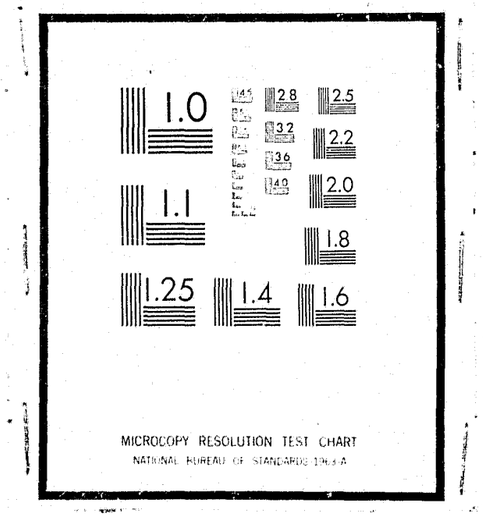

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EXEMPLARY PROJECT VALIDATION REPORT:

Project Candidate:

THE BOSTON ALCOHOL DETOXIFICATION PROJECT

Submitted to:

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National Institute of Law Enforcement and Criminal Justice
Law Enforcement Assistance Administration
U.S. Department of Justice
Washington, D.C.

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1.0 Introduction

At the request of the National Institute, Abt Associates recently conducted a brief validation of the Boston Alcohol Detoxification Project, an experimental diversion and treatment alternative for public drunkenness offenders. The validation included a review of existing project documents referenced in the Appendix as well as three days of on-site observation. During the period of on-site review, an Abt staff member conducted interviews with project administration and staff as well as state planners and representatives of agencies receiving project referrals.

This report is intended to assist the National Institute and its Exemplary Projects Advisory Board in evaluating project achievements and assessing the potential for project replication in other communities. Following an overview of the project's operations and organization, Section two briefly reviews the Detox project in light of each of the criteria for Exemplary Project selection. The final section of this report presents a summary of overall project strengths and weaknesses and conclusions relating to the project's exemplary candidacy.

1.1 Project Design

The activities of the Boston Alcohol Detoxification Project fall into five major components, as follows:

- Rescue

A five-man civilian rescue team, staffed entirely by recovering alcoholics, is responsible for the admission of all persons to the detoxification center. Team members work four ten-hour shifts per week, and are on-call seven days per week. Individual men and women come to the facility in two primary ways:

(1) The Street Rescue Team, usually traveling in pairs and using a radio-equipped station wagon, patrols Police Districts #4 and #1, surveying the streets, alleyways, and other known "haunts" of alcoholics in the area. When a potential client is encountered, a team member will offer him or her the opportunity

to enter a five-day withdrawal program at the center. (People are never forced to come to the center against their will.) Willing persons are transported to the facility as candidates for admission.

(2) Under provisions of the Alcoholism Treatment and Rehabilitation Act which became effective on July 1, 1973, police officers may take a person into protective custody for being drunk in public view. Police officers are then obligated to notify the detoxification center that a person or persons are being held at the station. The rescue team responds to calls of this type when beds are available at the center, travels to the station and transports willing intoxicated men or women to the detoxification center. Rescue team members also make regular, informal visits to the police station to pick up intoxicated persons about whom the center has not yet been notified.

It is important to note that although the center considers potential "criminal justice system" cases to be its primary target, and gives first priority to persons who have been or might be picked up by the police, there are in fact other ways in which an intoxicated person might be referred to the center. Referrals may be phoned into the center by halfway houses, hospitals, and a variety of other sources. When such a call comes in, the switchboard operator asks that the person be held at the referral point, or sent to Room 5 at Boston City Hospital (which is used as a "holding facility" by the center). If there are beds available at the center, the referral point will then be visited by the rescue team and the intoxicated person, if willing, will be transported to the center. Self-referrals are also advised to go to Room 5 at Boston City Hospital (or some other holding facility, such as the Pine Street Inn) to await pick-up by the rescue team.

- Medical Screening

Once an inebriated person arrives at the detoxifcation facility, he is evaluated for admission by nursing and trained paramedical personnel (corpsmen and medical aides). If some serious problem is diagnosed with which the center cannot deal (e.g., potential heart failure, serious wounds), the patient is transported to hospital facilities in the center-owned van (which has also recently been equipped with a two-way radio). Hospital services in connection with the project have traditionally been provided

by the Lemuel Shattuck Hospital, although the center has recently made increasing use of Boston City Hospital, a facility closer to the center. If no serious medical problems are discovered upon initial medical screening, the patient is admitted, given a shower, and the detoxification process begins.

- Detoxification

Following admission, the patient is given a thorough medical examination by nursing and paramedical staff. If the patient has been to the center previously, his or her medical record is updated; if not, a new record is initiated. (If the patient is too inebriated to undergo a thorough physical at the time of entry, this can be postponed for several hours.) The patient is then sent to the "Intensive Care Unit," a 15-bed facility on the second floor of the center, and is usually kept there, under close observation, for approximately 24-48 hours after admission. During this time patients are given medication according to a detailed medical regimen devised by Dr. Frank Iber, former Medical Director of the detoxification project. Following initial intensive detoxification, patients are sent to the fourth or fifth floor of the facility, where they spend their remaining stay at the center. The fourth and fifth floors feature community dining and recreation spaces, and are further divided into sleeping spaces holding approximately five beds each; the atmosphere on these floors is pleasant, relaxed, and as non-institutional as possible.

- Assessment and Referral

Patients are assessed by a team of counselors during their stay on the fourth/fifth floors. Each patient's case is discussed daily during a case conference attended by both medical and counseling personnel. Plans for after care placement are discussed with the patient by a variety of staff members, and all members report the patient's reactions to various plans at the case conference. If the patient requests a specific referral (e.g., a specific halfway house), all efforts are made to place him there; if, for example, the house does not plan to have a vacancy for three days, a counselor at the detoxification center will attempt to find a "holding placement" for the patient during those three days, so that he can eventually enter the facility of his choice. Referrals are commonly made to alcohol rehabilitation agencies, self-help groups (e.g., AA), and to agencies providing legal assistance. The detoxification unit

itself provides no formal aftercare services. Heavy emphasis is placed on the effective use of existing facilities in Boston and its environs for both short- and long-term treatment of physically sober individuals.

- Research and Evaluation

The project includes a small but active research component. Unfortunately, due to funding problems during the past year, research activities have been partially curtailed; however, a number of surveys and narrative studies have been published, and the research team, including its part-time consultant, Dr. Earl Rubington of Northeastern University, plans to have full documentation of the center's activities, caseload, and effectiveness by December of 1974. To this end, the project is currently compiling information from two general sources: project admission records and records of the Criminal Histories Systems Board of the Commonwealth (the detoxification project is one of only two approved organizations to have access to these latter data). Project medical/administrative records provide the following types of information: patient's name, case number, admission number, birth date, race, sex, date in/out of the center, rescuer, rescue location, type of rescue (street, agency referral), counselor, disposition); police records include the person's age, race, sex, stated place of residence (by census tract), where and when picked up, whether a detoxification facility was contacted, disposition, previous protective custodies, days between protective custodies. Data from both of these major sources have already been keypunched by the center. Among the types of reports which will eventually be compiled from this and other secondary sources of information are the following:

-- Number of persons provided detoxification and clinical evaluation services;

-- Number of persons provided rehabilitation and treatment services through referral and follow-up;

-- Extent of services provided directly and by referrals;

-- Percentage of persons provided services who do not subsequently require detoxification in the Boston Detoxification Project or elsewhere;

-- Reduction achieved in the number of public drunkenness offenders who are processed through the criminal justice system;

-- Cost-effectiveness of the project (i.e., is the maximum impact being obtained with the money expended?)

1.2 Project Organization

The Boston Alcohol Detoxification Project is overseen by a Board of Directors (see Appendix A for a list of Board members) and administered by a staff of four, including the Executive Director, a Project Director, an Assistant Director, and a (part-time) Medical Director/Staff Physician. In addition to regular medical, counseling, clerical, rescue team, and other service personnel, the project also employs a part-time Research Consultant and two research team members. Brief descriptions of the tasks performed by various key personnel are provided below. An organization chart is presented on the following page.

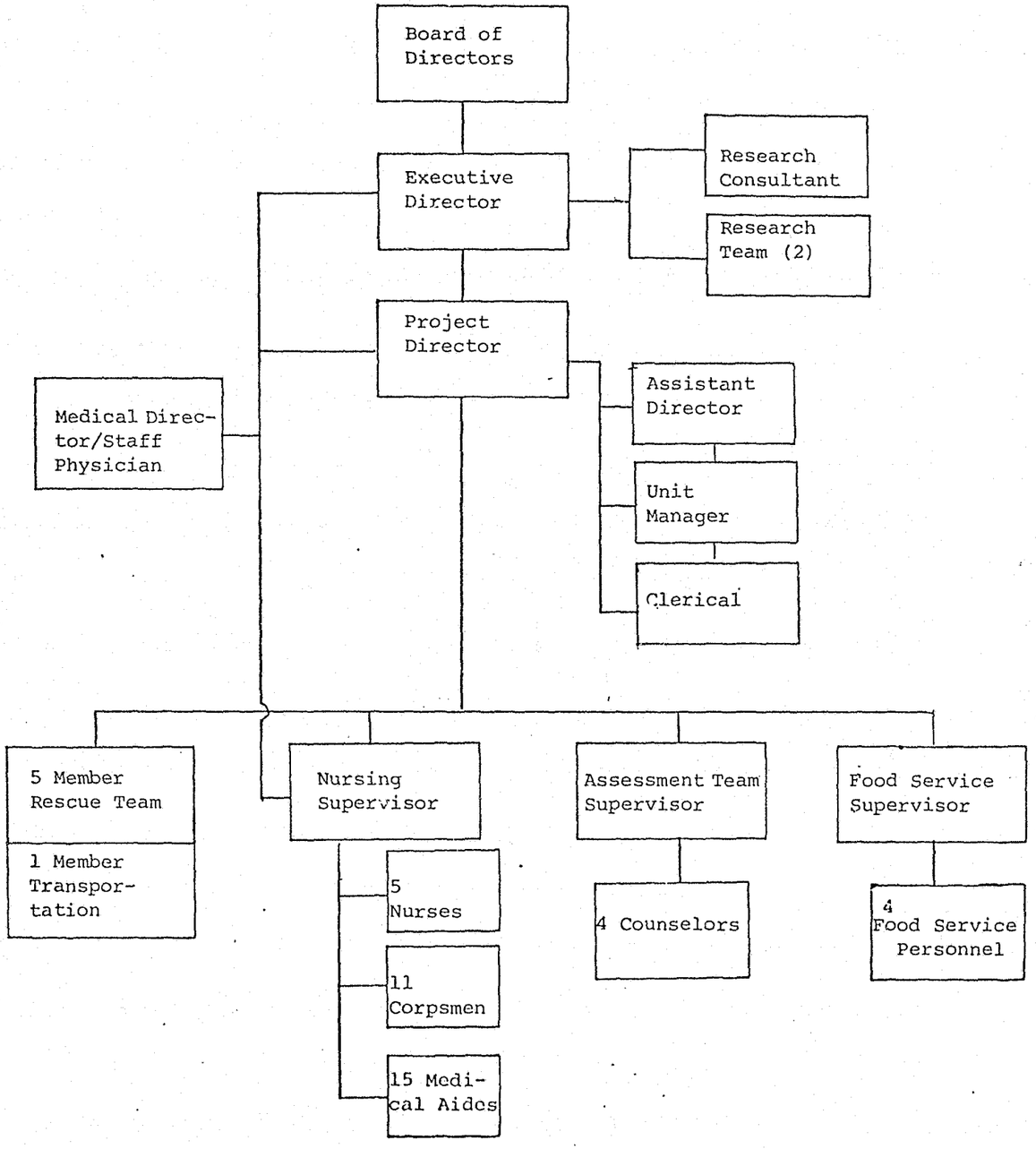
- Administration -- The Executive Director, who is involved in all major project decisions, is primarily responsible for dealing with outside agencies, for community relations, and for seeking funding for project activities. He is reported to by the Project Director and Assistant Director, who are responsible for the financial records of the project, for hiring and firing, for personnel management, payroll, etc. In short, the Project Director and Assistant Project Director are responsible for all day-to-day operations and management. The part-time Medical Director, who also serves as Staff Physician, has major supervisory authority for the medical staff, and also makes daily rounds of all the patients in the facility.

- Unit Manager -- The Unit Manager, a recovering alcoholic, oversees all clerical work for the project and supervises building maintenance, inventory, etc.

- Rescue Team -- The rescue team is responsible for all outreach and intake services described earlier. Team members approve all admissions to the facility, assuring that beds will be filled at all times (and that no persons are brought in if beds are unavailable).

- Transportation -- The transportation driver takes patients from the facility to other referral points (i.e., to a hospital if the patient is too seriously ill to be cared for at

Figure 1
Organization Chart



the facility, and to halfway houses and other community agencies once the patient has been detoxified and released from the facility.

- Nursing Supervisor and Nurses -- Nurses at the detoxification unit perform physical examinations,screening, and administer medication. They are also responsible for in-service training of medical aides and corpsmen, and for supervising corpsmen in performing their own physical examinations and administering medication. Nurses are primarily responsible for referrals to outside medical agencies, and for liaison with the medical community.

- Corpsmen -- Corpsmen at the center have overall authority for shift and floor activities and can do complete physical examinations and administer medication to patients. Many of the corpsmen were former medical aides in the armed services, and several have come to the detoxification facility through the MEDEX program.

- Medical Aides -- Medical aides are responsible for admission and discharge of patients and for the related recordkeeping. They give showers to new admissions and are responsible for monitoring the vital signs of patients once they have been admitted to the facility and are undergoing detoxification. Medical aides also monitor the general conditions of patients, see to their comfort and report any changes in patients' conditions to corpsmen or nurses.

- Assessment Team Supervisor and Counselors -- The Assessment Team Supervisor makes hiring and firing recommendations for counseling staff to the Project Director and Assistant Project Director. He runs the daily case conferences of medical and counseling staff where each patient's case is discussed. He is also responsible for relations with outside agencies to whom the project refers clients, and from whom it receives referrals. The counseling staff, four-fifths of which is comprised of recovering alcoholics, speaks to patients about their plans after discharge from the facility, tries to help the patient choose an appropriate aftercare agency with which to work (halfway houses, AA, etc.), and arranges referrals with aftercare and rehabilitation agencies.

- Food Service Supervisor and Personnel -- The food service is responsible for planning, preparing, and serving three meals per day to patients in the facility. The food service also makes hot coffee available on all floors for the patients at all times.

2.0 Selection Criteria

2.1 Goal Achievement

As stated in a project memorandum, the overall goal of the project is as follows:

> ". . . to design, implement, and evaluate an experimental community-based program for the pickup, intake, medical screening, medical detoxification, clinical evaluation, referral, and follow-up of public drunkenness offenders. The project will seek to relieve the police, courts, and correctional institutions of the burden of processing large numbers of problem drinkers, through the provision of humane and effective treatment to male and female public drunkenness offenders who prefer to be assisted through a non-criminal process. This objective is part of a long-range goal to provide adequate treatment for and to remove the public drunkenness offenders from the jurisdiction of the criminal justice system."

Delineated below are more specific project objectives, each followed by a commentary summarizing the project's achievements to date.

1) "reducing the number of persons taken into protective custody by the Boston Police for being drunk in public"

Since the concept of protective custody only became viable on July 1, 1973, when the law decriminalizing public drunkenness went into effect in Massachusetts, available comparative data on the number of admissions to the detoxification center and the number of public inebriates taken into protective custody is necessarily limited. Understandably, the available data cannot at this time lead to a firm conclusion that the Boston Alcoholic Detoxification Project has in fact reduced the absolute number of protective custody events which take place in Police Districts #1 and #4. A detailed study relating police pick-ups to rescue team pick-ups in the center's service area is currently being conducted by one of the project's research team. Preliminary data have been collected and are shown in Figure 2. These data suggest that the detox facility is progressing satisfactorily towards the achievement of its diversion objective.

Figure 2
Drunkenness Protective Custody Events - Boston
July 1, 1973 to December 31, 1973

Police District	Number of P.C. Events	Number to Boston Detox	Number to Kenmore Detox	Number to Andrew House
1	1399	220	10	3
2	28	0	10	0
3	156	1	0	0
4	1172	208	4	0
5	239	1	0	0
6	579	1	1	9
7	121	3	14	0
11	587	7	0	8
13	65	1	1	16
14	24	0	0	0
15	40	0	0	0
Totals	4410	442	39	36

Different Cases = 3396

As indicated by Figure 2, Districts 3, 5, 14 and 15 have no assigned detoxification centers. As a result, they typically do not send protective custodied alcoholics to any centers. Referrals, if they do occur, are made on an informal basis. The majority of protective custody events (58.3%) during the period from July 1, 1973 to December 31, 1973, occurred in the two districts assigned to the Boston Alcoholism Detoxification Project, and the majority of persons sent to detoxification facilities from protective custody (85.5%) were sent to the project under study.

A smaller study done for the month of December 1973 indicated that a total of 919 protective custody events were recorded by the Boston Police Department during the month. (This number does not include informal drop-offs, direct turnovers to rescue teams, or unrecorded protective custody events.) Detoxification centers in the city were notified of 564 such events during the month, or 61.4% of all those recorded. (The remaining 355 events included 160 where no detox was notified, 109 which occurred in a Police District with no detox to notify, and 86 with miscellaneous outcomes (no answer, patient refused, etc.).

Of the 564 notifications, the Boston Alcohol Detoxification Program received notice of 435 (77.1%) and project staff made a response which resulted in admission to the center 97 times. Although this represents only 22.3% of all protective custody notifications, it must be interpreted in the light of project staff availability. During the day, the center responded to 92% of all notifications; during the evening (4:00 PM to midnight) they responded to 8.2% of notifications, and during the night (midnight to 8:00 AM), they responded to only .08% of protective custody notifications.

The project, which is already understaffed, suffers its most severe staff shortages during the evening and at night, when rescue teams are on-call only, and when medical personnel are also at a minimum. Moreover, by evening, the 56 beds available at the center are generally already filled with patients who have been admitted during the day, or with those remaining from previous days. Certainly in most cases the 15 beds in the Intensive Care Unit are filled, and no patients can be admitted to the facility without spending some time initially in the unit.

This may also account for the police's failure to notify the center of protective custody in some cases, since they are undoubtedly familiar with this problem; data show that failure to notify the Bostor. Detox occurred most often in the evening (in 50% of the cases) and next most often at night (in 33% of the cases), while police failed to notify the center of a protective custody in only 17% of the cases recorded during the day.

2) "saving the space and time of police, court and correctional personnel and facilities; demonstrating a cost-effective method for the treatment of the public inebriate and other problem drinkers;"

Despite problems caused by understaffing, it is clear that the police are willing to cooperate with and make use of the detoxification facilities available in the city, specifically the Boston Alcohol Detoxification Project. The work of the rescue teams in picking up potential protective custody arrests off the street before the police need do so, the presence of the rescue teams for informal turnovers by the police, the fact that the teams will come to the station to transport inebriates to the center, and the mere fact that the detoxification center is available as an easy, viable, and humane disposition for public inebriates once they have been taken to the station,has undoubtedly relieved the workload of law enforcement and court personnel (specific cost figures are presetned in Section 2.4).

Center personnel state that, over the time during which the detoxification facility has been operating, they have indeed noted improvements in police attitude toward the center, and in the willingness of police officers to cooperate with the center's activities. A proposal to conduct a more detailed evaluation of police attitudes and change in attitudes attributable to the existence and activities of the center has recently been submitted by the project to LEAA.

3) "improving the quality of health care received by homeless inebriates;"

There can be little doubt that the quality of health care received by the homeless men and women in the South End target area of the center has been considerably improved by the existence of the Boston Alcohol Detoxification Project. Men and women brought into the center receive a thorough physical upon admission, and are assigned a medical record which is updated each time they return to the center. Those with serious medical problems are referred to an appropriate medical facility for treatment, usually either the Lemuel Shattuck Hospital or the Boston City Hospital. No such medical treatment and referral was available to these homeless inebriates prior to the center's operations. Moreover, the center conducts regular tuberculosis detection services for its patients. Staff members also emphasize that the provision of five days of a drink-free, clean environment, as well as

attention to various medical problems, has undoubtedly been a major contributing factor in prolonging the lives of many homeless inebriates in the South End.

4) "improving the existing network of community agencies serving alcoholics and containing the public inebriate within that network;"

The Boston Alcohol Detoxification Project in itself has improved the existing network of community agencies dealing with alcoholics by the mere fact of serving as another link in this network, where no such link existed before. During the planning process for the facility, project personnel made contact with over 60 community agencies serving alcoholics in Boston and the surrounding areas, and staff have gone to considerable lengths to maintain the favorable contacts thus inaugurated. State and community agency representatives interviewed were unanimous in their praise of the detoxification unit's activities, and one interviewee went so far as to say that he felt that he perceived an "80% better chance of recovery" among referrals from the detoxification facility than from hospitals and jails in the past.

Since a general requirement for admission to alcoholic rehabilitation and treatment facilities such as halfway houses is sobriety, the public inebriate often "drops out" of the alcoholism agency network because he cannot qualify for admission to such facilities either before or after he has been processed by the police. The detoxification project has made a significant contribution to containing the public inebriate within the network by providing services which enable men and women found on the street to gain sobriety for a sufficient period to quality as candidates for admission to rehabilitation/treatment agencies in the community. At the same time, halfway houses and similar agencies are beginning to evidence a willingness to accept a wider variety of client types (viz., chronic alcoholics) due to the detoxification project's work with them. A full list of referral facilities utilized by the project is provided in the Appendix.

5) "improving the attitude of citizens toward the homeless inebriates;"

Although members of the project staff have appeared on television and at various gatherings to explain the operation of the facility, there has as yet been little time (and fewer funds) to mount any

sort of community campaign which would contribute to improving the attitude of lay citizens toward the homeless inebriate. However, some improvement may have arisen from the fact that citizens observing intoxicated men and women on the street may now call the center to notify them of the problem.

6) "training and employing recovering alcoholics from the community in positions of responsibilities in the detoxification facility;"

As has been noted previously, all of the regular members of the rescue team at the detoxification facility are recovering alcoholics and, in fact, this is almost a requirement for work on the team (although the Project Director and Assistant Director, neither of whom are recovering alcoholics, do serve as substitute members of the team on weekends). In all, a total of from 40-50 recovering alcoholics have been trained and are currently working at the facility. Apart from the rescue team, the majority are serving as corpsmen, medical aides, and counselors. Although the unit manager is also a recovering alcoholic, there are currently no other recovering alcoholics in upper-level administrative positions; the Executive Director has observed that former alcoholics often become too involved in the project and its clients' problems to be able to serve effectively in a high-level administrative role. Moreover, the perhaps necessary rigidity which allows a person to make a recovery from alcoholism is seen to have a somewhat hampering effect on the flexible administrative orientation at the project. Non-alcoholics are therefore assigned to administrative roles as liaison between the recovering alcoholics and the non-alcoholic technical staff.

As can be noted, the project does not indicate, in its statements of goals and objectives, any intention to reduce public drunkenness or to rehabilitate public inebriates, nor is its staff willing to claim such an accomplishment. However, within its wisely limited goal horizon, the project does in fact seem to be succeeding remarkably well, and to this extent appears to have produced an improvement in the operations of one aspect of the criminal justice system in the City of Boston.

Related Projects

Once again, since the center has been in operation only a relatively short time (less than three years), conclusive data are not available to prove that the project has been notably more successful than other projects which address the problem of alcoholism and, more specifically, detoxification. Moreover, given the project's mandate to concentrate on cases which otherwise would involve criminal justice system activity, the Boston project operates under a somewhat different orientation and different goal set than other projects. Nevertheless, figures presented earlier would seem to indicate that police do make significantly more referrals to the Boston Alcohol Detoxification Project than its counterparts at Kenmore and Andrews House, even given the Boston project's larger bed capacity (56 as opposed to approximately 20 beds in each of the other two facilities).

An administrator at the Division of Alcoholism of the Massachusetts Department of Public Health indicated that the Boston Alcohol Detoxification Project has in fact been used as a model for all other such projects run by the state. Because of the specificity of its client types and the intensive training which its staff (particularly medical aides and corpsmen) have received, the project also appears to deliver more specialized, and in some cases, more appropriate treatment to its patients than would, for example, a general hospital emergency room.

2.2 Replicability

In 1969, a total of 20,130 arrests were made for public drunkenness in the City of Boston, accounting for 58.7% of all the arrests made in the city during that year. The costs of arresting, processing and incarcerating public inebriates were estimated to be in the neighborhood of $1,015,000 for the year.
In July of 1973, a Massachusetts law went into effect eliminating public drunkenness as a criminal offense in the state. The new law did not of course remove the immediate concern itself; public inebriates continue to be a problem for the City, the police, and themselves. Although Massachusetts -- and Boston in particular -- has a higher incidence of public drunkenness than many other states and cities, public drunkenness remains a question of common concern for all of the states in the nation. The Boston Alcohol Detoxification Project appears to present one viable means of dealing with this concern.

A general understanding of the project's methodology and operation may be obtained from a variety of sources, including the project's application materials, and various materials published by the project's research staff. Another useful document describing the project's methodology and the planning which preceded it, which is included in Appendix C, is entitled "Alcohol Detoxification: A Case Study in Program Development," This document concentrates in great part on what appears to be one of the major contributors to the Boston project's success -- the careful, even meticulous planning which preceded the formation of the project. Notably, core staff, including the Executive Director and the Research Consultant, made a total of over 60 visits to community agencies dealing with alcoholism during the planning process, established close liaisons with various members of the political bureaucracy in the city and state, and visited detox facilities in other states.

During agency visits, the project staff determined what each organization's precise role in the alcoholism "system" was and what its staff thought to be the major needs and deficiencies of the system. Through this process, they won a great deal of community support for the project, and set up invaluable lines of communication with agencies which would eventually be involved in sending referrals to and accepting referrals from the detoxification project. Members of the criminal justice system, from judges to patrolmen, were also consulted closely for their opinions and suggestions; in fact, one of the participants in the planning process was Boston's Superintendent of Police, who is a member of the project's Board of Directors.

A great deal of thoughtful planning was also given to the location and eventual remodeling of the project's operating facility, which is considered by some to be one of its major strengths. While the project set up initial small-scale operations at the Pine Street Inn, a shelter for homeless men, a thorough search was made for a location which would place the project as close as possible to the center of public drunkenness activity in the target area, as well as to other service facilities such as hospitals, halfway houses, etc. Once the building in the South End was chosen, staff consulted closely with the architects charged with remodeling, carefully delineating the route which patients would follow from admission to disposition, and matching the building's remodeled structure as closely as possible to this route. Efforts were made to reduce as much as possible the "institutional" atmosphere of the facility, by means of small room arrangements and cheerful decor.

The Training program for project employees -- particularly medical aides and corpsmen -- and the medical regimen which these employees follow with patients, was another focus of planning. Dr. Frank Iber of the Lemuel Stattuck Hospital in Boston, who served as the project's first Medical Director, devised an intensive six-week course of training which includes both lectures and practica, and which prepares graduates to perform complete physical examinations of new admissions, concentrating on central nervous system involvement and the "row of symptomatology" of alcoholism (i.e., identifying the implications of various symptoms evidenced by the patient). In the past 2-1/2 years, between 40-50 corpsmen and nurses have graduated from the training course, including Boston project employees and staff sent from other detoxification facilities around the state. The examination format and medical regimen designed by Dr. Iber for the project are extremely thorough and well-defined, making it possible for corpsmen to do a great deal of the work (examinations, administration of medication) which would ordinarily be assigned to nurses or physicians.

The fact that corpsmen are allowed to take over such responsibilities is an indicator of what appears to be, in fact, one of the most important contributing factors to the project's success -- its flexibility. Most staff are aware of all of the activities taking place at the center and, within reasonable limits, can interchange jobs without a great deal of "to-do" when such interchange is required. All staff, for example, have ridden with the rescue team, and can serve as substitute rescue team members if need be. (In fact, the Project Director and Assistant Director now serve regularly one day per week as substitute members.) This flexibility extends to the project's organizational structure and administration, discussed further in Section 3.0.

Another important contributor to the project's success -- and an extremely important one, it would seem -- relates to the fact that the project has set and has maintained its allegiance to a limited set of goals. Informally stated, the project's primary goal is to "get public inebriates off the street and into medical care," and to relieve the criminal justice system of the burden of the public inebriate. The staff do not see the project as "the answer to the problem of alcoholism," nor do they see themselves as professional rehabilitators. They have correctly identified their function as one of dealing with the immediate medical problems of their clientele, and breaking the drinking problems of their patients long enough for these patients to qualify for the services of rehabiliation agencies, to which they are duly referred. The adherence to these limited goals has prevented the staff of

the detoxification facility from "spreading themselves too thin," and thereby suffering not only personal frustration, but also failing in the stated objective of the facility.

In any discussion of elements contributing to the success of the Boston Alcohol Detoxification Project, the concept of the rescue team must be taken into consideration. The rescue team has a great deal of responsibility within the project, since no patient can be admitted without the team's "OK". Team members, who are all recovering alcoholics, know the "ins and outs" of Boston street life -- they know where to look for homeless men sleeping on the street, they know how to talk to the men once they find them. Moreover, the team members' obvious dedication to and enthusiasm for their work, and their willingness to deal closely with inebriates who are often dirty and equally as often quarrelsome and difficult to handle, has apparently won the respect, or at least the cooperation, of local police. Staff at the detoxification facility see the rescue team as a central force in the project's activities, and it is not clear that a detoxification facility in a large metropolitan area such as this could succeed quite as well without such an adjunct.

Apart from the enthusiasm and dedication of rescue team and other staff members, most of the features noted here could be successfully reproduced in a variety of settings. However, there are some limitations on the replicability of a facility such as the Boston project. The kind of aggressive activity in which the project engages, exemplified by the rescue team, demands a fairly dense population, with a high demand for this kind of service. A large-capacity detoxification unit, and especially one serviced by a mobile rescue team, would probably be neither feasible nor cost-effective in a rural setting or, for that matter, in a suburban setting with a low incidence of public inebriation. Such area would probably be better accommodated by small screening centers feeding into a larger central detoxification unit.

A second factor that might limit project replicability is the number and nature of other resources in the "alcoholism system" of the city or community in which the project is to be located. If a wide variety of rehabilitation and aftercare resources is available to patients of the facility, this will reduce the pressure on the facility to perform services other than detoxification. If such resources are severely limited within the community or within a reasonable distance from it, the project might have to consider incorporating shelter and/or rehabilitation services which could detract from the primary goals of diversion and detoxification.

2.3 Measurability

A major long-range objective of the project is to develop a "continuing active evaluative research component to study and to measure the effectiveness of the program for alcoholic clients, the effect of the project on the criminal justice system, the relationship of alcohol to criminal activity; and to execute theoretical and empirical studies of alcoholism and related medical, psychological and sociological issues."

Among the narrative reports published by the project through its research component are the following:

- "The Disposition of Drunkenness Cases in a Municipal Court," a 60-page research study performed by a former member of the project's research team;

- "Rescue Location Study," a study designed to isolate the main areas of rescue performed by the center's rescue team, to locate these areas in terms of police reporting areas, and to examine the relationship between rescue locations and arrest areas of Boston Police District #4;

- "Disposition, Length of Stay and Repeater Study," a data collection document which offers a first systematic look at the practice of the detoxification unit, following clients selected for admission candidacy and examining how long those clients remained in the unit, where they went when they left the project, and how often, if at all, population members returned to the detoxification facility.

- "Shattuck Hospital Referral Study," a study which examines referral activity to the Lemuel Shattuck Hospital (the back-up facility for the detoxification project), including the day of stay at the detoxification facility when the referral was made, a profile of referred patient characteristics, a comparison of referred men to total detoxification project population, length of stay at the Shattuck and conditions of departure, medical problems for which the detoxification facility refers and the Shattuck admits, monthly variations in numbers and reasons for detoxification referrals.

A full report of project operations, including history, planning procedures,and extensive analysis of the data presently being collected is expected to be ready by December, 1974. Unfortunately, most evaluation activity is likely to end in December as it appears that the project's new implementing agency, the Division of Alcoholism, does not have sufficient funds to continue to support this component.

2.4 Efficiency

To date, the project has serviced approximately 8,200 admissions (2,200 different individuals) and according to available statistics, is currently maintaining a utilization rate of 98-100% per week, with an average length of stay of 3.5 days. (Patients are encouraged to stay a full five days, although not infrequently, a patient will leave "Against Medical Advice" after the initial detoxification period. On the other hand, some patients with particular medical problems may stay up to 10 days.)

Operating costs over the period 7/15/70 to 6/30/74 totaled $1,336,000 exclusive of one-time planning and renovation expenses. Estimating admissions through June 1974 at 9,370 with 3.5 days per admission, yields a total of 32,795 patient days or $40.73 per patient per day. This figure includes the period that the project operated a 12-bed facility with invevitably higher per capita costs.

For the period August 1973 through January 1974, operating costs for the 56-bed facility were $339,315. A total of 2,785 admissions were recorded during this period (approximately 9,748 patient days) at a cost of $34.80 per patient per day.

Available data indicate that this cost is considerably lower than that charged by other medical facilities and slightly lower than other detoxification projects. The cost of maintaining a patient at the Lemuel Shattuck Hospital is estimated at $78 per day, while the Boston City Hospital estimate is $95 per day. Other state-supported detoxification projects in Massachusetts are currently operating at a cost of approximately $38 per patient per day.

Estimates of the costs of criminal processing include: $15/arrest; $25/court appearance; and $430 for an average 60-day jail commitment. Project staff feel that not only have these costs been reduced but that the presence of the detoxification facility had considerable weight in the decision to close the Boston City Jail, which handled only inebriates.

2.5 Accessibility

With the expiration of funds in July, 1974, the project is assured of continued (albeit reduced) support through the Division of Alcoholism of the Massachusetts Department of Public Health. Project personnel were extremely cooperative and hospitable, and are completely agreeable to any further evaluation, publicity, and visitation.

3.0 Summary of Project Strengths and Weaknesses

Project Strengths

- The Flexibility of Staff Assignments. Staff at the facility are both capable of and willing to take over a variety of other staff members' jobs when the need arises: Project administrators serve as back-up members of the rescue team; the Unit Manager is able to function as a corpsman, rescue team member and transportation driver.

- A Responsive Organizational Structure. Staff flexibility permits a highly streamlined organization: when it was found that the posts of Security Admissions Officer and Rescue Team Supervisor were not cost-effective for the project, they were eliminated from the organization. Policies for how long a patient is to be kept at the unit are also fairly elastic and reflect the project's individualized response to client needs.

- The Accessibility of Project Administration. Flexibility in philosophy and organization contribute to an atmosphere of relaxation and coopération at the center. This atmosphere is most certainly augmented by the accessibility of the administration and the staff's realization that administrators are not so far-removed from the everyday activities of the center that they are unwilling to pitch in and perform line tasks.

- The Balance between Medical and Counseling Activities. In developing the project, planners were convinced that neither a strict medical model nor a strict rehabilitation model was desirable for the project. As a result, the project and its staff have gone to some lengths to assure that medical care is not overshadowed by counseling, and vice versa. One practice which contributes to maintaining this balance is the daily case conference attended by nurses, corpsmen and counselors. During these conferences, each patient is discussed, and medical staff and counseling staff exchange information gathered during the previous 24 hours. Nurses usually comment on the patient's condition and how close he is to being ready for discharge, and counselors note their plans as well as the patient's own expectations. Attendance at one of these conferences brought out the interesting fact that medical staff often serve as informal coun-

selors at the project, and vice versa. (One nurse reported a conversation with a patient in which he had expressed a desire (as yet unknown to the counselors) to go to a particular half-way house; counselors also made observations concerning various patients' medical conditions and how this might affect their readiness to leave the center.)

- The Supervisory Model. Corpsmen are allowed to do complete physical examinations and to administer medication to patients under the official supervision of the nursing staff. The corpsmen have received intensive training in these practices, and have an extremely clear and safe medical regime to follow in the administration of medication. In addition to the cost-savings, the independence which is suggested by this practice, and which is encouraged among all staff members, has contributed a great deal to the staff's job satisfaction and enthusiasm for the project. Although nurses were initially hesitant about allowing this degree of independence among the corpsmen, they now agree that the method is entirely workable, and appreciate the fact that some of their time is thus freed up for tasks such as community and medical agency liaison.

- Relations with Outside Agencies. Project staff have gone to great efforts to establish and maintain excellent relations with outside agencies, including both alcoholism service agencies and the various components of the criminal justice system. As a result of these efforts, the detoxification project receives a great deal of outside support and cooperation. It is one of only two organizations in the city, for example, which has been approved to receive information from the Criminal History Systems Board of the Commonwealth. Alcoholism rehabilitation and treatment agencies have also been extremely cooperative in receiving project referrals and apparently have made considerable adjustments in some cases to accept these individuals. The quality of the project's relations with outside agencies has been attributed at least in part to the skill and energy of its administrators -- particularly its Executive Director -- whose energy and community organization skills were commented on favorably by several outside observers.

- The Rescue Team Concept. Unquestionably, the philosophy of aggressive outreach which is exemplified by the rescue team is one of the primary strengths of the project. Moreover, the practice of staffing the rescue team with recovering alcoholics has contributed a great deal to its effectiveness.

Project Weaknesses

- Inability to Admit Patients on a 24-Hour Basis. Although the rescue team is on-call on a 24-hour basis, funding limitations do not permit team members to be paid for round-the-clock work. Nor is it possible to maintain a full complement of staff on a 24-hour basis, although some medical staff are present at all times. Moreover, there are only 15 beds in the Intensive Care Unit at present. Since no patient can be admitted without being sent directly to Intensive Care for preliminary detoxification, evening and night admissions are rarely possible as these beds are usually filled during the day. Because of bed and staff limitations, the Center cannot accept self-referrals, which has caused some frustration among staff and has led some clients to feel that they are being refused treatment unfairly.

- Facility Structure. Although plans for remodeling the project's facility were carefully made, some aspects of the structure could not be changed. The building's seven-floor arrangement makes it difficult to spread staff out evenly, and the structure has only one elevator for patient transportation. Staff feel that the building is not perfectly adapted to medical services, and believe that a two-story structure with more floor space on each story would be ideal. This type of building was not available in the project's target area.

- Inability to Recruit and Maintain Staff. Although staff turnover has decreased considerably since the early days of the project, the detoxification unit still experiences problems in recruiting and maintaining staff -- particularly Registered Nurses. Staff at the project are expected to operate with a great deal of independence, and to make quick decisions in a variety of situations; older nurses particularly have some problems with this kind of loose organizational atmosphere. More important, although salaries at the center are relatively competitive, they are by no means "tops," and nurses sometimes leave when they receive offers of higher wages from other medical service agencies.

- Measurability. Although the project does have an active research component, funding cuts during the past year have forced the temporary lay-off of one of the research team. The Research Consultant (who is part-time) and the two remaining researchers are involved in collecting a tremendous amount of useful information, but the small-size of the team obviates the possibility of their fully utilizing this data.

It is clear that the weaknesses noted are largely related to problems of insufficient funding and associated staff shortages. As such, they represent administrative difficulties rather than flaws in the actual project design. Moreover, data presented earlier does suggest that the project is beginning to meet its diversion objectives.

Although a fuller analysis of the project's diversion benefit would be desirable, there appears to be ample evidence to document the achievement of several of its secondary goals; the demonstration of a relatively low-cost means of providing improved medical care to intoxicated men and women; the training and employment of recovering alcoholics; and the effective utilization of related agencies in the Boston "alcoholic system."

Should the Exemplary Projects Advisory Board decide to proceed with a documentation effort, it appears that this project could be presented according to the Institute's general documentation format: a brochure, operations manual, and visual briefing materials.

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APPENDIX A

Board of Directors

Arthur N. Papas, M.D. (Psychiatrist)
Former President of CMSA (Community Agencies Serving Alcoholics)
Medical Director, Metropolitan Hospital

Donald F. Taylor
Treasurer, Associate Area Director, Boston University Mental Health Center

Marion McElhaney
Clerk, former Director People's Urban Renewal Committee (South End Housing Program). Presently Boston Municipal Housing Court.

Ed Doherty
Director, Division of Homeless Men, Department of Welfare

Jack Donahue
Executive Director, Hope House (halfway house in South End)
President - Massachusetts Association of Halfway Houses
Member - Governor's Advisory Council on Alcoholism

Mary Frances Powers
Formerly employee of Mayor's Committee
Presently Assistant to Clerk of Supreme Court, Boston

William J. Taylor
Superintendent-in-Chief, Boston Police Department

James J. Scott
Director, Alcohol Programs, Department of Health and Hospitals, City of Boston

Vincent McCarthy, Counsel
Lawyer, Hale and Dorr

(This group includes 3 recovered alcoholics, 2 blacks, 1 female)

APPENDIX B

Referral List

AA
Anchor House
Action for Boston Community Development
Austin Unit (BCH)
Barnstable County Hospital
Boston City Hospital
Bedford Veteran's Administration
Beech Hill
Bell Nursing Home
Boston Council on Alcoholism
Boston State Hospital
Boston Veterans Administration
Brockton Veterans Administration
Bridgewater State Hospital
Caspen Halfway House
Cape Cod Hospital
Casper House (halfway house)
Chelsea Soldiers Home (nursing home)
Commonwealth Service Corps
Danvers State Hospital
Division of Employment
Dimmock Health Center
Doctor's Hospital
E. Boston Rehab. House (halfway house)
Faith House (halfway house)
Flynn House (halfway house)
Foxboro State Hospital
Framingham State Hospital
Gradner House (halfway house)
Gentry House (halfway house)
Goddard Hospital
Haley House (halfway house)
Harmony House (halfway house)
Hanley House (halfway house)
Hanley Hospital
Hello House (halfway house)
High Street Inn (halfway house/women)
Homeless Men's Division
Hope House (halfway house)
Harbour Lights (halfway house/
old age program run by Salvation Army)
Jamaica Plains Veterans Administration
Jude House (halfway house)
Kenmore Hospital
Legion of Mary
Lenuel Shattuck Hospital
Lindeman Center
Long Island Hospital
Lowell Mental Health Center
Lowell House (halfway house)
Malden Halfway House
Marion House (halfway house)
Mass. Assocation for Mental Health
MAss. General Hospital
Mass. Mental
Mattapan Halfway House for Women
Mattapan Chronic Disease Hospital
Medfield State Hospital
Metropolitan State Hospital
Meridan House (halfway house)
Middlesex County Hospital
Morgan Memorial
Mt. Pleasant Hospital
New England APAC
New England Medical Center
Naukeag Hospital
Norfolk County TB Sanitorium
North Cottage (halfway house)
Open Ear (black halfway house)
Our Brother's Place (nursing home)
Pathway House (halfway house)
Peter Bent Hospital
Pilot House(halfway house)
Pine Street
Rutland Heights Hospital
Salvation Army
Stepping Stone (halfway house)
South End Center (drop-in center -
used mostly by Indian population)
South End Health Unit
St. Elizabeth's Hospital
Sweet House (halfway house)
Talbot House (halfway house)
Taunton State Hospital
Tewksbury State Hospital
Today House (halfway house)
Unity House (halfway house -first
co-ed house)
Washingtonian Center for Addictions
Westboro State Hospital
Court Street Veterans Service

ALCOHOL DETOXIFICATION:

A CASE STUDY IN PROGRAM DEVELOPMENT

Harold Klubertanz,

Criminal Justice Project

NATIONAL LEAGUE OF CITIES
AND
UNITED STATES CONFERENCE OF MAYORS
1612 "K" Street, N.W.
Washington, D.C. 20006

Fall, 1972

This paper is addressed to Mayors, City Managers, and their assistants; and to criminal justice planners and agency heads, to assist them in better understanding the complex problems represented in their new and developing criminal justice programs. The paper is one of a series being published by the Criminal Justice Project of the National League of Cities and United States Conference of Mayors, covering criminal justice issues in local government. The author, a staff member on the Criminal Justice Project, is a former city councilman from Madison, Wisconsin and County Supervisor from Dane County, Wisconsin, a graduate of the Urban Fellows Program, and also formerly an assistant to the Mayor of Indianapolis, with responsibility for drug abuse programs.

INTRODUCTION

Tens of thousands of programs have been funded over the last four years with the purpose of improving the criminal justice system and reducing the impact of crime. A great deal -- albeit not nearly enough -- has been written about these programs, their goals and objectives and sometimes even about their results. Very little -- almost nothing, in fact -- has been written about the experience of actually implementing these programs.

Preliminary work -- planning, "touching bases", "laying groundwork", and the period when a program is started up -- plays a vital role in the final result of a project, as we all know. Despite ample lip-service paid the importance of careful program development, however, almost all of the literature deals with textbook-level, academic investigations and explications of formal planning theory. We also all know that while theory is an excellent jumping off point, the theory somehow never seems to begin to express the feeling and appearance of planning <u>in practice</u>.

This paper results from our desire to explore the "nitty-gritty" of program implementation -- to study, however briefly and superficially, the strategies and tactics used in the early stages of program development.

We have chosen the Boston Community-Based Alcoholic Detoxification Project as a case example, in which to look at program development. This program, funded by LEAA, through the Massachusetts State Planning Agency and the Mayor's Safe Streets Advisory Committee in Boston, is a very good example of early goal determination, objective setting, and sophisticated planning and implementation of plans. The planning process used by the project staff recognized explicitly certain key tasks which influenced the design and development of the program itself. This project also has had some severe difficulties at critical points in its development, for example in shifting from planning to operating phases, and in construction and the control of physical resources.

We believe that the history of the development of this project, organized as it is below, presents some potentially useful lessons for the developers of many other projects of many types within the criminal justice system.

(The project began operation in September of 1971 in an interim 10 bed facility, and has more recently moved into its finished 75 bed facility, serving about 5,200 patients per year. The project has a total staff of between 30 and 35, and an annual operating budget of $450,000.)

KEY TASKS

Taken together, the following tasks are a shopping list of the particular points that were found to be critical to any real degree of success in the Boston project.

- Form a clear picture of public drunkenness (the problem), and how it affects the criminal justice system;
- Examine, and understand, the component parts of the criminal justice system's attitudes and practices toward the public drunk, and understand the likely effect of these attitudes and practices upon solutions to the problem (some constraints and the context);
- Examine the agencies currently dealing with the problem of drunkenness (resources) and strive to understand their inter-relationships, and to measure what effect their activities and relationships may have on the problem and its solution;
- Examine the medical community's attitude toward the treatment of drunkenness, and try to gather specifically how that attitude may effect the problem and its solution;
- Identify and define the roles and attitudes of other key people who may influence decisions relating to the problem and its solution (especially community and political opinion leaders);
- Determine, analytically from data gathered, the basic format for the program, and the resulting staffing needs, for addressing the problem (the "plan"; or can be alternative plans);
- Examine in detail the physical and social community in which the program and its facility would be located;
- Examine possible funding sources and how, by virtue of bureaucratic constraints, timing, philosophy, and personality, these sources may effect the final solution.

A. FORM A CLEAR PICTURE

Forming a useful, understandable, and reasonably accurate identification of the "problem", as it affects the criminal justice system, was probably the most important basic task.

In Boston, superficially, all the outward indications were that the primary alcohol problem as it related to the criminal justice system was one of excessive numbers of chronic drunkenness offenders, and a lack of rehabilitative programs. However, a close examination focused upon a number of not-so-obvious issues at hand, and allowed an identification of a more useful problem in description, and a clearer picture of what was going on. This examination disclosed that:

- The Boston Police Department made in excess of 20,000 public drunkenness arrests annually. These arrests represented more than half of all arrests made by that department. Each arrest consumed a considerable amount of the arresting officer's time, taking him from other, potentially more useful, activities.

- Those arrested needed to be processed through other segments of the criminal justice system, the courts and corrections system, swelling already overloaded calendars and caseloads. The result, of course, was assembly line justice with the offender finding himself either released, confined to the City Jail, or shipped off to a State Correctional Institution for "rehabilitation", in seemingly arbitrary fashion.

- This process of arrest, court, correction, and eventual return to the street -- "the revolving door" -- was costing Boston and its institutions (police, courts, welfare, etc.) $1,200,000 annually.

- A detailed analysis of arrest records disclosed that most of the drunkenness arrests were accounted for by the repeated arrest of approximately 2,000 chronic repeaters.

- Most of the repeatedly arrested offenders resided within several clearly identifiable sections of the city, namely the Boston Common area of Police District 1 and the area known as the South End within Police District 5.

- Most of these repeaters were homeless men, skid row "drunks" -- men with a long history of alcohol arrest, abuse, and joblessness. Biographies of chronic drunkenness offenders testify to the failure of the criminal justice system to provide treatment and rehabilitation service to these problem drinkers.

Armed with these facts, a thorough review led to the articulation of the issue that needed to be confronted.

The community had over 20,000 drunk arrests annually, resulting in the consumption of a very large portion of the criminal justice system's time -- at great expense; and, these arrests resulted in no more than temporary, forced, abstinence on the part of the offenders, in some cases with the near certainty that he would be arrested again. Boston was able to say, then, that a good share of the problem lay in the fact that the drunkenness offenders were arrested at all.

While it may have appeared at first glance that alcohol and the resulting drunkenness was the primary problem (it may indeed have been the initiating factor), the real issue in this criminal justice planning effort was the arrest and re-arrest of a relatively small number of habitual offenders. This realization led Boston to the development of a program that focused upon the skid-row drunk, living in a target area, with the objective of keeping these drunks out of the criminal justice system by providing an opportunity for their detoxification and related health and social services, as an alternative to their arrest, should they choose such an option.

This clear picture of a specific, concrete objective kept the project from going astray as the program evolved. It enabled the designers to realize they could not hope to pick up every drunk in the city and to avoid falling into the trap of trying to design a program which hopes to rehabilitate every alcoholic. They were, however, interested in keeping some specific drunks from continuing their burden on an already overworked system.

B. STUDY THE CRIMINAL JUSTICE SYSTEM'S ATTITUDES AND PRACTICES

The roles played, and the attitudes conveyed by the various component parts of the criminal justice system (i.e., police, probation, the court and corrections) will heavily influence the entire effort. The role of each of these agents of social control must be clearly understood.

The City of Boston is fortunate to have had two high ranking officers who had for years recognized the prcblems created by the public drunk on the criminal justice system. A police Superintendent who retired shortly before planning began for the detoxification center began, and the Superintendent-in-Chief (the highest ranking sworn officer in the department, reporting to the Commissioner), had for years publicly advocated the need for changes; and the Superintendent-in-Chief had published a number of articles on the subject.

The detox project staff undertook a serious study of attitudes and practice relative to the drunkenness offender, in the police department, building upon the advocacy of these two officers in particular, and undertook similar studies in the courts, probation, and corrections at the city, county, and state levels. Most of the work consisted of close observation and review of the practices of each. In probation and police departments particularly, these observations were followed up by in-depth conversations with key personnel. These conversations ended up serving a double purpose, importantly, by both allowing deeper understanding of the problem, and exposing these key officials to the preliminary goals and objectives of the program.

In the police department, the study focused especially upon the daily activities of the district patrolman on the street, in order to understand his role relative to the public drunk, and so to understand how that role might effect the design of the program. Some of the major findings on the police role are listed below:

- Close examination of arrest patterns disclosed that the time of day had a direct bearing on the probability of an individual's being arrested in various segments of the city. Arrest on a main street of the city was more probable during the hours when the drunk would be visible to the greatest number of citizens -- during times when people were going to or coming from work -- than it was during the evening hours, or at times between peak traffic.

- The attitude of the drunk, at the time of confrontation with the police, played an important role in the decision about whether he would be picked up, or advised to move on.

- While the Superintendent-in-Chief was highly supportive of efforts to remove this burden from his department and had been instrumental in initiating the probe for solutions, he nevertheless took a highly legalistic view of the department's role and policy with regard to drunkenness. In his opinion, Massachusetts statutes pertaining to public drunkenness gave the department little discretion with the handling or disposition of drunks. His perspective suggested the need for detox planning staff to obtain a detailed and sound legal interpretation of the police role as alluded to in the statutes. The law would inevitably affect the solution format. The legal review which was conducted helped communicate to the Chief the alternatives in the police role in the entire scheme.

- Patrolman behavior was reviewed to determine how these men viewed the drunk and their role in handling him.

This behavior in face-to-face situations has a very strong bearing on any approach toward a solution.

Conversations with officers, both in the District Station and on the street (occasionally in the process of making an arrest) disclosed the fact that the average beat patrolman had a very positive view of himself in the act of arresting a public drunk. An overwhelming majority viewed themselves as "social workers" -- helping a "poor unfortunate" who, without their assistance, might have gone hungry, suffered from exposure, or even died. Nevertheless, officers, given an intelligent alternative, would have no objection to the drunk being handled in another manner, even if it was done by civilians. On numerous occasions they expressed willingness to pick up drunks and deliver them to a suitable facility, other than a jail; or even to call upon others to do the same, provided such a practice was within the law and authorized by the department.

In other parts of the criminal justice system, other equally important things were found:

- A number of drunks, usually after their fourth arrest, were being sentenced to a State Correctional Institution. A review of this practice revealed that such dispositions did little more than consume both valuable court docket time, and space at the institution.

- This practice met with the approval of the sentencing judges who displayed little indication of willingness to change in any way that would assist in a solution.

The project, then, was directed back to devising a method of preventing the drunk's entering the system, finding his way to the court and eventually to an institution.

A number of basic decisions were made about the project as a result of these reviews of attitude and practice. Inasmuch as a good share of the cause of the dilemma was that the initiative for pursuing drunkenness arrests was equally rigorous in administrative attitudes on the part of the department, and in the altruistic view of such arrests held by the arresting officers -- there appeared to be a need to try to modify some of these attitudes and practices.

With regard to other criminal justice agencies, support would be sought from those willing to change, and others would be by-passed for the time being.

C. EXAMINE THE EXISTING NON-CRIMINAL JUSTICE AGENCIES

Within any larger community, there exist a number of agencies directing at least a portion of their time toward assisting, in this case, alcoholics. The stated purposes of these agencies, and the format of approach to the problem are as numerous as their numbers. The detox planning staff undertook an inventory of each of these organizations, to determine the type and extent of service each rendered. Equally important topics for this study were 1) the basic attitudes and practices underlying these services and how these affect the type of clientele they may serve; 2) the effectiveness of their services; and 3) the manner in which each agency related to its sister agencies, and how that relationship affected the problem. The inventory was to provide much needed data on the programs presently carried on, their effectiveness, where they might eventually fit in a final solution design, and to point out community weaknesses that may need to be met by any proposed program.

Boston began with agency-by-agency interviews. Separate records were maintained for each organization contacted, noting key personnel, services rendered, types of clientele served, eligibility requirements for their services, follow-up procedures (if any), and notes resulting from a close examination of their treatment regimen (e.g., were they advocates of Alcoholics Anonymous). In addition, for each agency, staff noted their source of funding, the other agencies they saw as vital to their existence, and those organizations with which they had little or no contact. This resulted in an overview of the community dynamics and organizations affecting the lives of the alcoholic.

The roster for this inventory was obtained as a result of several days spent in the State Department of Public Health, Division on Alcoholism, discussing the problem with key department personnel, and by reviewing information contained in a recent survey conducted by the department in their effort to prepare an Alcoholism Services Directory. It turned out that this was time extremely well spent, as it eventually provided the names of more than 60 agencies, many of whom were previously unknown, along with a list of key personnel to be contacted at each of these agencies. As the inventory progressed, the survey staff noted that in many instances the person filling out the State's questionnaire was a key person in that particular organization, and on a number of occasions, was not the "executive", but rather a staff person.

D. EXAMINE MEDICAL COMMUNITY ATTITUDES

Alcoholism has been firmly defined as a disease. As in the case of any illness, it has both medical and social implications. Little is really known about the overall effects of this illness. Consequently, even less is known about methods of treating and coping with those afflected. Within the medical community, there exists a vast range of opinion as to how an alcoholic should be treated. It became extremely important to gauge the adamancy and extent of these various opinions, to determine how they might influence the development of a program format.

Within the Boston medical community, there existed two predominant concepts of alcohol detoxification and treatment. On one hand there was a vigorous advocacy for a centrally located, hospital-based, detoxification unit, utilizing the direct services of physicians and other highly trained and validated personnel. Those advocating this concept contended that such an arrangement was an absolute necessity, and that in the absence of such an arrangement, no attempt should be made to provide any services.

On the other hand, there are those in the medical community that subscribed to the theory that proper and adequate treatment was possible outside of the very expensive hospital setting, provided arrangements were made for full medical back-up should the need arise.

The Boston program took on the appearance of the latter approach. Studies had shown that competent, well-trained paraprofessionals working under the supervision of professional nurses and a physician, could provide detoxification services to nearly ninety percent of the population to be served by the programs.

This position was strengthened with the back-up services of a major Public Health Hospital, familiar with the needs of the acutely ill intoxicated person, was secured.

A crucial point in what had become a very real and heated discussion within the medical community -- about the desirability of professional versus paraprofessional approaches -- was reached at a meeting of the Board of Trustees of the Boston City Hospital about four months into the planning of the center. At that meeting several key medical professionals argued that only doctors could adequately screen alcoholics with medical problems from the general population of street-corner alcoholics. In response, the medical director for the

planning stages of the project described an experiment he had run in the small detoxification unit he ran in a nearby state hospital. He had, he said, instructed a paraprofessional screener, trained by himself, to work up a full report on all admittals brought from Boston City Hospital (BCH) over a period of six months, without looking at the workup done at BCH by the physician on the emergency room floor. He said he had then had one of his own physicians do a third workup without looking at the first two, and compare all three workups. After reviewing discrepancies between the three, and re-checking the patient where discrepancies existed, the medical director said he had found that his own paraprofessional screener had had a lower error rate than had the physicians at BCH.

He carefully explained, then, that he had been forced to conclude, not that paraprofessionals did a better job, but that given careful training a paraprofessional could do at least as accurate a job in screening acute alcoholic patients, because they were focusing upon a single general type of patient, and because they had more time and better working conditions than did the emergency room physicians.

When he had concluded the report on his experiment, the advocates of professional-only care ceased to maintain a no-compromise position, because of the combined weight of his evidence and his personal prestige in the medical community.

E. FOCUS UPON THE ROLE OF KEY INDIVIDUALS

The success of a program like this one is directly proportional to the quality and the quantity of the community support mustered for its goals. Consequently, unless community people who have strong influence on particular community attitudes are identified, and their endorsement sought and obtained, chances for the success of the project are slim. This identification, base-touching, and "courting" process needs to begin early, and the "courtship" often must be carefully timed to meet the needs and advancement of the program.

- A particular priority in this case was the support of the city itself: support from the city fathers -- the Mayor and the City Council. It became important to understand and identify the strengths and weaknesses of each. While Boston has a strong Mayor system of government, the City Council and Mayor tended at the time the program was developed to be antagonistic towards each other, and each had to be contacted, advice sought, and the endorsements and support of each carefully balanced. From the start

it was clear that the Mayor's office was the prime mover in the project. However, in Council hearings a crucial piece of testimony was that of several individuals currently operating alcoholic halfway houses and rehabilitative facilities, who testified that the proposed detoxification center addressed a number of their current problems, as well as addressing problems of the police department.

- In addition to the usual Council leadership, although it was not the problem in Boston, there may be a particular need to cope with the attitudes of those councilmen whose wards may be affected by such a facility. (An individual councilman, opposed to the location of such a facility in his ward, can, in many instances, swing greater weight than may the Mayor, and could spell disaster.)

- The police department, being so directly involved in the entire program, played a very important role. It was necessary to address its hierarchy, its politics, and to identify key decision-makers. (In other cities, the Chief may be answerable to a Police Commission, and the Commission members and chairman may possess particular influence with regard to police policies.)

- Once the drunk is arrested, and caught up in the criminal justice system, the leadership, and strengths and weaknesses of probation and the courts play vital roles.

- A program cannot stand alone; it must have the support of similar organizations dealing with the problem. As noted above, the identification of key people within these various agencies played a crucial role with the City Council. The understanding of your goals by parallel agencies, your assurance that you do not pose a direct threat to them, will play a very key role in generating their support. Usually, these agencies have many influential citizens serving as members of their Boards of Directors. Knowing these people, knowing where they fit in the entire scheme, and knowing their likes and dislikes, can provide a city with a score for the orchestration of their support. Usually, one or two key people on each board possess a disproportionate amount of influence. Identify them and cultivate their support.

- The medical community has definite interest at stake. There are often ideological clashes. Identify the leadership of each of these various "camps". Medical associations within the community, while often more social than

operational, carry a huge amount of influence, and their leadership should be identified. In addition, many of these key medical people may sit on the boards of other needed sources of support.

- Most importantly, do not ignore the everyday citizen: the people living in the community, specifically the community where such an operation may locate. Their understanding of the program and its intended goals plays a very vital role. Without a neighborhood to locate a facility, one really does not have a program.

The Boston project was fortunate to begin with a number of people "on its side". The Superintendent-in-Chief had advocated change for a number of years and was instrumental in bringing the program into being. The initial thrust for the project resulted from a recommendation from the Director of the Division of Alcoholism of the Commonwealth of Massachusetts. This support at the state level was crucial to the funding and initial design of the program. The Mayor's Safe Streets Act Advisory Committee wrote the project into their action plan for 1971, thereby lining up a staff and the Mayor's organization.

City Council support was achieved, in part, as the result of the endorsement of the program to the Council by a highly respected operator of one of the city's halfway houses. His was one of the agencies that had been cultivated for support.

The concurrance of the medical community resulted in large part from the choice of the medical director for the new program. As a very prominent liver pathologist, full professor at a local medical school, and operator of a very successful alcohol program for a number of years in another community, he was highly respected within the medical community. This physician provided leadership in the medical community, became an advocate of the program and legitimized the view that a free standing (non-hospital-based) program could provide safe and efficient medical care to the indigent problem drinker.

In total, the entire process of seeking out key personnel within the community was done carefully and self-consciously, in a methodically planned and timed manner.

F. DETERMINE THE PARAMETERS OF PROGRAM AND STAFF

The operating format of any program and its staffing requirements will reflect much of that discovered and achieved in the efforts mentioned above, along with the limitations of funding and facility location, mentioned later.

Detoxification programs have many similarities, yet may vary greatly. To a significant degree, this variety reflects the outlook and training of those who develop the program, along with the attitudes and practices surrounding the public drunk within the community, or even the state. Programs developed primarily by psychologists place heavy emphasis on rehabilitation; one designed from a root of strong "Alcoholics Anonymous" convictions will most often reflect those in its final plan; close ties with advocates of a pure hospital setting, or design by physicians, will often result in a program located in the setting and with the style of a hospital. In addition, communities reluctant to totally release the drunk from the purview of the criminal justice system, will usually reflect that attitude by retaining the police to pick up or deliver the drunk to a new facility.

The chief design discipline of the Boston project, and that of the project's Director, was sociology. That discipline is reflected in several characteristics of this particular detoxification project which are different from many other detoxification projects. Some are worth noting:

- The project does not engage in any direct rehabilitative activities. Instead, it employs diagnostic processes to help guide referrals out to other existing community resources.

- The project does not engage in any direct attempts to influence the kind of aftercare provided by other agencies to which the detox project refers its clients. Rather, it follows its clients, and send others to places which have been "successful" with prior clients, as measured by a combination of what percentage of the clients have to come back to be detoxified, and what the clients think about the aftercare agency.

- The project is extremely self-conscious about its setting: the milieu of individuals in its community, agencies, governments, professions, and communities of thought.

- The research and evaluation component of the program is particularly strong and well thought-out.

- The program sees its clientele, as will be discussed below, as those skid-row alcoholics who are "candidates for arrest", rather than as skid-row alcoholics generally, again showing its consciousness of the relationship of its role to those of police, the client population itself and others. (Early research had shown that there was a strong consentual element involved in the drunk arrest: most arrestees had

placed themselves at one of a number of normal pick-up points; or in a position where they were sure to be arrested, i.e. prone on the sidewalk.)

- The program makes extensive use of para-professional personnel, in all phases of the program, to avoid professional "distance", reduce cost, and maximize the use of prior "hands-on" experience in its staff (e.g. the use of recovered alcoholics on the rescue team and in other segments of its work).

With the possible exception of the first few detoxification programs appearing in this country, few communities addressed their problem totally anew. Each began with a number of basic ideas obtained from the study of others already in the detox business. Even those pioneering such endeavors took heed from the successes demonstrated in numerous European cities.

Boston studied a number of programs throughout the country. Personnel journeyed to all program sites that seemed likely to inform them about their needs.

The Boston project is broken down into several component parts, each interrelating and working in unison. These include the "rescue team", intake and screening, detoxification, assessment and referral, and research and evaluation segments.

- The rescue team consists of a three man, civilian team whose task it is to patrol and monitor the target area in search of public inebriates in an arrest situation. They must be likely candidates for arrest, not just drunks on the street. The characteristics of many arrest situations were studied and documented during the planning period, as a part of the study of police activity.

  When a prospective arrestee is spotted, the team approaches the individual and offers him their assistance. He is informed that medical assistance is available, should he choose to come with them, and that such a choice is his alone to make. If he decides to avail himself to the team's offer of aid (as most do), he is transported, via the project's stationwagon to the facility, to begin a five day, voluntary, drying-out period.

  The Police Department gave its official sanction to the operation of the rescue team in the community. The Police and project agreed formally that if the team reached a drunk before the police, they could have him. The two also informally agreed that as the program grew, the Department would probably begin to radio the team to pick up the drunks, rather than continuing to have officers waste their

valuable time in simultaneous response to the call, and sometimes arresting and transporting them. (In fact, several simultaneous arrivals of team and police occurred early in the project, and the police held back and let the team make the pick-up.)

A particular concern of the Police Department was for the safety of the team on those rare occasions where a drunk would become violent, and even the great experience of the rescue team was insufficient to quiet him.

- Once the inebriate reaches the facility, he begins the process of admission, which is conducted by paramedics and nursing personnel. Should there be any indicator that he should not be admitted, such as broken bones, the possibility of coma, etc., the patient is immediately taken to a nearby hospital which has agreed to serve as a medical back-up. However, if he appears physically suited to remain at the facility, he is showered, shaved and given a complete physical. The detox unit's staff gather the pertinent information to be maintained in his charts.

The paramedics in the unit are all former military corpsmen, most of whom served in Viet Nam. They are fully capable of functioning well in an acute or traumatic situation. They spent one month prior to their assuming duties as staff in training with the project's medical director at a local hospital. There, they assisted him in the examination of patients and were trained in what to look for in the alcoholic patient.

- The entire medical regimen of the facility is directly under the supervision of the Medical Director (as distinct from the Project Director). Once daily, he examines each patient, and prescribes or administers medication or other appropriate care. In addition, he conducts weekly training sessions for staff personnel. These two hour sessions usually consist of lectures on various alcoholism problems, such as the effects of alcohol on the liver, or how certain drugs affect the patient.

- The daily operations are supervised by a registered nurse. The nurse's primary role is to supervise the entire operation, maintain an appropriate level of health care, set schedules, administer medication, and assist in the teaching of both staff and patients.

- The project's detoxification regimen is quite similar to many other programs. Initially, it consists of administering Librium to assist the patient in alcohol withdrawal. Dilantin is administered to those patients who, upon examination, reveal a history of seizures. Sometime during the second day, after he has "slept it off" and is awake, the recovering patient is placed on a diet high in vitamins and fluids.

- When the patient is feeling better, he is visited by a counselor to begin plans for his release and aftercare. The counselor's task is to match the patient and his needs with the most appropriate aftercare agency. Much of his knowledge about agencies, and agreements for cooperation from them, were obtained during the agency evaluation period. At the end of the five day stay, the patient is released to an aftercare agency, upon which he and the counselor have agreed.

- The barometer of success for the operation is its evaluation process: checking how it stacks up against goals and expectations, in terms of both impact on the criminal justice system, and costs and benefits relative to the old arrest process for handling drunks.

During the months of preparation, the project obtained the names of over 4,000 previously arrested chronic inebriates. All will be key punched for input into an alcoholic data bank. As the program advances, additional names will be added, along with other pertinent information. This computerization will provide a means to quickly evaluate parts of the results, and modify the design of the project as it becomes appropriate. The evaluation will address the number of persons provided detoxification, clinical evaluation, rehab, and treatment through referral and follow-up, in addition to the number of patients not subsequently arrested, along with those who do not require further assistance of any kind. Also, the project intends to measure the effects of the program on the attitudes toward drunkenness offenders of the police, courts, medical profession and even the project staff itself.

G. LOCATE A FACILITY

The program must be located near the population it intends to serve. In detox, this allows maximum staff contact with the population served, and makes possible a walk-in detox clientele. Much thought and study must be given to this segment of the program. Much of what occurs here will determine the attitudes toward the program of both the community, and those whom the program is attempting to help.

Most people within the community where the Boston project was located were enthused about any effort to provide help for the alcoholic. They heartily endorsed the establishment of a detoxification center and provided encouragement for the planning efforts; all except those where the facility was located near their home, or in their business neighborhood. Then it was often viewed as threatening or harmful. While a "rational" response can demonstrate that such a reaction is highly "emotional" and "irrational", these reactions must nevertheless be taken seriously.

CONTINUED

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Boston conducted a detailed study of the general area frequented by the public drunks.

- The residential and business character of each block was noted in a block by block inventory of available location sites. Early in this process, it was clear that the program could not successfully locate in any predominately residential area. About two-thirds of the target community was residential. Resident opposition would spell doom. Subsequently the search zeroed in on the remaining third of the target community, a heavy industrial-service area.

- Upon closer inspection of this section, one particular very large and centrally located building, currently unoccupied, became a prime prospect. The building was owned by the city, which was in the process of forming an association of prospective tenants for remodeling and occupancy. If this building was to be a potential site it would be necessary to relieve the concerns of these prospective fellow tenants and convince them that an alcoholic detoxification center would be a good neighbor. Much of this work had to be accomplished on a one-to-one approach to each of the other prospective tenants of the building. These meetings were carefully planned including who would go to the meeting, what would be said by whom, and, on occasion, what should be worn to such a meeting.

  From this, the project was accepted as a fellow tenant, joined the Tenants Association, and began to work with the other tenants in the planning and development of the remodeling of the building.

- While awaiting the building's renovation, the project temporarily located in the basement of a shelter for homeless men, operated by a religious order. This arrangement was made possible by the rapport and communications established early in the planning process. The temporary location allowed the program to begin to staff up, seek patients, and begin operation close to those it intended to serve, in a facility that had long ago overcome the location problem.

H. IDENTIFY FUNDING SOURCES

Last, but certainly not least, is the need to determine where the money for such a program is going to come. In this case, in recent years, there have been a number of programs that have earmarked money for some aspect of the problem of alcoholism.

- The U. S. Department of Transportation has money available for the treatment of alcoholic related problems. The prime thrust of their program is directed at the drunk driver, and safety on the highways. D.O.T. suggests that those seeking

their funds tie rehabilitation and detoxification portions of highway safety programs to other possible funding sources such as the National Institute of Mental Health (NIMH).

- NIMH is beginning to have detoxification and rehabilitation funds available. However, this agency takes a dim view of programs that attempt solely to address the question of detoxification.

- In many states, H.E.W. Vocational Rehabilitation Administration (Voc Rehab) Case Service Money has been earmarked for use in detoxification programs. A check with a state's Department of Voc Rehab will determine if such money is available.

- For the design intent of this program, the most readily available money was from the Department of Justice, Law Enforcement Assistance Administration (LEAA). These funds are directed specifically at devising programs that will reduce crime, in this case by relieving some of the burden placed upon the criminal justice system by the problem of alcoholism. This was the source of Boston's funds.

Originally, the Director of the Mayor's Safe Streets Act Advisory Committee, the Superintendent-in-Chief of the Boston Police Department and the Director of the Massachusetts Division of Alcoholism approached the Governor's Public Safety Committee (the State Planning Agency in Massachusetts which plans for, receives, and disburses to units of local general government funds from LEAA). On the basis of a series of discussions -- where the City pointed to the fact that of 40,000 arrests annually in Boston, 20,000 were for drunkenness, and half of those occurred in one police district -- the State earmarked $150,000 for the planning and start-up of a detoxification center in Boston the following year.

Funds for the establishment of detoxification programs are available under Parts C and E of Title I of the Safe Streets Act. Part C provides for "block grant" funding and Part E provides funds for correctional endeavors. The earmarking of these funds for such programs as detox become the principal responsibility of each SPA. This is accomplished through inclusion of the program in their annual State Plan. (Should a state not have made such provisions, it may become necessary to urge the SPA to make such allowances when they submit their next plan, or to seek an amendment to the annual plan from LEAA.)

A proposal was drafted and submitted to the SPA. It was eventually funded, and the amount of $150,000 covered the first year's period of conceptualization, planning and development, and the first two months of operation of the facility.

CONCLUSION

By way of a conclusion, two temporarily destructive errors in the planning and implementation of this project are instructive. Both have to do with the question of who manages what tasks.

First, there were a series of serious delays in the construction of the new facility, resulting in the project being at its temporary site 4 months longer than was originally planned.

Secondly, there were early problems with staff morale, inertia, and turnover, together with communications problems, resulting from confusion between the roles of the administrative director of the project, and the director during the planning stages, the latter having maintained a role during initial operations.

The delay in construction resulted from a number of things: lady luck played her part as 7 different trade unions struck at different times, by happenstance within the construction phase; and bureaucratic behavior played a role, as the state changed its guidelines on public bidding procedures after most of the bids were in, lowering the maximum allowable purchase without bid, from the city's requirement for public bids "over $2,000", to the State's "over $500." This forced the city to repeat much of its purchasing process. These issues could not have been anticipated, however. On the other hand, during the planning phase of the project, functional analyses and purchase decisions were decentralized to the functional specialists who were studying hiring, training, medical regimen, rescue team, and other functions; and when the project moved into implementation this was not changed. The result was uncoordinated resource scheduling, which was partly to blame for the construction delays. In planning phases, resource scheduling activities often should be decentralized. Boston failed to reexamine this issue when they began to implement, and the result was a delay.

The project also failed initially to recognize the need for a change in the style of management required for implementation and operations. The planning director -- by virtue of the superior depth of his experience with the project over that of the newly-hired administrative director and the fact that city regulations required his signature on everything -- retained without explicitly wishing it the overall command of the project after its initiation. The results were temporarily destructive to the operation of the project: staff were not sure to whom they reported, and so "crossed signals"; and a less effective style of management was maintained after it had lost its usefulness. The planning director was skilled at telling people what to look for, and at coming rapidly to decisions about hypotheses and general direction. He was not skilled at telling people what to do and not to do, and he was not on site to make rapid, potentially risky decisions that were required. Too many decisions were deferred for study or returned to the questioner.

The result of these experiences is the suggestion that one more key issue be added to the list which began this paper:

- Re-examine periodically the organization being used to plan, implement, and operate the project. Recognize that different organizations and styles of management will be required at different points, especially, this experience would suggest, in resource scheduling, and at the point where the project begins operations.

BRIEF DESCRIPTIONS OF OTHER

ALCOHOL DETOXIFICATION PROJECTS

For those readers who are interested in Alcohol Detoxification per se, and not reading this paper primarily for its focus upon program development, we have included brief descriptions of five other major detoxification projects.

ALCOHOLISM AND INEBRIETY AGENCY
605 4th Avenue, South
Minneapolis, Minnesota

Daniel Hertsgaard, Program Director

The Minneapolis program has a number of operations working jointly to provide what they call "a continuum of treatment". The program consists of an alcoholic information and referral service operated in its 4th Avenue office; a twenty-two bed rehabilitation unit, called the Meadowbrook Treatment Center; a fifty-six bed receiving unit; and a therapy and acute detoxification unit. These five units and their 90 beds are supervised by a staff of 88, approximately 95% being classified as professionals.

The program's treatment mode is described as therapeutic, that is, one aimed at providing whatever therapy is deemed necessary to assist a patient to recover. The treatment regimen places heavy emphasis on the use of antebuse, along with limited use of librium. The treatment period spans a number of weeks. It begins with two weeks in acute detoxification; two weeks at the rehab unit; then two or more weeks as a "day patient" wherein he receives group and individual therapy while spending evenings at home. The program provides services for both males and females. It is expected that after the first of the year the program will be expanded to include those dependent upon such drugs as heroin.

The operation is part of the Hennepin County Welfare Department and serves all the residents of the county. It receives funds from a number of sources. Some of these are: Federal monies through the Social Security Act, Social Rehabilitation, Section 4A; State funds from the State of Minnesota Department of Mental Health, with additional funds expected shortly as the result of a newly passed State Statute on alcohol and drugs; and on the local level it obtains funds through the county tax levy as part of the Welfare Department's budget.

While the program has to rely on either the police bringing the drunks to their facility, or any other similar methods, it

has been giving serious thought to the use of a rescue team. To a large extent, this has been prompted by the new Minnesota state law which no longer declares drunkenness an arrestable offense.

HARRISON TREATMENT AND REHABILITATION HOSPITAL
725 6th Street
Des Moines, Iowa

Quentin Hunter, Administrator
C. W. Wyman, M.D., Medical Director

The Des Moines community has two alcohol rehabilitation programs in operation. One is in its early developmental stages and is funded by Model Cities and LEAA monies. The other, the Harrison Treatment and Rehabilitation Hospital, is a well established program, licensed by the State of Iowa to handle people from a large area of the State as well as local inebriates.

The Harrison Hospital operates a 40 bed program that serves as a teaching program for the Des Moines College of Osteopathic Medicine and Surgery. It has a staff of 46, 15 of whom are professionals. Junior Osteopathic students also serve a three week rotating clerkship at the unit. The college's hospital serves as the program's medical back-up.

The program places its greatest emphasis on detoxification, involving its patients in a ten day detox regimen that includes a very minimum of drugs. They rely heavily on vitamins and a muscle relaxant drug. On rare occasions they use librium and dilantium. The program does use antabuse.

The program also places heavy emphasis upon the role of AA in the life of the alcoholic after detoxification. It has a large Alumni Group that serves as sort of a basic training AA group, speaking to service clubs, and providing a watch on its fellow members' sobriety.

The program accepts both male and female patients. The bulk of the patients are referred from the court of Judge Harrison, after whom the center is named. The center has counsellors who appear in court each day to screen and assist the Judge in his disposition of drunkenness cases.

While the program operates in the private sector, it receives funds from the State of Iowa's Commission on Alcoholism (35%); from the county (legal residence charges, 35%); and from insurance, such as Blue Cross (30%). It is one of two licensed hospitals for the treatment of alcoholics in the State of Iowa.

MANHATTAN BOWERY PROJECT
8 East Third Street
New York, New York

Steven Manos, Executive Director
Robert R. Morgan, Medical Director

The Bowery Project operates a 48 bed facility in the heart of the Manhattan Bowery. One of the original detoxification projects, it is one of the most successful and one of the few truly free standing projects.

The project concentrates on the detoxification of alcoholics, but it provides rehabilitation and out-patient services as well. The out-patient services include an antabuse program, counseling, medical prescription service, psychotherapy, and AA programs. Phenobarbital (IM) is a principal drug used.

The project has a rehab program underway in Brooklyn in which men engaged in a work program live in a half-way house. The men are paid for the services rendered, such as clearing debris from city owned lots to be used for playgrounds.

The project receives its funds from two sources: the City of New York's Department of Mental Health and Rehabilitation Services, and the City's Manpower and Career Development Agency.

The project uses a rescue team approach for acquiring the bulk of its patients, using one civilian and one police officer in civilian clothes. The main purpose for the use of a police officer is the protection of the civilian and the drunks -- the Bowery is a very rough section of the city.

ST. LOUIS DETOXIFICATION AND DIAGNOSTIC EVALUATION CENTER
5400 Arsenal Street
St. Louis, Missouri

Joseph B. Kendis, M.D., Medical Director

The St. Louis program operates a 28 bed facility in a wing of the St. Louis State Hospital Complex (Mental). The program is staffed around the clock by 25 persons, including a number of externs, RNs and one M.D. The program concentrates on detoxification along with a 6 to 8 week voluntary in-patient rehabilitation phase that offers group and individual therapy, and out-patient medical attention and AA follow-up.

The program is funded in the State Mental Health budget. At its inception it was funded with money received from LEAA and the St. Louis Police Department. While the program initially focused its services on three police districts in St. Louis, it

presently serves the entire metropolitan area. The primary source of patients is from the arrests by the St. Louis Police Department. It also accepts self referrals.

The program, as it was originally designed, is thoroughly described in the Report of the President's Commission on Law Enforcement and Administration of Justice: Task Force on Drunkenness.

SEATTLE TREATMENT CENTER
500 17th Avenue
Seattle, Washington

John O. Brons, Executive Director

The Seattle program operates a 65 bed facility on the fourth floor of Providence Hospital, where it rents space. While the program is autonomous of that institution, Providence Hospital does back it up, admitting acutely ill inebriates, as does a public hospital.

In addition to providing services to alcoholics, three of its beds are reserved for those who exhibit second stage withdrawal symptoms from heroin. Fourteen of the beds are set aside for the use of private patients, whose fees help defray the cost of the public beds.

The program operates what can best be described as a therapeutic community aimed at instilling self respect in the patient and stimulating incentives to seek additional rehabilitative help. The program places heavy emphasis on love in its treatment process. The staff try to make the patient feel like he really is somebody. For example, no one in the facility wears any type of identifiable uniform that may separate the patient from the staff, including the nurses and doctors.

While the primary objective of the program is detoxification, the program attempts to guide the patient into proper aftercare programming before he leaves. They try to make certain that no one leaves without the provision of a home, food, and clothing. The treatment regimen includes primarily librium, administered IM, and a heavy emphasis on vitamins. Those subject to seizures are given dilantium.

Presently, the program relies on police arrest of drunks as their prime method of obtaining patients. However, they anticipate going to a rescue team approach in a few months.

The program also has two counselors, both Indians (and brothers), that devote most of their time working with Indian inebriates. The program, while it has black staff and serves both black

and white communities, is thinking of using a black team to better relate to the black inebriate.

The program is funded with Model Cities and LEAA monies, as well as National Institute of Mental Health funds. Shortly, the program will be funded through the King County Health Department. At that time it will serve the entire county.

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