variety of states to develop innovative alternatives to SAA or the program supplied transportation (e.g., utilization of regional transportation systems for multiple use including the public inebriate program).

Suggestions

States who have developed or are negotiating to develop innovative approaches to the transportation should share their experience with other states through CSTAA.

IV. GENERAL OBSERVATIONS

Since the public inebriate is still visible in the community and since merchants, public officials, and the general public continue to call upon the police to "handle" them, the SAA needs to be sensitive to the needs of the law enforcement community.

Recommendations

1. NIAAA should fund a definitive study on the entire question of protective custody--its nature, intent, and use.

2. NIAAA should continue to cooperate with LEAA and other Federal agencies to develop model implementation guidelines for the use of police departments.

3. CSTAA should establish a cooperative Task Force with the International Association of Chief's of Police to develop a study on the vulnerability of police officers in handling public inebriates.

4. CSTAA should establish a cooperative study group with other interested agencies to investigate the nature and use of substitute charges to circumvent the decriminalization provisions of the Uniform Act.

V. GENERAL OBSERVATIONS

As a state implements the Uniform Act and roles of the criminal justice system, the law enforcement system, and elements of the health care delivery system change to meet the new law members of these systems need training and education assistance to prepare them for their new roles.

Recommendations

NIAAA and CSTAA should negotiate interagency cooperative arrangements with appropriate federal agencies and other national groups and associations to develop training and educational packages for:

- CJS on Uniform Act provisions,
- Law enforcement system on Uniform Act provisions,
- Police personnel on intervention in social crisis strategies,
- Non-medical personnel in alcoholism programs and emergency services in emergency procedures encountered in the treatment of alcoholic,
- Movitational and crisis intervention techniques for CJS, law enforcement, and health care personnel.

VI. GENERAL OBSERVATIONS

The emphasis on voluntarism is a necessary safeguard to the civil rights of the public inebriate. At the same time, the complete freedom of an individual to leave treatment at his own discretion tends to transplant the revolving door syndrome from the jail drunk tank to the alcohol treatment program. Effective means of dealing with this population need to be explored from several stances.

Recommendations

1. NIAAA should fund demonstration projects in such areas as hostels, wet-farms, dry-farms, use of non-health care facilities, job banks, etc.

2. States should fund in-state and/or interstate long term treatment and maintenance facilities demonstration projects.

3. CSTAA should compile an experience bank from individual states for interstate sharing of information and technology concerning:

- Emergency commitment procedures
- Involuntary commitment procedures
- Legal challenges to emergency and involuntary commitment procedures

Suggestion

If Congress holds hearings or does any study on the impact and/or efficacy of the Uniform Act, the entire question of voluntarism versus involuntarism should be investigated in more depth.

VII. GENERAL OBSERVATIONS

There is a real need for a uniform statistical system at the national level which will assist NIAAA and the states in measuring the results of the treatment systems' successes in dealing with public inebriates. One of the by-products of the incentive grants for implementation of the Uniform Act is that there is enough similarity across the implementing programs to provide several sets of base line information.

Recommendations

1. NIAAA should fund a project to include the following data sets in the MIS collection systems:

- Develop a system of cost elements for the Uniform Act
- Determine a nationwide profile of chronic public inebriates
- Determine state-by-state staffing patterns for Uniform Act program components

2. CSTAA should begin a study to determine cost-effective and cost-benefit data of the Uniform Act for the treatment system, courts system, and law enforcement system.

3. CSTAA should survey all the states to determine the nature and extent of the perceived public inebriate population in the country.

VIII. GENERAL OBSERVATIONS

The stated purpose of the Uniform Act is to remove public inebriates from the criminal process and to bring them into treatment. In order to qualify for an incentive grant a state must be able to show that it has a comprehensive and coordinated prevention, treatment, and rehabilitation program in place. There is an implication that this will assure quality care to the alcoholics and alcohol abusers who enter into the treatment system. Credentialing mechanisms (licensing, certification, and accreditation) are tools which may aid in assuring that the best possible conditions exist to provide quality care.

Recommendations

1. CSTAA should place more emphasis in providing states with technical assistance in establishing regulations and standards for credentialing:

- Licensing of facilities and programs--especially non-hospital based programs
- Accreditation of hospital based programs
- Certification of personnel

2. States should endeavor to have their credentialing process in place either before implementing the Act or during the first year of implementation.

3. CSTAA should make technical assistance available to states to aid in the development of the necessary enabling legislation for credentialing.

IX. GENERAL OBSERVATIONS

The Task Force feels that several studies should be conducted as soon as possible by NIAAA, CSTAA, individual states, or consortia of states. These are listed below with the blanket recommendation that whoever does a study should use CSTAA as the vehicle to disseminate information to the states.

Recommendations

- A study of jail based detoxification centers.
- A comparison of jail based programs with non-jail based facilities.
- Comparison of court costs for dealing with public inebriates before and after implementing the Uniform Act.
- Study the utility of state Interdepartment Coordinating Committees.
- A comprehensive and intensive study of funds spent by non-alcohol agencies for alcoholism services on both federal and state levels.
- A national level study of the cost of decriminalization with treatment as compared to the costs of arrest and jail.

X. GENERAL OBSERVATIONS

When a Task Force completes its basic task the remaining task is to self-destruct. Officially, when this document is appended to the Executive Summary, we have completed the task for which we were constituted. The suggestions and recommendations addressed to CSTAA we commend to the Board of Directors of CSTAA for their action and assignment to staff. We also request that the Board instruct the staff to monitor developments relating to the other recommendations and suggestions.

CSTAA

COUNCIL OF STATE AND TERRITORIAL ALCOHOLISM AUTHORITIES, INC.
1101 15th Street, NW, Suite 206, Washington, DC 20005

REPORT ON THE IMPACT STUDY OF THE UNIFORM ALCOHOLISM AND INTOXICATION TREATMENT ACT

VOL. 2 GUIDANCE MANUAL FOR THE IMPLEMENTATION OF THE UNIFORM ALCOHOLISM AND INTOXICATION TREATMENT ACT

$15.00

GUIDANCE MANUAL
FOR
IMPLEMENTATION OF THE
UNIFORM ALCOHOLISM AND INTOXICATION
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TECHNICAL REPORT

November 30, 1976

Prepared for

Council of State and Territorial
Alcoholism Authorities, Inc.
1101 15th Street, N.W., Suite 206
Washington, D.C. 20005

INSTITUTE FOR RESEARCH IN PUBLIC SAFETY
School of Public and Environmental Affairs
Indiana University
400 East Seventh Street
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Indiana University
400 East Seventh Street
Bloomington, Indiana 47401

Authors

Gary J. Scrimgeour, Ph.D.
Professional Studies Associates
P.O. Box 464
Bloomington, Indiana 47401

James A. Palmer, J.D.
Institute for Research in Public Safety

Research Staff

James A. Palmer, J.D., Project Director
Gary J. Scrimgeour, Ph.D.
Barbara J. Hill, R.N.
Lynn W. Buttorff, M.Div.
Grace L. Moser, M.L.S.

ACKNOWLEDGMENT

The Guidance Manual is the product of the initiative, insight, and effort of many individuals. The major contributors, however, were the administrators and staff of the state alcoholism agencies in states which have adopted some form of the Uniform Alcoholism and Intoxication Treatment Act. Five of these state agencies agreed to on-site visits during the summer, 1976, by the research staff to view the Uniform Act in operation and to interview participants involved in the implementation of the Uniform Act: state and local alcohol program representatives, legislators, consumers, criminal justice personnel, governmental managers, and many others. Their contribution was critical; those involved in the day-to-day process of making the Uniform Act work were considered best situated to relate the problems and successes of this major health-legal program.

In September, 1976, twenty state alcoholism agency directors and representatives met in New Orleans, Louisiana, to review the draft Guidance Manual. Assisting in this review process were representatives of the National Association of Counties and the U.S. Conference of Mayors, two national organizations concerned about alcohol abuse and the role of government in its control and treatment. The constructive comment from this conference was invaluable in determining the orientation and content of the final Manual.

Special thanks are due to W. Claude Reeder and Lois Whitley of the National Institute on Alcohol Abuse and Alcoholism for their support in promoting the development of this Guidance Manual.

Finally, the Council of State and Territorial Alcoholism Authorities, a service organization for the state alcoholism agencies, saw this study and the resulting Manual as a service desperately needed by states considering enactment and implementation of the Uniform Act. Thomas E. Price, Ph.D., Executive Director of CSTAA and his staff, Gary F. Jensen and Lynn W. Buttorff, aided the study team throughout in the development of the Manual. The authors and remainder of the study team are pleased to be able to present the resultant Guidance Manual, comprised of an Executive Summary and a Technical Report, to CSTAA for the use and benefit of the CSTAA constituency---the states and communities seeking an eventual resolution of our national alcohol problem.

Gary J. Scrimgeour, Ph.D.
James A. Palmer, J.D.

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Appendices

NOTE: The references to terms such as "all states," "some states," and "no states" in this text mean "among those responding to the study's questionnaire." Twenty states which have enacted laws significantly similar in policy to the Uniform Alcoholism and Intoxication Treatment Act were questioned. Some of those states did not answer all questions.

SECTION I: INTRODUCTION

INTRODUCTION

The overall project which produced this Guidance Manual was entitled an "Impact Study of the Effects of the Uniform Alcoholism and Intoxication Treatment Act." The relationship between an "impact study" and a "guidance manual" deserves explanation.

The Uniform Act was promulgated by the National Conference of Commissioners on Uniform State Laws in 1971. Its main intention was to replace the criminal justice system approach to alcoholism and intoxication by a health care approach. It was preceded by much careful work by various bodies, accompanied by other significant legislation improving the delivery of alcoholism services, and anticipated by the enactment in several states of statutes decriminalizing public inebriacy.

Since 1971, it has proven very popular. By late 1976, a majority of states and territories had decriminalized public drunkenness and passed variations of the Uniform Act itself. To assist implementation, Congress authorized special incentive funds available to those states which had decriminalized. These funds (small in amount, but worthwhile) began flowing to the states in 1975 and an increase was authorized as a result of congressional action in 1976.

Very early, a significant problem emerged. There was no single agency with responsibility for finding out exactly what was happening in states and communities--and to public inebriates--as a result of Uniform Act or similar legislation. Even the new National Institute on Alcohol Abuse and Alcoholism had no express responsibility for analyzing or implementing or monitoring the success of the Uniform Act and decriminalization. Soon, perturbing stories began to filter up from communities, and the first reports available at both federal and state level showed that decriminalization was not universally successful or popular at the local level. Perhaps worse, as the states decriminalized one by one, each state was undertaking its own planning and implementation separately. Coordination between states was informal and spasmodic, and states about to decriminalize grew eager to benefit from states which had longer experience.

In this environment, the Council of State and Territorial Alcoholism Authorities (CSTAA), by action of its Borad of Directors, determined the necessity in early 1976 to find out exactly what is happening around the country the state and community level: what has been the impact of the Uniform Act? CSTAA contracted with the authors of this Manual to

help organize the response of the states and communities. Together, we quickly surveyed available literature, and then made one-week site-visits to five states, visiting at least five communities in each state and interviewing a number of people in each community by means of a structured interview guide. We also interviewed the public inebriates themselves.

From the beginning this study was not intended to be a definitive report on the Act's impact, and it should not be taken as such. It is a collection of opinions and observations from people and communities dealing with the Uniform Act in operation, and it does not pretend even to be complete. It was also early decided to avoid statistics. Statistical data are beginning to appear in many of the areas covered by the study, but no one pretends that they are authoritative, and their appearance in a study of national scope could be severely misleading. For similar reasons, the study deliberately avoids naming individual states or jurisdictions, which might thereby be inaccurately associated with a general statement. The present document thus contains many opinions and impressions, rather than being severely factual and meticulously documented.

This does not mean it is unauthoritative. The raw information came from the people who know most about the operations of the Uniform Act. Those people include representatives of the state alcoholism agencies from some twenty states and territories, who provided both some questions and many answers during individual meetings and during a two-day group meeting conducted in September, 1976. The Manual was thus based on a simple premise: that at this moment the states which have prior experience with the Uniform Act are the most knowledgeable about the pitfalls and requirements of implementation, and they understand best both the impact of the Uniform Act and the kind of guidance which states facing decriminalization require.

The authors, however, accept full and sole responsibility for the content and opinions of the Manual. In many cases we simply acted as scribes for comments from Uniform Act states and program personnel, incorporating their observations, caveats, beliefs, opinions, and advice into the text and questions. But in other cases we have reported our own independent observations and recommendations, resulting from a thorough exposure to more Uniform Act states and programs than anyone else has yet experienced.

Our objective has been twofold. First we want to give some idea of what it is like "out there" to people who need to know what is happening, that is, policy-makers at both

the federal and the state level. Second, we hope to provide some help to states and communities facing implementation of the Uniform Act, especially decriminalization. This is why we have called it a Guidance Manual.

The Manual is organized generally according to the major policy intentions of the Uniform Act, although the first section presents information on the overall impact of the Act and the range of attitudes toward it, and the last section focuses on the major issues of implementation. The policy intentions which are reflected in this organization are:

- A voluntary, non-criminal, treatment approach to the care and control of alcoholics and intoxicated persons is desirable and required.
- Alcohol treatment programs must be planned, established, and maintained through an appropriate state agency with necessary authority and broad responsibility.
- The quality of alcohol treatment services must be assured by specifying and enforcing minimum program standards.
- A comprehensive and coordinated program of a broad range of alcohol treatment services must be established.
- Services and procedures for the immediate care and limited control of alcohol-impaired persons must be provided.
- Services and procedures for longer-term care and involuntary control of persons with continuing severe alcohol impairment (resulting in incapacitation or dangerousness) must be provided.

Each section of the Manual is divided into two basic parts: (1) questions to be answered by the user and (2) commentary presenting the insight of state and local experience on the problems raised by the questions, and identifying issues (or unanswered or unresolved problem areas) for the user to be aware of. The questions are designed to guide the user to a real understanding of the current status of a state's progress in Uniform Act implementations or a

realistic anticipation of the potential problems involved in implementation. The commentary with each section will complement the questions by providing current information on implementation from most states with a version of the Uniform Act, as well as other information the authors were able to collect from the scanty literature on the subject. The commentary will also alert the user with caveats as to those major problem areas or issues for which no one has as yet found generally acceptable solutions.

SECTION II: THE UNIFORM ACT'S IMPACT: ATTITUDES AND RESOURCES

The Uniform Act's Impact: Attitudes and Resources

QUESTIONS

1. What was the motivation of your state's legislature in passing the Uniform Act or similar legislation?

_____ Humanitarianism

_____ Acquiescence to the wishes of the alcoholism lobby

_____ Court decisions (in-state or out-of-state)

_____ Potential availability of federal funds

_____ Potential effectiveness of the treatment approach

_____ Public concern for inebriates and/or alcoholics

_____ Potential criminal justice system savings

_____ Decriminalization

_____ Motives unclear

2. Indicate (by checkmark) any of the following who have reacted unfavorably to any of the provisions of the Uniform Act:

_____ Public inebriates

_____ Existing providers of alcoholism services

_____ State executive agencies

_____ Press or television

_____ General public

_____ Downtown merchants

_____ Private service-deliverers (e.g., missions)

_____ Alcoholics Anonymous

_____ Elements of the criminal justice system

_____ Medical profession

3. What do people see as the main weaknesses in the present operation of the Uniform Act?

_____ Insufficient funding

_____ Poor handling of repeaters

_____ Poor commitment procedures

_____ Inadequate treatment facilities

_____ Reluctance of medical profession

_____ Unsightly streets downtown

_____ Dominance of the state alcoholism agency

4. Indicate which of the following groups were (A) unhappy with the decriminalization legislation at the beginning; (B) are still unhappy with decriminalization; and (C) had high expectations which have not been met.

	A	B	C
Police	_____	_____	_____
Other criminal justice system components	_____	_____	_____
Treatment agencies	_____	_____	_____
Local (city/county) management	_____	_____	_____
General public or press	_____	_____	_____
Public inebriates	_____	_____	_____
Medical or hospital establishment	_____	_____	_____
Merchants	_____	_____	_____
Legislators	_____	_____	_____
Correctional personnel (e.g., prisons)	_____	_____	_____

5. Which of the following factors contributed to that unhappiness? (Check and comment if you wish.)

_____ Frustration caused by chronic repeaters

_____ Increased costs

_____ More drunks on the street

_____ Worse health care for skid-row persons

_____ Lack of control over treatment duration

_____ Disillusionment after high expectations

_____ Disagreements between different agencies

_____ Lack of control over persons while intoxicated

_____ Misperception of the purpose of decriminalization

6. Currently the public is reacting toward decriminalization

_____ Adversely

_____ Favorably

_____ No visible opinion

_____ A little uneasily

7. Is the attitude toward decriminalization basically a question of economics; that is, would most people favor decriminalization if adequate funding were available?

_____ Yes

_____ No

_____ Some truth in statement

8. What can be done about any unhappiness about decriminalization?

_____ Change the most objectionable features of the law

_____ Increase funding of public inebriate services

_____ Conduct a public education campaign

_____ Give personal attention to converting major detractors

_____ Educate and motivate the treatment community

_____ Nothing

9. Some critics say that decriminalization has resulted in strengthening the amount of "police-dispensed justice" to which public inebriates are subject (i.e., has removed legal protections). Is this your belief or worry?

_____ Yes

_____ No

_____ In some communities

10. Some people allege that providing reasonable care for public inebriates attracts more public inebriates to a community or to a certain area within a community. Has this been the experience in any communities within your state?

_____ Yes _____ No

11. Do hospital staff show a more positive attitude toward, and an increased ability to recognize alcoholism among their regular clientele as a result of dealing with the problems of decriminalization?

_____ Yes _____ No _____ Some

12. A major intention of the Uniform Act was to ensure that chronic public inebriates would be treated more humanely. Are they?

_____ Yes

_____ No

_____ We've made a good start

13. Has the Uniform Act, in your opinion, encouraged <u>early</u> identification and treatment of alcoholics?

_____ Yes _____ No

14. Which of the following problems characterize your present program? (Check.)

_____ Overload in receiving and detoxification centers

_____ Large numbers referred to outpatient services without adequate follow-up

_____ Confusion about terminology from one group to another (e.g., criminal justice system vs. treatment personnel)

_____ Treatment facilities handling large numbers of repeaters with poor treatment results

_____ Serious differences in "comprehensiveness" from one geographical area to another

_____ Partial decriminalization

_____ Decline in overall services for public inebriates

_____ Overemphasis on public inebriate programs at the expense of other programs

_____ Resistance from law enforcement officers

_____ Resistance from local government toward funding alcoholism services

_____ Anxiety about survival or programs without special federal funds for Uniform Act implementation

_____ Anxiety about survival of <u>public inebriate</u> programs without federal funds of some kind

_____ Probable move in legislature to "recriminalize" public intoxication

_____ None of the above

15. At the community level, what do your alcoholism services most strongly and frequently rely on? (Check.)

_____ Police/jail assistance

_____ Hospitals and other medical agencies

_____ Mental health centers

_____ Community-funded agencies

_____ State-funded agencies

_____ Independent alcoholism programs

_____ Non-governmental service agencies

16. Examining the issue of increased or decreased costs due to the Uniform Act and particularly decriminalization, indicate which of the following provisions of the Act either increased (I) or decreased (D) costs to state and local government, or where there was no real change (NC), or simply a transfer of costs from one branch of government to another (T). (You may check more than one column for each item.)

	(I)	(D)	(NC)	(T)
a. Expansion of state alcoholism agency	____	____	____	____
b. Decriminalization	____	____	____	____
c. Increase in local-funded treatment services	____	____	____	____
d. Increase in state-funded treatment services	____	____	____	____
e. Emergency services in hospitals	____	____	____	____
f. Pick-up and transportation services	____	____	____	____
g. In-patient services	____	____	____	____
h. Medical evaluation/diagnosis	____	____	____	____
i. Outpatient services	____	____	____	____
j. Alternative-to-jail facilities	____	____	____	____
k. Monitoring and treatment plans	____	____	____	____
l. Court costs	____	____	____	____
m. Costs of overnight jail	____	____	____	____
n. Costs of longer term prison	____	____	____	____

17. Of the total costs of handling public inebriates under a decriminalized system, what proportion was earlier being paid out through the criminal justice system?

_____%

18. How much more or how much less does it cost to handle public inebriates through the alcoholism treatment system than it did through the previous criminal justice system approach?

$_____ more/less

19. Does decriminalization increase state and local expenditures without benefits enough to justify increased costs?

_____ Yes _____ No

20. Indicate with a checkmark which of the following agencies have to rely on alcoholism funds to pay for increased costs due to decriminalization, and which have other sources of funds.

	Alcoholism Funds	Other Funds
Police	_____	_____
Courts	_____	_____
Hospital emergency rooms	_____	_____
Hospital in-patient wards	_____	_____
Non-hospital detoxification centers	_____	_____
Non-hospital residential facilities	_____	_____
Counseling centers	_____	_____
Transportation agents	_____	_____

21. What proportion of your total alcoholic population consists of public inebriates?

_____ Less than 10%

_____ About 25%

_____ About 50%

_____ More (specify)

_____ Don't know

22. What proportion of all alcoholism funds in your state go to dealing with the public inebriate population?

_____ Less than 10%

_____ About 25%

_____ About 50%

_____ More (specify)

23. Has emphasis on funding programs for public inebriates substantially distorted your state's total funds for alcoholism services in any way adversely (e.g., by depriving some existing programs of funds)?

_____ Yes _____ No

24. Has the Uniform Act caused an increase in the total amount of alcoholism monies available from state and local government?

_____ Yes _____ No

25. If federal incentive funds for Uniform Act implementation were not available, what proportion of your alcoholism monies would go to the public inebriate programs?

_____ None

_____ Less than 10%

_____ About 25%

_____ About 50%

_____ More (specify)

26. In your opinion, is the amount of attention now (since decriminalization) paid to the needs of public inebriates by the government (state, local, federal) too little or too much?

	Federal	State	Local
Too little	_____	_____	_____
About right	_____	_____	_____
Too much	_____	_____	_____

27. Is it worthwhile to spend as much public money on public inebriates as currently seems necessary?

_____ Yes _____ No

28. In the opinion of public inebriates, is the amount of attention now paid to their needs by the government too little or too much?

_____ Too little _____ Too much

_____ About right _____ Don't know

29. Which of the following providers of services have a reputation as "revolving doors?"

_____ Emergency care centers

_____ Detoxification centers

_____ Sleep-off or drop-in centers

_____ In-patient

_____ Intermediate

_____ Outpatient

_____ Residential

30. Which is more effective at breaking up skid-row?

_____ Police action

_____ Urban renewal

_____ Alcoholism treatment

_____ None of the above

31. What proportion of the public inebriate population should we just leave alone? Indicate why.

_____%

32. If you had your free choice of methods for dealing with public inebriates, what would you recommend for and against?

For	Against	
_____	_____	Continuation of the present decriminalized system
_____	_____	The present system with added treatment resources
_____	_____	Return to the old system (recriminalization) but with better facilities and resources
_____	_____	Handling by police and jails only, but without criminal record or penalties
_____	_____	Entirely voluntary system
_____	_____	Return to involuntary incarceration, plus mandated treatment
_____	_____	A diversionary program which retained criminal penalties as a threat to those who did not cooperate with treatment

The Uniform Act's Impact: Attitudes and Resources

COMMENTARY

Introduction

The Uniform Alcoholism and Intoxication Treatment Act requires a major reorientation of traditional attitudes toward the alcoholic population, especially public inebriates, and toward the nature and amount of resources we are willing to spend on them. Simply because of the magnitude of the change it wants, the Act could expect to encounter opposition, resistance, even antagonism. The objective of the following section of this study is to examine whether the Act has been received negatively; what attitudes it has affected or been affected by; and whether those attitudes have seen reflections in the amount of resources allocated to implementing the Act.

In the twenty states or territories interviewed which had already passed versions of the Uniform Act, many people were asked what they thought to have been the legislature's major motivation at the time of passage. The list of possibilities presented in Question 1 was compiled from respondents' answers. The outstanding factor in many states was that the legislature's motives were unclear. Normally the legislation had been shepherded through the legislative process with little controversy, often with none. Public concern about inebriates was very rarely a factor, but a very important force seems to have been a fuzzy humanitarianism coupled with pressure from a competent alcoholism treatment lobby, and surrounded by a generalized belief that "treatment" is effective with "alcoholics." In many states, costs were not discussed or only lightly mentioned. At the time most states passed the legislation, the Federal incentive funds to aid implementation did not exist and were not a motivating factor. There was, however, considerable belief in many states that the Act would save communities money.

The crucial determinant everywhere was the Act's decriminalization provision. It is doubtful, in fact, that many legislators realized that they were committing themselves to anything more than decriminalization. The Act's vital provisions reorganizing the state alcoholism agency and calling for a comprehensive and coordinated treatment program seem to have been regarded as minor accompaniments, although both led the state into a major new stance toward alcoholism and committed it to the eventual expenditure of much greater funds.

Most states report that there was a generally uncritical attitude toward decriminalization; it was in the air, however, a part of the times. Important court cases, either out-of-state and in-state, had made clear that something new

probably had to be done about public inebriacy. The courts, and the lawyers who make up a large proportion of many legislatures, were eager to get inebriates out of the court system. There was a common belief in some states that the criminal justice system would see great savings when decriminalization rid police, courts, and jails of inebriates; and public drunkenness was the most frequent of the several "victimless crimes" which are still in process of decriminalization.

It may be correct to say, in sum, that the Act passed because of decriminalization and despite the costs of a comprehensive and coordinated treatment program. Very few state legislatures knew exactly what those costs would be. And a large minority of states passed the legislation but appropriated no funds whatsoever for its implementation. (One state has still not appropriated funds though it decriminalized in 1969, prior to promulgation of the Uniform Act.)

There are three important riders to the above generalizations. First, a handful of states, with the help of their state alcoholism agencies, reported approaching the Uniform Act with care and knowledge, including prevision of the costs. These states tended to be more interested in the comprehensive program than in decriminalization. They examined prospective costs and savings more closely and appropriated adequate funds for staged implementation. Second, most states which approached either the legislation or the funding carelessly at first have since made needed appropriations and/or amendments which remedy their original oversights. (And no state has repealed either the Uniform Act or decriminalization of public drunkenness.) Third, some of the original states compromised with decriminalization, unwilling to proceed the full way, and placing their emphasis on treatment programs rather than on decriminalization.

There is much evidence that states which have not yet passed the Uniform Act are tackling the legislation more cautiously and knowledgeably than most of the early group, so that there may be for some time a number of hold-out states. Several states contemplating decriminalization this year have shown a much warier attitude toward the expenditure of state resources, learning from other states that the Act has more impact on resources than they originally thought. It remains true today, as it was when the other states passed decriminalization, that passage and implementation of the Act depend deeply on a state's attitude toward expenditure of resources for alcoholics and intoxicated persons. Examination of those attitudes is therefore now perhaps a necessity for persons seeking passage of the legislation.

Reactions after Enactment

It is possible to anticipate elements of the almost inevitable reaction when the Uniform Act is implemented. Responses to Question 2 indicate that downtown merchants are almost certain to dislike the new police powerlessness to "clean the streets," and they will find echoes among the general public and in the media. They will receive support from some elements of the criminal justice system. Further, reorganization of the state alcoholism agency is likely to upset other state agencies, and some of the existing providers of alcoholism services. The medical profession (or elements of it) may be disturbed by any or all of the Act's provisions, from emergency services to commitment. But neither the public inebriates nor most providers either of alcoholism services or of services to skid-row residents will be upset; they will indeed support the Act.

What will opponents criticize? The list of choices which appears in Question 3 was assembled from interviewees. The heaviest points of criticism are "insufficient funding" and "inadequate treatment facilities," but all items on the list received large votes. The list shows more importantly that inadequacy in the implementation of the Act's decriminalization provision is the main problem. Attitudes toward decriminalization by itself therefore merit deeper examination.

Answers to Question 4 varied very widely in different jurisdictions and according to the respondent's viewpoint, but a general pattern emerged. The police, the press, and the merchants tend to begin with opposition, which then softens. City and county management, on the other hand, tend to grow into opposition, as does the medical or hospital establishment. In both cases, the main problem is unanticipated increases in costs. At base, much disillusionment results from unreasonably high or false expectations. Thinking that "treatment" will somehow magic away the problems of public intoxication, everyone expects too much at first, gets irritated when public inebriates remain more frequent than successful treatment programs, then settles down to the new realities. Jurisdictions interviewed were in various stages of this general process.

Question 5 particularizes the general process somewhat. (This list was again assembled from interviewees' responses.) Apart from costs and disillusionment, most people reported frustration because of the chronic repeaters, which was associated with lack of control over treatment duration. Following closely were the appearance of "more drunks on the street," which many people saw as indicating "worse health care" and "lack of control over intoxicated persons." In other words, the main problem was the Act's emphasis on voluntariness, the very essence of decriminalization. Some observers pointed out that many people misperceived decrimi-

nalization; they thought it would take inebriates out of jails but mandate them into treatment, thus leaving the public order unruffled.

Despite these problems, no respondent reported massive or even large public dislike for decriminalization. Asked Question 6 about current public reaction, one state alcoholism agency reported presently experiencing a welling of antagonism which it believes temporary, while several others reported some public uneasiness, but the great majority reported a favorable public reaction. There remain distinct bubbles of opposition amongst groups dealing with public inebriates (e.g., merchants, police), but again the root cause seems to be inadequate funds and treatment facilities. Asked in Question 7 whether adverse attitudes toward decriminalization could be assuaged through more funding, all respondents answered yes. Asked in Question 8 what could be done about adverse attitudes toward decriminalization, the respondents overwhelmingly chose "increase funding of public inebriate services" and "conduct a public education campaign"--specifically to explain the real meaning of decriminalization.

There has been a lot of anxious talk to the effect that "decriminalization is not working." At present, expert opinion can say only that decriminalization has not everywhere been supported with enough funds to meet the expectations for it which many people originally held.

There remain two longer-term anxieties about decriminalization. A minority of critics believe that it has removed or will remove legal protections from public inebriates, replacing court supervision with "police-dispensed justice" (Question 9). By far the greatest number of interviewees thought this unlikely, but there was evidence in some jurisdictions (and belief among some public inebriates) that this is happening in certain circumstances. The other anxiety is that if a community provides better care for public inebriates than neighboring communities, it will attract increased numbers of inebriates. Again, most people reported that their states had not seen this phenomenon (Question 10), but a minority indicated that it had already occurred.

There are also positive attitude changes resulting from decriminalization. For instance, all responding states indicated that decriminalization had improved the attitudes and skills of hospital staff when dealing with their regular (other than public inebriate) patients (Question 11). This is a major inroad and achievement. And a vast majority of respondents indicated that the Uniform Act had resulted in more humane treatment for chronic repeaters, though a minority (again from unfunded states) disagreed (Question 12). There was even a majority belief that the Uniform Act had encour-

aged early identification and treatment of alcoholics (Question 13), because many persons brought to detoxification centers had never had a prior contact for drunkenness with either police or treatment programs. This represents a change from the earlier preconception that almost all public inebriates were regular repeaters.

Situations Seen as Program Problems

The present study made no attempt to analyze numerical data to determine where program problems lay. It relied instead on the judgment of interviewees and respondents. Information as to program problems may therefore be inaccurate, but the answers to the following questions at the very least reveal where people believe there are problems and therefore give important insight into their attitudes. Question 14 provides a summary checklist of the major problems as identified by respondents and interviewees.

Three areas were seen by a great majority of respondents as major problems. First, they identified treatment facilities as handling large numbers of repeaters with poor treatment results. This situation was seen as caused primarily by inadequacy of funds and the subgroup of habitual repeaters, but some respondents also indicated that the voluntariness provisions of the Act forestalled successful treatment in some cases, and others indicated that the quality or appropriateness of the treatment offered was inadequate. Second, almost all states saw great differences in comprehensiveness from one area to another, meaning that a full treatment structure is not in place throughout any state. This was seen as a product of funding, of time since decriminalization, and of local attitudes. Third, a large majority reported resistance from local government toward funding alcoholism services. (This issue is discussed fully elsewhere in this report.)

A second pair of problems reported as slightly less frequent had to do with immediate services to public inebriates. Many states reported an overload in receiving and detoxification centers, especially in large urban areas. There are not enough facilities for the population, and many inebriates are being ignored, held in jail overnight, or released prematurely from treatment. An equal number of states reported trouble with the referral process recommended by the Uniform Act. Large numbers of public inebriates are referred to outpatient services, but they are not appearing and not being followed up. Voluntariness and the special nature of the referred population are the problems here, but also treatment centers have rarely developed regular systems to accomplish, ensure, and monitor referral. The fact that these two problems were identified is evidence that program personnel are NOT satisfied with the effectiveness of their immediate services, even though (as is shown elsewhere) they are optimistic about future success.

A third pair of problems was connected with the flow of money. Many states indicated anxiety that their public inebriate programs would not survive without federal funds of some kind. (This is clearly connected with the pronounced anxiety about local government funding attitudes.) On the other side of the coin, even more states believed that there is presently an overemphasis on public inebriate programs at the expense of other programs. (This issue is discussed elsewhere.) Minorities of states also reported problems in resistance from law officers; anxiety about the survival of alcoholism programs in general without federal funds; and a decline in overall services for public inebriates as a result of decriminalization.

These attitudes show widespread basic acceptance of the major intentions of the Uniform Act: to replace criminal charges with treatment, and to establish a community-based comprehensive treatment system. Also on the positive side, no one indicated the likelihood of any legislative move toward recriminalization, and no one reported worrying about decriminalization being only partial.

The study team wishes to draw attention to two problems not emphasized by those interviewed or responding to Question 14. First, partial decriminalization was more common than alcoholism treatment personnel were aware, while other alcoholism professionals accepted partial decriminalization as positively beneficial. Partial decriminalization, however, does not fulfill the intentions of the Uniform Act. Second, the study team noted a great and destructive confusion in terminology from one group of interviewees to another. The alcoholism profession is of course not noted for the clarity of its terminology, and this is normally not very harmful, but in the case of decriminalization, confusion can be dangerous because it can lead to false expectations. For instance, the study team found that "detoxification" might mean six hours for "sleeping it off" to, say, jailers; one to two days of time in bed to staff of detoxification centers; and as much as six days of medically supervised inpatient treatment to physicians. The result was that when a "detoxification center" was planned (and the term is universal), everyone anticipated different facilities, periods of hold, staffing, and (most important) results, but they did not realize that they had different expectations because all were using the term detoxification. Similarly, one cannot move from city to city or state to state and expect terms such as "inpatient treatment," "residential care," "withdrawal," "emergency services," "medical screening," etc. to mean the same thing everywhere. Communication between professionals from different areas must be chaotic. A minority of respondents to Question 14 had noted the problem, and all thought it a major difficulty.

To summarize this brief section, program personnel indicate that there are indeed situations throughout the new system which they see as problems. There is not enough statistical information to determine how significant these problems may be. None of the problems bring into question the basic intentions of the Uniform Act. We may be talking about attitudes as much as real problems, and those attitudes seem on the whole very positive but by no means uncritically enthusiastic.

Attitudes, Resources, and Costs

As stated previously, lack of funding is widely seen as the major overriding problem with all the major intentions of the Uniform Act. The Act itself did not intend to cause a great increase in funding needs, or at least it intended to minimize those needs. It repeatedly reveals its intention not to create new treatment or administrative networks but to exploit existing programs and "piggyback" on existing structures. In this respect it may have been naive.

This study did not collect extensive fiscal data or attempt analysis of the "cost" of treatment or decriminalization. Several states have undertaken or are undertaking such analyses, and it would be extremely useful to collect all local and state studies to attempt an estimate of nationwide costs associated with the Uniform Act. It would be equally useful to devise a methodology for measuring costs, since the analyses seen by the study team all used different methodologies and came to very different conclusions.

The area of costs which the study team did analyze, however, was whether states and communities believe that their resources are being strained by the costs associated with the Uniform Act. The following group of questions deals with this subject. As a preliminary, Question 15 sought to determine what community-level agencies are the main bases for the delivery of alcoholism services under the Uniform Act, and by implication whether existing structures were being used to the extent recommended by the Act. By far the majority of respondents indicated that "state-funded agencies" are the main support, chosen three times as often as community-funded agencies. This pattern alone is enough to indicate the importance of state initiative (whether in resources or funds or attitudes). Interviews confirmed the pattern; most communities have had small or inadequate treatment programs, and only a small minority establish them at their own initiative and with their own funds. "Mental health centers" received the second largest number of votes, indicating (as interviews confirmed) that a large number of states are economically piggybacking their alcoholism programs on the mental health programs established a few years earlier. The alcoholism profession is profiting from the experience of mental health professionals and administrators.

Next most popular support was that provided by "independent alcoholism programs," and added to them were the "non-governmental service agencies." Interviews showed that in many communities the alcoholism programs are receiving much help from existing agencies who dealt with alcoholics, particularly those started by the National Council on Alcoholism and Family Service Agencies. Although independent programs were cooperating with state alcoholism agencies in every community visited, they did however show a persistent bias against skid-row or homeless inebriates, and a strong preference for working, resident alcoholics with families, incomes, and health insurance.

A very small number of states indicated a pattern of support which the Uniform Act does not encourage: primary dependence on police and jails. And support from hospitals was much weaker than the Act seems to intend; only one state chose "hospitals and other medical agencies" as their primary source of support. (This is one more indication both of the growing autonomy of the alcoholism profession, and of the general reluctance of hospitals to provide free treatment.)

Quite clearly, then, most states are exploiting existing social structures for the delivery of services, but community attitudes about funds are placing a strong demand on the provision of money by the state.

The next question (Question 16) sought to determine where state alcoholism agencies <u>believe or know</u> that there have been changed costs because of the Uniform Act, especially because of decriminalization. In each named category, they were asked to indicate whether costs to state and local government had increased or decreased, whether there had been no change, or whether the Uniform Act had simply transferred costs from one agency to another. Of the 14 possible categories in this question, all but three were named by the states as having experienced an increase in costs. That is, the only three agencies reported to have seen a decrease of costs in all or almost all states were the courts, jails, and prisons.

As to the costs due to the Uniform Act, <u>all</u> the provisions of the Act were reported as having caused increased costs in at least a minority of states. "Expansion of the state alcoholism agency" has proven an inexpensive provision of the Act; a large number of states saw no cost changes in this area. The least expensive provision was that for "emergency services in hospitals;" numbers of states seeing increased costs in this area were exactly equalled by the number seeing either no change or decreased costs. At the other extreme, all reporting states saw increases resulting from the Act's provisions for "decriminalization," "increase

in local-funded treatment services," "increase in state-funded treatment services," "outpatient services," and "monitoring and treatment plans." There is, then, absolutely no doubt that state alcoholism agencies believe that they need extra money to implement the main treatment provisions of the Act.

All other lesser provisions related to the Act's major provisions were also associated with increased costs. For instance, while a minority of states saw the costs of "pick-up and transportation services" as either unchanged or as simply transferred from one agency's budget to another, twice as many states saw them as increased. (This was a puzzling response, since interviews seemed to indicate lower costs in this area.) Again, twice as many state alcoholism agencies reported "in-patient" costs as increased as reported them decreased. "Medical evaluation/diagnosis" costs were almost universally seen as increased, though one state reported them less, and several indicated that they were at least partially transferred. The identical pattern was reported with "alternative-to-jail facilities."

We cannot place absolute reliance on these reports by state alcoholism agencies. They are now generally moving toward the measurement of costs, but this is an art new to the area of public intoxication whether at arrest or in treatment stages. Some states are much more advanced in measurement than others, and this is an area where increased expertise and the exchange of information from state to state is essential for accurate knowledge. In sum, we cannot prove yet that the provisions of the Uniform Act cost more, but informed opinion overwhelmingly believes that they do, and that the only beneficiaries of savings are the courts and correctional facilities.

The basic question asked by community and state managers about costs is, "How much more of our total resources will we have to spend on public inebriates than we did before?" No generalized answer is available, unfortunately. Questions 17 and 18 need to be asked if the community and state managers are to receive a generalized answer. They need to know how much it costs to handle public inebriates under the criminal justice system, and how much more or less it will cost to use a decriminalized system. No state was able to provide clear answers to these difficult questions, and some state alcoholism agencies believed that they should not be asked because they are dangerously misleading, placing too strong an emphasis on social control of public inebriates in contrast to the Act's emphasis on providing treatment. Such interviewees believed that the correct approach is simply to admit that decriminalization will cost more, and to emphasize that communities will be doing more and getting more benefits. Interviewed community managers certainly understood this argument, but whether they were willing to

accept it depended on their broader attitudes toward both alcoholism treatment and the local budget. They were very understanding of the "cost/benefits" argument. Asked directly whether decriminalization brought enough benefits to justify increased costs, (Question 19), the overwhelming majority of all respondents agreed that it did. (Though again, a noteworthy minority believes that it does not.)

It is also useful to measure the pressure on funds allocated specifically to alcoholism treatment. Answers to Question 20 indicate that alcoholism funds provide the bulk of any increased costs. State alcoholism agencies indicated that alcoholism funds are (naturally) the source of any increased costs accruing to non-hospital detoxification centers, non-hospital residential facilities, and counseling centers. In a majority of states, hospital emergency rooms and transportation agents are also relying on alcoholism funds, as are police and courts in the minority of states needing increased funds in those agencies. This means that many agencies are not picking up the extra costs of decriminalization from their own traditional sources. The new decriminalized system thus looks principally to special alcoholism funds, revealing the attitude that "alcoholism" is an "alcoholism treatment" problem, different from other issues in public health or public safety. This attitude was widespread also among interviewees.

Attitudes Within the Alcoholism Profession

The next set of attitudes to have importance on the allocation of resources and the impact of the Uniform Act is clearly then those of the alcoholism treatment profession itself, and the next set of questions was aimed primarily at measuring their response to decriminalization. The main question to answer is: does the alcoholism profession believe that its resources are being allocated appropriately to the needs and extent of the public inebriate population as compared to other subgroups? Asked what proportion of their total alcoholic population was made up of public inebriates (Question 21), all respondents indicated less than 25%, and most indicated less than 10%. (Accurate figures are nowhere available, but some states have made scientific estimates.) Asked what proportion of all alcoholism funds in their state went to dealing with the public inebriate population (Question 22), about half the state alcoholism agencies indicated 25% or less (commensurate with the population size), while the other half reported 50% or more. Asked whether these allocations of funds were inappropriate (Question 23), two-thirds of responding alcoholism agencies replied that they were not, though the minority was vociferous in indicating that public inebriate programs were depriving other alcoholism programs of needed funds. Finally, the state alcoholism agencies were asked whether enactment of the Uniform Act had increased the total

amount of monies from state and local government available to alcoholism treatment (Question 24). All except the states whose legislation has never been accompanied by appropriations indicated that it had. There is thus a general attitude that the Uniform Act has had beneficial effects on alcoholism funding, though there are clear problem areas.

Another group of questions on this subject asked only for straight professional opinions. Question 25 sought to determine attitudes about the effect of the federal incentive grants to aid implementation of the Uniform Act. Answers showed that there would be sharp declines in a handful of states, i.e., that the federal funds are very important to their public inebriate programs. A majority of states, however, indicate that their priorities would be roughly the same with or without federal incentive funds. This remark, however, should be heavily qualified. All state alcoholism agencies reported that crucial elements or activities in the public inebriate area would be in difficulty during the implementation phase without federal incentive funds, and they all welcomed recent increases in those funds. The general impression was that they are seeking to use the incentive funds for important leverage in areas where state funding is difficult or impossible to obtain, which is the precise intent of Congress. Further, two states reported that they would have no public inebriate treatment programs without federal incentive funds.

State alcoholism agencies (and other personnel) were asked whether they think government in general is now spending the right amount of attention on public inebriates (Question 26). They divided almost evenly between the three opinions: too little, about right, and too much. Attitudes here depended, of course, on how much attention is being paid within their own states. Asked simply whether it is "worthwhile" to spend as much money on public inebriates "as seems necessary" (Question 27), three times as many respondents answered that it is as answered that it is not. Asked whether they believed the public inebriates think the government is paying the right amount of attention to their needs (Question 28), the vast majority of respondents said they didn't know, reflecting our widespread failure to find out whether the consumers of our services are satisfied or not.

These last three questions measured attitudes toward the public inebriate population as much as attitudes toward resources. Are these individuals worth our time and efforts? Do they use our services, or merely exploit them? Should we leave them alone or ignore them? Does too much attention to this subgroup reinforce general public beliefs that all alcoholics are "bums"? What is the point of our intervening on skid row? These are the kinds of anxieties with which people in the alcoholism field are now contending.

CONTINUED

1 OF 4

For example, the alcoholism profession is naturally eager to develop a reputation for effectiveness, and that reputation is now clearly threatened if they fail to cope with the public inebriate population, even though that population is widely regarded as the subgroup of alcoholics least likely to show marked improvement. The treatment profession does not want to gain the "revolving door" reputation which the criminal justice system is trying to discard. But, when they were asked which elements of their service had already won a reputation as a revolving door (Question 29), they almost all indicated "emergency care centers," "detoxification centers," and "sleep-off or drop-in centers." This poor reputation of the immediate services provided by the alcoholism profession worries them, even though they acknowledge that this portion of a treatment program cannot and was not expected by the Uniform Act to provide "cures." The problem, as they see it, is the false expectations of people outside the alcoholism profession, who see these elements of the system as cure centers rather than care centers.

There is also some anxiety in the profession that alcoholism treatment is being exploited as a means of breaking up skid row. Interviews showed that indeed many people in a community (managers, merchants, and public) see alcoholism treatment as another weapon in the arsenal against skid row, whereas the alcoholism profession sees itself as helping some people who live on skid row. This difference in attitudes can and will cause major problems when city budgets are at issue, and treatment programs reported anxiety that they would be unfairly blamed for not achieving what they were not even chartered to achieve. Posed Question 30, the great majority saw "urban renewal" as a much more effective weapon against skid row than is alcoholism treatment. They pointed out that (a) many skid-row residents are not alcoholics; (b) treatment agencies have no power to remove people from skid row; (c) some skid-row alcoholics are "incurable" and even untreatable; (d) skid rows rarely vanish, they simply relocate. Further, people in treatment programs strongly stated that the intention of the Uniform Act is not to force treatment on people. Asked what proportion of the public inebriate population should be left alone (Question 31), everyone answered more or less "whatever proportion wants to be left alone." The voluntariness provisions of the Act are much more important to treatment programs than the problems of keeping the streets clear of unrespectable people.

Summary of Attitudes

Finally, program personnel and state alcoholism agencies were asked what system for handling public inebriates would they choose if they had completely free choice (Question 32).

Almost to a person they chose the present decriminalized system with added treatment resources. Almost to a person they were strongly opposed to a return to the old system based on police and jails, even if that system was bolstered with better facilities and resources and even if it was deprived of its criminal charges and penalties. They were unanimously opposed to the use of involuntary incarceration with mandated treatment, showing very strongly that they do not want to "put the drunks away for good or until they give up drinking." (This latter attitude was favored among some people in groups outside the alcoholism profession.)

The only subject that caused some hesitation was the total voluntariness called for in the Uniform Act, and this hesitation was caused by the small subgroup of habitual repeaters about whom no one knows quite what to do. Respondents indicated some dissent with the "entirely voluntary system" advocated by the Act, and there was significant support for a diversionary program which used the threat of criminal sanctions to induce cooperation with treatment. This latter system operates already in some non-decriminalized states, and many treatment programs have recently seen the success of the Alcohol Safety Action Projects, which use court-based coercion into treatment with drinking drivers. The issue of court-based diversion, in other words, is still alive and deserves examination.

In total, however, support for the intentions of the Uniform Act to remove inebriates from the criminal justice system and place them in the health care system remains very, very strong. Even after preliminary experience with programs, states which have implemented decriminalization still support the Act strongly. They believe there are many problems. They want greater, or adequate, funds. They are worried about the group of habitual repeaters. They do not promise total success and have trouble with other people's false or unrealistic expectations. But the Act's overall approach wins their strong endorsement. The other two main intentions of the Act--the strengthening of the state structure for the delivery of alcoholism services, and the creation of a statewide comprehensive and coordinated program for those services--win even more enthusiastic endorsement. Most people therefore believe that the basic philosophy and the major provisions of the Uniform Act are proving operationally to have been right on target.

SECTION III: THE NEW SYSTEM IN OPERATION: DECRIMINALIZATION, VOLUNTARINESS, AND TREATMENT

The New System in Operation: Decriminalization, Voluntariness, and Treatment

QUESTIONS

1. Do your statutes uncompromisingly set the policy that a voluntary, non-criminal approach to alcohol-abusers will replace a criminal approach, so that they may not be "subjected to criminal prosecution because of their consumption of alcoholic beverages?"

   _____ No

   _____ Yes

   _____ Partially

   _____ Expressly stated

   _____ Implied

2. Do your statutes mandate the state to provide adequate and appropriate treatment for alcoholics and intoxicated persons?

   _____ Yes

   _____ No

   _____ For some but not all

   _____ Yes, but without appropriate funds

3. The recommended Uniform Act prohibits any state or local law which (1) includes drinking, being a common drunkard, or being in an intoxicated condition as one of the elements of an offense and (2) provides a criminal or civil penalty for its violation (except for "driving under the influence" and ABC laws). Does your state law have the same or substantially similar "decriminalization" provision?

   _____ Identical

   _____ Substantially similar

   _____ Not state policy

4. If your state law departs from the Uniform Act provision, how would you assess the effect of the variations?

_____ Useful

_____ Undesirable

_____ No effect

5. Would a legislative resolution that "alcoholics not be treated as criminals" have been as effective as statutory decriminalization in changing police practices with public inebriates?

_____ Yes _____ No _____ Don't know

6. Would such a legislative resolution have increased treatment resources as much as your current legislation has done?

_____ Yes _____ No

7. Had the small towns and rural areas in your state largely "decriminalized" public drunkenness (i.e., in real practice) before decriminalization?

_____ Yes _____ No

8. In such areas, has decriminalization added treatment options which did not previously exist?

_____ Yes _____ No _____ Somewhat

9. Indicate which of the following legal charges (state or municipal) still exist in your state; then indicate which charges permit an overnight hold in a jail-type facility.

	Still Exist?	Jail?
Drunk and disorderly	_____	_____
Disorderly intoxication	_____	_____
Disorderly conduct	_____	_____
Vagrancy or loitering	_____	_____
Public drunkenness	_____	_____
Drunk in public (or public place)	_____	_____
Drinking from open container	_____	_____
Protective custody up to 12 hours	_____	_____
Other (specify)	_____	_____

10. Indicate which of the following charges (state or municipal) are used within your state with some intent to circumvent (C) decriminalization, and whether there has been a substantial increase (I) or decrease (D) since decriminalization.

	C	I	D
Drunk and disorderly	_____	_____	_____
Disorderly intoxication	_____	_____	_____
Disorderly conduct	_____	_____	_____
Vagrancy or loitering	_____	_____	_____
Public drunkenness	_____	_____	_____
Drunk in public (or public place)	_____	_____	_____
Drinking from open container	_____	_____	_____
Other (specify)	_____	_____	_____

11. Have the numbers of "substitute" charges increased since removal of public drunkenness as an offense?

_____ Yes

_____ No

_____ Yes, but not significantly

12. Has the concept of "civil hold" or "protective custody" simply replaced "public drunkenness" as a means of removing public inebriates from the street?

_____ Yes _____ No _____ Partially

13. How do you know if the Uniform Act policy for a decriminalized, treatment approach is being followed?

_____ Visits to communities to monitor compliance

_____ Periodic surveys of local laws or practices

_____ Reports from local contacts (e.g., local alcoholism agencies)

_____ Complaints from alcohol abusers (or their attorneys)

_____ Certification of compliance by local officials

_____ General "feel" for situation

_____ No procedure used--don't know status

14. When a community or county somehow circumvents the statewide policy of decriminalization, what course do you recommend for and against?

For	Against	
_____	_____	Leave them alone
_____	_____	Apply political or financial pressure from the state level
_____	_____	Apply legal pressure from the state level
_____	_____	Apply professional/educational pressure
_____	_____	Undertake and publicize a local needs study
_____	_____	Apply local pressure
_____	_____	Increase funding
_____	_____	Have a state alcoholism agency work with them forcefully
_____	_____	Establish a state-funded pilot program
_____	_____	Join them administratively with a cooperating county

15. Have the numbers of people flowing through jails decreased as a result of decriminalization?

_____ Yes _____ No (specify why)

By what amount?

16. Concerning the following groups of persons, indicate whether decriminalization has resulted in a substantial increase (I) or decrease (D) in the numbers seeing the inside of a jail.

	I	D
Juvenile drinkers	_____	_____
Persons drunk in a bar or restaurant	_____	_____
Intoxicated persons causing a disturbance offensive but not harmful to the public	_____	_____
Intoxicated persons neither causing a disturbance nor incapacitated	_____	_____
Skid-row types	_____	_____
Intoxicated persons involved in domestic disputes	_____	_____
Drinking drivers	_____	_____
People in public with open containers	_____	_____
Persons incapacitated in public	_____	_____

17. What proportion of persons who used to be charged with public drunkenness still reach jail-type holding facilities, with or without a misdemeanor charge?

_____ 0%

_____ About 5%

_____ About 10%

_____ About 25%

_____ About 50%

_____ More than 50% (specify why)

18. Are chronic public inebriates still reaching the jails, with or without misdemeanor charges?

_____ Yes _____ No

19. Are chronic inebriates still reaching prisons or prison farms (e.g., on 30-day sentences for some offenses)?

_____ Yes _____ No

20. Does your law agree with the Uniform Act requirement that treatment may not be provided at a correctional institution (except for inmates)?

_____ Yes _____ No

21. Do some groups report that some skid-row regulars died as a result of decriminalization?

_____ Yes (specify)

_____ No

_____ Yes, but I don't believe them

_____ Don't know

22. Is the physical health of chronic inebriates better or worse since decriminalization?

_____ Better

_____ Worse

_____ Don't really know

23. Is the lifestyle of a chronic inebriate more or less agreeable to him since decriminalization?

_____ More

_____ Less

_____ Don't really know

24. Since decriminalization, has there been a decline or an improvement in services for skid-row alcoholics?

_____ Decline

_____ Improvement

_____ No change

25. Do chronic inebriates get more or fewer simple "shelter" services (e.g., baths, food, lodging) as a result of decriminalization?

_____ More

_____ Fewer

_____ Same

_____ Don't really know

26. Do chronic inebriates get more or fewer health care services (e.g., medical screening, detoxification) as a result of decriminalization?

_____ More

_____ Fewer

_____ Same

_____ Don't really know

27. Which groups have seen a net savings in time, resources, and money because of decriminalization?

_____ Courts

_____ Police

_____ Jails

_____ Long-term corrections facilities

_____ Probation departments

_____ Mental health hospitals

_____ Other (specify)

28. Have the city and county jails changed in any substantial way as a result of decriminalization? (Please indicate how.)

29. Which of the following groups has less or more contact with public inebriates since decriminalization? (Check.)

No Change	Less	More	
_____	_____	_____	Police
_____	_____	_____	General public
_____	_____	_____	Merchants
_____	_____	_____	Health care agencies
_____	_____	_____	Private health care agencies on skid row (e.g., missions)
_____	_____	_____	Hospital general wards
_____	_____	_____	Hospital emergency wards

30. Which of the following groups seem generally content that they now have less to do with public inebriates?

_____ Police

_____ Courts

_____ Jails and prisons

_____ Hospitals

_____ Other (specify)

31. Does decriminalization increase or decrease the individual police officer's discretion about what to do with an intoxicated person?

_____ Increase

_____ Decrease

_____ No change

_____ Don't know

32. How do public inebriates feel about their relationship with police since decriminalization?

_____ Police action is more arbitrary

_____ Police are more helpful

_____ Police leave them alone

_____ No change

33. Has decriminalization increased the amount of knowledge among alcoholism personnel in your state about the skid-row population?

_____ Yes

_____ No

_____ In one or two communities

34. Do alcoholism personnel find the present situation especially frustrating?

_____ Yes

_____ No

_____ Yes, but for a minor reason

Specify reasons:

35. Since decriminalization, has city and county management been more or less positively concerned about public inebriates?

_____ More concerned

_____ Less concerned

_____ More knowledgeable

_____ More irritated

36. Decriminalization has resulted in ---

_____ More alcohol-abusers being treated

_____ Fewer alcohol-abusers being treated successfully

_____ Some classes of alcohol-abusers being neglected

_____ Overemphasis on the least productive subgroup

_____ More alcohol-abusers moving through a continuum of services

37. Is the Uniform Act's strong preference for voluntary treatment in your opinion desirable on the whole?

_____ Yes _____ No

38. Which of the following groups has less or more control over public inebriates since decriminalization? (This question relates to the voluntariness emphasized in the Uniform Act.)

Less	More	
_____	_____	Police
_____	_____	Courts
_____	_____	Jails and prisons
_____	_____	Special alcoholism agencies (e.g., detoxification centers)
_____	_____	Other health care agencies
_____	_____	Other (specify)

39. Which of the following groups is unhappy to any degree about their present lack of control over public inebriates?

_____ Police

_____ Courts

_____ Jails and prisons

_____ Special alcoholism agencies (e.g., detoxification centers)

_____ Other health care agencies

_____ Other (specify)

40. Roughly what proportion of your typical detoxification center's clientele comes in of its own accord (without being brought by police)?

Specify percentage:

41. Roughly what proportion of your typical outpatient counseling center's clientele comes in without governmental coercion?

Specify percentage:

42. Which type of person gets a fuller range and duration of treatment--an involuntary referral or a voluntary referral?

_____ Voluntary

_____ Involuntary

_____ Same

_____ Don't know

43. Are fewer or more people reaching a state mental hospital as a result of decriminalization? (Check one.)

_____ Fewer

_____ A few more

_____ Clearly more

_____ Many more

44. Should there be a stronger emphasis on involuntary treatment for certain subgroups or under certain circumstances?

_____ Yes _____ No

If yes, please give details.

45. Should there be provision somewhere of a "protected living situation" for those habitual repeaters who do not give up drinking, and who want such a living situation?

_____ Yes

_____ No

_____ A major dilemma

The New System in Operation: Decriminalization, Voluntariness, and Treatment

COMMENTARY

Introduction

The best-publicized intention of the Uniform Act is to move the handling of alcoholics and intoxicated persons away from the criminal justice system and into the health care system, where, if possible, they are to receive treatment for their alcohol problems. Public inebriates no longer are to be subject to arrest or penalties on account of their drinking only. The estimated 2 million annual arrests nationwide for public drunkenness should dwindle to zero. Court action against inebriates on account of their intoxication should almost vanish. The number of police actions against inebriates should diminish sharply, and the nature of those actions should completely change. Incapacitated inebriates may still be involuntarily subject to some societal actions but not arrest, while persons intoxicated but not incapacitated should not be subject to police action against their will, as long as they are committing no other offense.

Instead, then, of being (in terms of numbers of arrests) the greatest single population handled by the criminal justice system, public inebriates are to move into the health care system, where they receive medical screening and shelter, and where they could receive treatment. This would be voluntary. The commentary to the Act states: "Voluntary treatment is more desirable from both a medical and legal point of view. Experience has shown that the vast majority of alcoholics are quite willing to accept adequate and appropriate treatment . . . ." Involuntary treatment is permitted only in exceptional and very clearly prescribed circumstances.

Further, the provision of treatment is mandatory upon the state. The Act explicitly requires the state alcoholism agency to provide "adequate and appropriate treatment for all alcoholics and intoxicated persons."

The combination of decriminalization, voluntariness, and mandatory provision of treatment represents a powerful change in all states, and not all of them have accepted it. Complete decriminalization has not occurred even in all those states which have adopted versions of the Uniform Act. Voluntariness in many states is not as extensive as the Uniform Act recommends (e.g., where "diversion" is used). And by no means have all states accepted the obligation to fund complete treatment programs, even though their statutes call for it.

Questions 1 and 2 enable measurement of the degree to which state statutes comply with the expressed intent of the Uniform Act in these areas. Interviews showed that not all states which have "decriminalized" answer these two questions affirmatively.

Questions 3 and 4 enable determination of the exact nature and overall effect of departures from the provisions of Section 19 of the Uniform Act. Respondents in some states answered both questions awkwardly, because (as will be seen later) either state statutes or county and municipal ordinances had compromised with the absolute decriminalization intention of the Act. Further, because of the lack of legal training among alcoholism personnel in general, some program directors were genuinely unaware that their statutes did not call for absolute decriminalization.

Some states without absolute decriminalization supported their own variations with fervor, largely because they allowed more "control" or because they permitted the continued use of jails as holding facilities when needed. Sentiment in some states which have not enacted the Uniform Act maintains that statutory decriminalization is not necessary, and that a legislative resolution would be as effective. Asked whether this was so (Question 5), however, states which have decriminalized voted overwhelmingly that the Act changes police practices more than would a legislative resolution. They also overwhelmingly indicated that such a resolution would not have increased treatment resources as effectively as has their legislation (Question 6). Some non-decriminalized states reported that informal decriminalization is already occurring and that they prefer to leave it thus to local option. Decriminalized states reported that some decriminalization had taken place in their small towns before the Act was passed (Question 7), but again they overwhelmingly indicated that informal decriminalization did not approach the success of the Act in creating treatment resources (Question 8).

Circumvention of Decriminalization

The Uniform Act provides that no county, municipality, or other political subdivision may interpret or apply any law of general application to circumvent absolute decriminalization. Commentary to the Act states that it intended to "preclude the handling of drunkenness under any of a wide variety of petty criminal offense statutes, such as loitering, vagrancy, disturbing the peace, and so forth;" further, "the normal manifestations of intoxication--staggering,

lying down, sleeping on a park bench, lying unconscious in the gutter, begging, singing, etc.--will therefore be handled under the civil provisions of this Act and not under the criminal law."

Both interviews and responses to Question 9 indicate that a national-level agency should examine both state and local attempts to circumvent decriminalization by both statutes and ordinances. Question 9 ascertains what criminal charges and penalties remain after decriminalization. Of the eight alternatives offered, only "public drunkenness" had vanished from all responding states. "Disorderly conduct" still exists everywhere, as of course it should. But apparently in a majority even of decriminalized states, either "drunk and disorderly," "disorderly intoxication," "drunk in public," and/or "drinking from an open container" remain as legal charges, sometimes at the state level, sometimes at the local level, sometimes at both. Have jurisdictions retaining such charges genuinely decriminalized, at least as much as the Uniform Act requires? Interviews with District Attorneys and Attorneys General produced ambivalent opinions. An occasional written legal opinion declared that police could still arrest an intoxicated person if they chose the right substitute charge. Some states' Attorneys General may have certified that their legislation is in compliance with the Uniform Act's intentions without having studied in sufficient detail the Uniform Act itself or their state statutes and local ordinances.

Question 10 is designed to determine whether the magnitude of circumvention is great enough to cause concern. Unfortunately, it was composed too late to acquire accurate figures from all decriminalized jurisdictions (and many states could not produce such figures). Available statistics, however, show a very sharp decrease in arrests for public drunkenness or substitute offenses. Total arrests within these categories in responding states have dropped substantially, but in no state had such arrests vanished. Some jurisdictions have seen sharp increases in numbers of substitute charges (Question 11); others have seen temporary increases then gradually decreases; others have seen sharp and continuing decreases.

The substitute charges may be popular for two reasons: (a) some jurisdictions do not agree with the state policy of decriminalization and simply switch to a different charge; (b) some police agencies feel that they need some method of keeping control over certain elements of the misdemeanant population, used to use "public drunkenness," and have now switched to another charge. (For instance, some states report a rise in "driving under the influence" arrests after decriminalization of public drunkenness.)

The Uniform Act requires that persons who are "incapacitated" (not just intoxicated) be taken into "protective custody" and "forthwith brought to an approved public treatment facility for emergency treatment." The Act continues: "In taking the person into protective custody, the detaining officer may take reasonable steps to protect himself. A taking into protective custody under this section is not an arrest. No entry or other record shall be made to indicate that the person has been arrested or charged with a crime."

There are obvious dangers in this use of "protective custody," previously used only for helping people incapacitated by, for example, heart attacks or accidents, and never before applied to such a large and common population as public inebriates--who, moreover, have previously been treated as misdemeanants. It permits a taking into custody; it discourages certain kinds of formal record; it eliminates rapid, required court review; it could be used to "clean the streets." Answers to Question 12 indicated that in most states "protective custody" is <u>not</u> being used to circumvent the intention of the Act, but a minority of states indicated that it is indeed being used as a "substitute charge."

There are two major methods of using protective custody to circumvent decriminalization. First is to fail to take a person "forthwith" to an "appropriate" public treatment facility. Interviews in various jurisdictions showed some defining "forthwith" as "within 24 hours," which allowed officers to jail an intoxicated person considered incapacitated and then release him the next morning when sober. On other occasions there is no "appropriate" treatment facility. For example, a distant detoxification center is declared inappropriate, and the local jail used instead, a practice not uncommon in rural areas lacking adequate treatment programs. Both tactics allow officers to do less than under the previous situation, and they do not allow for treatment.

The second method of using protective custody allows it to be applied against intoxicated persons. Since the Act admits that the ultimate decision between intoxication and incapacitation must rest with the detaining officer, and in fact contains a clause protecting officers from criminal and civil liability for false arrest or imprisonment as long as he acts in good faith, officers may simply declare that an <u>intoxicated</u> person whom they wish to take into custody is in their judgment incapacitated.

Although both methods of circumvention are occurring in many jurisdictions, there is no evidence of massive, widespread, or even substantial police evasion of the correct procedures. On the contrary, there was convincing evidence

that most police in most circumstances comply completely and willingly with decriminalized procedures as they understand them. (This issue is discussed further in the section of this report on attitudes.) Officers in some states reported uneasiness about protective custody because (a) they felt vulnerable to civil suits where statutes did not protect them in the manner recommended by the Uniform Act; and (b) they saw that inebriates were vulnerable to abuse by some officers.

However, there was a widespread absence of guidelines for the police, and some of the guidelines obtained during interviews were clearly in error. Further, many jurisdictions (including their District Attorneys) adopted a laissez faire attitude to the problem. It is therefore very apparent that careful national guidelines should state what an officer may and may not do during this decision-making process in order to implement the intent of the Uniform Act. Equally, state and local government should provide their police with written guidelines as to the requirements stemming from their varied statutes. No interviewed police officer had read the Uniform Act itself, and few interviewed District Attorneys were familiar with its recommendations. Many statutes apparently depart from the specificity of the Uniform Act in this area. There was every evidence that clear guidelines would be welcomed and implemented by the police, who seem generally uneasy with the present situation.

Such guidelines should pay attention to the need for the police to maintain control over the street population. Faced with many difficult situations and under pressure from public or merchants, police tend to regret the loss of the easy power given by a "public drunkenness" arrest since most of the incidents in which they are involved also involve alcohol abuse. They frequently told anecdotes of their new inability to intervene and "defuse" situations, and of their powerlessness to respond to calls from spouses and families requesting help in controlling an inebriate. No statistical evidence was available in this area, but the anecdotes from both police and inebriates' families were convincing.

Many state alcoholism agencies did not know the exact situation at the point of decision between police and inebriates. It was difficult for them to determine whether the decriminalized, voluntary, treatment approach was being followed at the community level. Asked to suggest how one might determine compliance, they compiled the list of suggestions presented in Question 13. "Reports from local contacts" was by far the most recommended choice.

State alcoholism agencies did know whether a community in general was circumventing decriminalization, as were at least isolated communities in every state for many varied reasons. Asked what action they would recommend in this situation (Question 14), they voted unanimously against "leave them alone," and they voted unanimously for "apply professional/educational pressure." Generally, they saw the state alcoholism agency as having a very powerful role here, spearheading an effort to apply both state and local pressure from both legal and professional sources.

The main reason for communities to refuse cooperation is money. Especially since many counties are short of funds because of inflation and rising costs, they do not want to spend money on a powerless, small, and "shiftless" population. State alcoholism agencies seem to evaluate county judgments realistically, neither accepting nor rejecting the lack-of-funds argument uncritically. Where possible, they will supply extra state funds for, e.g., a pilot program, special training, or special personnel. Two unusual tactics have been used with success. One state regularly undertakes a local "needs study," with results that often surprise local managers and either motivate or reassure them. A handful of states administratively link poor or uncooperative counties with wealthier or cooperative counties, thus spreading resources and increasing motivation.

The continued use of jails for public inebriates is an issue of major importance to police, local managers, and treatment personnel. The Uniform Act intends that no one will see the inside of a jail simply because he is intoxicated or incapacitated. But the local jail is the most convenient, the cheapest, and often the only holding facility possessed by a community, and it is traditional. Conflict over their continued use is therefore probable. There has been a substantial decrease in the total numbers of people held in community jails in most decriminalized states. Asked how great a decrease (Question 15), states reported decreases ranging from 35% to 85%. But decreases depend on previous policies and on the proportion of the detained population represented by public inebriates. In one of the nation's largest metropolitan areas, without decriminalization, public inebriates constitute only 2% of the county jail population.

All interviewed jail personnel in decriminalized states, whether urban or rural, reported a decline in the number of public inebriates reaching them. Even in those small communities where there is no detoxification center, or where part of the jail is used as a detoxification center, there has been a decline, as there has been in urban areas where the capacity of detoxification centers is inadequate.

Further, Question 16 asked what kinds of drinkers were now less likely to see the inside of a jail, and respondents indicated a decline in all the categories contemplated by the Uniform Act: incapacitated persons, intoxicated persons, juvenile drinkers, and skid-row types particularly. No increases were reported. However, asked what proportion of the persons who used to be jailed for public intoxication are still jailed (Question 17), only two states answered 0%. The majority estimated between 10% and 25%. And two states (neither adequately funded for treatment programs) answered more than 50%. It is therefore clear that both national and state authorities would benefit from a closer analysis of exactly who still does reach the inside of jails and under what circumstances.

The habitual repeaters or chronic inebriates may still be discriminated against. Asked whether this group was still reaching the jails (Question 18), a heavy majority of states reported that they were. In at least two states, the same group continues to serve time in prison (Question 19).

The issue is further confused by the use of jail-based detoxification centers. In visited states, some of these centers were of very good quality, while others did not even pretend to provide treatment. Rural community jails tended to be no more than kindly, but some also had affiliated themselves with treatment programs. Doors were still locked, but not cells, and inebriates could have them opened after a reasonable amount of time. Their intoxication was monitored, and their medical needs usually screened. They were released without further criminal record (though not invariably) or appearance before a court (though not invariably). In some communities they were visited the next morning either by a counselor from a treatment agency or a volunteer, someone who would check their situation and offer the kind of treatment that they would accept.

However, the Uniform Act fails to address itself to important issues concerning jail-based detoxification: is a local jail a "correctional institution?" and is a non-arrested inebriate an "inmate?" The Act (Question 20) clearly states that "treatment may not be provided at a correctional institution except for inmates." Different interpretations of this statement could either eliminate or encourage the use of jail-based detoxification centers. State alcoholism authorities show strong theoretical dislike for the continued use of jails, yet they also fund pilot projects which use them and point with pride to the better examples. It seems clear that some intoxicated persons will continue to be held in some jails, especially in small towns, and that alcoholism programs should pay close attention to the amount and quality of treatment which these persons receive.

Services to Consumers

With the Uniform Act mandating states to provide adequate and appropriate treatment for alcoholics and intoxicated persons, it becomes important to determine whether public inebriates (and especially skid-row inebriates) are better or worse off as a result of decriminalization. Is the health care system doing a better job than did the criminal justice system?

Many police officers and jailers see themselves as providing an important and vital service to many subgroups of public inebriates. Arrest, jail, and time in prison allow these individuals to "dry out," get "cleaned up," and "get their heads together," according to respondents. Many criminal justice systems provide such elementary services as delousing, showers, basic nutrition, sometimes a bed, medical screening and services, etc. Many jailers are proud of what they do for an otherwise neglected population. Jails and prisons are sometimes incorporated into the skid-row lifestyle. Some patrol officers become friends. Interviewed habitual repeaters obviously had found a certain psychological structure in the pattern of arrest and institutionalization and could tell interviewers who were the best and worst "cops," judges, jails, and prisons. Some lamented loss of the work which prison-farms had provided them, missing the physical labor. There was, in sum, occasional nostalgia for the old system, and one may suspect some romanticism that nears myth.

This may account for the curious answers received to Questions 21 through 23. Interviewers everywhere encountered rumors that some skid-row regulars had died as a result of decriminalization, since they were now neglected by the police and jails. The rumors were especially frequent from jailers and in areas of especially cold weather. Some seemed authoritative, from informed sources, and a majority of state alcoholism agencies reported having heard them also (Question 21). Unfortunately there was no documentation to either prove or disprove the reports. Some reports, publicized by people openly antagonistic to decriminalization, were demonstrably absurd (e.g., one police chief claimed that the life expectancy of inebriates in his jurisdiction had been reduced from seven to three years by decriminalization, but he had no way of measuring either mortality rate).

Asked whether they thought that the physical health of chronic inebriates was better or worse since decriminalization (Question 22), respondents divided almost evenly between the three choices. In fact, no one knew precisely;

the question measured attitude, not fact. Asked whether the chronic inebriates' lifestyle was more agreeable now (Question 23), a vast majority of respondents said either that it was or that they didn't really know. Interviewed inebriates in detoxification centers reported that it was, but this of course was a highly selected population. Inebriates on the street were usually too intoxicated to answer the question.

The obvious fact is that no one is checking the public inebriate population as a whole. Police and detoxification center personnel know most about them, but few of these personnel have the skills, time, or motivation to investigate scientifically. Since the art of analyzing the skid-row population has advanced considerably during recent years, it would seem desirable for both national and state organizations to investigate extensively the opinions of th population they serve.

People seem certain that better services are available to skidrow alcoholics since decriminalization (Question 24), so that the real issue might be the voluntariness of treatment. With arrests, services were forced on skid-row. With decriminalization, there may be many people now ignored because they choose to be. Asked whether ultimately the chronic inebriates get more shelter services and health care services (Questions 25 and 26), program managers largely (but not unanimously) reported that they do, though in areas which have not funded detoxification centers, they are clearly getting less. These questions should be asked carefully jurisdiction by jurisdiction. The objective should be to determine (a) whether the jurisdiction has followed the Uniform Act mandate to provide services; and (b) whether the Act's emphasis on voluntariness means that some people are not getting available services. (Since a proportion of the skid-row people who drink are also brain-damaged or retarded, one cannot expect them all to find their way easily and voluntarily into a new care system; for this population, police services were often reported as essential.)

Criminal Justice Savings

A major reason for support of decriminalization has been the projected saving of time, resources, and money for the criminal justice system. The following group of questions attempts to discover whether savings have occurred. Analysis should separate the various categories of savings. Agencies may have saved time and resources, but both may either lie idle or now be expended elsewhere, with the result that there has been no saving in money. This, in fact, is the almost universal picture.

Question 27 produced a remarkable consensus. The most frequent beneficiaries of decriminalization savings seem to have been the courts. They now see few or no public inebriates. Court savings, however, have not been substantial. Public inebriate cases usually occupy absolutely minimal time at the beginning of the court's day, and though the numbers of public inebriates flowing through the courts has been huge, they flow quickly. No example was found, for instance, of a community where a court had been closed or where one had even shortened its day as a result of decriminalization. Public inebriates now cost the courts almost nothing, but they never costed them very much. A small number of probation departments also reported minor savings.

Answers to Question 27 brought almost unanimous judgment that the police too had saved time and resources--but no money. Less preoccupied now with the public inebriate population, they now have more time for other activities, but no interviewed agency reported a net savings in money. Some agencies (e.g., county sheriffs) reported increased costs because of the need to transport inebriates to distant detoxification centers, and others complained that processing took longer than before. However, all interviewed officers reported that they spend a smaller proportion of their patrol time on inebriates than before.

Jails have also seen savings. Responses to Question 28 showed that the major change in jails has been a reduction in the number of drunk tanks. Decriminalization also allowed the closing of some jails altogether, usually those seedy and moribund facilities regarded as too insecure for anyone other than public inebriates. Many jails saw a reduction in the numbers of detainees, and they saw cost-savings in laundry and food bills (if they had previously provided sheets, clothing, meals, etc.). However, jail savings have not been universal. Drunk tanks still exist in most large urban areas. In other areas jail staff and facilities are used to run a "detoxification center" or to hold inebriates not taken to health care. Further, some jails complained that decriminalization had <u>increased</u> their costs. Where inebriates were imprisoned in local jails for a period of days, they were used as trustees, did much of the janitorial and housekeeping work (including cooking and serving meals), cleaned police cars, etc. Corrections personnel at both short-term and long-term facilities occasionally reported that they now either had to pay for these services or do them themselves. The problem, however, did not seem of great magnitude at any jurisdiction visited.

The whole issue of criminal justice savings merits further and thorough investigation, of the kind carried out in a handful of major urban areas. Sample studies show that (a) the public inebriates did not cost as much to all units of the criminal justice system as had been thought; and (b) net savings from decriminalization may be much less than anticipated. The present study allowed for no quantitative or fiscal analysis, and it collected only enough information to indicate that states deciding whether or not to decriminalize should not decide in favor of it on the basis of anticipated criminal justice system monetary savings, but rather emphasize savings of police time.

Opinions About Decriminalization

The following series of questions aim at detecting opinions about decriminalization, which for people dealing with public inebriates often means their opinions about their own jobs.

Question 29 merely checks who is seeing more or less of the public inebriate population since decriminalization. A majority of respondents reported that police, hospital emergency wards, and hospital general wards now had less contact (though some states disagreed strongly). Clear majorities replied that health care agencies and missions are seeing many more inebriates, reflecting the growth of detoxification centers and the increased freedom of the inebriates to find beds for themselves. Most respondents agreed that the general public and merchants now have more contact with inebriates. In this last respect, there were many stories about the early stages of decriminalization, when "drunks littered the streets." There are still numerous complaints from merchants in some downtown areas that inebriates bother their customers, damage or soil their property, lower the tone of their neighborhood, and commit petty crimes more often.

Going one stage further, Question 30 asks whether those who have less contact with inebriates are happy about the change. Overwhelming majorities reported that the courts and jails are happy. Police were reported as more ambivalent than might be expected, and most people did not know how hospital personnel feel. A key issue that needs determination is whether police officers feel contentment that they have fewer contacts with inebriates, or whether they are unhappy because the streets are full of inebriates and the merchants or public are complaining.

Question 31 seeks to determine whether the provisions of decriminalization are seen by the police as decreasing or increasing their discretion. Some officers feel that they have been restrained from doing their public duty, while others feel that they can still do exactly what they wish, including choosing to ignore an unpleasant task. A minority felt that their discretion has been increased in that they now have an additional

alternative of taking someone to a treatment center. Factually speaking, the Uniform Act in most states increases the individual officer's discretion by offering him a number of choices instead of just the traditional "arrest" or "no arrest" decision. Answers to this question therefore vary considerably from area to area.

Question 32 asks inebriates how they feel about their new relationship with police, or alternatively how other people believe the inebriates feel. And Question 33 creates insight into whether alcoholism personnel actually know the inebriates' sentiments, or whether they are still guessing at them. The alcoholism profession has NOT traditionally dealt with public inebriates nationwide and knew very little about skid-row when decriminalization began. Respondents indicated that the profession is learning fast, and that for the first time in many areas the alcoholism professionals are growing to know skid row.

Morale among alcoholism professionals dealing with the skid-row population is apparently high. Question 34 was one of several used as an index to that morale. Though it was phrased to evoke negative opinions, a majority of respondents indicated that the alcoholism personnel either did not find the present situation frustrating or found it so for a minor reason (shortage of funds being the major source of frustration).

Opinion among city and county managers also merits examination (Question 35). Respondents showed no widespread antagonism to decriminalization or alcoholism treatment theory, but they now tend to be either more concerned or more irritable about public inebriates than they were. In many rural counties, antagonism toward the state-level statute is strong, especially if it either did not include funding for treatment or if it required counties to provide funds. This was a major problem in several states, and in some states county managers are fighting decriminalization only because they do not want to fund treatment programs. Urban counties are similarly feeling the pressure of funding, and there have been major moves in some metropolitan areas to force direct state or federal funding for programs treating inebriates.

Finally, Question 36 seeks to determine general opinion about the actual results of decriminalization. The overwhelming majority of respondents indicated that they believe more alcohol abusers are now receiving treatment. A substantial minority reported their belief that decriminalization has caused overemphasis on the least productive subgroup (public

inebriates). People apparently believe that the level of treatment activity has increased overall, but they are not sure that all of this extra activity is worthwhile.

Voluntariness

Asked directly whether they supported the Uniform Act's emphasis on voluntariness (Question 37), everyone said yes, but hesitation occurred as soon as specifics were examined. People believe voluntariness is good because the alternative is intolerable, but many people have in mind specific subgroups whom they think should be handled involuntarily. Of course, even the Uniform Act allows for both emergency and involuntary commitment. The problem is when and how to draw the line.

Question 38 shows how strongly voluntariness has shifted society's control over inebriates. Almost all respondents indicated that the police, courts, jails, and prisons now have much less control, while the health care agencies were reported as having much more, even the detoxification centers which hold people only on a voluntary basis. However, when asked whether various agencies were happy with their loss of control (Question 39), a majority of respondents indicated that the police are not, and large minorities indicate that each of the other units is to some degree unhappy.

Very clearly, the problem of voluntariness is a major issue at the operational level. Voluntariness stops social agents from doing what they want with some public inebriates--whatever it is they may want. The police cannot move them whenever they want to. The courts cannot keep them out of the way. The health care agencies and detoxification centers cannot keep them in treatment as long as they would wish--or reject them when they wish. Particularly difficult is the issue of long-term control over the habitual repeaters, who were a concern to everyone questioned.

The Uniform Act states that a vast majority of persons treated under the terms of the Act would cooperate voluntarily. To a certain extent this avoids the most important issue: would a majority enter treatment voluntarily? Statistics indicate that many public inebriates (the proportion is unknown) do not come voluntarily to treatment, and in interviews some reported that they do not want treatment. Theoretically, they should be left alone as long as they are not incapacitated, though as we have seen some police still pick up some intoxicated persons against their will. Nonetheless, there remains a substantial population of public inebriates who do not enter or stay in the health care system.

Of those who do enter the system, it is unclear whether the majority enters voluntarily. Responses to Question 40 were not accurate or complete, but they ranged from a low of 10% to a high of 90%, with the average falling between 25% and 50%. This is not the "vast majority" referred to in the Uniform Act. Volunteers are much more common at outpatient counseling centers. Answers to Question 41 ranged between 25% and 100%, with the average somewhere near 75%. The Act seems to have overlooked the difference between the status and motivation of persons receiving immediate emergency services and those seeking long-term treatment or help.

The quality of the treatment response to the voluntary clientele is apparently much higher than that to the involuntary clientele. Responses to Question 42 were heavily in favor of "voluntary." This may not be the fault of the clients themselves. The alcoholism profession is still much happier working with voluntary than with involuntary clients, and it is only just now developing treatment modes specific to the psychology of involuntary referrals (for instance, with drinking-driver clients referred under court control).

Long-term control is an unresolved issue. Respondents to Question 43 split down the middle. Half of responding states indicated that more people were reaching state mental hospitals since the Uniform Act, and half indicated that fewer were doing so. Interviews with state mental hospitals indicated that they are having major problems retaining referred inebriates. There were also frequent complaints from sheriffs that state hospitals are releasing patients far too quickly on the grounds that either they are untreatable or the hospital lacks the power to hold them against their will. These issues are discussed further in the section on commitment. They are also closely related to changes of policy in the larger mental health care system: right to treatment, the decay of commitment laws, community-based and outpatient preferences, etc. Suffice it to say here that the long-term control of a certain proportion of chronic inebriates is a major administrative and system problem in many states and deserves further investigation.

Thus, when state alcoholism agencies were asked whether there should be a stronger emphasis on involuntary treatment for certain subgroups or under certain circumstances (Question 44), it was clearly this subgroup of chronic inebriates that led precisely half of the states to answer--unexpectedly--yes. Apparently the Uniform Act prescriptions for long-term control are inadequate to the needs of the population.

There is another increasingly popular solution to the problem of voluntariness over the long term. The Uniform Act does not mandate all inebriates and alcoholics to accept treatment, whether or not society thinks they should. Nor does it require them to give up drinking, not even in order to accept treatment. Thus the emerging popularity of the "wet hotel" concept. Asked whether the habitual repeaters who do not want to give up drinking ought to be offered a government-sponsored "protected living situation" (Question 45), a large minority of people either thought it a good idea or would be willing to consider it. They were motivated by both humanitarianism and the desire to keep communities "tidy." Some of this population, they report, are beyond "cure," but they should not therefore be incarcerated. A compromise would be the provision of government-sponsored residences, which would take away business from the hotels which offer accommodation in many skid-row areas. "Government-sponsored" need not mean "government-paid." The present hotels operate at a profit, and there was some belief among interviewed personnel that the government could do the same job less exploitatively and better. Other interviewees were highly skeptical of the idea.

The combination of decriminalization, voluntariness, and treatment is thus not powerful enough to do everything a community might wish. It deliberately limits society's powers over public inebriates, though without any apparent damage to social or community structure. The important remaining problem is what to do about those inebriates who do not accept the standard pattern contemplated by the Uniform Act. Are the police and the treatment agencies obligated to provide them with the care they want? Reciprocally, to satisfy society's demands that the public inebriate population not offend or disturb them, must we weaken voluntariness and make custody, treatment, and confinement mandatory for some public inebriates?

It should be noted that at present a majority of states (including some in which the Uniform Act has been passed) retain some police powers and some treatment methods by means of which community control may continue. Compromise is in other words already frequent, and clearly the easier route. Unless policy about these subgroups is clarified, more communities will take the easy route, and the intentions of the Uniform Act will be diluted.

SECTION IV: STATE AGENCY RESPONSIBILITY AND PROGRAM STANDARDS

State Agency Responsibility and Program Standards

QUESTIONS

1. Does your state's version of the Act establish a state alcoholism agency of substantially the same nature and authority as outlined in the Uniform Act?

   _____ Yes _____ No

2. If yes, would such an agency have come into being without the Uniform Act?

   _____ Yes

   _____ No

   _____ Unlikely

   _____ Probably

3. What effect did the enactment of the Uniform Act have on state government organization and responsibility for alcohol services?

   _____ None

   _____ Created the state alcoholism agency

   _____ Reassigned responsibility for alcohol services to state department of health or mental health

   _____ Required appointment of qualified professional as director of state alcoholism agency

   _____ Increased the powers or authority of the state alcoholism agency

   _____ Increased the duties of the agency

   _____ Created a state interdepartmental coordinating committee

   _____ Created a citizen's advisory council on alcoholism

4. Has the state alcoholism agency been strengthened or weakened by the Uniform Act (or related legislation)?

_____ No appreciable impact

_____ Greatly strengthened

_____ Weakened

_____ Needed stature in state government achieved

_____ Stature reduced

_____ Agency submerged in a department (e.g., health, mental health)

_____ Agency given needed authority over treatment programs

_____ Antagonism caused between agency and treatment programs

_____ Agency strengthened on paper, but not in funding or staff

5. Which of the powers or authority of the agency have caused the most uneasiness?

_____ Plan, establish, and maintain treatment programs

_____ Contract for services with public and private agencies

_____ Solicit and accept funds from any source (including federal government)

_____ Cooperate with the federal government in securing alcohol funds

_____ Administer or supervise the administration of any state plan submitted for federal funding of alcohol services

_____ Coordinate agency activities and cooperate with alcohol programs in this and other states

_____ Maintain records and collect statistics

_____ Engage in research

_____ Acquire real property and provide alcohol treatment facilities through lease or construction

_____ Contract for use of treatment facilities

6. Which of the duties of the state alcohol agency have caused the most uneasiness in your state?

_____ Develop and promote plans for prevention and treatment of alcoholism

_____ Provide technical assistance and consultation

_____ Solicit and coordinate public and private efforts in prevention and treatment

_____ Cooperate with the state corrections agency in establishing and conducting treatment programs for inmates and parolees

_____ Cooperate with educational agencies in programs in prevention and treatment (including preparation of school curriculum materials)

_____ Prepare and disseminate educational materials on the nature and effect of alcohol

_____ Develop and implement an educational program on the nature and effect of alcohol as an integral part of alcohol treatment programs

_____ Organize and foster training programs for treatment personnel

_____ Sponsor and encourage research in the causation and treatment of alcoholism

_____ Serve as a clearinghouse for alcohol information

_____ Specify uniform methods for keeping statistical information by all agencies

_____ Provide relevant statistical information

_____ Advise the governor in the preparation of the alcohol treatment component of any state comprehensive health plan

_____ Review all state health, welfare, and treatment plans to be submitted for federal funding and advise the governor on the alcohol services provisions

6. Continued. . . .

_____ Assist and cooperate with alcohol education and treatment programs for state and local employees

_____ Assist and cooperate with alcohol education and treatment programs for business and industry

_____ Utilize all resources (particularly recovered alcoholics) to encourage alcoholics to enter treatment voluntarily

_____ Cooperate with state highway safety agencies to establish and conduct programs for drinking drivers

_____ Encourage hospitals and health facilities to admit alcoholics and intoxicated persons without discrimination

_____ Encourage hospitals and health facilities to provide alcoholics and intoxicated persons with adequate and appropriate treatment

_____ Encourage all health and disability insurance programs to include alcoholism as a covered illness

_____ Submit annual reports to the governor on the activities of the state agency

_____ Establish a comprehensive and coordinated program for the treatment of alcoholics and intoxicated persons

_____ Establish standards for approved treatment facilities

_____ Inspect programs and ensure compliance with standards

_____ Adopt rules for acceptance of persons into alcohol treatment programs

_____ Maintain custody and provide care of alcoholics who have been committed involuntarily to the state agency

7. Within the state, who is uneasy (or likely to be) about the powers and duties of the state alcoholism agency (as outlined in the Uniform Act)?

_____ State alcoholism agency

_____ State funding units (legislative or executive)

_____ State Health Department

_____ State Mental Health Department

_____ State or local drug programs

_____ Public alcoholism programs

_____ Private alcoholism programs

_____ Police and other criminal justice personnel

_____ Medical profession

_____ General public

_____ Alcoholics and intoxicated persons

_____ Volunteer alcohol service providers (e.g., AA)

8. Where are the five particular weaknesses and strengths of your state alcoholism agency in working with communities to provide services dictated by the Uniform Act (or equivalent)? (Check five in each column.)

	Strength	Weakness
Advance planning	_____	_____
Staffing	_____	_____
Funds	_____	_____
Training and education	_____	_____
Setting standards and guidelines	_____	_____
Direct delivery of services	_____	_____
Monitoring nature of program operations	_____	_____
Monitoring success of operations	_____	_____
Monitoring budget	_____	_____
Coordination statewide	_____	_____
Coordination at the community level	_____	_____
Setting annual or biennial program priorities	_____	_____
Working with the legislature	_____	_____
Setting up demonstration or pilot projects	_____	_____
Invoking help of state legal system	_____	_____
Invoking help of other state agencies	_____	_____

9. Indicate how many staff, and what king of staff, should be added to the state alcoholism agency in order to implement the Uniform Act.

10. Does your state have a Citizen's Advisory Council as recommended in the Act?

_____ Yes _____ No

11. Does such a Council assist implementation?

_____ Yes _____ No

12. How can the Citizen's Advisory Council best be used to assist in the implementation of the Uniform Act?

_____ Has no practical role

_____ Act as a political buffer

_____ Approve (or recommend approval) of grant requests

_____ Advise on broad policies and goals

_____ Advise on operational decisions

_____ Carry on public education activities

_____ Review and approve state alcohol plans

_____ Assist with legislators

_____ Assist with community managers

_____ Create an alcoholism constituency

13. Does your state have an Interdepartmental Coordinating Committee as provided in the Act?

_____ Yes _____ No

14. Is such a Committee worth the effort?

_____ Yes _____ No

15. How can the Interdepartmental Coordinating Committee best be used to assist in the implementation of the Uniform Act?

_____ Has no practical role

_____ Coordinate state-agency programs for delivery of alcohol services

_____ Promote alcohol services for employees of state government

_____ Provide constructive input into the state plans for alcohol services

_____ Generate funding support at the state level for alcohol services

_____ Place pressure on federal agencies to change priorities

16. In what areas has your state alcoholism agency (or legislature) promulgated guidelines and standards for the treatment of alcoholics?

_____ Defining treatment terminology

_____ Establishing minimum facility needs

_____ Laying out the continuum of care

_____ Describing general operational principles

_____ Describing detailed legal requirements

_____ Specifying staffing requirements

_____ Specifying staffing credentials and qualifications

_____ Setting goals for various types of treatment

_____ Defining minimum standards for "therapy" and "education"

_____ Record-keeping

17. Do such guidelines and standards promote or stifle local quality and creativity in alcoholism treatment?

_____ Promote

_____ Stifle

_____ A little of both

_____ Don't know

18. Has your state adopted the minimum program standards required by the Uniform Act?

_____ All _____ Most _____ Some

19. Have minimum standards for public and private treatment facilities and programs been adopted by either statute or regulation?

Yes	No	
_____	_____	Health standards for a facility
_____	_____	Standards of treatment to be afforded patients at a treatment facility
_____	_____	Standards for immediate services (including emergency care and shelter) for intoxicated and incapacitated persons
_____	_____	Standards for acceptance in a treatment program
_____	_____	Standards on admission, minimum assistance, and referral of alcoholics (for non-immediate services)

20. Do the standards for immediate services at approved treatment facilities comport with the requirements of the Uniform Act?

Yes	No	
_____	_____	An immediate examination by a licensed physician is required as soon as possible
_____	_____	An intoxicated person may come voluntarily for emergency treatment at an approved facility
_____	_____	An incapacitated person must be brought involuntarily by the police or emergency service patrol for emergency treatment at an approved facility
_____	_____	A person (intoxicated or incapacitated) may be admitted to the facility, referred to another health facility, or refused admission
_____	_____	The referring facility must arrange for transportation to another health facility
_____	_____	If a person is not admitted or referred and is without funds, the facility may take him to his home
_____	_____	If a person is not admitted or referred, is without funds, and has no home, the facility must assist him in obtaining shelter
_____	_____	After immediate services, a patient must be encouraged to agree to further diagnosis and appropriate voluntary treatment (if the physician in charge of the approved facility determines it is for the patient's benefit)

21. Do the standards for the admission, minimum assistance, and referral of alcoholics (for non-immediate services) comport with the requirements of the Uniform Act?

Yes	No	
_____	_____	An alcoholic may apply for voluntary treatment directly to an approved treatment facility
_____	_____	The facility administrator may determine who will be admitted
_____	_____	The facility administrator must refer refused applicants to another approved facility if possible and appropriate
_____	_____	The approved facility personnel must encourage outpatient or intermediate care after a patient leaves inpatient care
_____	_____	The state alcoholism agency must arrange for assistance in obtaining supportive services and residential facilities for alcoholics who require such help
_____	_____	The state alcoholism agency must make reasonable provisions for transportation home or to another facility for those patients leaving an approved facility
_____	_____	The state alcoholism agency must assist homeless patients in obtaining shelter upon leaving an approved facility

22. Have minimum standards for acceptance of persons into treatment programs been adopted by statute or regulation?

_____ Yes _____ No

23. Do these "acceptance" standards reflect the policy guidelines expressed in the Uniform Act?

Yes	No	
_____	_____	A preference for treatment on a voluntary basis, if possible
_____	_____	A preference for outpatient or intermediate treatment (unless inpatient treatment is required)
_____	_____	No denial of treatment solely because of prior withdrawals or relapses
_____	_____	Preparation and maintenance of an individual treatment plan for each patient
_____	_____	Provision for a continuum of coordinated treatment services as needed in each individual case

24. Does the Act's provision that a person cannot be denied treatment solely because he is a repeater affect adversely the operations of your treatment agencies? Which agencies?

	Affected	Unaffected
a. Emergency care (hospitals)	_____	_____
b. Sleep-off or drop-in centers	_____	_____
c. Detoxification centers	_____	_____
d. Inpatient care (hospital or other)	_____	_____
e. Intermediate care	_____	_____
f. Outpatient	_____	_____
g. Residential	_____	_____

25. Which of the following agencies cannot or will not cooperate with the "current individual treatment plans" called for in the Act? (Check.)

_____ Hospital emergency rooms

_____ Hospital regular wards

_____ Hospital psychiatric wards

_____ Sleep-off or drop-in centers

_____ Jail-based detoxification centers

_____ Other detoxification centers

_____ Inpatient centers

_____ Outpatient counseling centers

_____ Residential centers

26. Which of the following agencies can and does regularly <u>initiate</u> an individual treatment plan?

_____ Hospital emergency rooms

_____ Hospital regular wards

_____ Hospital psychiatric ward

_____ Sleep-off or drop-in centers

_____ Jail-based detoxification centers

_____ Other detoxification centers

_____ Inpatient centers

_____ Outpatient counseling centers

_____ Residential centers

27. Is it easier or harder for large urban areas to operate individual treatment plans than for small-town or rural areas?

_____ Easier _____ Harder _____ Don't know

28. What are the best ways to ensure that minimum standards for treatment facilities and programs are met?

_____ State licensing or "approval" of facilities and programs

_____ State licensing or certification of treatment professionals

_____ Outside accreditation of programs

_____ Voluntary compliance only

_____ Application of criminal penalties

_____ Provision of financial incentives

_____ Application of financial penalties for non-compliance

_____ State provision of technical assistance

_____ Periodic monitoring and inspection

29. If a hospital regularly refuses to admit inebriates for needed treatment (other than physical injury), what course of action would you recommend for and against?

	For	Against
a. Attempts to educate staff	_____	_____
b. Written agreements with management	_____	_____
c. Switch to a more cooperative medical unit	_____	_____
d. Fund a special reception unit in the hospital	_____	_____
e. Fund a special receiving center outside the hospital	_____	_____
f. Turn to legal action which could result in hospital losing federal funds	_____	_____

30. Does the state alcoholism agency have responsibility for ensuring the quality of alcohol treatment facilities and services by adopting minimum treatment and health standards?

_____ Yes

_____ No

_____ Partial responsibility

31. If no or partial responsibility, what other agencies have this responsibility?

List:

State Agency Responsibility and Program Standards

COMMENTARY

Responsible State Agency

The Uniform Act requires creation of a responsible state alcoholism agency, with clearly defined powers and duties. Some experts believe that the support lent by the Uniform Act to the broader movement making Divisions of Alcoholism viable and important agencies within state government may in the long run prove more significant than its support for decriminalization. Certainly, the Act's impact in this movement has been neglected by observers, and the following set of questions is to enable determination as to whether or not the Act has had the high degree of impact it intended in this area.

Question 1 simply determines whether or not a state alcoholism agency of the kind contemplated by the Act does exist. (Experience shows that titles should NOT be accepted as evidence of compliance with the Act's provisions.) Question 2 attempts to estimate whether the Act alone created the agency or was a coincidental occasion for its creation. Of the twelve state alcoholism agencies asked this question, four chose "No" or "Unlikely," indicating that the Act has indeed had a major impact in establishing state alcoholism agencies.

Question 3 investigates whether the specific provisions of the Act concerning the state government's role as regards alcoholism were implemented, and whether the Act caused changes in government organization. In some very few states, most of these provisions were enacted independently of the Act, while in other states there was a period of general reorganization during which similar provisions and decriminalization were enacted piecemeal. But again, a substantial minority of states attributed these important elements of reorganization directly to the Uniform Act.

Question 4 investigates further whether the reorganization was beneficial. Respondents found it necessary to give explanations to their answers here, but the general impression was twofold: the Act has strengthened the state alcoholism agencies in relation to both other state agencies and local treatment programs, but at present a period of negotiation and exploration is taking place with the result that final results are not clear.

Agency Powers and Duties

The Uniform Act carefully outlines a series of powers and duties of the state alcoholism agency. "Powers" signifies areas where the agency has the authority to act if it so chooses; "duties" signifies areas where it is required by law to act. Though the current study did not examine the particulars of each state's legislation, it emerged that many states alter

or diminish the list appearing in the Uniform Act--a major reason for concluding that the Act has proven more "model" than "uniform."

Further, amendment of the original legislation is becoming frequent, particularly if it moved quietly through the legislature when first passed. Questions 5 and 6 therefore become important in determining what is happening or likely to happen as a result of experience, pressure, or legislative horse-trading. Finally, many state alcoholism agencies have not yet had time (or staff) to pay attention to all their prospective powers and duties, especially those where planning prior to enactment was too brief or where the legislature failed to provide adequate funds. Thus, these questions enable determination of the priorities of the state alcoholism agency itself.

Interviews with state alcoholism agencies provided no clear picture of what is happening nationwide in this area. Generally speaking, the powers and duties traditional to any government agency seem to have caused no difficulties (e.g., planning, funding, coordinating, contracting). Different states are choosing different patterns, and showing different degrees of initiative and achievement, as one would expect.

Answers to Question 5, concerning powers, indicated weakness or neglect in "research" and in the maintenance of "records and statistics," but even here there were notable exceptions. Many state agencies are still trying to establish administrative procedures, while others are moving rapidly into more activist areas.

Answers to Question 6, concerning duties, showed considerable scattering. One general complaint emerged: that Federal government priorities as reflected in available funding often caused conflict with the orderly assumption of Uniform Act duties. Apparently the strong pressure placed by categorical grants sometimes overworks small state agency staffs, causing them to interrupt other duties. Apparently also the speed with which federal priorities have changed recently is too great for the slower and more orderly progression needed in state-to-community relationships.

It seems that two general areas are causing widespread problems: relationships with state agencies in other areas; and relationships with treatment programs. For instance, relationships with state corrections agencies are generally weak (and even weaker with other criminal justice agencies and state criminal justice planning agencies). However, a handful of states have moved far ahead of others and of the Federal government in this area, simply because they find

the relationships very productive. Similarly, cooperation with state highway safety agencies seems to have been spasmodic or token in most states, though it is frequent at the community level, and again a handful of states are moving ahead and finding great rewards in the process. Advanced states in both areas believed that increased emphasis from the federal level, including the dissemination of information from state to state, would be highly beneficial, and many states complained that the equivalent federal departments (DHEW, DOJ, DOT) lack coordination.

Relationships with the medical profession and hospitals remain uneasy (as appears also in this report's section dealing with immediate services). Decriminalization is definitely causing positive changes in some hospital staff concerning alcoholism as a disease, but no state agency reported satisfaction with its current inroads with the medical profession as a whole.

New problems are apparently emerging with alcoholism treatment programs because of the duties to establish and monitor standards ("approval"), to inspect and ensure compliance, and to collect data for management information and project evaluation. Irritation at the state agency was frequently expressed by programs unused to state requirements, and most states reported considerable expenditure of effort in defining their different roles.

Information collected on other issues raised by Questions 5 and 6 (e.g., insurance programs) was inadequate to allow this study to make generalizations.

Answers to Question 7 provided some surprises but no consensus. The question is aimed at determining whether the Act has had impact by raising the visibility of the state alcoholism agency, and it has apparently done so, to the extent that all the listed categories received at least one vote, except for "general public" and "alcoholics and intoxicated persons." Some funding units had shown their suspicions during the process of enactment and restricted the powers and duties of the state alcoholism agency. Some alcoholism agencies were themselves uneasy about their new powers, as were the parent departments. Within the alcoholism field, there is much jostling for position with newly energized state agencies, and the medical profession was reported as an especially difficult companion. Answers to the question, however, depend very much on state dynamics, and there was no overall complaint about the Uniform Act's concept of the desirable degree of visibility.

In summary, the following is a list of the powers and duties reported during interviews by at least two agencies as having caused areas of difficulty:

- commitment laws
- clients being committed to custody of state alcoholism agency
- mandatory medical powers possessed by agency
- agency mandated, but not funded, to provide treatment
- licensing of treatment facilities
- regulation of treatment facilities
- preference for voluntary services
- emphasis on outpatient services
- program standards (monitoring and evaluation)
- local accountability to state agency

The state alcoholism agencies were asked in Question 8 to evaluate the strengths and weaknesses of their own agency in relationship to communities. They found the question difficult to answer, and there was a scattering of replies. The extremes, however, were reasonably clear. Most state alcoholism agencies regard themselves as strong at advance planning, at setting standards and guidelines, and at working with the state legislature. They see themselves as weak in direct delivery of services, staffing, and monitoring budgets. They see themselves more often as strong than weak in funds, training and education, and invoking the help of the state legal system or other state agencies. They regard themselves more often as weak than strong in monitoring the success and the nature of program operations (connected with staffing), setting up demonstration or pilot projects, and coordination at the community level. (This set of choices reveals the current uneasiness in state and local relationships.) Interestingly, equal numbers chose "statewide coordination" as a strength and as a weakness, the only category where there was a draw.

Finally, Question 9 indicated that many delays in implementation of the Uniform Act are being caused by a failure to add staff to the state alcoholism agency. Answers to the questions were too diffuse to report, but the general pattern of understaffing was clear and seemed real. Most agencies want more planning and evaluation personnel (especially data experts), and many need more field personnel (e.g., area coordinators, educators). Numbers of extra staff requested were small, but they seemed significant. (One issue worth examination was raised by interviewees, and that is the high value of alliance with Public Health and Mental Health Regional staffs. Though such alliances produce their own problems, several state agencies exploiting these structures reported reductions in their overload.)

Citizen's Advisory Council

The Uniform Act requires the Governor to establish a Citizen's Advisory Council for the two main purposes of advising the state alcoholism agency and assisting creation of an alcoholism constituency.

All interviewed states (Question 10) had created such a Council, and two-thirds of them found it useful (Question 11). The list of possible activities for such a Council presented in Question 12 was suggested by interviewees, and the Councils are performing these functions in at least one state each. However, the nature of a Council's activities depends on the nature of the membership and of the Director of the state alcoholism agency, and some Directors felt very strongly for or against individual items on the list. There seemed a lack of researchers on such Councils (contrary to the Act's recommendation). Some state agencies had created the Council before decriminalization and had used it to help pass Uniform Act legislation.

Interdepartmental Coordinating Committee

The Uniform Act calls for creation of an Interdepartmental Coordinating Committee, with recommended composition of representatives from public health, mental health, education, public welfare, corrections, highway safety, public safety, vocational rehabilitation, other appropriate agencies, and the director of the state alcoholism agency.

A narrow majority of states reported having such a Committee (Question 13), but in some states still lacking a Committee, this was despite the efforts of the state alcoholism agency. A heavy majority voted that such a committee was "worth the effort" (Question 14).

Answers to Question 15 indicated some skepticism about coordinating committees (a minority of states chose "no practical value"), but everyone voted for most of the other choices, indicating that the state directors are alert to the opportunities of joint programs and funds, the need to exploit and educate existing programs in other subject-areas, and the value of harmonious state attitudes when facing federal policy. Several states have already produced documents and programs well ahead of national-level intentions, especially in the areas of criminal justice, corrections, and highway safety. Alcohol services for state government employees seemed an especially weak area. Respondents also reported almost unanimously that more effort should go into Interdepartmental Coordinating Committees and expressed regret that coordination is not greater at the federal level.

Program Standards

The Uniform Act calls for the state alcoholism agency to establish, promulgate, and monitor guidelines and standards for treatment programs for alcoholics and intoxicated persons, and most state agencies are in the process of doing so (Question 16). Almost all have attempted to define treatment terminology and establish minimum facility needs, while a majority have described the care continuum and general operational principles for programs. Problems surround the specification of staffing requirements, credentials, and qualifications, and the setting of standards and goals for treatment, since these intrude more deeply upon treatment programs and adversely affect some ongoing programs. Record-keeping standards and--distressingly--legal requirements have received markedly less attention.

The level of activity in the whole area of program standards did not seem high. At least half of the interviewed states reported large gaps. Some have no guidelines and standards, or token standards. Confusion and caution, rather than neglect, are the cause for this low level of activity. It was noteworthy that a majority of states indicate this as the most important single area where they thought federal or national agencies could help, especially by the exchange of standards and guidelines from state to state.

Most states thought that guidelines and standards were necessary and an appropriate function of state alcoholism agencies, an area where they performed well. But a noteworthy minority of states thought that such standards could stifle local creativity in a field where no one yet knows what is best (Question 17). The general opinion, however, was best expressed by one director, who said there had been "chaos without them," and by the advice of several directors that they should be promulgated in advance of decriminalization.

The next sequence of questions is aimed at determining whether the program standards in the state are the same as those in the Uniform Act. The general answer must be: not always. For instance, when asked whether their states had adopted the minimum program standards required by the Act, the response of the majority appeared to be "most" or "some" (Question 18). But when responding to a series of more specific inquiries, they reacted much more affirmatively. For example, all questioned states have adopted minimum standards for treatment facilities (Question 19), following or anticipating the Act's intent. The specific requirements of the Uniform Act as to standards for "immediate services"

(Question 20) and for "non-immediate services" (Question 21) have been overwhelmingly carried out, but there was some hedging on the part of respondents, and some strange and important departures from the norm. It is suspected that the Act may be less uniform nationwide in this area than was intended, and an appropriate national organization would provide a useful service by examining the situation in all states. (Interviews showed also that many of these program standards were NOT always being met by programs.)

The dilemma became clear in answers to Questions 22 and 23. Minimum standards for the acceptance of persons into treatment appeared in all states, either in statutes or in subsequent regulations. Examined to see whether those standards reflected those of the Uniform Act, state situations showed a less clear picture, particularly when implementation at the program level was studied. All states show, for instance, a "preference" for voluntary treatment, but a few statutes allow reliance on coercion (though not involuntariness) in a significant number of situations. The preference for outpatient treatment was universal, though not always expressed in statute, and the situation was the same for "no denial because of withdrawal or relapses," and for the "individual treatment plans." Statutes called everywhere for the establishment of a continuum of coordinated services, but state alcoholism agencies complained that funds for implementation were inadequate or absent. Operationally, some standards are not always enforced at the program level: particularly the provisions for no denial, individual treatment plans, and continuum of services.

Some respondents reported that compliance with all these standards could and should be evaluated at both the state level and the program level. Others advised that evaluation of compliance would be premature. Many states are already attempting evaluation, and they report difficulties at the program level in both morale and capability. No agency at the federal level is presently charged with evaluating compliance from state to state.

The problems of compliance and evaluation emerge, for instance, in the answers to Question 24, dealing with the acceptance of habitual repeaters. Though the great majority of respondents indicated that their operations were <u>not</u> adversely affected by being compelled to accept habitual repeaters, significant numbers in all groups of treatment facilities indicated that they were indeed adversely affected. Detoxification centers, striving not to become revolving doors, are particularly vulnerable to this requirement, and not all of them obey the legal requirement universally and invariably. At the same time, no agency could produce

figures to show whether habitual repeaters were being rejected, or if so, how many. It is therefore currently impossible to judge whether this is a major problem. Compliance and noncompliance, and their programmatic significance, cannot yet be evaluated other than anecdotally.

As another example, respondents to Question 25 concerning the requirement for individual treatment plans suggest that a majority of hospital emergency rooms, hospital regular wards, and sleep-off or drop-in centers in a majority of states either cannot or will not cooperate with the individual treatment plan provision. There were significant failures also among jail-based detoxification centers, residential centers, and psychiatric wards, but the detoxification centers, inpatient centers, and outpatient counseling centers were reported as performing well in this regard. The problem may lie in the initiation of the individual treatment plan, as shown by answers to Question 26. Inpatient and outpatient centers were reported as excellent at initiating plans, and residential centers ranked only slightly behind. Detoxification centers and psychiatric wards were ranked as performing reasonably well, but the record of jail-based detoxification centers, sleep-off or drop-in centers, hospital regular wards, and hospital emergency rooms is apparently very poor. Of course, the concept of a treatment plan may be simply inappropriate to this latter group, and it may be that the Uniform Act's requirement needs refinement. The issue needs attention; in some states requiring treatment plans, some program personnel did not know that they existed, while others were being both thorough and imaginative. An additional problem is, of course, interagency records. Systems of transfer are almost everywhere hopelessly inadequate. Answers to Question 27 divided equally between the three categories, indicating that most jurisdictions perhaps are not even examining the problems.

The final group of questions deals with the activities of the state alcoholism agency in enforcing program standards. The list of suggestions in Question 28 as to methods of ensuring compliance with minimum program standards was gleaned from both the Uniform Act and the state alcoholism agencies. The Act's recommendations for "approval" and "monitoring" of programs by the agency were universally acceptable but evaluated as very difficult. "Voluntary compliance" was distrusted, strongly. All other categories received scattered support.

Question 29 raised the particularly thorny issue of acceptance by hospitals, where cooperation is generally weak. Everyone favored "attempts to educate staff" and

"written agreements with management." A majority favored leaving the hospital alone by either switching to a "more cooperative" medical unit or funding an outside detoxification center, though minority disagreement was vociferous. Some state agencies advocated compromise: give the hospital funds for a special unit. A vocal minority advocated militancy: have HEW take action under P.L. 93-282 to threaten hospitals receiving federal funds with loss of those funds if they failed to comply with the law. This was regarded as a necessary (and in some jurisdictions, imminent) last resort.

The last two questions (30 and 31) raise the basic reason for the existence of program standards: who is in charge of seeing that alcoholics and intoxicated persons receive good quality treatment?

One of the Uniform Act's major significances is its attempt to encourage quality in a field where people for so long have been content that anything at all was being done. The implication behind many of its standards is that the state alcoholism agency should engage in a search for quality by defining it, requiring it, and disaffiliating from those programs which do not provide it. The Act emphasizes only minimum standards, but it clearly does not restrict the state alcoholism agency to the role of watchdog. This thrust caused some uneasiness among state division directors and program directors, but there was widespread agreement that improved quality of programs was a legitimate aim for government.

If legislation does not specify who is in charge of assuring quality, system weaknesses can quickly appear, and interviews show that they have already done so. For example, one detoxification center was in danger of forced closure because a local fire department had declared its building unsafe. No person interviewed could tell us whether this was a legitimate ruling, or one resulting from the desire of downtown merchants to shift the center elsewhere. And no program person had checked with the fire department in advance of opening the center. Whose was the responsibility? Again, in two states interviewed there were problems for programs certified by the state alcoholism agency but now faced with inspection to fit the standards of other departments of state government (e.g., Public Health). Problems of another nature emerged with facilities following a theory of treatment that did not meet the expectations of the state alcoholism agency, or with programs whose fiscal systems were suspect in the eyes of the bureaucracy. In one community, an old-time flophouse qualified (for a time) for

supplementary government funds because of the absence of promulgated standards. These horror-stories are extremely rare. They are told here only to indicate the need for clarity in the area of standards enforcement, upon which all state alcoholism agencies agreed.

SECTION V: COMPREHENSIVE AND COORDINATED TREATMENT

Comprehensive and Coordinated Treatment

QUESTIONS

1. Did your state have or intend a comprehensive and coordinated program for the treatment of alcoholics and intoxicated persons prior to the Act?

   _____ Yes _____ No _____ Sort of

2. Did passage of the Uniform Act (or equivalent) substantially alter the state's intentions concerning creation of a coordinated and comprehensive treatment program?

   _____ Yes _____ No

3. Did the state have programs or planned programs specifically for public inebriates prior to the Act?

   _____ Yes _____ No _____ Sort of

4. Did passage of the Uniform Act (or equivalent) substantially alter the state's intentions concerning providing treatment for public inebriates?

   _____ Yes _____ No

5. How much effect did the Uniform Act have on directing your state toward a comprehensive and coordinated program?

   _____ None

   _____ A little

   _____ Moderate

   _____ Much

   _____ Considerable

6. Toward which area of concern--comprehensiveness or coordinated program--has the state agency directed its primary attention?

_____ Resource development (comprehensiveness)

_____ Resource coordination

_____ Equal attention to both

_____ Inability to focus on either area

7. Which elements of the comprehensive and coordinated program are strongest and weakest in your state?

	Strong	Weak
Emergency medical services	_____	_____
Sleep-off	_____	_____
Detoxification centers (non-jail)	_____	_____
In-patient	_____	_____
Residential care	_____	_____
Outpatient	_____	_____
Follow-up and referral	_____	_____
Prevention	_____	_____
Spectrum of modalities	_____	_____
Variety of facilities	_____	_____
Transportation	_____	_____
Education and consultation	_____	_____
Integration with other services	_____	_____

8. In your opinion, does your state at present provide adequate and appropriate treatment for intoxicated persons and alcoholics who are...

	Yes	No
a. Admitted voluntarily	_____	_____
b. Admitted under protective custody	_____	_____
c. Under emergency commitment	_____	_____
d. Under involuntary commitment	_____	_____
e. In need of long-term custodial care	_____	_____
f. In need of crisis intervention	_____	_____

9. Which groups of drinkers are not receiving anything like the degree of attention which you would like to see available to them? (Choose three only.)

_____ Habitual public inebriates

_____ Functioning alcoholics

_____ Women

_____ Juveniles

_____ Polydrug addicts/abusers

_____ Racial minority groups

_____ Drinking drivers

_____ Prison population

_____ Families of alcoholics

_____ Aged persons

_____ Employees

10. Which of the following groups of drinkers are receiving, in your opinion, undue attention, i.e., at the expense of groups who need or deserve it more? (Choose three only.)

_____ Habitual public inebriates

_____ Functioning alcoholics

_____ Women

_____ Juveniles

_____ Polydrug addicts/abusers

_____ Racial minority groups

_____ Drinking drivers

_____ Prison population

_____ Families of alcoholics

_____ Aged

_____ Employees

11. In your opinion, is the Uniform Act (or equivalent) responsible for any inequities among subgroups?

_____ Yes _____ No

12. Which kinds of service have been created or strongly stimulated as a direct result of the Uniform Act?

_____ Emergency civilian patrol

_____ Emergency medical services

_____ Transportation

_____ Sleep-off

_____ Detoxification centers (non-jail)

_____ In-patient for public inebriates

_____ Outpatient

_____ Residential care

_____ Follow-up and referral

_____ Prevention

13. Does your state program follow the Uniform Act requirement that emergency treatment (including detoxification) be provided by a facility affiliated with or part of the medical service of a general hospital?

_____ Follow

_____ Ignore

_____ Attempt to follow where possible

14. Has your state made use of intra-state regionalization for the conduct of the state program, a recommended option in the Act?

_____ Yes _____ No

15. Does regionalization help or not help in the following areas:

	Help	No help
Statewide uniformity in service delivery	_____	_____
Creation of "alcoholism constituency"	_____	_____
Solution of funding problems	_____	_____
Equity between rural and urban areas	_____	_____
Local vs. state disputes	_____	_____
Monitoring and management	_____	_____
Flow of information (data)	_____	_____
Overcoming resistant communities	_____	_____
Planning services delivery	_____	_____

16. Should services to public inebriates be organized on the basis of---

_____ Single communities

_____ Individual counties

_____ A district formed of several counties

_____ A region designated by a state agency

_____ Statewide

_____ Other (specify)

17. Within a community with a significant public inebriate population, which agency should coordinate the public inebriate program?

_____ Police

_____ A single treatment agency

_____ A consortium of treatment agencies

_____ A single administrative agency (specify)

_____ The courts or a judge

_____ Citizen's committee

_____ Employee of city or county management

_____ A community board with defined responsibility

_____ State alcoholism agency

18. Should any coordinator of a community's public inebriate program be paid by---

_____ The community

_____ The state

_____ Special federal funds

_____ All of the above

19. Has the state alcoholism agency successfully followed the policy of the Uniform Act in coordinating and using of all appropriate public and private resources in the state program?

_____ Successful

_____ Unsuccessful

_____ Not state policy

20. What degree of cooperation has there been between private and governmental agencies delivering services to the skid-row population?

_____ None

_____ A little

_____ Considerable

_____ A great deal

21. Has the amount of private and charitable activity in skid-row areas declined since governmental services became available?

_____ Yes _____ No _____ Don't know

22. Is increasing involvement of the government with public inebriates likely to cause a decline in private or charitable services to the population?

_____ Yes _____ No _____ Don't know

23. Which of the following kinds of non-government services are available to the skid-row population in your state's urban areas?

_____ Salvation Army shelter

_____ Mission shelter

_____ Free or charity-supplied food

_____ Dormitory-type shelter (private)

_____ Flophouses

_____ Casual labor referral center

_____ Check-cashing protection

_____ Banking

_____ Storage of personal items

_____ Private or charitable medical services

24. Should the government provide special voluntary protective services (non-residential) for skid-row persons, whether or not they are drinking, e.g., banking, storage, mail receipt?

_____ Yes _____ No

25. Should the government encourage private agencies to offer such life-style maintenance?

_____ Yes _____ No

26. Indicate whether you are for or against the concept of a government-supported "wet" hotel for certain subgroups.

_____ For _____ Against

27. Is anyone in your community or state government, in a voluntary or official capacity, assigned the task of protecting the rights of the public inebriate population?

_____ Yes _____ No

28. Which two terms best describe the present system in your state for handling chronic public inebriates?

_____ Warehousing

_____ Revolving door

_____ Custodial care

_____ Treatment

_____ Lifestyle maintenance

_____ Neglect

_____ Emergency care

_____ Fragmented

29. Based on experience of present programs, indicate what proportion of repeating public inebriates (A) are capable of marked improvement; (B) are incapable of marked improvement; (C) will make marked improvement under present programs; (D) would make a marked improvement if more funds were available.

	A	B	C	D
2%	_____	_____	_____	_____
Less than 10%	_____	_____	_____	_____
About 25%	_____	_____	_____	_____
About 50%	_____	_____	_____	_____
More than 50% (specify)	_____	_____	_____	_____

30. Is the process of referral from detoxification centers to outpatient counseling--for public inebriates--working well?

_____ No

_____ Minimally

_____ Needs work

_____ Reasonably

_____ Very well

31. Are public inebriates entering outpatient counseling staying with the program a reasonable amount of time and with some success?

_____ No

_____ Minimally

_____ Some

_____ Many

_____ Most

32. Has the Uniform Act reduced the size of the inebriate population on skid row?

_____ Yes

_____ No

_____ A little

_____ Don't know

33. Has the state alcoholism agency been successful in meeting the Uniform Act mandate to establish a comprehensive and coordinated program for the treatment of alcoholics and intoxicated persons?

_____ Yes _____ No _____ Reasonably

34. Indicate the two major reasons for inadequacies in comprehensiveness and coordination. Lack of...

_____ Funding

_____ Trained personnel

_____ Time since enactment

_____ Concern at the community level

_____ Spectrum of modalities and services

_____ Records system

_____ Clear demarcation of agency responsibility

35. What is the best strategy for achieving statewide implementation of comprehensive and coordinated treatment programs? (Check one.)

_____ State mandate, initiative, and responsibility

_____ Regional organization

_____ Local (community or county) initiative over time

_____ Liquor tax with earmarked funds to local government

36. What positive results has implementation of the Uniform Act caused?

_____ A marked expansion of alcoholism services

_____ Greater integration of coordination of services statewide

_____ Better coordination of services at the community level

_____ More interagency cooperation between government units

_____ Creation of kinds of service previously inadequate

Comprehensive and Coordinated Treatment

COMMENTARY

Introduction

In terms of ultimate effects on communities and states, the Uniform Act's requirement for a "comprehensive and coordinated program for the treatment of alcoholics and intoxicated persons" is at least as important as its call for decriminalization. The issue now, of course, is whether it has succeeded in achieving that very ambitious goal.

The Act in Section 8 emphasizes four categories of treatment program: emergency; inpatient; intermediate; outpatient and followup. Its commentary provides definitions of these categories. Section 2 of the Act recognizes that "there is no single or uniform method of treatment that will be effective for all alcoholics" and emphasizes "a flexible approach with a variety of kinds of medical, social, rehabilitative, and psychological services according to the individual's particular needs." Thus while the Act sets a minimum definition on comprehensiveness, it does not exclude any treatment-oriented approach from consideration. Similarly, "coordination" in the Act means, first, provision of a full continuum of services, and second, georgraphical equity of services, and although recommending regionalization, it does not exclude any method which a state may use to achieve its statewide continuum.

Effects of the Act

The Act's call for such a continuum was not novel. Both federal and state legislation was already heading in the same direction. It is therefore apropos to ask whether people believe the Act assisted this general movement. Asked whether their states already had plans for a comprehensive and coordinated program before the Act (Question 1), a majority of states indicated that something was already on paper or in the works, though a minority replied "no." Asked whether the Act had affected such state plans (Question 2), twice as many states indicated that it had as that it had not. This seems a fair indication that the Uniform Act did indeed spur the state-level creation of comprehensive and coordinated treatment programs.

Its impact on plans for public inebriates was even greater. Asked whether the state had previously planned or operated programs for this population (Question 3), a large minority of states indicated they had not; and asked

whether the Uniform Act legislation had affected public inebriate programs (Q.4), the states voted more than three to one that it had.

When the state alcoholism agencies were asked to evaluate loosely how great the Act's impact had been on state plans (Q.5), half chose "much" or "considerable," and another third chose "moderate," leaving a minority (consisting of states without adequate funding) choosing "none" or "a little." Interviewed as to whether state alcoholism agencies had emphasized comprehensiveness or coordination (Q.6), respondents gave no clear picture. States without many funds seem to have concentrated on coordinating existing resources, while those which lacked treatment programs but acquired funds with the Act have concentrated much more on developing comprehensive programs. Improvisation has been the rule in some states, while others have planned thoroughly and carefully both before and after implementation of the legislation.

To begin more specific measurement of the effects of the Uniform Act, state alcoholism agencies in decriminalized states were asked to evaluate the current state of their own programs. (Dates of decriminalization varied from 1968 to 1976). Answers to Question 7 (which determines where they think the strongest and weakest elements of their comprehensive and coordinated programs lie) varied widely. Strengths are generally more frequent among emergency medical services, detoxification centers, in-patient and residential care, outpatient services, and variety of facilities. These strengths parallel very closely the major treatment categories named in the Act. Weaknesses lie mostly in prevention, follow-up, sleep-off, and transportation, only one of which (follow-up) is named as a high priority by the Act. However, there were marked and perturbed exceptions in all categories, and no state reported satisfaction with all its elements.

A similar pattern appeared with answers to Question 8, which seeks to determine if the state is responding to the various avenues by which someone can come to the attention of treatment programs. The agencies were more usually satisfied than not with their programs' response to voluntary clients, those in crisis, and those committed involuntarily. They were less happy with responses to those in protective custody (largely public inebriates) or entering under emergency commitment, and they were very dissatisfied with responses to those in need of long-term custodial care.

The next two questions (9 and 10) were matched to determine whether state personnel think that certain elements

of the drinker population are being neglected at the expense of others, another way of looking at comprehensiveness. Answers to Question 9 showed a very clear belief that women, juveniles, families of alcoholics, and prison populations receive specially inadequate attention, but substantial votes went to every category. Asked rather ruthlessly in Question 10 whether they believed any subgroup was receiving undue attention, respondents overwhelmingly stated that the habitual public inebriates were getting services at the expense of groups who need or deserve them more. The vote, however, provoked great debate and numerous qualifications, and it means agencies believe not that the public inebriate programs are receiving too many funds but that other groups are receiving too few. In fact, when asked whether they believed that the Uniform Act itself had caused inequities among subgroups (Question 11), a clear majority said it had not.

The truth seems to be that the Act's emphasis has valuably stimulated activities in a few, specific elements of the treatment continuum. Asked which services had been specially strengthened by the Act (Question 12), respondents chose "detoxification centers" overwhelmingly, with "out-patient" a distant second. Disappointingly low votes went to "emergency civilian patrol," "transportation," "sleep-off," "follow-up and referral," and "prevention," indicating that the Act's emphasis on comprehensiveness and coordination has not yet been realized even in the area of public inebriates.

Treatment Requirements and Recommendations

The Uniform Act contains certain specific requirements and recommendations concerning the nature of a comprehensive and coordinated treatment program. The following group of questions is intended to determine the degree to which they are being followed.

The single most notorious program requirement is the affiliation between detoxification centers and the "medical service of a general hospital," particularly when this is coupled with the requirement of examination of all persons brought to a facility "by a licensed physician as soon as possible." Conversations and reading show that the Uniform Act authors did not intend exclusive endorsement of a medical model for immediate services, only to ensure that appropriate medical care would be provided. Nonetheless some state legislation requires the full medical model, which is reportedly much more expensive than a non-hospital center with medical triage and back-up.

Since this is a familiar area of dispute, the present

study did not investigate it, believing that if the dispute continues, then a thorough fiscal study of the various models would now be appropriately timed and essential. The study asked whether the various state programs follow the medical model (Question 13) and received two majority reports: (a) many states are attempting to follow it where possible; and (b) all except one state reported it as too expensive. Some states reported that mandatory medicalization would mean the end of their public inebriate programs because neither states nor communities could afford it.

A second important recommendation (but not requirement) of the Uniform Act is intrastate regionalization in order to achieve program comprehensiveness. Behind this recommendation is an overt intention to keep treatment community-based. A clear majority of states has regionalized, often following the existing structure for mental health or public health services (Question 14), though a large minority has not. Regionalized states strongly endorsed the concept, as did some non-regionalized states. Asked by Question 15 where regionalization helped most, respondents voted most heavily for "creation of an alcoholism constituency" and "planning services delivery." All other choices were close behind--except two. Apparently the "flow of data" is unaffected by regionalization, and a majority of states indicated that it was no help in promoting "statewide uniformity in service delivery." (This pattern of responses seems contradictory, and the issue needs further examination.) Two particularly interesting uses of regionalization were the linking of rich with poor counties (often urban with rural) to achieve equity, and the linking of cooperative with resistant communities to increase motivation. Both tactics were reported as successful by the states using them.

Interviews with regional boards in one state showed that they can be invaluable. These boards were not only providing the usual fiscal and monitoring services, they were also actively engaged in research and publication, working closely with city and county elected officials, and identifying operational problems as they occurred. If their posture can be maintained, such regional boards would provide an invaluable intermediate service between the state alcoholism agencies and the local treatment programs, becoming the crucial link in both comprehensiveness and coordination.

Concerning programs for public inebriates specifically, state alcoholism agencies were asked to identify the best

method of administrative organization (Question 16). "Region" was the most frequent choice, "single communities" the least frequent, but all answers had supporters. Discussion showed that the most popular basis for decision was a combination of population size and political jurisdiction, with most agencies emphasizing the use of pre-existing organizational patterns and advice from local planners. Interestingly, no one recommended organization on the basis of the size of the public inebriate population in an area, though this is a major determinant of the attitudes of local planners.

State alcoholism agencies were also asked for advice on who should coordinate a public inebriate program within a community (Question 17). There was an overwhelming preference for treatment agencies as coordinators, either one by itself or a consortium aimed at comprehensiveness. Almost all other choices were acceptable to minorities, with two important exceptions: the police, and the state alcoholism agency. Asked who should pay for the role of coordination (Question 18), a majority of state agencies accepted that duty for themselves while demanding contributions from local government. (A minority chose federal funds.) This question is one of several aimed at determining who should have the financial responsibility for public inebriates. The question is discussed elsewhere in this report, but here the majority clearly believed in continuing the traditional system of local payment, with supplementary state funds for new state requirements.

Government and Non-government Programs

Traditionally, non-government sources have been the major contributors of services to public inebriates. Missions, churches, shelters, the Salvation Army, Alcoholics Anonymous, and many others have carried out a great charitable function. Less altruistically, flophouses, "feeding stations," bars, labor marts, and other private enterprises have serviced skid row. The Uniform Act in effect creates a major government intrusion into an area where only the police and urban renewal have previously dramatized the government presence.

The Uniform Act does not intend that the government should eliminate the non-governmental network of services. Its commentary recommends that "all existing appropriate private and public resources be coordinated with and used whenever possible," and that "the creation of a new and separate network of treatment facilities for alcoholics

would not be desirable, practical, or effective." What, then, has been the impact of the Uniform Act on non-government programs?

Asked (in Question 19) whether the state had successfully coordinated government with non-government programs, many states indicated success. Asked how much cooperation there is between the two sources of service (Question 20), they overwhelmingly chose "considerable" and "a great deal." Interviews showed that there was minimal competition. For instance, in the provision of shelter, missions continue to provide different kinds of services or to serve different kinds of populations and needs than the government-sponsored centers. There was some grumbling, and a few examples of duplication, but no widespread competition. The same is probably true of private hotels and labor marts, though this area was not investigated. There was, however, a strong warning that cooperation and coordination should take place at the local level, not between private local programs and the state alcoholism agency's guidelines and standards.

It may well be that at the local level these programs are coordinating their services spontaneously and without need for managerial intervention. Local private services are usually very much in touch with the needs and problems of the public inebriate population, and within their policy limits, they respond quickly and flexibly. Interviews with inebriates suggested that their level of familiarity with and trust in the private services was much steadier than as regards the government services. They knew what to expect and what not to expect.

Asked directly whether the introduction of government services had caused a decline in private services (Question 21), respondents usually said no, but a minority indicated yes. The question deserves further investigation, because an even greater number of respondents indicated that they expected to see a further decline in private services (Question 22). We need to determine precisely which services are in decline, where they are in decline (e.g., large city or small town), and why they are in decline. Their departure would for the most part be highly undesirable; but the new alcoholism services might not necessarily bear the blame for this. All over the country skid rows are changing because of urban renewal, declines in agricultural labor demand, shifts in transportation modes, alterations in social-security income, and new developments within the service organizations. At the moment it seems that many

government and non-government programs coordinate their services naturally, but in the future government-sponsored programs may see themselves expected to provide different kinds of service in different locations. Rigidity could be their downfall.

Services for Skid-Row Inebriates

The Uniform Act, of course, emphasizes alcoholism treatment but does not require sobriety. Does this mean that the government may or should provide other than treatment services to public inebriates, especially in skid-row areas of urban centers? Since skid-row inebriates usually either exclude themselves or are excluded from government services provided to the rest of the population, should the government make deliberate efforts to extend services into skid row, and should it provide services unrelated to alcoholism treatment of the kind which this particular population needs?

This line of thought provoked great controversy among interviewees, and the sociological debate could be profitably examined in some detail by asking how comprehensive a "treatment program" should be, and where "treatment" begins and ends when one is talking about skid-row drinkers. In Question 23, respondents were asked what kinds of non-government services were already available in their skid-row areas. It seems that Salvation Army and mission shelters are almost universal, as are labor marts, and charity-supplied food; further, some kind of overnight shelter is available in most skid rows if the person has some small amount of money. But other services of great importance to the skid-row population are not available.

For instance, skid-row people worry a great deal about their health, their possessions, and their cash. Interviews and answers to Question 23, however, showed that private or charitable medical services are rare (and difficult where present), so that the Uniform Act's emphasis on the provision of emergency medical care performs an important service which was previously approximated only by the jails and police. Free storage of personal items was available almost nowhere, and it is now difficult for skid-row people even to find paid places for storage. This is a problem not only to them but also to the police, because muggings, assaults, and robbery are apparently on the increase as the skid-row population becomes increasingly prey to outsiders--often called "jack-rollers." This is an area where local program managers might develop services useful to both skid-row people and police, and at least one program manager felt that a storage service could legitimately be

classified under "prevention" of the need for "emergency medical services" (because of muggings).

Again, residents told interviewers that there is now more cash, and more money in check form, than ever before on skid row: unemployment, disability, retirement, etc. checks from the government. There are few banks on skid row. Checks normally get cashed at private sources, and they are normally cashed at a discount. With no personal security on skid row, money will be stolen. Cash may be banked at a private non-bank source, at an exhorbitant premium. Is this then a legitimate area for government concern? Some treatment programs are discovering that the public inebriate population contains more people with regular (if small) incomes than we had thought. Is it desirable that those incomes be nibbled at by predators, or snatched by thieves? This seems another area which local program managers might properly investigate, with the aim of at least improving private services. Asked whether the government should provide simple protective services for skid row, program managers divided sharply (Question 24). Many of them had not previously considered the idea. However, asked whether the government should stimulate private action in this area (Question 25), all interviewed program managers agreed that it was a good idea.

Attention might well be paid, therefore, to the model offered by a program in Portland, Oregon, called the Transit Bank. Started by a non-alcoholic resident of skid row, and supported by donations from individuals and businesses (with minimal government funds), the Transit Bank provides at extremely low cost a series of these services to the skid-row population (e.g., banking, storage, mail receipt, medical referral). It is one of the few genuinely novel ideas which the interviewers encountered, and they were impressed by its enormous popularity among skid-row residents. Though without naming alcoholism treatment as a major goal, the Transit Bank certainly provides comprehensive and coordinated services, and it seems to be placing a floor under a large segment of the city's inebriate population and therefore creating a potential for treatment that might otherwise not exist.

The Transit Bank was not universally popular among local alcoholism treatment personnel because it raises the thorny issue of lifestyle maintenance. Treatment personnel tend to regard anything which enables a public inebriate to maintain his drinking as counterproductive and they may well be right. However, the Uniform Act requires neither treatment nor sobriety. Does it therefore intend to

exclude services directed at lifestyle maintenance? Or is lifestyle maintenance a genuine element of a comprehensive program for alcoholics and intoxicated persons? The same questions were debated when respondents were asked whether the government should provide a "wet hotel" for certain sub-groups (Question 26)--another idea popular amongst an energetic minority of program managers.

Another important service is not available to skid-row inebriates: legal services. This study did not investigate the availability of personal legal services to public inebriates (either through poverty programs or public defenders). Of equal concern, however, was the issue raised in Question 27: is anyone protecting the general rights of public inebriates at either the state or the community level? The issue seems important because the Uniform Act itself arose at least partially from the efforts of one citizen's legal organization and a single attorney to protect the legal rights of public inebriates. Interviewers unfortunately found no community or state in which an independent individual or agency was formally charged with protecting their rights--the state alcoholism agency itself not being regarded as an "independent" or "disinterested" party.

These issues become important because, although we know what we mean by "comprehensive and coordinated treatment program" for alcoholics in general, we seem very unclear as to what it means for public inebriates and especially for skid-row residents. They are a population different in goals and dynamics from those with which most alcoholism professionals deal. This showed very clearly in answers to Question 28. Respondents divided precisely between "revolving door" and "treatment", with only a scattering for other choices, as the favorite terms to describe their present system for dealing with chronic public inebriates. This seems to indicate a high level of confusion as to whether or not the treatment we are providing is the treatment the population needs and wants, and whether it is the kind envisaged by the Uniform Act.

The answer does not, however, indicate pessimism. Asked to reveal their prognosis for the public inebriate population on the basis of their experience with present programs (Question 29), respondents were almost universally optimistic. Answers covered the full range of choices, some few predicting marked improvement for as little as 2%, some seeing a good future for more than 50%. Most thought that a third to a half of the population could make a marked improvement and that a third to a half could not. Since most respondents do not think their present programs are adequate, this

optimism was surprising. It rose substantially further when they were asked to make assumptions about programs with more funds. Complete pessimism attached itself only to about 25% of the public inebriate population, of whom many are irretrievably damaged by alcohol or other causes. Since many of the treatment programs are very new, there are no reliable figures that would indicate ultimate success rates, but program managers at least see a reasonable prognosis.

The major weakness in comprehensiveness and coordination as far as public inebriates are concerned is clearly in the long-term treatment process. Detoxification centers were widely regarded as successful within their limits, but answers to Question 30 showed that no one thinks the process of referral from detoxification centers to outpatient counseling is working very well, and only a minority thought it working "reasonably." (Strong referral programs exist apparently where detoxification centers are associated with residential programs, but the latter can handle only small numbers of referrals.) Once referred, public inebriates seem not to be receiving appropriate treatment modalities. Asked whether public inebriates are staying with outpatient counseling (Question 31), by far the majority of respondents answered "some" or "minimally," though a good minority chose "many."

There seems to be a major difference between programs dealing with skid-row populations and those dealing with other public inebriates, as in small towns. This needs much further investigation, because there is an evident need to develop modalities appropriate to different populations. It may also be that the Uniform Act's strong preference for outpatient counseling is inappropriate for a large number of public inebriates. This too needs investigation. Program managers reported that there should be a major difference between programs for public inebriates with families and possessions, and those for public inebriates who are homeless and impoverished. Evaluation results about skid-row programs can simply not be expected to be convincing this soon, though isolated demonstration projects have been reporting good rates of success. Asked the ultimate question (Question 32)--"Has the Uniform Act reduced the size of the inebriate population on skid row?"--almost everyone answered that they didn't know.

Problems and Potentials

In summary, the Uniform Act's requirements that a state establish a comprehensive and coordinated program for all

alcoholics and intoxicated persons seems reasonable, even when services for public inebriates are included. Asked whether they had yet been successful in establishing the program (Question 33), most state agencies said they had been reasonably successful. The problem everywhere was lack of funds. Those states which had received no state or local funds have had small success, and most (but not all) other states indicated a need for more money. Other problems (surfaced by Question 34) included a lack of enough appropriately trained personnel, and a lack of concern at the community or state level. All other items also received a scattering of votes.

State alcoholism agencies were asked to advise their colleagues as to the best strategy for implementing the statewide program (Question 35). Almost all indicated that the state agency would have a heavy amount of responsibility and that it would have to seize the initiative. Leaving it to local option would not, they reported, encourage comprehensiveness or coordination. Clearly then a major problem is the burden placed on the state alcoholism agency by the authority given them under the statute.

Asked as professionals to judge whether the burden was worthwhile, they all thought that most definitely it was. Answers to Questions 36 showed that almost all state alcoholism agencies believe that the Uniform Act results in a marked expansion of alcoholism services, greater integration or coordination of services statewide, better coordination at the community level, more interagency cooperation between government units, and, finally and most important, the creation of kinds of service previously inadequate. This is a singularly heavy vote of confidence and shows that original beliefs in the potential of the Uniform Act to bring about change currently seem vindicated.

SECTION VI: IMMEDIATE SERVICES

Immediate Services

QUESTIONS

1. For picking up and transporting public inebriates, which methods do you recommend for and against?

For	Against	Neutral	
_____	_____	_____	Regular police patrol
_____	_____	_____	Special police patrol
_____	_____	_____	Mixed police/civilian patrol
_____	_____	_____	Special civilian patrol
_____	_____	_____	Volunteer patrol (unpaid)
_____	_____	_____	Regular ambulance service
_____	_____	_____	Special ambulance service
_____	_____	_____	Contract taxi service

2. For identifying public inebriates in need of care, which systems would you recommend for and against?

For	Against	Neutral	
_____	_____	_____	Regular police patrol
_____	_____	_____	Special police patrol
_____	_____	_____	Special civilian patrol
_____	_____	_____	No patrol

3. Has the switch from police transportation to non-police transportation ---

_____ Saved a lot of police time

_____ Saved some police time

_____ Saved no police time, really.

_____ Increased drain on police time in other ways

4. When a public inebriate voluntarily requests transportation to a treatment center, who should provide that transportation?

For	Against	Neutral	
_____	_____	_____	Regular police patrol
_____	_____	_____	Special police unit
_____	_____	_____	Special civilian unit
_____	_____	_____	Treatment center staff
_____	_____	_____	Volunteers
_____	_____	_____	Contract taxi
_____	_____	_____	No one

5. Which agencies experience an increase or decrease in their transportation requirements as a result of decriminalization?

	Increase	Decrease	No Change
Large law enforcement agencies	_____	_____	_____
Small law enforcement agencies	_____	_____	_____
Ambulance services	_____	_____	_____
Treatment agencies	_____	_____	_____
City police departments	_____	_____	_____
County sheriff's departments	_____	_____	_____

6. How do small law enforcement agencies (e.g., in rural areas, small towns) solve the manpower problems caused by transportation requirements?

_____ Hire extra police personnel

_____ Hire non-police services or personnel

_____ Ignore public inebriates

_____ Jail inebriates when transportation unavailable

_____ Sometimes leave community without police protection

_____ Ignore decriminalization

_____ Use volunteers for transportation

_____ Pay off-duty police overtime

7. When a police officer far from a detoxification center encounters a public inebriate who is not incapacitated, what does he do?

_____ Check him out and leave him alone

_____ Take him home

_____ Take him to a local jail

_____ Take him to a distant detoxification center

_____ Call someone else to transport him

_____ Take him to a hospital or other health care center

8. Are pick-up and transportation in urban and rural areas since decriminalization ---

	Urban	Rural
Much more a problem	_____	_____
A little more difficult	_____	_____
About the same	_____	_____
Easier	_____	_____
Much easier	_____	_____

Why?

9. The Uniform Act recommends the following sequence of choices to a police officer faced with a public inebriate: (a) get him home; (b) get him to a treatment center; (c) do nothing. Do the police generally follow and like that sequence of choices?

_____ Yes _____ No

If not, what would they prefer?

10. Does your law specify criteria for distinguishing intoxication from incapacitation?

_____ Yes _____ No

11. Have police agencies provided officers with written instructions as to the criteria for distinguishing intoxication from incapacitation?

_____ Yes _____ No _____ Some

12. What course of action does your law require of a police officer faced with an intoxicated person not causing a disturbance?

_____ Nothing specified by law

_____ Ignore him

_____ Take him home

_____ Take him to a treatment center

_____ Take him to a holding facility under protective custody

_____ Charge him with a substitute offense

_____ Call a counselor

_____ Evaluate for most appropriate action

Do most police in a given jurisdiction take this course of action?

_____ Yes _____ No

13. What course of action does your law require of a police officer faced with an intoxicated person causing a mild disturbance?

_____ Nothing specified by law

_____ Ignore him

_____ Intervene to quiet the disturbance but nothing else

_____ Take him home

_____ Take him to a treatment center

_____ Take him to a holding facility under protective custody

_____ Charge him with a substitute offense

_____ Evaluate to determine most appropriate action

Do most police in a given jurisdiction take this course of action?

_____ Yes _____ No

14. What course of action does your law require of a police officer faced with an incapacitated person?

_____ Ignore him

_____ Check him then ignore him

_____ Take him home

_____ Take him to a treatment center

_____ Take him to a holding facility under protective custody

Do most police in a given jurisdiction take this course of action?

_____ Yes _____ No

CONTINUED

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15. What should a police officer do if a public inebriate who is NOT incapacitated refuses help?

_____ Leave him alone

_____ Arrest him on a substitute charge

_____ Coerce him into accepting help

_____ Treat him as incapacitated

_____ Any of the above, depending on judgment

_____ Offer to take home

16. Does the technical difference in the Uniform Act between intoxicated and incapacitated persons really affect police operations?

_____ Yes _____ No

17. Do police agencies report difficulties distinguishing between intoxication and incapacitation?

_____ Yes _____ No

18. Which of the following criteria for <u>intoxication</u> does a police department use?

_____ Mental or physical functioning substantially impaired

_____ Officer's judgment

_____ Smell of alcohol

_____ Stability

_____ Speech

_____ Ability to care for self

_____ Technological measure (e.g., blood alcohol concentration)

19. Which of the following criteria for incapacitation does a police department use?

_____ Unconsciousness

_____ Incapable of rational decision with respect to treatment

_____ Threat to self, others, property

_____ Inability to care for self

_____ Officer's judgment

_____ Inability to stand

_____ Staggering

20. Are the police happy with their increased discretion in dealing with public inebriates?

_____ Yes _____ No _____ Don't know

21. Are the public inebriates happy about the increased police discretion in dealing with them?

_____ Yes _____ No _____ Don't know

22. Are alcoholism program managers happy about the increased police discretion in dealing with public inebriates?

_____ Yes _____ No _____ Not my concern

23. Is there strong sentiment in your communities for dis-associating detoxification centers entirely from jail facilities?

_____ Yes _____ No _____ Some

24. What is the average time a police officer now spends transporting a public inebriate? (Exclude time spent transferring custody.)

Urban: Rural:

25. What is the average time a police officer spends transferring custody after he has transported a public inebriate?

At a jail:

At a detoxification center:

At an emergency room:

26. Do hospitals refuse to accept public inebriates brought by the police to their attention?

_____ Yes _____ No _____ Sometimes

27. Do detoxification centers refuse to accept public inebriates brought by the police to their attention?

_____ Yes _____ No _____ Sometimes

28. Do the detoxification centers prefer...

_____ Self-referrals

_____ Police referrals

_____ No preference

29. Do the police and detoxification centers work together on a daily basis to solve each other's problems concerning overload?

_____ Yes _____ No _____ Not really

30. Which type of emergency receiving center requires the most paperwork? (Rank in order.)

_____ Hospital, regular emergency room

_____ Hospital, special receiving center

_____ Non-hospital receiving center

_____ Jail

31. Do the police remain for a period of time at the hospital or detoxification center when they bring in a public inebriate?

_____ Yes

_____ No

_____ Only if inebriate is disorderly

If yes, for how long?

32. Have the police and hospitals worked out an arrangement satisfactory to both sides for controlling inebriates who cause disturbances at hospitals?

_____ Yes

_____ No

_____ In some communities

33. Do such arrangements include any of the following?

_____ Permanent presence of police officer

_____ Delays for each transporting officer

_____ Emergency calls to police

_____ Hiring of special hospital staff (guards)

_____ Use of drugs to sedate inebriates

_____ Use of "holding" or "security" room with specially trained staff

_____ Use of trained volunteers

_____ Special training programs for personnel

34. If a hospital has problems with inebriates causing disturbances, what solutions would you recommend for and against?

	For	Against
a. Special training for the medical staff	_____	_____
b. Special staffing for emergency room	_____	_____
c. Police presence during processing	_____	_____
d. Use of medication	_____	_____
e. Use of physical restraints	_____	_____
f. Transfer to jail	_____	_____
g. Transfer to special treatment center	_____	_____
h. Transfer to security unit in hospital	_____	_____
i. Transfer to psychiatric ward	_____	_____
j. Verbal counseling	_____	_____
k. Use of trained volunteers	_____	_____

35. If there are difficulties about handling public inebriates between police and hospital personnel, what solution would you recommend?

_____ More education of hospital personnel

_____ More education of police personnel

_____ More cooperative planning between the two agencies

_____ Greater attention by program directors to procedures and guidelines

_____ More effort from hospital administrators

36. What percentage of the public inebriates picked up in your jurisdictions require an emergency medical response of any kind? (Estimate percentage or indicate "unknown.")

_____%

37. Do all public inebriates picked up in your state receive medical screening for medical problems?

_____ All (if not all, indicate percentage)

_____ In most communities

_____ In some communities

_____ If taken to a detoxification center

38. Do all public inebriates admitted to detoxification centers in your state receive medical screening for medical problems?

_____ All

_____ Most

_____ Some

39. Who does the screening for medical problems in a majority of instances?

_____ Physician

_____ Hospital nursing staff

_____ Non-hospital nursing staff

_____ Paramedicals

_____ Criminal justice personnel

40. Is examination of all entering inebriates by a licensed physician (check those applicable):

_____ Necessary

_____ Unnecessary

_____ Too costly

_____ Impossible in some areas

_____ Desirable but difficult

_____ Overkill

_____ Legally required

41. Which is the most effective and cheapest model for ensuring that public inebriates receive needed emergency medical care? (Rank in order.)

_____ Hospital emergency care

_____ Non-hospital care with medical triage decision

_____ Jail with nursing staff

_____ Jail with medically trained jailers

42. What personnel other than physicians can perform a routine screening examination as effectively as necessary? (Check.)

_____ Registered nurses

_____ Licensed practical nurses

_____ Paramedical or EMT

_____ Police officers

_____ Police officers with EMS training

_____ Non-medically trained professionals

_____ Trainee nurses

_____ Recovering alcoholics

43. In your state, have all the people who determine a public inebriate's need for emergency medical care had special training, e.g., in emergency medical services?

_____ Yes

_____ No

_____ Some (specify)

44. In your state, have all the people who determine a public inebriate's need for emergency medical care had special training in alcohol-related medical problems and alcoholism?

_____ Yes

_____ No

_____ Some (specify)

45. Does a "drunk tank" still exist in any of your large urban areas?

_____ Yes _____ No

46. Does a "drunk tank" still exist in any of your smaller urban or county jails?

_____ Yes _____ No

47. In the case of small communities with small public inebriate populations, what recommendation about detoxification centers would you make? (You may check more than one.)

	For	Against
a. Establish a separate detoxification center	_____	_____
b. Alter the local jail structurally	_____	_____
c. Alter local jail procedures only	_____	_____
d. Transport to distant detoxification center	_____	_____
e. Arrest on substitute charge	_____	_____
f. Rely on officer's discretion	_____	_____
g. Ignore the homeless inebriates	_____	_____
h. Pay nearby private or public hospital	_____	_____
i. Use hospital without special payment	_____	_____
j. Use alternative health care unit (e.g., nursing home)	_____	_____

48. In communities where inebriates are brought to a jail-type facility for overnight hold, are any of the following personnel available?

_____ Physician

_____ Physician on back-up call to the facility

_____ Paramedical

_____ Nursing personnel

_____ Officer trained in emergency medical services

_____ Other medical personnel

_____ None of the above

49. In those communities still using jails for public inebriates, which procedure will work best for diagnostic and health purposes?

_____ Placing a medical person in a jail detoxification facility

_____ Providing a jail detoxification facility with outside medical back-up

_____ Insisting that no inebriates be taken to jail without prior medical scrutiny

50. Since decriminalization, have your local hospitals become more or less involved with public inebriates?

_____ More

_____ Less

_____ About the same

_____ Unknown

Why?

51. Which kinds of hospital are least and most likely to cooperate with public inebriate programs? (Rank in order.)

_____ Public

_____ Private (i.e., proprietary)

_____ Charitable

_____ Veterans' Administration

_____ U.S. Public Health Service

52. How often does payment for treatment determine a hospital's cooperation with the emergency medical needs of public inebriates?

_____ Almost always

_____ Most of the time

_____ Sometimes

_____ Never

53. Since decriminalization, have hospitals complained about any of the following? (Check.)

_____ Increased numbers of inebriates in their facilities

_____ Increased costs due to treatment

_____ Increased disorderliness

_____ Pessimism concerning treatment

54. Have your hospitals acquired special equipment, staff, and training for handling public inebriates purposefully since the advent of decriminalization?

_____ Yes _____ No _____ Some

55. Is there a difference in attitudes toward public inebriate needs between hospital medical personnel and hospital administrative staff?

_____ Yes _____ No _____ Somewhat

56. When public inebriates are taken to a hospital for emergency care or diagnosis, should they be taken to --- (Check.)

_____ A special receiving station

_____ The regular emergency room

57. When a hospital admits a public inebriate to a bed for emergency services, should he be admitted to --- (Check.)

_____ Regular hospital ward

_____ Special alcoholism ward

_____ Psychiatric ward

_____ Depends on medical need

_____ A "quiet room" or sleep-off area

58. How long is the average stay of a public inebriate at the receiving station of a hospital?

_____ Less than 1/2 hour

_____ About 1 hour

_____ About 2 hours

_____ Longer

59. How long is the average stay of a public inebriate in a hospital bed, when admitted for an alcohol-related diagnosis only?

_____ Overnight

_____ 24 hours

_____ Up to 72 hours

_____ Longer

60. Which of the following types of public inebriate are your hospitals most likely to accept and reject? (Indicate A (accept) or R (reject).)

_____ Suffering from visible physical injury

_____ Undergoing or about to undergo D.T.'s

_____ Undergoing or about to undergo withdrawal

_____ Underlying medical problems (e.g., heart)

_____ Requiring admission to a medical ward

_____ Evident psychiatric disturbance

_____ Unconscious or insensate

_____ Belligerent or antagonistic

_____ Walk-in self-referral

_____ Member of any specific minority (specify)

_____ Police referral

_____ Regular customer

_____ Unable to pay

61. Is it feasible (i.e., practical and cost-effective) for the hospitals in your communities to handle all needs of public inebriates (medical and detoxification, but not counseling or social), as some versions of the Uniform Act require?

_____ Yes _____ No _____ Maybe

62. Which type of emergency receiving center costs most? (Rank in order.)

_____ Hospital, regular emergency room

_____ Hospital, special receiving center

_____ Non-hospital receiving center

_____ Jail

63. What kind of personnel are needed to staff a non-hospital detoxification center which handles a large number of inebriates (e.g., over 20 per night)?

	Needed	Not Needed
a. Physician, staff	_____	_____
b. Physician, on call	_____	_____
c. Registered nurse	_____	_____
d. Licensed practical nurse	_____	_____
e. Counselor	_____	_____
f. Paramedical or EMT	_____	_____
g. Secretarial	_____	_____
h. Physically strong male/female	_____	_____
i. Pharmacist back-up	_____	_____
j. Maintenance, housekeeping, cooking	_____	_____

64. What kind of personnel are needed to staff a non-hospital primary care center which handles a small number of inebriates (e.g., 10 or fewer per night)?

	Needed	Not Needed
a. Physician, staff	_____	_____
b. Physician, on call	_____	_____
c. Registered nurse	_____	_____
d. Licensed practical nurse	_____	_____
e. Counselor	_____	_____
f. Paramedical or EMT	_____	_____
g. Secretary	_____	_____
h. Physically strong male/female	_____	_____
i. Pharmacist back-up	_____	_____
j. Maintenance, housekeeping, cooking	_____	_____

65. Should there be physician's standing orders concerning the giving of medication at a detoxification center staffed by nursing personnel?

_____ Yes _____ No

66. What percentage of intoxicated persons admitted to detoxification centers receive some kind of medication prescribed by physician or under physician's standing orders?

_____ 0% _____ 50%

_____ 5% _____ 75%

_____ About 10% _____ 90%

_____ 25% _____ 100%

67. What medication is regularly given to a public inebriate upon arrival at a detoxification center?

_____ Librium

_____ Valium

_____ Visteril

_____ Disulfiram

_____ None

_____ Other (specify)

68. What percentage of the people brought by police to detoxification centers are primarily looking for a place to sleep and eat for a few days?

_____ 5%

_____ 25%

_____ Less than 50%

_____ More than 50%

_____ 90%

_____ 100%

69. What percentage of the people who refer themselves to detoxification centers are primarily looking for a place to sleep and eat for a few days?

_____ 5%

_____ 25%

_____ Less than 50%

_____ More than 50%

_____ 90%

_____ 100%

70. What percentage of detoxification center clients are primarily looking for alcoholism treatment as opposed to a friendly shelter for a few days?

_____ 5%

_____ 25%

_____ Less than 50%

_____ More than 50%

_____ 90%

_____ 100%

71. What percentage of the persons appearing at detoxification centers will eventually achieve sobriety)?

_____ 1%
_____ 5%
_____ 10%
_____ 20%
_____ 25%
_____ 50%
_____ More than 50%
_____ Too soon to guess

72. Have the detoxification centers in your large urban areas become as much revolving doors as were the drunk tanks?

_____ Yes _____ No _____ Partially

73. Do the police feel that the detoxification center is becoming a revolving door?

_____ Yes _____ No _____ Some

74. Do the staff of the detoxification center feel that it is becoming a revolving door?

_____ Yes _____ No _____ Some

75. Which types of public inebriate are your non-hospital detoxification centers likely to accept or reject? (Indicate A (accept) or R (reject).)

_____ Suffering from physical injury

_____ Undergoing or about to undergo D.T.'s

_____ Undergoing or about to undergo withdrawal

_____ Underlying medical problems (e.g., heart)

_____ Requiring admission to a medical ward

_____ Evident psychiatric disturbance

_____ Unconscious or insensate

_____ Belligerent or antagonistic

_____ Member of any specific minority (specify)

_____ Walk-in self-referral

_____ Police referral

_____ Regular customer

_____ Unable to pay

76. On what grounds are detoxification centers turning away self-referrals?

_____ Too few beds

_____ Too many police referrals

_____ Space must be left for police referrals

_____ Person has already been through facility

_____ Person's medical needs too great

_____ Person's psychological state too bad

_____ Person refuses to stop drinking

_____ Person not likely to be "cured"

_____ No refusals

77. Are any detoxification services refusing clients on the grounds that they are not good prospects for cure?

_____ Yes _____ No

78. Do your detoxification centers place a limit on the number of times a repeater may be admitted, or may be admitted within a certain period?

_____ Yes _____ No _____ Somewhat

79. What is the average amount of time an individual spends in a non-hospital detoxification center?

_____ 12 hours or less

_____ 12-24 hours

_____ 24-48 hours

_____ 48-72 hours

_____ 72-96 hours

_____ Longer (specify)

80. What is the average amount of time an inebriate spends in a jail or a jail-based detoxification center?

_____ 2 hours

_____ 4 hours

_____ 6 hours

_____ Until morning release time

_____ 24 hours

_____ 25-72 hours

_____ Longer (specify)

81. Which of the following are necessary (rather than just desirable) elements of an urban detoxification center?

	Necessary	Unnecessary
a. Food and drink	_____	_____
b. Beds	_____	_____
c. Armchairs	_____	_____
d. Television	_____	_____
e. Books and games	_____	_____
f. A darkness or "quiet" room	_____	_____
g. A sitting room for walk-ins	_____	_____
h. Private lockers	_____	_____
i. A locked front door	_____	_____
j. Bed-sheets	_____	_____
k. Pajamas, gowns, slippers	_____	_____
l. Space to move around in	_____	_____
m. Craft or work spaces and equipment	_____	_____
n. Special room for withdrawal patients	_____	_____
o. Attractive surroundings	_____	_____
p. Modern decor	_____	_____
q. Downtown location	_____	_____
r. Out-of-downtown location	_____	_____

82. If a public inebriate wants to leave a hospital against medical advice, what should the hospital do? (Check.)

_____ Let him go happily

_____ Let him go reluctantly

_____ Resort to subterfuge to keep him

_____ Have him arrested

_____ Notify the police

_____ Not notify the police

_____ Insist on voluntary minimum stay

_____ Notify relative or other community contact

83. Should a public inebriate be allowed to leave a detoxification center against medical advice? (Disregard what the legislation requires.)

_____ Yes _____ No _____ Yes, if sober

84. In real-world practice, under what conditions may an inebriate leave a detoxification center?

_____ Whenever he wishes

_____ Not for a certain period if a police-referral

_____ Depends on physician's order

_____ When he is drunk

_____ When he is disorderly or confused

_____ Only after a minimum period to which he has voluntarily agreed in writing

85. In your state, how long can a receiving center hold someone against his expressed desire to leave?

_____ No time

_____ 4 hours

_____ Less than 12 hours

_____ Between 12 and 24 hours

_____ Between 24 and 48 hours

_____ Up to 72 hours

_____ Longer (specify)

86. How long should a physician's order be able to hold someone in treatment? (You may check more than one.)

_____ No time

_____ Until sober

_____ 12 hours

_____ 24 hours

_____ 72 hours

_____ 96 hours

_____ Up to 10 days in some cases

_____ Longer periods at discretion

87. How long should a public inebriate be held (by anyone) for "sobering up?" Which of the following periods is too long or too brief?

	About right	Too long	Too brief
a. 4 hours	_____	_____	_____
b. 6 hours	_____	_____	_____
c. 8 hours	_____	_____	_____
d. 12 hours	_____	_____	_____
e. 24 hours	_____	_____	_____
f. 48 hours	_____	_____	_____
g. 72 hours	_____	_____	_____
h. 96 hours	_____	_____	_____

88. What techniques do your detoxification centers use to discourage persons from leaving?

_____ Physical restraint

_____ Medication

_____ Deprivation of clothing or shoes

_____ Pajamas

_____ Hospital gowns

_____ Verbal advice

_____ Threat of arrest

_____ Other (specify)

89. Do Native American public inebriates cause any special problems for your overall system for handling public inebriates?

_____ Yes _____ No

Specify:

90. Do such problems cause Native Americans to receive less attention or worse care than other public inebriates?

_____ Yes _____ No

91. Do female public inebriates cause any special problems for your overall system for handling public inebriates?

_____ Yes _____ No

Why?

92. Do such problems cause female public inebriates to receive less attention or worse care than male public inebriates?

_____ Yes _____ No

93. Do juvenile public inebriates cause any special problems for your overall system for handling public inebriates?

_____ Yes _____ No

94. Do such problems cause juvenile public inebriates to receive less attention or worse care than adult public inebriates?

_____ Yes _____ No

95. Of all public inebriates, how large a percentage consists of the really habitual repeaters?

_____ Less than 10% _____ About 25%

_____ About 10% _____ About 50%

96. What proportion of the funds for transportation, medical screening, and detoxification centers are being used by the small group of habitual repeaters--the regular customers?

_____ Less than 10% _____ About 50%

_____ About 25% _____ More than 50%

97. Which types of public inebriate are unlikely to be referred into further treatment after they have received primary health care services?

_____ Regular customer

_____ Indigent

_____ Member of a specific minority (specify)

_____ Resistant or hostile person

_____ Solitary person

_____ Local resident with family and job

Immediate Services

COMMENTARY

Transportation

These questions deal with the transportation needs of public inebriates. Pick-up and transportation have been traditionally the responsibility of police patrols, whether the public inebriates were intoxicated, incapacitated, or causing a disturbance. The Uniform Act encourages a decline in the total amount of police transportation activity, and as an option the creation of an emergency services patrol. Basic questions asked by communities include the following: do we now ignore a proportion of public inebriates? who identifies their need for care? under what circumstances do we pick them up? where do we transport them? who is responsible for the costs of transportation? The objectives of decriminalization are (a) to save the police time by removing their obligation to pick up all public inebriates; (b) to provide public inebriates with the transportation they need and/or want; (c) to reduce the number and change the nature of contacts between the police and public inebriates.

The previous police-based system of pick-up and transportation was taken for granted as an inevitable duty. The police do not find it a pleasant task, and their widespread opinion was that it is "great to get out of the drunk business." The public inebriates reported that they now enjoy "not being hassled so much by the police." Disengagement therefore seems to satisfy both sides. However, basic issues remain: are public inebriates receiving the health care intended by the Uniform Act? and what problems do communities experience as a result of abandonment of the traditional transportation system?

Respondents to Question 1 voted heavily and equally for "regular police patrol" and "special civilian patrol." They freely recognized the supremacy of the police at both identifying and transporting inebriates because police are (a) the only social agents on regular street patrol; (b) used to the public inebriate population; (c) equipped for transportation; (d) still legally obliged to remove some public inebriates from the scene. However, respondents showed a very strong preference for replacing police activity with civilian/medical activity. Thus there was strong opposition to "special police patrol," and many respondents liked ambulance or contract taxi service. The great obstacle to the shift from police to civilian transportation was funds, and both ambulance and contract taxi service were regarded as too expensive to be feasible. There was a marked difference in communities which are experimenting with alternate

civilian modes of transportation (e.g., mixed police/civilian patrol; unpaid volunteer patrol), which they tend to regard as highly effective and desirable. In sum, the Uniform Act concept of an "emergency service patrol" is very popular in theory but difficult to fund. Alternatives to police transportation have therefore appeared in few communities. Since little information about the costs of any transportation system were found, research in this subject and the promulgation of model systems would seem desirable if community wishes are to be realized.

Respondents to Question 2 were heavily against ignoring the needs of public inebriates ("no patrol"). Though almost unanimously in favor of "special civilian patrol," they also recognized that the police will continue inevitably to exercise their invaluable power to identify public inebriates in need of care. The only real issue was the degree to which a community would rely on police activity.

It was very clear that one of the major effects of decriminalization has been to save the police "some" or "a lot" of time (Question 3), which was reported by all interviewed police as a major benefit.

Many public inebriates have learned to ask the police for a ride to a detoxification center or to their homes. Police attitudes to this new development (Question 4) were mixed. Some patrolmen resent having to provide such a service, others regard it as traditional and desirable. Treatment personnel were willing to provide transportation when called by either police or inebriates, though such services are rarely funded or used to the extent needed.

Responses to Questions 5, 6, 7, and 8 revealed the impact of one of the major problems of decriminalization: the difference between rural and urban areas. Small law enforcement agencies and rural areas suffer from greatly increased transportation needs. They complain almost unanimously that, in the absence of a nearby detoxification center, they have to spend slender resources and strip the community of protection in order to take an inebriate a long distance. This perturbed them so greatly that even those who support decriminalization continue to put inebriates in the local jail overnight if they cannot take them home. Some communities have hired extra or overtime personnel for transportation, and others have used volunteers; the choice depends very much on local circumstances and attitudes. Treatment personnel are very sympathetic to police problems in this matter, and in many communities are helping with transportation calls. If the transportation issue is not solved, police in

rural and small-town areas will continue to take inebriates to jails for an overnight hold; treatment personnel would prefer them to be taken to a treatment center.

Police Discretion

This group of questions deals with the new set of decisions which decriminalization requires of police officers. Decriminalization increases the variety of choices open to an officer encountering a public inebriate, in particular by making a crucial distinction between "intoxicated" and "incapacitated." It also removes the easy pattern of taking inebriates to jail under arrest, therefore lessening the degree of enforcement control possessed by an officer. Questions 9, 12, 13, 14, and 15 require answers because the Uniform Act recommends distinctly different patterns in response to various types of inebriate, but many state statutes have not embodied those patterns (Question 10). Alternatively, the patterns of response are being determined differently in different states (by attorney general opinions or state alcoholism agency guidelines), and in different communities within the same state by district attorney opinions or by police department policy, either formal or informal (Question 11). The result is that there is no standard national policy viable at the level of street operations, and some policies clearly circumvent the intention of the Act. On the one hand the police are confused, and on the other the inebriates are open to inequitable treatment in neighboring jurisdictions.

Respondents report some conflict between the desires of the Uniform Act and the needs of the police in this area. The Uniform Act emphasizes (a) voluntariness where the inebriate is capable of decision; and (b) assistance where the inebriate needs or wants help. Regardless of police attitudes toward these issues, officers also need to maintain public order (especially because of pressure from downtown merchants) and to maintain authority (and some control) over the public inebriate population. This conflict means that officers are required to make difficult individual decisions; and while in the vast majority of cases they are clearly implementing the Uniform Act's intention, there is also a clear danger that disillusionment will lead officers to make the convenient decision regardless of its correctness. (For instance, some officers, faced with an intoxicated person over whom they want control, simply declare him to be incapacitated--a decision which the Uniform Act clearly allows them to make, but for very different purposes.)

This group of questions therefore enables anyone to determine whether there is confusion within a state or a jurisdiction about the basis for police decisions, and to analyze actual police practice. Respondents to Questions 16, 17, 18, and 19 revealed the current state of confusion by the diversity of their answers. While everyone had the intention of fulfilling the Uniform Act's desires, there was a great lack of official guidelines in most communities, a great difference between states, and a significant difference between treatment theory and police practice at the operational level. As criteria for "intoxicated" and "incapacitated," the two most difficult items were "inability to care for self" and "incapable of rational decision," which were equally classified under the two different headings--a confusion which reveals the weight of decision on the individual police officer. Most respondents felt that--for the sake of equity and consistency--this area requires further attention from both policy-makers and operational personnel.

Responses to Questions 20, 21, and 22 revealed almost no suspicion or distrust of present police operations. Generally, the police were unhappiest about the decisions they were called upon to make (Question 20). Public inebriates questioned (Question 21) felt that they were on the whole "better off," though they also related stories of police abuse. Alcoholism program managers were most happy with increased police discretion (Question 22), though many of them did not know (a) what the public inebriates thought, and (b) that many public inebriates were still being taken to jail or ignored.

Police/Treatment Relationships

Contrary to belief when the Uniform Act was formulated, police endorse the idea of alcoholism treatment for public inebriates. It was common for interviewed officers to declare that "alcoholism is a disease," and to express a rather unquestioning optimism about the outcome of the new treatment structure. There was minuscule theoretical support for the use of jails rather than detoxification centers (Question 23). Operationally, however, matters are not going as well.

The first problem concerns time. To police officers, the virtue of jailing an inebriate is that it takes very little time: jails are nearby, and they have trained processing staff who allow the arresting officer to go back on patrol as quickly as he wishes. Detoxification centers and hospitals, on the other hand, are more distant, and their personnel rarely assume full responsibility for processing. Questions 24 and 25

are therefore crucial in determining whether treatment agencies can equal jails in efficiency from the police viewpoint.

A second problem involves acceptance as well as time. Jails (especially drunk tanks) have room for almost anyone the officers bring in. Hospitals and detoxification centers never equal the capacity of the jails. The result far too often is that both hospitals and detoxification centers refuse some inebriates brought to them by the police, which causes police to lose time and grow skeptical about the "usefulness" of detoxification centers. Hospitals additionally give last priority to persons who are only inebriated rather than in need of medical attention for other reasons. Refusals of police-referrals are (according to the police) more common than is realized at both hospitals and detoxification centers in large urban areas (Questions 26 and 27). Some detoxification centers ignore the mandate of the Uniform Act to accept any inebriate needing care. Answers to Question 28 indicate that some prefer voluntary self-referrals (which represents service to the public inebriates and anticipated greater success), while others prefer police-referrals (which represents service as an alternative-to-jail facility). Nor is "first come, first served" always a good detoxification center policy since it may result in refusals of either self-referrals or police-referrals at a later time of day. Successful programs work with the police on a daily basis to solve overload problems (for example, using the police communications network to determine availability), though responses to Question 29 indicate that this is rare. Clearly the most popular solution to this problem--offered repeatedly by both police and treatment personnel--was to increase the capacity of the detoxification centers.

The third set of problems arises during the transfer of custody from police to treatment personnel. The first bane is paperwork. Responses to Question 30 showed that emergency rooms require the most paperwork, jails the least. Police often graded a detoxification center by how much paperwork it required.

However, responses to Question 31 reveal "disorderliness" as a greater problem than paperwork--by far the majority of respondents checked "only if inebriate is disorderly." Nurses at emergency rooms reported fear and even "terror" at the kind of disturbance some inebriates cause, and most (but not all) detoxification centers rely on police officers to bring aggressive persons under control, sometimes calling upon them to arrest and jail the individual. Police cooperation is high. They normally remain until the individual is calmed, and they respond quickly to disturbance calls, but they also regret

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that they must take over functions which they could previously hand over to jailers, and few communities report cooperation from hospitals in working out regular arrangements for such situations (Question 32). Answers to Question 33 indicate "emergency calls" and "delays to each transporting officer" as the most common result. The most frequent medical solution to disturbances is "use of drugs to sedate inebriates."

Asked by Question 34 to recommend solutions to the problem of disturbances, respondents indicated that their least popular choices were "police presence during processing," "use of physical restraints," "transfer to jail," and "transfer to psychiatric ward." The unpleasant disturbances sometimes occurring in the emergency rooms of urban hospitals are obviously unpopular with all participants. Sentiment was very clearly in favor of a more humane system. Thus, while use of medication remained a frequent solution, much more popular was belief in the capability of the alcoholism profession; the most common choices from Question 34 were "special training for the medical staff" and "use of trained volunteers," followed closely by "special staffing for emergency room," "verbal counseling," and "transfer to special treatment center." There was a clear belief amongst all professionals that specialists in alcoholic behavior could solve a problem which confuses both medical and police personnel. Thus responses to Question 35 emphasized the importance of special alcoholism training for all involved, and the assertive involvement of alcoholism program directors in the issue.

Medical Screening

The Uniform Act calls for examination of all public inebriates brought to a treatment facility, by a licensed physician as soon as possible. Because of the cost of physicians, this has been a major problem nationwide, and the requirement is more honored in the breach than in the observance. A small minority of public inebriates require an emergency medical response--according to answers to Question 36 only about 5%, and at most 10%. Their numbers and needs, however, are great enough that everyone is in favor of a medical screening, and in an overwhelming majority of communities, most public inebriates picked up receive such a screening (Question 37), especially if they go to a detoxification center (Question 38), but not necessarily if they go to a jail.

However, examination by a physician is neither universal nor popular even in those states where it is required by law (Questions 39 and 40). A minority of interviewees indicated that a physician's examination is necessary, and a larger

minority that it is desirable. The majority clearly believed it unnecessary in all cases, too costly, and impossible in many jurisdictions. This is clearly an area where sentiment and experience oppose a provision of the Uniform Act.

This does not mean that interviewees were opposed to the medical profession, simply that they found physician-examination inappropriate. By far the most popular answer to Question 41 was "non-hospital care with medical triage decision." Answers to Question 42 indicated that nurses (either registered or licensed practical) were the almost universal choice as screeners, but that the key issues regarding all potential screeners were (a) whether they had medical training; and (b) whether that training was specific to alcoholism.

Efforts to give such training have begun. Answers to Question 43 indicate that most (but not all) screening personnel have received emergency medical services training, but answers to Question 44 indicate that much more effort is needed to make that training alcoholism-specific. Hospital staff were everywhere reported as lacking enough knowledge of alcoholism, and interviews showed that emergency room staff who were well trained in this subject are extraordinarily rare. The issue was regarded as especially important by medical personnel with alcoholism training, since they report many occasions on which harm or unnecessary suffering is caused to alcoholics because regular medical staff are ignorant of the special medical and medication needs of alcoholics. It is, in fact, a major source of anxiety.

Another major anxiety surrounds the continued use of "drunk tanks" in both large urban areas and small towns. Though the number of drunk tanks has decreased dramatically in decriminalized states, they still exist. Though the numbers of inebriates held in them has dropped greatly, people are still held overnight and released in the morning. In many small towns they are the only holding facility available (Questions 45 and 46). No one likes them. They exist because (a) there is no convenient alternative, especially no detoxification centers; (b) the detoxification centers lack capacity or have cumbersome procedures; or (c) the inebriates placed in them are regarded as requiring the extra though temporary restraint of a jail. Many small communities find that the former drunk tank is the only detoxification center they can afford, and they adapt procedures and physical structure accordingly. Many large communities change the procedures but not the physical structure for inebriates. In sum, jails still remain in many communities a major repository for inebriates, and many jailers (and city or county managers) are converting parts of their jails into detoxification centers.

Most alcoholism program managers resist the continued association of detoxification centers with jails. Some, however, accept the financial inevitabilities that lead to the association and assist the jailers to humanize their facilities. Program managers responding to Question 47, which applies to the problems of small towns, overwhelmingly voted in favor of "transport to distant detoxification center" and "use nearby hospital." This of course shifts the problem either to the police (for transportation) or the hospitals, and most police and hospital personnel voted for "establish a separate detoxification center." City and county managers were the main supporters of "alter the local jail structurally," for purely economic reasons. Both community managers and police see detoxification centers primarily as alternatives to jail, whereas most alcoholism program managers see them as the first locus of treatment. In sum, these conflicting attitudes and needs indicate that this is a major area for problem analysis.

The issue has been included in this section because interviews showed that--apart from distaste for the appalling atmosphere of drunk tanks--everyone was anxious about the adequacy of medical screening carried out in a jail environment. On the one hand, there are horror stories of people dying or committing suicide in drunk tanks, for reasons both related and unrelated to alcoholism. On the other hand, many county sheriffs were proud of the medical screening capability which their jails possessed before decriminalization and which has since been reduced under the belief that the jails no longer contain inebriates. Responses to Question 48 showed that by far the majority of jails have either an officer trained in emergency medical services, or a physician on back-up call, and larger jails often have nursing staff. Nowhere, however, was the medical screening of inebriates a priority, and very rarely was the degree of monitoring recommended by the Uniform Act (officer within sight or at least hearing) being accomplished. In small-town jails, "medical screening" depends entirely on the training, good will, and workload of the watch officers, whose peacekeeping duties are primary.

Question 49 was directed toward solutions of this problem. Again there was a split between alcoholism program personnel on the one hand and police and community managers on the other. Program managers made "insist on medical scrutiny prior to jail" (which involves hospitals and police time) their first choice, and "medical back-up" as a minimal necessity. Police believed that either nursing personnel or officers with emergency medical training could do the job best, inside the jail, and they found either of the other

two choices perhaps necessary but certainly time-consuming and inefficient. Some local programs have compromised, bringing outside medical screeners to the jail early in the morning to make judgments on medical need, referral, and even the timing of release.

Hospitals

If health care instead of incarceration is to be provided to public inebriates, hospitals and detoxification centers emerge as crucial. Their entry into the field of immediate services for inebriates has been one of the most outstanding changes brought about by the Uniform Act.

In light of their importance to the system, local hospitals were surprisingly little consulted during planning for decriminalization, and many hospital staff interviewed reported that they were never consulted in advance (with noteworthy exceptions). Once decriminalization took place, however, hospitals had to respond because many people looked to them for immediate services, especially in emergency rooms. They responded in very different ways: some few cooperated fully; many cooperated partially; some refused cooperation. Relationships with hospitals have become a major irritant in many communities, and this group of questions deals with the causes and solutions of the irritations.

Respondents to Question 50 divided evenly between all three choices, suggesting that probably only a third of all local hospitals have seen a greatly increased impact on their facilities from decriminalization. The degree of impact should be measured hospital by hospital, since it is determined by both hospital and police policy, and by the presence of alternative detoxification centers. Hospitals serving large populations are reported to have felt the greater impact, and public hospitals are reported to be suffering from overload more than others. Choices on Question 51 indicate that public hospitals are far more likely than any other kind to accept public inebriates (as one would expect), but there are problems apparent with all other types of hospital. Separate negotiations with each kind of hospital will be required from each alcoholism program manager.

Responses to Questions 52 and 53 indicate basic reasons for lack of cooperation from hospitals. Respondents to Question 52 (and interviewees) indicated that the costs of treating a population believed to be indigent are a great and real deterrent, and in the case of most hospitals the lack of payment leads them to refuse or minimize treatment "almost always" or "most of the time." In fact, much of the inebriate

population is not indigent, and some alcoholism programs have found governmental sources to reimburse hospitals. This particular issue is therefore clearly one which deserves the study of program managers. All hospitals, including public hospitals and especially those in metropolitan areas, are suffering from the cost burden of treatment for public inebriates.

Responses to Question 53 indicated that "increased numbers" and "disorderliness" were equal with costs as factors leading hospital staff to dislike public inebriate programs. Especially the majority of emergency room personnel actively disliked dealing with inebriates, but their viewpoint was strongly contested by others with special alcoholism and counseling training. A majority also were pessimistic about treatment success. Alcoholism program managers, however, believe that these negative perceptions stem from lack of special alcoholism training of hospital staff, and interviewed hospital staff (especially nurses) freely admitted to ignorance and feelings of incompetence as regards this population. Answers to Question 54 showed that most hospitals are clearly not taking any initiative in providing their staffs with <u>any</u> special resources for dealing with public inebriates. Some alcoholism programs, some volunteer organizations, and rare medical personnel are encouraging and providing training, and they offer strong anecdotal evidence that it is successful. Again, training of hospital staff emerges as a need of major consequence to the success of this portion of a public inebriate program. Answers to Question 55 indicate that there was a major additional staff problem involving administrative personnel, whose attitudes tend to be even more negative than those of medical personnel, the main cause again being "costs" and "disorderliness." Alcoholism program managers in some communities had had success by working out careful guidelines and routines with administrative staff; in brief, they helped the hospitals feel that they are not being "dumped on."

Many people believe that the hospital problem is primarily an emergency room problem; that is, adding public inebriates to the overload experienced already by most emergency rooms is unfavorable to both inebriates (who often go to the end of the waiting-line) and to other patients. Other interviewees believed that emergency rooms offer the best medical triage and that inebriates should be treated just like other patients. Thus respondents to Question 56 divided equally between "special receiving station" and "regular emergency room." Many respondents again identified special alcoholism training as the key issue, overriding that of physical structure.

Opinion was equally divided about the nature of the ward to which alcoholics should be admitted. Answers to Question 57 showed that "psychiatric ward" is intensely unpopular, though some hospitals use it for "unruly" inebriates. The choice between "regular ward" and "special alcoholism ward" seemed determined by (a) staff training, and (b) medical need. Almost everyone reported anxiety that the special symptoms of alcoholism withdrawal, and the interrelationships between alcohol-addiction, other medical problems, and medication, were not known to most hospital staff. The concept that a hospital might provide a special "quiet room" for intoxicated persons not in need of medical care was new to most interviewees, just as it was popular with some hospitals who had experimented with it.

In sum, hospital staff have clearly not made up their minds whether or not to treat public inebriates as regular patients or as a special subgroup. Triage concepts are not working in this area (beyond the original "emergency" decision). The problem is serious, as is indicated by (a) the negative attitudes of many hospital personnel, and (b) the length of stay at the hospital. Answers to Question 58 showed that it requires at least 1 hour, and in many cases more than 2 hours, for an inebriate to be processed through an emergency room. This affects both the police and the patients adversely, and it is a marked difference from the speedier detoxification centers. For the other side of a coin, those inebriates admitted to a hospital bed occupy that bed for at least a day and more likely for three days (Question 59), suggesting that their medical need is strong.

Question 60 serves to place the hospital situation in a clear light. Responses indicated that an inebriate "suffering from a visible physical injury," "unconscious or insensate," "requiring admission to a medical ward," or identified as having "underlying medical problems" is the most likely to be admitted. Such persons fit the staff's regular medical orientation. If, however, an ordinary inebriate without purely medical needs walks in, he will almost certainly be rejected. If he becomes belligerent or antagonistic, he will be rejected, and he is likely to be rejected if he suffers from any "psychiatric disturbance," or even if he is a "regular customer." He has slightly better chances if the police bring him in or if he is visibly undergoing withdrawal, but delirium tremens is the only symptom of alcoholism that by itself will gain him entry. Very clearly, the hospitals will meet medical needs, but they do not respond to the usual problems of the public inebriate population or to the Uniform Act's main intention of guaranteeing treatment for alcoholism.

The combination of adverse attitudes, high costs, and inappropriate alcoholism response currently eliminate most hospitals from consideration as mainstays of the system for providing for the immediate needs of the public inebriate. Thus all but a tiny minority of alcoholism program directors indicated (Question 61) that it was definitely neither practical nor cost-effective to ask community hospitals to provide for those immediate needs. Many lamented that rejection of public inebriates by the hospitals means that alcoholism was still not accepted as a disease. They expressed forcefully the opinion that current laws requiring federally-funded hospitals to provide treatment for alcoholics should be enforced, and they drew attention to the Uniform Act provision which calls upon the state division of alcoholism to "encourage" hospitals to admit intoxicated persons "without discrimination" and to provide "adequate and appropriate treatment."

Detoxification Centers

With hospitals proving unsatisfactory, "detoxification centers" independent of hospitals have mushroomed throughout the country. The commentary on the Uniform Act finds the term "detoxification center" stigmatizing, and prefers "emergency services," which include "medical services, emergency social services, and appropriate diagnostic and referral services." Such emergency treatment (according to the Act) should be "provided by a facility affiliated with or part of the medical service of a general hospital."

The amount of affiliation between hospitals and detoxification centers is not, operationally, nearly as close as the Uniform Act recommends. Some detoxification centers are located within hospitals, just as some are located within jails. Many more--almost certainly the majority--are geographically separate, though there is often an administrative or supervisory connection. The general impression is that detoxification centers are increasing their autonomy.

A major reason for separation is cost. Responses to Question 62 indicated unanimously that hospital emergency rooms cost the most, followed closely by special receiving centers within hospitals. Non-hospital receiving centers are substantially lower in cost, almost as cheap as (and in some cases cheaper than) jails. (Note: comparative costs have been collected by some states; other states have reduced hospital costs to the point that they become feasible.)

The main challenge facing detoxification centers is the quality of care they provide, and this is often reflected in

outsiders' attitudes toward them. Are they regarded as treatment centers? or as alternatives to jail? or as government-sponsored flophouses?

The detoxification centers' medical orientation can be approximately measured by answers to Questions 63, 64, 65, and 66. A heavy majority of respondents, for instance, indicate that a staff physician is not needed at either a large or a small detoxification center (though noticeable minorities disagreed) but that an on-call physician is needed at either kind of center (again, there was minority dissent). Respondents indicated almost unanimously that large centers needed a registered nurse and that a licensed practical nurse was desirable, while small centers emphasized licensed practical nurses. Thus there was a strong medical orientation in the centers--but many respondents indicated that not even trained nurses were essential. Emphasized unanimously as needed in both small and large centers were "counselors" and "paramedical or EMT personnel." This seemed a significant choice, indicating that the detoxification centers concentrate on triage and referral, finding that the medical problems associated with alcoholism are less significant than the addictive problems which are alcoholism-specific. (This correlated with the universal opinion that at most 10% of clients require an emergency medical response.) Association with medical personnel, loose affiliation with a medical facility, medical back-up, and paramedical or EMT personnel were all indicated by interviewees as much more useful than a strictly medical model.

Other indications of the preference for the paramedical rather than medical model came from the almost equal division between respondents to Question 65 (as to whether there should or not be physician's standing orders for medication) and the full scattering of replies to Question 66. At different detoxification centers, all or none of the admitted inebriates may be given medication, or any percentage in between, and there was passion in the argument between proponents of either extreme. Most notable argument was over the danger of substitute addiction. Where prescription drugs are given, they are almost always Valium and Librium (Question 67), both potentially very addictive, and alcoholism professionals reported many of their clients already taking massive (and dangerous) doses of these drugs. Thus, though most respondents believed that medical assistance is necessary in certain cases, they were apprehensive about medical help which did not fully understand the special problems connected with addictive personalities and with the substance alcohol.

The attitudes of detoxification centers toward their clientele proved as important as their medical orientation. Are the centers' personnel seeking to provide treatment? life-style maintenance? general health or social care? referral? Are they optimistic or pessimistic about their clients' prospects? Are they more humane than the police and jail personnel from the old system? Have we changed orientation, or are we doing the same old thing in different facilities with different personnel?

Answers to these questions are very difficult to find, and the next sequence of questions is aimed at approximating them. For example, the sequence of Questions 68, 69, and 70 is aimed at determining the opinion of detoxification center personnel as to why their clients come to them. There is absolutely no valid statistical information about the inebriates' motives, and the spread of answers from detoxification center personnel was so great as to reveal only our ignorance about client motivation. Answers and interviews showed that some personnel were optimistic, others deeply pessimistic about their clientele's motivation. Perhaps significantly, they showed no overall difference in attitudes toward self-referrals and police-referrals, though individual detoxification centers feel very strongly that self-referrals are more likely to be seeking treatment than are police-referrals. This is clearly a matter for research, since results could affect the structure, philosophy, and morale of the detoxification centers.

Skepticism about the inebriates' motivation in first coming to a center very significantly did NOT extend to their probability of achieving sobriety, as was indicated by a series of questions of which Question 70 is an example. A majority of respondents indicated that they thought about half or more of their clients would eventually achieve sobriety, indicating at least that the morale of detoxification center staff is at present high.

Questions 72, 73, and 74 give further insight into attitudes. Answers to Question 72 (which may be posed to anyone in a community) showed that the great majority believe that the detoxification centers have "partially" become revolving doors, while minorities report firmly that they either have or have not. Answers to Questions 73 and 74 divided right down the middle, indicating that police and detoxification center personnel are equally concerned that we may simply have relocated the revolving door. It must be emphasized, however, that interviews indicated very

different attitudes toward the continued existence of the revolving door. Clearly, there were some naive expectations (especially among youthful police officers), that creating detoxification centers would lead to "cures" whereas more experienced personnel realized, as did the drafters of the Uniform Act, that a large proportion of public inebriates would continue to revolve. Disillusionment after original, high, unreal expectations is nonetheless a significant danger to detoxification centers.

Another set of crucial issues emerged when questions were asked about the admissions policy of detoxification centers. The Uniform Act clearly intends that no appropriate client should be refused admission. As long as he is intoxicated, or an alcoholic, and in need of treatment which the center can provide, then the center should admit him or see that other appropriate action (transport home or to another care agency) is accomplished. Unfortunately, various factors water down this uncompromising policy. Two factors emerged as dominant: the capacity of the centers and their philosophy.

For example there are the answers to Question 75 which is a twin to Question 60 about hospital policies (discussed earlier). These answers showed a generally satisfactory picture. Most detoxification centers are reported unanimously as likely to admit walk-in self-referrals, police referrals, regular customers, and those unable to pay. If they are not located within a hospital, they are almost certain to refuse and refer persons suffering from a physical injury, undergoing D.T.'s, requiring admission to a medical ward, possessing identified underlying medical problems, unconscious or insensate, or with an evident psychiatric disturbance. In all these areas detoxification centers are a mirror-image of hospitals, each accepting whomever the other rejects, just as one would theorize to be appropriate. The only areas where policy was divided were "belligerent or antagonistic" persons (who are likely to be rejected by everyone except the police), and persons undergoing withdrawal, who may or may not be accepted by detoxification centers depending (apparently) on the capability of their personnel.

So far, so good. But interviews and other questions (for example, Question 76) showed a different and much less rosy picture. Lack of capacity again emerges as a major problem which worsens when a community tries to decide whether a detoxification center is primarily a treatment center or an alternative to jail. If its capacity is too small, it must turn away clients. In some jurisdictions

police-referrals receive priority, resulting in the irony of self-referrals being refused or in empty beds while inebriates sleep in the outside street-world. If self-referrals receive priority, police become disillusioned by being turned away, resulting in increasing disregard of the center by officers. Very few centers indicated that there were "no refusals." Increased capacity is the only long-term solution, though many centers are improvising solutions by daily or hourly communications with the police. Another solution recommended by some personnel was the creation of two detoxification centers: one for police-referrals and regular customers (alternative to jail), the other for self-referrals genuinely wanting treatment.

More justifiable grounds for refusing admission are "person's medical needs too great" or "psychological state too bad." Generally, detoxification centers seemed wary of stretching further than their expertise and resources allow, and a majority gave the above as causes for referral. Inebriates who refuse to stop drinking while staying in the center apparently cause indecision, as indicated by answers to Questions 76, 77, and 78. Detoxification centers do not want to become "wet," and most have stated policies against drinking on the premises or off the premises while resident, but some centers see dangers in making cessation of drinking an inevitable prerequisite of treatment. The special problem here is caused by the regulars who have no desire to give up drinking, who seek the comparative comfort of a detoxification center, and who incorporate the center into their lifestyle. The Uniform Act explicitly refuses to make enduring sobriety a precondition for readmission to an emergency service center: "a person shall not be denied treatment solely because he has withdrawn from treatment against medical advice on a prior occasion or because he has relapsed after earlier treatment." Responses and interviews, however, show that at least a large minority of detoxification centers eventually refuse admission to regulars or place a limit on the number of times they may be admitted. These refusals may be informal, or they may result from written policy.

After admission, what happens in a detoxification center? The first measure of a center's activities is provided by answers to Question 79. Most centers monitor and record the duration of stays. Averages vary greatly according to the equipment and intention of the center, and it should be possible to collect nationwide data on the subject. Reports indicate that clients certainly stay longer in detoxification

centers than they do in jails, where release within four to six hours is the norm (Question 80). Unlike the jails, the centers' aim is to have them stay at least until sober, which apparently ranges between 24 and 96 hours. The desirable length of stay is an issue which needs more attention. It affects the meaning of "treatment," since the prognosis seems better if the stay is longer. It affects the availability of beds, total capacity over time, and therefore the center's responsiveness to the whole inebriate population. It affects the voluntariness of treatment, since many center staff regret the speed with which many clients leave but cannot legally retain them. It affects the validity of jails as bases for detoxification. And it affects the philosophy of the center: is it there primarily to provide lifestyle maintenance (shorter stays) or is it moving toward in-patient treatment (longer stays). Many centers place a maximum on the length of time an inebriate may stay (e.g., 7 days, 30 days), and there is a general but not universal reluctance to turn them into quarterway or halfway houses. (Some detoxification centers are physically and organizationally close to halfway houses, and transfers regularly occur.)

Within detoxification centers, treatment is very differently defined. Some insist that all admissions have beds. Others allow people to sleep on bare floors when beds are filled, or they provide sitting-rooms for persons who want a few hours' shelter. Some insist that all admissions receive counseling, and some that everyone join a group therapy situation, while others allow certain individuals to come and go with minimal interference. Some give everyone medical treatment, while others refuse any medication. Most centers try to refer departing clients to other treatment centers, but none of them reported happiness about their performance in this area.

Another measure of what happens inside a detoxification center can be gained from answers to Question 81 which lists the items which a center might provide their clients. Of this list, only four items were unanimously identified as necessary: food and drink; beds; bed-sheets; and pajamas, gowns, and slippers. These are minimal, but all are dramatic departures from what is provided in drunk tanks, and they show the centers' desire to provide greater comfort and dignity. Next most chosen were armchairs; a sitting-room for walk-ins; space to move around in; and a special room for withdrawal patients. These represent dramatic departures from both jails and hospitals. Clearly the detoxification centers are providing a very new kind of government service for inebriates.

Next in popularity (and supported by a large majority) were a series of minimal comforts or conveniences: television; books and games; attractive surroundings; downtown location; and private lockers. (Minorities indicated that items in this last group were unnecessary.) Regarded as unnecessary were an out-of-downtown location; modern decor; craft or work spaces and equipment; and a darkness room. A locked front door was regarded as undesirable as well as unnecessary. Respondents pointed out that each of these items had program implications, revealing for instance the program's accessibility, or its degree of treatment orientation, or its attitude towards what the clients deserved.

Very clearly no one is seeking to provide public inebriates with luxury. Detoxification centers' needs and wishes are very modest, and they represent a legitimate desire to create a health care alternative at the least possible cost. In fact, to an outsider all detoxification centers seem antiquated and depressing, but all those visited were clean, orderly, minimally comfortable, and vastly superior to drunk tanks and jails.

A major dissatisfaction for detoxification centers (and also for some hospitals) is caused by the Uniform Act's emphasis on voluntariness of treatment. No reports were found of any patient being kept against his will, but this goes against the grain of treatment personnel trying for success. For instance, respondents to Question 82 voted overwhelmingly for hospitals to let an unwilling patient go "reluctantly" or to "insist on a voluntary minimum stay." If he left, they felt that a relative should be notified quickly, and if he was brought by the police, a measurable minority felt that the police should be told he had left against advice (for the sake of the center's reputation). Respondents to Question 83 believed almost unanimously that an inebriate should be able to leave a detoxification center against medical advice, though some coupled departure with sobriety. Responding to Question 84, all non-medical detoxification centers answered "whenever he wishes," while a scattering of medical centers replied "depends on physician's order" or indicated special conditions on police-referrals. Few centers had tried a voluntary, pre-contracted minimum stay, though two of those visited reported successful results. Though none officially reported that inebriates could leave while still drunk or if behaving in a disorderly or confused state, interviews with both program staff and inebriates indicated that such departures take place, and a major police complaint was that "the drunks are staggering back on the street as soon as we leave." This, indeed, accounts for a major part of the centers' reputation as ineffectual.

There seems to be some major confusion about the law in this matter. Asked (Question 85) how long a receiving center could hold someone against his will (e.g., under physician's hold), state-level personnel indicated varying periods from 24 hours to five days, with only a minority indicating "no time." Program personnel in the same states, however, either did not use the Uniform Act's emergency commitment provisions or did not know that they could (or did not wish to) implement the law. As there is also a wide disparity from state to state in this matter, it seems worth the attention of both national and state policy-makers.

Unfortunately there seems no theoretical consistency about the problem either among program managers or directors of state divisions of alcoholism. Asked how long a physician's order should be able to hold someone (Question 86), answers ranged through the entire spectrum from "no time" to "longer periods at discretion," though 72 and 96 hours were marginally more popular. Asked a slightly different question (Question 87) aimed at determining a definition of "sobering up," respondents were a little clearer. All indicated that anything less than 24 hours was inadequate, and almost all that anything more than 72 hours was too long. Clustering occurred at 48 and 72 hours. Of course people disagreed as to (a) what "sobering up" means; and (b) whether detoxification centers could force someone to sober up. Nonetheless, these contradictions and confusions indicate further the need for more attention to the subject, especially where there are jail-based detoxification centers.

Currently, detoxification centers expend great ingenuity in keeping people from leaving inappropriately. Respondents to Question 88 indicated that only in rare cases (with ill or disturbed persons) do they resort to physical restraints or police help (threat of arrest), and their reluctance in both areas was obvious. "Verbal advice" was a unanimous choice, and interviews showed that the "good talkers" on a center's staff were highly prized by both the other staff and by the clients. Pajamas and medication were used by many centers not only for reasons of health and cleanliness but also to discourage premature departure, and some centers deliberately sent clothing "to the laundry" on occasion, or used hospital gowns (open at the back) instead of pajamas to bring embarrassment to their aid.

Special Populations

No matter how well the majority of the public inebriate population may be being treated, there are weaknesses in the immediate services offered to certain special subgroups. For

example, several interviewed states contain large Native American populations in certain areas. Answers to Questions 89 and 90 showed that these populations do cause special problems and receive worse care. The problem is probably not racism. Community officials reported that Native Americans living on reservations (federal land) get drunk in town and are grossly overrepresented in the population of public inebriates. Community officials resented lack of payment by the Native American government for treatment services provided off the reservation. It was clear that (a) some communities are beginning to avoid entering reservation-residents into the community treatment system (i.e., they are ignoring them, or having the police dump them onto reservation land, or continuing to jail them); and (b) few communities have worked out successful agreements with reservation authorities to guarantee either treatment or payment. The problem obviously deserves attention, and we were told that some communities have already solved it.

Uneasiness about female inebriates (Questions 91 and 92) is very evident. Though much fewer than males, they are increasing in number according to interviewees. Usually they were taken home or to "a home" by the police, thus avoiding the possibility of treatment. If they enter treatment, they require special facilities from detoxification centers. In some areas their small numbers apparently result in their receiving more individual attention, but program directors' uneasiness suggests that their situation should be further studied.

Ignorance concerning juvenile inebriates (Questions 93 and 94) was even worse. Police tend to treat them differently. The first choice is to get them home one way or the other, and family or friends are thus the first recourse. Second police choice is to segregate them until they "come to their senses," or, if they are unconscious, to take them to a hospital. They may arrest them if they are causing a disturbance, but the juvenile justice system will then normally guarantee that nothing further happens to them. We were unable to find any complete statistics as to either the numbers or the disposition of juvenile inebriates. Very few of them were reported to be entering any kind of alcoholism treatment such as is available to adults, and no one reported any special problems. This attitude was in marked contrast to studies showing vast increases in juvenile drinking-driving and in juvenile alcoholism, and if only for the sake of prevention programs, the situation ought to be more closely investigated.

The current study made no attempt to investigate other noted minority groups (for instance, blacks, Spanish-surname, drug addicts, or poly-addicts).

The minority group causing the most trouble to the system is undoubtedly that of the habitual repeaters, and their emergence as a special subgroup with dynamics and needs very different from the majority of public inebriates is perhaps one of the most singular and important results of decriminalization. Their number is not large. Different states indicated that they represent some 10 to 25% of the total public inebriate population (Question 95), though some thought them a larger or a much smaller proportion. But all programs reported them to be a serious problem. Respondents to Question 96, for instance, indicated that a half or more of all funds for public inebriate immediate services are going to habitual repeaters in more than half of all communities interviewed. Habitual repeaters were regarded as very unlikely prospects for treatment, and they were widely blamed for winning revolving-door reputations for detoxification centers. Few people liked to deal with them--neither police nor hospitals nor detoxification center personnel. And there is some evidence that they may soon be screened out of the care system. Responses to Question 97 indicated that persons who are solitary, resistant, indigent, regular customers are the least likely to be referred into further treatment. Anecdotal evidence indicates that they are restricted to "sleep-off" care, and police in several communities reported that they could not get even emergency medical care for the "town bums." To respond to this population, several state directors of Divisions of Alcoholism were beginning special studies, and it is clear that such efforts should be intensified in order to determine (a) the exact nature and extent of this subgroup; (b) the type of care which the government should provide; (c) the method of providing that care, especially whether or not it should be voluntary; and (d) the relevance of the Uniform Act's commitment provision to the subgroup.

SECTION VII: CONTINUING INVOLUNTARY CARE

Continuing Involuntary Care

QUESTIONS

1. Does your state law follow the provisions of the Uniform Act authorizing continuing involuntary care under short-term emergency commitment and long-term involuntary commitment?

   _____ Yes, both procedures

   _____ Emergency commitment only

   _____ Involuntary commitment only

   _____ Substantially similar

   _____ No

2. How many commitments are made each year for alcoholism? (Approximate annual total.)

   _____ Emergency commitment

   _____ Involuntary commitment

3. What are appropriate reasons for seeking emergency commitment (i.e., short-term commitment for emergency care)?

   _____ Unconsciousness

   _____ Diagnosis as an habitual drunkard or chronic alcoholic

   _____ Need for treatment

   _____ Danger to self

   _____ Danger to others

   _____ Helplessness

   _____ Conviction for alcohol-related offense(s)

   _____ Severely impaired judgment (incapable of realizing or making rational decision about need for treatment)

   _____ Number of contacts with police, jail, or detoxification center

4. Who makes the emergency commitment decision?

_____ Court

_____ State alcoholism agency

_____ Administrator of treatment agency

_____ Physician

_____ Area mental health board

5. How long can an emergency commitment last?

_____ Days

6. How long should it last?

_____ Days

7. What groups in your state do not know and understand the commitment procedures for alcohol abusers?

_____ State alcoholism agency personnel

_____ Police

_____ Judges

_____ Local alcohol program people

_____ Families of alcoholics

_____ Merchants

_____ Local governmental officials

_____ Alcohol abusers

_____ General public

8. Who is not satisfied with the emergency commitment procedure?

_____ Committing judges

_____ Police

_____ State alcoholism agency

_____ Treatment agency to which commitments are made

_____ Alcoholic population

_____ State attorney general

_____ Legal profession (e.g., civil liberties attorneys)

_____ Medical profession

_____ Families of alcoholics

9. What are the primary reasons for dissatisfaction?

_____ Commitment period is too short

_____ No control is exercised over the person

____ Procedure to commit is too cumbersome

_____ Procedure is legally suspect

_____ Treatment services are ineffective

_____ Appropriate treatment services are not available

10. Is emergency commitment used as a "substitute" for incarceration for public intoxication?

_____ Yes _____ No

11. Does the emergency commitment procedure provide adequate safeguards of patient rights?

_____ Yes _____ No

12. What rights does your Uniform Act guarantee an individual subjected to an emergency commitment proceeding?

_____ Reasonable time limit on length of commitment

_____ Opportunity to consult an attorney

_____ Notice of basis for commitment (application and/or physician's certificate)

_____ Release when reason for commitment no longer exists

_____ Pre-commitment review by court

_____ Post-commitment review by court

_____ Adequate immediate care

_____ Right to seek discharge from commitment by writ of habeas corpus

13. What are appropriate reasons for seeking <u>involuntary</u> commitment?

_____ Diagnosis as an habitual drunkard or chronic alcoholic

_____ Need for treatment

_____ Danger to self

_____ Danger to others

_____ Helplessness

_____ Repeated conviction for alcohol-related offenses

_____ Severely impaired judgment (incapable of realizing or making a rational decision about need for treatment)

_____ Number of contacts with police, jail or detoxification center

_____ Alternative to conviction if an alcoholic

_____ Cost to the community

14. Who makes the involuntary commitment decision?

_____ Court

_____ State alcoholism agency

_____ Administrator of treatment agency

_____ Physician(s)

_____ Mental Health board

15. How long can an involuntary commitment last?

_____ Days maximum for initial commitment

_____ Days maximum length of commitment

_____ Until released through an administrative or judicial review

_____ Until treatment is no longer necessary or is ineffective

_____ No limitation

16. How long should it last?

_____ Days maximum for initial commitment

_____ Days maximum length of commitment

_____ Until released through an administrative or judicial review

17. Who is not satisfied with the involuntary commitment procedure?

_____ Committing judges

_____ Police

_____ State alcoholism agency

_____ Treatment agency to which commitments are made

_____ Alcoholic population

_____ State attorney general

_____ Legal profession (e.g., civil liberties attorneys)

_____ Medical profession

_____ Families of alcoholics

_____ General public

18. What are the primary reasons for dissatisfaction?

_____ Initial commitment period too short

_____ Total maximum commitment period too short

_____ Commitment period too long

_____ No control is exercised over the person

_____ Procedure to commit is too cumbersome

_____ Procedure is legally suspect

_____ Treatment services are ineffective

_____ Appropriate treatment services are not available

19. Does the involuntary commitment procedure provide adequate safeguards of patient rights?

_____ Yes _____ No

20. What rights does your Uniform Act guarantee an individual subjected to the involuntary commitment process?

_____ Right to a timely pre-commitment hearing

_____ Right to receive notice of the hearing and a copy of the petition

_____ Right to be notified of his rights

_____ Right to contest the commitment application

_____ Right to counsel

_____ Right to appointed counsel if indigent

_____ Right to be examined by a physician of his choice

_____ Right that a physician who certifies findings in support of a commitment petition shall not be an employee of the admitting facility or the state alcoholism agency

_____ Right to seek discharge from commitment by writ of habeas corpus

_____ Right to adequate and appropriate treatment

_____ Right not to be committed unless a court finds, by clear and convincing proof, that he is a dangerous or incapacitated alcoholic and that the state alcoholism agency is able to provide adequate and appropriate treatment which is likely to be beneficial

_____ Right to be discharged, when committed as a dangerous alcoholic, if no longer an alcoholic or the likelihood he will inflict physical harm no longer exists

_____ Right to be discharged, when committed as an incapacitated alcoholic, if the incapacity no longer exists, if the treatment is not likely to bring about significant improvement, or if the treatment is no longer adequate or appropriate

_____ Right to be discharged at the end of the determinate commitment period unless recommitted

21. Is involuntary commitment used as a "substitute" for incarceration for public intoxication?

_____ Yes _____ No

22. Are more inebriates being involuntarily committed under inappropriate diagnoses?

_____ Yes _____ No

23. Even if involuntarily committed under an inappropriate diagnosis, are they receiving appropriate alcoholism care?

_____ Yes _____ No

24. What is your final back-up facility for chronic repeaters and those suffering from, e.g., permanent brain damage? (Check.)

_____ State medical hospital

_____ State mental hospital

_____ State prison

_____ State "farms"

_____ Local detention facility

_____ Local medical facility

_____ Local alcoholism facility

_____ None

_____ Nursing homes

_____ Chronic disease hospital

25. Should there be provision somewhere for involuntary residential or custodial care of habitual repeaters who do not give up drinking?

_____ Yes

_____ No

_____ A major dilemma

Continuing Involuntary Care

COMMENTARY

Introduction

The Uniform Act's policy in favor of voluntariness of treatment is reflected in the limited occasions and carefully circumscribed conditions in which government agencies or private individuals are permitted to interfere in the life of an alcoholic without his consent. The most common intrusion occurs when protective custody is employed by police to ensure that needed immediate emergency services are provided for the incapacitated inebriate. Protective custody intervention is usually quite limited in duration (48 hours in the Uniform Act) or until the individual is no longer incapacitated if less than the maximum hold limit. The issues involved in the exercise of police discretion in making street decisions on when to invoke protective custody have been discussed earlier in the section on immediate services. This section explores the situations requiring emergency medical attention beyond the time limit for protective custody, or longer-term custody for alcoholics who are a threat to public safety or treatment for continuing incapacitation.

Of all the provisions of the Uniform Act in which the states are anything but "uniform," the sections relating to emergency and involuntary commitment seem particularly susceptible to local variation and change (Question 1). Some states have accepted the commitment provisions of the Uniform Act virtually verbatim, others have made significant modifications to reflect local needs, and many states rely upon preexisting general mental health commitment procedures rather than any special alcoholic commitment authority.

The Uniform Act commitment procedures, both for emergency and involuntary commitments, reflect the concern of the authors of the Act in providing a timely, workable procedure which meets evolving "due process" requirements to ensure protection of patient rights. The "due process" clause of the 14th Amendment to the U.S. Constitution has been construed to require both substantive and procedural protections. Substantive due process precludes state or local intervention into the lives of alcohol abusers through involuntary control unless there is a compelling state interest, such as assisting those unable to help themselves or protecting the public from threats of harm. In addition, "due process" demands certain procedural protections before an individual can be confined against his will, e.g., adversarial hearing on the issue of non-emergency commitment, right to representation by an attorney, and right to contest commitment by a writ of habeas corpus. There is emerging

law on the right to adequate and appropriate treatment for those committed on the basis of need for such treatment, another concern covered in the Uniform Act. The clear trend is one of increasing rights and protections for alcohol abusers subject to potential deprivation of liberty through the often archaic state commitment laws.

The question of frequency of commitments for emergency care and longer-term involuntary control (Question 2) brought out the fact of a wide disparity in the use of these procedures in different states. Some states use both procedures infrequently or not all, while a few engage in extensive use (for example, approximately 500 emergency commitments and 1500 involuntary commitments in one state). Most respondents were not certain about the exact usage rates; but concurred, in any event, that commitment of any kind is an extraordinary action in most states, reserved only for the most exceptional cases. In some states which have not completely decriminalized (in the strictest sense of decriminalization as the concept is presented in the Uniform Act), a considerable number of commitments originate with police-initiated charges for alcohol-related offenses.

Emergency Commitment

The policy of the Uniform Act clearly limits the occasions in which the commitment process can be used in the care and control of intoxicated persons (not necessarily alcoholics). The Uniform Act authorizes commitment for emergency treatment for intoxicated persons who have inflicted (or are likely to inflict) physical harm or who are incapacitated by alcohol because of unconsciousness or severely impaired judgment. Simply stated, dangerousness and incapacitation due to alcohol are the only reasons for emergency commitment. The respondents in those states with emergency commitment authority confirmed these Uniform Act criteria as an appropriate basis for emergency commitment (Question 3). Most of the state directors thought that dangerousness, either to the inebriate himself or to others, was adequate grounds for emergency commitment. The Act allows only potential danger to others; although an individual presenting a threat of harm to himself could reasonably be considered to be "incapacitated." "Helplessness" and "severely impaired judgment" were frequently selected, both examples of incapacitation by alcohol. Some few respondents chose reasons unrelated to immediate need for emergency restraint or care.

Questions 4, 5, and 6 follow up on the question of state emergency commitment procedures. The emergency commitment decision is one requiring prompt action due to the immediate threat of harm or continuing condition of

incapacitation. The Uniform Act recognizes this need and authorizes the administrator of an approved public treatment facility to make the emergency commitment decision upon written application by any responsible person and accompanied by a physician's certificate supporting the need for emergency treatment. This is the prevalent locus of decision-making in half of the responding states; while in most of the remaining states, an appropriate court is given this responsibility. In at least one state, a physician makes the commitment decision. The responses reflect state concerns for protection of patient rights through formal process (judge) versus a need for a speedy response which can be provided more appropriately outside the judicial process (facility administrator).

The Uniform Act places a reasonable time limit (5 days) on the duration of commitment for emergency care, although the patient must be discharged when the grounds for emergency commitment no longer exist (unless being processed for involuntary commitment). Responding states typically noted an existing authorization for a maximum commitment period of 3-5 days, a substantial concurrence with the Uniform Act limitations. When queried as to the desirable length of such commitment, the respondents varied widely as to the time, some opting for longer control, others for even less, but most recommending a limited period around 3 days.

During the interviews with state and local people, it became apparent that a number were unfamiliar with the commitment procedures in the state or were in error as to the correct procedure (Question 7). Since the Uniform Act authorizes commitment only upon quite limited grounds and for similarly limited purposes, considerable resentment and adverse reaction to the state program can result because of lack of accurate information. Individuals not involved in the commitment process (merchants, local governmental officials, general public) cannot appreciate why certain chronic public inebriates are not being institutionalized under commitment procedures. State alcoholism agencies agree that information and guidelines on the purposes, grounds, and procedures for commitment of alcohol abusers need to be publicized, not only to those not involved in the process, but also to the participants in the commitment process. For example, if alcohol treatment facility administrators are to act as the committing authority upon application for emergency commitment, knowledge of their duties and obligations becomes critical. In this area, the state alcoholism agency, in cooperation with its staff attorney or the state attorney general, can develop, publish, and disseminate appropriate guidelines and informational materials about the commitment process.

The emergency commitment procedures in operation in the states have been considered entirely satisfactory by some groups (Questions 8 and 9). Among all the responding states, a number of different groups emerged as being dissatisfied in at least 2 or 3 different states: "committing judges," "police," "state alcoholism agency," "treatment agency to which commitments are made," and the "alcoholic population" itself. The reasons for this dissatisfaction were also diverse. The primary complaint of those involved in the commitment process was that the "procedure to commit is too cumbersome," a view understandable in states which require judicial involvement in this short-term type of commitment requiring prompt action. A small number felt that the commitment was inadequate because the "commitment period is too short" or the "procedure is legally suspect," two dissatisfactions which require legislative action to remedy. Another small number was dissatisfied with the way the commitment was carried out: there may be no place available to provide necessary care, the care provided may not be appropriate, or the treatment personnel may fail to exercise control (or cannot according to state law) over the committed inebriate. The analysis of state dissatisfaction with emergency commitment procedures indicates that these procedures must be both workable (if they are to be used) and legally sound (meeting current "due process" concerns), and must be linked to a program of appropriate emergency treatment (available and effective) and effective physical control to ensure the individual remains with the program during the period of commitment. The Uniform Act provisions appear to meet these requirements. States which have not adopted the Uniform Act commitment provisions could profitably consider them to ensure a fair, but efficient, procedure to provide needed emergency care and control for dangerous or incapacitated inebriates.

Question 10 examines the use of emergency commitment procedures as a potential circumvention of decriminalization in a state. All respondents indicated their impression that it was not used for such purpose. Monitoring of commitment practices is necessary to assure the process is used appropriately.

Questions 11 and 12 raise the timely issue of patients' rights. Two-thirds of the respondents indicated that the emergency commitment procedure provides adequate safeguards of patient rights. Most of the rights concerned with potential loss of liberty are associated with long-term commitments (e.g., 30 days). "Due process" requirements for short-term confinement for the purpose of immediate emergency care or control are not as stringent; however, the exact range of permissible state action without such things

as a hearing are not well defined. The Uniform Act procedures appear adequate to satisfy any legal concern. The Uniform Act requires an emergency commitment to be based upon a written application for commitment, supported by a physician's certificate (based on a timely examination of the individual) supporting the need for treatment. The administrator of an approved public treatment facility is authorized to approve the commitment if the grounds for commitment are met. The patient must be given a copy of the commitment application and physician's certificate within 24 hours after commitment and must be provided a reasonable opportunity to consult counsel. There was general agreement as to the obligation of the state alcoholism agency to monitor compliance with guaranteed patient rights and to ensure that its legal advisor (staff attorney or attorney general) is abreast of developments in this area. Appropriate legislative changes may be required to bring commitment procedures within the guidelines of recent court decisions.

Involuntary Commitment

The second type of involuntary control authorized by the Uniform Act is "involuntary commitment of alcoholics." Emergency commitment contemplates short-term control for the purpose of emergency care, while involuntary commitment involves longer-term control for individuals classified as "alcoholics" according to the Act (who habitually lack self-control) and who are likely to inflict physical harm on another or are incapacitated by alcohol. In sum, only dangerous or incapacitated alcoholics can be committed involuntarily.

Respondents were requested to provide appropriate reasons for involuntary commitment (Question 13). All the listed reasons received endorsement by some respondent; however, as with emergency commitment, dangerousness ("danger to self" and "danger to others") prevailed as the primary reason for involuntary commitment. Once again it should be noted that "danger to self" is not adequate justification under the Uniform Act unless you construe "danger to self" to be a sign of incapacitation (which it well might be). Incapacitation criteria (e.g., "helplessness" and "severely impaired judgment") were endorsed by half the states. Surprisingly, about half the states also considered "repeated conviction for alcohol-related offenses" and "number of contacts with police, jail or detoxification center" as appropriate reasons. Perhaps, these rationales reflect an "habitual offender" orientation more appropriate to a criminal approach than to a voluntary, treatment approach. The Uniform Act presumes voluntariness unless dangerousness or incapacitation is shown. States which

employ number of convictions, contacts, or arrests as the primary basis for commitment (rather than for determining the condition of incapacitation) may not be complying with the spirit of the Uniform Act.

Questions 14, 15, and 16 expand on the procedures involved in involuntary commitment. The Uniform Act allows the family, a certifying physician, or the administrator of a treatment facility to initiate the involuntary commitment proceeding by filing a petition with the appropriate court. The petition must be accompanied by a physician's certificate (based on a timely physical examination performed by a physician not in the employ of the admitting agency or the state alcoholism agency and supporting the allegations of the petition). A hearing must be conducted by the court within ten days, at which time testimony is heard (including testimony from at least one examining physician). If the grounds for commitment (dangerous or incapacitated alcoholic) are established by clear and convincing proof and it is found that the state is able to provide adequate and appropriate treatment likely to be beneficial (at least for an incapacitated alcoholic), the committing judge may order the individual committed to the custody of the state alcoholism agency. The initial period of commitment is for 30 days (unless the individual is discharged earlier). Two further recommitments are authorized for 90-day periods each; total commitment length, then, is 210 days maximum. In summary, involuntary commitment under the Uniform Act can be ordered only by a judge after a timely hearing, must be based on the grounds of dangerousness or incapacitation of an alcoholic, and lasts for determinate periods of time while the grounds for commitment exist (but not exceeding 210 days).

In the case of longer-term confinement of alcoholics, virtually all states require formal involvement by a court in the commitment decision (Question 14). The length of involuntary commitment, both for an initial period of commitment and for total maximum commitment period, varied considerably among the participating states (Question 15). The length for initial commitment varied from 3 to 120 days; the length of the total maximum period varied from 5 to 180 days. The Uniform Act itself, as noted earlier, allows 30 days for the initial period and a possible maximum of 210 days (2 subsequent 90-day commitment periods being authorized). Not only was there no consensus in what the various state laws currently allow, but the state program directors varied widely in the periods for initial and maximum total commitment which they considered desirable (Question 16). The conclusion to be derived is that there is no particular desirable level of commitment which the states feel will meet the needs of the states and of the committed alcoholics. Certainly, further research seems needed to determine

the specific objectives of commitment and the periods of control which fulfill treatment agencies' and alcoholics' needs and satisfy legal constraints and protections. The susceptibility to involuntary control because of alcohol problems should not depend on the jurisdiction in which one happens to be at the time. The area of involuntary commitment is one in which compliance with the "uniformity" provided by the commitment provisions of Uniform Act might be firmly promoted in national policy.

The issue of satisfaction with the involuntary commitment laws was raised by Questions 17 and 18. There was a broad spectrum of dissatisfied groups, with perhaps one or two dissatisfied groups in each state. By far the most common dissatisfied group is the "committing judges." Since this type of commitment requires the commitment decision to be made by the judiciary in most states, it is not surprising that judges may be uneasy. Each of the other groups was dissatisfied in at least one state, with "police," state alcoholism agency" and "alcoholic population" receiving half as many votes as judges. The reasons for the discontentment were also scattered; however, half chose the fact that the "procedure to commit is too cumbersome" as the primary reason. This agrees with the general dissatisfaction toward emergency commitment also. Not only judges, but anyone with a valid interest in initiating an involuntary commitment proceeding, will be disinclined to pursue the action if the procedure is overly difficult, time consuming, costly, and complicated.

The important issue of alcoholics' rights in the involuntary commitment process is raised in Questions 19 and 20. All but one of the state program directors felt that the involuntary commitment procedures operative in their states provided adequate safeguards of patient rights (Question 19). The list of rights afforded by the Uniform Act (Question 20) is quite extensive, reflecting a deep concern by the authors of the Act for the provision of procedural "due process." These rights ensure that the individual is afforded continuing opportunities to test or challenge the basis for a commitment (e.g., notice and hearing, habeas corpus, determinate periods of commitment). The Uniform Act sets limited criteria for commitment (dangerousness and incapacitation of an alcoholic); consequently, if these grounds no longer exist, the alcoholic must be discharged. For example, if he is committed for being a threat to others, he must be released when the likelihood he will inflict physical harm no longer exists. Or, if committed because of incapacitation, he must be released if the incapacitation no longer exists, if the treatment is not likely to bring about significant improvement, or if the treatment is no longer adequate or appropriate. The adequacy and effectiveness of treatment are critical to continued commitment of incapacitated alcoholics.

In view of the diversity of state commitment laws and procedures, close attention should be paid to each state's statute to ascertain if the Uniform Act's policy intentions and procedural protections are being met in the state law. Here, as with emergency commitment, the state alcoholism agency, with the assistance of legal counsel, should develop, publish, and disseminate guidelines and informational materials on the commitment procedures for use by the public, local treatment agencies, the medical profession, police, and even the courts.

Questions 21, 22, and 23 focus on the actual purposes which the commitment process serves. All but one of the state program director respondents indicated that involuntary commitment procedures are not used as a "substitute" for incarceration for public intoxication, that is, as a circumvention device. In at least one jurisdiction, conviction for an alcohol-related charge (in the case of a repeat offender) will cause involuntary commitment proceedings to be commenced. One or two other states tie in arrest or conviction for drinking-related charges to the commitment process, a practice not totally harmonious with the intent of the Uniform Act.

It was the feeling of some interviewees that the commitment process was being used as a warehousing or custodial mechanism for some alcoholics who were not truly dangerous or incapacitated (Question 20). The prevalence of this use (or perhaps abuse) could not be determined, but should be looked into further as an alternative being used by those local treatment personnel, police, and judges who are frustrated with their inability to cope with the chronic repeater. As Question 21 suggests, it may be the case that those alcohol abusers being inappropriately diagnosed and committed are receiving appropriate alcoholism care which they would not have received without the coercion afforded by the commitment process. The "ends", perhaps, are being used to justify the "means;" however, again the exact situation regarding the propriety of commitments and the care provided during commitment is not known with any certainty.

Questions 24 and 25 are extensions to the previous two questions, asking the nagging question about what to do with the chronic repeater population--those who will not or cannot respond to repeated therapeutic interventions in their lives. Most state program directors acknowledged the "state mental hospital" as the final back-up facility or last resort for chronic repeaters and untreatables (e.g., brain damaged) (Question 24). The second most frequent selection was "local alcoholism facility," indicating continuing reliance on those local resources which continue to be exploited by the hard core of chronic repeaters. No state suggested a non-health care institution for this

group. And finally, in Question 25, is presented an idea suggested in a number of states of providing involuntary residential or custodial care for the habitual repeaters who do not give up drinking. The pragmatic realism and programmatic desperation of state and local alcohol program managers has led to increasing support for the concept of diverting chronic repeaters involuntarily (though many opt for a voluntary set-up) to a residential or domiciliary facility created especially for them. This program has the attraction of allowing alcohol treatment people the freedom and opportunity to concentrate their energies and resources on treatable alcohol abusers, while at the same time being assured that the needs of the chronic repeaters are being met. The concept raises certain legal, ethical, funding, and acceptance issues which should be explored, both at the national level and by interested states.

SECTION VIII: ADVICE ABOUT IMPLEMENTATION

Advice About Implementation

QUESTIONS

1. Please indicate the date on which the operation of the Uniform Act (or equivalent legislation) began in your state:

   Effective date of Act: _____

   Effective date for decriminalization: _____

   Please indicate the status of the above provisions in your state as of today; that is, which have been implemented (I), not completely implemented (NI), or started but not completed (S)..

		(I)	(NI)	(S)
a.	Creation of state alcoholism agency	_____	_____	_____
b.	Interdepartmental Coordinating Committee	_____	_____	_____
c.	Citizen's Advisory Council	_____	_____	_____
d.	Comprehensive and coordinated program	_____	_____	_____
e.	Regionalization (optional)	_____	_____	_____
f.	State regulation of treatment facilities	_____	_____	_____
g.	Preference for voluntary treatment	_____	_____	_____
h.	Preference for outpatient treatment	_____	_____	_____
i.	No denial of services because of relapses	_____	_____	_____
j.	Individual treatment plans	_____	_____	_____
k.	Continuum of coordinated services	_____	_____	_____
l.	Decriminalization compliance	_____	_____	_____
m.	Examination by licensed physician	_____	_____	_____
n.	Transportation (including emergency service patrol)	_____	_____	_____
o.	Commitment policies and procedures	_____	_____	_____
p.	Immediate services for public inebriates	_____	_____	_____

2. Indicate which of the provisions of the Act were effectively implemented by enactment (E); which can be implemented immediately after enactment (I); which take up to a year to implement (1); which take up to two years (2); and which take longer (2+).

	(E)	(I)	(1)	(2)	(2+)
a. Creation of state alcoholism agency	___	___	___	___	___
b. Interdepartmental Coordinating Committee	___	___	___	___	___
c. Citizen's Advisory Council	___	___	___	___	___
d. Comprehensive and coordinated program	___	___	___	___	___
e. Regionalization (optional)	___	___	___	___	___
f. State regulation of treatment facilities	___	___	___	___	___
g. Preference for voluntary treatment	___	___	___	___	___
h. Preference for outpatient treatment	___	___	___	___	___
i. No denial of services because of relapses	___	___	___	___	___
j. Individual treatment plans	___	___	___	___	___
k. Continuum of coordinated services	___	___	___	___	___
l. Decriminalization compliance	___	___	___	___	___
m. Examination by licensed physician	___	___	___	___	___
n. Transportation including emergency service patrol	___	___	___	___	___
o. Commitment policies and procedures	___	___	___	___	___
p. Immediate services for public inebriates	___	___	___	___	___

3. Which of the following provisions of the Uniform Act have or have not caused any trouble? Of those which caused trouble, please indicate whether the difficulty was temporary and whether it was worth it.

	Temporary Trouble	Continuing Trouble	Worth It
a. Creation of state alcoholism agency	_____	_____	_____
b. Interdepartmental Coordinating Committee	_____	_____	_____
c. Citizen's Advisory Council	_____	_____	_____
d. Comprehensive and coordinated program	_____	_____	_____
e. Regionalization (optional)	_____	_____	_____
f. State regulation of treatment facilities	_____	_____	_____
g. Preference for voluntary treatment	_____	_____	_____
h. Preference for outpatient treatment	_____	_____	_____
i. No denial of services because of relapses	_____	_____	_____
j. Individual treatment plans	_____	_____	_____
k. Continuum of coordinated services	_____	_____	_____
l. Decriminalization compliance	_____	_____	_____
m. Examination by licensed physician	_____	_____	_____
n. Transportation (including emergency service patrol)	_____	_____	_____
o. Commitment policies and procedures	_____	_____	_____
p. Immediate services for public inebriates	_____	_____	_____

4. During enactment by the state legislature, which of the following strategies would you recommend as the best way of implementing the provisions and intentions of the Uniform Act? Which of the following strategies are you for and against? (You may choose more than one.)

	For	Against
a. Try for legislative passage of the entire Uniform Act at one time and with only minor amendments	_____	_____
b. Modify existing statutes and regulations piecemeal	_____	_____
c. Separate decriminalization from the other provisions of the Act, and proceed with decriminalization---		
i. first	_____	_____
ii. last	_____	_____
d. Encourage passage of legislation (including decriminalization) without the funding	_____	_____
e. Discourage passage of legislation (including decriminalization) without the funding	_____	_____
f. Encourage passage of legislation, with a formal written delay for decriminalization	_____	_____
g. Encourage passage of legislation and immediate implementation	_____	_____
h. Fund pilot projects in communities which decriminalize <u>before</u> passage of legislation	_____	_____

5. After enactment, what are the best ways to ensure statewide implementation? (Indicate For or Against.)

	For	Against
a. Concentrate on special target populations serially but statewide (e.g., begin with public inebriates then move on to other groups, or vice-versa)	_____	_____
b. Concentrate on selected geographical areas first (e.g., large urban areas, or communities already active), allowing the others to go their own way or do nothing for a while	_____	_____
c. Emphasize uniform provision statewide of selected treatment components (e.g., detoxification centers)	_____	_____
d. Work statewide with all members of one component of the whole system (e.g., police, or state agency heads, or existing treatment structure)	_____	_____
e. Provide each community with guidelines and standards as to (a) resources, (b) population needs, (c) necessary services; then monitor their activities	_____	_____
f. Focus on developing new state-paid resources	_____	_____
g. Set up small demonstration projects of different types and encourage adoption by other communities after testing	_____	_____
h. Focus almost entirely on building up existing resources	_____	_____
i. Hold community-level planning meetings of all responsible persons, aimed at creating a comprehensive system within the community	_____	_____
j. Focus on planning and evaluation, and offer education	_____	_____

6. What are the best and worst ways to ensure that decriminalization will be implemented with some success? (Indicate For or Against.)

	For	Against
a. Include a delay for implementing decriminalization in the original legislation	_____	_____
b. Go for immediate statewide decriminalization, allowing the problems to emerge later	_____	_____
c. Accompany passage of the legislation with much publicity and education	_____	_____
d. Keep a very low profile and avoid publicity	_____	_____
e. Try to act aggressively in providing input to the original legislation	_____	_____
f. Act passively toward the decriminalization provisions, allowing other members of the alcoholism constituency to deal with the debate	_____	_____
g. Establish in advance those provisions of the Act which you can establish by administrative regulation or independent action	_____	_____
h. Prepare a detailed, statewide plan for implementation	_____	_____

7. How long a period of advance planning is necessary to facilitate reasonable implementation of all provisions of the Act? (Includes state agency reorganization, as well as decriminalization.)

_____ Six months

_____ 12 months

_____ Two years

_____ Longer (specify)

8. Which of the Act's provisions require the longest period for advance planning?

_____ Decriminalization

_____ Comprehensive and coordinated services

_____ Reorganization of state agency

_____ Commitment procedures

_____ Treatment program standards

_____ Immediate services for public inebriates

9. Which provision of the Act was the most and least difficult to implement in your state? (Rank in order.)

_____ Decriminalization

_____ Comprehensive and coordinated services

_____ Reorganization of state agency

_____ Commitment procedures

_____ Treatment program standards

_____ Immediate services for public inebriates

10. Do you recommend for or against the following strategies for implementing decriminalization?

	For	Against
a. Piggybacking new alcoholism services on an existing statewide structure (e.g., mental health, general health)	_____	_____
b. Systematically avoiding creation of new agencies for delivering services to public inebriates	_____	_____
c. Bolstering existing private or volunteer public inebriate programs with government funds	_____	_____
d. Creating an umbrella "Public Inebriate Program" within each community	_____	_____
e. Creating a special "Public Inebriate Program" statewide	_____	_____
f. Deliberately avoiding joining public inebriate programs with existing alcoholism services	_____	_____
g. Having the same agency provide primary care, referral, and counseling for public inebriates	_____	_____
h. Hiring former skid-row residents as program managers or coordinators	_____	_____

11. During implementation, should the initiative for creating local programs move---

	Yes	No
a. From the community level up to the state agency?	_____	_____
b. From the state agency into the communities?	_____	_____
c. From the federal level to the state agency?	_____	_____
d. From the federal level to communities?	_____	_____

12. Select the five most probable obstacles to implementation in your state:

_____ Total absence of state funds

_____ Inadequate funds

_____ Delayed funds

_____ Lack of trained personnel

_____ Resistance to decriminalization from police or press

_____ Inadequate treatment programs/facilities

_____ Variations in geography/population

_____ Resistance or indifference to state alcoholism agency

_____ Lack of interest or antagonism among legislators

_____ Lack of interest or antagonism among executive personnel

_____ Lack of advance planning

_____ Resistance from county commissioners

_____ Lack of appropriate physical plant

_____ Lack of models and guidelines, especially about cost-effective public inebriate programs

13. Prior to or during enactment of the Uniform Act provisions, would you advise the state alcoholism agency to . . .

	For	Against
a. Prepare accurate fiscal projections of the cost of implementation, based on the need for services?	_____	_____
b. Play down the issue of increased costs due to decriminalization?	_____	_____
c. Specify those costs associated with handling public inebriates, separate from other costs of the Uniform Act?	_____	_____
d. Insist on adequate funding at the time of enactment?	_____	_____
e. Plan for realistic phase-in of funds over period of time?	_____	_____
f. Proceed with enactment regardless of funds?	_____	_____

14. Did your state enact the Uniform Act (or equivalent) without appropriating special funds of its own?

_____ Yes _____ No

15. If so, has the state legislature subsequently appropriated funds?

_____ Yes _____ No

16. If so, what changed their minds?

_____ Inadequacy of other funding sources

_____ Influence of alcoholism lobby

_____ Complaints about public inebriates

_____ Commitment to implement legislative policy

_____ Change in political composition of state government

_____ Indorsement of key executive or legislative leader

17. Which of the following agents are likely to find lack of money the major influence on their attitudes toward decriminalization?

_____ State legislature

_____ State executive

_____ Local government leaders

_____ Police

_____ Courts

_____ Treatment agencies, governmental

_____ Treatment agencies, private

_____ Jails, and other correctional agents

_____ State alcoholism agency

_____ Voluntary alcoholism agencies

18. To run a successful program for public inebriates, how much more money per year would you estimate your state would need?

$_____

19. Can you accurately measure the cost of the arrest-and-incarceration system for handling public inebriates?

_____ Yes _____ No _____ Well enough

20. How much more or less does it cost to handle public inebriacy through the decriminalized system than through the previous criminal justice system?

_____ 50%

_____ 75%

_____ Same

_____ 125%

_____ 150%

_____ More (specify)

21. Which of the following agents will experience a significant increase or decrease in costs due to decriminalization?

	Increase	Decrease
Police	_____	_____
Courts	_____	_____
Hospital emergency rooms	_____	_____
Hospital in-patient wards	_____	_____
Non-hospital detoxification centers	_____	_____
Non-hospital residential facilities	_____	_____
Counseling centers	_____	_____
Transportation agents	_____	_____

22. Which level of government is paying the largest share of the costs of public inebriate care?

_____ City government

_____ County government

_____ State

_____ Federal funds

23. What proportion of the present costs of public inebriate programs is borne by local government?

_____ None

_____ Less than 10%

_____ About 25%

_____ About 50%

_____ More than 50%

24. Who should pay for the costs of first implementing decriminalization? (Rank in order of preference.)

_____ Local funds

_____ State funds

_____ Federal funds

_____ A mixture of two or three of the above

25. Who should pay for ongoing decriminalization costs after the public inebriate programs have become established? (Rank in order.)

_____ Local funds

_____ State funds

_____ Federal funds

_____ A mixture of two or three of the above

26. Who pays for the costs of transporting public inebriates? (Checkmark.)

_____ Police funds

_____ Hospital funds

_____ Special transportation funds

_____ County or city general funds

_____ County or city alcoholism funds

_____ State funds

_____ Federal funds

27. If your state has moved from transportation by police to any form of non-police transportation, would you describe the costs now involved as---

	Urban	Rural
_____ Much greater	_____	_____
_____ A little more	_____	_____
_____ About the same	_____	_____
_____ A hidden cost now revealed	_____	_____
_____ A little less	_____	_____
_____ Much less	_____	_____

Why?

28. Who should be primarily responsible for the costs of providing long-term services to public inebriates?

_____ City government

_____ County government

_____ State government

_____ Federal government

_____ Private organizations

_____ Combination of state and local

_____ All of the above

29. Is the trend within your state-level government toward providing more or less funds for public inebriate care?

_____ More

_____ Less

_____ The same

_____ None

30. What are the best and worst ways of acquiring state funds for public inebriate programs? (Rank 1-5, from best to worst.)

_____ From existing appropriations for alcoholism services

_____ From new appropriations specifically tied to decriminalization

_____ From allocations for specific types of services (e.g., transportation; detoxification centers)

_____ From reapportionment of existing departmental allocations (e.g., police budget, alcoholism budget, mental health budget, public health budget)

_____ From a new income source (e.g., liquor tax)

31. In the next few years, will your local communities be putting more or less money into public inebriate programs?

_____ More

_____ Less

_____ Dramatically less

_____ Same

32. Should the decriminalization laws require local matching funds?

_____ Yes _____ No _____ Voluntary only

33. As regards public inebriate services, which elements of the programs should receive priority claim on (a) federal special implementation grant funds; (b) state funds; (c) local funds. Under each column, check five elements only.

	Federal	State	Local
Pick-up/transportation	_____	_____	_____
Emergency medical care	_____	_____	_____
Emergency triage care	_____	_____	_____
Medical diagnosis	_____	_____	_____
Medical back-up	_____	_____	_____
Non-hospital detoxification	_____	_____	_____
Shelter (drop-in, sleep off)	_____	_____	_____
Quarterway houses	_____	_____	_____
Halfway houses	_____	_____	_____
Long-term residential (for "regulars")	_____	_____	_____
Custodial care	_____	_____	_____
Outpatient counseling	_____	_____	_____
Outpatient social services	_____	_____	_____
Research/evaluation	_____	_____	_____
Monitoring and records (MIS)	_____	_____	_____

34. What percentage of your public inebriate population can pay for treatment at least partially from any of the following:

Source	Percentage
a. Own income	_____
b. Private health insurance	_____
c. Government health insurance	_____
d. Medicare (retirement)	_____
e. Vocational rehabilitation (disability)	_____
f. Medicaid (financially needy)	_____
g. Title XX (social services)	_____
h. Supplemental Security Income (income supplement)	_____
j. Other government source	_____
i. CHAMPUS	_____

35. Which do you prefer of the following sources of funds from consumers of alcoholic beverages?

_____ Client-pay, on graduated scale

_____ Special liquor tax into general funds

_____ Special liquor tax into special treatment fund

_____ Special allocation from existing liquor tax

_____ Allocation from general revenues

36. Has there been any instance in which part of the criminal justice system budget has been formally transferred to another agency for use in the public inebriate programs?

_____ Yes _____ No

37. Have communities received funds from LEAA either directly or through the state criminal justice planning agency, specifically for dealing with public inebriates?

_____ Yes _____ No

Advice About Implementation

COMMENTARY

Introduction

The ultimate purpose of this Guidance Manual is to help states still faced with decriminalization and with enactment or implementation of the Uniform Act. Thus this final section concentrates on advice and recommendations garnered from states and communities which have gone through the process. Some of the questions were posed to the state alcoholism agencies of decriminalized states, and these answers will be of interest to other state agency heads and of use as they plan. Other questions are for use by the state alcoholism agency in determining what problems it may face during implementation. These questions should be directed by the state alcoholism agency to other personnel and agencies throughout the system.

Enactment to Implementation

State alcoholism agencies were asked by Question 1 to give some indication of how long it takes to implement the various provisions of the Uniform Act. Though dates of enactment and implementation differed widely from state to state (1969 to 1976), there was a clear pattern in the responses. Many states have not yet implemented two provisions: the Interdepartmental Coordinating Committee, and the emergency service patrol (although the latter is discretionary). Implementation nationwide is slowest in the creation of a comprehensive and coordinated program, and of a continuum of coordinated services at the community level. Significant numbers of states are having trouble with state regulation of treatment facilities, examination by a licensed physician, and the commitment provisions. Regionalization is an option not chosen by half the states. Individual states are having problems with other provisions, but there are no widespread difficulties in these areas.

Question 2 is another way of measuring the relationship between enactment and implementation, and a pattern emerged very similar to that of Question 1. Again, the creation of a comprehensive and coordinated program and of a continuum of local services takes more than two years in the opinion of most states, with only a few indicating they can be accomplished faster. Creation of the state alcoholism agency, everyone agrees, can be accomplished at once or within a year at most; the Interdepartmental Coordinating Committee and the Citizen's Advisory Council can be set up with the same expeditiousness. Interestingly, decriminalization and "no denial because of relapses" are thought to

take longer; some people think they can be done at once, but many others say they take one or even two years. The same judgment was made about regionalization; preference for outpatient treatment; and individual treatment plans. There was a spread from "immediate" to "longer than two years" concerning examination by a licensed physician; emergency service patrol; commitment; state regulation of treatment facilities; and the preference for voluntary treatment.

In general, therefore, a state alcoholism agency can count on spending two years of intensive effort, at the end of which it may still have several specific problems to solve and almost certainly will still be working hard at the continuum of coordinated services. Many states indicated that portions of their legislation could be implemented either administratively or de facto before enactment, and most recommended that this be done. All strongly urged the beneficial effects of advance planning, both within the state alcoholism agency and among the communities.

Seeking a third way of looking at the problems of implementation, Question 3 asked which provisions had caused temporary or continuing trouble, and whether such trouble was worth it. The only provisions not selected by anyone as causing trouble were "creation of state alcoholism agency," "Citizen's Advisory Council," and "regionalization." Other answers followed the pattern of a state's own experience as indicated in the previous two questions, except that "commitment policies and procedures" and "examination by a licensed physician" were both identified as causing emphatic (but not necessarily continuing) trouble because of negotiations involving both the law and the medical profession. Interestingly, all problems except one were identified as worth the trouble; the exception was "examination by a licensed physician," which fewer than half the states which had had trouble thought the effort was worth the result.

All state alcoholism agencies recommended that successful implementation depended heavily on involvement during the process of enactment of the legislation. Their disagreements lay only over what degree of involvement and what kind. Question 4 therefore deals with desirable strategies to use during enactment to ensure successful implementation. There was overwhelming support for the idea that one should try for legislative passage of the entire Uniform Act at one time and with only minor amendments. Reciprocally, there was unanimous advice against modifying existing statutes and regulations piecemeal. This opinion was especially significant because a large number of the responding states either had enacted piecemeal legislation or had seen large departures from the provisions of the Uniform Act creep into their state's legislation. The advice, clearly, was to stick to the Uniform Act as a pack-

age, with only minor amendments suited to local needs (e.g., commitment laws, examination by a physician, authority of the state alcoholism agency).

Opinion divided, however, over decriminalization. Half the states were in favor of separating decriminalization from other provisions of the Act in some way, and three-quarters of the responding states advised that the legislation should include a formal written delay for decriminalization, while others recommended funding pilot projects in communities which de facto decriminalized before the legislation. The reasoning was that formal passage coupled by formal delay both forced and enabled everyone to face up to the situations brought about by decriminalization, changing attitudes on the one hand, and on the other creating the time to establish immediate services. However, a significant number of states were against this strategy, in the belief that faster and better solutions would come if the problem was simply dumped on the public, the system, and the legislature by swift enactment and immediate implementation.

Opinion also divided over funding. In many states, lack or inadequacy of appropriations is the sole stumbling-block to enactment. What posture should the state alcoholism agency then take? Three-quarters of responding states indicated that one should discourage enactment without funding, judging that there are other tactics available which will eventually ensure funding. Several states, however, had passed legislation without funding, and after original bad public response, their legislatures had provided funding within the year. (Some few legislatures remain recalcitrant.) Thus a quarter of the responding states judged it safe to proceed with legislation even without funds, on the grounds that they would eventually be forthcoming.

The state alcoholism agencies were then asked for advice on strategies for implementation after enactment of the Uniform Act, considering the whole Uniform Act first, and then separately the decriminalization provisions. Question 5 showed considerable disagreement about general strategies. Everyone was in favor of the general managerial responsibility of the state alcoholism agency, and they therefore almost all encourage the issuance and monitoring of guidelines and standards. Majorities also favored concentrating on special target groups statewide and serially, and they advised against first concentrating instead on selected high-population areas. Most state agencies favored the uniform provision statewide of selected treatment components, i.e., concentrating first on a part of the treatment continuum statewide. Their main concern was detoxification services. They also recommended holding planning meetings statewide at the community level, to make sure everyone was

getting the same message. A majority also reported that focus was necessary on developing new state-paid resources, because new resources are needed and communities cannot be relied upon to fund them. Responding agencies also favored the idea of providing model programs by setting up pilot projects in certain areas, upon which other communities could later model themselves. They voted against taking a passive role (i.e., planning, evaluation, and education only), though indicating that all such activities were needed. As to the strategy of working on all members statewide of a single component of the whole system, opinion divided equally. The same even split occurred about the strategy of focussing primarily on building up existing resources (though again, others indicated that the state had to create new resources or there would be nothing.)

Question 6 then asked the state alcoholism agencies to recommend strategies for implementing decriminalization. Everyone recommended aggressive input into the original legislation, especially concerning time and funding. Almost everyone recommmended going ahead with provisions that could be handled by administrative fiat, in advance of legislation. Almost everyone voted against passivity, whether it was as regards the substance of the Act or publicity about the Act. In fact, all but one state advocated accompanying passage of the Act with a heavy, special publicity and education campaign about the purposes of decriminalization. The only split occurred over whether decriminalization should or should not be delayed, with states voting two to one in favor of a formal delay in the legislation and against immediate implementation of decriminalization. Finally, almost everyone favored preparation of a detailed, statewide plan for a decriminalization, but several agencies were doubtful that it could be done in advance of legislation because the task is so big.

Planning emerges as a major virtue in the eyes of those states which have decriminalized, since most of them believe they did not do enough. Asked how long a planning period is desirable (Question 7), a majority chose one to two years, while a very few said it could be done within six months, and one state thought it took much longer to do a proper job. Asked which provisions took the longest planning, states scattered answers among all the alternatives in Question 8, but there was a definite concentration around "comprehensive and coordinated services," and only one checkmark next to "reorganization of state agency." Asked to rank the six major provisions of the Uniform Act in order of difficulty as to implementation (Question 9), states scattered so widely that no order was discernible.

Long-term strategies for implementing decriminalization were the next subject on which the state alcoholism agencies were questioned (Question 10). Everyone voted for bolster-

ing existing agencies with new government funds, and against keeping public inebriate programs separate from existing alcoholism services. It seems that the Uniform Act's recommendation to build on the existing services network gets strong approval from operational personnel. Thus agencies voted four to one against creating a special statewide "Public Inebriate Program," and two to one in favor of piggybacking new services on an existing statewide health structure. Opinions about all the other strategies were almost evenly divided. Equal numbers believed that one should and should not create new agencies to deliver public inebriate services, and community-level "Public Inebriate Programs." A narrow majority favored fostering a single-agency concept for public inebriates within a community, while others thought this population should be fed into regular services. A narrow majority favored harnessing the energies of former skid-row residents as program coordinators. Asked where the initiative for implementing local programs should come from (Question 11), twice as many state alcoholism agencies thought it had to come from the state as thought it should begin with the communities, though there were frequent qualifications as to strategies and differences between communities. Everyone was against direct contracts between the Federal government and local communities (except in limited, specific circumstances), but most felt that Federal initiatives directed toward state agencies were beneficial. (A minority disagreed bitterly.)

Finally, the states were asked to identify the major obstacles to the early stages of implementation. The list presented in Question 12 was compiled from their answers. Three of those choices emerged as more significant than the others: inadequate funding; inadequate treatment programs or facilities; and lack of advance planning. Any or all of the other obstacles, however, are likely to occur, or to occur at different stages of the process, and clearly one cannot identify which will emerge when.

Funding at Time of Enactment

During the course of this study, funding (or resources or costs) has emerged as a constant problem. The remainder of this section is therefore devoted to relaying the experience of decriminalized states with funding issues.

The first phase of funding problems occurs during the period of enactment of the Uniform Act, and the state alcoholism agencies were asked for their advice at this stage of affairs (Question 13). With only a single exception they voted in favor of preparing accurate fiscal projections of the cost of implementation, based on the need for services. They also recommended analyzing, if possible, the costs of the present arrest-based system. This is a dangerous tactic, and some decriminalization legislation has been turned down

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because of the size of projected budget needs, but nonetheless the responding states voted four to one against playing down the issue of increased costs. Apparently they believe that honesty remains the best policy. They also recommended three-to-one in favor of insisting on adequate funding at the time of enactment, feeling that insistence was better than the problems that would follow poverty. If faced with the inevitable, however, a majority voted in favor of proceeding with enactment without funds, believing that funds would in the long run become available. Heavy majorities also favored a phase-in of funds over time (as programs became adequately operational) and separation of public inebriate costs from those of the Act's other provisions.

When asked whether their state legislatures had in fact enacted Uniform Act legislation without accompanying appropriations (Question 14), almost half indicated that this had indeed happened. Were the results as disastrous as one might expect? In all but two of these states, the legislature has subsequently appropriated funds (Question 15), normally during the following year, and normally because the inadequacy of unfunded decriminalization was painfully obvious to them and the public. The list of motives for legislative changes of heart in Question 16 was provided by respondents, and the most frequent pattern seems to have been the pressure of public opinion being used by the alcoholism lobby to work on the legislature through key legislative and executive personnel.

The study team sought to examine the role of the special funds provided by Congress as an incentive to aid implementation of the Uniform Act. Since these funds did not become available until 1975, almost all responding states had enacted their legislation without the prospect of such funds, and therefore only four states could indicate that the existence or promise of those funds had possibly influenced their legislatures. Most state alcoholism agencies thought the original incentive grants were too small in relation to projected costs to substantially influence their legislatures, though they did have extra influence because they represented direct Congressional endorsement of the Uniform Act.

Funding for Implementation

The state alcoholism authorities were asked to identify those agencies and people likely to be most averse to implementing decriminalization because of the lack of money or the prospective high costs (Question 17). The group by far most often selected was "local government leaders," and interviews confirmed this judgment. Local government absorbs unquestioningly the cost of the criminal system for handling public inebriates, and many local leaders are interested in

decriminalization only in so far as it will save money in local budgets. This is not because they are inhumane, but because recent inflation and increasing costs have placed local governments in an increasingly difficult situation. They are especially unwilling to fund new programs for a populace which has no responsibility toward the community, and they regard most public inebriates as falling into that category. Legislatures and state executives are reported as also increasingly wary of the costs of decriminalization.

But very few states or communities were reporting ultimate failures to funds. This is clearly because of efforts by the alcoholism profession to provide both education and the needed supporting funds. They report that careful individualized efforts at influencing legislators, elected officials and local managers by accurate information are almost always effective. Some "lobbying" may be necessary, and of course the requirements of the statutes are predominant, but where there is still resistance, state alcoholism agencies report success by presenting analysis of the community's or state's needs in this area, accompanied by accurate projections of cost.

It is not easy for them to measure either needs or costs. When asked, for instance, how much more money it would cost their state to run a successful program for public inebriates (Question 18), only a handful of states ventured an answer. The necessary data are not available. For instance, it would be extremely useful ammunition to know the cost of the present arrest-and-incarceration system for handling public inebriates, but when asked if they could measure it (Question 19), a great majority of respondents indicated they did not know how to do so. (Some communities have advanced the state of this art considerably, and their efforts merit dissemination.) Or again, when asked to report the extra "cost" of handling public inebriates through treatment programs rather than through the old system (Question 20), most state alcoholism agencies replied with answers that were only rough estimates.

However, they reported having found it useful to provide officials with a rough breakdown of anticipated costs and savings to the various criminal justice system and health care agencies listed in Question 21. Answers to this list tend to show savings to the criminal justice system, stable costs for the existing health care system, and increased costs only for new services. This becomes important because elected officials are highly conscious of the sources of funds, and most of the new services do not require funding from local taxes since they are mandated by state-level legislation. Thus, when asked which level of government was paying the largest share of the costs for the new services (Question 22), state alcoholism agencies overwhelmingly chose "state," with the other sources receiving equal small

numbers of votes. Asked what proportion of public inebriate program costs is borne by local government (Question 23), almost all states indicated "less than 10%" and only one estimated higher than 25%. It is therefore possible with ingenuity to show that local government does not and will not bear an increased cost burden--that in fact it may realize cost savings.

This is not to advocate payment for public inebriate programs from the state level. This would represent a major shift in traditional social policy, and it is by no means universally popular. For instance, when state alcoholism agencies were asked who should pay for the costs of first setting up decriminalization programs (Question 24), they for the most part agreed that a mixture of state and federal funds should pioneer the original high costs, but when asked who should pay for the cost of established programs (Question 25), they clearly advocated a mixture of state and local funds, with the emphasis on local.

The impression of the study team was that the costs of first implementing public inebriate programs was usually a matter of negotiation, of putting together various packages of funds from multiple sources and levels of government. Though troublesome, the funding issue could be solved. The one area where a widespread failure was noted was in transportation, either after the original pick-up of an inebriate or when an inebriate has to be taken to another more distant treatment facility. Asked who is presently paying these costs (Question 26), most states indicated that the police were still paying the major share as part of their normal routine, though in some states enforcement officers (especially county sheriffs) were resistant. Fewer than a quarter of responding states had special funds for transportation, and about the same number were using general funds from city or county government. About half the states reported the burden shifted to county or city alcoholism funds, and more than half the states indicated that either state funds or federal funds were being used (directly or indirectly) for this purpose. It seems clear that better guidelines should be sought in this area, particularly since in some communities disagreements about payment are causing some public inebriates not to receive the transportation which the law requires. Asked whether the increased costs of transportation were substantial (Question 27), most states chose "a little more," but almost as many chose "about the same" or "less." (This included states operating emergency service patrols.)

Funding for Long-term Operations

Although there are few states which have operated public inebriate programs over a long period, the study team asked some questions concerning the long-term picture, envisaging the full existence of comprehensive and coordi-

nated treatment programs. Respondents sometimes gave surprising answers when asked to think in this manner, rather than of just the immediate and short-term impact of the Uniform Act.

For example, when respondents were asked who should pay for long-term costs of public inebriate services (Question 28), a majority of both local-level and state-level personnel agreed that cities and counties should have the main responsibility. The other possible choices received only scattered votes. Again for example, state alcoholism agencies were asked whether the trend in their state government was to provide more or less funds for public inebriates care (Question 29), and despite anxieties about the present funding situation, twice as many states chose "more" or "the same" as chose "less," and only one chose "none," thus showing a more optimistic view than might be expected.

These changes in viewpoint when faced with the long term arose from careful thought about permanent funding bases for public inebriate programs. People are now contemplating the incorporation of such programs into the regular expenditures of government, the true sign of the programs' acceptance. In this respect, the list of alternatives for long-term state funding presented in Question 30 becomes an important basis for long-term planning. States report various mixtures of all these sources, with growing popularity for a special liquor tax dedicated to the treatment of alcoholism. Interviews showed increasing public support for this latter concept of a "user tax" as the only long-term solution. Again, respondents seemed optimistic about local communities assuming a greater share of the long-term costs. Asked (in Question 31) whether they expected more or less local funding in future years, state alcoholism authorities voted three-to-one for "more" or the "the same," and no one chose "dramatically less." Some states have already linked state and local funds by requiring local matching funds in state public inebriate legislation. Sometimes this match is mandatory, sometimes it is optional upon acceptance or rejection of the entire alcoholism program in a community. States experienced with such legislation reported mixed experiences: some antagonism, but a definite increase in overall funds and overall programs. Question 32 thus may prove a very important long-term question for planners. And Question 33 will help planners determine where the various sources of funds ought to or want to expend their money for public inebriates.

There needs to be much deeper exploration of funding sources other than alcoholism treatment funds. Many program personnel pointed out that alcoholism funds are now being expected to provide money for services which have to do with public order, public safety, and public convenience, rather than concentrating on alcoholism treatment. However, the

study team found little evidence that alternative sources are being investigated nationwide. For instance, program directors are fortuitously finding one unexpected source of funds in the public inebriates themselves. Many public inebriates are not impoverished. Some have incomes from either private or government sources, and there was some sentiment among program personnel that they should spend that money on treatment rather than alcohol. Others have various government sources available to them once they enter treatment, so that alcoholism treatment programs can get some reimbursement just like other medical programs. Question 34 contains a list of such sources created by respondents and accompanied by their recommendation that any program manager have a close look at his clientele to determine whether or not they have access to payment from any of these sources. It seems probable that percentages may be higher than we expect, though this will vary according to the local nature of the public inebriate population. The study team found few program mangers who had investigated their clientele's income sources, and guidance from national and state personnel in this area would seem appropriate.

Question 35 lists variations of the "user tax" suggested by respondents. All sources found adherents among interviewees, though the "special liquor tax into general funds" was almost always regarded as ineffective.

Finally, there was sentiment that criminal justice funds should be reallocated into public inebriate care. This argument had three distinct parts. First, alcoholism funds are now absorbing functions previously paid for by criminal justice funds. Second, since the criminal justice system has presumptively made savings, those savings should be shifted to the public inebriate care system. Third, since alcohol is the substance whose consumption is most clearly correlated with most categories of criminal offense, the criminal justice system would benefit from aiding the alcoholism profession to reduce consumption. This logical chain has not yet proven convincing. Asked for examples of communities where criminal justice funds had been reallocated (Question 36), not one state could come up with a single example. Asked whether federal or state formula grant criminal justice funds were going to public inebriate programs (Question 37), almost all states replied affirmatively--though the amounts were small. Clearly there is a disjunction between national and local policy in this area, and it would seem profitable for national, state, and local planners to examine the subject much further.

APPENDIX A:

Uniform Alcoholism and Intoxication
Treatment Act
(Full Text)

UNIFORM ALCOHOLISM AND INTOXICATION TREATMENT ACT

(WITH COMMENTS)

Drafted by the

NATIONAL CONFERENCE OF COMMISSIONERS
ON UNIFORM STATE LAWS

and by it

APPROVED AND RECOMMENDED FOR ENACTMENT
IN ALL THE STATES

at its

ANNUAL CONFERENCE
MEETING IN ITS EIGHTIETH YEAR
AT VAIL, COLORADO
AUGUST 21–28, 1971

SECTION 1. [*Declaration of Policy.*] It is the policy of this State that alcoholics and intoxicated persons may not be subjected to criminal prosecution because of their consumption of alcoholic beverages but rather should be afforded a continuum of treatment in order that they may lead normal lives as productive members of society.

COMMENT

This section is intended to preclude the handling of drunkenness under any of a wide variety of petty criminal offense statutes, such as loitering, vagrancy, disturbing the peace, and so forth. As the crime commissions pointed out, drunkenness by itself does not constitute disorderly conduct. The normal manifestations of intoxication—staggering, lying down, sleeping on a park bench, lying unconscious in the gutter, begging, singing, etc.—will therefore be handled under the civil provisions of this Act and not under the criminal law. See *District of Columbia* v. *Greenwell*, 96 Daily Wash. L. Reptr. 2133 (D.C. Ct. Gen. Sess. December 31, 1968).

SECTION 2. [*Definitions.*] For purposes of this Act:

(1) "alcoholic" means a person who habitually lacks self-control as to the use of alcoholic beverages, or uses alcoholic beverages to the extent that his health is substantially impaired or endangered or his social or economic function is substantially disrupted;

(2) "approved private treatment facility" means a private agency meeting the standards prescribed in section 9(a) and approved under section 9(c);

(3) "approved public treatment facility" means a treatment agency operating under the direction and control of the division or providing treatment under this Act through a contract with the division under section 8(g) and meeting the standards prescribed in section 9(a) and approved under section 9(c);

(4) "commissioner" means the commissioner [or] of the department;

(5) "department" means [the State department of health or mental health];

(6) "director" means the director of the division of alcoholism;

(7) "division" means the division of alcoholism within the department established under section 3;

(8) "emergency service patrol" means a patrol established under section 17;

(9) "incapacitated by alcohol" means that a person, as a result of the use of alcohol, is unconscious or has his judgment otherwise so impaired that he is incapable of realizing and making a rational decision with respect to his need for treatment;

(10) "incompetent person" means a person who has been adjudged incompetent by [the appropriate State court];

(11) "intoxicated person" means a person whose mental or physical functioning is substantially impaired as a result of the use of alcohol;

(12) "treatment" means the broad range of emergency, outpatient, intermediate, and inpatient services and care, including diagnostic evaluation, medical, psychiatric, psychological, and social service care, vocational rehabilitation and career counseling, which may be extended to alcoholics and intoxicated persons.

COMMENT

The term "alcoholic" is defined in two alternative ways for two different purposes. The first alternative is a relatively narrow definition based on lack of self-control regarding the use of alcoholic beverages. Lack of self-control may be manifested either by the inability to abstain from drinking for any significant time period, or by the ability to remain sober between drinking episodes but an inability to refrain from drinking to intoxication whenever drinking an alcoholic beverage. This relatively narrow definition has been the basis for the court decisions holding an alcoholic not criminally responsible for his intoxication.

The second alternative definition adopts the World Health Organization's broad approach that alcoholism can be defined as the use of alcoholic beverages to the extent that health or economic or social functioning are substantially impaired. The purpose of this broad definition is to make as large a group as possible eligible for treatment for alcoholism and related problems. Encouraging early treatment for drinking problems will ultimately lead to prevention. This broad definition of alcoholism is useful in making voluntary treatment available to as large a group as possible, but would be wholly inappropriate to define those alcoholics who justify civil commitment for involuntary treatment.

The Act defines "treatment" broadly to include a wide range of types and kinds of services to reflect the fact that there is no single or uniform method of treatment that will be effective for all alcoholics. The Act provides a flexible approach with a variety of kinds of medical, social, rehabilitative, and psychological services according to the individual's particular needs.

SECTION 3. [*Division of Alcoholism.*] A division of alcoholism is established within the department. The division shall be headed by a director appointed by the commissioner. The director shall be a qualified professional who has training and experience in handling medical-social problems or the organization or administration of treatment services for persons suffering from medical-social problems.

SECTION 4. [*Powers of Division.*] The division may:

(1) plan, establish, and maintain treatment programs as necessary or desirable;

(2) make contracts necessary or incidental to the performance of its duties and the execution of its powers, including contracts with public and private agencies, organizations, and individuals to pay them for services rendered or furnished to alcoholics or intoxicated persons;

(3) solicit and accept for use any gift of money or property made by will or otherwise, and any grant of money, services, or property from the Federal government, the State, or any political subdivision thereof or any private source, and do all things necessary to cooperate with the Federal government or any of its agencies in making an application for any grant;

(4) administer or supervise the administration of the provisions relating to alcoholics and intoxicated persons of any State plan submitted for Federal funding pursuant to Federal health, welfare, or treatment legislation;

(5) coordinate its activities and cooperate with alcoholism programs in this and other States, and make contracts and other joint or cooperative arrangements with State, local, or private agencies in this and other States for the treatment of alcoholics and intoxicated persons and for the common advancement of alcoholism programs;

(6) keep records and engage in research and the gathering of relevant statistics; and

(7) do other acts and things necessary or convenient to execute the authority expressly granted to it;

(8) acquire, hold, or dispose of real property or any interest therein, and construct, lease, or otherwise provide treatment facilities for alcoholics and intoxicated persons.

SECTION 5. [*Duties of Division.*] The division shall:

(1) develop, encourage, and foster statewide, regional, and local plans and programs for the prevention of alcoholism and treatment of alcoholics and intoxicated persons in cooperation with public and private agencies, organizations, and individuals, and provide technical assistance and consultation services for these purposes;

(2) coordinate the efforts and enlist the assistance of all public and private agencies, organizations, and individuals interested in prevention of alcoholism and treatment of alcoholics and intoxicated persons;

(3) cooperate with the [department of correction and board of parole] in establishing and conducting programs to provide treatment for alcoholics and intoxicated persons in or on parole from penal institutions;

(4) cooperate with the [department of education], [boards of education], schools, police departments, courts, and other public and private agencies, organizations and individuals in establishing programs for the prevention of alcoholism and treatment of alcoholics and intoxicated persons, and preparing curriculum materials thereon for use at all levels of school education;

(5) prepare, publish, evaluate, and disseminate educational material dealing with the nature and effects of alcohol;

(6) develop and implement, as an integral part of treatment programs, an educational program for use in the treatment of alcoholics and intoxicated persons, which program shall include the dissemination of information concerning the nature and effects of alcohol;

(7) organize and foster training programs for all persons engaged in treatment of alcoholics and intoxicated persons;

(8) sponsor and encourage research into the causes and nature of alcoholism and treatment of alcoholics and intoxicated persons, and serve as a clearing house for information relating to alcoholism;

(9) specify uniform methods for keeping statistical information by public and private agencies, organizations, and individuals, and collect and make available relevant statistical information, including number of persons treated, frequency of admission and readmission, and frequency and duration of treatment;

(10) advise the Governor in the preparation of a comprehensive plan for treatment of alcoholics and intoxicated persons for inclusion in the State's comprehensive health plan;

(11) review all State health, welfare, and treatment plans to be submitted for Federal funding under Federal legislation, and advise the governor on provisions to be included relating to alcoholism and intoxicated persons;

(12) assist in the development of, and cooperate with, alcohol education and treatment programs for employees of State and local governments and businesses and industries in the State;

(13) utilize the support and assistance of interested persons in the community, particularly recovered alcoholics, to encourage alcoholics voluntarily to undergo treatment;

(14) cooperate with [the commissioner of public safety] [highway commission] in establishing and conducting programs designed to deal with the problem of persons operating motor vehicles while [intoxicated];

(15) encourage general hospitals and other appropriate health facilities to admit without discrimination alcoholics and intoxicated persons and to provide them with adequate and appropriate treatment;

(16) encourage all health and disability insurance programs to include alcoholism as a covered illness; and

(17) submit to the Governor an annual report covering the activities of the division.

COMMENT

Section 5(9) gives the division the responsibility of specifying uniform methods for keeping statistical information, and collecting and disseminating such information. Confidentiality of individual patiet records will be protected in accordance with Section 15.

Sections 5 (10) and (11) authorize the division to advise the Governor with respect to the inclusion of alcoholism and intoxication under the State comprehensive health plan, and under all other State health, welfare, and treatment plans submitted for Federal funding. Under the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (Public Law 91–616), each State must prepare a comprehensive alcoholism plan for Federal funding. The Comprehensive Health Planning and Public Health Services Amendments of 1966 (Public Law 89–749) and the Partnership for Health Amendments of 1967 (Public Law 90–174) have also been amended by the 1970 Act to require that comprehensive State health plans must "provide for services for the prevention and treatment of alcohol abuse and alcoholism, commensurate with the extent of the problem" in order to receive Federal funds. Finally, numerous other relevant State plans, such as for vocational rehabilitation, are submitted for Federal funding. It will be the responsibility of the division to be certain that alcoholism and intoxication are included in all such pertinent State plans.

Section 5(15) gives the division the responsibility of encouraging general hospitals and other appropriate health facilities to admit and provide adequate treatment to alcoholics and intoxicated persons. This provision is particularly important because the 1970 Federal Act includes a provision under which a general hospital can be denied Federal funds under this law for discriminating against alcoholics.

Section 5(16) gives the division the responsibility of encouraging all health and disability insurance programs to include alcoholism as a covered illness. This provision applies to both private and governmental programs.

SECTION 6. [*Interdepartmental Coordinating Committee.*]

(a) An interdepartmental coordinating committee is established, composed of the [commissioners of public health, mental health, education, public welfare, correction, highway, public safety, vocational rehabilitation, and other appropriate agencies] and the director. The committee shall meet at least twice annually at the call of the commissioner, who shall be its chairman. The committee shall provide for the coordination of, and exchange of information on, all programs relating to alcoholism, and shall act as a permanent liaison among the departments engaged in activities affecting alcoholics and intoxicated persons. The committee shall assist the commissioner and director in formulating a comprehensive plan for prevention of alcoholism and for treatment of alcoholics and intoxicated persons.

(b) In exercising its coordinating functions, the committee shall assure that:

(1) the appropriate State agencies provide all necessary medical, social, treatment, and educational services for alcoholics and intoxicated persons and for the prevention of alcoholism, without unnecessary duplication of services;

(2) the several State agencies cooperate in the use of facilities and in the treatment of alcoholics and intoxicated persons; and

(3) all State agencies adopt approaches to the prevention of alcoholism and the treatment of alcoholics and intoxicated persons consistent with the policy of this act.

SECTION 7. [*Citizens Advisory Council on Alcoholism.*]

(a) The Governor shall appoint a citizens advisory council on alcoholism, composed of [15] members. The members shall serve for overlapping terms of 3 years each; one third of the members first appointed [, as nearly as may be practicable,] shall be appointed for one-, two-, and three-year terms respectively. Members shall have professional, research, or personal interest in alcoholism problems. The council shall meet at least once every [3] months and report on its activities and make recommendations to the director at least once a year.

(b) The council shall advise the director on broad policies, goals, and operation of the alcoholism program and on other matters the director refers to it, and shall encourage public understanding and support of the alcoholism program.

(c) Members of the council shall serve without compensation but shall receive reimbursement for travel and other necessary expenses actually incurred in the performance of their duties.

COMMENT

The qualifications of the members are defined broadly. It is expected that the Governor would appoint to the council individuals representing a broad range of background and experience, including representatives of citizens groups, voluntary organizations, professional groups, and recovered alcoholics.

SECTION 8. [*Comprehensive Program for Treatment; Regional Facilities.*]

(a) The division shall establish a comprehensive and coordinated program for the treatment of alcoholics and intoxicated persons. [Subject to the approval of the commissioner, the director shall divide the State

into appropriate regions for the conduct of the program and establish standards for the development of the program on the regional level. In establishing the regions, consideration shall be given to city, town, and county lines and population concentrations.]

(b) The program of the division shall include:

(1) emergency treatment provided by a facility affiliated with or part of the medical service of a general hospital;

(2) inpatient treatment;

(3) intermediate treatment; and

(4) outpatient and followup treatment.

(c) The division shall provide for adequate and appropriate treatment for alcoholics and intoxicated persons admitted under sections 11 to 14. Treatment may not be provided at a correctional institution except for inmates.

(d) The division shall maintain, supervise, and control all facilities operated by it subject to policies of the department. The administrator of each facility shall make an annual report of its activities to the director in the form and manner the director specifies.

(e) All appropriate public and private resources shall be coordinated with and utilized in the program if possible.

(f) The director shall prepare, publish, and distribute annually a list of all approved public and private treatment facilities.

(g) The division may contract for the use of any facility as an approved public treatment facility if the director, subject to the policies of the department, considers this to be an effective and economical course to follow.

COMMENT

Whether or not the director divides the State into regional units for purposes of administration, it is desirable that all treatment services be community based. Alcoholics and other ill persons are treated more effectively through treatment services in their own communities, located conveniently to population centers so as to be quickly and easily accessible to patients and their families, rather than in large institutional settings.

The Act uses the concept of emergency treatment rather than the more popular phrase "detoxification center" as the latter concept tends to stigmatize alcoholics and set them apart from people with other illnesses or problems. These emergency services should be available 24 hours a day and readily accessible to those who need this assistance. In addition to medical services, emergency social services and appropriate diagnostic and referral services should be included.

"Inpatient treatment" refers to full-time residential treatment in an institution. Although alcoholics and intoxicated persons ordinarily do not require full-time inpatient treatment services, such care must be available for those who do need it. Since long-term inpatient services are inappropriate for alcoholics, inpatient treatment should be designed to facilitate the patient's return to his family and the community or to other appropriate care services as rapidly as possible.

"Intermediate treatment" refers to residential treatment that is less than full time and that can be provided in a variety of community facilities, such as halfway houses, day or night hospitals, or foster homes.

"Outpatient and followup treatment" includes the same wide range of treatment services and modalities offered in inpatient or intermediate service settings, but in outpatient treatment, the client is not a full or part-time resident of the treatment facility. Such services may be offered in a wide variety of settings in the community, such as clinics and social centers and even in the patient's own home.

Section 8(a) requires that all existing appropriate private and public resources be coordinated with and used whenever possible. For example, general hospitals may be used for emergency care services, and community mental health centers may be utilized for a variety of kinds of services for alcoholics. The creation of a new and separate network of treatment facilities for alcoholics would not be desirable, practical, or effective.

Section 8(c) requires the department to provide adequate and appropriate treatment for all alcoholics and intoxicated persons, including both the vast majority of persons who will come to these facilities voluntarily and the small minority who may be involuntarily committed, in accordance with the provisions of sections 13 and 14 of the Act.

SECTION 9. [*Standards for Public and Private Treatment Facilities; Enforcement Procedures; Penalties.*]

(a) The division shall establish standards for approved treatment facilities that must be met for a treatment facility to be approved as a public or private treatment facility, and fix the fees to be charged by the division for the required inspections. The standards may concern only the health standards to be met and standards of treatment to be afforded patients.

(b) The division periodically shall inspect approved public and private treatment facilities at reasonable times and in a reasonable manner.

(c) The division shall maintain a list of approved public and private treatment facilities.

(d) Each approved public and private treatment facility shall file with the division on request, data, statistics, schedules, and information the division reasonably requires. An approved public or private treatment facility that without good cause fails to furnish

any data, statistics, schedules, or information as requested, or files fraudulent returns thereof, shall be removed from the list of approved treatment facilities.

(e) The division, after holding a hearing, may suspend, revoke, limit, or restrict an approval, or refuse to grant an approval, for failure to meet its standards.

(f) The [district] court may restrain any violation of this section, review any denial, restriction, or revocation of approval, and grant other relief required to enforce its provisions.

(g) Upon petition of the division and after a hearing held upon reasonable notice to the facility, the [district] court may issue a warrant to an officer or employee of the division authorizing him to enter and inspect at reasonable times, and examine the books and accounts of, any approved public or private treatment facility refusing to consent to inspection or examination by the division or which the division has reasonable cause to believe is operating in violation of this Act.

SECTION 10. [*Acceptance for Treatment; Rules.*] The director shall adopt and may amend and repeal rules for acceptance of persons into the treatment program, considering available treatment resources and facilities, for the purpose of early and effective treatment of alcoholics and intoxicated persons. In establishing the rules the director shall be guided by the following standards:

(1) If possible a patient shall be treated on a voluntary rather than an involuntary basis.

(2) A patient shall be initially assigned or transferred to outpatient or intermediate treatment, unless he is found to require inpatient treatment.

(3) A person shall not be denied treatment solely because he has withdrawn from treatment against medical advice on a prior occasion or because he has relapsed after earlier treatment.

(4) An individualized treatment plan shall be prepared and maintained on a current basis for each patient.

(5) Provision shall be made for a continuum of coordinated treatment services, so that a person who leaves a facility or a form of treatment will have available and utilize other appropriate treatment.

COMMENT

Section 10(1) expresses the Act's clear preference for voluntary over involuntary treatment. Voluntary treatment is more desirable from both a medical and legal point of view. Experience has shown that the vast majority of alcoholics are quite willing to accept adequate and appropriate treatment. Section 14 of the Act makes it clear that involuntary treatment is permitted only in exceptional and very clearly prescribed circumstances.

Section 10(2) is based on the fact that most alcoholics do not need long term inpatient care, but can be more successfully treated in outpatient or intermediate care settings (such as halfway houses). This section covers both voluntary and involuntary treatment, for section 14(h) allows the division to transfer a committed patient from a more restrictive to a less restrictive treatment modality whenever such transfer is "medically advisable."

Section 10(3) recognizes that alcoholics, like persons with other chronic illnesses, may relapse. Such relapses are to be expected as part of the illness and the individual should not be penalized. Prior treatment and withdrawal from treatment, even if repeated, should not bar a person from subsequent participation in a treatment program. It was deemed desirable to include this specific provision in the Act in view of the more punitive provisions against readmission in many older laws.

Section 10(4) provides that an individualized treatment plan must be prepared and maintained for each patient on a current basis. Such an individualized plan would include the factual record of all treatment provided and must be specifically tailored to meet the needs of each patient. A "boiler plate" treatment form for all patients would *not* meet the requirements of this section. This provision will ensure that patients are receiving treatment in accordance with their specific needs, and is crucial in the case of civilly committed patients in order to guard against the possibility of commitment without appropriate treatment.

Section 10(5) reinforces the Act's strong emphasis on the need for a continuum of coordinated treatment services (see also section 1 and section 8(a)) and requires the division to ensure that when a person leaves a form of treatment, other appropriate treatment services will be available to him.

SECTION 11. [*Voluntary Treatment of Alcoholics.*]

(a) An alcoholic may apply for voluntary treatment directly to an approved public treatment facility. If the proposed patient is a minor or an incompetent person, he, a parent, a legal guardian, or other legal representative may make the application.

(b) Subject to rules adopted by the director, the administrator in charge of an approved public treatment facility may determine who shall be admitted for treatment. If a person is refused admission to an approved public treatment facility, the administrator, subject to rules adopted by the director, shall refer the person to another approved public treatment facility for treatment if possible and appropriate.

(c) If a patient receiving inpatient care leaves an approved public treatment facility, he shall be encouraged to consent to appropriate outpatient or intermediate treatment. If it appears to the administrator in charge of the treatment facility that the patient is an alcoholic who requires help, the division shall arrange for

assistance in obtaining supportive services and residential facilities.

(d) If a patient leaves an approved public treatment facility, with or against the advice of the administrator in charge of the facility, the division shall make reasonable provisions for his transportation to another facility or to his home. If he has no home he shall be assisted in obtaining shelter. If he is a minor or an incompetent person the request for discharge from an inpatient facility shall be made by a parent, legal guardian, or other legal representative or by the minor or incompetent if he was the original applicant.

COMMENT

Most patients treated under this Act will voluntarily seek treatment. The provisions of this section allow the patient to seek treatment in the same manner as he would for any other health problem or illness. The Act encourages voluntary treatment by not requiring the patient to agree to voluntarily commit himself for a specified length of time or to accept any of the other restrictions that apply to involuntarily committed patients. Section 11 does not require either a predetermined minimum voluntary stay or a specified number of days of notice prior to seeking discharge. Such provisions would discourage treatment and would subject patients to restrictions that do not apply to patients with other medical problems.

Section 11 also requires the division to provide coordinated services (see also sections 1, 8(a), and 10(e)) and to assist the patient in getting from one service to another, including the arranging of transportation if necessary. Section 11(d) expressly provides that the division must make such provision even if the patient leaves the treatment facility against medical advice.

SECTION 12. [*Treatment and Services for Intoxicated Persons and Persons Incapacitated by Alcohol.*]

(a) An intoxicated person may come voluntarily to an approved public treatment facility for emergency treatment. A person who appears to be intoxicated in a public place and to be in need of help, if he consents to the proffered help, may be assisted to his home, an approved public treatment facility, an approved private treatment facility, or other health facility by the police or the emergency service patrol.

(b) A person who appears to be incapacitated by alcohol shall be taken into protective custody by the police or the emergency service patrol and forthwith brought to an approved public treatment facility for emergency treatment. [If no approved public treatment facility is readily available he shall be taken to an emergency medical service customarily used for incapacitated persons.] The police or the emergency service patrol, in detaining the person and in taking him to an approved public treatment facility, is taking him into protective custody and shall make every reasonable effort to protect his health and safety. In taking the person into protective custody, the detaining officer may take reasonable steps to protect himself. A taking into protective custody under this section is not an arrest. No entry or other record shall be made to indicate that the person has been arrested or charged with a crime.

(c) A person who comes voluntarily or is brought to an approved public treatment facility shall be examined by a licensed physician as soon as possible. He may then be admitted as a patient or referred to another health facility. The referring approved public treatment facility shall arrange for his transportation.

(d) A person who by medical examination is found to be incapacitated by alcohol at the time of his admission or to have become incapacitated at any time after his admission, may not be detained at the facility (1) once he is no longer incapacitated by alcohol, or (2) if he remains incapacitated by alcohol for more than 48 hours after admission as a patient, unless he is committed under section 13. A person may consent to remain in the facility as long as the physician in charge believes appropriate.

(e) A person who is not admitted to an approved public treatment facility, is not referred to another health facility, and has no funds, may be taken to his home, if any. If he has no home, the approved public treatment facility shall assist him in obtaining shelter.

(f) If a patient is admitted to an approved public treatment facility, his family or next of kin shall be notified as promptly as possible. If an adult patient who is not incapacitated requests that there be no notification, his request shall be respected.

(g) The police or members of the emergency service patrol who act in compliance with this section are acting in the course of their official duty and are not criminally or civilly liable therefor.

(h) If the physician in charge of the approved public treatment facility determines it is for the patient's benefit, the patient shall be encouraged to agree to further diagnosis and appropriate voluntary treatment.

COMMENT

A small minority of intoxicated persons are incapacitated in that they are unconscious or incoherent or similarly so impaired in judgment that they cannot make a rational decision with regard to their need for treatment. Section 12(b) authorizes the police or emergency service patrol to take such individuals into protective custody and to a public treatment facility for emergency care. This is intended to assure that those most seriously in need of care will get it.

Protective custody under (b) is similar to the way in which the police provide emergency assistance to other ill people, such as those in accidents or those who have sudden heart attacks. It is a civil procedure, and no arrest record or record which implies a criminal charge is to be made. Since the police officer may sometimes have to decide whether a man who refuses help appears to be incapacitated by alcohol or because of some other reason, section 12(g) protects the policeman should his conclusion, made in good faith, be incorrect. It provides that he cannot be held criminally or civilly liable for false arrest or imprisonment as long as he is acting in compliance with this section. Willful malice or abuse, however, would not be considered to be in compliance with this section of the Act.

Section 12(d) provides that an incapacitated person can be held at a treatment facility without consent or further civil procedures for not longer than 48 hours. By the end of 48 hours, most persons who have been incapacitated by alcohol will be sufficiently detoxified to be able to make a rational decision about their need for further treatment. To provide for those very few individuals who may still be incapacitated (perhaps even unconscious) at the end of 48 hours, section 13 provides for an emergency commitment procedure based on a written application and a certificate from a physician who is not employed by the division.

Other provisions of section 12 provide that the individual in a public treatment facility must be examined by a licensed physician as soon as possible. This is to ensure, in accordance with section 8(b), that these facilities will provide the necessary medical services.

SECTION 13. [*Emergency Commitment.*]

(a) An intoxicated person who (1) has threatened, attempted, or inflicted physical harm on another and is likely to inflict physical harm on another unless committed, or (2) is incapacitated by alcohol, may be committed to an approved public treatment facility for emergency treatment. A refusal to undergo treatment does not constitute evidence of lack of judgment as to the need for treatment.

(b) The certifying physician, spouse, guardian, or relative of the person to be committed, or any other responsible person, may make a written application for commitment under this section, directed to the administrator of the approved public treatment facility. The application shall state facts to support the need for emergency treatment and be accompanied by a physician's certificate stating that he has examined the person sought to be committed within 2 days before the certificate's date and facts supporting the need for emergency treatment. A physician employed by the admitting facility or the division is not eligible to be the certifying physician.

(c) Upon approval of the application by the administrator in charge of the approved public treatment facility, the person shall be brought to the facility by a peace officer, health officer, emergency service patrol, the applicant for commitment, the patient's spouse, the patient's guardian, or any other interested person. The person shall be retained at the facility to which he was admitted, or transferred to another appropriate public or private treatment facility, until discharged under subsection (e).

(d) The administrator in charge of an approved public treatment facility shall refuse an application if in his opinion the application and certificate fail to sustain the grounds for commitment.

(e) When on the advice of the medical staff the administrator determines that the grounds for commitment no longer exist, he shall discharge a person committed under this section. No person committed under this section may be detained in any treatment facility for more than [5] days. If a petition for involuntary commitment under section 14 has been filed within the [5] days and the administrator in charge of an approved public treatment facility finds that grounds for emergency commitment still exist, he may detain the person until the petition has been heard and determined, but no longer than 10 days after filing the petition.

(f) A copy of the written application for commitment and of the physician's certificate, and a written explanation of the person's right to counsel, shall be given to the person within 24 hours after commitment by the administrator, who shall provide a reasonable opportunity for the person to consult counsel.

COMMENT

The test contained in the definition of "incapacitated by alcohol" is whether the person's judgment is so impaired that he is incapable of realizing and making a rational decision with respect to his need for treatment. Section 13(a)(2) may, therefore, cover the alcoholic who threatens suicide. If he falls within the definition, he would be subject to commitment for emergency treatment.

It is anticipated that the need to resort to short term commitment for emergency medical care under this section will arise most infrequently, but the procedure does provide a means of dealing with situations not covered by other parts of the Act. It is meant to be utilized only in true emergency situations where immediate action to cope with the crisis is essential and where the delay of court proceedings would be dangerous. For example, it might be necessary to use this emergency commitment procedure for an alcoholic who becomes intoxicated at home and whose behavior becomes assaultive, or for an in-

capacitated alcoholic already detained involuntarily in a treatment facility for the 48-hour maximum who continues to be so severely incapacitated, perhaps because of brain damage, that he cannot make a rational decision about his continuing need for care.

SECTION 14. [*Involuntary Commitment of Alcoholics.*]

(a) A person may be committed to the custody of the division by the [district] court upon the petition of his spouse or guardian, a relative, the certifying physician, or the administrator in charge of any approved public treatment facility. The petition shall allege that the person is an alcoholic who habitually lacks self-control as to the use of alcoholic beverages and that he (1) has threatened, attempted, or inflicted physical harm on another and that unless committed is likely to inflict physical harm on another; or (2) is incapacitated by alcohol. A refusal to undergo treatment does not constitute evidence of lack of judgment as to the need for treatment. The petition shall be accompanied by a certificate of a licensed physician who has examined the person within [2] days before submission of the petition, unless the person whose commitment is sought has refused to submit to a medical examination, in which case the fact of refusal shall be alleged in the petition. The certificate shall set forth the physician's findings in support of the allegations of the petition. A physician employed by the admitting facility or the division is not eligible to be the certifying physician.

(b) Upon filing the petition, the court shall fix a date for a hearing no later than 10 days after the date the petition was filed. A copy of the petition and of the notice of the hearing, including the date fixed by the court, shall be served on the petitioner, the person whose commitment is sought, his next of kin other than the petitioner, a parent or his legal guardian if he is a minor, the administrator in charge of the approved public treatment facility to which he has been committed for emergency care, and any other person the court believes advisable. A copy of the petition and certificate shall be delivered to each person notified.

(c) At the hearing the court shall hear all relevant testimony, including, if possible, the testimony of at least one licensed physician who has examined the person whose commitment is sought. The person shall be present unless the court believes that his presence is likely to be injurious to him; in this event the court shall appoint a guardian *ad litem* to represent him throughout the proceeding. The court shall examine the person in open court, or if advisable, shall examine the person out of court. If the person has refused to be examined by a licensed physician, he shall be given an opportunity to be examined by a court-appointed licensed physician. If he refuses and there is sufficient evidence to believe that the allegations of the petition are true, or if the court believes that more medical evidence is necessary, the court may make a temporary order committing him to the division for a period of not more than [5] days for purposes of a diagnostic examination.

(d) If after hearing all relevant evidence, including the results of any diagnostic examination by the division, the court finds that grounds for involuntary commitment have been established by clear and convincing proof, it shall make an order of commitment to the division. It may not order commitment of a person unless it determines that the division is able to provide adequate and appropriate treatment for him and the treatment is likely to be beneficial.

(e) A person committed under this section shall remain in the custody of the division for treatment for a period of [30] days unless sooner discharged. At the end of the [30] day period, he shall be discharged automatically unless the division before expiration of the period obtains a court order for his recommitment upon the grounds set forth in subsection (a) for a further period of [90] days unless sooner discharged. If a person has been committed because he is an alcoholic likely to inflict physical harm on another, the division shall apply for recommitment if after examination it is determined that the likelihood still exists.

(f) A person recommitted under subsection (e) who has not been discharged by the division before the end of the [90] day period shall be discharged at the expiration of that period unless the division, before expiration of the period, obtains a court order on the grounds set forth in subsection (a) for recommitment for a further period not to exceed [90] days. If a person has been committed because he is an alcoholic likely to inflict physical harm on another, the division shall apply for recommitment if after examination it is determined that the likelihood still exists. Only 2 recommitment orders under subsections (e) and (f) are permitted.

(g) Upon the filing of a petition for recommitment under subsections (e) or (f), the court shall fix a date for hearing no later than [10] days after the date the petition was filed. A copy of the petition and of the notice of hearing, including the date fixed by the court, shall be served on the petitioner, the person whose commitment is sought, his next of kin other than the petitioner, the original petitioner under subsection (a) if different from the petitioner for recommitment, one of his parents or his legal guardian if he is a minor, and any other person the court believes advisable. At the hearing the court shall proceed as provided in subsection (c).

(h) The division shall provide for adequate and appropriate treatment of a person committed to its custody. The division may transfer any person com-

mitted to its custody from one approved public treatment facility to another if transfer is medically advisable.

(i) A person committed to the custody of the division for treatment shall be discharged at any time before the end of the period for which he has been committed if either of the following conditions is met:

(1) In case of an alcoholic committed on the grounds of likelihood of infliction of physical harm upon another, that he is no longer an alcoholic or the likelihood no longer exists; or

(2) In case of an alcoholic committed on the grounds of the need of treatment and incapacity, that the incapacity no longer exists, further treatment will not be likely to bring about significant improvement in the person's condition, or treatment is no longer adequate or appropriate.

(j) The court shall inform the person whose commitment or recommitment is sought of his right to contest the application, be represented by counsel at every stage of any proceedings relating to his commitment and recommitment, and have counsel appointed by the court or provided by the court, if he wants the assistance of counsel and is unable to obtain counsel. If the court believes that the person needs the assistance of counsel, the court shall require, by appointment if necessary, counsel for him regardless of his wishes. The person whose commitment or recommitment is sought shall be informed of his right to be examined by a licensed physician of his choice. If the person is unable to obtain a licensed physician and requests examination by a physician, the court shall employ a licensed physician.

(k) If a private treatment facility agrees with the request of a competent patient or his parent, sibling, adult child, or guardian to accept the patient for treatment, the administrator of the public treatment facility shall transfer him to the private treatment facility.

(l) A person committed under this Act may at any time seek to be discharged from commitment by writ of habeas corpus.

[(m) The venue for proceedings under this section is the place in which the person to be committed resides or is present.]

COMMENT

The Act specifically states that a refusal to undergo treatment does not by itself constitute evidence of lack of judgment with respect to the need for treatment. Thus, involuntary commitment would *not* be warranted merely because the person needs treatment, or has substantially inconvenienced his family, or has frequently been intoxicated in public, or because his drinking is harmful to his health. Commitment would be warranted, however, if the alcoholic exhibited cognitive deficiencies and was so debilitated that his thinking was confused not only with respect to his drinking problem but in other areas of behavior as well.

Section 14(d) prohibits mere custodial care by providing that a person may not be committed unless the division is able to provide "adequate and appropriate treatment for him and the treatment is likely to be beneficial."

The burden of proof in each recommitment is on the petitioner since each is an independent action.

If it is necessary to hold an individual beyond the maximum period, other provisions of State law must be used.

SECTION 15. [*Records of Alcoholics and Intoxicated Persons.*]

(a) The registration and other records of treatment facilities shall remain confidential and are privileged to the patient.

(b) Notwithstanding subsection (a), the director may make available information from patients' records for purposes of research into the causes and treatment of alcoholism. Information under this subsection shall not be published in a way that discloses patients' names or other identifying information.

COMMENT

The treatment of privileged information in the courts and disclosure with the consent of the patient are matters of general State law. This section does, however, provide for the use of treatment records for research purposes so long as patients' names and other identifying information are not disclosed.

SECTION 16. [*Visitation and Communication of Patients.*]

(a) Subject to reasonable rules regarding hours of visitation which the director may adopt, patients in any approved treatment facility shall be granted opportunities for adequate consultation with counsel, and for continuing contact with family and friends consistent with an effective treatment program.

(b) Neither mail nor other communication to or from a patient in any approved treatment facility may be intercepted, read, or censored. The director may adopt reasonable rules regarding the use of telephone by patients in approved treatment facilities.

SECTION 17. [*Emergency Service Patrol; Establishment; Rules.*]

(a) The division and [counties, cities and other municipalities] may establish emergency service patrols. A patrol consists of persons trained to give assistance in the streets and in other public places to persons who are intoxicated. Members of an emergency service patrol shall be capable of providing first aid in emergency situations and shall transport intoxicated persons to their homes and to and from public treatment facilities.

(b) The director shall adopt rules for the establishment, training, and conduct of emergency service patrols.

COMMENT

The experience of using civilians and plainclothes policemen, has demonstrated the effectiveness of this method. In some communities, for example, existing rescue squads that supply help and transportation in other medical emergencies might be used to assist intoxicated and incapacitated individuals. This provision does not require the establishment of an emergency service patrol, but authorizes such a patrol, should it meet the needs of a particular community.

SECTION 18. [*Payment for Treatment; Financial Ability of Patients.*]

[(a) If treatment is provided by an approved public treatment facility and the patient has not paid the charge therefor, the division is entitled to (1) any payment received by the patient or to which he may be entitled because of the services rendered, and (2) from any public or private source available to the division because of the treatment provided to the patient.]

[(b) A patient in an approved treatment facility, or the estate of the patient, or a person obligated to provide for the cost of treatment and having sufficient financial ability, is liable to the division for cost of maintenance and treatment of the patient therein in accordance with rates established.]

[(c) The director shall adopt rules governing financial ability that take into consideration the income, savings and other personal and real property of the person required to pay, and any support being furnished by him to any person he is required by law to support.]

SECTION 19. [*Criminal Laws Limitations.*]

(a) No county, municipality, or other political subdivision may adopt or enforce a local law, ordinance, resolution, or rule having the force of law that includes drinking, being a common drunkard, or being found in an intoxicated condition as one of the elements of the offense giving rise to a criminal or civil penalty or sanction.

(b) No county, municipality, or other political subdivision may interpret or apply any law of general application to circumvent the provision of subsection (a).

(c) Nothing in this Act affects any law, ordinance, resolution, or rule against drunken driving, driving under the influence of alcohol, or other similar offense involving the operation of a vehicle, aircraft, boat, machinery, or other equipment, or regarding the sale, purchase, dispensing, possessing, or use of alcoholic beverages at stated times and places or by a particular class of persons.

COMMENT

An important corollary to section 19 is section 37, which provides for the repeal of the State laws that are inconsistent with this Act. Under section 37, therefore, States would be expected to repeal all the relevant portions of their criminal statutes under which drunkenness is the gravamen of the offense with the exception of (c).

SECTION 20. [*Severability.*] If any provision of this Act or the application thereof to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the Act which can be given effect without the invalid provision or application, and to this end the provisions of this Act are severable.

[SECTION 21. [*Application of Administrative Procedure Act.*] Except as otherwise provided in this Act, the State Administrative Procedure Act applies to and governs all administrative action taken by the director.]

[SECTION 22. [*Applicability and Scope.*] Sections 23 to 34 apply to the director and prescribe the procedures to be observed by him in exercising his powers under this Act]

[SECTION 23. [*Public Information; Adoption of Rules; Availability of Rules and Orders.*]

(a) In addition to other rule-making requirements imposed by law, the director shall:

(1) adopt as a rule a description of the organization of his office, stating the general course and method of the operations of his office and methods whereby the public may obtain information or make submissions or requests;

(2) adopt rules of practice setting forth the nature and requirements of all formal and informal procedures available, including a description of all forms and instructions used by the director or his office;

(3) make available for public inspection all rules and all other written statements of policy or interpretations formulated, adopted, or used by the director in the discharge of his functions;

(4) make available for public inspection all final orders, decisions, and opinions.

(b) No rule, order, or decision of the director is effective against any person or party, nor may it be invoked by the director for any purpose, until it has been made available for public inspection as herein required. This provision is not applicable in favor of any person or party who has knowledge thereof.]

[SECTION 24. [*Procedure for Adoption of Rules.*]

(a) Prior to the adoption, amendment, or repeal of any rule, the director shall:

(1) give at least 20 days' notice of his intended action. The notice shall include a statement of either the terms or substance of the intended action or a description of the subjects and issues involved, and

the time when, the place where, and the manner in which interested persons may present their views thereon. The notice shall be mailed to all persons who have made timely request of the director for advance notice of his rule-making proceedings and shall be published in [here insert the medium of publication appropriate for the adopting State];

(2) afford all interested persons reasonable opportunity to submit data, views, or arguments, orally or in writing. In case of substantive rules, opportunity for oral hearing must be granted if requested by 25 persons, by a governmental subdivision or agency, or by an association having not less than 25 members. The director shall consider fully all written and oral submissions respecting the proposed rule. Upon adoption of a rule the director, if requested to do so by an interested person either prior to adoption or within 30 days thereafter, shall issue a concise statement of the principal reasons for and against its adoption, incorporating therein his reasons for overruling the considerations urged against its adoption.

(b) No rule is valid unless adopted in substantial compliance with this section. A proceeding to contest any rule on the ground of noncompliance with the procedural requirements of this section must be commenced within 2 years from the effective date of the rule.]

[SECTION 25. [*Filing and Taking Effect of Rules.*]

(a) The director shall file in the office of the [Secretary of State] a certified copy of each rule adopted by him. The [Secretary of State] shall keep a permanent register of the rules open to public inspection.

(b) Each rule hereafter adopted is effective 20 days after filing, except that, if a later date is specified in the rule, the later date is the effective date.]

[SECTION 26. [*Publication of Rules.*]

(a) The [Secretary of State] shall compile, index, and publish all effective rules adopted by the director. Compilations shall be supplemented or revised as often as necessary.

(b) Compilations shall be made available upon request to [agencies and officials of this State] free of charge and to other persons at prices fixed by the [Secretary of State] to cover mailing and publication costs.]

[SECTION 27. [*Petition for Adoption of Rules.*] An interested person may petition the director requesting the adoption, amendment, or repeal of a rule. The director shall prescribe by rule the form for petitions and the procedure for their submission, consideration, and disposition. Within 30 days after submission of a petition, the director either shall deny the petition in writing (stating his reasons for the denial) or shall initiate rule-making proceedings in accordance with the provisions on procedure for adoption of rules (section 24).]

[SECTION 28. [*Declaratory Judgment on Validity or Applicability of Rules.*]

The validity or applicability of a rule may be determined in an action for declaratory judgment in the [. . . court] if it is alleged that the rule, or its threatened application, interferes with or impairs, or threatens to interfere with or impair, the legal rights or privileges of the plaintiff. The director shall be made a party to the action. A declaratory judgment may be rendered whether or not the plaintiff has requested the director to pass upon the validity or applicability of the rule in question.]

[SECTION 29. [*Declaratory Rulings by Director.*] The director shall provide by rule for the filing and prompt disposition of petitions of declaratory rulings as to the applicability of any statutory provision or of any rule of the director. Rulings disposing of petitions have the same status as decisions or orders in contested cases.]

[SECTION 30. [*Contested Cases; Notice; Hearing; Records.*]

(a) In a contested case, all parties shall be afforded an opportunity for hearing after reasonable notice.

(b) The notice shall include:

(1) a statement of the time, place, and nature of the hearing;

(2) a statement of the legal authority and jurisdiction under which the hearing is to be held;

(3) a reference to the particular provisions of the statutes and rules involved;

(4) a short and plain statement of the matters asserted. If the director or other party is unable to state the matters in detail at the time the notice is served, the initial notice may be limited to a statement of the issues involved. Thereafter upon application a more definite and detailed statement shall be furnished.

(c) Opportunity shall be afforded all parties to respond and present evidence and argument on all issues involved.

(d) Unless precluded by law, informal disposition may be made of any contested case by stipulation, agreed settlement, consent order, or default.

(e) The record in a contested case shall include:

(1) all pleadings, motions, intermediate rulings;

(2) evidence received or considered;

(3) a statement of matters officially noticed;

(4) questions and offers of proof, objections, and rulings thereon;

(5) proposed findings and exceptions;

(6) any decision, opinion, or report by the officer presiding at the hearing;

(7) all staff memoranda or data submitted to the hearing officer or members of the office of the administrator in connection with their consideration of the case.

(f) Oral proceedings or any part thereof shall be transcribed on request of any party [, but at his expense].

(g) Findings of fact shall be based exclusively on the evidence and on matters officially noticed.]

[SECTION 31. [*Rules of Evidence; Official Notice.*] In contested cases:

(1) irrelevant, immaterial, or unduly repetitious evidence shall be excluded. The rules of evidence as applied in [non-jury] civil cases in the [. . . court of this State] shall be followed. When necessary to ascertain facts not reasonably susceptible of proof under those rules, evidence not admissible thereunder may be admitted (except where precluded by statute) if it is of a type commonly relied upon by reasonably prudent men in the conduct of their affairs. The director shall give effect to the rules of privilege recognized by law. Objections to evidentiary offers may be made and shall be noted in the record. Subject to these requirements, when a hearing will be expedited and the interests of the parties will not be prejudiced substantially, any part of the evidence may be received in written form;

(2) documentary evidence may be received in the form of copies or excerpts, if the original is not readily available. Upon request, parties shall be given an opportunity to compare the copy with the original;

(3) a party may conduct cross-examinations required for a full and true disclosure of the facts;

(4) notice may be taken of judicially cognizable facts. In addition, notice may be taken of generally recognized technical or scientific facts within the director's specialized knowledge. Parties shall be notified either before or during the hearing, or by reference in preliminary reports or otherwise, of the material notices, including any staff memoranda or data, and they shall be afforded an opportunity to contest the material so noticed. The director's experience, technical competence, and specialized knowledge may be utilized in the evaluation of the evidence.]

[SECTION 32. [*Decisions and Orders.*]

A final decision or order adverse to a party in a contested case shall be in writing or stated in the record. A final decision shall include findings of fact and conclusions of law, separately stated. Findings of fact, if set forth in statutory language, shall be accompanied by a concise and explicit statement of the underlying facts supporting the findings. If, in accordance with rules of the director, a party submitted proposed findings of fact, the decision shall include a ruling upon each proposed finding. Parties shall be notified either personally or by mail of any decision or order. Upon request a copy of the decision or order shall be delivered or mailed forthwith to each party and to his attorney of record.]

[SECTION 33. [*Judicial Review of Contested Cases.*]

(a) A person who has exhausted all administrative remedies available before the director and who is aggrieved by a final decision in a contested case is entitled to judicial review under this part. This section does not limit utilization of or the scope of judicial review available under other means of review, redress, relief, or trial *de novo* provided by law. A preliminary, procedural, or intermediate action or ruling of the director is immediately reviewable if review of the final decision of the director would not provide an adequate remedy.

(b) Proceedings for review are instituted by filing a petition in the [. . . court] within [30] days after [mailing notice of] the final decision of the director or, if a rehearing is requested within [30] days after the decision thereon. Copies of the petition shall be served upon the director and all parties of record.

(c) The filing of the petition does not itself stay enforcement of the decision of the director. The director may grant, or the reviewing court may order, a stay upon appropriate terms.

(d) Within [30] days after the service of the petition, or within further time allowed by the court, the director shall transmit to the reviewing court the original or a certified copy of the entire record of the proceeding under review. By stipulation of all parties to the review proceedings, the record may be shortened. A party unreasonably refusing to stipulate to limit the record may be taxed by the court for the additional costs. The court may require or permit subsequent corrections or additions to the record.

(e) If, before the date set for hearing, application is made to the court for leave to present additional evidence, and it is shown to the satisfaction of the court that the additional evidence is material and that there were good reasons for failure to present it in the proceeding before the director, the court may order that the additional evidence be taken before the director upon conditions determined by court. The director may modify his findings and decision by reason of the additional evidence and any modifications, new findings, or decisions with the reviewing court.

(f) The review shall be conducted by the court without a jury and shall be confined to the record. In cases of alleged irregularities in procedure before the director, not shown in the record, proof thereon may be taken in the court. The court, upon request, shall hear oral argument and receive written briefs.

(g) The court shall not substitute its judgment for that of the director as to the weight of the evidence on questions of fact. The court may affirm the decision of the director or remand the case for further

proceedings. The court may reverse or modify the decision if substantial rights of the appellant have been prejudiced because the administrative findings, inferences, conclusions, or decisions are:

(1) in violation of constitutional or statutory provisions;

(2) in excess of the statutory authority of the director;

(3) made upon unlawful procedure;

(4) affected by other error of law;

(5) clearly erroneous in view of the reliable, probative, and substantial evidence on the whole record; or

(6) arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion.]

[SECTION 34. [*Appeals.*] An aggrieved party may obtain a review of any final judgment of the [. . . court] under this part by appeal to the [. . . court]. The appeal shall be taken as in other civil cases.]

SECTION 35. [*Short Title*] This Act may be cited as the Uniform Alcoholism and Intoxication Treatment Act.

SECTION 36. [*Application and Construction.*] This Act shall be so applied and construed as to effectuate its general purpose to make uniform the law with respect to the subject of this Act among those States which enact it.

SECTION 37. [*Repeal.*] The following Acts and parts of Acts are repealed:

(1)

(2)

(3)

SECTION 38. [*Effective Date.*] This Act shall become effective [90] days after its passage.

APPENDIX B:

Uniform Act (Topical Analysis)

UNIFORM ALCOHOLISM AND INTOXICATION ACT

Topical Analysis

I. Declaration of policy. Treatment approach for alcoholics and intoxicated persons rather than criminal prosecution approach is express policy of the state.

II. Definition of key terms. The major purpose of the definition section is to identify the classes and conditions of drinkers subject to the provisions of the act.

A. "Alcoholic." Two definitions of alcoholic are provided: (1) a person who habitually lacks self-control as to the use of alcoholic beverages and a broader definition, (2) a person who uses alcoholic beverages to the extent that (a) his health is substantially impaired or endangered or (b) his social or economic function is substantially disrupted.

B. "Incapacitated by alcohol." This term defines the condition which will permit alcoholics or intoxicated persons to be subjected to the protective custody, emergency commitment, and involuntary commitment provisions of the act. It means the condition occurring when a person, as a result of the use of alcohol, is (1) unconscious or (2) has his judgment otherwise so impaired that he is incapable of realizing and making a rational decision with respect to this need for treatment.

C. "Intoxicated person." This term is applied to a person whose mental or physical functioning is substantially impaired as a result of the use of alcohol.

D. "Treatment" is defined to include a broad range of medical, psychological, social, and rehabilitative services.

III. State acceptance of responsibility for alcohol services

A. Creation of state alcoholism agency

1. Division of Alcoholism within appropriate state agency

2. Professional agency director

3. Grant of adequate powers to the agency (including authority to plan, establish, and maintain treatment programs)

4. Specification of leading role of the agency (through the statement of duties, e.g., program planning, development, and coordination; technical assistance and consultation, etc.)

5. Creation of state-level coordination mechanism (by establishment of inter-departmental coordinating committee)

6. Creation of mechanism for citizen input into policy-making (by appointment of a Citizen's Advisory Council on Alcoholism)

IV. State establishment of a comprehensive and coordinated program

A. Requirement for division to establish comprehensive and coordinated program

B. Regionalization of the state for conduct of the program (optional)

C. Requirement of a broad range of treatment services in the state programs:

1. Emergency treatment provided by a facility affiliated with or part of the medical service of a general hospital

2. Inpatient treatment

3. Intermediate treatment

4. Outpatient and follow-up treatment

D. Requirement of adequate and appropriate treatment

E. Proscription of treatment at a correctional institution (except for inmates)

F. Requirement for division to maintain, supervise, and control state alcohol facilities operated by it

G. Coordination and use of all public and private resources

H. Publication of approved public and private treatment facilities

I. Authorization to contract for use of a facility as an approved public treatment facility (APTF)

V. State regulation of treatment facilities authorized (through an "approval" process)

A. Standard setting by state for approved public and private treatment facilities

B. Inspection

C. Periodic reporting by facilities

D. Administrative procedure for limiting or withdrawing approval

E. Judicial issuance of search warrants authorized

VI. State adoption of rules on acceptance into treatment (including preference for voluntary treatment)

A. Division required to adopt rules for acceptance into treatment

B. Guiding standards must be followed:

1. Preference for voluntary treatment

2. Preference for outpatient or intermediate treatment

3. No denial because of prior withdrawals or lapses

4. Individual treatment plans required

5. Continuum of coordinated treatment services required

VII. General criteria for admission, referral, and minimum assistance

A. Direct application by an alcoholic for treatment at an APTF is authorized

B. APTF director to determine who will be admitted

C. Referral to other APTFs is preferred if admission refused

D. APTF personnel must encourage outpatient or intermediate care after inpatient care

E. State division to arrange for assistance in obtaining supportive and residential facilities for alcoholics in APTFs requiring help.

F. State division to provide for transportation home or to another facility for patients leaving APTF

G. State division to assist in obtaining shelter if homeless

VIII. Care and control of intoxicated persons and alcoholics

A. Emergency treatment

1. State policy that emergency treatment for intoxicated persons is voluntary unless the person is incapacitated by alcohol

2. Emergency treatment procedures

a. Voluntary admission into emergency treatment at an APTF by intoxicated persons authorized

b. Intervention with intoxicated persons

(1) Intervention by police or an emergency service patrol with persons who appear to be intoxicated in a public place and in need of help must be consented to

(2) Consenting intoxicated persons may be assisted at discretion of police or emergency service patrol (ESP) to home, APTF, approved private facility or other health facility

c. Intervention with persons incapacitated by alcohol (protective custody)

(1) Intervention by police or ESP with persons who appear to be incapacitated by alcohol (apparently not necessarily in public) is required

(2) Persons who appear to be incapacitated by alcohol must be taken into protective custody and taken forthwith to a APTF for emergency treatment (or to an emergency medical service if no APTF is readily available

(3) Responsibility of police/ESP to make reasonable effort to protect incapacitated person's health and safety

(4) Taking into protective custody is not an arrest

(5) No record of taking into protective custody as indication of an arrest or criminal charge can be made

d. Admission and referral procedures

(1) Prompt examination required; all persons (intoxicated or incapacitated) must be examined by licensed physician as soon as possible at APTF

(2) All persons may be admitted or referred

(3) If referred, APTF must arrange transportation

(4) If no referral and person has no funds, ATPF may have him taken home, if any.

(5) If no referral, no funds, and no home, ATPF must assist him in finding shelter

(6) If admitted, family or next of kin must be notified (unless adult patient requests no notification).

(7) If physician in charge of APTF determines it is for patient's benefit, he must be encouraged to accept further diagnosis and treatment.

e. Release procedures

(1) After medical examination determining a person is incapacitated by alcohol, person must be released from custody (1) when no longer incapacitated by alcohol or (2) after remaining incapacitated for 48 hours (unless held under an emergency commitment).

(2) Patient may consent to remain as long as physician in charge believes appropriate.

f. Emergency Service Patrol

(1) The state alcoholism division (and local governmental units are authorized to create emergency service patrols (ESP).

(2) The ESP's function is to provide assistance to persons intoxicated in public.

(3) Members of the ESP must provide emergency first aid and transportation of public inebriates to and from APTFs or to their homes.

g. Police/ESP immunity--(no civil or criminal liability when acting in compliance of emergency treatment provision or in course of official duty).

B. Commitment for emergency treatment (emergency commitment)

1. Policy that only those intoxicated persons who are dangerous or incapacitated may be committed for emergency treatment.

2. Emergency commitment procedures

a. Intoxicated persons who (1) have inflicted or are likely to inflict physical harm on another or (2) are incapacitated by alcohol can be committed to an APTF for emergency treatment.

b. Commitment procedure

(1) Administrator in charge of APTF has authority to commit appropriate intoxicated persons upon written application by any responsible persons showing facts and accompanied by timely physician's certificate supporting need for emergency treatment.

(2) Committed patient to be retained at facility to which admitted or other appropriate public or private facility until discharged.

c. Release procedure. Administrator must discharge patient when (1) on advice of medical staff it is determined that the grounds for commitment no longer exist or (2) 5 days have elapsed (unless petition for involuntary commitment has been filed and grounds for emergency commitment still exist, then until the petition is determined but for no longer than 10 days after filing).

d. Patient rights

(1) Patient must be given copy of commitment application and physician's certificate within 24 hours after commitment.

(2) Patient must be given reasonable opportunity to consult counsel.

C. Involuntary commitment of alcoholics

1. State policy that alcoholics should not be committed involuntarily for treatment (other than emergency care) unless they are dangerous or incapacitated by alcohol.

2. Involuntary commitment procedures

a. Person who (1) is an alcoholic who habitually lacks self-control as to the use of alcoholic beverages and (2) either (a) has threatened, attempted or inflicted physical harm on another and is likely to inflict such harm unless committed or (b) is incapacitated by alcohol can be committed to the custody of the state alcoholism division by order of an appropriate court.

b. Commitment procedure

(1) Petition. Family, certifying physician or APTF administrator may petition appropriate court showing required facts accompanied by a timely physician's certificate or statement that the physician's exam was refused.

(2) Hearing. Hearing must be held within 10 days of filing, at which time all relevant testimony will be presented (including the testimony of at least one examining physician) and the court will examine the person

(3) Order of medical exam. If person has refused medical exam, court may issue a temporary order commiting the person to the state alcoholism division for no more than 5 days for purposes of a diagnostic exam

(4) Order of commitment. If (1) grounds for commitment are established by clear and convincing proof and (2) it is determined that the state alcoholism division is able to provide adequate and appropriate treatment which is likely to be beneficial, commitment must be ordered

(5) Duration of commitment. Person remains in custody for treatment for 30 days unless discharged earlier or recommitted.

c. Recommitment procedure

(1) 90-day recommitment (2 maximum). Division may seek recommitment for 90 days if original grounds still exist

(2) The division must seek recommitment if the patient is an alcoholic and still likely to inflict physical harm on another.

(3) A second 90-day recommitment may be sought on the same basis as the first 90-day recommitment. Only 2 90-day recommitments are permitted.

d. Release procedure

(1) End of commitment period. Persons are discharged at end of commitment period unless recommitted or discharged earlier.

(2) Grounds for commitment no longer exist. If an alcoholic is likely to inflict harm, he must be discharged if no longer an alcoholic or a likelihood of physical harm no longer exists.

(3) Continuing treatment is not appropriate. If incapacitated by alcohol, person must be discharged if incapacity no longer exists, or treatment not likely to bring about significant improvement or is no longer adequate or appropriate.

e. Patient's rights

(1) Petition for commitment (or recommitment) and notice of hearing must be served on the alcoholic person.

(2) Notification of rights required, (e.g., right to contest commitment application, right to counsel, right to appointed counsel if indigent, right to be examined by physician of his choice)

(3) Right to seek discharge by writ of habeas corpus is guaranteed.

f. Effective treatment required. The state alcoholism division has a duty to provide adequate and appropriate treatment for committed persons.

g. Transfer permitted.

(1) Division may transfer patient to any appropriate APTF if medically advisable.

(2) Administrator of APTF may transfer to private treatment facility at request of competent patient, relative, or guardian.

IX. Confidentiality of records. Registration and treatment records of treatment facilities are confidential and privileged to the patient; however, exception is permitted for records used for purposes of research without identifying the patient.

X. Patients' Rights (general).

A. Patients must be given opportunity for adequate consultation with counsel.

B. Patients must be given opportunity for continuing contact with family and friends.

C. Mail and other communications to and from the patient cannot be intercepted, read, or censored.

XI. Payment for Treatment (Optional)

A. State alcoholism division is entitled to payments from third-party sources for eligible unpaid treatment services provided in its APTFs.

B. Financially responsible patients are liable to the division for the cost of maintenance and treatment in accordance with rates established by the division.

XII. Decriminalization (Criminal laws limitations)

A. Local governments cannot adopt or enforce laws which (1) have drinking, being a common drunk and, or being found in an intoxicated condition as an element and (2) result in the application of a criminal or civil penalty.

B. No law of general application may be interpreted or applied to circumvent the decriminalization policy.

C. DUI (and similar offense) and ABC laws are not affected by the policy.

D. State laws which are inconsistent with the policy of this act are repealed.

XIII. Fair and open administrative rule making and adjudication procedure

XIV. Specification of effective date of Act (or various provisions)

XV. Appropriation (not in Act)

APPENDIX C:

Special Grants for Implementation of the Uniform Alcoholism and Intoxication Treatment Act (Public Law 93-282)

SPECIAL GRANTS FOR IMPLEMENTATION
OF THE UNIFORM ALCOHOLISM AND INTOXICATION TREATMENT ACT
AS AUTHORIZED BY THE COMPREHENSIVE ALCOHOL ABUSE AND
ALCOHOLISM PREVENTION, TREATMENT, AND REHABILITATION
ACT AMENDMENTS OF 1974
[Public Law 93-282, 88 Stat. 125 (May 14, 1974)]

The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (42 U.S.C §4541 et seq.) was amended to provide a special grant program to assist states in the implementation of the Uniform Alcoholism and Intoxication Treatment Act. 42 U.S.C §4574 provides:

(a) To assist States which have adopted the basic provisions of the Uniform Alcoholism and Intoxication Treatment Act (hereinafter in this section referred to as the "Uniform Act") to utilize fully the protections of the Uniform Act in their efforts to approach alcohol abuse and alcoholism from a community care standpoint, the Secretary, acting through the Institute, shall, during the period beginning July 1, 1974, and ending June 30, 1977, make grants to such States for the implementation of the Uniform Act. A grant under this section to any State may only be made for that State's costs (as determined in accordance with regulations which the Secretary shall promulgate not later than July 1, 1974) in implementing the Uniform Act for a period which does not exceed one year from the first day of the first month for which the grant is made. No State may receive more than three grants under this section.

(b) No grant may be made under this section unless an application therefor has been submitted to, and approved by, the Secretary. Such application shall be in such form, submitted in such manner, and contain such information as the Secretary shall by regulation prescribe. The Secretary may not approve an application of a State under this section unless he determines the following:

(1) The State and each of its political subdivisions are committed to the concept of care for alcoholism and alcohol abuse through community health and social service agencies, and, in accordance with the purposes of sections 1 and 19 of the Uniform Act, have repealed those portions of their criminal statutes and ordinances under which drunkenness is the gravamen of a petty criminal offense, such as loitering, vagrancy, or disturbing the peace.

(2) The laws of the State respecting acceptance of individuals into alcoholism and intoxication treatment programs are in accordance with the following standards of acceptance of individuals for such treatment (contained in section 10 of the Uniform Act):

(A) A patient shall, if possible, be treated on a voluntary rather than an involuntary basis.

(B) A patient shall be initially assigned or transferred to outpatient or intermediate treatment, unless he is found to require inpatient treatment.

(C) A person shall not be denied treatment solely because he has withdrawn from treatment against medical advice on a prior occasion or because he has relapsed after earlier treatment.

(D) An individualized treatment plan shall be prepared and maintained on a current basis for each patient.

(E) Provision shall be made for a continuum of coordinated treatment services so that a person who leaves a facility or a form of treatment will have available and utilize other appropriate treatment.

(3) The laws of the State respecting involuntary commitment of alcoholics are consistent with the provisions of section 14 of the Uniform Act which protect individual rights.

(4) The application of the State contains such assurances as the Secretary may require to carry out the purposes of this section.

For purposes of subsection (a), the term "basic provisions of the Uniform Alcoholism and Intoxication Treatment Act" shall not in the case of a State which has a State plan approved under section 303 [42 U.S.C §4573] include any provision of the Uniform Act respecting the organization of such State's treatment programs (as defined in the Uniform Act) which are inconsistent with the requirements of such State plan.

(c) The amount of any grant under this section to any State for any fiscal year may not exceed the sum of $100,000 and an amount equal to 10 per centum of the allotment of such State for such fiscal year under section 302 [42 U.S.C §4572] of this Act. Payments under grants under this section

may be made in advance or by way of reimbursement, and at such intervals and on such conditions, as the Secretary finds necessary.

(d) For the purpose of making payments under grants under this section, there are authorized to be appropriated $13,000,000 for the fiscal year ending June 30, 1975, and for each of the next two fiscal years.

This document was produced by the Council of State and Territorial Alcoholism Authorities, Inc., 1101 15th Street, N.W., Suite 206, Washington, D.C. 20005; Grant #1 R18 AA01742-01, National Institute on Alcohol Abuse and Alcoholism. The opinions expressed herein do not necessarily reflect the views of the granting agency.

END