COMMUNITY RESOURCES IN PROGRAMS FOR DRUG AND ALCOHOL ABUSE AND DELINQUENCY PREVENTION

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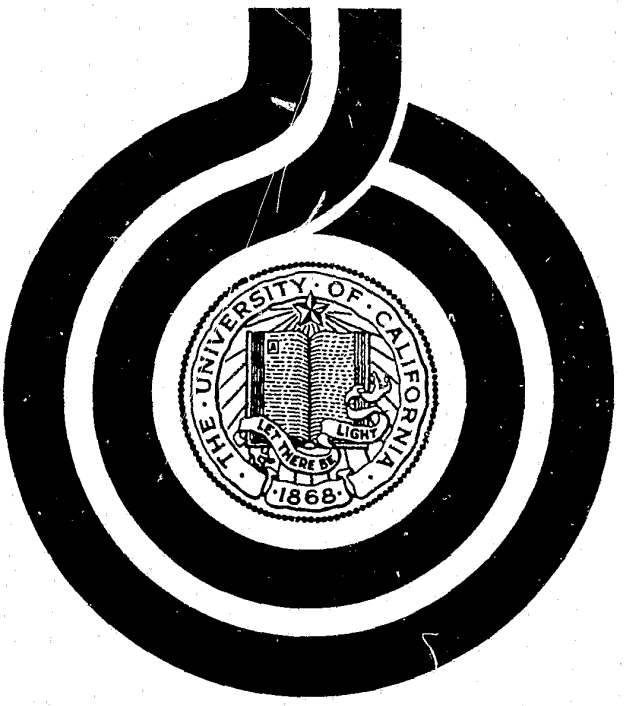
J.C. Ries, Barbara Gross,
and Alene Pettee

INSTITUTE OF GOVERNMENT
AND PUBLIC AFFAIRS



VERSITY OF CALIFORNIA, LOS ANGELES

COMMUNITY RESOURCES IN PROGRAMS FOR DRUG AND ALCOHOL ABUSE AND DELINQUENCY PREVENTION

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J.C. Ries, Barbara Gross,
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A Report of a Study

conducted for

Los Angeles Regional Criminal Justice
Planning Board

by

Institute of Government and Public Affairs
University of California
Los Angeles, California

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ERRATA

"Community Resources in Programs for Drug and Alcohol Abuse and Delinquency Prevention"

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Page	
45	Footnote: add, p. "42."
77	Line 2 (Long-range policy), column 7 (Both): change "5" to "6."
80	Note a: change Table number from "323" to "23."
88	Line 5 (Fund raising), column 15 (250,000 - 500,000): change ";" to "1."
98	Add "Long" to "Range Goals."
153	Second paragraph, last sentence should read: Four cities (18%) said that such facilities were proposed and created without opposition and 4 (18%) said that such facilities were proposed, met considerable resistance, and were either not developed or located elsewhere.
172	II - C (Service Needs), second line: ". . . to initiate consumer (not "summer") education activities and projects. . ."
178	I - D (Geographic Scope): ". . . open to whole county." (not "country")
239	First paragraph, second line: ". . . and each contractor receives more funds from DOL if he handles (not "they handle") more slots."
239	List of funding: Total of agencies listed is $7,010,150; balance of $8,491,000 shown is accounted for by other and miscellaneous.
245	First paragraph, last sentence: Should read "The results were extensive (not "ex-ensive") and in some respects promising."
255	Second paragraph, first sentence: Should read "A new (not "few") facility . . ."

TABLE OF CONTENTS

EXECUTIVE SUMMARY

MAJOR RESULTS AND FINDINGS

There is a network of persons, agencies, funding sources, and activities in Los Angeles County devoted to providing services for delinquents, drug abusers and alcoholics. Some of these are public and some are private, although the line dividing the two is hazy because of the number of private agencies that receive public funds. This study is a survey of the capabilities and needs of the private agencies of the system, undertaken to assist the Los Angeles Regional Criminal Justice Planning Board in developing plans and policies that will enhance private resources. To refer to these agencies concerned with delinquents and addicts as parts of a system is not to say there are well-defined and agreed-upon goals, a clear-cut division of labor among agencies, and a coordinated set of programs or a rational allocation of resources for reaching these goals. Indeed, none of the above conditions exists and the system is both fragmented and disorganized.

There are no data on the number of delinquents, drug addicts, and alcoholics in Los Angeles County nor on the number who receive some treatment from the system. There are widely diverging and conflicting views on what constitutes effective treatment and no data on the cost or effect of the services provided. Agencies in the three program areas (delinquency prevention, drug abuse, and alcoholism) do not consider themselves as parts of some larger system that includes a public component and have relatively little contact among themselves. Cleavages appear along public versus private, program emphasis, and ethnic lines.

Data collected during the course of this study suggest there are approximately 640 agencies providing services for addicts, alcoholics, and delinquents in the county. Almost three quarters of these agencies are concerned with delinquency; the remaining agencies are about equally divided between alcoholism and drug addiction programs. A plurality of agencies are multipurpose, attending to needs in two or all three program areas. Most agencies studied have been in existence for six or fewer years; half of

them had revenues last year of $100,000 or less and operate with small staffs who have had little formal training.

System Components

Programs in all three areas can be organized under three functional components: client intake, treatment, and aftercare. In each program area, intake is the most developed component and treatment is emphasized more than aftercare. The most frequently found intake services are referral, crisis intervention, community education-prevention, and psychological testing. With respect to treatment, the services most provided are counseling, recreation, out-patient services, and remedial reading. In the case of aftercare, follow-up is the most prevalent service. Additional intake needs include: more community education, crisis intervention, emergency shelter, psychological testing, and medical diagnosis. Further treatment needs include medical care, legal assistance, detoxification, self-help programs, big brother relationships, half-way houses and other residential facilities, and cultural enrichment programs. Aftercare needs are for job counseling (including in many instances job training and placement) and follow-up.

Characteristics, Capabilities and Needs of Agencies Surveyed in the Study

Services. Most frequently provided services are counseling, referral, crisis intervention, recreation, community education, follow-up, psychological testing, out-patient care, remedial reading, and cultural enrichment. Three services reported as most demanded—job counseling, detoxification, and emergency shelter—are not among the ten most frequently provided. Similarly, six of the ten additional services most desired by the reporting agencies are not among the ten most provided services. They are job counseling, legal aid, self-help programs, big brother relationships, half-way houses, and emergency facilities.

Service patterns and perceived needs vary among agencies according to their programmatic emphasis. Juvenile delinquency prevention agencies most frequently provide follow-up, remedial reading, big brother relationships, and referral services; these agencies feel the need of additional services most strongly in the areas of big brother relationships, legal aid, follow-up, and remedial reading. Agencies emphasizing drug abuse programs most

frequently provide follow-up, legal aid, and cultural enrichment services; their greatest reported needs are for additional services in follow-up, legal aid, and big brother relationships. Agencies concerned with alcoholism most frequently provide self-help, big brother programs, and follow-up services; they want additional services in legal aid, follow-up, and job counseling.

Clients served. While the average number of clients served by all agencies last year was 5,400, half of all agencies regardless of program emphasis or size of budget serve 500 or fewer clients. Of these agencies a third operate on small budgets ($50,000 or less, last year) and a plurality have been in existence three years or less. Agencies report few limits on client eligibility. The most frequently mentioned are age, geographic area, and ability to pay.

Agency age. A quarter of the agencies surveyed have been in existence for two years or less and a majority for six years or less. Nineteen agencies are fifty years old or older. Drug abuse agencies are the youngest, followed by alcoholism and juvenile delinquency agencies. Generally, younger agencies serve fewer clients than do the longer-established ones. Income, however, is not strongly associated with age except in the case of those agencies with budgets in excess of $200,000; a majority of such agencies are over ten years old. Age seems to be associated with funding sources. Older, more established agencies are the primary recipients of United Way support. Younger agencies, regardless of program emphasis, rely more heavily on client fees, private foundations, fund raising, and public sources.

Skill patterns and needs. Three quarters of all responding agencies reported that all of their staff have had some training. For the most part, this training is informal; almost half of the agencies report six or more staff with only informal training. One third reported employing no staff with administrative or managerial training. Juvenile delinquency agencies tend to have more staff with training in all categories. Most frequently mentioned training needs were for informal, on-the-job training, followed by general counseling, community organization, and methods of drug prevention. Delinquency prevention programs, reporting the greatest range of

training needs, mention general counseling most frequently. Drug abuse agencies emphasize the need for informal training, while alcohol abuse agencies report the fewest training needs.

Staffing patterns. Most agencies report few full-time and part-time administrative, professional, paraprofessional, clerical, or volunteer staff. Twenty to thirty agencies (depending upon the job category reported) report six or more full-time staff in each category. Staffing patterns are generally low, regardless of program emphasis, although delinquency prevention programs report the most staff. Staff is associated with income only quantitatively—the greater the income, the greater the staff. Income does not seem to be associated with job categories. Greatest use of paraprofessionals is by drug agencies, followed by delinquency programs. Most commonly assigned duties are general counseling, which is also identified as the greatest need for additional paraprofessionals.

Finance. Median income of all reporting agencies last year was $97,600. Thirty-eight percent of the agencies had incomes of $50,000 or less; five agencies reported incomes in excess of $1 million each. A majority of agencies charge their clients fees. Other sources of revenue, in order of frequency of their mention, are: fund raising, United Way, federal grants, private foundations, and local or county tax revenue.

Most agencies receiving funds from United Way or private foundations report that such sources account for less than 25 percent of their income. Almost one quarter of the agencies depend solely upon client fees. Fund raising generates only a modest amount of revenue for those agencies which attempt it. A majority of agencies receiving governmental support (federal and local) get more than half of their income from such sources.

Delinquency prevention agencies receive a larger percentage of their incomes from United Way, private foundations, and public sources than do drug abuse and alcoholism programs. Most drug agencies gain most of their income from federal sources, client fees, and fund raising. Most alcoholism programs gain the majority of their revenue from client fees.

Approximately half of all responding agencies have applied for federal funds. A greater percentage of the drug programs (69%) than of delinquency (48%) or alcoholism (24%) programs have applied. Over half of these agencies (regardless of program emphasis) are young ones (in existence for five years

or less). Most frequently mentioned problems in gaining funding are: lack of knowledge of sources and policies and lack of expertise in preparing proposals. Problems in gaining federal funds seem to be associated with staffing patterns. Generally, agencies with full- or part-time administrative, professional, or paraprofessional staff members mention fewer problems than those with primarily clerical or volunteer staffs.

More than half (52%) of all agencies reported they were either not sure of the adequacy (17%) or that current income was inadequate (35%) to meet costs. More drug abuse agencies (61%) reported their incomes to be adequate than did alcoholism (45%) and delinquency (41%) agencies. In the event of a budget deficit, all agencies tended to favor similar remedial steps: seek additional or emergency funds, reduce services, and (or) defer services in the planning stage. On the other hand, the primary uses to which additional revenues would be put are: new facilities, research on problem areas, expanding present programs or services, additional programs or services, additional staff and increasing staff salaries, and purchasing supplies and equipment.

Income does seem to be associated with staff. Agencies with larger budgets are better staffed with administrators and professionals. Delinquency agencies are better staffed than drug and alcohol abuse agencies.

Half of all reporting agencies serve 500 clients or fewer, regardless of income. However, drug and alcohol abuse agencies serve fewer clients than do delinquency programs. A rather large number of delinquency agencies serve few clients, despite rather large budgets. Generally, large numbers of clients are served by agencies operating with small budgets.

Interagency cooperation. Without regard to program emphasis, existing forms of interagency cooperation are information sharing and referral. Most interest is expressed in cooperation for research, grants and contracts, program development, and long-range policy. However, there are important cross-program differences. Alcoholism agencies are presently engaged in substantially more interagency cooperation for fund raising and less involved in contracts and proposals, shared facilities and equipment, purchasing, publicity, information sharing, and referral. Alcoholism agencies are most interested in developing interagency cooperation in purchasing, publicity, information sharing, and referral.

Drug abuse agencies are currently engaged in more interagency cooperation for contracts and proposals and publicity and less active in shared facilities. They are most interested in developing interagency cooperation for shared facilities and for contracts and proposals (note, they are also most active in contracts and proposals) and least interested in developing publicity (in which they are also already most active).

Delinquency prevention agencies presently engage in the most interagency cooperation to share facilities and are least active in long-range policy and referral. They are most interested in developing cooperation arrangements in fund raising and long-range policy and least interested in contracts and proposals, information sharing, and referral.

Agencies giving equal emphasis to all three program areas have the most cooperative arrangements for information sharing and referral and are most interested in developing them in combining services and program development. They are least interested in such arrangements for sharing facilities, purchasing, and publicity.

Response rates to questions about current interagency cooperation and interest in developing them are low and may be a crude measure of the extent to which agencies do not perceive themselves as parts of an interdependent or, at least, interrelated system.

All agencies presently engaged in some form of interagency cooperation prefer local to countywide interagency arrangements. Delinquency prevention agencies are more likely to prefer countywide cooperation. Preferences for geographical scope of interagency cooperation do not seem to be affected by staffing patterns of agencies; however, agencies with fewer administrators are more interested in developing some form of cooperation, as are agencies with smaller budgets and which have been in existence 10 years or less.

Cooperation with law enforcement. Many agencies have cooperative arrangements with law enforcement and are considerably interested in extending them. Existing relationships include (in order) referral, sharing information, public education, and financial.

Interest in additional arrangements are (in order) public education, financial support, information sharing, and referral. Delinquency agencies

have the most frequent incidence of cooperation for information sharing. A greater percentage of drug abuse agencies cooperate in educational arrangements than is the case with agencies emphasizing other programs. Multipurpose agencies are more likely to have referral arrangements. Alcoholism agencies have the greatest interest in developing cooperative arrangements for referral, while drug abuse and multipurpose agencies are most interested in developing some form of financial arrangements.

Planning. Approximately three quarters of all agencies conduct planning in the following areas: long- and short-range goals, program development, and services. A majority of them plan program evaluation and fund raising. Research planning is much less frequent (26%). The frequency of various kinds of planning for those agencies which do plan is remarkably constant, regardless of program emphasis. However, alcoholism agencies are less likely to plan for short-range objectives and for program development and evaluation. Drug abuse agencies are more likely to plan research and program evaluation. Delinquency prevention agencies are less likely to plan for short-range objectives and program development. Planning patterns seem to be insensitive to the number of clients served.

Community support. An overwhelming majority of agencies report moderate to great community support for their programs.

Clusters and Gaps in Services

Drug programs. Drug abuse agencies are clustered in West, South Central, and Central Los Angeles and in Long Beach. Many areas of the county show gaps in drug abuse services. The most significant gaps are in the San Fernando Valley, San Gabriel Valley, and South Bay. Also, East Los Angeles has only a small number of drug abuse programs, in comparison with the dense population of that area. The only concentration of residential treatment programs is in the Venice-Santa Monica area; the other programs are scattered throughout the county.

Alcohol programs. Alcoholism treatment and recovery agencies are clustered in Long Beach, Central Los Angeles, and Pasadena. Pasadena is a fairly small area to have so many alcoholism agencies. Long Beach is larger, but it too has a cluster. South Central and East Los Angeles, the

San Gabriel Valley, and the South Bay area have large populations, yet these areas, along with Glendale-Burbank, show the largest gaps in services. (Although Alcoholics Anonymous offers services throughout the county, most of its local clubs were not surveyed.)

Delinquency prevention. South Central and West Los Angeles have the largest number of services. Because of the great differences in services offered, a large number of agencies in an area does not necessarily show that the needs of youth in that area are being met. The Glendale-Burbank and Southeast Los Angeles areas show the largest gaps in delinquency prevention service.

Two sections of the county are almost completely devoid of services in all three of the program areas. They are the unincorporated portions of the east and southeast edges of the county and the northwest section of the San Fernando Valley. The former is populated by low-income families with limited resources; the latter by families of modest income. These are areas where many of the missing services are needed. In addition to being remote, there are some indications that they lack the community (or organizational) resources necessary to articulate their needs and acquire services.

Policy Issues Raised by the Findings

1. Apparent imbalance among system components, that is, relative strength of intake components, emphasis on treatment, limited emphasis and services for aftercare.

2. In the absence of good measures of service needs in various communities, gaps in facilities must be viewed as resulting in unfulfilled community needs.

3. Accessibility of services, including problems of transportation (related to the scattering, clusters, and gaps) and cost of service to clients.

4. Problems of referral; differential emphasis on intake, treatment, and aftercare; duplication of functions and facilities; and forms of cooperation and planning are all exacerbated by the fragmentation of the system—within program areas, between program areas, and between public sector and private agencies.

5. Existing forms of cooperation and interest in extending cooperative arrangements offer a potential for coping with system problems.

   a. There is a clear preference for local as opposed to countywide cooperative arrangements.

   b. New, smaller agencies operating without full-time administrators and on small budgets express the most interest in interagency cooperation.

6. Cooperative arrangements with law enforcement agencies are extensive and there is interest in extending them in all program areas.

7. Agencies indicate they are heavily engaged in all forms of planning and are interested in extending their planning activities.

8. Funding stability is a major concern of all agencies, as is current emphasis on "model" or "innovative" programs by public funding sources. Funding sources apparently have their own priorities and do not coordinate their funding policies.

9. Agencies are sparsely staffed, express interest in increasing their staff skill levels, and define further needs for paraprofessionals. There is a need for increased administrative skills in all organizations.

FIRST PRIORITY RECOMMENDATIONS

1. Highest funding priority should be given to aftercare facilities, job counseling, and follow-up. Make provision of aftercare a condition of funding. Give next priority to crisis intervention; community education and other preventive programs; legal assistance; self-help programs; big brother relationships; recovery homes and other residential facilities; and detoxification facilities. Give next priority to medical care, cultural enrichment, psychological testing, and drug and delinquency programs for girls and alcoholism programs for all youth.

2. Make physical location of a facility a criterion in approving requests for funds.

3. Publicize, encourage, and subsidize interagency cooperation and planning.

4. Call attention to long-run funding problems and encourage units of local government to provide some financial support to programs that are located within their boundaries and serving their communities.

5. Call attention to the need for a continuing and extensive program of community education.

6. Require agencies seeking or receiving Board funds to concern themselves with problems of service clusters and gaps, interagency cooperation, long-run funding, accessibility, planning, and aftercare services.

7. Encourage joint proposals by law enforcement and agencies in all program areas.

NEEDED RESEARCH

1. Development of measures of success of treatment and rehabilitation programs.

2. Development of methods of making services accessible to those needing them.

3. Determination of the actual demand or need for services.

INTRODUCTION

PURPOSE AND SCOPE OF THE STUDY

This study was commissioned on January 3, 1972, by the Los Angeles Regional Criminal Justice Planning Board to assess community resources in the program areas of juvenile delinquency prevention and drug and alcohol abuse and to make recommendations to the Board for enhancing these resources. The scope of the study includes the capabilities and needs of private agencies in Los Angeles County that provide services in the three program areas.

METHODOLOGY AND PROCEDURES

Defining the Study Population

In many instances the distinctions between a public and a private agency are clear and unambiguous. In other instances, such is not the case. This study employed a legal criterion to resolve doubts. All agencies offering services in the three program areas which are incorporated either as profit or nonprofit corporations were included in the study.

Distinguishing Private Agencies by Program Emphasis

Many agencies clearly emphasize one of the three program areas and their names clearly indicate such specialization. In other cases, especially in the area of delinquency prevention, either the program emphasized is not clear or agencies are multipurpose. Agencies responding to the mailed survey were asked to indicate the program or combination of programs emphasized. Agencies not responding to the survey were categorized on the basis of (1) their title, if descriptive, (2) their literature, if available, and (3) by interviews with knowledgeable people. The study included all agencies which offer their facilities to juveniles, whether or not their stated purpose is preventing a juvenile from becoming delinquent.

Those responding to the mailed questionnaire were divided into seven categories: emphasizing all program areas equally; emphasizing alcoholism;

emphasizing alcoholism and delinquency; emphasizing drugs; emphasizing drugs and delinquency; emphasizing delinquency; and emphasizing some other problem but giving equal emphasis to all three program areas as they relate to the other problem. In the analysis of the questionnaire data, the first and the last categories were frequently grouped together and labeled, "Emphasizing all program areas equally." When analysis was limited to agencies' most emphasized program, the multipurpose organizations were excluded unless stated otherwise.

Identifying and Documenting the Population to be Studied

Verbally, the population to be studied is easy to define and identify: "all private agencies providing services in the areas of delinquency prevention, drug abuse and alcoholism treatment." In fact, it is very hard to develop an accurate list of these agencies. There is no single source for such a list. All directories are either incomplete or out of date—usually both. Constantly, new agencies are being founded and others are going out of existence.

The procedure used in the study was to compile an independent list by consulting all such documentary sources as directories, lists, and referral sheets as well as making intensive efforts to interview knowledgeable persons in both public and private agencies throughout the county. Documentary sources included both public and unpublished files and directories. The effort resulted in a card file in which each agency's name, address, telephone number, and services offered were recorded and color-coded by program emphasis. The file was constantly being enhanced and updated throughout the duration of the study. It consists of approximately 640 entries.

Data Collection Procedures and Methods

Three different kinds of data were needed for the study. First were patterns of characteristics, services, and needs of agencies. These data were collected through a mailed survey. Second, preliminary interviews with knowledgeables in public and private agencies indicated the need to gather more qualitative and detailed data about relationships among agencies within and across program areas and between public and private agencies, the nature and character of treatment and aftercare facilities and services,

problems of program and agency management, other factors affecting agency viability, and so forth, not readily amenable to a mailed survey instrument. Twenty-one agencies (seven in each program area) were selected on the basis of their geographical location, age and stability, variety of services offered, nature of facility, and philosophy of treatment. At least one senior staff member (usually, the director) was asked (and in all cases agreed) to permit a personal, open-ended interview. An additional 26 interviews were conducted with knowledgeables in public and private agencies, medical professionals, academicians, and researchers. A third method of data collection involved conventional research projects and case studies such as the city manager survey, inventory of detoxification facilities, positive and negative instances of community acceptance, and the like. Most of these studies are summarized in the Appendixes.

Preparation of the Mailed Questionnaire

The content of the questionnaire was partially determined by the terms of the contract itself. However, other dimensions of the instrument were developed on the basis of interviews with members of the staff of eleven agencies. A special effort was made to cast the survey instrument in the perspective of agency personnel.

After the categories of information desired were identified, the UCLA Survey Research Center was employed to construct and pretest the instrument. The pretest was administered in April 1972 to 45 agencies (15 in each program area selected at random). The pretest results were used to revise the instrument and develop the final questionnaire.

Several steps were taken to increase response rate, including limiting the size of the instrument and simplifying its instructions, inclusion of a brief covering letter explaining the purpose of the study, and a stamped return-addressed envelope. The survey was mailed in two waves. The first, on May 19, 1972, went to all agencies not previously covered in the pretest or through personal interviews. The second wave was mailed on June 7, 1972, to all agencies which had not responded to the first wave. All surveys returned by July 15, 1972, were included in the study. Of the 566[1] agencies

1. Seventy-four of the 640 agencies were removed from the population for the following reasons: 29 agencies were in the preliminary interviews or in the special sample of 21 (or both); 45 were in the pretest.

circulated, 201 responded (the response rate was 35.5 percent).

Sampling Procedures and Factors Affecting Response Rate

On the advice of our survey consultant, questionnaires were sent to the entire population of 566 agencies. As anticipated from research literature, it was discovered that the longer the questionnaire remained in the field, the more likely a response. The original cut-off date, set for June 15, 1972, was moved back one month. Questionnaires are still being returned while this report is being written.

Adequacy of Response Rate and Sample Bias

One can be confident there is substantial bias in any mailed survey. The task is trying to identify the nature of the bias and consider its implications for the study. The first concern with respect to bias is the probability of systematic differences between respondents and nonrespondents. Sample survey lore is of considerable assistance in this regard.

> Surveyors have found that such factors as (1) the characteristics such as sex, economic status, and educational level of the groups solicited; (2) the interest in the subject of the investigation; (3) the prestige of the sponsoring groups among the recipients of the questionnaires; (4) the appeal of the particular questionnaire, and (5) strong agreement or disagreement with the propositions about which they are surveyed, are all related to the proportion of replies obtained.[2]

Because this study hopes to contribute to the development of policy and plans, bias springing from strongly held opinion or interest in the study itself is probably not damaging and may well be an asset. However, bias resulting from differences in the education or economic status of the recipient is of concern. Nonresponse relating to perceptions of either UCLA or LARCJPB are hard to pin down, but personal interviews revealed considerable suspicion on the part of private agencies toward public agencies. But once again, nonresponse related to such factors is probably

2. Mildred Parten, Surveys, Polls, and Samples: Practical Procedures (New York: Harper and Brothers Publishers, 1950), p. 391.

not a serious problem in an exploratory and policy-oriented study and can be partially compensated through other methods of data collection.

Three steps were taken to further identify patterns of bias in the response. (1) The distribution of response by most emphasized programs in the population of 566 agencies was calculated as follows:

Agency Emphasis	Population		Sample	
	Number	Column percent	Number	Column percent
Drug abuse	70	13%	34	17%
Juvenile delinquency	417	73%	144	72%
Alcoholism	79	14%	23	11%

This test is necessarily a crude one because of the lack of complete confidence about the most emphasized program of nonrespondents. The importance of these comparisons is further reduced if one bears in mind the inability to categorize the population of 566 agencies in terms of multiple program emphases. On the other hand, 56 of the 144 responses from delinquency agencies indicated a combination of delinquency prevention and one of the other programmatic emphases. In any event, the comparison suggests no reason to be particularly concerned about bias stemming from different program emphasis aside from the fact of great disparity of emphases among agencies in the population itself.

(2) The geographical distribution of responses was compared to the geographical distribution of the entire population of agencies. For this purpose, the county was divided into eleven areas. Response rates were fairly uniform across areas, with three notable exceptions. South Central Los Angeles and East Los Angeles are seriously underrepresented (26% and 18% respectively) and Glendale-Burbank is vastly overrepresented. These are likely to be very important biases and should be borne in mind when reading the section of this Report which summarizes the survey data. This is especially true in the case of East and South Central Los Angeles where the geographical boundaries coincide with ethnic and racial as well as class factors.

Area	Number	Response	Area	Number	Response
South Bay	26	42%	Pasadena	41	36%
San Gabriel Valley	56	39%	Central Los Angeles	82	38%
South Central Los Angeles	73	26%	East Los Angeles	60	18%
			West Los Angeles	79	33%
Southeast Los Angeles County	36	38%	Long Beach	42	35%
			San Fernando Valley	56	43%
Glendale-Burbank	15	60%			

(3) Finally, a random sample of agencies not responding was called and asked why they had not. No pattern emerged. Reasons varied from, "If the government would quit spending money studying our problems and use it to support worthwhile programs. . ." to promises (not kept) to return the questionnaire forthwith to, "We get so many of these we only respond to every tenth one and you just don't happen to be the tenth."

In view of both the literature of survey research and the tests made, we conclude the primary bias about which there should be concern stems from the underrepresentation of South Central and East Los Angeles.

Use of Statistical Tests

Tests of statistical significance were not used for the data because of the problem in defining the population and the biases noted in the sample, as well as because of the nature of this study. The purpose of the study is exploratory in the fullest sense of the term. There were neither existing studies nor theory about this population or even closely related to this population upon which one could draw. Hence the study could not be conceived of as confirmatory, that is, one in which statistical tests are used to refine or further validate what is already believed to be true.[3] While it would certainly be desirable to know whether the associatio suggested by examining the survey data are a product of chance, the preconditions of such confirmatory analysis are not met in this case.

On the other hand, the Board needs more than impressionistic information with which to identify policy issues. This purpose can be served

3. For a fuller discussion of this problem in an analogous context and in social science research in general, see Seymour M. Lipset, et al., Union Democracy (Glencoe, Ill.: The Free Press, 1956), Appendix I, Methodological Note, esp. pp. 427-28, 430-32.

through nonstatistical analysis of the survey data, along with the other information contained in the study that was not based on the survey.

The objectives of this study, then, are met by using the survey data as a basis for developing hypotheses about the agencies in the population in order to make inferences about the larger policy system of which these agencies are a part. Therefore, the second through ninth sections of "Agency Characteristics, Capabilities and Needs," of this Report should be viewed (1) as accurate descriptions of the 201 responding agencies, but (2) as hypothesis about the 640 agencies which constitute the population, bearing in mind the underrepresentation of two important geographical areas.

AGENCY CHARACTERISTICS, CAPABILITIES, AND NEEDS: ANALYSIS OF SAMPLE SURVEY DATA

DEFINITION OF TERMS

There are five general categories of service: (a) community centers, (b) residences, (c) referral, counseling, and outreach, (d) youth, drugs, and education, and (e) hotlines. Within each of these are specific kinds of services, each of which may be offered in all three of the program areas: alcohol and drug abuse, and juvenile delinquency prevention.

Community Centers

Such centers may work with drug abusers, alcoholics, or youth; some centers work with all three. Many centers work with families, and thus encounter these as well as many other problems. The size and type of staff varies with the type of services provided. Generally there is a director with full- or part-time secretarial, social work, recreational and (or) counseling staff.

One of the principal functions of community centers is liaison between individuals and the services they need. These centers are quite involved with their clients and communities. In many cases they provide transportation, or, if the need is communitywide, they bring the service to the community, e.g., a tuberculosis testing clinic.

The direct services provided vary, but usually include recreation and craft activities, cultural enrichment and education programs, clubs for adults and youth, remedial education and tutoring, and social casework or counseling. Many serve as centers for community organization and provide a meeting place for members of the community to use for many purposes.

Community centers may be housed in churches, in buildings originally intended for industry, or in structures the centers have built with their own funds.

Residence Services

There are a variety of residence services in the three program areas; these services can best be understood if discussed individually by program area.

Alcoholism. One of the major means of treating alcoholism in the county is the recovery home. A few are very large hotels that have been renovated to provide residence, counseling, social work and (when possible) job placement services to men and to some women. Most recovery homes are small, housing 10 to 20 people, and most are for men. They exist primarily on the public assistance subsidies received by their residents. Some residents work and contribute part of their salaries, and some incomes are received from donations. Treatment varies with the philosophy of the home. Most do not provide direct medical services but have made arrangements to make public or private facilities available to their residents.

Recovery homes are of two types: in one the client lives and works; the second is somewhat like a half-way house, in which the client does not live but spends time working or in other activities. Most recovery homes are the second type. The kind and size of staff depends on the size of the home, as well as on the services provided. Few homes have their own professional staff.

A few psychiatric hospitals or psychiatric wings of hospitals provide short-term residential treatment for those alcoholic patients who have received the hospital's detoxification services. A few hospitals and convalescent homes specialize in providing residence and treatment for alcoholics; such homes are very expensive. However, most recovery homes are free or a charge is made in accordance with a resident's ability to pay.

The attitude of hospitals is quite clinical: the resident is a patient to be treated, not a member of a household. However, many recovery homes rely on the participation of residents in the total support of the home—economic, psychological, and emotional. Recovery homes consider such participation and the mutual support of the residents, in a family-like setting, to be part of their treatment. The fact that most recovery homes are in old houses that have been renovated contributes to familial atmosphere.

Drug abuse. With the striking exception of one or two very large programs, drug abuse residence programs are fairly small. Most are of the half-way house type. The majority of their residents work outside the house and return in the evening for counseling sessions, for other forms of treatment, and to perform household obligations. Many require a resident to remain at the house full-time during an initial period, working and joining in treatment activities. Several of the half-way houses add a third step to their programs: those residents who have left the house to live on their own are allowed to, or in some cases are asked to, return several nights a week for continued counseling. This step is an attempt to continue, for people reentering society on their own, the support they felt while they were in the house. After this third step, ex-residents are often encouraged to return whenever they wish. Most houses provide crisis intervention help—help to the addict or user when he needs immediate counseling or medical treatment. A few perform detoxification; however, most houses contract with public or private hospitals for this service.

In many cases the staff includes residents who have gone through treatment and remained as members of the staff. Such programs seem to be quite solvent, since many receive federal funds.

Community pressure has been a problem for many of the residences for drug abusers. Other residents of communities where there are half-way houses may fear the house members and feel that the house will only damage the community's image or property values. Some fear the effect of contact between house residents and community children. In some places zoning regulations have been changed to preclude such a residence. In other cases more subtle forms of pressure, e.g., threatening phone calls to house members and (or) supportive community members, have caused houses to close.

Besides in-depth counseling of all kinds, some residences themselves provide and others act as liaison in the provisions of services—legal aid, job counseling and placement, educational counseling, and many other types of referral. These residences, too, provide a home-like, supportive atmosphere, with the expectation that all residents will participate fully in all aspects of the program.

Juvenile delinquency prevention. There are a variety of homes for small groups of juveniles, scattered throughout the county. Some, for young people who are considered already delinquent, are treatment-oriented in the sense of rehabilitation. Others, directed more toward prevention; they harbor homeless children and children whose own homes are not suitable. Such children may have behavioral and psychological problems. The staffs of homes for juveniles include many paraprofessionals and some professionals. Whenever possible the children attend public schools.

Referral, Counseling, and Outreach

These services cut across program areas. Most agencies that offer referral, counseling, and outreach services advertise themselves as mental health centers, counseling centers, and psychiatric clinics, and charge for their services. They do not offer medical treatment. There are various free clinics, that do offer medical treatment, which would be included in this category because their philosophy is otherwise similar to that of the clinics and centers which charge for their services.

A few referral, counseling, and outreach programs are quite large and attached to large hospitals. Others were set up with federal funds as community mental health centers. A large association of family service agencies is included in this service category. Funding is from a variety of sources and all receive client fees if possible.

All counseling, referral, and outreach operate on a walk-in basis. Clients find the centers themselves or are referred to them by other agencies, both public and private. Some centers have staff capability to serve several thousand clients a year but most serve only a few hundred because of the length of much psychological treatment. Most emphasize working with children and their families, some only with youth, and a few with alcoholics and their families. Some provide follow-up services, but most do not have the staff to do so.

Approaches vary. Some agencies provide only social casework. Many have professional, paraprofessional, and volunteer staff who have a wide variety of skills to meet the variety of problems encountered. When they cannot meet a person's needs they try to refer him to an agency that can. Almost all of these agencies participate in community education and reach

out into the larger community to educate the general public about the problems they work with and the services they provide.

A few agencies specialize in community outreach and education regarding mental health and alcoholism.

Youth, Drugs and Education

Some agencies are involved in drug treatment but offer neither residence nor hotline-referral services. These agencies provide crisis intervention counseling, group and individual therapy, various kinds of community educatio and referral, but only as these services are needed by young people involved with drugs. One agency provides interim education so that young people can finish school; another emphasizes family counseling so that the problem is dealt with openly and realistically by each family member. Others are deeply involved with their city governments, attempting to include drug education in the schools for staff as well as for students.

The facilities and staff of these agencies vary tremendously. Most are small in size and consider this to be a factor of success, a means of dealin with the problems of youth in drugs more realistically.

Hotlines

A service that has emerged in recent years is the hotline, or helpline. It is usually a part of an existing service, and is sponsored by churches, drug programs, a few hospitals, community centers, and free clinics.

The staff are usually volunteers, most of whom have been given some degree of training in crisis intervention counseling. Their budgets are very small. Only one of the many that have responded to this study pays all staff members. Many operate on a 24-hour basis; some are available only at certain hours of each day or night.

Their primary service is on-the-spot counseling and listening to people who call. The problems vary from housing needs to potential suicides. Many hotlines also try to refer people to in-depth agencies that might be of help.

SUMMARY OF SERVICES[4]

The private agencies that responded to the mailed questionnaire appear to be strongest in the following service areas: counseling, referral, crisis intervention, recreation, community education, follow-up, psychological testing, out-patient care, remedial reading, and cultural enrichment. Three of the ten services most demanded—job counseling, detoxification, and emergency shelter—do not fall within the ten most frequently provided services. Six of the ten most wanted additional services fail to appear among the ten most frequently provided services: job counseling, legal aid, self-help programs, big brother programs, half-way houses, and emergency shelter facilities.

Service patterns and perceived needs vary among agencies with different program emphases. Those agencies which emphasize juvenile delinquency prevention programs most frequently provide follow-up, remedial reading, big brother, and referral services. Such agencies feel the need of additional services most strongly in the areas of big brother relationships, legal aid, follow-up, and remedial reading. Agencies that emphasize drug abuse programs most frequently provide follow-up, legal aid, and cultural enrichment services. Their greatest needs are for additional services in follow-up, legal aid, and big brother relationships. Agencies concerned with alcoholism most frequently provide self help, big brother programs, and follow-up services; they want additional services in legal aid, follow-up, and job counseling.

With respect of selected services: 78% of the agencies emphasizing alcoholism programs ranked detoxification as very important to their programs, followed by fast diagnosis (70%), reliable follow-up (68%), half-way houses (60%), and crisis intervention (60%). These data, coupled with the information above about additional services wanted, identify reliable follow-up as among the most important and needed services in alcoholism programs. Of the

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4. The reader is cautioned to bear in mind the limitations of these data discussed in "Methodology and Procedure," pp. 11-17, supra.

agencies emphasizing drug abuse programs, 73% ranked reliable follow-up as very important to their programs, followed by fast diagnosis (69%), half-way houses (60%), detoxification (58%) and crisis intervention (58%). Because follow-up was mentioned as the most wanted additional service and is ranked as most important to success in drug abuse programs, follow-up can be viewed as both the most important and the most needed service in the area of drug abuse. Of the agencies emphasizing juvenile delinquency prevention programs 55% ranked reliable follow-up as very important to program success, followed by crisis intervention (52%), fast diagnosis (48%), half-way houses (45%) and detoxification (27%). As in the case of drug abuse programs, follow-up was cited as most important by a majority of responding agencies and most needed additional service by a majority of responding programs. In all three program areas, these data suggest follow-up to be the single most needed and important service.

There was no similar agreement with respect to the need for a centrally based clinical record service.

SUMMARY OF CLIENTS SERVED

While the average number of clients served by all agencies is 5,400, half of all agencies regardless of program emphasis or size of budget serve 500 or fewer clients. Of these agencies a third operate on small budgets ($50,000 or less last year) and many (44%) have been in existence three years or less.

SERVICES

Existing Services

The services provided by, demanded of, and desired by the 201 agencies are presented in Table 1. The four services most commonly provided are counseling (157 agencies), referral (145 agencies), crisis intervention (106 agencies), and recreation (97 agencies). Agencies did not respond as frequently to the question about the services most demanded of them as

Table 1

SUMMARY OF SERVICES PROVIDED, DEMANDED OF, AND MOST DESIRED BY RESPONDING AGENCIES*

	Services Provided	%	Services Most Demanded	%	Additional Services Wanted	%
1. Psychological testing	75	37	17	9	41	20
2. Counseling: individual and group	157	78	61	30	35	17
3. Crisis intervention	106	53	39	19	50	25
4. Medical evaluation and care	52	26	15	8	33	16
5. In-patient care	54	27	17	9	19	10
6. Emergency shelter	16	8	19	10	41	20
7. Half-way house	38	19	15	8	43	21
8. Out-patient care	72	36	27	13	34	17
9. Methadone	6	3	13	7	15	8
10. Detoxification	26	13	25	12	31	15
11. Community education	92	46	25	12	74	37
12. Job counseling, etc.	61	30	26	13	60	30
13. Referral	145	72	23	11	32	16
14. Recreation	97	48	17	9	35	17
15. Cultural enrichment	61	30	11	6	36	18
16. Remedial reading	65	32	22	11	46	23
17. Self-help	45	22	14	7	35	17
18. Follow-up	79	39	26	13	61	30
19. Legal aid	32	16	11	6	52	26
20. Big brother	28	14	12	6	47	23

* % refer to % of the 201 agencies offering, demanding, or desiring a particular service.

they did to the question about the services they provide. The service most demanded of responding agencies (61 agencies, or 30%) as well as most provided (157 agencies, or 78%) was counseling. Other services demanded of the agencies, though no service was demanded by more than 20% of the agencies, include crisis intervention (39 agencies, or 19%), out-patient (27 agencies, or 13%), follow-up and job counseling (each by 26 agencies, or 13%). More agencies responded to the question about additional services wanted than to that about services most demanded. The most wanted services include community education (74 agencies, or 37%), job counseling (60 agencies, or 30%), follow-up (61 agencies, or 30%), legal aid (52 agencies, or 26%), and crisis intervention (50 agencies, or 25%).

Table 2 provides a rank ordering of the first ten services in each category and provides a useful overall summary of agency capabilities, their assessment of client demand, and their priorities for additional services needed. The additional service most wanted is community education; it is seventh on the list of perceived demand and fifth on the list of services now provided. Job counseling, second in priority of services wanted, is fourth on the list of perceived demand and does not appear on the list of the ten most provided services. The table also suggests that counseling and referral needs are being pretty well served. Fairly extensive crisis intervention services are being provided, and they are also in high demand; the appearance of this service as fifth on the list of most desired additional services suggests that the demand still is not being met. On the other hand, the recreational services provided are substantial and apparently are meeting the demand. Because of the low response rate for services most demanded and services most wanted, these data would be viewed only as a starting point for assessing needs in relation to demands and to existing capabilities.

Services Provided By Agency's Most Emphasized Program

Comparison of the services provided by each agency's most emphasized program indicates that the juvenile delinquency programs provide the widest array of services, followed by drug and the alcohol programs. The 78 delinquency prevention programs provide follow-up and remedial reading most frequently, plus big brother and referral services. The 32 drug abuse programs provide follow-up, legal aid, and cultural enrichment most

Table 2

RANK ORDERING OF SERVICES

	Provided	Most Demanded	Most Wanted
1.	Counseling	1. Counseling	1. Community education
2.	Referral	2. Crisis intervention	2. Job counseling
3.	Crisis intervention	3. Out-patient care	3. Follow-up
4.	Recreation	4. Job counseling	4. Legal aid
5.	Community education	5. Follow-up	5. Crisis intervention
6.	Follow-up	6. Detoxification	6. Self-help
7.	Psychological testing	7. Community education	7. Big brother
8.	Out-patient care	8. Referral	8. Half-way house
9.	Remedial reading	9. Remedial reading	9. Psychological testing
10.	Cultural enrichment	10. Emergency shelter	10. Emergency shelter

frequently. The 20 alcoholism programs offer self-help, big brother, and follow-up services. Those agencies offering services in all program areas provide follow-up and referral most frequently.

The 49 juvenile delinquency programs responding perceived the following services as most demanded of them: big brother, remedial reading, recreation out-patient, crisis intervention, and follow-up services. The 34 drug abuse programs perceive detoxification, follow-up, and legal aid as most demanded. The 23 alcohol programs see a need for detoxification.

Comparison of the additional services wanted by each agency's most emphasized program shows that of the 62 delinquency prevention programs responding, the most desired service is big brother relationships, followed by legal aid, follow-up, and remedial reading services. This list is quite similar to the list of services that these agencies stated were most provided and demanded. The 29 drug abuse programs responding stated that they want follow-up, legal aid, and big brother services. This also parallels the lists of services provided and are most demanded. The 19 responding alcoholism programs want legal aid, follow-up, and job counseling services.

Importance of Selected Services to Agencies

Respondents were asked to rate the importance of certain services on a scale of 1 = very important to 7 = very unimportant. Of the 186 agencies who responded, 108, or 58%, felt that crisis intervention was important (1 or 2 on the scale). Fifty-seven agencies, or 31%, felt the services were moderately important (3-5 on the scale), 21 agencies, or 9%, felt they were unimportant (6 or 7). Of the 186 agencies rating the importance of detoxification facilities, 85 agencies, or 46%, felt they were very important (1 or 2); 33 agencies, or 18%, felt they were of moderate importance; and 68 agencies, or 37%), felt they were very unimportant. One hundred eighty-five agencies rated the importance of half-way houses and after-care faciliti as follows: 107 agencies, or 55%, felt they were important (1 or 2); 45, or 24%, felt they were moderately important (3-5); and 39, or 21%, felt they were unimportant (6 or 7). Of the 186 agencies who rated the importance of fast and accessible medical diagnostic services, 103 agencies, or 55%, felt they were important services (1 or 2); 46 agencies, or 25%, felt they were moderately important (3-5); and 37 agencies, or 20%, felt they were

unimportant (6 or 7). In rating the importance of reliable follow-up on services provided, 118 agencies, or 63%, felt this was important (1 or 2); 48 agencies, or 26%, felt they were moderately important (3-5); and 20 agencies, or 11%, felt they were unimportant (6 or 7).

In each of the three program areas—delinquency prevention, drug abuse, and alcoholism—the ratings of the importance of certain services are as follows:

The delinquency prevention agencies ranked reliable follow-up, crisis intervention, and fast diagnosis as most important, and detoxification services as least important. (See Table 3.)

Responses of the drug agencies in the sample are as follows: All of the services are considered to be very important to the drug programs with about equal intensity. (See Table 4.)

As is so of the drug agencies, most alcoholism agencies rated all of the services as important. (See Table 5.)

Of the 187 agencies who answered the question about need for centrally based clinical records, 68 agencies, or 36%, said yes; 56, or 30%, said no; and 63 agencies, or 34%, said they were not certain.

CLIENTS

The number of clients they served during the past year was reported by 179 agencies. Half of them see less than 500 clients per year. The average number of clients seen by all agencies is 5,400 per year. Twelve agencies reported serving 20,000 clients. A more specific breakdown is shown in Table 6.

The agencies are fairly evenly grouped by number of clients—there are no observable clusters.

Number of Clients Served by Agency's Most Emphasized Program

Of the 22 alcoholism programs, 16 programs, or 73%, each served 500 clients or fewer last year. Three of them each served more than 20,000 clients. Of the 34 agencies serving drug abusers, 17, or 50% each served 500 clients or fewer. Four served more than 20,000 clients each. Among the agencies with programs for delinquents, there is a fairly even

Table 3

IMPORTANCE OF SELECTED SERVICES TO DELINQUENCY PREVENTION PROGRAMS
(by number of programs)

Rank	Important (1,2)	Moderately Important (3,4,5)	Unimportant (6,7)	Total
1. Reliable follow-up	40	22	10	72
2. Crisis intervention	38	24	11	73
3. Fast diagnosis	35	18	19	72
4. Half-way houses	33	18	22	73
5. Detoxification	20	19	34	73

Table 4

IMPORTANCE OF SELECTED SERVICES TO DRUG ABUSE PROGRAMS
(by number of programs)

Rank	Important (1,2)	Moderately Important (3,4,5)	Unimportant (6,7)	Total
1. Reliable follow-up	24	6	3	33
2. Fast diagnosis	22	6	4	32
3. Half-way houses	21	9	5	35
4. Crisis intervention	19	11	3	33
5. Detoxification	19	4	10	33

Table 5

IMPORTANCE OF SELECTED SERVICES TO ALCOHOLISM PROGRAM
(by number of programs)

Rank	Important (1,2)	Moderately Important (3,4,5)	Unimportant (6,7)	Total
1. Detoxification	18	2	3	23
2. Fast diagnosis	16	5	2	23
3. Reliable follow-up	15	5	2	22
4. Half-way houses	13	6	3	22
5. Crisis intervention	12	5	3	20

Table 6

AGENCIES BY NUMBER OF CLIENTS SERVED

Number of Clients	Number of Agencies	Adjusted Cumulative Percentage
0-65	18	10
66-100	17	20
101-200	19	30
201-360	18	40
361-500	19	51
501-1,000	17	60
1,001-2,000	19	74
2,001-4,000	18	81
4,001-9,999	15	89
10,000-20,000	9	94
20,000 +	10	100

distribution. Thirty-three agencies, or 43%, each served 500 clients or fewer. The 20 agencies giving equal emphasis to all of the programs are less evenly distributed, with only 4, or 24%, each serving fewer than 500 and 4, or 25%, each serving more than 20,000 clients.

Of the alcohol and drug abuse programs, 50% each served 500 or fewer clients each, last year. About 33% of the delinquency programs served 500 or fewer. More than 40% in each program area served fewer than 200 clients each, last year.

Number of Clients and Agency Gross Income

There were 135 agencies who reported both the number of their clients and their gross income. Of the 64 agencies (50%) who served 500 clients or fewer, 21 (33%) each operate on less than $50,000 per year; 8 (12%) each have incomes of between $50,000 and $100,000; 11 (17%) each have between $100,000 and $200,000; 13 (20%) each have between $250,000 and $500,000; and 4 agencies each operate on more than $1 million.

Two other clusters are worth mentioning. Of the 14 agencies serving 4,000 to 10,000 clients, 6 (almost one half) have incomes under $50,000 each. Fifteen agencies each serve more than 20,000 clients, and 7 (again, almost half) each have gross incomes under $50,000. Ten (two-thirds) of the agencies serving more than 20,000 each, per year, operate on less than $100,000 per year.

Comparison of gross income by number of clients by program emphasis reveals the same pattern (with one exception which is discussed in the subsequent section of this report on program finance): regardless of income, most agencies serve 500 clients or less. However, more drug and alcohol abuse than delinquency programs with incomes under $50,000 serve 500 or fewer clients. A significant number of agencies on small budgets serve large numbers of clients.

Clients and Agency Age

The only noticeable pattern revealed by comparison of age of program with number of clients is that of the 89 agencies serving fewer than 500 clients, 39 (44%) of the agencies are less than three years old.

SUMMARY OF AGENCY AGE

Of 198 reporting agencies, 26% have been in existence for 2 years or less, and 52% for 6 years or less. On the other hand, 19 of the agencies are 50 years old or older. Drug abuse agencies are the youngest, followed by alcoholism and juvenile delinquency agencies.

Generally, younger agencies serve fewer clients than do the longer-established ones. Income, however, is not strongly associated with age except in the case of those agencies with budgets in excess of $200,000; a majority of such agencies are over 10 years old. Age seems strongly associated with funding sources. Older, more-established agencies are the primary recipients of United Way support. Younger agencies rely more heavily on client fees, private foundations, fund raising, and public sources, regardless of program emphasis.

AGE OF AGENCY

General Patterns

The length of time that an agency has been in existence is strongly associated with many aspects of the agency's operations. The 198 responses showed that 52 agencies (26%) have been in existence 2 years or less. One hundred and two agencies (52%) have been in existence 6 years or less. The oldest agency is 74 years old, yet there are only 19 agencies (18%) that are over 50 years old. It appears that most of the agencies are quite new, and therefore not firmly established.

Agency Age and Agency's Most Emphasized Program

Table 7 summarizes the 154 responses regarding the age of the agency in relation to the agency's most emphasized program.

The drug abuse agencies are the youngest, since 17 (50%) are less than 2 years old and the 50% point occurs in delinquency agencies between 11 and 19 years of age and in alcoholism agencies at 10 years of age. Sixty-seven agencies (44% of all of the agencies above) are less than 5 years old. There is a cluster of 52 agencies (34%) between 11 and 50 years

Table 7

AGENCY AGE, BY PROGRAM EMPHASIS

	Juvenile Delinquency	%*	Drug Abuse	%	Alcohol	%	Equal Emphasis	%
2 years or less	10	13	17	50	7	32	6	30
3-5 years	13	17	8	24	2	9	4	20
6-10 years	8	10	3	9	2	9	4	20
11-19 years	12	15	4	12	6	27	2	10
20-50 years	20	26	1	3	5	23	2	10
50-74 years	15	19	1	3	-	-	2	10

* Column percentages are calculated for each program area.

of age; they are predominantly juvenile delinquency prevention (32) and alcoholism (11) agencies. Only 18 agencies (12%) are over 50 years old, of which 15 are delinquency prevention agencies. Of the 34 responding drug abuse agencies, one half are 2 years old or less and only 2 are more than 20 years old. The agencies emphasizing all the programs equally follow a pattern similar to that of the drug abuse agencies: 6 (30%) are less than 2 years old and 2 (10%) are over 20 years old.

Agency Age and Agency Client Population

There is an even spread of agencies throughout the sample, when comparison is made of the number of clients who used a service in the past year and the number of years the agency has been in existence. Eighty-nine of the 196 agencies (45%) each serve fewer than 500 clients per year. Thirty-nine, or 43%, of these 89 are less than 3 years old. Generally, those agencies which are new serve fewer clients than do the older ones.

Agency Age and Income

Interestingly, an agency's income is not strongly associated with its age. Sixty-nine (52%) of the 135 responding agencies operate on budgets of less than $100,000, and 45 (65%) are 10 years old or younger. Of the 43 agencies operating on budgets in excess of $200,000, 27 (62%) are over 10 years of age.

Older, more-established agencies seem to be the primary recipients of United Way funds. Of the 54 agencies who reported that they receive all or part of their funds from United Way, 14 (26%) are less than 10 years old. Thirty-one of the 54 agencies (57%) are 20 years or older. Of the 20 agencies who receive 50% or more of their funds from United Way, 11 are over 20 years old. In striking contrast to the fact that 52% of all agencies in the sample are 6 or fewer years old, United Way contributed more than 50% of the funds of 11 (of 20) agencies over 20 years old.

A summary of percentage of income from client fees by age of program is shown in Table 8.

Younger agencies, 38 out of the 88 (43%) tend to rely more on client fees than do older ones. Of those 38, 14 (37%) receive 100% of their income from this source. Thirty-two agencies (36%) receive 25% or less

Table 8

PERCENTAGE OF AGENCY INCOME FROM CLIENT FEES, BY AGE OF AGENCY

	1-10 years	11-30 years	31-50 years	50-74 years	Total
1-25%	11	7	6	8	32
26-50%	5	3	-	2	10
51-75%	4	4	1	1	10
76-99%	4	4	2	1	11
100%	14	8	2	1	25
	38	26	11	13	88

from client fees, which is the largest percentage group and is followed by the 25 agencies receiving 100%.

Analysis of the percentage of funds an agency receives from private foundations by the number of years the agency has been in existence shows that the younger agencies (1 to 10 years old) receive more funds from foundations (43%) than do the older agencies. Three fourths (72%) of the agencies receiving foundation support receive 25% of their income, or less, from foundations. This is shown in Table 9.

Comparison of the percentage of funds raised by the agency with the age of the agency indicates that 39 agencies less than 10 years old obtained more funds from agency fund raising efforts than did older agencies. Fifty-seven percent of 47 out of 82 agencies receiving income in this manner received 25% of their budget, or less, in this manner, as shown in Table 10.

Of the 17 agencies responding that they receive funds from local or county tax revenue, 3 receive 25% or less, 3 receive 26-50%, 3 receive 51-75%, and 5 receive 76-99%. Three receive 100% of their income from tax revenue. Eleven of the 17 agencies (64%) are less than 10 years old.

Table 11 presents the percentage of funds received from federal grants or contracts, by the age of the agency. Thirty-three of the agencies (73%) receiving funds from federal grants or contracts are less than 10 years old. All agencies receiving 26-50%, 76-99%, and 100% of their funding from federal sources are less than 10 years old.

Table 9

PERCENTAGE OF AGENCY INCOME FROM PRIVATE FOUNDATIONS, BY AGE OF AGENCY

	1-10 years	11-30 years	31-50 years	50-74 years	Total
1-25%	11	7	2	11	31
26-50%	4	-	-	-	4
51-75%	-	-	-	-	-
76-99%	3	-	-	-	7
100%	-	-	-	-	-
	18	7	2	11	42

Table 10

PERCENTAGE OF AGENCY INCOME FROM AGENCY FUND RAISING, BY AGE OF AGENCY

	1-10 years	11-30 years	31-50 years	50-74 years	Total
1-25%	18	15	5	9	47
26-50%	10	3	4	3	20
51-75%	3	2	-	2	7
76-99%	6	-	-	-	6
100%	2	-	-	-	2
	39	20	9	14	82

Table 11

PERCENTAGE OF AGENCY INCOME FROM FEDERAL SOURCES, BY AGE OF AGENCY

	1-10 years	11-30 years	31-50 years	50-74 years	Total
1-25%	4	5	2	1	12
26-50%	4	-	-	1	5
51-75%	14	2	1	-	17
76-99%	2	-	-	-	2
100%	9	=	=	=	9
	33	7	3	2	45

SUMMARY OF AGENCY SKILL PATTERNS

Skill Patterns

Three quarters of all responding agencies reported that all of their staff have had some training. For the most part, this training is informal: almost half of them report six or more staff with only informal training. One third reported employing no staff with administrative or managerial training. Those who do employ trained administrative staff seldom employ more than one such person. Of the responding agencies, 83% employ persons with some professional or academic training. Only 35% employ former addicts or delinquents. Juvenile delinquency agencies tend to have more staff with training in all categories.

Skill Needs

Need for more informal training was mentioned most frequently, followed by training in general counseling, community organization, and methods of drug prevention. Juvenile programs report the greatest range of training needs, mentioning general counseling most frequently. Drug abuse agencies emphasize the need for informal training, while alcohol abuse agencies report the fewest training needs.

SUMMARY OF AGENCY STAFFING PATTERNS

General

Of 198 responding agencies, 114 employ either no one or only one person as full-time manager or administrator, 96 have either no one or only one full-time professional, 126 have either no one or only one full-time paraprofessional, 120 have either no one or only one full-time support or clerical personnel, and 155 have either no one or only one full-time volunteer. The mode, then, is very few full-time personnel in all job categories. At the other extreme, there are 20 to 30 agencies

(depending upon the job category reported) who report 6 or more full-time staff in each category. Most agencies also use very few part-time staff.

These patterns do not vary much with program emphasis, although delinquency programs are better staffed and drug programs are the least staffed in all categories. Staffing patterns are not related to income other than in a quantitative way, that is, the greater agency income, the higher the level of staffing.

Paraprofessionals

One hundred and forty-five agencies use paraprofessionals. Their greatest use is in drug programs, followed by delinquency programs. Paraprofessionals are most frequently assigned to counseling duties. Counseling is also the most frequently mentioned need for additional paraprofessionals.

SKILL AND STAFFING PATTERNS

Present Skills Levels

Seventy-seven percent of the agencies indicated that all of their staff had had some form of training. Training is varied, and is summarized in Table 12.

Most staff training is informal, that is, previous experience or on-the-job training. The median number of staff with prior or on-the-job training is 5.9 and 47% of the responding agencies have 5 or fewer staff with such informal training. One hundred and sixty-seven agencies (91%) have 5 or fewer staff members with managerial or administrative training, the lowest level of the five categories. Agencies with professional or academic training are fairly evenly spread throughout the categories: 32 agencies (17%) report no staff with such training and 20 agencies (13%) employ more than 21. Almost two thirds of the agencies (62%) have no staff who are former clients (addicts or delinquents), and of 35% who do, 25% employ 5 or fewer. Seventy-seven percent of the reporting agencies have employees with some training. Of the agencies which do use untrained personnel, most (26) employ 5 or fewer.

Table 12

EXISTING SKILL PATTERNS, BY NUMBER AND PERCENTAGE OF AGENCIES REPORTING

Number of Employees	TYPE OF TRAINING											
	Prior Experience or On-the-Job Training		Managerial or Administrative		Professional or Academic		Former Client		No Experience or Training		Other	
	Agencies		Agencies		Agencies		Agencies		Agencies		Agencies	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
0	41	22	64	35	32	17	113	62	141	77	173	94
0 - 5	47	25	103	56	74	40	43	24	26	14	7	4
6 - 20	50	27	12	6	55	28	14	7	13	7	2	1
21 +	40	21	1	5	20	13	8	4	4	2	1	-
Total	178	95	180	98	181	98	178	97	185	100	183	99

Note: Some percentage figures do not total 100% because some agencies reported "some" instead of a number of employees in a training category.

Skill by Program Emphasis

Sixty-nine of the 137 agencies in the sample (50%) have 6 or more employees with prior experience or on-the-job training. Of the 69, 38 (55% are delinquency prevention agencies. Thirty-two agencies (23%) employ no staff with only informal training. Using the same form of comparison but substituting managerial or administrative training, one-third of all agenci (47 out of 140) employ no staff with this background of training. Almost one-third of the remaining agencies (42 out of 93) employ only one staff member in this category. Of these agencies, 18 emphasize delinquency prevention, 11 drug abuse, 6 alcoholism, and 7 give equal emphasis to all three programs. Only 10 agencies (7%)—6 delinquency and 4 drug abuse agencies—employ more than 16.

Of the 140 agencies reporting staff with professional or academic training, 56 agencies (40%) employ more than 6; 35 (62%) emphasize delinque 11 (20%) are drug programs, and 9 (16%) give equal emphasis to all three programs. Twenty-eight agencies (20%) employ between 3 and 5 professionals, 12 (43%) are delinquency and 11 (39%) are drug abuse programs. Twenty-thre agencies (16%) employ no professional staff; of these, 10 (43%) are delinquency programs and 9 (39%) are alcoholism programs.

Of 135 responding agencies, 83 (60%) reported no delinquents or former addicts on their staff. Of these, 51 agencies (61%) were delinquency programs and 15 (18%) give equal emphasis to all three programs. Eighteen agencies (13%) hired more than 6 former clients; of these, 10 agencies (56%) emphasize drug abuse programs. One hundred and twelve (79%) of 142 responding agencies which can be classified by program emphasis reported all of their staff as having had some form of prior training. Twelve agencies (9%) employ more than 6 who have no experience and 8 of these agencies (67%) are in delinquency prevention programs.

Training Needs

One hundred and thirty-five agencies responded to the question about the types of training needed by staff in their agency. One hundred and twenty-three (94%) reported further skill needs, and mentioned 25 different kinds of desired training. Twenty-four agencies (18%) mentioned general informal training and 12 agencies (9%) mentioned general counseling. The

remaining 23 categories of training need varied from behavior modification (1%) to community organization (47%) and drug use prevention (5%). The similarities among the kinds of skills needed and the role previously mentioned[5] with respect to paraprofessionals is striking. This pattern may indicate that professionals need relief from many of their existing duties, so they may perform those for which they are trained, leaving the remainder for staff trained as paraprofessionals.

Table 13 summarizes the types of training mentioned by agencies with different program emphases. Only those categories mentioned by at least 5 respondents are included. The data show the delinquency prevention programs have more needs than do the drug, alcohol or those programs giving equal emphasis to all programs. Delinquency prevention needs are primarily for general informal training. The drug abuse programs also mentioned the need for general informal training frequently. The alcohol abuse programs did not indicate any strong preferences for needs, nor did the combination programs.

Staffing Patterns

To the questions asking for a breakdown in staff, 198 agencies responded. The totals by size of staff and by numbers of agencies are shown in Table 14.

One hundred and fourteen agencies have either none or only one full-time administrative staff member, 96 have none or only one full-time professional, 126 have none or only one full-time paraprofessional, 120 have none or only one full-time support or clerical staff, and 155 have none or only one full-time volunteer. At the other extreme, there are 20-30 agencies with 6 or more full-time staff in several skill categories.

Most agencies have no part-time staff of any kind. Of the 198 that responded, 157 have no part-time administrative, 118 no part-time professional, 122 no part-time paraprofessional, 127 no part-time clerical, and 103 no part-time volunteer staff.

The number of staff employed in each job category by agencies in each type of program are presented in Table 15. The percentage of agencies in each program category reporting one or more staff in each job category is

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Table 13

SUMMARY OF PERCEIVED TRAINING NEEDS,
BY AGENCY'S PROGRAM EMPHASIS

	Number of Mentions			
	Alcohol	Drug	Delinquency	Equal Emphasis
1. Formal classwork	-	-	5	-
2. Social work	-	1	3	1
3. General informal training	2	5	12	1
4. Communication	1	1	3	-
5. Group leadership	-	-	3	-
6. Community organization	2	1	1	-
7. Administration	-	3	3	-
8. Helping services	-	-	5	-
9. General counseling	1	2	4	2
10. Group therapy	-	1	2	2
11. Drug use prevention	1	2	-	1
Total Mentions	7	16	41	7

Table 14

FULL- AND PART-TIME AGENCY EMPLOYEES, BY SIZE OF STAFF

Size of Staff	Administrative or Managerial		Professional		Support or Clerical		Paraprofessional		Volunteers	
	Full-time	Part-time	Full-time	Part-time	Full-time	Part-time	Full-time	Part-time	Full-time	Part-time
0	5	157	75	118	81	127	105	122	148	103
1	64	122	21	14	39	35	21	11	7	7
2	34	9	19	10	18	10	4	9	5	6
3-5	33	3	39	23	26	11	22	25	5	16
6+	13	5	44	30	32	12	44	28	25	50
Total Agencies Responding	196	196	198	195	196	195	196	195	192	190

Table 15

FULL- AND PART-TIME AGENCY EMPLOYEES, BY PROGRAM EMPHASIS AND SIZE OF STAFF

Size of Staff	Managerial		Professional		Paraprofessional		Clerical		Volunteer	
	Full-time	Part-time	Full-time	Part-time	Full-time	Part-time	Full time	Part-time	Full-time	Part-time
	Alcoholism Programs									
0	4	20	10	18	10	20	16	19	19	17
1	10	-	6	2	3	-	1	3	0	1
2	2	1	2	-	1	1	2	-	1	1
3,4	4	1	4	1	4	-	1	-	1	2
5+	1	-	0	1	2	1	2	-	1	-
Total Agencies	21	22	22	22	20	22	22	22	22	21
	Drug Abuse Programs									
0	9	25	14	17	16	19	16	17	24	18
1	11	5	5	2	4	2	6	5	2	-
2	6	-	4	5	-	1	2	3	1	2
3,4	4	-	4	5	5	7	4	5	2	5
5+	4	3	7	4	9	4	6	3	5	8
Total Agencies	34	33	34	33	34	33	34	33	34	33

Table 15 (continued)

Size of Staff	Managerial		Professional		Paraprofessional		Clerical		Volunteer	
	Full-time	Part-time	Full-time	Part-time	Full-time	Part-time	Full-time	Part-time	Full-time	Part-time
	Delinquency Prevention Programs									
0	16	68	26	51	38	43	20	48	58	36
1	22	6	4	3	10	6	16	18	3	3
2	20	1	4	3	1	4	9	2	1	2
3,4	13	-	23	6	7	10	16	4	3	5
5+	6	1	20	12	21	13	16	3	11	24
Total Agencies	77	76	77	75	77	76	77	75	76	70
	All Programs Equally Emphasized									
0	9	14	8	6	14	15	7	12	16	11
1	6	3	-	3	2	1	8	5	1	1
2	3	2	4	1	1	1	1	2	-	-
3,4	2	-	4	5	1	2	1	-	1	1
5+	-	1	4	5	2	1	3	1	1	7
Total Agencies	20	20	20	20	20	20	20	20	18	20

presented in Table 16. These tables suggest that staff patterns are similar regardless of the agency's program emphasis, with few notable exceptions. However, inspection of the more detailed data on employees by size of staff suggest that delinquency programs tend to report the greatest numbers of staff in all categories. Juvenile delinquency agencies report a greater use of professionals and clerical workers. Fewer alcohol programs report staff in all categories except for managerial. Multipurpose programs report the fewest incidence of managerial paraprofessionals and volunteer categories. Interestingly, of the agencies participating in this study, those emphasizing alcoholism programs depend the least on part-time staff, while drug abuse programs depend upon them the most. Drug abuse and delinquency programs depend most heavily upon volunteers.

The Number and Use of Paraprofessionals

Of the 201 agencies, 145 use paraprofessionals in some way as part of their staff. Of the 22 alcoholism agencies, 11 (50%) have paraprofessionals, as do 30 (89%) of the 34 drug abuse agencies and 52 (67%) of the 77 delinquency prevention agencies. The balance of the programs with paraprofessional staff emphasize all program areas equally or in some combination, e.g., drug abuse and delinquency.

Paraprofessionals function as counselors in 50 agencies, providing assistance as general counselors in 32, group counselors in 9, peer group counselors in 4, family counselors in 3, and individual counselors in 2. Eleven agencies have paraprofessionals providing some form of medical care, and in another 14 they direct recreational activity.

Of the 11 alcoholism agencies, 4 use paraprofessionals for counseling, 1 as administrators, 2 to provide medical care, 1 in a residential facility, and the duties of others were not mentioned.

Of the 30 drug abuse agencies, 14 use paraprofessionals for counseling, 3 in medical care, 2 for clerical help and many agencies use them to fill a variety of other functions.

Of the 52 delinquency agencies, 18 use paraprofessionals as counselors. Other major uses are 5 in residential facility, 4 in medical care, 3 each in recreational activity, at daycare programs, as teaching aides, and as community organization aides.

Table 16

PERCENTAGE OF FULL- AND PART-TIME AGENCY STAFF, BY SKILL AND PROGRAM EMPHASIS

Program Emphasis	Managerial		Professional		Paraprofessional		Clerical		Volunteer	
	Full-time	Part-time	Full-time	Part-time	Full-time	Part-time	Full-time	Part-time	Full-time	Part-time
Alcoholism	80	9	55	18	50	9	27	14	14	19
Drug abuse	74	24	59	48	53	42	53	48	30	45
Juvenile delinquency	79	10	66	32	51	43	74	36	34	43
Equal emphasis	55	30	60	70	30	25	65	40	11	45

Other Needs for Paraprofessionals

Only 75 agencies mentioned other needs for paraprofessionals. Eight of them mentioned general counseling; 4 each mentioned medical care, social work, and group counseling. Beyond these, no significant number of agencies reported specific needs for paraprofessionals.

Staffing Patterns and Agency Gross Income

A comparison of 115 agencies' responses to questions about gross income and number of full- or part-time staff indicates that agencies with higher incomes have more full- and part-time clerical and full-time volunteer staffs. Forty-one percent of the agencies which have full-time staff members have annual incomes of less than $150,000. Of 64 agencies reporting part-time volunteers, 26 (41%) have incomes under $50,000. Three-fourths of the agencies with full-time volunteers have incomes between $100,000 and $250,000. Eighty-two percent of the agencies with part-time volunteers have incomes under $50,000.

SUMMARY OF AGENCY FINANCES

General Patterns

Median income of all reporting agencies is $97,600 per year. Thirty-eight percent of all agencies have incomes of $50,000 or less and 5 agencies have incomes over $1 million. A majority of agencies charge fees of their clients. Other sources of revenue, in order of the frequency of their mention, are: fund raising, United Way, federal grants, private foundations and local or county tax revenue.

Patterns by Sources of Income

Most agencies receiving funds from United Way or private foundations report that such sources account for less than 25% of their income. Almost one quarter of the agencies depend solely upon client fees. Fund raising generates only a modest amount of revenue for those agencies which attempt

it. A majority of agencies receiving governmental support (federal and local) get more than half of their income from such sources.

Patterns by Program Emphasis

Delinquency prevention agencies receive a larger percentage of their incomes from United Way, private foundations, and public sources than do drug abuse and alcoholism programs. Most drug agencies gain most of their income from federal sources, client fees, and fund raising. Most alcoholism programs gain the majority of their revenue from client fees.

Federal Support

Approximately half of all responding agencies have applied for federal funds. A greater percentage of the drug programs (69%) than of delinquency (48%) or alcoholism (24%) programs have applied. Over half of these agencies (regardless of program emphasis) are young ones (in existence for five years or less). Most frequently mentioned problems in gaining funding are: lack of knowledge of sources and policies and lack of expertise in preparing proposals. Problems in gaining federal funds seem to be associated with staffing patterns. Generally, agencies with full- or part-time administrative, professional, or paraprofessional staff members mention fewer problems than those with primarily clerical or volunteer staffs.

Funding Adequacy

More than half (52%) of all agencies reported they were either not sure of the adequacy (17%) or that current income was inadequate (35%) to meet costs. More drug abuse agencies (61%) reported their incomes to be adequate than did alcoholism (45%) and delinquency (41%) agencies. In the event of a budget deficit, all agencies tended to favor similar remedial steps: seek additional or emergency funds, reduce services, and (or) defer services in the planning stage. On the other hand, the primary uses to which additional revenues would be put are: new facilities, research on problem areas, expanding present programs or services, additional programs or services, additional staff and increasing staff salaries, and purchasing supplies and equipment.

Income and Staff:

Income does seem to be associated with staff. Agencies with larger budgets are better staffed with administrators and professionals. Delinquen agencies are better staffed than drug and alcohol abuse agencies.

Relation of Clients, Income and Program Emphasis

Half of all reporting agencies serve 500 clients or fewer, regardless of income. However, drug and alcohol abuse agencies serve fewer clients than do delinquency programs. A rather large number of delinquency agencies serve few clients, despite rather large budgets. Generally, large numbers of clients are served by agencies operating with small budgets.

FINANCES

One hundred and thirty-four of the 201 respondents noted their 1971 gross income. Average income was $255,000, but the median is much lower. Half of the reporting agencies (67) operate on a gross income below $97,600. Fifty-one (38%) of all the agencies operate on $50,000 or less. Only 5 agencies report having over $1 million in the past year.

Table 17 indicates that a large percentage of alcoholism agencies operate on incomes of less than $100,000. Slightly less than half of the drug abuse agencies are in this budget category, and a much larger percentage of delinquency agencies have higher incomes.

Of the 4 agencies with incomes of more than $1 million each, 3 are drug agencies and the other emphasizes all areas equally.

Funding Source by Program Emphasis

The source of agency funding, the number of reporting agencies receiving funds from that source, followed by a breakdown by program emphasis of agencies receiving funds from each source, are shown in Table 18.

Table 17

PROGRAM EMPHASIS OF AGENCIES WITH INCOMES LESS THAN $100,000

	Under $50,000	$50,000-$100,000		
Alcoholism	10 (24%)	3 (20%)	=	13 of possible 16 agencies
Drug Abuse	9 (22%)	1 (7%)	=	10 of possible 21 agencies
Delinquency	12 (29%)	11 (73%)	=	23 of possible 61 agencies
Total	41	15		

Table 18

FUNDING PATTERNS BY SOURCE AND PROGRAM EMPHASIS

Source of Funds	Total Number Funded in Three Program Areas	Percent of Total[2]	Number Funded by Program Area			
			Alcohol	Drugs	Juvenile Delinquency	Equal Emphasis
United Way	42	31	3	4	30	5
Client fees	76	57	16	10	38	12
Private foundation	37	28	3	7	22	5
Fund raising	68	51	4	12	44	8
Local or county tax revenue	15	11	1	4	9	1
Federal grants	39	29	2	11	20	6
Other sources	52	39	8	10	29	5
	329[1]		37[1]	58[1]	192[1]	42[1]

1. Column total exceed the sample size because of multiple responses, that is, a single agency receives funds from more than one source.

2. Percentages refer to the number of agencies in the sample of 134 who receive funds from that source.

Income Levels by Income Sources

Of the 54 agencies[6] funded by United Way, 27 (50%) receive 25% or less of their funds from that source. Twenty-five (27%) of the 91 agencies receiving funds from client fees get 100% of their income from such fees; 45 (49%) of them receive 50% or less. Of the 40 agencies receiving private foundation support, 32 (80%) receive 25% or less of their funds from such support.

Of the 82 agencies doing fund raising, only 8 (10%) receive 75% or more of their funds this way; 49 (60%) receive 25% or less.

Of the 20 agencies receiving local or county tax revenue, 10 (50%) receive 50% or more of their funds from such revenue. Of the 52 programs funded federally, 35 (67%) get 50% or more, and 9 (17%) receive 100% federal support.

Patterns of Funding Sources by Program Emphasis

Following are tabulations of the percentage of funds received by agencies in each area of emphasis, from each funding source.

United Way

3 Alcoholism	4 Drug Abuse	30 Delinquency Prevention
1 at 10%	3 (75%) at 5% or less	11 (37%) at 25% or less
1 at 30%	1 not clear	9 (30%) at 25-50%
1 at 60%		9 (30%) at 50% or more
		1 not clear

United Way funds more delinquency prevention programs than drug or alcohol abuse programs. The delinquency agencies also receive a larger

6. Twelve agencies not included in Table 18 appear in thse summaries. They are agencies which emphasize various combinations of the three program areas. Other discrepancies between data in the following discussion and those shown in Table 18 are accounted for in the same fashion.

percentage of their income from United Way than do the drug abuse or alcoholism agencies.

Client Fees

16 Alcoholism	10 Drug Abuse	38 Delinquency Prevention
0 at less than 20%	3 (30%) at 6% or less	22 (58%) at 25% or less
4 (20%) at 20-80%	3 (30%) at 50-60%	4 (10%) at 25-75%
11 (69%) at 90% or more	3 (30%) at 90% or more	11 (29%) at 75% or more
1 information not available from data	1 information not available from data	1 information not available from data

Of those programs receiving client fees, a much larger percentage of those treating alcoholism receive a major portion of their income from such fees. Client fees provide a small percentage of the income of delinquency agencies.

Private Foundation Support

3 Alcoholism	7 Drug Abuse	22 Delinquency Prevention
1 at 0.1%	3 (43%) at 3% or less	18 (82%) at 25% or less
1 at 10%	3 (43%) at 25-50%	2 (9%) at 90% or more
1 at 30%	1 (14%) at 80%	2 information not available from data

Regardless of program emphasis, most of these agencies do not receive a significant portion of their income from private foundations.

Agency Fund Raising

4 Alcoholism	12 Drug Abuse	44 Delinquency Prevention
2 (67%) at 10%	5 (42%) at 25% or less	28 (67%) at 25% or less
1 (33%) at 25%	4 (33%) at 25-50%	5 (11%) at 25-50%
1 information not available from data	3 (25%) at 90% or more	6 (14%) at 50-80%
		3 information not available from data

The overwhelming majority of those agencies doing fund raising receive 25% or less of their incomes from this source.

Local or County Tax Revenue

1 Alcoholism	4 Drug Abuse	9 Delinquency Prevention
1 at 14%	1 (25%) at 32%	4 (44%) at 50% or less
	2 (50%) at 100%	5 (56%) at 75% or more
	1 information not available from data	

Very few agencies receive local or county tax revenue. Of those that do, most receive 75% or more of their income from this source.

Federal Grants or Contracts

2 Alcoholism	11 Drug Abuse	20 Delinquency Prevention
1 (50%) at 10%	2 (18%) at 35% or more	8 (40%) at 50% or less
1 (50%) at 100%	6 (55%) at 50-75%	7 (35%) at 50-80%
	2 (18%) at 100%	3 (15%) at 90% or more
	1 information not available from data	2 information not available from data

Few alcoholism agencies receive federal funds. A large percentage of drug abuse agencies receive over half of their incomes from federal sources.

Other Sources

8 Alcoholism	10 Drug Abuse	29 Delinquency Prevention
2 (25%) at 50% or less	5 (50%) at 50% or less	19 (65%) at 50% or less
2 (25%) at 50-80%	4 (40%) at 90% or more	3 (10%) at 50-85%
4 information not available from data	1 information not available from data	6 (21%) at 90% or more
		1 information not available from data

A larger percentage of drug agencies than of other agencies receive a great deal of their income from unspecified sources.

Federal Funding, by Program Emphasis

One hundred and eighty-nine agencies responded to the question asking if they had applied for federal funding. Ninety said "yes" and 99 said "no." This response may be compared with area of program emphasis, as follows:

Federal Funds ?	Alcoholism	Drug Abuse	Delinquency Prevention
YES	[redacted]	22	37
NO		10	40
	21	32	77

Thirty-seven (48%) of the 77 delinquency agencies have applied for federal funds and 40 (52%) have not. However only 5 (24%) of the 21 alcoholism agencies have applied and, at the other extreme, 22 (69%) of the 32 drug abuse agencies have applied.

Federal Funding, by Age

Ninety-two agencies receiving federal funds responded to the question about their age. Forty-six (50%) have been in operation five years or less;

the rest show a fairly even age distribution, with a cluster of 9 agencies (10%) in the 10 to 20-year-old range.

Problems Regarding Federal Funds

One hundred and eighty-four agencies responded as follows to the 8 possible choices given as problems they had experienced with obtaining federal grants or contracts.

	YES	NO
1. Lack of knowledge of sources	38	145
2. Inadequate knowledge of funding policies	35	148
3. Lack of expertise in writing proposals	37	146
4. Unreasonable time limits for submitting proposals	28	155
5. Excessive demands regarding allocation of funds	30	154
6. Compliance with grant or other controls	24	160
7. Personal problems with funding source	10	173
8. Others	21	163

Generally, the major problems in obtaining federal grants are the first three.

Problems, by Program Emphasis

Those who answered "yes" to having experienced difficulty with federal sources of funds are divided by program emphasis as follows:

	23 Alcohol	31 Drug	78 Delinquency
1. Lack of knowledge of sources	3	9	18
2. Inadequate knowledge of funding sources	4	9	14
3. Lack of expertise in writing proposals	2	8	17
4. Unreasonable time limits for submitting proposals	1	5	15
5. Excessive demands regarding allocation of funds	1	3	16
6. Compliance with grant or other controls	1	6	8
7. Personal problems with funding source	0	3	5

The general pattern holds true across program emphases. A slightly higher percentage of drug agencies have problems with compliance, and more delinquency agencies have problems regarding excessive demands.

Problems of Funding, by Age

In almost every category of problem at least 50% of the agencies that mention each as a problem are five years old or less. There are no noticeable clusters among the older programs.

	Five Years or Less	Over Ten Years	Total Number
1. Lack of knowledge of sources	19 (50%)		38
2. Inadequate knowledge of funding policies	19 (60%)		35
3. Lack of expertise in writing proposals	19 (51%)		37
4. Unreasonable time limits for submitting proposals*	6 (16%)	15 (54%)	28
5. Excessive demands regarding allocation of funds	14 (47%)		30
6. Compliance with grant or other controls	13 (54%)		24
7. Personal problems with funding source	6 (60%)		10

* This is the one overwhelming exception. Of the 28 programs having problems with unreasonable time limits, 15 (54%) are over 10 years old.

Problems of Funding, by Staffing Patterns

One hundred and sixty agencies with full-time staff and 149 with part-time staff reported having experienced problems with federal funding, as follows:

Type of Staff	Number of Agencies	
	Full-time	Part-time
Administrative	13	1
Professional	14	12
Paraprofessional	13	17
Clerical	81	29
Volunteers	51	83

One hundred and sixty agencies answered both problems of funding and type of full-time staff and 149 by part-time staff. The results of the comparison are charted below by type of problem. Only noted are those that mention the problems; they are divided into agencies with full-time or part-time staff in each category.

		Full-time	Part-time
Lack of Knowledge of Sources	Administrative	2	1
	Professional	4	0
	Paraprofessional	2	5
	Clerical	24	5
	Volunteer	3	20
Inadequate Knowledge of Funding Policies	Administrative	2	1
	Professional	3	0
	Paraprofessional	3	5
	Clerical	18	4
	Volunteer	6	16
Lack of Expertise in Writing Proposals	Administrative	2	1
	Professional	2	0
	Paraprofessional	2	3
	Clerical	21	5
	Volunteer	6	19
Unreasonable Time Limits for Submitting Proposals	Administrative	1	1
	Professional	3	1
	Paraprofessional	1	6
	Clerical	16	1
	Volunteer	4	17
Excessive Demands Regarding Allocation of Funds	Administrative	1	1
	Professional	4	1
	Paraprofessional	1	5
	Clerical	18	2
	Volunteer	6	16

		Full-time	Part-time
Complying With Grant or Other Controls	Administrative	1	0
	Professional	2	0
	Paraprofessional	1	1
	Clerical	13	1
	Volunteer	4	14
Personal Problems with Funding Source	Administrative	1	0
	Professional	1	0
	Paraprofessional	1	1
	Clerical	6	1
	Volunteer	1	8

Many of the agencies responding have some type of clerical or volunteer staff. Few have administrative, professional, or paraprofessional staff. Only a very small percentage of those with either full-time or part-time administrative, professional, or paraprofessional staff mentioned any of the funding problems as their own. More significant percentages of the agencies with clerical and volunteer help reported having experienced almost all of the eight possible problems in obtaining federal grants.

Summary of Problems with Federal Funding

Almost half of the agencies that have applied for federal funds are 5 years old or less; more of these are delinquency and drug abuse than alcoholism agencies. Very few alcoholism agencies have applied for federal funds.

Across program emphases, the major problems with obtaining federal funds are lack of knowledge of sources, inadequate knowledge of funding policies, and lack of expertise in writing proposals. Again, young agencies encounter these problems more than others.

The data show that few agencies with administrative, professional, or paraprofessional staff encounter these problems. Agencies with volunteer and clerical staff encounter them much more frequently.

Income and Expenditure Needs

Asked whether the gross income it reported would meet its expenditure needs, 120 agencies that emphasize either alcoholism, drug abuse, or delinquency prevention responded. Fifty-eight (48%) answered yes, 42 (35%) answered no, and 20 (17%) answered that they were not sure.

By area of program emphasis, a slightly higher percentage of drug abuse than of alcoholism or delinquency agencies will be able to meet their needs. Beyond this, the pattern established by the total number of answers holds.

	Alcoholism	Drug Abuse	Delinquency Prevention	
YES	9 (45%)	19 (61%)	30 (41%)	
NO	8 (40%)	9 (29%)	25 (36%)	
NOT SURE	3 (15%)	3 (10%)	14 (23%)	
	20	31	69	= 120

Results of Deficit

A rather large percentage of all the agencies will not be able to meet their expenditure needs; these, combined with those who are not sure, make up 62 (52%) of the 120 agencies. These agencies were asked to choose between nine possible courses of action to take in event of a deficit. Their responses, by program emphasis, are as follows:

	Alcohol	Drug	Juvenile Delinquency	All Others	Total
Reduce services	3	3	13	6	25
Refer clients elsewhere	1	4	7	5	17
Place clients on waiting list	0	4	4	6	14
Turn away clients	1	3	3	2	9
Program or services eliminated	2	3	3	1	9
Staff hours reduced	0	2	5	1	8
Staff size reduced	1	1	8	4	14
Services in planning stage shelved	2	4	9	3	18
Seek additional or emergency funding	3	8	16	10	37

Looking at these agencies together, their most predominant reactions to a deficit are to seek additional or emergency funding, reduce services, shelve services in planning stage, and refer clients elsewhere, in that order. This pattern generally holds across categories as well, except that only one alcoholism program would refer clients elsewhere.

Reactions to New Funds

When asked what they would do with a substantial amount of unexpected money, 183 agencies responded by allocating what percent of those funds would go into each of 10 categories.

	Percent of Allocation by Number of Agencies	
	0-25%	25-100%
Hiring additional staff	125	54
Increasing staff salaries	158	12
New facilities	256	25
Purchasing equipment, supplies	170	8
New programs or services	149	31
Expanding present programs or services	131	48
Program or service evaluation	181	1
Research on problem areas	200	3
In-service training	178	3
Public relations	179	2

New facilities, research, addition to or expansion of services and programs, adding staff and increasing their salaries are the choices receiving the greatest allocations by the largest numbers of agencies.

New Allocations by Program Emphasis

The first five choices were shown as programs in each area of emphasis chose them to determine how their particular priorities compared to those of all the agencies. Twenty-two alcoholism, 30 drug abuse, and 73 delinquency programs responded to both sets of questions. The pattern remains for the most part.

Hiring Additional Staff

Percent	Alcohol	Drug	Juvenile Delinquency
0-25	16	18	47
25-100	5	12	23

New Facilities

Percent	Alcohol	Drug	Juvenile Delinquency
0-25	17	22	54
25-100	4	6	7

New Programs or Services

Percent	Alcohol	Drug	Juvenile Delinquency
0-25	17	28	56
25-100	4	4	15

Increasing Staff Salaries

Alcohol	Drug	Juvenile Delinquency
20	29	65
1	1	6

Purchasing Equipment, Supplies

Alcohol	Drug	Juvenile Delinquency
20	28	67
1	2	3

THE RELATIONSHIPS AMONG STAFFING PATTERNS, INCOME, AND PROGRAM EMPHASIS

The description of staffing patterns and the description of finances raise the question, what is the relationship, if any, among staffing patterns and income, by major program area? The data suggest that few agencies have full-time administrative or full-time professional staff. Also, that half of the agencies are operating on fairly small budgets, i.e., under $100,000. The majority of all the agencies receive incomes under $500,000, therefore only these income categories were considered. The comparison then made is among the three major program emphases (alcoholism, drug abuse, and delinquency prevention), by number of full-time administrative or professional staff, by gross annual income.

Description of the Data

Repeating what was described in an earlier section, 134 of the 201 agencies in the sample reported their income. Fifteen (65%) of a possible 23 were alcoholism agencies, 16 (47%) of a possible 34 were drug abuse agencies, and 53 (68%) of a possible 78 were delinquency agencies. The balance combine emphases in various ways. The income breakdown under $500,000 is below:

$0-$100,000	$100,000-$199,999	$200,000-$499,999
13 (81%) alcohol	1 (5%) alcohol	1 (5%) alcohol
10 (48%) drug	3 (14%) drug	3 (14%) drug
23 (38%) delinquency	12 (20%) delinquency	18 (30%) delinqu
46	16	22

The figures in parentheses are the percentages of cases of the total that reported income by program area; e.g., the 13 alcoholism agencies wit incomes under $100,000 equal 81% of the 16 alcoholism agencies reporting income.

Administrative staff. Thirty-nine of the 46 agencies with incomes under $100,000 reported some full-time administrative staff; all reported some professional staff. Twelve of the 16 in the $100,000-$200,000 bracke reported some administrative staff; all reported professional staff. Fifteen of the 22 between $200,000-$500,000 reported some administrative staff; all reported professional staff. The breakdown of number of staff by number and type of agency, by income is below.

Of the 39 agencies whose incomes are less than $100,000, 13 (33%) each have no full-time administrative staff, 20 (51%) each have 1 administrator and 6 (15%) each have 2 or more. A larger percentage of drug abuse agencies in this income bracket have no full-time administrators. More alcoholism than delinquency agencies have 1 or more.

Of the 12 agencies having between $100,000 and $200,000, 1 (8%) has no full-time administrator, 6 (50%) each have 1, and 5 (42%) each have 2 or more. Again, more delinquency agencies have more full-time administrat

Of the 15 agencies in the $200,000-$500,000 income bracket, none are without full-time administrative staff, 1 (7%) has 1 administrator, and 14 (93%) each have 2 or more. The number of delinquency agencies in this bracket is a larger percentage of the total number than is the number of drug abuse agencies. Also, a much larger percentage of those delinquency agencies have 2 or more full-time administrators.

These data are summarized in Table 19.

Professional staff. Of the 46 agencies with incomes under $100,000, 26 (57%) have no full-time professional staff, 9 (20%) each have 1 professional, and 11 (23%) have 2 or more. The percentage with none is about the same, across lines of program emphases. A larger percentage of alcoholism agencies have 1 professional, and a larger percentage of delinquency agencies have 2 or more.

Of the 16 agencies whose incomes are between $100,000-$200,000, 4 (25%) have no full-time professional staff, 1 (6%) has 1 professional, and 11 (60%) have 2 or more. A larger percentage of delinquency programs in this bracket have none; more drug programs have 1; and the percentage with 2 or more is about even.

Of the 22 agencies with incomes between $200,000-$500,000, 2 (9%) have no full-time professional staff, 1 (5%) has 1, and 19 (86%) have 2 or more. A much larger percentage of delinquency agencies than of drug agencies have 2 or more.

These data are summarized in Table 20.

Summary of Staffing, Income, and Program Relationships

Lower-income agencies, under $100,000, have fewer full-time administrative and professional staff than do others in higher-income brackets. Fifty percent of all agencies operate on $100,000 or less per year, and these data show that 57% of these have no full-time professional staff while 33% have no full-time administrative staff.

Delinquency prevention agencies have more full-time administrative and professional staff than do any of the others; second in percentage are alcoholism agencies; and the reporting drug abuse programs have the fewest.

Table 19

NUMBER OF FULL-TIME ADMINISTRATIVE STAFF BY AGENCY INCOME

Number of Full-Time Administrative Staff	Alcohol	Drug	Delinquency	Total
	Incomes Between $0 - $99,999			
0	2	5	6	13
1	8	1	11	20
2+	2	1	3	6
	12	7	20	39
	Incomes Between $100,000 - $199,999			
0	0	0	1	1
1	0	2	4	6
2+	1	0	4	5
	1	2	9	12
	Incomes Between $200,000 - $500,000			
0	0	0	0	0
1	0	0	1	1
2+	0	2	12	14
	0	2	13	15

Table 20

NUMBER OF FULL-TIME PROFESSIONAL STAFF BY AGENCY INCOME

Number of Full-Time Professional Staff	Alcohol	Drug	Delinquency	Total
	Incomes Between $0 - $99,999			
0	7	6	13	26
1	4	2	3	9
2+	2	2	7	11
	13	10	23	46
	Incomes Between $100,000 - $199,999			
0	0	0	4	4
1	0	1	0	1
2+	1	2	8	11
	1	3	12	16
	Incomes Between $200,000 - $499,999			
0	0	1	1	2
1	0	1	0	1
2+	1	1	17	19
	1	3	18	22

RELATIONSHIPS AMONG NUMBER OF CLIENTS, INCOME, AND PROGRAM EMPHASIS

This section examines relationships among number of clients served and agency income, by each major program area. The data suggest that although half of all the agencies operate on budgets of less than $100,000, quite a few of these serve fairly large numbers of clients.

Description of the Data

Forty-one of the 46 agencies under $100,000 also reported the number of clients they saw in the past year. Fifteen of the 16 between $100,000 and $200,000 reported the number of clients, as did 18 of the 22 between $200,000 and $500,000. The breakdown of number of clients by number and type of agency, by income is shown in Table 21.

Of the 41 agencies with incomes under $100,000, 25 (61%) each served 500 or fewer clients, 10 (24%) each served between 500 and 4,000, and 6 (15%) served between 4,000 and 10,000 clients in the past year. A greater percentage of delinquency agencies in this income bracket saw a larger number of clients.

Of the 15 agencies with incomes between $100,000 and $200,000, 7 (47%) each served 500 or fewer clients, 7 (47%) each served 500 to 4,000 clients, and 1 (6%) served between 4,000 and 10,000 clients in the past year. Again, a larger percentage of delinquency agencies served many clients, but the largest agency here is a drug abuse agency.

Of the 18 agencies with incomes between $200,000 and $500,000, 11 (61%) each served 500 or fewer clients, 5 (28%) each served between 500 and 4,000, and 2 (11%) each served 4,000 to 10,000 clients. Sixteen of these are delinquency agencies, which makes comparison across program emphasis insignificant.

Summary of Clientele, Income, and Program Relationships

These data substantiate the earlier description of half of the agencies as serving 500 or fewer clients. This holds true across income divisions but not across lines of program emphasis, i.e., a fairly large percentage

Table 21

NUMBER OF CLIENTS BY AGENCY INCOME

Number of Clients \ Number of Agencies	Alcohol	Drug	Delinquency	Total
	Incomes Between $0 - $99,999			
1-500	9	6	10	25
501-3,999	1	2	7	10
4,000-10,000	2	1	3	6
	12	9	20	41
	Incomes Between $100,000 - $199,999			
1-500	1	2	4	7
501-3,999	0	0	7	7
4,000-10,000	0	1	0	1
	1	3	11	15
	Incomes Between $200,000 - $499,999			
1-500	0	1	10	11
501-3,999	1	0	4	5
4,000-10,000	0	0	2	2
	1	1	16	18

of higher-income agencies serve small numbers of clients. A larger percentage of drug and alcohol abuse agencies serve a small number of clients.

A surprisingly large number of agencies on small budgets serve large numbers of clients. It is these same agencies who have few or no full-time administrative and (or) professional staff.

SUMMARY OF INTERAGENCY COOPERATION AND PLANNING

Without regard to program emphasis, existing forms of interagency cooperation are information sharing and referral. Most interest is expressed in cooperation for research, grants and contracts, program development, and long-range policy. However, there are important cross-program differences. Alcoholism agencies are presently engaged in substantially more interagency cooperation for fund raising and less involved in contracts and proposals, shared facilities and equipment, purchasing, publicity, information sharing, and referral. Alcoholism agencies are most interested in developing interagency cooperation in purchasing, publicity, information sharing, and referral.

Drug abuse agencies are currently engaged in more interagency cooperation for contracts and proposals and publicity and less active in shared facilities. They are most interested in developing interagency cooperation for shared facilities and for contracts and proposals (note, they are also most active in contracts and proposals) and least interested in publicity (in which they are also most active).

Delinquency prevention agencies presently engage in the most interagency cooperation to share facilities and least active in long-range policy and referral. They are most interested in developing cooperation arrangements in fund raising and long-range policy and least interested in contracts and proposals, information sharing, and referral.

Agencies giving equal emphasis to all three program areas have the most cooperative arrangements for information sharing and referral and

are most interested in developing them in combining services and program development. They are least interested in such arrangements for sharing facilities, purchasing, and publicity.

Response rates to questions about current interagency cooperation and interest in developing them are low and may be a crude measure of the extent to which agencies do not perceive themselves as parts of an interdependent or, at least, interrelated system.

All agencies presently engaged in some form of interagency cooperation prefer local to countywide interagency arrangements. Delinquency prevention agencies are more likely to prefer countywide cooperation. Preferences for geographical scope of interagency cooperation do not seem to be affected by staffing patterns of agencies; however, agencies with fewer administrators are more interested in developing some form of cooperation, as are agencies with smaller budgets and which have been in existence 10 years or less.

Cooperation with Law Enforcement

Many agencies have cooperative arrangements with law enforcement and are considerably interested in extending them. Existing relationships include (in order) referral, sharing information, public education, and financial.

Interest in additional arrangements are (in order) public education, financial support, information sharing, and referral. Delinquency agencies have the most frequent incidence of cooperation for information sharing. A greater percentage of drug abuse agencies cooperate in educational arrangements than in the case with agencies emphasizing other programs. Multipurpose agencies are more likely to have referral arrangements. Alcoholism agencies have the greatest interest in developing cooperative arrangements for referral, while drug abuse and multipurpose agencies are most interested in developing some form of financial arrangements.

SUMMARY OF PLANNING

Approximately three quarters of all agencies conduct planning in the following areas: long- and short-range goals, program development, and

services. A majority of them plan program evaluation and fund raising. Research planning is much less frequent (26%). The frequency of various kinds of planning for those agencies which do plan is remarkably constant, regardless of program emphasis. However, alcoholism agencies are less likely to plan for short-range objectives and for program development and evaluation. Drug abuse agencies are more likely to plan research and program evaluation. Delinquency prevention agencies are less likely to plan for short-range objectives and program development. Planning patterns seem to be insensitive to the number of clients served.

INTERAGENCY COOPERATION AND PLANNING, INCLUDING LAW ENFORCEMENT

Interagency Cooperation

General patterns. Table 22 summarizes current agency participation and future interests in various forms of cooperation. In seven categories the number of agencies interested in developing cooperation exceeds the number of agencies presently engaging in them. Ninety agencies cooperate in referral services and 73 agencies share information; these are the two most frequent forms of present cooperation. The forms of cooperation of greatest interest to the agencies are, in order, research, grants and contracts, program development, and long-range policy development.

Table 23 shows the existing types of cooperation, by most-emphasized program.

More useful comparisons come from examining the percentages for each category of planning (thereby one taking into account differences in the number of agencies in each program category). Using the percentages in the last column as a basis of comparison, those agencies which are multi-purpose are most involved in various forms of cooperation and are well above the sample norm in contracts and proposals, information sharing, and referral. Such an outcome is not surprising, since such agencies frequently deal with drug, alcohol, and delinquency problems but only as they relate to other kinds of difficulties such as family or marriage problems. Drug abuse agencies are well above the norm in cooperation with respect to contracts and proposals and to public relations and publicity. They are substantially below the norm with respect to sharing equipment and

Table 22

SUMMARY OF COOPERATION

Form of Cooperation	Existing	Rank Order*	%	Both	%	Interested in Developing	Rank Order*	%	Valid Observations - Total Responses	%
Combining services	39	4	51	8	10	30	9	39	77	100
Long-range policy	35	6	38	5	7	50	4	55	91	100
Program development	43	3	39	15	15	54	3	48	112	100
Share facilities or equipment	39	4	44	19	21	31	8	35	89	100
Fund raising	21	8	27	11	15	45	5	58	77	100
Grants and contracts	36	5	36	8	8	55	2	56	99	100
Research	16	10	20	8	10	58	1	70	82	100
Purchasing	18	9	39	2	4	26	10	57	46	100
Public relations, publicity	31	7	39	9	11	40	6	50	80	100
Share information	73	2	54	25	18	38	7	28	136	100
Referral services	90	1	62	33	23	22	11	15	145	100
Other forms	4	11	44	1	12	4	12	44	9	100

* Rank order is based on frequency of mention. Percentages were included to take into account the different frequency with which such forms of cooperation is mentioned.

Table 23

EXISTING FORMS OF COOPERATION

	Alcohol	Column[a] %	Drugs	Column[a] %	Juvenile Delinquency	Column[a] %	Equal Emphasis	Column[a] %	Valid Observations Totals	Column[a] %
Combining services	3	13	5	15	18	23	4	20	30	19
Long range policy	5	22	6	18	11	14	4	20	26	17
Program development	6	26	7	21	18	23	3	15	34	22
[illegible]				6[c]	18	23	6	30	29	18
				9	6	8	1	5	12	8
				26[b]	12	15	5	25[b]	29	18
				9	7	9	2	10	13	8
				9	7	9	2	10	12	8
				21[b]	11	14	4	20	25	16
				41	31	40	9	45[b]	58	37
				44	34	44	13	65[b]	69	44
				-	2	3	2	10	4	3
					78		20		157[d]	

[illegible] on the basis of the total number of agencies in the sample in each program classification. Such a procedure permits comparisons across program areas. The final column provides a norm for each form of cooperation across program areas.

b. Percentage is at least 5 percentage points above the sample norm.

c. Percentage is at least 5 percentage points below the sample norm.

d. Only 157 agencies are included in this table because the remaining 44 cannot be classified by either a single program emphasis or as giving equal emphasis to all program areas.

facilities. Alcoholism agencies are well above the norm in cooperative fund raising and well below it in sharing equipment and facilities, contracts and proposals, purchasing, information sharing, and referral. They also lead in cooperating for planning and program development. Juvenile delinquency prevention agencies lead in cooperating to combine services, but seemingly do the least long-range planning.

Since the percentages used for making comparisons across program emphases were based on sample total whether or not the responding agency answered the question about existing forms of cooperation, the number of mentions within each category are worth noting. Regardless of program emphasis, agencies who did answer the question mentioned referral and general information sharing most frequently.

Table 24 summarizes the forms of cooperation the agencies are interested in developing, by program emphasis.

Comparisons across program emphases suggest that alcohol programs are the most interested in cooperation for purchasing, information sharing, referral, and public relations and publicity (in each of these forms of cooperation, we find expressions of interest are well above the sample norm). Interestingly, in each of these areas, alcohol programs are well below the sample norm with respect to existing cooperative arrangements. Whereas they lead in existing cooperative arrangements in long-range policy and program development, they show interest well below the sample norm in extending such arrangements. They were also well above the norm in cooperation for fund raising yet show very little interest in further cooperation in this regard. Finally, they were involved in relatively few cooperative arrangements for shared facilities and show little interest in furthering such efforts.

Drug programs report the most interest in sharing facilities and equipment and cooperating on contracts and proposals. To date they report the least cooperation with regard to shared facilities but the most in contracts and proposals. They express the least interest in further cooperation with respect to publicity—a form of cooperation in which they are heavily involved at present.

Juvenile delinquency prevention programs express great interest in cooperating with other agencies to raise funds. They are also interested

Table 24

INTEREST IN DEVELOPING COOPERATION

	Alcohol	Column[a] %	Drugs	Column[a] %	Juvenile Delinquency	Column[a] %	Equal Emphasis	Column[a] %	Valid Observations Totals	Column[a] %
Combining services	3	13	4	12	11	14	4	20[b]	22	14
Long range policy	4	17[c]	9	26	22	28	5	25	40	25
Program development	5	22[c]	10	29	21	27	8	40[b]	44	28
Share facilities or equipment	3	13	8	23[b]	13	17	2	10[c]	26	17
Fund raising	3	13[c]	6	18[c]	25	32[b]	5	25	39	25
Contract, proposal	6	26	11	32[b]	19	24	6	30	42	27
Research	7	31	10	29	25	32	4	20	46	29
Purchasing	5	22[b]	6	18	8	10[c]	2	10[c]	26	17
Public relations, publicity	7	31[b]	3	9[c]	15	19	2	10[c]	27	17
Sharing information	8	35[b]	8	23	10	13[c]	4	20	30	19
Referral	6	26[b]	4	12	6	8	3	15	19	12
Other	1	4	-	-	2	3	-	-	3	19
Number of Agencies	23		34		78		20		157[d]	

Notes: a. As in Table 323, column percentages are based on the total agencies in the sample.

b. Percentage is at least 5 percentage points above the sample norm.

c. Percentage is at least 5 percentage points below the sample norm.

d. Only 157 agencies are included in this table.

in cooperation with respect to long-range policy development, an area in which they currently have few cooperative arrangements, in comparison with other agencies.

Multipurpose agencies express the greatest interest in cooperation with respect to combining services and program development (in which they presently fall considerably below the sample norm).

Table 25 is a summary which compares existing forms of cooperation with interest in developing new cooperative arrangements.

This array provides some useful insights about the prospects for cooperation across program emphases for the agencies included in this study.

In several instances, agencies within program areas already engage in considerable cooperation (I)[b] and do not rank further effort in this direction very high (4 or 3). Alcohol programs already cooperate in long-range policy, program development, and fund raising and give low priority to further effort in these kinds. A similar situation exists among drug agencies with respect to publicity and among multipurpose agencies regarding shared facilities and equipment, research, purchasing, and publicity.

In other instances relatively little cooperation presently exists (IV or III) and there is not too much interest in expanding it (4). This situation exists for drug programs in the area of combining services and for delinquency prevention programs in contracts and proposals, information sharing, and referral.

In other instances relatively little cooperation presently exists (IV), but there is a great deal of interest in expanding it (1,2). This situation exists for alcohol programs in areas of purchasing, publicity, information sharing, and referral; for drug programs in shared facilities and equipment and for multipurpose programs in program development.

Finally, in some instances there is a great deal of cooperation at present (I) and considerable interest in increasing it (1,2). This is the case for drug programs with respect to contracts and proposals, for delinquency prevention programs with respect to combining services and for multipurpose programs regarding referral.

Table 25

COMPARISON OF EXISTING FORMS OF COOPERATION WITH INTEREST IN DEVELOPING COOPERATION BY PROGRAM EMPHASIS

	Alcohol		Drugs		Juvenile Delinquency		Equal Emphasis	
Combining services	IV	3	III	4	I	2	II	1[c]
Long range policy	I	4[d]	III	2	IV	1	II	3
Program development	I	4[d]	III	2	II	3	IV	1[c]
Share facilities or equipment	III[d]	3	IV[d]	1[c]	II	2	I	4[d]
Fund raising	I[c]	4[d]	II	3[d]	III	1[c]	IV	2
Contracts, proposals	IV[d]	3	I[c]	1[c]	III	4	II[c]	2
Research	III	2	II	3	II	1	I	4[d]
Purchasing	IV[d]	1[c]	II	2	II	3[d]	I	3[d]
Public relations, publicity	IV[d]	1[c]	I[c]	4[d]	III	2	II	3[d]
Share information	IV[d]	1[c]	II	2	III	4[d]	I[c]	3
Referral	III[d]	1[c]	II	3	IV	4	I[c]	2

Notes: a. The roman numerals show the rank ordering of the percentages from Table 23 for each existing type of cooperative arrangement.

b. The arabic numerals show the rank ordering of the percentages from Table 24 for each type of cooperation agencies are interested in developing.

c. Percentage at least 5 percentage points above the sample norm.

d. Percentage at least 5 percentage points below the sample norm.

Table 25 from which the foregoing comments were derived was constructed to compare relative emphasis across program areas. And while it does help illuminate the different conditions and needs of different programs, it should not obscure the fact that some interest is expressed in all forms of cooperation.

A more troublesome aspect of the issue of interagency cooperation is the generally low response rates concerning both existing and desired forms of cooperation. For example, in Table 25, only 34 (44%) of a possible 78 agencies indicated they were engaged in cooperative arrangements for referral with other agencies. Does no response mean such cooperation does not now exist for the remaining 44 agencies? While one cannot be sure, such an inference seems reasonable. When one takes into account the low frequency of response to each category of cooperation (a low of 6 to a high of 34) and the fact that most of those agencies who responded to one category of cooperation also responded to one or more others, the inference is strengthened that existing interagency cooperation is low.

The matter of response rates is even more troublesome in the case of interest in developing forms of cooperation. Again using the example of delinquency prevention programs, does the fact that only 6 agencies expressed interest in developing cooperation for referrals mean that the remaining 38 agencies (of the 44 who did not report cooperative arrangements for referral) neither have nor are interested in developing them? Similar questions can be posed of all forms of cooperation in all program areas. If the data are accepted as valid, the relatively low response rates for both existing and new cooperative arrangements force one to consider several possibilities. Among them are:

1. Agencies are relatively self-sufficient and need not engage in interagency cooperation,
2. Many agencies do not perceive a benefit in such cooperation, and
3. Agencies are unwilling to pay the coordinating and other costs (for example, some loss of autonomy) of cooperation.

The choice among these alternatives can be eased by examining some of the characteristics of agencies who presently engage in or express interest in interagency cooperation.

Preferences About Geographical Scope of Interagency Cooperation

Of the 172 agencies responding to the question of preference for cooperation being countywide, local, or not at all, 46 (26%) preferred it to be countywide, 80 (46%) prefer it to be local, 12 (0.6%) replied not at all, and 34 (27%) circled more than one response.

Table 26 summarizes the preferences of agencies for the geographical scope of such cooperation, regardless of program emphasis. The table includes only those agencies which reported they presently engage in some form of interagency cooperation. The data in the table are weighted in favor of those agencies engaging in several kinds of cooperation—for example, if an agency engaged in cooperation for services, long-range policy, and program development and if it preferred a local scope for cooperation, it would be counted in the "local" column three times. This procedure was followed in order to give greater weight to the responses of those agencies who have experience in more than one form of cooperation.

The data show overwhelming interest in local cooperation. The categories of cooperation in which there is some interest in countywide support are referral (14), sharing information (14), combining services (11) and sharing facilities or equipment (10), followed closely by long-range policy (9) and program development (9). Interestingly, there is some interest in cooperation at both county and local levels for referral (17) and information sharing (14).

Table 27 summarizes preferences for geographical scope of cooperation expressed by those respondents who indicated an interest in beginning cooperation in one or more areas. Once again, the responses are weighted.

Again the strong preference is for localized cooperation in each category. Agencies expressing interest in interagency cooperation for research (18), grants and contracts (15), fund raising (14), long-range policy (12), program development (12), and public relations (12), were somewhat more likely to prefer countywide scope than those interested in other forms of interagency cooperation. Once more, some preferences were expressed for a combination of county and local scope.

The rather clear preference for local cooperation among agencies reporting either existing or interest in potential interagency cooperation

Table 26

PREFERENCES FOR GEOGRAPHICAL SCOPE OF COOPERATION OF THOSE AGENCIES PRESENTLY ENGAGED IN FORMS OF INTERAGENCY COOPERATION

	Countywide	Local	Both
Combining services	11	20	5
Long range policy	9	15	5
Program development	9	21	7
Sharing facilities or equipment	10	17	9
Fund raising	3	10	4
Contracts and proposals	5	18	8
Research	4	5	5
Purchasing	4	9	4
Public relations	4	15	7
Sharing information	14	32	14
Referral	14	46	17
Other forms	1	1	-

Table 27

PREFERENCES FOR GEOGRAPHICAL SCOPE OF COOPERATION OF THOSE AGENCIES EXPRESSING INTEREST IN FORMS OF INTERAGENCY COOPERATION

	Countywide	Local	Both
Combining services	6	11	9
Long range policy	12	24	10
Program development	12	24	14
Share facilities or equipment	6	15	7
Fund raising	14	21	7
Grant, contract	15	25	9
Research	18	24	13
Purchasing	5	11	9
Public relations	12	18	8
Share information	8	15	8
Referral	8	7	4
Other	-	1	1

suggests the costs of coordination are of some concern. These costs are lower if cooperation is restricted to adjacent agencies and at the same time opportunities for first-hand contacts and relationships are increased.

Without regard for present involvement in such efforts, comparing responses to the question of preference for local or countywide cooperation or no cooperation at all with the agency's most emphasized program suggests that those preferring countywide cooperation are predominantly delinquency prevention programs (53%) and those preferring local cooperation are more evenly spread among delinquency prevention programs (42%), drug (23%), and alcohol (12%). Of the 12 agencies indicating that they felt no cooperation was necessary, 42% were delinquency prevention programs, 17% drugs, and 8% alcohol programs. Of those agencies circling more than one preference, 48% were delinquency prevention programs, 26% drugs, and 10% alcohol programs.

In each of the three program areas, the dominant preference is for local cooperation.

Interagency Cooperation and Staffing

The various forms of interagency cooperation taken together with the number of full-time administrative or managerial staff suggest that the agencies with 3 or fewer administrative or managerial staff members are more interested in developing cooperation than are agencies employing more staff members. In some categories of cooperation there is more interest in developing cooperation than presently exists and, in some categories the opposite situation seems to prevail. The number of full-time administrative or managerial staff does not seem to discriminate among the forms of interagency cooperation in which an agency is interested.

Interagency Cooperation and Agency Income

Table 28 shows types of cooperation by agency income. The data indicate that the agencies on smaller budgets, about one-half of all agencies in the survey, participate more in interagency cooperation than do agencies receiving larger incomes.

Table 28

PREFERENCE FOR TYPES OF COOPERATION, BY AGENCY INCOME

	<$1,000	%	1,000-50,000	%	50,000-100,000	%	100,000-150,000	%	150,000-200,000	%	200,000-250,000	%	250,000-500,000	%	500,000-1,000,000	%	1,000,000 plus	%
Combining services	-		11	11	2	4	2	7	1	4	-		6	10	3	14	2	9
Long range policy	1	17	6	6	6	12	2	7	1	4	-		6	10	-		2	9
Program development	-		8	8	7	14	4	14	3	11	-		7	12	2	10	2	9
Sharing facilities	1	17	10	10	3	6	4	14	3	11	-		4	7	1	5	1	5
Fund raising	-		4	4	3	6	1	4	3	11	-		3	5	;	5	2	9
Grants, contracts	-		7	6	3	6	-		2	8	1	17	6	10	3	14	2	9
Research	-		3	3	2	4	1	4	1	4	2	33	3	5	-		1	5
Purchasing	-		2	2	2	4	1	4	1	4	1	17	3	5	2	10	1	5
Public relations	-		7	7	6	12	2	7	1	4	-		2	3	-		3	14
Information sharing	2	33	16	17	8	16	5	17	3	11	1	17	10	17	4	19	3	14
Referral	2	33	21	22	9	18	7	25	7	27	1	17	9	15	4	19	3	14
Other	-		1	1	-		-		-		-		1	2	1	5	-	
Total	6		96		51		29		26		6		60		21		22	

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Interagency Cooperation and Age of Program

Table 29 compares the number of years an agency has been in existence with forms of interagency cooperation.

The agencies less than ten years old have shown that they are more interested in various forms of interagency cooperation. Those 11 to 30 years old seem to be the next most active, but the differences between this and the 31 to 50 and 50 to 74 year-old groups are small.

The same pattern, of the younger agencies being most interested in developing forms of cooperation, holds for the forms of cooperation the agencies are most interested in developing. The agencies seem to be interested in more cooperation for program development, fund raising, grants and proposals, and research.

Cooperation with Law Enforcement

Summaries of relationships with law enforcement officials. Table 30 summarizes the relationships existing between the agencies and local law enforcement officials and the relationships the agencies feel would be desirable.

The most-mentioned existing forms of cooperation are referral of users (91) and sharing information (80). The agencies indicate interest in developing cooperation for public education (46) and financial support (41). Financial support shows the greatest difference between existing cooperation (13%) and that which agencies wish to develop (85%). Referral of clients currently exists (67%), but only 25% of agencies show an interest in developing such cooperation.

Table 31 shows existing relationships between agencies and local law enforcement officials by program areas.

These data suggest extensive cooperation by agencies in each program area with law enforcement. Some rather interesting patterns emerge. A greater percentage of all delinquency prevention agencies cooperate with law enforcement agencies for information sharing, but drug programs cooperate more in joint educational efforts while multipurpose agencies have the most cooperation when it comes to referral.

Table 29

PREFERENCE FOR TYPES OF COOPERATION, BY AGE OF AGENCY

	0-10 years	Rank Order	11-30 years	Rank Order	31-50 years	Rank Order	51-74 years	Rank Order	Total	% by Column
Combining services	26	(3)	7	(6)	2	(6)	4	(6)	39	(4)
Long range policy	20	(7)	7	(5)	1	(7)	7	(3)	35	(6)
Program development	25	(4)	8	(4)	5	(3)	5	(4)	43	(3)
Share facilities or equipment	21	(6)	9	(3)	5	(4)	4	(7)	39	(4)
Fund raising	14	(8)	4	(7)	-		3	(9)	21	(8)
Grants, contracts	24	(5)	4	(8)	3	(5)	5	(5)	36	(5)
Research	11	(10)	2	(11)	2	(7)	1	(11)	16	(10)
Purchasing	12	(9)	3	(10)	-		3	(10)	18	(9)
Public relations, publicity	21	(6)	4	(9)	2	(8)	4	(8)	31	(7)
Share information	47	(2)	11	(2)	6	(1)	9	(1)	73	(2)
Referral	59	(1)	17	(1)	6	(2)	8	(2)	90	(1)
Other	4	(11)	-		-		-		4	(11)

Table 30

EXISTING AND DESIRABLE TYPES OF COOPERATION BETWEEN AGENCIES AND LOCAL LAW ENFORCEMENT OFFICIALS

	Exists	%	Like to Develop	%	Both	%	Valid Observations Total Responses
Share information	80	63	36	29	10	8	126
Public education	49	48	46	45	7	7	102
Financial support	6	13	41	85	1	2	48
Referral	91	67	34	25	11	8	136
Other	16	64	9	36	-	-	25

Table 31

EXISTING TYPES OF COOPERATION BETWEEN AGENCIES AND LOCAL LAW ENFORCEMENT OFFICIALS, BY PROGRAM EMPHASIS

	Equal Emphasis	Column[a] %	Alcohol	Column[a] %	Drugs	Column[a] %	Juvenile Delinquency	Column[a] %
Share information	5	25	8	35	12	35	37	47
Public education	5	25	2	9	13	38	20	25
Financial support	-	0	-	0	-	0	3	4
Referral of users	13	65	10	43	13	38	34	44
Other	1	5	1	22	7	21	4	5
Number of Agencies	20		23		34		78	

Note: a. Percentages are based on total agencies, by program emphasis responding.

Table 32 shows the relationships the agencies would like to develop with local law enforcement officials by program area.

Two of the more interesting items which emerge from this table are the extent to which alcohol agencies would like to get more referrals from law enforcement agencies and the extent to which drug and multi-purpose agencies are interested in developing cooperative financial arrangements.

Once again, the incidence of nonresponse by agencies in all program areas is troublesome. However, in this instance respondents were asked to specify reasons if they had no interagency cooperation with law enforcement. Only 33 responded, as follows:

10 agencies (30%) said not necessary
9 agencies (27%) said no trust
8 agencies (24%) said no time
6 agencies (18%) said another reason
33

Planning Activities

Summaries of existing planning activities. Of the 190 agencies responding to the question concerning planning activities:

150 agencies (78.9%) plan program development
143 agencies (75.3%) plan short-range objectives
143 agencies (75.3%) plan long-range goals
138 agencies (72.6%) plan services
104 agencies (54.7%) plan program evaluation
104 agencies (54.7%) plan fund raising
87 agencies (45.8%) plan special projects or proposals
49 agencies (25.8%) plan research

Close to three fourths of the responding agencies plan long- and short-range objectives, program development, and services. About half plan for program evaluation, fund raising, and special projects or proposals. Only one fourth of the agencies plan research.

Table 33 compares planning activities by program emphasis. The kind of planning in which those agencies engaged in planning report (the C percentages), is remarkably uniform regardless of program emphasis. However,

Table 32

DESIRABLE TYPES OF COOPERATION BETWEEN AGENCIES AND LOCAL LAW ENFORCEMENT OFFICIALS, BY PROGRAM EMPHASIS

	Equal Emphasis	Column %	Alcohol	Column %	Drugs	Column %	Juvenile Delinquency	Column %
Share information	3	15	5	22	4	12	14	18
Public education	6	30	5	22	6	18	17	22
Financial support	6	30	2	9	10	29	14	18
Referral of users	1	5	7	30	5	15	13	17
Other	-	-	2	9	1	3	3	5
Number of Agencies	20		23		34		78	

Table 33

AGENCY PLANNING ACTIVITIES BY PROGRAM EMPHASIS

	Alcoholism	T %	C %	Drugs	T %	C %	Juvenile Delinquency	T %	C %	Equal Emphasis	T %	C %	Total	TT %	C %
Plan long range	16	70	16	25	74	14	58	75	15	14	70	15	113	72	17
Plan short range	14	60	14	25	74	14	61	62	17	14	70	15	114	72	15
Program development	14	60	14	26	76	15	61	62	17	15	75	16	116	73	15
Services	17	74	17	22	65	12	57	73	15	14	70	15	110	70	15
Program evaluation	10	43	10	22	65	12	42	54	12	9	45	9	83	53	12
Fund raising	12	52	12	17	50	9	45	62	11	12	60	13	86	55	12
Special projects	10	43	10	18	53	11	34	44	10	9	45	9	71	45	9
Research	5	22	5	13	38	7	15	19	4	6	30	6	39	25	4
Other areas	1	4	1	3	9	6	4	5	2	2	10	2	10	6	1
	99		100	171		100	377		100	95		100	747		100
Number of Agencies	23			34			78			20			157		

Notes: T percentages are calculated on the basis of total number of number of agencies in the sample which fall into each program classification. Such a procedure permits comparisons across program areas.

C percentages are calculated on the basis of total number of responses within each program area. Such a procedure permits comparisons across program areas for those agencies presently engaged in planning.

TT percentages are calculated on the basis of all agencies in sample falling into the four program classifications appearing in the table. This procedure establishes a norm against which comparisons can be made within this sample.

when the total planning of all agencies within the sample (sorted by program emphasis), is considered, a few distinctive patterns emerge. Alcohol agencies do substantially less short-range, program development, and program evaluation planning than do delinquency prevention, and multipurpose agencies. Drug agencies do substantially more program evaluation and research planning than do other programs. Delinquency prevention agencies do substantially less short-range and program development planning than do drug and multipurpose programs.

In the previous section on interagency cooperation, alcohol programs reported the most cooperation for program development. Drug programs reported the second highest incidence of interagency cooperation for research. Delinquency prevention programs reported the second highest incidence of interagency cooperation for program development.

Planning Activities and Number of Clients Served Per Year

Table 34 summarizes planning functions by number of clients served during the past year.

The number of clients does not appear to stimulate or retard planning activities. The pattern of more planning for short- and long-range objectives, program development, and services than for program evaluation, fund raising, special projects, or research seems unaffected by the number of clients served.

Planning Activities and Age of Agency

Table 35 summarizes age of agencies by planning activities.

The data show that programs under ten years old are more engaged in planning activities than are older programs. Agencies 11 to 19 years old also are quite involved in planning. The trend does not continue, since the agencies 50 to 74 years old plan more frequently than those between 31 and 50. Agencies seem to plan more for short- and long-range goals, whatever the age of the program. One hundred and forty-one agencies stated that they planned for short- and long-range goals and in each instance 57% of those agencies were less than 10 years old. Program development is planned for more frequently than any of the other activities and 84 (56%) of these agencies are less than 10 years old.

Table 34. AGENCY PLANNING ACTIVITIES BY NUMBER OF CLIENTS SERVED

Types of Planning	Agencies	NUMBER OF CLIENTS																	
		1-69		70-100		101-200		201-360		361-500		501-1,000		1,001-1,999		2,000-3,999		4,000-10,000		10,001-20,000		20,000 +	
	Total No.	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Long Range	128	14	10	12	9	14	10	12	9	13	10	11	10	13	10	13	10	13	10	7	6	6	6
Short Range	142	12	9	12	9	13	9	13	9	10	8	13	9	13	9	12	9	17	11	6	4	21	14
Program Development	149	14	9	9	7	15	10	13	8	12	8	15	10	15	10	13	8	15	10	8	6	20	14
Services	136	12	18	11	8	15	11	8	5	11	8	12	8	16	11	9	6	16	11	7	5	19	13
Program Evaluation	103	11	11	5	5	11	11	9	9	6	6	9	9	10	10	10	10	13	12	5	5	14	13
Fund Raising	103	6	6	5	5	12	11	9	9	9	9	8	8	13	12	10	10	17	16	5	5	9	9
Special Project	86	6	7	5	6	10	11	8	9	6	7	6	7	12	14	9	10	13	15	2	2	9	10
Research Projects	48	4	8	3	6	5	10	6	12			4	8	5	10	5	10	5	10	2	5	4	8
Other Areas	13	1	8	2	16			1	8			1	8	3	24	1	8	2	16			2	16

Table 35

AGENCY PLANNING ACTIVITIES BY AGE OF AGENCY

	0-10 yrs.	%	11-19 yrs.	%	20-30 yrs.	%	31-50 yrs.	%	51-74 yrs.	%	Total	%
Range Goals	80	69	24	100	9	65	12	66	16	100	141	71
Short Range Objectives	82	71	19	79	9	55	15	83	16	100	141	71
Program Development	84	73	23	96	10	65	15	83	17	100	149	75
Services	76	66	21	82	10	61	13	72	16	100	136	69
Program Evaluation	60	52	16	67	5	41	9	50	13	81	103	52
Fund Raising	63	54	17	71	9	51	4	22	11	69	104	52
Special Projects	52	45	14	58	4	35	6	36	11	69	87	44
Research	36	31	7	29	1	16	2	11	3	35	49	25
Other	12	10	--	--	2	4	--	--	--	--	14	7

The agencies which have been in existence 11 to 19 years are of special interest because there are so many of them and because they seem to be relatively more active in planning activities than the other age groupings. Looking at their staffing patterns, the only category which has more than 5 employees is volunteers. Only 3 agencies have 1 administrative staff member and 1 agency has 2. Fourteen agencies have clerical staff and 6 of these employ 3 to 5. Twenty-five agencies employ part-time staff, 13 of which have between 3 and 5 part-time volunteers and 3 employ more than 5 part-time volunteers. The only other cluster is the 4 agencies who each employ 1 part-time clerical worker.

Of the agencies who are 11 to 19 years old, 10 agencies operated on less than $99,999 gross income; 6 on $100,000-$199,999; and one agency on $200,000-$499,999. Table 36 summarizes the percentage of funds from various funding sources received by the group of agencies 11 to 19 years old.

These agencies seem to receive the largest portion of their funds from client fees. Eighteen agencies are in this category; 8 received between 75 and 100% of the funds from the fees and 3 received between 50 and 75% in this manner. The next largest category is fund raising, but 10 of the 11 agencies receiving funds in this manner only receive 25% or less in this manner.

Hence, newer agencies and those with smaller budgets and most dependent on client fees seem more engaged in planning.

COMMUNITY SUPPORT

One hundred and ninety agencies responded to the question about how much endorsement the community gives their program; the responses are as follows:

	Number of Agencies	Percentage
Great amount	57	30
Moderate amount	80	42
Slight amount	44	23
No endorsement	8	4

Table 36

SOURCES OF FUNDS OF THOSE AGENCIES BETWEEN 10 AND 20 YEARS OLD

Percent of Funds	United Way	Client Fees	Private Foundation	Fund Raising	Federal Grants or Contracts	Local or County Taxes	Other Sources
1-5%	2	-	2	4	-	1	1
6-10%	1	-	-	4	1	-	-
10-25%	1	6	1	2	2	-	4
26-50%	2	1	-	1	-	-	1
51-75%	2	3	-	-	2	-	1
76-100%	-	8	-	-	-	-	-
	8	18	3	11	5	1	7

Almost three quarters of the agencies receive great or moderate support, and only one quarter receive slight or no endorsement.

The types of problems and the number of agencies having these problems, which prohibit more satisfactory community endorsement, are as follows:

	Number of Agencies	Percentage
Poor relations with city government	6	3
Bad publicity from media	4	2
Unfavorable relations with police	4	2
Services not used by community	15	8
Community perceives threat from agency's clients	17	9
Opposition from pressure groups	9	5
Community unfavorable to nature of program or staff	11	6
Other	17	9

CLIENT ELIGIBILITY

A summary of the data from the 97 agencies responding to the question about client eligibility shows that the most-mentioned criteria are age (30 or 31%), geographic area (22 or 23%), need (19 or 20%), and ability to pay (17 or 18%). Twenty-four agencies (25%) said that all potential clients are eligible. The criteria mentioned second were age (21%), need (18%), geographic area (14%), income level (10%), sex (10%), and other (18%).

CLUSTERS AND GAPS IN SERVICES

Methodology

In order to identify the patterns of services in the program areas of alcoholism, drug abuse, and juvenile delinquency, the County was divided into 11 geographic areas. The divisions were determined first by locating all facilities in the inventory, by means of their postal zip codes.

Population characteristics, natural boundaries, and apparent clusters or gaps of services became the basis for delineating the areas.[7]

In some areas there are obvious clusters of services, usually by program area. In others there are gaps in service. However, a service gap does not necessarily imply a service need.

Distribution of Services

Table 37 shows the number of services in each geographic area by type of program and totally. Not all of these agencies responded to the questionnaire, and therefore, the numbers are approximate. However, in all but two areas (East and South Central Los Angeles) the response rate was representative of the total sample, and these numbers are exemplary of the actual services available.

Distribution by Type of Program

Drug abuse patterns. Drug abuse agencies are clustered in West, South Central, and Central Los Angeles, as well as Long Beach. Many areas of the county show gaps in drug abuse services. The most significant gaps are in such very large areas as San Fernando Valley, San Gabriel Valley, and South Bay. East Los Angeles also has a small number of drug abuse agencies, in comparison with the dense population of that area. The only concentration of residential treatment programs is in the Venice-Santa Monica areas; the others are scattered throughout the county.

Alcoholism treatment patterns. Alcoholism treatment and recovery agencies are clustered in Long Beach, Central Los Angeles, and Pasadena. Pasadena is a fairly small area to have so many alcoholism agencies. Long Beach is larger, but it is surprising that there is a cluster here as well. South Central and East Los Angeles, the San Gabriel Valley, and the South Bay area have large populations yet, like the Glendale-Burbank area, these areas show the largest gaps in alcoholism services. Although Alcoholics Anonymous offers services throughout the county, most of its clubs were not surveyed.

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7. See Table 38, page 116 for a breakdown of these areas.

Table 37

NUMBER OF AGENCIES BY PROGRAM AND LOCATION

Area of the County	Drug Abuse	Alcoholism	Delinquency Prevention	Row Totals
South Bay	4	2	20	26
San Gabriel Valley	4	3	49	56
South Central Los Angeles	9	2	62	73
Southeast Los Angeles	8	10	18	36
Pasadena	5	8	28	41
Glendale-Burbank	2	3	10	15
San Fernando Valley	2	7	47	56
Central Los Angeles	5	24	53	82
East Los Angeles	6	3	51	60
West Los Angeles	14	6	59	79
Long Beach	12	10	20	42
Column Total	71	78	417	566

Delinquency prevention patterns. Six of the 11 areas have over 50 agencies that provide services directed toward delinquency prevention in some way. South Central and West Los Angeles have the largest groupings. The variety of these services is tremendous. A large number of agencies does not necessarily show that the needs of youth in that area are being met. The Glendale-Burbank and Southeast Los Angeles areas show the largest gaps in delinquency prevention service.

Unique and Significant Clusters and Gaps

Clusters. The Pasadena area offers a unique example of a cluster of services. It is a very small geographic area, yet the total number of agencies that serve Pasadena is relatively large. Pasadena is one of the oldest communities in the county. There is a great sense of community pride and a well-organized coalition of public and private organizations and individuals who have expressed through action their concern for the state of the area. These groups have initiated and, perhaps more important, have sustained support for the private agencies there who provide services in the areas of alcoholism, delinquency prevention, and, more recently, drug abuse.

The Long Beach area is larger than Pasadena, both in area and in population, yet it is smaller than many other areas and it has a significant cluster of services. The differences for this grouping, as compared with Pasadena, are important.

Long Beach is an old city, but only in the last 15 years has it begun to recognize its socially-related urban problems. Most of the agencies here were started in the early 1960s, and many are very young. These programs appear to operate almost completely independent of one another, yet most are successful and well-established in the services they offer. Communication seems to occur only when it is necessary; not out of any desire for coordination or because of community spirit.

There are other clusters of large numbers of services, but the condition of their initiation or continued existence show no such unique or unusual factors.

Gaps. Two sections of the county are almost completely devoid of services in all three of the program areas. They are the unincorporated

portions of the east and southeast edges of the county and the northwest section of San Fernando Valley. The former is populated by low-income families with limited resources; the latter by families of modest income. These are areas where many of the missing services are needed. In addition to being remote, these areas seem to lack the community (or organizational) resources needed to articulate the need or to acquire the services they need. For example, in the east and southeast area there are also very few public agencies and a rather loose community political structure. This makes it difficult for citizens to express their needs or to find a focus to stimulate community action.

In contrast, many highly organized middle-income communities have surprisingly few facilities in the three program areas. The South Bay and Glendale-Burbank areas are the primary examples. This could reflect the tendency of many funding agencies to define problems of drugs and delinquency as primarily problems of the poor.

Finally, there are almost no facilities in very wealthy areas of the county—the cities of Beverly Hills and San Marino are examples. However, this situation reflects the ability of wealthy families to meet their service needs invisibly and without regard to the proximity of services or to the cost. To some extent, middle-income families have this mobility, but not to the degree that is shown by the lack of services in their areas, especially in terms of drug abuse and alcoholism services, but also in delinquency services, for the more nonconforming youngsters of these areas.

Patterns of Service Within Each Area

South Bay area. The South Bay cities offer no detoxification facilities, prevention programs or recovery half-way houses for the alcoholic. Therefore, people needing these services must travel outside the area to receive them or not receive them at all. The other available drug services are hotlines which make referrals primarily outside the area. A few scattereed counseling or residential facilities that will serve the addict exist, but they are not able to handle the drug problems, especially those stemming from the congregations of youth in the beach cities. There seem to be ample counseling services for youth but few recreational programs and rap centers. Also, there are few agencies for young people with criminal records.

The two alcoholism agencies are the South Bay Christian Church in Manhattan Beach, which offers a variety of services, and the Southwest Alano Club, which is an AA agency. There are no detoxification or prevention programs, nor are there any recovery or half-way houses.

None of the drug abuse agencies offered provide detoxification or prevention services, and there are no half-way houses. Besides the hotlines, there is a Nar-Anon Family Group located in Palos Verdes for the families of addicts. Virtually no other drug services are available, except the counseling offered by youth programs. Considering the large number of young people in the beach areas, it is surprising how few services are available. The youth programs for the area include only two recreational centers, one free clinic, a few counseling centers, and a variety of other, more specialized services. The industrial areas offer a few more services than do the beach areas, but not many.

San Gabriel Valley, including the East Valley. The San Gabriel Valley, including the East Valley, is made up of many communities which each offer a few services. There is a substantial lack of drug abuse and alcohol programs and the program needs in these areas are detoxification facilities, residential treatment, recovery homes, and aftercare. There are expensive sanitarium-hospitals for alcoholics who can pay but there are no treatment, prevention, or detoxification services for those who cannot. There are several clinics and community centers scattered throughout the valley but few clubs, family services, and recreational programs, which seem to be needed. The existing services are very far apart and people living between them are forced to travel great distances to obtain them or 90 without the services.

Most of the services in this area are delinquency prevention services. They include several homes for children and emergency services for families. There are also several expensive psychiatric hospitals in the valley.

Among the drug services is a small detoxification facility in Rosemead, but there are no other treatment programs that include any kind of residence.

The alcoholism services are offered by two sanitarium-hospitals for those who can pay and by one recovery home.

Rosemead, Claremont, Pomona, and Covina have a larger number of services compared to other cities, but the four or five in each can hardly be called clusters. However, these services appear to be fairly centrally located in each community, leaving the borders between them unserviced. They are unserviced because many of these border areas are unincorporated, and it is here, either pushed in between industries or just physically more isolated, that one finds the low-income areas of the San Gabriel Valley, populated mostly by poor Mexican-Americans and some blacks. Two outstanding examples are near South El Monte and the Bassett area.

South Central Los Angeles and Compton. More alcoholism recovery and treatment facilities are needed throughout this area. The three private programs and the few public clinics available are not sufficient. This area experiences a high concentration of drug abuse and desperately needs more detoxification facilities, more residential treatment programs, and an intensive, high-quality education program in the schools and the community. The large number of delinquency prevention programs is offset by the lack of mobility experienced by most of the young people in this area.

Among the 62 delinquency prevention programs are some of the most successful and best known agencies in the county. The Westminster Neighborhood Association, Inc. offers a variety of developmental programs and has been in Watts for years. The Watts Labor Community Action Committee is well known for its job training programs. There are other well-established groups doing significant work here. There are also many very small, neighborhood-oriented centers providing much needed service in this area, like the Wesley Social Service Center and the Henderson Community Center. The Kedren Community Mental Health Center offers extensive help to families, and Operation Bootstrap and the Urban League provide other needed vocational training possibilities. As excellent as these services may be, they do not meet the needs of these communities simply because many of the young people can't get to them.

Of the drug abuse agencies, only one includes residential treatment; a few clinics offer some treatment, and the rest are primarily counseling groups.

The alcoholism programs are both recovery homes, one in Watts and one near the northern boundary.

The geographic spread of the agencies is good and the variety of services is extensive. However, a factor that must be remembered is the relative isolation of many people in these areas. Most do not have cars and public transportation is costly and very inconvenient. Although many of the agencies offer high-quality service, it does no good if the people in need can't get to them unless the proper connections and transportation can be provided.

Southeast Los Angeles County. The Southeast area of the county, in general, is greatly underserviced. The few services that exist are clustered, leaving gaping unserviced areas. There are no private residential drug treatment facilities and of the few drug services that exist none are treatment oriented. The existing drug counseling services are significant but in no way adequate for the large population. The same situation exists for the alcohol services except that there are a few treatment programs. Many different types of services need to be developed to meet the differing problems of alcoholics. The majority of the services offered to youth are neighborhood centers which offer a variety of services.

Considering the size of the area and the large suburban working population, surprisingly few services are available. The highest concentration is in the Whittier-Pico Rivera area. There is another scattered grouping in the west area. Among the alcoholism services are three sanitarium-hospitals, one recovery home, and a few education and counseling groups. There are no residential drug treatment facilities except for the detoxification program at Norwalk's Metropolitan State Hospital which is public. The other drug programs include two hotlines, a crisis intervention group, and a few educational counseling groups. The delinquency prevention or youth programs are concentrated in the areas mentioned and are made up of several neighborhood centers that offer recreation, counseling, and other activities, a few guidance and counseling centers, one general hotline, two family service associations, and a variety of more nebulous programs.

One is impressed by the fragmentation of the area, its cities, its diverse population, and its services. There seems to be no coordination among existing services, and the small number of programs may also reflect this division.

Pasadena. The Pasadena system of services is unique within the county. An example was the creation of a drug withdrawal center by the city's Community Planning Council, who saw the need for such a facility. More residential treatment facilities are needed as are aftercare facilities. Numerous facilities exist for alcoholics provided they can pay for them. The present need is not for a broader range of services for the alcoholic but rather for the services to be extended to those who cannot pay. There are mahy services to youth but for the most part they are treatment oriented and not prevention oriented. Many foundations and organizations are located in Pasadena and lend their expertise to other services as well as offer local services themselves.

Among the drug services, there is one residential treatment facility, one hospital offering detoxification, a community relations center, a psychiatric group, and a clinic.

The situation is much better for those alcoholics who can pay for the services they receive. There are six recovery homes, each requiring fees of differing amounts and differing commitments of time to be spent in the program. Both Huntington Memorial Hospital and Las Encinas offer detoxification services but at high cost. The Pasadena Alcoholism Center is a public agency that attempts to coordinate and supplement the private resources with public ones. The Center bolsters agencies that needs funds and clients. It is this kind of coordination along with the Community Planning Council and the Pasadena Council on Alcoholism, that makes the Pasadena system of services as complete as it is.

Of the 28 services to youth, seven are clinics and four are children's homes. Several private hospitals offer counseling and emergency services to those who can pay. As in the West Los Angeles area, numerous private psychological services are available to youth whose parents can afford to pay. The unusual aspect of delinquency prevention programs is that there are few recreational programs to prevent delinquency; the existing services

are treatment oriented. There are very few clubs and after-school programs, which are more prevalent in less affluent areas of Pasadena. Many organizations that do research on child development are located in Pasadena and lend their expertise in overall child development to agencies in the area.

Glendale-Burbank. The Glendale-Burbank area has alcoholism services, in expensive hospitals, which are available only on an ability-to-pay basis. Therefore, services such as prevention, detoxification, and recovery treatment appear to be needed by those who can pay little or nothing. For all of the youth in this residential area, more drug education programs, treatment and crisis intervention services, recovery homes, and recreation programs are needed.

Of the three drug programs, one is a hotline and one an educational outreach agency. There are three hospitals that treat alcoholics, probably at fairly high rates. There are no other alcoholism agencies in the area. The delinquency prevention agencies here prefer to think of themselves as youth development, and include Junior Achievement, an employment service, and several counseling centers. They total 10 in number.

The population in this area is made up of families with school-age children and retired people. Considering the number of youths in the area there appears to be few services offered by the private sector, but this may be balanced by public programs. It is true that children of middle-class families are less prone to overt delinquency, but that does not mean that they are without problems and needs.

San Fernando Valley. The San Fernando Valley, which contains more than one million people, has only two private drug abuse programs. They are hardly sufficient to serve the very large residential communities. All kinds of treatment and prevention services for the addict and potential addict are needed and enough must be developed to adequately serve the population. Of the existing delinquency prevention services, the majority are neighborhood centers or community mental health centers. Certain communities in the valley appear to have the many type of youth services they need, whereas other communities appear to have few or none. Frequently this lack of services corresponds to low income levels of the communities.

There are far too few alcohol programs to serve the population. The existing services are varied and effective but, like the drug programs, not convenient or affordable to all who probably need the services.

It is alarming to realize that an area with a population of one million includes only two drug abuse agencies. One is the well-known treatment center, El Proyecto del Barrio, the other, RAFE, is a group counseling center of ex-addicts for ex-addicts.

Central Los Angeles. The alcoholics on skid row do not go to the recovery programs in Central Los Angeles because they do not know about them. A facility to provide screening and placement in this area, such as that proposed by the Interagency Coordinating Committee of the Recovery House Association, is badly needed. The severity of the drug problem is relatively unknown at this time for this area of Los Angeles. Comprehensive services, especially in delinquency prevention and youth programs, are needed in some of the more isolated poverty areas of Pico-Union, William Mead, parts of Chinatown, Echo Park and Elysian Valley. There are 24 alcohol programs, 10 in downtown, and mostly recovery homes. The headquarters of many well-established youth programs, as well as a large number of various kinds of services, are here. There are 5 drug programs in the area including Children's Hospital hotline and the well-known Manhattan Project treatment facility of the Salvation Army.

There are 24 alcohol programs, most of which are in the downtown area. This reflects the needs of the men on skid rown and of transients and the homeless. These services are exclusively small recovery or aftercare homes with few detoxification or prevention services. The Wilshire Center area has a more diversified group of services. The Alcoholism Council of Greater Los Angeles is here. Other alcoholism services include a detoxification and treatment center, numerous recovery homes, two private hospitals specifically offering services to alcoholics, and Al-Anon and Al-Teen. Because the alcoholics are poor and lack knowledge, and because of the poor transportation system, there is little use of the alcoholism services in Wilshire Center by the alcoholics in downtown Los Angeles. The only alcoholism programs in Silverlake-Griffith Park-Los Feliz are the

central offices of Alano and Alcoholics Anonymous. However, this population is quite mobile and easily able to travel to Wilshire Center for needed services.

There are four drug abuse agencies located in downtown Los Angeles. The Manhattan Project is a very effective half-way house for youths. The only available drug services in the Silverlake-GriffithPark-Los Feliz area include the Children's Hospital hotline, Edgemont Hospital, and the Narcotics Educational Foundation of America. Three half-way houses of varying effectiveness provide the Wilshire Center with the only other drug services the area receives.

Of the 53 delinquency prevention programs in the area, about 25 are in the Wilshire Center area. The services range from special schools and homes for delinquent youths to mental health centers and different kinds of boys clubs. Several foundations and organizations specializing in services to youths are located in this area, as are numerous religious institutions providing similar services. The same situation holds true for the downtown area: organizations like Volunteers of America, Salvation Army, YMCA, and Catholic Big Brothers and Sisters have their headquarters in this area and provide services. There are also several clinics and recreational programs for youths. In the Silverlake-Griffith Park-Los Feliz area numerous hospitals and health centers offer services to youth. There are also free clinics, child guidance facilities, and headquarters of youth organizations such as Boy Scouts and Boys Republic.

East Los Angeles. East Los Angeles services must be easily accessible to the much less mobile population, and bilingual, to be effective. Because East Los Angeles is a poverty area eligible to receive federal funds for programs, there are clusters of services that meet the needs of the certain residents. However, areas not around public housing or not in the Model Cities areas frequently are devoid of services. In all of East Los Angeles there are only four programs for alcoholics. This could be because there are few alcoholics and therefore no people to be served, or that the federal money and community concern is not for alcoholics. One half of the drug programs offered in East Los Angeles are in Boyle Heights, which obviously

reflects a need. However, of all the programs in East Los Angeles only one offers residential treatment facilities.

There are several public housing projects in East Los Angeles with accompanying public and private services. This is especially apparent in the cluster of agencies around the Maraville projects, since it has been declared a target of Model Cities. Another factor in analyzing the service system in East Los Angeles is the presence of East Los Angeles College and California State University at Los Angeles. These schools provide services to the community that probably would otherwise not be offered.

The interesting aspect of the service system is the contrast between the intense clustering of services in some areas and the great lack of services in certain other areas. Whittier Boulevard in East Los Angeles is amply provided for, whereas an isolated poverty pocket in Glassell Park and the middle-class community of Monterey Park have virtually no services. Boyle Heights and East Los Angeles appear to have the greatest concentration of services.

In all of East Los Angeles there are only three alcoholism agencies. Included in these are the Boyle Heights help and prevention program and White Memorial Medical Center services to alcoholics. Mt. Washington has the Lincoln Care Center but no other alcohol program.

Six drug abuse agencies exist within the area and three are located in Boyle Heights. They are the Narcotics Prevention Project, Empleo, and Victory Outreach. The East Los Angeles Drug Advisory Council is located in City Terrace, the Mexican-American Youth Organization is in Mt. Washington, and LUCHA (League of United Citizens to Help Addicts) is in East Los Angeles. Only the Narcotics Prevention Project offers residential treatment facilities.

The greatest number of services offered are for youths and their families. There are 51 services with an amazing variety of programs. They range from the Barrio Free Clinic to the Los Angeles Times' Boys' Club. There are youth clinics, numerous boys' and girls' clubs, recreational and community centers, opportunity programs and counseling programs, and one boys' home. The emphasis appears to be more on recreation than on treatment or counseling services. There are many programs emphasizing community action, youth and adult leadership, and cultural awareness.

West Los Angeles. One third of the drug abuse agencies in West Los Angeles are located in Venice. Those in Venice are primarily half-way house whereas the services in the other communities are primarily hotlines and drop-in centers. There are a few private hospitals offering out-patient counseling services. A rather unique program in Hollywood is the drug analysis service offered by the Do-It-Now Foundation. Of the alcoholism agencies in the West Los Angeles area, only two are recovery houses and they are both in West Hollywood; there is a sanitarium in Inglewood. Another third of the alcoholism agencies only offer referral services, which must be outside the West Los Angeles area. One of the goals of the C.L.A.R.E. Foundation, one of these resources, is to encourage the development of more services for alcoholics in West Los Angeles, since there are now so few.

The majority of services and facilities are for youths. These range from numerous private and expensive counseling and psychological services to several health centers and family services. The delinquency prevention agencies, in general, seem to be the most evenly distributed but inaccessible to many of the residents due to the high cost of many of the services.

The Venice community has the greatest concentration of services, reflecting its serious problems and residents' concern. This cluster is also because there is a densely populated low-income area in Venice, the Oakwood area, made up primarily of poor blacks and Mexican-Americans. The nine youth programs have not been mentioned; they range from a family health clinic to a bilingual, multipurpose center. The cities of Inglewood, Culver City, and Santa Monica contain a diverse number of services which are more accessible, in terms of costs, to their residents than are the services in the West Los Angeles section of the city of Los Angeles.

Beverly Hills and Topanga are located in West Los Angeles but offer no services. Pacific Palisades has one hotline; Malibu has a camp for delinquent boys and no other private services. However, this apparent lack of services is not significant because most of the residents have the transportation and the money to go elsewhere for the services they need.

Throughout the West Los Angeles area more low-cost, or free, youth development and (or) delinquency prevention programs are needed, especially

in those sections that are part of the city of Los Angeles. More drug treatment agencies, spread evenly, would ease the pressure on the existing ones, most of which are limited in size. The alcoholics in the western area are primarily from middle-class families, but services are needed just as badly by them as by the poor. Temporary residential treatment facilities followed by in-home counseling (and retraining, if necessary) are badly needed in West Los Angeles.

Long Beach area. The Long Beach-Lakewood area has recovery homes and some detoxification services for alcoholics but not enough to meet the demands. Also needed are prevention and counseling services. Available drug services include various kinds of intensive counseling and referrals to services outside the area but virtually no treatment. Therefore, detoxification, recovery, hospital care, and aftercare facilities are needed. The North Long Beach area appears to have a cluster of delinquency prevention programs but the rest of Long Beach, Wilmington, and Lakewood have virtually none. The area has an abundance of family service and psychological counseling centers but few private recreation programs. On the other hand, Wilmington, which includes a sizable poverty area, is almost devoid of services in all of the program areas. Lakewood does not have many, but its population is quite mobile.

Table 38

BREAKDOWN OF PRINCIPAL GEOGRAPHIC AREAS

SOUTH BAY

1. Hawthorne
2. Carson
3. Torrance
4. Gardena
5. Redondo Beach
6. Manhattan Beach
7. Rolling Hills Estates
8. Palos Verdes

SAN GABRIEL VALLEY

1. El Monte
2. LaVerne
3. Pomona
4. W. Covina
5. La Puente
6. Rosemead
7. Glendora
8. Arcadia
9. San Gabriel
10. Monrovia
11. Azusa
12. Baldwin Park
13. Claremont
14. Covina
15. Duarte
16. San Dimas

SOUTH CENTRAL LOS ANGELES

1. South Central Los Angeles
2. Compton

SOUTHEAST LOS ANGELES

1. Pico Rivera
2. Sante Fe Springs
3. Whittier
4. Montebello
5. La Habra
6. La Mirada
7. Bell Gardens
8. Huntington Park
9. Downey
10. Lynwood
11. Norwalk
12. Hawaiian Gardens
13. Paramount
14. City of Industry

PASADENA

1. Pasadena
2. Alhambra
3. Altadena
4. South Pasadena

GLENDALE-BURBANK

1. Sun Valley
2. Burbank
3. Sunland
4. Glendale

SAN FERNANDO VALLEY

1. Granada Hills
2. Tarzana
3. Woodland Hills
4. Van Nuys
5. Sherman Oaks
6. North Hollywood
7. Canoga Park
8. Chatsworth
9. Encino
10. Reseda
11. Pacoima
12. San Fernando
13. Sepulveda
14. Northridge

CENTRAL LOS ANGELES

1. Silverlake
2. Los Feliz
3. Griffith Park
4. Plaza Area
5. Downtown
6. Wilshire District
7. Wilshire Center

EAST LOS ANGELES

1. East Los Angeles
2. Mt. Washington
3. Glassel Park
4. Monterey Park
5. City Terrace
6. Boyle Heights
7. Lincoln Heights
8. Highland Park

WEST LOS ANGELES

1. Bel Air
2. Westwood
3. West Los Angeles
4. Culver City
5. Mar Vista
6. Miracle Mile
7. West Hollywood
8. Venice
9. Hollywood
10. Inglewood
11. Pacific Palisades
12. Malibu
13. Santa Monica

LONG BEACH

1. Lakewood
2. San Pedro
3. Wilmington
4. Long Beach

POLICY ISSUES[8]

SERVICE PATTERNS

There is a network of persons, agencies, funding sources, and activities in Los Angeles County devoted to providing services for delinquents, drug abusers and alcoholics. Some of these are public and some of them are private, although the line dividing the two is hazy because of the number of private agencies that receive public funds. This study is a survey of the capabilities and needs of the private agencies in the system. To refer to these agencies concerned with delinquents and addicts as parts of a system is not to say there are well-defined and agreed-upon goals, a clear-cut division of labor among agencies, and a coordinated set of programs for reaching these goals. Indeed, none of the above conditions exist and the system is both fragmented and disorganized.

There are no data on the number of delinquents, drug addicts, and alcoholics in Los Angeles County nor on the number who receive some treatment from the system. There are widely diverging and conflicting views on what constitutes effective treatment and no data on the cost or effect of the services provided. Agencies in the three program areas do not consider themselves as parts of some larger system that includes a public component and have relatively little contact among themselves. Cleavages appear along public versus private, program emphasis, and ethnic lines.

Data gathered during this study suggest there are approximately 640 agencies that provide services for addicts, alcoholics, and delinquents in the County, most of which have been in existence for 6 years or less, half of which have revenues of $100,000 or less and operate with small staffs who have little formal training. Treatment is emphasized more than rehabilitation and intake is the most-developed part of the system.

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8. The discussion in this section is based on the 57 personnel interviews and the other studies (summaries of which are found in the appendices) as well as the results of the mailed questionnaire.

System Components and Their Functions

Intake. System intake consists of four key elements: client entry, crisis intervention, diagnosis, and referral.

1. Client entry is either self-initiated or prompted as a result of detection of a problem by persons or organizations outside the system, for example, policemen, judges, parole and probation officers, clergymen, teachers, and parents.

2. Crisis intervention is often a critical components of client entry. Potential clients may be on the verge of self-destruction or violence and need immediate and intensive response. The families of addicts who have become violent may need a place to stay and care while they try to re-establish the basis of more independent existence.

3. Regardless of the mode of client entry, the first immediate need is tentative diagnosis to determine the client's psychological and (or) medical treatment needs. The diagnosis may result in a referral or in treatment on the premises, depending upon both the resources available to the counseling source and the treatment needs of the client.

These key elements of the intake system are sketched in Figure 1.

Treatment. Treatment consists of four key elements: medical care, legal assistance, detoxification, and therapy.

1. Most of those who are addicted to drugs or alcohol also have other medical problems, frequently related to their addiction.

2. Legal assistance. Most clients have legal problems, ranging from a host of family-related and other civil offenses to criminal charges.

3. Drug and alcohol addicts must frequently be detoxified before any further services can be provided for them.

4. Treatment varies widely, depending upon the nature of the client's problems and the philosophy of the facility. Among the more frequent forms of treatment are counseling, recreation, cultural enrichment programs, big brother relationships, and remedial reading. In most instances, clients attend programs while living in their normal places of residence. In some instances, the agency has facilities for the client to live in—recovery homes. Within this latter category are a number of facilities referred to as half-way houses which offer a wide range of treatments and

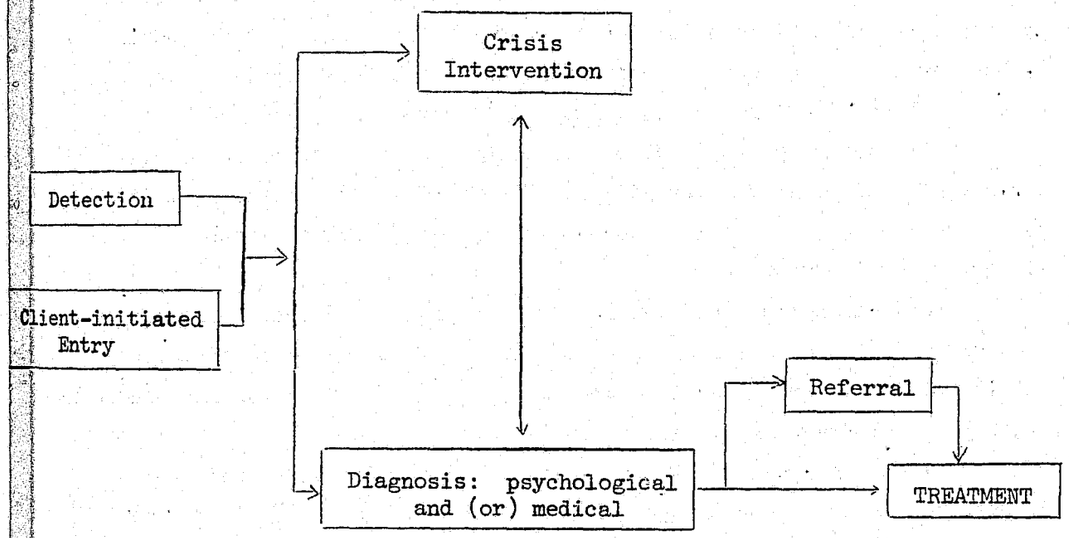


Figure 1. Intake Elements

which usually emphasize the client's need to help himself. One of the most important aspects of treatment is the frequency with which a patient may need more than one form of treatment. The key elements of the treatment system are summarized in Figure 2.

Aftercare. The line separating aftercare from treatment is both tenuous and disputed. Some professionals argue that aftercare is an integral component of treatment. However, because it seems to be the one component of the system which commands least resources and for which the demand is greatest, the analytic distinction is made for the purposes of emphasis. It has three key components: continuing contact between facility and client, job or vocational counseling, and follow-up.

1. Continuing contact between facility and client involves a wide variety of activities such as additional referrals for continuing medical care, continuing psychological counseling and close contact with a supportive environment.

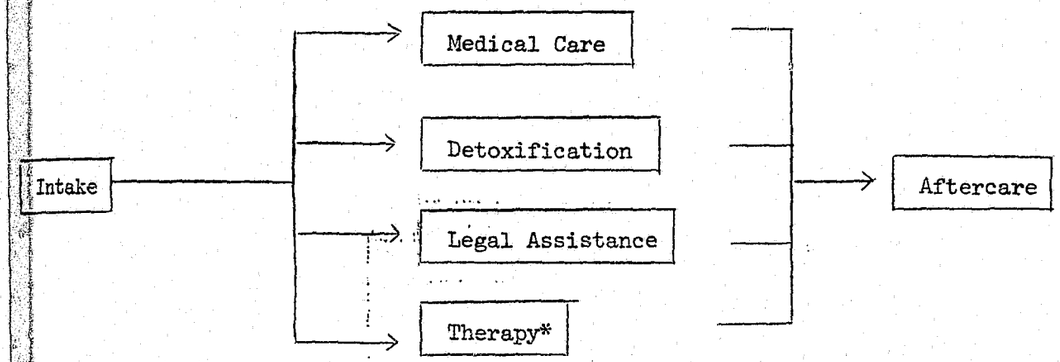
2. Job counseling includes not only helping the client to determine what his marketable skills are but also helping him locate an employer who is willing to employ an ex-addict or delinquent. Some further education or skill development might also be involved.

3. There is considerable unanimity among professionals that follow-up must continue for a reasonably prolonged period after the most severe of the client's symptoms have been treated. There is, however, virtually no agreement on the nature of follow-up.

Figure 3 summarizes the elements of aftercare.

System Capabilities and Needs

Viewed as a system of interrelated services, the intake components are emphasized at the expense of the treatment and aftercare components. Because of the absence of information about demand for services and the difficulty in compiling a complete and exhaustive inventory of all agencies, the facilities, services, and client loads, a rather arbitrary criterion is employed in this report to determine system capabilities. If 30% of the responding agencies reported they provided a given service, that service was deemed to be provided by the system at an adequate level. Since all of the data on services are available in another section of this report,



*Counseling, cultural, recreation, remedial reading, big brother, out-patient, half-way houses.

Figure 2. Treatment Elements

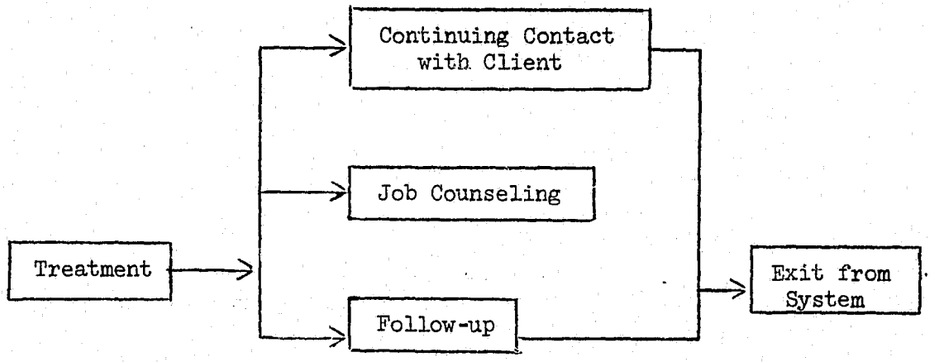


Figure 3. Aftercare Elements

those persons who wish to use a more relaxed or a more stringent criterion are able to do so. However, using the 30% criterion produces the following diagnosis of system capabilities:

1. Intake: referral (provided by 72% of reporting agencies), crisis intervention (53%), community education/prevention (46%), and psychological testing (37%).

2. Treatment: counseling (78%), recreation (48%), outpatient (36%), and remedial reading (32%).

3. Aftercare: follow-up (39%)

Three criteria were used to assess the level of need for the set of services which compose the system: (1) assertion by the respondent that there were additional needs for that services and that the agency would like to add (or increase the level of) the service, (2) among the top ten of the list of services which agencies reported were most demanded of them, and (3) the service is provided by less than 30% of responding agencies. Using these criteria, the following diagnosis of system needs emerges:

1. Intake: community education^{+} (a plus sign after a service indicates that the service meets two of the criteria mentioned above), crisis intervention,$^{+}$ emergency shelter,$^{+}$ psychological testing, and medical diagnosis.

2. Treatment: medical care, legal assistance,$^{+}$ detoxification, self-help programs,$^{+}$ big brother relationships,$^{+}$ half-way houses^{+} and other residential facilities, and cultural enrichment programs.

3. Aftercare: job counseling^{++} (a double plus after a service indicates that it meets all three criteria), and follow-up.$^{+}$

Systemwide Needs

Job counseling meets all three criteria used to assess the degree of need of a service within the system. It is closely followed by follow-up, which all programs rank as important and list among the top three of desired additional services. Agency preferences for additional services must not be ignored, and respondents listed community education, job counseling, and follow-up as most desired additional services.

Meeting two of the three criteria for assessing the degree of need are: crisis intervention, emergency shelter, community education, legal assistance, self-help programs, big brother relationships, half-way houses. Therefore, they are designated next to most important system needs.

Finally, detoxification facilities (especially for barbituate users), medical care, cultural enrichment, and psychological testing each meet one of the criteria for assessing the level of system needs and constitute a third category.

When the respondents are separated on the basis of whether they emphasize one of the programs, a similar ranking of needs emerges: Alcoholism programs listed follow-up, legal assistance, and job counseling. Drug programs listed follow-up, legal assistance, and cultural enrichment. Delinquency prevention programs listed follow-up, crisis intervention, fast diagnosis, half-way houses, and detoxification facilities.

These findings have clear implications for service and facility needs within the system. Much more emphasis should be given to treatment and aftercare.

ACCESS TO SERVICES

Agencies are neither evenly nor randomly distributed throughout Los Angeles County. Some areas have clusters of facilities and services, others have gaps. Without some means of determining demand for different kinds of services, it is impossible to determine whether the existing distribution of services is adequate.

> Policy Implication. Until demands for service can be matched with available facilities, emphasis should be placed on areas with fewer facilities and services. Priority should be given to drug abuse facilities in San Fernando Valley, San Gabriel Valley, South Bay area, East Los Angeles; to alcoholism facilities in South Central and East Los Angeles, San Gabriel Valley, South Bay, and Glendale-Burbank; and to delinquency prevention programs in Glendale-Burbank and Southeast Los Angeles.

Another aspect of access is the ability of clients to get to a facility—i.e., transportation. This is mentioned as a problem in all aspects of service delivery, but most frequently with regard to referral. Many referrals cannot be made because the clients have no means of transportation. The long-run solution is an adequate public transportation system in Los Angeles County. In the meantime, two possibilities could be pursued. Each facility should have a van or some other low-cost form of transportation. Another possibility is encouraging more small multi-purpose facilities, in all communities. Both possibilities are rather expensive.

The final aspect of access is cost. Some level of service must be available regardless of a client's ability to pay.

SYSTEM RELATIONSHIPS

The existence and continued reenforcement of the separation of public and private agencies providing services in the three program areas has important consequences for (1) the differential emphasis on the three system functions, that is, the relative strength of the intake components and relative weakness of the treatment and aftercare components, (2) referral, (3) duplication of services and facilities, and (4) all forms of cooperation and planning.

The specific problems and perceptions that underlie the antipathy of private agencies for public agencies are so complex and deep-rooted as to seriously threaten the success of any efforts by agencies in the public sector to initiate cooperation in the areas that would benefit the system the most, namely, coordination and planning. While there are few hard data with respect to these problems, the content of personal interviews makes clear that such efforts by the public sector might well be viewed as an intrusion into the affairs of private sector agencies, possibly a threat to their autonomy, and perhaps an effort to control them.

> Policy Implication. Public agencies should be extremely cautious in their efforts to "organize," "rationalize," or even take the lead in coordinating the private sector.

Cooperation Within the Private Sector

More than half of the agencies responding reported at least one form of interagency cooperation and more than a third expressed an interest in developing one or more forms of cooperation. Greatest interest is expressed in cooperation for research (which was also listed as the second priority for use of additional funds), grants and contracts, program development, and long-range policy. Alcoholism agencies are most interested in cooperative arrangements for purchasing, publicity, information sharing, and referral. Drug abuse agencies are most interested in the facilities sharing, contracts, and proposals. Delinquency prevention agencies express most interest in the fund raising and long-range policy.

> Policy Implication. Many of the types of coordination in which agencies express an interest in participating are precisely those which might help redress the imbalances within the system that have been noted in this report. Clearly, this interest should be recognized, encouraged, and built-upon. Special note should be made of agency interest in research.

Patterns of Cooperation

Those agencies presently engaged in cooperative arrangements express a clear preference for local, as opposed to countywide, cooperation.

> Policy Implication. Considering (a) the fear private agencies have of intrusion by the public sector into their affairs, (b) the imbalance and gaps within the system, and (c) existence of some interest in local cooperative arrangements, efforts to make the system more "rational" through cooperation should be restricted to encouraging or facilitating such arrangements at local levels within each program area.

Character of Agencies Involved in or Interested in Interagency Cooperation

Such agencies tend to be new, small, without full-time administrators, and operating on small budgets.

> Policy Implication. These data suggest that agencies with the characteristics listed constitute the best candidates for encouraging different forms of interagency cooperation.

Cooperation with Law Enforcement

An overwhelming majority of agencies report good to excellent relationships with law enforcement, but only a bare majority report cooperative arrangements and only one quarter of them express interest in developing some form of cooperation. Interest in cooperation in the following areas is mentioned: public education, financial support, general information, and referral.

> Policy Implication. The benefits of cooperative arrangements between law enforcement and the drug abuse, alcoholism, and delinquency programs are obvious. Law enforcement agencies should be encouraged to increase their cooperative efforts.

PLANNING

Agencies either recognize and respond to the current social acceptability of planning or in fact do quite a bit of it. A vast majority of all agencies report doing some planning. There is considerably more planning (in order of frequency) for program development, short-range goals, long-range goals, and services than for program evaluation, fund raising, or special projects. The least-mentioned category of planning is for research.

> Policy Implication. If agencies are engaged in as much planning as they indicate, and if they could be encouraged to cooperate with one another for planning, many of the problems previously identified regarding system imbalances and gaps in services would be recognized and, possibly, rectified. Encouraging cooperation in all forms of planning would seem to have an enormous payoff and should be a high system priority.

PUBLIC-PRIVATE SECTOR RELATIONSHIPS[9]

The variability and sensitivity of relationships between agencies in the public and private sectors were manifested during all facets of the study. This section discusses the issues as they presently exist and offers examples of how these relationships have been positive and negative.

Separation

Perhaps the most important issue is the fact that there are both public and private sectors. The private sector tends to perpetuate this separation more than the public sector does. Many private agencies prefer no or little attachment to public agencies. Many representatives of public agencies have been so disappointed with the services of private agencies that they prefer to disregard the private agencies. Other public agencies have varying degrees of formal and informal agreement with some private agencies regarding funding, contracting for services, in-kind contributions, information sharing, and referral. Often the strongest relationships are those between individuals in each kind of agency. These relationships are informal and thereby perpetuate the separation. These relationships facilitate using each other's strengths and avoid working through bureaucratic channels to accomplish certain ends. Most private agencies participate in the political and bureaucratic spheres of the public agencies only to the extent necessary to serve their self-interests. Beyond that, they have little general desire for participation.

Many agency representatives recognize the need for better delivery of services, more sharing of information, and other benefits of increased interaction. However, the private agencies are not yet willing to fully take the risks that deep involvement with the public agencies also includes, e.g., perceived loss of control or autonomy.

Coordination and Planning

The problem of how to plan and coordinate the services and programs of the public and private sector agencies appears to be almost insoluable.

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9. Data based on 57 personal interviews with members of public and private agencies.

Well-executed coordination of services would prevent duplication. Careful planning by both sectors might result in a more even distribution of all services to the areas that presently lack one or all services. Coordination of information on a continuing basis might develop into faster and better referral systems to help clients.

One of the biggest stumbling blocks to further planning is the determination of authority relationships. Many private agencies (including those who now have formal relationships with the public sector) fear that participation in joint coordination or planning would result in loss of the autonomy they now enjoy.

The private sector is especially divided on the need for coordination. Some agencies prefer to limit the scope of their community participation to the particular area that they serve. Others recognize a greater need, but prefer to communicate with other agencies, public or private, either very informally or for very specific purposes, e.g., reciprocal referral or contracting for a specific service like detoxification.

A more obvious problem of combined coordination and planning is that so little of this is done within either sector that it is difficult to conceptualize a joint planning effort. Many of the private agencies that provide the same services have no association with each other, and those that do are aware that they do not represent all agencies. In the public sector several different health departments or even several different branches within each department may have drug programs; however, this does not mean that each knows what the other is doing.

Many private agency staff recognize the honest intent of those public officials who are interested in further coordination and planning. Such staff fear not so much the persons as the process of large bureaucratic structures, i.e., they fear that joining in compromise over decision making too often results in sacrifice of further autonomous decision-making.

Other representatives of private agencies feel that the interest of the public sector in the private sector constitutes indirect admission that governmental agencies assigned to provide services and education on alcoholism, drug abuse, and delinquency prevention have not been doing their jobs—that their interest is recognition of the very good job being done by private agencies. If this is true, greater formal relationships

could result in less successful delivery of services rather than an improvement.

Several private agencies' staff also fear that official association with some public agencies will damage the acceptance and support they now experience in their communities. Program sponsorship or co-sponsorship by a public agency that is not trusted in a community can be a "kiss of death" to a program.

Attempts at Improving Planning and Coordination

Several promising efforts are being made to remedy this problem. The county, for example, has combined its many health departments in an attempt to promote internal communication and coordination. Prior to this the Department of Mental Health initiated the Drug Task Force in an attempt to coordinate public and private drug abuse programs. This Task Force is attempting to obtain funds for comprehensive planning and to develop needed service facilities.

Members of the private sector have always participated on city and county study and planning commissions; however, in some cases the membership has not changed in proportion to the growing number of concerned leaders in the fields of alcoholism, drug abuse, and delinquency prevention.

Professional associations are emerging as meeting grounds for communication, especially in the area of delinquency prevention. The independence of these organizations from either public or private agencies may be the most promising factor in the future use of these associations as planning or coordinating bodies.

Funding

Many private agencies receive a part or all of their funds from public, mainly federal, sources. The county contracts with some to provide to a community services that the county cannot directly provide. A few private agencies must do research as well as provide services in order to receive funds.

Although the federal government is an increasing large source of funds for drug abuse and delinquency prevention programs (and a growing source for alcoholism programs), there is a reluctance among some private agencies to apply for funds from federal (or any other public) sources. The

primary reasons are a lack of knowledge of the sources available and their funding policies. There is also the fear that to receive public funds requires adherence to very strict guidelines or controls.

Several of the private agencies interviewed either had firsthand experience with federal funds being cut before the period of funding had ended or knew of other valuable programs that no longer exist due to funding cuts. The question here is the reliability of public promises, inasmuch as there are frequent changes among the political powers that control funds.

Other agencies that have received public funds for experimental or demonstration projects find there are no public sources of sustaining funds past the experimental period. As a result, much of the private sector resents the apparent trend of public funding to grant money to demonstration projects but deny support to ongoing programs that have proved their worth or success over time.

Examples of Positive and Negative Public-Private Funding Relationships

The various community mental health centers receive most of their funds from public agencies, but in a variety of ways. Kedren Community Mental Health Center in South Central Los Angeles has a contract with the county to provide mental health services to a particular area. This arrangement works well for them; it is one of Kedren's most stable sources of funds and the contract agreement specifies very few controls. A large portion of Kedren's funds comes from NIMH's Community Mental Health Centers Act. These funds vary in amount from year to year but they are stable and ongoing. Other sources, especially client fees, vary, but altogether this is an example of a positive and ongoing public-private relationship.

Haven House in Pasadena provided the only emergency shelter in the county for the families of violent alcoholics. Yet this agency was forced to close because of the lack of experience and sophistication of its directors in the procedures and policies of acquiring large amounts of public funding.

Several experimentally funded projects that are making positive changes in their communities are now reaching the end of their 3-year funding periods. In some cases it appears that local governments will assume sponsorship and some funding responsibility at the end of the period; however, the balance of the funds needed to continue must be raised elsewhere. The time that could be spent continuing services is now being spent in fund raising.

A well-established agency in East Los Angeles accepted no federal funding, until recently. It has existed for over 5 years on private funds raised by its board of directors. It has been a very positive catalyst in providing and bringing needed services to its community. Only now, when it can exist independently on its private income, will it accept federal funds. This has been a long procedure to ensure continued existence but it was felt to be important in view of the instability of public funds.

Community Pressure and Community Support

The relationship that an agency has with the community in which it is located often determines its success or failure. Sometimes the relationship is not even an issue, but it always has the potentiality of becoming one. Most of these agencies desire to be located in residential areas, which in each instance requires a zoning variance supported by the local residents and city officials. Sometimes the facility is welcomed by the community and obtaining the variance presents no problem. However, in the case of the New Connection in Glendale, the local citizens used the zoning ordinance as a means of evicting the drug half-way house from the community. Some citizens in Beverly Hills attempted to establish a private referral-counseling center within the city limits, to the dismay of those local residents and city officials who were told the facility was to conduct a drug program. After considerable controversy and months of hassling, the facility was established.

Tuum Est, a half-way house for former drug addicts, located in Venice, is welcomed by the community as one solution to their substantial drug problems. From the beginning the board of directors of Tuum Est and city officials have worked together to resolve mutual problems. The Los Angeles Times Boys Club in East Los Angeles has been an integral part of the community since its creation 25 years ago. Many of the present local

leaders are alumni of the agency, which works closely with local government officials to solve local problems. The director of the Boys Club is on the board of directors and advisory boards of many public and private agencies and organizations, which fosters numerous types of relationships that are of benefit to the club.

Police Relationships

Some agencies have been more successful than others in maintaining satisfactory relationships with local law enforcement officials. The data indicates that for the most part the relationships have been very positive. Concern has been expressed over unequal treatment of the staff members of certain programs by the police and residents. Project Culver, however, is an example of an attempt by the city and police to do something positive to halt the drug crisis in Culver City; it operates out of the police department and has the support and cooperation of the police. It is recognized that successful programs like Project Culver help the police with their responsibilities.

SYSTEM RESOURCES

Funding

Although almost half of the responding agencies report that their incomes are adequate, certain patterns emerge. Alcoholism and delinquency prevention agencies seem to have the greatest financial difficulties. Agencies said they would deal with deficits by seeking additional funds and, if necessary, reducing services.

Those receiving funds from United Way gain less than 25% of their income that way. About one quarter of all agencies depend solely on client fees; and most of those agencies which receive public support get half or more of their income from public sources.

United Way tends to fund older, more-established, and delinquency prevention agencies. Federal funds go primarily to newer agencies, and those emphasizing drug abuse and delinquency prevention. Alcoholism agencies depend on client fees for the most part.

The most frequently mentioned problems encountered in seeking federal funds are lack of knowledge of sources and policies as well as lack of expertise in preparing proposals. Agencies with more professional staff report fewer difficulties.

Budgets seem unrelated to number of clients served; however, some delinquency prevention agencies serve relatively few clients despite their rather large budgets.

In interviews with agency personnel several other funding problems were raised. Alcohol programs see themselves discriminated against by all funding sources, especially federal. Many criticized a perceived emphasis, especially among public funding sources, on "model," "innovative," and "experimental" programs at the expense of "older, more established" or "more traditional" programs. Others expressed concern about the tendency of public sources to fund such "model" programs for a short period of time, at the end of which the agency either collapses or drastically alters its program for lack of funds. Finally, some perceive public sources as promoting competition among ethnic groups.

Policy Implication. Although coordination among all funding sources is probably impossible to obtain, some local body could keep track of the patterns of financial support and call attention to imbalances. Is alcoholism really a third funding priority? Does United Way consciously favor older, more-established agencies and delinquency prevention programs? If so, is this appropriate?

The system would benefit from more information about federal funding sources and policies, as well as assistance in preparing applications for funds.

Long-term financial stability seems to be a major concern of all agencies. Perhaps local governments could play a larger role in their support.

Whether or not the perception about ethnic competition reflects a reality, all funding sources would benefit from some information about system needs and gaps in service.

Hence the previous policy issues relating to inter-agency cooperation and planning could relate to information needs of funding sources.

Skill Patterns and Training Needs

Although three quarters of all responding agencies report some skilled staff, most agencies have few staff and low skill levels. Greatest needs seem to be for administrative or managerial skills and such paraprofessional skills as general counseling, community organization, and drug education. Drug agencies report the greatest need for trained personnel (in personal interviews, lack of basic management skills was cited as the frequent cause of an otherwise sound program's failure), and alcohol programs report the least need. Delinquency prevention programs seem to be better staffed in all skill categories. Despite constant mention of the need for more staff, agencies ranked increasing staff fourth in priority for expenditure of funds (after new and expanded facilities and services and research).

Policy Implication. Agencies would benefit from having some kind of rudimentary management training available and readily accessible to their directors and/or staff, perhaps in the form of workshops. The availability of paraprofessional training should be made known to agencies.

MISCELLANEOUS POLICY-RELATED ISSUES

Relationships with Medical Profession

Personal interviews revealed a widely held opinion that the medical profession was insufficiently involved in problems of alcoholism and drug abuse. In the eyes of the interviewees, the lack of involvement is manifested by (1) shortage of detoxification facilities, (2) inadequate emphasis on public education and other preventive measures, and (3) the emphasis on treatment and the relative lack of emphasis on rehabilitation. Regardless of the accuracy of these perceptions, they are widely held and should be brought to the attention of local medical associations.

SUMMARY OF AGENCY AND PROGRAM NEEDS[10]

FACILITIES AND SERVICES

Crisis Intervention Services

Eighty-nine percent of all agencies surveyed cited crisis intervention services as important to the success of programs in the three areas under study. Such services also ranked third among the responses of agencies to the query about services most desired. They are considered equally important by all agencies, regardless of program emphasis. Crisis intervention facilities include places for runaways and for potential suicide victims to receive help at critical times, counseling for young drug users and problem children when they decide to look for help, as well as places to which other organizations such as schools or law enforcement can make referrals on a 24-hour basis, and temporary shelter for whole families, especially those of violence-prone alcoholics or addicts.

Follow-up Services

Eighty-nine percent of all agencies rated follow-up services as important to the success of their programs. It was ranked second among those services most desired. Follow-up services include continuing counseling, but more important are education, training, and job placement. Among the reasons cited for the importance of educational, occupational, and follow-up services are the extent to which occupational failure is tied up with the causes of addiction to alcohol and drugs. Many addicts have either failed in previous career attempts or have no marketable skills. Many delinquents, also, suffer from a low level of educational achievement and job skills. Most programs in all areas view employment as a very important part of the rehabilitation process, through which independence and self-esteem are developed.

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10. The discussion in this section is based on the 57 personal interviews with agency personnel and the special studies (summaries of which are in the appendices) as well as the mailed questionnaire.

Timely and Adequate Medical Diagnosis

Eighty percent of the respondents rated medical services as important to program success. This is especially the case for alcohol and drug programs, many of whose clients have major medical problems. During interviews with program staff there emerged a clear feeling on their part that the medical profession has remained too detached from the problems of both alcoholics and drug addicts. Cited as evidence are the few facilities in hospitals for detoxification and the failure of local medical associations to make the problems of addiction a high health priority. Agency personnel perceive no systematic effort on the part of the medical profession to become heavily involved in these problems of either treatment, rehabilitation, or public education. Regardless of their validity, these perceptions do exist widely among practitioners.

Centrally based clinical records. Despite widespread agreement among those interviewed as to the importance of accurate information about an addict's previous medical history, there is no wide agreement about the desirability of developing a central records depository to which agencies could go for information about clients. Only 36% of those responding considered such a facility desirable, while 30% considered it undesirable and 34% were not sure.

Residential Facilities and Half-way Houses

Seventy-nine percent of the respondents rated such facilities as important; juvenile delinquency agencies were less concerned with this issue than were drug and alcohol programs. Residential facilities include recovery homes, residential half-way houses, and aftercare services. Treatment is provided in a structured but home-like atmosphere and is viewed by agency staff members as a fruitful means of rehabilitation for drug users and alcoholics. The demand for such facilities appears to far exceed their supply. Most professionals regard long-term residence—6 to 9 months—to be much more beneficial than short-term stays. However, because of the heavy demand for their services, most such facilities set a maximum residency as low as 30 days and as high as 90 days. This is a conscious tradeoff on the part of residence directors between their view of

adequate treatment and their desire to respond to the great demand. All of those interviewed personally ranked residence facilities among the greatest need.

In personal interviews, a need was expressed for more residential facilities of all kinds, especially half-way houses and recovery homes. They are important because their functions span two key system components, treatment and aftercare. They encounter many problems. Agency personnel feel that both facilities can accomplish their rehabilitation activities better if located in residential neighborhoods; however, zoning ordinances usually forclose such location. Recovery homes frequently receive public fees from different levels of government with different standards; they are also subject to local ordinances covering building standards. Recovery homes especially have a sufficient number of common problems to benefit from additional centralized effort to identify and deal with them. (Alcohol programs have made a start through the Southern California Recovery House Association.)

Detoxification

Seventy-six percent of the drug and alcohol agencies responding ranked detoxification facilities as important (66% ranked it very important). Fifty-nine percent of the juvenile agencies considered it important. The personal interviews suggested that detoxification facilities of all kinds were important, but especially for persons using barbituates, amphetamines, and heroin. An important qualitative dimension applies to detoxification: the provision of such services by persons familiar with addicts and their problems and who can relate to them. Since detoxification involves medical services, it is usually provided in general-purpose hospitals. Medical staffs may or may not be sensitive to the special problems of addicts.

Accessibility of Services and Facilities

There are two aspects to the problem of accessibility. The first involves cost of services. There are many good facilities which are under-utilized because they are private businesses and must depend upon client fees for revenue. Many addicts and delinquents are in no position to pay even token amounts for the services they receive. Agencies that gain the

majority of their revenue from sources other than client fees simply are unable to meet the demand for services. Hence discrimination on the basis of income is an integral part of the service delivery system. Those least able to pay receive the least services—quantitatively and qualitatively.

The other aspect of the problem of accessibility is the uneven geographic distribution of various kinds of services and facilities. One of the problems of referral most frequently mentioned in the personal interviews was the inability to make "realistic" referrals, that is to say, even though a service needed by a client was available in the county, the client could not gain access to it because of its distance from his residence.

Referral

All agencies report referral problems. Among the problems most frequently mentioned are (a) unwillingness to refer to an agency about which the person making the referral does not have personal knowledge. Reasons for this range from the fact of widely varying views about what constitutes good treatment and rehabilitation to the fact that some agencies do not actually provide the services they advertise, (b) the difficulty of keeping a list of services and agencies up-to-date, and (c) knowledge that the client has no transportation to the referral.

There is no support whatsoever for a central, comprehensive directory for the reasons cited above. Most referral networks are local in scope and based on firsthand knowledge, which suggests that any efforts of this kind must be decentralized.

There is great skepticism about hotlines. Some have been exploitive, others too poorly informed and staffed to be of any value. The most successful ones are those associated with a treatment facility.

STAFF NEEDS

All agencies in all program areas are sparsely staffed. Delinquency prevention agencies seem to be somewhat better off than drug and alcohol agencies. An observation frequently made by persons interviewed was that some worthwhile programs have collapsed for lack of adequate administration

or management. The survey results tended to bear out this observation; 50 agencies reported no full-time staff and 157 reported no part-time administrative or managerial staff. Furthermore, staffing patterns may be associated with such other positive attributes of agencies as planning, and success in fund raising. Agencies in all program areas, then, need improved management and administrative skills.

No strong patterns emerged from the questionnaire responses concerning perceived skill needs, although twenty-five skills were cited. Among those most frequently citied were: general counseling, community organization, and drug abuse prevention. Interestingly, these skills are consistent with the kinds of training presently available for paraprofessionals.

FUNDING

Forty-eight percent of the agencies responding to the mailed questionnaire reported current income to be inadequate to meet program needs. It is worth noting that 52% said their income would cover projected service expenditures. Half of the agencies work on budgets of $100,000 or less (and of these one-half have no full-time professionals associated with the program). Alcoholism programs receive the least funds, while delinquency programs are among the best funded. One of the most pressing funding needs is for stable and continuous funding. The emphasis on "stable and continuous" stems from two factors. Since many agencies have no assured sources of funds, revenue raising is a continuous and uncertain endeavor. Considerable energy must be taken away from service delivery and devoted to the matter of mere survival. In many instances, meeting the rent payment is a monthly crisis. A second problem relates to the emphasis among public funding sources for "model" or "innovative" or "demonstration" projects. Funds are assured for short periods, typically 3 to 5 years. Many agencies were encountered which had no idea where funding would come from after the "demonstration" grant expires. Another aspect of this trend is resentment on the part of older, more established, and (by at least some criteria) traditional programs, who feel they are prejudiced in their search for support because of the emphasis on "new

approaches." Finally, there is perceived competition among programs for rather limited funding resources. Alcoholism programs feel they receive the lowest priority among funding sources, despite the fact that the incidence of alcohol addiction is higher than that of drug addiction and is strongly associated with delinquency problems. Ethnic groups feel they are placed in competition with one another for public funds.

PLANNING AND INTERAGENCY COOPERATION

Virtually all agencies accept the importance of planning and three-quarters of them report planning for program development, long- and short-range objectives, and services. However, in light of the staffing patterns of all agencies, one must not overestimate the extent to which formal and systematic planning characterize the system. Planning for program evaluation, fund raising, special projects, and research was reported far less frequently than in the previously mentioned areas. Delinquency agencies seem more engaged in planning, followed by drug agencies and alcohol agencies in that order.

Interagency Cooperation

Interagency cooperation is greatest in referrals and general information sharing. However, the data available suggest referrals take place locally and selectively. Referral to a nearby facility relates to the problem of accessibility discussed previously. Such selectivity is an integral part of the particular culture or system. There are so many philosophies of treatment and notions about what constitutes successful treatment that most of those interviewed stated they make a referral only when they have extensive and firsthand information about the facility to which they are considering a referral. Among the agencies most interested in seeing various forms of interagency cooperation develop are the newer ones and those with the lowest staffing and budget levels. These agency characteristics suggest that both newer and small agencies perceive such cooperation as a method of offsetting the problems of inexperience and small scale by giving them access to resources and skills not available internally.

There is less interest in cooperation in program development, sharing facilities and services, seeking funds, developing long-range policies, and publicity.

RELATIONS WITH LAW ENFORCEMENT

Most agencies report extensive cooperation with law enforcement agencies and virtually all report interest in increasing the scope of cooperation. Although there are slight variations by program area, there is interest in further cooperation in referral and public education. The problem of referral by law enforcement to a facility is compounded, especially in the area of drugs, by legal considerations. Persons under the influence of a drug or with drugs in their possession are guilty of a crime. However, law enforcement agencies have expressed interest in developing alternatives to arrest, especially for first offenders, where that is possible. One of the major limiting factors is the absence of crisis intervention or other round-the-clock facilities to which police can send a potential client. Finally, there is the problem of insufficient staff and services among those facilities which are available. Few problems in cooperation with law enforcement were reported.

COMMUNITY ACCEPTANCE

Most agencies reported community acceptance of their presence as moderate (42%) to great (30%). When asked to cite specific problems, the following were mentioned: clients perceived as threatening (9%); services not used by the community (8%); and poor relations with city government, bad press, difficulty with police, opposition from other community groups each received a few mentions. Despite this rather positive picture, which emerges from the mailed questionnaire, concern about community acceptance was expressed by those interviewed personally. A few instances of disputes about the location of facilities in communities have been reported in the press. Therefore a survey of city managers was undertaken, and from this survey a clear pattern emerges. City leaders are sympathetic with programs in all of these areas. Problems

emerge in two instances: when residence or other facilities which attract numbers of noncommunity members are located in residential areas, and when those developing and planning the facility fail to consult with the appropriate city agencies.

PREVENTION AND EDUCATION

Agencies in all program areas assign the highest priority to educating the general public to the nature, scope, and treatment of delinquency and addiction. Personal interviews with agency staff members revealed the strong perception that public education has the lowest priority for funding sources. It receives the least financial support and is the first to be cut when funds are scarce.

Another aspect of education of the public is making known the existence of facilities (limited though they might be) where assistance can be found. Clearly, some channels of information are more important than others. Schools, law enforcement agencies, social workers, employment agents, manager of recreational facilities, the clergy, and the medical profession have the greatest potential for contact with delinquents and addicts and they need to know how to place a person in contact with assistance.

MISCELLANEOUS NEEDS

Practitioners report an increasing incidence of alcohol abuse in youngsters. Sometimes this abuse is in conjunction with various forms of drug abuse, but increasingly it involves alcohol alone. There is little public awareness of this apparently increasing problem and few facilities and services aimed at redressing it except as minor adjuncts to other programs.

Practitioners also report that the problems of drug abuse and delinquency among teenage girls are sufficiently different that this class of clients requires special services and facilities. Virtually none exist.

Finally, both delinquents and addicts—and frequently their families—find themselves embroiled in a variety of legal problems. Legal aid was cited as the most desired program by alcoholism agencies and the second most desired program by drug abuse and delinquency prevention agencies.

RECOMMENDATIONS

Not all of the needs and policy issues of the Los Angeles private-sector system for delinquency prevention and drug and alcohol abuse services fall within the scope of activity of the Los Angeles Regional Criminal Justice Planning Board. However, as the primary channel for federal funds appropriated under the Omnibus Crime Control and Safe Streets Act of 1968 to Los Angeles County, the Planning Board has enormous financial leverage and occupies a strategic position with respect to both public and private agencies. It can exploit that leverage and capitalize on its strategic position to the benefit of society as well as the enhancement of community resources in the three program areas by undertaking the following steps.

Highest Priorities

1. Give highest funding priority to aftercare facilities, job counseling and follow-up; make the provision of some aftercare a condition of funding; give next to highest priority to crisis intervention; community education and other preventive programs; legal assistance; self-help programs; big brother programs; recovery homes, and other residential facilities; and detoxification facilities. Next priority should be for medical care, cultural enrichment, psychological testing, and drug and delinquency programs for girls and alcohol programs for youth.

2. Make physical location a criterion in approving an application for funds, giving priority to drug facilities located in the San Fernando and San Gabriel Valleys, the South Bay area, and East Los Angeles; to alcohol facilities in South Central and East Los Angeles, San Gabriel Valley, the South Bay area, and Glendale-Burbank; and to delinquency prevention facilities in Southeast Los Angeles, and Glendale-Burbank and to all programs in the unincorporated sections of East and Southeast Los Angeles County.

3. Publicize the need for, encourage, and subsidize interagency cooperation (especially long-range policy) and planning (begin with those newer, smaller, lower-budgeted agencies which express considerable interest in cooperation).

4. Call attention to long-run funding problems and encourage units of local government to provide some financial support to programs located within their boundaries and serving their residents. Encourage cities to see these as community problems. Encourage liaison among agencies. Work with League of California Cities to get cities to examine zoning policies for facilities in the three program areas.

5. Call attention to the need for a continuing and extensive program of community education. Direct attention to groups most likely to detect problems: law enforcement, teachers, social workers, recreational personnel, clergy, and medical professionals. Also the existence of existing facilities needs to be more widely advertised.

6. Require agencies seeking or now receiving Board funds to address themselves to the following issues in their proposals:

   a. The need for the service to be provided in relation to services available through nearby facilities.
   b. Nature and extent of cooperation with other private and public agencies and willingness to cooperate with adjacent agencies as appropriate.
   c. Plan for funding when the LARCJPB grant expires.
   d. Any anticipated problems of accessibility (transportation).
   e. Nature and extent of agency planning.
   f. Arrangements for aftercare facilities and services.

7. Solicit joint proposals by law enforcement and agencies in all three program areas to develop alternatives to arrest for first offenders. Project Culver provides one working model.

Second-Order Priorities

1. Encourage all public agencies providing services or generating clients for all three program areas and private agencies to consider themselves as part of a single system composed of intake, treatment, and aftercare components.

2. Call the perceived lack of their involvement to the attention of the medical profession.

3. Call attention to the increasing incidence of alcohol abuse among teenagers.

4. Central clearing house for recovery homes regarding shared facilities and services; examine effect of different standards by different levels of government on operations of such facilities.

5. Assemble, publish and widely distribute information about all funding sources and their policies, including "model" proposals and a checklist to aid those preparing applications. Update as needed.

6. Maintain an up-to-date summary of the funding patterns and apparent priorities of all public and quasi-public agencies providing support to each of the three program areas. Make this summary available to the funding sources so they can evaluate their own priorities.

7. Encourage agency participation in management and paraprofessional training.

8. Give a relatively high priority to proposals by agencies in the three program areas or law enforcement agencies to develop or extend cooperative arrangements.

9. Set aside some funds for aiding agencies through short-run financial crises.

STRATEGIES FOR IMPLEMENTING RECOMMENDATIONS

Highest Priorities

1. & 2. The first two recommendations relate to internal practices by the Board and its staff. They are self-executing, if the Board accepts these recommendations.

3. Publicizing the need, encouraging and supporting interagency planning and cooperation, while a very promising contribution to maximizing resources in the private sector, is probably one of the hardest to implement. Three constraints must be observed: (1) The geographical scope of the cooperative arrangements must be local, at least initially; (2) It must not be controlled or appear to be controlled by any public agency; (3) It must probably observe or somehow honor the differing needs, interests and, at times mutual suspicions of agencies emphasizing different program areas.

These constraints suggest a series of local coordinating councils with sections for each program area controlled by the private agencies themselves. Such an undertaking may well be beyond the capability of LARCJPB; however, the potential payoff is so high, the Board may wish to consider some combination of the following strategies:

a. Approaching a few private agencies in each of the eleven areas delineated in this report and assist them in trying to organize community councils. (The Pasadena experience suggests it only takes one respected, "old timer" who is convinced of the value of cooperation to bring such cooperative arrangement into being.)
b. Subsidizing or providing staff services to such councils if they form.
c. Encouraging other funding sources to subsidize them.

d. Favoring the funding requests of agencies which are part of such councils and encouraging other funding sources to do likewise.
e. Consider giving such local councils some participation and influence over Board policies and priorities in these three program areas.
f. Consult with the County Department of Community Services to see if the Board can assist their efforts.

4. Long-run financial support and involvement by local units of government. If agencies in the three program areas are perceived as dealing with an important community problem, local units of government are more likely to assist in their continuance (the life cycle of Project Culver is instructive in this regard). If agencies in city government were to take a more active interest and mobilize community organizations, problems of facility location, funding and interagency coordination could well be alleviated. Probably the most promising start could be made by discussing the possibility with Southern California League of Cities.

5. With respect to general public and special target population education, the Board's strategic location is such as to call continuing attention to the need. It can certainly approach all agencies involved—all elements of the criminal justice system, schools, medical associations, church organizations, DPSS, etc., and appraise them of the importance of continuing to budget their educational programs. Perhaps some funds should be allocated by a consortium of public agencies to make more effective use of public service programming by the media.

6. Requiring funding applicants and current recipients to think about system priorities, cooperation, long-term funding, accessibility, planning and aftercare is self-executing, if the Board adopts this recommendation.

7. Joint efforts by law enforcement and private agencies is also self-executive, if the Board decides to solicit such proposals.

Second-Order Priorities

1. Encouraging all involved agencies to view themselves as part of one integrated, if decentralized, system is probably impossible. However, if local councils could be formed, the next step of linking them to public agencies would probably come as a matter of course. The Board may also wish to prepare and widely distribute a "state of the system" report which could draw heavily on the content of this report as well as the Board's staff expertise. Included might be such items as: (1) imbalance in system components; (2) gaps in service by area; (3) directory of funding sources and their policies; (4) information about other system needs and policy issues, e.g., training, detoxification, successful cooperative efforts and the like; (5) LARCJPB's plans and priorities in the three program areas, and (6) invitation for feedback about the report.

2. The various sections of the County Medical Association could be asked to provide a self-assessment of the adequacy of the profession's involvement in tbe areas of drug and alcohol treatment and rehabilitation. The Board could serve as a catalyst to further efforts on their part.

3. With respect to increased alcohol abuse among youngsters, the Board could use its funding policies and its existing communication channels to call attention to the problem.

4. Concerning the problems of recovery homes, the Board could contact the Southern California Recovery House Association and determine how assistance might be provided.

5. A staff member of the Board could prepare a pamphlet summarizing pertinent information about funding sources.

6. Monitoring all funding patterns of agencies in the three program areas and feeding back such information to the sources is a manageable, if expensive, staff activity. The potential payoff of such an effort is very great because of the opportunity it provides the Board to rectify system and service gaps. The Board is the only agency with responsibilities of sufficient scope and legitimacy to undertake such a project.

7. Encouraging the upgrading of agency staff can take several forms such as: (1) reimbursing individuals for training costs; (2) commissioning

and paying costs of short courses which would be offered "in the field" with no charge to trainees; (3) making existence of existing training programs known to agencies.

8. More cooperative programs with law enforcement can be brought about by encouraging submission of such proposals and informing law enforcement of both the interest and receptivity of agencies to cooperative arrangements.

9. Maintaining an emergency fund for private agencies in short-run financial crisis can be suggested to both public and private funding sources.

RESEARCH NEEDED

Measures of Successful Treatment and Rehabilitation

Until such measures are developed, there is no way to determine whether resources going to the areas of treatment and rehabilitation of drug and alcohol abuses and delinquency prevention are paying off. There is no way to allocate resources rationally among programs or within programs. The present state of the system is that no one knows where he is going but everyone thinks he is going in the right direction. Under such circumstances any step is in the right direction.

Using its influence with public agencies, especially the CCCJ and LEAA, the Board should urge the appropriate sources of research funding, both public and private, to give efforts to develop such measures a very high priority.

Accessibility

The Board should utilize its staff (or contact with an outside source) to develop methods of alleviating the problems of access to agencies. There are probably more alternatives than the two suggested in this report (more small multipurpose facilities located in communities or some form of low-cost transportation provided to agencies), but at least these two should be carefully analyzed. Also, attention should be given to the cost of services to clients.

Demand

The records of law enforcement agencies, principally probation and parole, contain the beginnings of an assessment of client demand for services. If school records and those of hospitals could be tapped, the assessment could be even better. A thorough analysis of demand patterns through time is badly needed, if the adequacy of public and private facilities is to be determined. Such a study could be undertaken by the Board itself.

APPENDICES

CITY MANAGER SURVEY

Letters were sent to city managers in 75 cities in Los Angeles County, soliciting responses to three questions concerning the location of facilities for drug addicts, alcoholics, and juvenile delinquency prevention in residential areas. Responses were received from 23 cities and came from planners, community relations coordinators, administrative assistants, and chiefs of police as well as from city managers. The intent of the survey was to learn the extent to which the reluctance of residents to having such facilities located in their communities exists and comes to the attention of city governments. There was also an attempt to learn what the city governments did when problems of this nature arose.

The first question asked was whether if a situation had arisen in which residents opposed existing or proposed facilities for drug abusers, alcoholics, or delinquents. This question also sought information about the type of the facility and how the issue was resolved. Fifteen of the 23 cities (64%) reported that there had never been any attempt to create such facilities within their jurisdictions. Four cities (18%) said that such facilities were proposed, met considerable resistance, and were either not developed or located elsewhere.

The second question was whether the city manager felt it was a good idea to have such facilities in residential areas. Thirteen of the 23 city managers (56%) responded that it was not a good idea, 2 (1%) said not under qualified circumstances, and one was not responsive to the question. Two governmental agencies (19%) said it was a good idea and 4 agencies (17%) said yes under qualified conditions, including obtaining a variance in the zoning laws, if the area is middle-class or higher-income, and if there was little traffic in the area.

The third question was how those who wish to establish community facilities might proceed so as to gain the acceptance of the residents. The majority of the respondents report that the biggest roadblock is the residents' fear of negative influences on their families and the security of their homes. These respondents suggested that community and civic leaders of the proposed community should be involved in the planning at all stages and informed as to the operation of the facility. A suggestion was made to the developers of the facility to know community resources and problems and to honor all commitments made.

Education of the residents as to the use and need for the facility is considered to be an important factor in its acceptability. Resident

input and even direct participation have been recommended; these could mean hiring residents as staff as well as recruiting them as volunteer help.

The board of directors can be an important factor in the acceptability of a program. An active and respected board can gather support often not available to staff or to residents on their own. It is also felt to be important to publicize those in the community who are supporting the facility, in the hope that the support will catch on. A related idea is to approach the appropriate city government officials, to solicit their support and advise.

Other suggestions concerned the physical location of the facility. Many respondents suggested that facilities be established on the periphery rather than in the middle of residential areas. One explanation for this is that these facilities are in effect businesses and should be located in business districts. It is also felt that the facility should have ample parking space, which would be available in a high-density business area but not in a residential area. Residents do not like residential areas to be used for purposes other than residential; they feel that developing these agency facilities in residential areas is an abnormal use of the land. The resentment is not as strong in multiple-occupancy residential areas as it is in single-family residential zones.

It also seems that the city managers were more interested in considering drug prevention and education and social rehabilitation facilities in residential areas than half-way houses or detoxification centers. This is due to a lack of understanding and fear of the latter facilities. Those promoting such facilities must dispel the fear that such facilities will attract undesirable persons from outside the community. One city official suggested demonstrating that the facility will actually provide needed services to local people.

One city manager suggested emphasizing the medical nature of these facilities, and even locating near a hospital to emphasize the association. The ties between the hospital and the facility need not be very strong but the implied tie may improve acceptance of the facility.

The biggest obstacle is zoning. Residents of areas zoned for single-family dwellings usually oppose the location of any such facility within these areas and their city administrators tend to join in this opposition. There is less resistance to locating facilities in areas zoned for multiple-occupancy residences. Most respondents viewed facilities in the program areas of drugs, alcoholism, and delinquency as businesses which should be located in those areas of the city zoned for commercial uses.

ELEMENTS OF SUCCESSFUL PROGRAMS

Inherent in all discussions of needs and recommendations are determinations of the elements of successful programs. Because of the difficulty involved in defining successful there are no consistent measures which can be applied to all agencies. Added to this difficulty is the vast range of types of programs which offer many different kinds of services. Therefore, what may result in success for one program may be detrimental enough to another to cause it to go out of existence.

Although the question of what constitutes "success" haunts every aspect of this study, little useful information about it was gained. Such insights as were gleaned from our interviews and observations are here summarized. Initially the feeling was that the stability of a program was an indication of its success. However, many of the older programs providing some of the more traditional services do not even attempt to come to grips with many current problems. These programs, therefore, may be considered successful for what they accomplish but are not successful in meeting the real unmet needs of most of the people. Similarly, many newer programs provide very fine services but cannot continue to exist because of administrative factors such as a lack of funds or a lack of management ability, etc. There are charges that some agencies frequently perpetuate the old cycles, namely, treatment without rehabilitation leading to recidivism, which need to be broken to solve the problems.

The elements of successful programs summarized here come from three sources: from the agencies' philosophy of treatment, the elements of success as stated by the agencies themselves, and additional measures as perceived by the project staff. All sources feel that their ultimate goal is full treatment of an individual and his or her full return, completely rehabilitated, to society. In most instances this involves a reformation of a lifestyle as well as the provision of a new supportive environment to the individual.

Using the philosophies of treatment as stated by the agencies as elements of successful programs was not as useful as originally believed they would be. Each agency that expressed a philosophy mentioned an individual one and no obvious patterns were discernible. The philosophy expressed is based upon the circumstances of how the agency came to be founded and by whom, its location, the people it serves, and its intended level of sophistication of treatment. Because these factors could never be exact or similar in many of the agencies, neither are the resulting

philosophies of treatment. This supports the contentions of many people that there are no single answers to any of the problems and that a multi-service approach is necessary to any realistic discussions of planning solutions. All of these single agencies providing unique kinds of services cannot independently provide any answers but collectively they are effective. The fact that no patterns can be determined from the philosophies means that there are no simple answers to treating the problems.

Direct questioning of the agencies about what they feel has made their programs successful and what, in general, makes successful programs provide most insightful information. Some spoke of the specific criteria involved with the process of treatment and others mentioned what the final goal, product, or process might be. The agencies were asked what a successful program in their particular area of interest would be like; however, it was difficult for many of the agencies to project beyond their present scope of operations. The answers were always about what the particular agency would do to expand its present operations rather than ideas of what an independent model program might be like. One reason for this is that these people are so dedicated and active in their everyday operations that they really do not have very much time to look beyond. It is not a question of not being able to think beyond the everyday or not wanting to but simply not having the time to do so. This indicates the tremendous pressures on these people to meet the demand and what it takes to meet them, even in smaller agencies.

The two most common categories of elements of success mentioned by the agencies involved staff and funding. The issues of staffing were varied and included different talents and abilities; a balance of professional and ex-user, men, women, and minorities; staff dedication; quality of staff members; and participation of the staff in the community. Elements connected with funding include being sufficiently solvent without being dependent on government funds; having a stable source of funds; and having a stable relationship with a larger more stable institution enabling them to obtain more funds. Others mentioned were good screening processes, effective managerial ability, establishing good relationships with neighboring or similar agencies, providing a need which cannot be met elsewhere in the community; and strong community support and participation.

The last source of the elements of success is perceptions by the staff obtained during the various sets of interviews and from the reputations of and past experiences of agencies. These observations are admittedly subjective and impressionistic. The staff feels that having a hand-picked board which is politically and financially active in the community is a tremendous asset. This board can provide the respectability and security that many times the patients-clients or staff cannot. The board can raise money or prevent busts by the police which the agency frequently needs. Naturally the selection and actual function of the Board are crucial decisions which the founders of the agencies have to make. Agencies without active boards can be very successful but almost all agencies with active boards are guaranteed success.

Another factor affecting success occurs when and if an agency sets its sights to what it can realistically hope to accomplish. Realistic goals are much easier to reach than those which might sound more impressive to an outside agency. It was also observed that agencies who try to localize and focus their goals have a better chance of realizing them than do agencies which end up over extending their capabilities to try to accomplish even a part of what they said they would. A related measure of success is a realistic expectation by the funding agency and the community of what it can do. In other words, when an agency can feel secure enough to write a realistic proposal to a funding agency and use the money received for the purposes that it was given, the chances of a successful program are much greater than if the funds were obtained by making incredible promises which were impossible to ever keep.

The staff of an agency, especially the ability to attract and retain resourceful people, is an essential element of success. The ability to work together and innovate when necessary is very important to an agency's effectiveness. The staff must also know how to use resources effectively and to learn to find additional ones as needed. A flexible and competent staff is almost a guarantee of success. The same needs apply to volunteers and they are especially valuable when the agency cannot afford to hire all of the staff it may actually need.

Frequently an agency is not judged by its success in terms of individual cases but rater by how its operations are perceived to affect the community or neighborhood as a whole. This is especially true with agencies such as community centers or mental health centers. Although measuring success in terms of individual clients is extremely difficult it is much easier than trying to determine how an agency has affected an entire community's mental health.

The final staff perception is that those agencies which have adopted a specific and consistent philosophy and follow it closely in actions and treatment seem much more effective than agencies that do not.

APOAR HOUSE

I. Pattern of Service

A. Philosophy of Treatment - Purpose is to assist and direct those seeking relief from alcohol. Recovery is obtained by applying certain spiritual, physical, and mental laws to the individuals. Treatment involves using public and private medical facilities to cure the physical side effects; also tapes and discussions to inspire each individual to explore himself and life.

B. Services Provided - AA, medical services, group therapy, residence home, counseling.

C. Facilities - One halfway house

D. Geographic Scope - Recruits from jails, workcamps, prisons after the individuals have dried out.

E. Staffing Pattern - One person, the director, does everything with the occasional assistance of a cook.

II. Problems and Issues

A. Referrals - Not discussed.

B. Prevention/Education - Has a very heavy program using tapes and discussions for the men to learn about overcoming the influence of alcohol.

C. Service Needs - Expand by opening a second residence, a halfway house, for those who do not need the dependent atmosphere of APOAR.

D. Access - Does not appear to be a problem.

E. Staff Related Issues - Could use a more stable staff so as to divert all responsibility from the Director.

F. Funding - House is self-supporting but needs more money. Do not wish to be on DPSS registry because this would force them to accept all referrals and they only wish to work with the alcoholic. Would like to solicit funds from other sources but lacks expertise. Hopes membership in the Recovery House Association will help director to learn the necessary procedures.

G. Interagency Cooperation - An active member of the Southern California Recovery House Association. Recruits from jails, prisons, and workcamps.

APOAR HOUSE (continued)

H. Community Pressure - None mentioned.

I. Unmet Needs - None mentioned.

J. Miscellaneous - Need managerial expertise although director did not mention it. Director is a very dedicated man who needs assistance to survive.

BRIDGE BACK

I. Pattern of Service

A. Philosophy of Treatment - Rehabilitation to remove the drug dependent person from an undesirable environment and through encouraged specified life style exploration and change to increase his capacity for responsibility, ability to cope and discovery of self-reliance.

B. Services Provided -

1. detoxification
2. residential facility, 90 day temporary housing
3. development center, group discussions three (3) nights weekly, educational and vocational guidance, recreation and cultural enrichment activities
4. outreach, community awareness and speakers bureau
5. hotline, 24-hour telephone crisis intervention referral and informational service

C. Facilities - Residential facility.

D. Geographic Scope - Greater Watts Model Neighborhood.

E. Staffing Pattern - Almost entirely ex-drug dependent persons; other professionals and volunteers whenever possible.

II. Problems and Issues

A. Referral - Refer when necessary to meet the needs of new clients applying for service.

B. Prevention/Education - Not discussed.

C. Service Needs - 1. expansion of residential aftercare; and 2. additional transportation vehicles.

D. Access - No problem.

E. Staff Related Issues - There is a "unique" kind of communication among staff as most are ex-drug dependent persons which adds to their commitment.

F. Funding - Model Cities.

G. Interagency Cooperation - Work with other drug programs and participate in many city and county conferences, etc.

H. Community Pressure - They seem to be accepted in the community as a needed service.

I. Unmet Needs - 1. More residential rehabilitation programs for women and men; and 2. more job training programs with pay and actual placement of ex-drug dependent persons.

CALABASSAS HOSPITAL

I. Pattern of Service

A. Philosophy of Treatment - Treats alcoholic in a separate ward of neuropsychiatric hospital. Average stay is 10 days and an attempt is made to reeducate the individual and stimulate new interests.

B. Services Provided - Treats alcoholic as a behavioral problem, detoxification, physical pains from alcoholism attended to, therapy, counseling, recreation. Exposure to many kinds of therapy to see which one the patient will react to the best.

C. Facilities - One ward of the hospital presently accommodating about six patients but with the capacity of about 25.

D. Geographic Scope - No limit but usually project to the San Fernando Valley.

E. Staffing Pattern - Coordinator and alcoholism counselors—all part-time paid professional staff.

II. Problems and Issues

A. Referral - Referrals to the program are from physicians, Alcoholism Council, AA, recovered alcoholics, and big companies like Lockheed and Hughes. Some patients are referred to recovery homes after completing the hospital's program but that depends on the individual and his circumstances. People referred to this program who cannot pay are referred to public agencies. Sometimes an individual will come to the hospital to be detoxified and will be encouraged to enter the alcohol program in the hospital after detoxification has been completed.

B. Prevention/Education - More treatment oriented than preventive.

C. Service Needs - Funds to hire full-time staff.

D. Access - Not a problem as only wealthy people can afford to participate in the program.

E. Staff Related Issues - Need more staff and the funds to make the present staff full-time.

F. Funding - Alcoholics in the program pay $65/day as do all other hospital patients. Only those who can pay are admitted into the program. Need more appropriations from the hospital.

G. Interagency Cooperation - Know private agencies to refer people to who cannot pay. Relationships with big companies like Lockheed and Hughes and the group insurance pays the costs of treatment.

CALABASSAS HOSPITAL (continued)

H. Community Pressure - None mentioned.

I. Unmet Needs - None mentioned.

J. Miscellaneous - Hospital actively does public relations in the surrounding communities to promote their services. Few young people in the program but when admitted they are treated the same as the adults. Alcoholic Unit has a very impressive follow-up procedure which is used on each patient leaving the program.

CASA MARAVILLA

I. Pattern of Service

A. Philosophy of Treatment - To motivate and organize this particular community by offering needed services, be honest in their approach, and tough when necessary.

B. Services Provided -

1. referral of all kinds
2. counseling
3. community workers, for organization, communication and problem-finding.
4. emphasis on working to organize gangs, and thereby, rechannel the potential political power and educational ability of the community

C. Facilities - A large, one-story meeting place; in a couple of years they will run and operate a large community service center.

D. Geographic Scope - Maravilla housing project area in East Los Angeles.

E. Staffing Pattern - Two directors, the rest gang-community workers, mostly men, mostly Chicano; some secretaries and volunteers.

II. Problems and Issues

A. Referral - Only done to those agencies who are known to the staff; central referral would be of no help.

B. Prevention/Education - Not much of an issue because the problems, as interpreted by Casa, are specific to this area.

C. Service Needs - Most of these are being met by new funding.

D. Access - The Casa is located in the housing project and owns a van and a bus; services are mostly free.

E. Staff Related Issues - They have great difficulty finding qualified Chicano personnel; there is no real "work ethic" in the Chicano community and sometimes a hardline approach was necessary, although not desirable.

F. Funding - Over time and through a hand-picked Board of Directors, Casa has become self-supporting without government funds; now they are about to receive a large federal grant, but will insure their future by continuing to receive their basic funds.

CASA MARAVILLA (continued)

G. Interagency Cooperation - Hasn't been much of an issue, as their specialized work has required little interchange; relationships established where necessary; problems with public agencies "dumping" people on them because they work with addicts; their new center plans to work on community control of schools and better relations with the police.

H. Community Pressure/Acceptance - Lack of pressure has been more of a problem because motivation is so low, because expectations are so low.

I. Unmet Needs - More seconal detoxification.

CHILDREN'S HOSPITAL HOTLINE

I. Pattern of Service

A. Philosophy of Treatment - The hotline attempts to use its carefully selected, paid staff to listen to callers and suggest referrals which have been carefully checked out and are available. The hotline also attempts to suggest services which are needed and serve as a catalyst to develop them.

B. Services Provided - Referral, crisis intervention services, barbituate detoxification program.

C. Facilities - Placement into Children's Hospital or other hospitals for detoxification or treatment.

D. Geographic Scope - Los Angeles County

E. Staffing Pattern - They hire about 32 staff people as listeners but not all work regular hours. The concern is in hiring more than in training.

II. Problems and Issues

A. Referral - The biggest problem is the coordination of referrals in both the traditional and underground facilities. The flux is great in both areas as are the rules, procedures and personnel. Another problem is that they never have enough referrals for those who request them, especially for runaways. Suggests a human terminal service to be self-supporting by being on a subscription basis.

B. Prevention/Education - Not discussed.

C. Service Needs - Increase the staff, be open more hours, develop new programs.

D. Access - Need facilities in Los Angeles as Camarillo and Rancho are too remote for young people needing detoxification and transportation is a problem as hitchhiking is more dangerous than it used to be.

E. Staff Related Issues - Only hotline to pay its staff; would like to hire more staff so as to be able to be open more hours.

F. Funding - No problem, county funds and Children's Hospital provides in-kind funds, also have an IBM grant.

G. Interagency Cooperation - Hard to keep up with all the facilities to know if they still exist and provide the same services with the same intake and other procedures that they used to. Their problem is that they never have enough resources for those who need them and the good resources never have enough room for those needing it. Afraid coordination would eventually mean control.

CHILDREN'S HOSPITAL HOTLINE (continued)

H. Community Pressure - No immediate problems; well established and accepted.

I. Unmet Needs - Services for runaways, crash pads, detoxification facilities especially for kids on barbituates, services for the adolescent suicide, training program as a part of residential after-care facilities, rehabilitation services given concurrent with detoxification which would be supervised and "followed through" by a community worker.

J. Miscellaneous - Crash pads out of existence because they were very hassled, had to take too many risks, and were forced to be selective; hotlines not trusted as many were big rip-offs; Children's Hospital Hotline receives county funds and as a part of the contract, the Hotline staff logs in all calls and requests and informs the county of what services are requested and where the requests are from; they have a barbituate detoxification program but have no patients in it, partly because it is not known and secondly because so many people assume nothing will really help them; this hotline is successful, in part, because of its stable relationship with a larger institution.

CLARE FOUNDATION

I. Pattern of Service

A. Philosophy of Treatment - Most alcoholics are addicted or dependent to a dangerous but legal drug due to a physical condition that makes them susceptible to addiction. Emotional and psychological problems also play important roles. There is a need to offer practical help to the alcoholic and his family.

B. Services Provided -

1. Alcoholism Service Center that provides information, referral and social services. Services include non-medical emergency, transportation, home visits, acceptance and placement of court referrals.
2. Recovery home for male alcoholics.
3. Education programs that provide speakers and films to groups, churches, schools, etc.

C. Facilities - Recovery home only; no mental or medical services; 10 beds.

D. Geographic Scope - West Los Angeles area

E. Staffing Pattern - It appears as if Mr. Schonlau is most of the "staff" except for volunteers.

II. Problems and Issues

A. Referral - Suggests decentralization of IRS Directory; no need for centralized referral.

B. Prevention/Education - Advertising to explain that alcoholism is an addiction not a sickness is necessary.

C. Service Needs -

1. expanding court services
2. more available and regular medical help
3. can only provide beds for 1 out of 10 requests
4. expansion of present programs

D. Access - Could be solved by more community-based, very small service centers with recovery homes attached.

E. Staff Related Issues - Not applicable.

F. Funding - Any source on an ad hoc basis. Proposals to NIMH and to contract with County Department of Mental Health.

CLARE FOUNDATION (continued)

G. Interagency Cooperation - No problem; he has established contacts with people in many public and private organizations; relationships between existing alcohol programs are good due to the Alcoholism Subcommittee.

H. Community Pressure/Acceptance - Not an issue here.

I. Unmet Needs -

1. aftercare programs
2. recovery homes (especially in West Los Angeles)
3. more available, regular medical help
4. clinical record bank of an alcoholic's past treatment for screening
5. more places where one can walk in and get help

J. Other - Sanitariums are beginning to help alcoholics due to changes in insurance coverage.

DART

I. Pattern of Service

A. Philosophy of Treatment - Began as a three-hour session with kids who had had some contact with the law concerning drugs involved parents, a doctor, cop, and social worker.

B. Services Provided - Counseling, referral, drug education.

C. Facilities - No formal facilities of their own, used facilities of the Burbank City Schools.

D. Geographic Scope - Burbank only.

E. Staffing Pattern - Volunteer-doctor, cop, social worker.

II. Problems and Issues

A. Referral - Referrals to the program were from Burbank Police Department. Had lists of referral resources to use for services they couldn't provide.

B. Prevention/Education - Entire program was to prevent first offenses. Included a lot of counseling and drug education.

C. Service Needs - Detoxification facility and halfway houses. DART used to refer to Bridge but stopped because Bridge is only for hard core addicts and DART did not like referring first offenders to that program.

D. Access - No problems mentioned.

E. Staff Related Issues - Would like to have money to be able to hire staff to resume the DART program.

F. Funding - Program was successful and Burbank City Schools picked up thefunding. However, due to procedural changes the police ceased to pick up the kids and the referrals stopped. The parents no longer came and the program became a rap session. The Burbank Schools ceased to fund the program since it was no longer a parent-child drug program.

G. Interagency Cooperation - Cooperation with both the police and schools in Burbank was quite close. They did not look beyond the city itself.

DART (continued)

H. Community Pressure - Never had adverse pressure.

I. Unmet Needs - Bigger need is for a place in Burbank for young people to go to who just want a place of their own. There are sports and hobby programs but no place that kids can just congregate. The existing recreation programs forbid kids who have long hair and who smoke so they never get to use these facilities. More family counseling services are needed. MOre action needed by the Burbank Drug Council and Juvenile Delinquency Council instead of just talking about the problems.

J. Miscellaneous - Most of the parents of the kids in the program admitted to having or having had an alcohol problem.

DOWNEY COUNSELING CENTER

I. Pattern of Service

A. Philosophy of Treatment - The Center can successfully help people due to the warm personal attention given to each person soliciting help.

B. Services Provided - Referral, counseling.

C. Facilities - The Center itself.

D. Geographic Scope - Downey and surrounding communities.

E. Staffing Pattern - Director is the only paid staff member; 43 counselors are volunteer, mainly students who do the work as field experience.

II. Problems and Issues

A. Referral - Work extensively with other public and private agencies. Referred to by probation, police, schools, private medical profession. Use resource file done by the Department of Community Services. Able to find services for those who need it.

B. Prevention/Education - Recommends a drug education program for each community.

C. Service Needs - More staff to accommodate those on waiting list; funds to hire a Director of Training for their staff.

D. Access - Charge $1-$15 depending on the ability to pay so access not a problem.

E. Staff Related Issues - See service needs.

F. Funding - Operating under a tight budget, mainly through some fund-raising efforts and contributors. Would like to apply for funds from NIMH but doesn't know how to write a proposal.

G. Interagency Cooperation - Would consider cooperating with other agencies but feel they are too isolated from rest of agencies.

H. Community Pressure - Despite the conservative nature of Downey, there has been no community resistance.

I. Unmet Needs - Along with a drug education program suggested for each community should be a center where parents could go and receive immediate assistance in handling their children with drug problems.

EL SANTO NIÑO COMMUNITY DEVELOPMENT PROJECT

I. Pattern of Service

A. Philosophy of Treatment - Recognition of the individual is the guiding philosophy including respect of people and a positive attitude that anything is possible there.

B. Services Provided - Limited emergency financial aid, counseling, recreation, child-parent education (for Spanish speaking people) co-sponsored health clinics as T.B., immunization, etc. and a monthly Well Baby Clinic, Senior Citizen's Club and projects, immigration information and referral services, English Second Language classes for adults and children, tutoring service, (limited) sport activities, sewing classes for adults, Police Basic Car Plan meetings (films, discussion, all in Spanish). Services are provided for ages from one month to 109 years old and to all races and creeds.

C. Facilities - One main building and playground.

D. Geographic Scope - 92 blocks, north end of South Central Los Angeles: Central Ave. E., Main St. W., Jefferson Blvd. S. and Washington Blvd. N. (The target area).

E. Staffing Pattern - Director, community organization worker, bilingual, 1 case worker, 2 group workers (1 bilingual), 1 part-time boy's worker, and a full-time secretary, all of whom are paid. The summer staff was augmented by 13 Neighborhood Youth Corps workers and a varying number of volunteers throughout the year.

II. Problems and Issues

A. Referral - Referrals to and from public and private agencies and individuals.

B. Prevention/Education - Many of the programs are educational and preventive in nature.

C. Service Needs - Continue with the same services, but more extensively as workshops for community people to improve their skills, to initiate summer education activities and projects and help to develop more indigenous leadership and involvement in meeting the community needs. There is a need for better coordination of the total services from all of the churches, centers and schools in the area.

D. Access - The access problem of transportation is not very difficult to the center but is more difficult to many of the other private and public agencies of which there are very few within the immediate area.

EL SANTO NIÑO COMMUNITY DEVELOPMENT PROJECT (continued)

E. Staff Related Issues - Would like to expand their trained staff and recruit more volunteers.

F. Funding - Facilities and land owned by the Catholic Archdiocese of Los Angeles, but agency is funded by United Way, Inc. for operation, staff salaries, maintenance and general operation of the total program. Need for additional funding to increase staff.

G. Interagency Cooperation - There is very good cooperation with the city, county, public and private agencies, individuals, corporations, the Newton Street Division Police, Basic Car Plan program, the public and private schools and churches, several of the business places. E.S.N. is a private agency (project), 1 of 4 projects under Catholic Community Services of the Catholic Welfare Bureau.

H. Community Pressure - E.S.N. has experienced some pressure from militant groups, but understanding, interpretation of our goals and sincere outreach endeavors have resulted in improved relationships.

I. Unmet Needs - Discussed in terms of service needs.

J. Miscellaneous - Success of E.S.N.C.D.P. is credited to Miss Wharton, the director, a hard working conscientious staff and volunteers.

FOOTHILL FAMILY SERVICES

I. Pattern of Service

A. Philosophy of Treatment - Offer marriage and family counseling.

B. Services Provided - Forty percent marriage counseling. Forty percent for child centered problems. Fifteen percent other problems. Also offers crisis intervention services.

C. Facilities - One central office and one branch office in Altadena.

D. Geographic Scope - Pasadena and surrounding communities.

E. Staffing Pattern - Professionals doing counseling in their office and paraprofessionals work in minority areas in Neighborhood Family Counseling Service program.

II. Problems and Issues

A. Referral - No use for central referral, recommends a referral and resource area which someone or some agency assumes responsibility for. Refer clients to agencies they know to be good. Up to individual staff members to develop their referral lists.

B. Prevention/Education - Had a parent consultation service which was a prevention program but it was not refunded. Any additional funds would be used to start up this prevention program.

C. Service Needs - Prevention programs instead of merely relying on treatment programs. Be able to expand Neighborhood Family Counseling Services to low income whites and to the elderly. Management training for the director including training in proposal and grant writing.

D. Access - Not mentioned as a problem.

E. Staff Related Issues - None mentioned.

F. Funding - Seventy percent of funds from United Way, 22 percent from fees, and remainder is raised by the Board of Directors. When they need more money they look to United Way. As indicated, they would like training in grant and proposal writing.

G. Interagency Cooperation - Member of Southern California Council of Agencies for Family Services whose scope is Southern California, member of Pasadena Community Council and is active in both interagency Councils, accredited member Family Service Association of America.

FOOTHILL FAMILY SERVICES (continued)

H. Community Pressure - Well accepted and considered an integral part of the Pasadena Community of agencies.

I. Unmet Needs - Programs to catch juvenile's problems before they become severe. Medical psychiatric services for low income families. Management training to directors of programs.

J. Miscellaneous - Do not look to county for leadership as they feel all the county wants from them is a place to dump people they cannot handle. United Way, the director feels, is trying to bridge the gap between the public and private sectors.

GRANDVIEW FOUNDATION

I. Pattern of Service

A. Philosophy of Treatment - The Foundation is a home, comprised of two residences, dedicated to the rehabilitation of the suffering male alcoholic. Based on the theme "Recovery Through Discovery," a well balanced program is offered to help the resident to realistically evaluate the problems of alcoholism: mental, emotional, social, spiritual.

B. Services Provided - Homelike environment, group meetings, counseling, AA, spiritual.

C. Facilities - Main building for intake and for the first 30 days. A second residence a few blocks away is for an individual who wishes to work out and live in and participate in the program.

D. Geographic Scope - Southern California but usually Pasadena and Los Angeles County.

E. Staffing Pattern - The Director receives no salary and the medical staff including a doctor and registered and psychiatric nurses are all volunteers. Four volunteer counselors run the program at the residence.

II. Problems and Issues

A. Referral - Big problem as presently are below capacity of 34 due to a political hassle which has been resolved but which seriously interrupted their cash flow. Recommends the county refer alcoholics to recovery houses instead of the revolving door detoxification pattern. Wants publicity to advertise their facility but doesn't have the money.

B. Prevention/Education - Wants a full scale education program for the public to teach them that there are reccvery homes available to help treat alcohol problems.

C. Service Needs - Better detoxification and wants two beds in their facility for it; money to upgrade their facilities to keep up accreditation, wants to develop a more intensive program.

D. Access - Just publicity so people will use the facility.

E. Staff Related Issues - Not mentioned.

GRANDVIEW FOUNDATION (continued)

F. Funding - Wants the federal government and state government to give funds to the recovery homes as they do in some states. Of the money that is given, he resents that most of it is earmarked to administrative and planning costs and not to the recovery homes. The only money the Foundation takes in is from the small client fees and they are almost bankrupt. Objects to the government's policy of funding new ideas and programs but not those already proven to work; need to upgrade existing facilities and programs. Need money to work with the other recovery homes and to hire professional people to assist in writing grants.

G. Interagency Cooperation - Work within the Pasadena Council. Wants to work more with other recovery homes in the county and state but it takes more money they don't have. See referral re: County Departments.

H. Community Pressure - Complete community support.

I. Unmet Needs - Detoxification services, small recovery homes.

J. Miscellaneous - Drug programs receive so much more federal assistance than alcohol programs which is unfair. Need residential and not clinical setting for this type of treatment to work.

HAVEN HOUSE

I. Pattern of Service

A. Philosophy of Treatment - To make a time of crisis one of growth for the families of violent alcoholics.

B. Services Provided -

1. food, shelter, clothing
2. individual and group/family therapy and counseling
3. education on alcoholism
4. referral
5. AA meetings

C. Facilities - A large house that sleeps 23.

D. Geographic Scope - Primarily Pasadena, open to whole country.

E. Staffing Pattern - Paid director, fund-raiser and cook; other staff is volunteer.

II. Problems and Issues

A. Referral - Trouble finding agencies to meet clients' needs; sometimes refer not knowing what to expect.

B. Prevention/Education - They feel that much more public education is necessary, especially about the violent and the young alcoholic; they provide education about alcoholism as a disease to the resident families.

C. Service Needs -

1. actual child care facilities
2. employment and vocational counseling and placement
3. full-time counselor
4. expansion of present services and facilities
5. transportation (e.g., a van)
6. halfway house with child care for women beginning to make it on their own

D. Access - They have a big problem getting clients to the agencies they refer; many who need their services cannot get to Haven House.

E. Staff Related Issues - Most staff are ex-alcoholics or ex-wives of alcoholics which makes them dedicated workers.

HAVEN HOUSE (continued)

F. Funding - Presently they barely survive on donations and client fees; getting federal money is difficult due to present emphasis on drugs instead of alcohol.

G. Interagency Cooperation - There is good cooperation with agencies in the Pasadena area but little real contact outside.

H. Community Pressure/Acceptance - Not problem.

I. Unmet Needs -

1. more Haven House-type services
2. more public education and understanding regarding alcoholism

HOUSE OF HOPE

I. Pattern of Service

A. Philosophy of Treatment - Not AA per se but strictly adheres to its philosophy. Feels programs following this philosophy do not fail.

B. Services Provided - Recovery house, aftercare facilities.

C. Facilities - Their recovery house and some cottages next door which they own and are converting to a halfway house.

D. Geographic Scope - Not limited but usually San Pedro and nearby communities including Long Beach.

E. Staffing Pattern - Director and relief director are the only paid staff. Several volunteers help with transportation and fund raising.

II. Problems and Issues

A. Referral - Referred to by hospitals, State Department of Rehabilitation, clergy, word of mouth. They refer to State Department of Rehabilitation for medical and all other services. Little contact with other agencies.

B. Prevention/Education - Not discussed.

C. Service Needs - Bring their house up to standards and try to make it more comfortable.

D. Access - Not discussed.

E. Staff Related Issues - Not mentioned.

F. Funding - Self-supporting with funds from their thrift shop, contributions, and woman's ability to pay. No big design for new programs or expansion so do not seem to need additional funds. Annoyed with the strict, clinic-like restrictions the state has for funding prerequisites. Feels recovery homes would become clinics if they complied.

G. Interagency Cooperation - Can get women detoxified but has problems in having the hospitals keep the individuals for 2-3 days. Detoxification units are staffed by nonalcoholics who are difficult for the alcoholic to relate to. Occasionally they receive money from welfare and the State Department of Rehabilitation to keep a client.

H. Community Pressure - They do not feel direct community pressure but know they must be on their toes at all times.

I. Unmet Needs - Program for alcoholics under 30 who cannot relate to the older people in AA. Presently young people are sent to County Rehabilitation or are given money to go to a cheap hotel. Want to develop a program in vocational training for semi-handicapped people to keep them from drinking.

J. Miscellaneous - Would like to get all recovery house people together to plan and learn from each other but doesn't know who could organize and sustain the effort.

KEDREN COMMUNITY MENTAL HEALTH CENTER

I. Pattern of Service

A. Philosophy of Treatment - Improvement of community mental health through decentralized services in the areas of patient care, consultation and education; involving the community in its own treatment and education.

B. Services Provided -

1. individual and family therapy of all kinds
2. day treatment for children, adolescents and adults
3. social, recreational and work activities for patients
4. consultation to community organizations and agencies (e.g., schools)
5. speakers or programs to organizations wanting mental health education
6. 24-hour crisis intervention
7. contracted inpatient care

C. Facilities - Large building for counseling and varied therapy activities; plans for a new facility include their own inpatient care.

D. Geographic Scope - The Watts-Green Meadows area.

E. Staffing Pattern - Primarily professional psychological staff, one official administrator, paraprofessionals in all areas, clerical and many kinds of volunteers in all facets of the program.

II. Problems and Issues

A. Referral - Transportation makes referral a problem, but positive relationships with similar centers outside the area as well as agencies there have been established for referral purposes.

B. Prevention/Education - This is one of Kedren's primary emphases, but funding hassles have often caused neglect in this area; prevention and education reduce problems and make people more able to cope when they do occur; a proposal has been granted to train community people to be mental health workers which should improve Kedren's affect in this area.

C. Service Needs -

1. more clerical, administrative, and operational staff
2. more professional psychological staff
3. a new facility
4. more client follow-up
5. expansion of present services

KEDREN COMMUNITY MENTAL HEALTH CENTER (continued)

D. Access - Kedren is available to all in the area at no charge; it is centrally located and not hard to reach; fees are by ability to pay or paid by Medi-Cal or L.A. County's Short-Doyle Fund; they would like to be more involved in schools.

E. Staff Related Issues - There is a high turnover rate among professional staff; the main reason for this and the staffing needs mentioned is that the professional staff must spend an inordinate amount of time on funding responsibilities and activities because there is no one else to do it; the paraprofessional and clerical staff spend too much time on the paper work required by the funding sources.

F. Funding - Kedren's main grant is from NIMH, the Community Mental Health Centers Act; reimbursement from Medi-Cal and Short-Doyle, and client fees; they need more money just to expand present services.

G. Interagency Cooperation - Kedren wants more service-sharing with other private agencies but cannot do it without a coordinating mechanism; enjoy contractual agreement with Los Angeles County but want no closer ties.

H. Community Pressure/Acceptance - There is no pressure and none anticipated; accepted because they fill a need.

I. Unmet Needs -

1. more group private practices spread throughout the county
2. more stable, constant funding sources.

J. Miscellaneous - Funding sources should have more realistic expectations on observable results and require less constant reporting.

LOS ANGELES TIMES BOYS CLUB

I. Pattern of Service

A. Philosophy of Treatment - The Boys Club is similar to other boys clubs with the important exception that this club has six full-time staff people. Therefore, the boys can develop meaningful relationships with these people which leads to quality programming.

B. Services Provided - Tutoring program, recreation, adult program teaching English as a second language and swimming to adults and youth.

C. Facilities - One large facility.

D. Geographic Scope - East Los Angeles, especially the Model Cities target area.

E. Staffing Pattern - The director and six staff people are full-time paid staff. The staff is supplemented with youth from the Neighborhood Youth Corps and college work-study program. A consulting psychiatrist comes once every other week and is paid with state funds. Hired an individual to coordinate the students being tutored and the college volunteers.

II. Problems and Issues

A. Referral - The Club is an integral part of the community and makes referral when necessary.

B. Prevention/Education - Not mentioned.

C. Service Needs - Expand present facility or acquire a new one. Need more services and programs for girls.

D. Access - Problem with transportation—have a program to teach the students in each of the eleven surrounding schools to swim. However, when the actual swimming program ceases, the kids have no way to get to their pool. Would like to run their own buses for this.

E. Staff Related Issues - Feels staff morale is so high because most staff are alumni of the program and therefore are quite committed to it.

F. Funding - Club funded 100 percent by Los Angeles Times Fund. Times did not want them to solicit more funds but may do so now if they feel they need them.

ANGELES TIMES BOYS CLUB (continued)

G. Interagency Cooperation - Director is a commissioner of Model Cities, legal aid, and numerous other Boards which keep the Club in touch with other agencies. Their tutoring program keeps them in touch with the city schools.

H. Community Pressure - Club founded in 1944 and is well respected in the community.

I. Unmet Needs - Need an alternative to Juvenile Hall for police to take youths only needing a cooling off place when picked up late at night so that booking and a record can be avoided in minor offenses. Club offers a place on Friday and Saturday evenings until 3:00 a.m. but that is not enough. Program for girls.

J. Miscellaneous - Director feels black and brown communities learing to work together rather than compete for funds. Change due to new militancy by Chicano.

MANHATTAN PROJECT

I. Pattern of Services

A. Philosophy of Treatment - Providing a place where people can learn there is always God-given hope. A place where people can help each other to gain self-respect and a sense of purpose in life. The kids live in and work out or go to school and learn to run the houses together.

B. Services Provided - Halfway house, counseling, group experiences, arrangements made for medical care, recreation, job counseling.

C. Facilities - Four homes very close to each other and administrative headquarters in the Salvation Army building.

D. Geographic Scope - No limit—some are referred from Fresno and Salt Lake City as the Army runs similar projects in these cities.

E. Staffing Pattern - Five paid staff members including the educational coordinator and managers of the four residence homes. Members of the Salvation Army work for the Project as do young men fulfilling their obligations as conscientious objectors who receive token salaries.

II. Problems and Issues

A. Referral - Referred to Project by clergy, psychiatrists, case workers, probation officers. Tries to make arrangements with hospitals, like Children's, to interview kids for the program after they have been detoxified. Probation Department can refer but never commit an individual. Know directors of other drug programs and if they feel another program will better serve the individual, they will refer the individual to that program.

B. Prevention/Education - More treatment oriented.

C. Service Needs - More jobs for the kids in their program. Want to set up an apprenticeship program so as to train these people and give them skills and work experience. Would like to hire more staff so as to relieve pressures on the present staff.

D. Access - No problems mentioned.

E. Staff Related Issues - Problem that the staff receives little or no gratification as the kids do not know how to give, only take. It is hard work for the staff with little to show for it.

MANHATTAN PROJECT (continued)

F. Funding - Seventy percent of the costs for running the program come from fees of families who can pay, probation when they have referred someone, and rent assessed to each participant. Remaining 30 percent from operating budget of Salvation Army. Feel government grants are undependable so they do not depend on them.

G. Interagency Cooperation - Arrangement with Probation Department already discussed. Need more cooperation with employers and schools so as to make the members "away from home" experiences more meaningful. Most of the present success in this area is due to educational coordinator. Lack of coordination among agencies in Los Angeles is a source of frustration to the staff but they have no soltuions to the problem. Afraid of planning or cooperating mechanism ending up controlling.

H. Community Pressure - None mentioned.

I. Unmet Needs - More programs for kids.

J. Miscellaneous - Have a nonresident program for about 25 people including people too old for the program, former residents, cops, housewives, who participate in the activities and responsibilities of the house.

MARY LIND FOUNDATION

I. Pattern of Service

A. Philosophy of Treatment - To help anyone who has an alcoholic problem by teaching him how to be responsible for himself, in a clean, home-like atmosphere that is supportive, providing practical learning opportunities of all kinds.

B. Service Provided -

1. residence with/and board
2. some vocational counseling and job placement
3. social, recreational and educational services
4. AA meetings and other forms of therapy
5. Referral

C. Facilities - Four renovated hotels with approximately 550 beds.

D. Geographic Scope - The hotels are in central Los Angeles but residents come from all over the county and beyond.

E. Staffing Pattern - Many are ex-alcoholics and/or present residents; others are social workers, the director is wife of the late founder.

II. Problems and Issues

A. Referral - This is no problem; they receive more than they make, but Mary Lind is well-respected and established, and has good relationships with almost every related program or agency.

B. Prevention/Education - They believe in the great need in this area.

C. Service Needs -

1. money to improve the safety of the hotels
2. more social workers for long-term guidance and counseling

D. Access - It was not discussed, but isn't much of a problem; no one is rejected due to lack of funds.

E. Staff Related Issues - The director allows staff great freedom, and encourages initiative, yet knows everything that is going on; ex-alcoholics on the staff add to their expertise and understanding.

F. Funding - Presently some residents are subsidized by Los Angeles County General Relief, some from ATD; those who work pay room and board; they are primarily self-supporting in this manner; don't solicit donations.

MARY LIND FOUNDATION (continued)

G. Interagency Cooperation - They have good relationships with related public agencies, were instrumental in starting the Recovery House Association, are active in other planning groups.

H. Community Pressure - Not really a problem.

I. Unmet Needs -

1. a central clearing agency for recovery homes that would manage joint operational needs, provide consultation and education on common problems, and yet promote autonomy among the homes.
2. public education to understand alcoholism, but also to know about present alcohol programs, their worth and their needs.

Sandra Summe, Narcotics Consultant
LOS ANGELES COUNTY PROBATION DEPARTMENT

I. Pattern of Service

A. Philosophy of Treatment - To get a problemed young person together with the right person and/or program to meet his needs, especially as regarding drugs.

B. Services Provided - Personal referral and follow-through, consults private and public programs, evaluates services.

C. Facilities - None, physically.

D. Geographic Scope - The South Bay across and through South Central and South East Los Angeles County.

E. Staffing Pattern - One or two aides, one of whom is an ex-addict.

II. Problems and Issues

A. Referral - Personal knowledge and evaluation is key; cooperation and information should come from and be amoung the drug programs by area; central referral could never be up-to-date or useful in terms of specific individual needs.

B. Prevention/Education - Not discussed.

C. Service Needs - Not applicable.

D. Access - She prevents these problems by providing transportation and funds as much as possible; this works because treatment is usually part of each youth's probation.

E. Staff Related Issues - Too often pseudo-experts direct ill-fated programs; whether or not staff are ex-addicts is not important; the importance is ability to relate and work with people.

F. Funding - It is difficult for funding agencies to evaluate the worth and ability of drug programs because it is such a new area of concern; the competition over funding acts as a divisive element among drug programs.

G. Interagency Cooperation - The small drug programs must coordinate and share services for survival; she seems to have good rapport with many and tries to act as a liaison with all.

LOS ANGELES COUNTY PROBATION DEPARTMENT (continued)

H. Community Pressure - Parents of kids on drugs and communities are less afraid of programs dealing with pills and pot than of those working with heroin addicts; this affects the admission of addiction by youth, too.

I. Unmet Needs - The biggest one is halfway house, i.e., a long second step between detoxification and complete self-reliance.

THE NEW CONNECTION

(now extinct)

I. Pattern of Service

A. Philosophy of Treatment - The ex-user is the best one to relate to an addict; the ex-user gains by upgrading his own self-image while helping others.

B. Services Provided - Residential halfway house, counseling, referral.

C. Facilities - A residence at time of existence.

D. Geographical Scope - Glendale-Burbank.

E. Staffing Pattern - Mainly ex-users.

II. Problems and Issues

A. Referral - They developed and updated their own list, and personally evaluated each referral; the "good" programs usually could not meet the demand.

B. Prevention/Education - Not discussed.

C. Service Needs - Not applicable since program no longer exists.

D. Access - There are presently no residential drug programs in the Glendale-Burbank area.

E. Staff Related Issues - See philosophy and I.

F. Funding - Not discussed.

G. Interagency Cooperation - The New Connection went under because of community pressure acted out in zoning battles, police hassels, and threats to the Board of Directors.

H. Community Pressure - The "community" did not want the needed facilities within its jurisdiction; see above; it is felt that this affects all drug programs.

I. Unmet Needs -

1. halfway and residential treatment houses
2. detox facilities
3. less restrictive zoning

4. more cooperation and involvement of law enforcement and the medical profession
5. looser and less competitive federal funding procedures
6. increased cooperation among drug programs
7. a central bank of information to show needs and services
8. training for program directors
9. training of paraprofessionals to work with professionals
10. realistic controls for the different types of services

J. Miscellaneous -

1. the County should not be the agency to set standards or review programs
2. suspicious of independent evaluation
3. the drug addict is more complex than the alcoholic

PASADENA ALCOHOLISM CENTER

I. Patterns of Service

A. Philosophy of Treatment - Help anyone whose life is disrupted because of the use of alcohol, including the immediate family, using the multidisciplinary team approach since no one discipline or agency can provide all services to the alcoholic. Center's central role provides a supportive environment in which assistance is given to the patients to maintain sobriety and acquire the skills necessary to take care of themselves.

B. Services Provided - Education on alcoholism, vocational rehabilitation, limited medical and psychiatric treatment and group and individual counseling.

C. Facilities - Provides services on an outpatient basis. Also utilizes other community welfare resources. Has close coordination with recovery homes, DPSS, hospitals, Rehabilitation Centers and the Councils on Alcoholism.

D. Geographic Scope - Approximately 50 percent of the clients are from Pasadena, while the rest are from surrounding areas.

E. Staffing Pattern - A multidisciplinary staff of 17 at the Center, six of whom are part-time; two are State Department of Rehabilitation employees.

II. Problems and Issues

A. Referral - Referrals to this treatment program are self-referral and from other community agencies, such as the Los Angeles Council on Alcoholism, the Pasadena Council on Alcoholism, Probation Department, the courts, recovery homes, etc. Referrals are also made by the Center to recovery homes, hospitals, rehabilitation centers and welfare agencies. A cross referral system is used in order to give the most effective service.

B. Prevention/Education - Part of their program is to educate the community and family regarding alcoholism and its related problems. Speakers are provided for schools and community groups. The lecture portion of the program is open to the public (students, members of other agencies and community members) by prior arrangement.

C. Service Needs - More staff members in order that there might be time available to establish closer relationship with other agencies.

D. Access - Not mentioned as a problem.

E. Staff Related Issues - Communication between staff members and between members of other agencies.

F. Funding - Funds for the Center are from contractual and matching arrangements between the City of Pasadena, State Department of Rehabilitation and the federal government. It appears to be satisfactory.

G. Interagency Cooperation - See referral and philosophy of treatment. Close relationships maintained with many agencies in order to provide comprehensive services. Center is the coordinator for the alcoholism agencies, and it is the only one with a stable source of funding. Pasadena has been working toward this cooperation for years.

H. Community Pressure - Very much supported by the community.

I. Unmet Needs - Detoxification services and money for recovery homes.

J. Miscellaneous - Initiated the Casa de las Amigas project, which is now a self-supporting recovery home for women. Could only have been developed by cooperating agencies.

PASADENA DRUG TREATMENT CENTER

I. Patterns of Service

A. Philosophy of Treatment - "Continuity of care," same staff person who referred an individual agrees to follow that individual through each stage of treatment.

B. Services Provided -

1. medical detoxification for barbituate and amphetamine users
2. residential counseling and treatment center
3. follow-up after residence by staff
4. referral for clients which the Center cannot treat
5. free services, on a one-to-one basis

C. Facilities - Access to hospital detoxification, 8-bed.

D. Geographic Scope - Pasadena Junior College District.

E. Staffing Pattern - Men and women, professional and nonprofessional, some ex-addicts, one-third minority.

II. Problems and Issues

A. Referral - No problem in Pasadena, except for psychological services, would like to see some agencies who make referrals handle the problem and provide more services themselves.

B. Prevention/Education - If they could hire more staff, the Center would develop an outreach program.

C. Service Needs -

1. services to older heroin addicts
2. expansion of present facilities
3. outreach program
4. aftercare facility

D. Access - Not a problem in the Pasadena area.

E. Staff Related Issues - Some drug programs fold because staff does not stay clean, but this is not a problem here.

F. Funding - Matching plus CCCJ.

PASADENA DRUG TREATMENT CENTER (continued)

G. Interagency Cooperation - The Center was established by a consortium of public and private agencies in Pasadena, therefore, relationships are stable; they would like more contract with and training for school medical personnel who now feel there is no major drug problem in the schools.

H. Community Pressure/Acceptance - The program grew out of a need expressed and supported by the community and continues as such.

I. Unmet Needs -

1. programs for heroin addicts over 25
2. stronger aftercare program

PROJECT ARRIBA

I. Pattern of Service

A. Philosophy of Treatment - Youth development through strengthening the ability of the community to solve its own problems and work within the broader community; developing individual and group pride, especially regarding Mexican American culture.

B. Services Provided -

1. boys' education, enrichment, and recreational clubs
2. boys' relationship with positive adults
3. parent groups to express needs and initiate community action
4. counseling: psychological, individual, and family
5. provides the only community meeting place

C. Facilities - A fairly large industrial building which has been remodeled into offices and meeting rooms.

D. Geographic Scope - The city of South El Monte, a barrio within an industrial area.

E. Staffing Pattern - Staff is almost entirely Mexican-American; professional and paraprofessional; students (volunteer and paid) run the boys clubs; other volunteers.

II. Problems and Issues

A. Referral - Except for a couple of public agencies in El Monte, there are no agencies to refer to.

B. Prevention/Education - The Arriba parent council groups are involved in the prevention of juvenile delinquency. Presently a parent council education committee is working with the target schools regarding school district policies.

C. Service Needs -

1. transportation in order to make referrals
2. more services of all kinds in the area

D. Access - The project is within walking distance of clients. More projects like this one should be developed in other unincorporated and isolated poverty areas.

E. Staff Related Issues - Important to have positive relationships with adult males, especially Chicanos.

PROJECT ARRIBA (continued)

F. Funding - Funding sources should be less responsive to political pressure and more to need; more equality is needed, now more is given to blacks than to Mexicans.

G. Interagency Cooperation - Good relationship with public agencies; trying to influence schools' curriculum and gain community participation and control.

H. Community Pressure/Acceptance - Project has been accepted and fully supported from the start.

I. Unmet Needs -

1. more services in unincorporated and isolated poverty areas in Los Angeles

J. Miscellaneous - Arriba Board of Managers is 90 percent minority representation.

PROJECT CULVER

I. Pattern of Service

A. Philosophy of Treatment - A social work-oriented program to provide alternatives to arrest for youth (and their families) who are involved with drugs; emphasis on working with the family whenever possible.

B. Services Provided -

1. crisis intervention counseling and referral
2. individual and group counseling
3. referral, when necessary
4. an alternative to the Police Department concering youthful drug offenders
5. prevention through education in the schools and of school staff

C. Facilities - An open house drop-in and counseling center.

D. Geographic Scope - The Culver City area.

E. Staffing Pattern - Four social workers, four high school student liaisons.

II. Problems and Issues

A. Referral - There are few places to refer in Culver City; to go beyond involves transportation and usually what they want is not available due to demand or cost.

B. Prevention/Education - Intended to be a major program thrust but the amount of time spent with individual problems and families has prevented all but occasional programs; their idea is to conduct classes for school staff on recognition and treatment of drug abuse in schools.

C. Service Needs -

1. more staff with more specific functions
2. expansion of present services

D. Access - Not a problem, no fees for services.

E. Staff Related Issues - The four social workers too often want to participate in all aspects of the program and have difficulty both in rejecting appeals for help and in terminating client relationships; the result is that they are spread too thin and are not being as effective as possible.

PROJECT CULVER (continued)

F. Funding - Not a problem; CCCJ funds are matched by the city council and the police department.

G. Interagency Cooperation - They are a part of and have good relationships with local public agencies; can refer to other private ones; feel a need for some connection areawide or countywide with other drug-related services.

H. Community Pressure/Acceptance - There was some at first, primarily from churches, but now they are involved and accepted by most.

I. Unmet Needs - More communication and connection among drug-related programs throughout the county.

SPECIAL SERVICE TO GROUPS, INC.

I. Pattern of Service

A. Philosophy of Treatment - To build bridges among racial groups by helping to resolve social problems through implementation of research and action programs as the need is expressed by communities.

B. Services Provided -

1. management, training and consulting staff to community programs
2. consultation, staff training, and research and development advice to existing service agencies

C. Facilities - Found for projects as needed; administrative office operates out of a modest suite of offices.

D. Geographic Scope - Los Angeles County.

E. Staffing Pattern - An obvious attempt to achieve racial balance on all levels.

II. Problems and Issues

A. Referral - Not an issue here in terms of services.

B. Prevention/Education - Not applicable.

C. Service Needs -

1. expansion of present staff and services

D. Access - It is probable that many community groups who need the aid of an organization like SSG do not know about it.

E. Staff Related Issues - Director made a strong point that honesty among staff between organizations will benefit interorganizational relationships.

F. Funding - Funded by United Way and act as consultants in obtaining both public and private funds for new programs.

G. Interagency Cooperation - There is no other agency like SSG; they do have strong relationships with many public and private agencies in the county and beyond.

H. Community Pressure/Acceptance - Important for them to survey a community to see if the need expressed by a few is truly a community need.

I. Unmet Needs - Clearer knowledge of public funding policies and more agencies should actually provide the services to which they lay claim.

SYNANON

I. Pattern of Service

A. Philosophy of Treatment - One is expected to adopt a new communal living pattern and remain indefinitely; a key aspect is the Synanon game of confrontation therapy.

B. Services Provided -

1. cold turkey detoxification
2. complete medical, employment (except for professionals who are life-stylers), child care and education services

C. Facilities - In Los Angeles County they own a huge hotel complex, several apartments, a gas station; able to house 500 plus; includes a progressive school.

D. Geographic Scope - No limits.

E. Staffing Pattern - None recognizable; many grew from Synanon experience, some professionals.

II. Problems and Issues

A. Referral - They do none except to other Synanon facilities.

B. Prevention/Education - They do little outside of their own community, except for occasional fund-raising or resident-recruiting.

C. Service Needs -

1. more residents
2. more referrals from the courts

D. Access - Nst really a problem; cost for addicts is nothing; professional life-stylers donate their whole salaries and draw an allowance; others contribute by working at the Synanon-owned gas station and industries.

E. Staff Related Issues - None apparent.

F. Funding - They are now and have always been almost completely self-supporting; private donations helped in the earlier stages; present support is through resident salaries and Synanon-owned businesses and donations of goods and services.

G. Interagency Cooperation - They are not interested except to improve relations with courts to get more referrals; beyond that they see no reason for cooperating with other agencies or treatment programs as they have capacity and ability to absorb all the county's addicts; the California Adult Authority will not refer because they do not allow addicts to associate with known criminals (or ex-convicts) in a treatment situation.

SYNANON (continued)

H. Community Pressure/Accpetance - Pressure was a problem in the beginning with constant zoning battles; still somewhat of a problem, as is public credibility of their success.

I. Unmet Needs - None

THALIANS AND CHILD-STUDY CLINIC

Cedars-Sinai Hospital Psychiatric Division

I. Pattern of Service

A. Philosophy of Treatment - Therapy for the preschool and school age child and his family through family and group family counseling and individual psychotherapy.

B. Services Provided - Family counseling, group-family counseling, psychotherapy, outreach program with parent groups in local high schools. Consults for staff of other community agencies.

C. Facilities - Clinic in Cedars-Sinai Hospital.

D. Geographic Scope - Area between Doheny and LaBrea and between Hollywood Boulevard and Jefferson.

E. Staffing Pattern - All professionals, psychiatrists, psychologists and psychiatric social workers. Have resources of the hospital available to them.

II. Problems and Issues

A. Referral - Recognizes need for coordination of information and shared services among clinics. Some attempts at coordination of information with more community oriented agencies but not fruitful. Have referral agreements and contacts with other clinics when they cannot meet their demands.

B. Prevention/Education - Work with families for better harmony in self and towards others and community.

C. Service Needs - Coordination of information.

D. Access - No problems mentioned.

E. Staff Related Issues - None mentioned.

F. Funding - Large auxillary does fund raising and gets additional funds from the hospital as an operating budget. Shows importance of stable relationship with a large institution.

G. Interagency Cooperation - Member of formal body of psychiatrists on regional and national levels as well as on state commissions. Cooperation with other clinics. Will consult for grass roots organizations and is further extending in this direction.

THALIANS AND CHILD STUDY CLINIC (continued)

H. Community Pressure/Acceptance - Well respected in the community.

I. Unmet Needs - More clinics so as to have their approach accessible to more people than they alone can serve.

J. Miscellaneous - More interested in participating with other professionals and paraprofessionals in grass roots and interagency coordination.

TUUM EST

I. Pattern of Service

A. Philosophy of Treatment - Reeducation of narcotic addicts and their return to society as productive fulfilled individuals. Stress freedom of choice and that Tuum Est is an alternative to people in trouble who usually are not offered an alternative. People live and work in and the small number of people involved makes it all work. People are there because they want to be and can leave at will.

B. Services Provided - Halfway and residence homes, homelike environment counseling, encounter groups.

C. Facilities - Four houses on one block in Venice; own an adjacent lot they intend to build a meeting facility on.

D. Geographic Scope - No limit.

E. Staffing Pattern - Board of Directors volunteers its diverse services to the houses including medical and social services. Members of the houses elevated to staff positions as a reward for 'making it.' Paid staff involves director, administrator, coordinator, secretary/bookkeeper, four staff counselors, house coordinators.

II. Problems and Issues

A. Referral - Part of informal network of drug programs, directors know each other and easily refer potential clients to the appropriate program. Have a list of referral resources taken from HWIS.

B. Prevention/Education - Not mentioned as is a treatment-oriented agency.

C. Service Needs - Build meeting facility on acquired property and develop satellite houses where needed—housing for those who have to be turned away.

D. Access - Not mentioned as a problem.

E. Staff Related Issues - Problem that too much responsibility is shouldered on Jeffe Pratt and they are trying to spread the load more evenly.

F. Funding - One-half of the funding is from CCCJ and rest is raised by the Board from the community. Will soon qualify for United Way funds. Need more money to expand. Staff receives salary and rest is put in trust for when they leave.

TUUM EST (continued)

G. Interagency Cooperation - Respected by and work with courts and city.

H. Community Pressure/Acceptance - Great community support as community welcomes solutions to its drug problems.

I. Unmet Needs - More small community based programs which are the most successful and which the community becomes the most involved with.

J. Miscellaneous - No we/they relationship at Tuum Est which is prevalent at other institutions. Director and addicts relating to each other is unusual and important. About 100 on waiting list, those showing the most interest in the program are admitted.

VAN NUYS COMMUNITY SERVICE CENTER

I. Pattern of Service

A. Philosophy of Treatment - Only organized program for general Van Nuys Chicano population which has very few services. They try to handle all types of problems and those they cannot handle are referred to programs and agencies who can help.

B. Services Provided - Social services including job and vocational referrals, food stamps and welfare information, emergency food and clothing, legal services, health care; drug and alcohol prevention programs including rap groups and counseling; youth programs including Teen Council, leadership development, and remedial education. Total of 27 programs most of which refer to other services.

C. Facilities - The Center is a meeting place but the staff does most of its work in the streets and in peoples' homes.

D. Geographic Scope - Van Nuys Barrio.

E. Staffing Pattern - Mr. Rodriques and ten community workers, para-professionals, who are responsible for handling all types of problems while in the field.

II. Problems and Issues

A. Referral - Try to refer eligible people for government services. Government does not try to encourage people to use their services as they want to reduce and not increase their caseload. Refers to available services in the San Fernando Valley. Is the responsibility of the community workers to refer.

B. Prevention/Education - More concerned with general health problems than specifically drug and alcohol. Chicanos need to learn about what services are available to them.

C. Service Needs - Recreational program for youth, resolution of petty politics, seems as if all types of services are needed.

D. Access - Lack of services in Van Nuys area and do not have the resources or services available to use those located outside of their barrio.

E. Staff Related Issues - Staff feels insecure due to uncertain sources of funding for program. The funds are allocated but Reagan has vetoed many of the bills which worries the staff which the Director feels hampers their work.

VAN NUYS COMMUNITY SERVICE CENTER (continued)

F. Funding - A problem is created when the Federal government announces a grant to the community without stating what the specific uses of the funds will be. This causes mistrust and confusion within the community and could easily be avoided if the government allowed the grantee to announce the funds in a way the community would accept positively. Additionally, the program could provide more services with more funds.

G. Interagency Cooperation - Seem to cooperate as will run the aftercare program for Olive View Hospital since they have the expertise in the area. They had a health fair which involved extensive cooperation among many public and private agencies. Try to cooperate with other agencies since so great a portion of the program involves referrals.

H. Community Pressure/Acceptance - Does not seem to be any pressure; welcomed by the community, to an extent, as it is the only agency of its kind in the area.

I. Unmet Needs - Jobs for undereducated and underpaid Chicanos. Help for the serious health and nutrition problems of the Chicano population of Van Nuys. More money for the barrio community.

J. Miscellaneous - Kids on the street probably not receiving services as not asking the Center for them and there is nowhere else they would go to get them. Petty politics frequently kills Chicano group efforts, Board members have no financial interest in the Center and each wants to gain personal control.

WEST HOLLYWOOD CRISIS HOUSE

I. Pattern of Service

A. Philosophy of Treatment - Reformation of life style through acceptance of responsibility in a supportive residential atmosphere.

B. Services Provided -

1. full-time, long-term residence
2. regular, intensive counseling; group, individual and family
3. some employment and recreational counseling
4. detoxification (contracted in Ventura County)

C. Facilities - Residence with 12-bed capacity.

D. Geographic Scope - The whole county, but emphasis on the West Hollywood area.

E. Staffing Pattern - An executive director, a program director and other paid and volunteer staff.

Problems and Issues

A. Referral - Trouble finding enough detoxification services, referral to other drug programs is no problem, but demand exceeds capacity.

B. Prevention/Education - Not discussed.

C. Service Needs -

1. expansion of present services
2. regular, trained employment and vocational counselors
3. an aftercare program
4. more available medical and legal services

D. Access - Not discussed per se; residents are expected to work and pay $25 per week to the house.

E. Staff Related Issues - Dedication has been important as an element of success; to keep staff, there must be some observable changes (not possible when it was just a crash pad).

F. Funding - CCCJ plus salaries of residents; basically it is no problem for them.

WEST HOLLYWOOD CRISIS HOUSE (continued)

G. Interagency Cooperation - Good relationships with HRD and county personnel; would like more involvement with and help from legal and medical professions; feel need for a formal planning mechanism for and by the private sector by area (not whole county); have pursued and maintained good relationships with several drug-related programs.

H. Community Pressure/Acceptance - Has not been a problem for them, but feel that many good programs have folded because of community fear and pressure.

I. Unmet Needs -

1. more detoxification services
2. participation and service by legal and medical profession
3. planning and more cooperation within private sector, including important members of public sector
4. administrative training for program directors
5. crisis intervention services

J. Miscellaneous -

1. cooperation among all levels of agencies and services would result in development and execution of better services
2. involvement with Los Angeles Community Liaison Association

YOUTH DEVELOPMENT PROJECT, INC.--LEARNING CENTERS

I. Pattern of Service

A. Philosophy of Treatment - Learning Centers primarily for the juvenile on probation in Long Beach for drug offenses who may not attend the public schools because of the offense. Curriculum is basic education and learning how to live within the structure of our institutions.

B. Services Provided - Teen Council, narcotics education program, counseling, tutorial and remedial education, job counseling and placement, cultural enrichment and recreation programs.

C. Facilities - Five teen centers located within various low income sections of Long Beach.

D. Geographic Scope - Long Beach.

E. Staffing Pattern - Each Center has a director and assistant director and four to six youth workers from NYC and other organizations.

II. Problems and Issues

A. Referral - Only to known sources within geographic reach.

B. Prevention/Education - Narcotics education program.

C. Service Needs - An assistant to relieve the director of all the work and responsibility. More secretarial help.

D. Access - Not mentioned as a problem.

E. Staff Related Issues - Need administrative and secretarial help. Has been an advocate of giving more money to programs and less to administrators but now recognizes the need for some relief.

F. Funding - Need a stable source of funds once the CCCJ demonstration grant runs out.

G. Interagency Cooperation - Schools refer the teens to this program. Director has strong associations with key people in the community which helped get the program started.

H. Community Pressure - Not worried about it but have had problems more due to jealousy of other agencies not able to solicit funds themselves than for any other reasons.

I. Unmet Needs - None mentioned.

J. Miscellaneous - Success of program definitely a result of the director's drive and skills. Young people allowed to plan a lot of their own program.

INVENTORY OF DETOXIFICATION FACILITIES

The purpose of this project was to inventory all facilities offering detoxification services within Los Angeles County. Included in the inventory is the location, capacity, cost, and special admissions requirements of each facilitity. This information is necessary to support or disprove the statements of agencies who complained of a lack of these facilities. It is also important to have the list so as to be able to sort the existing facilities geographically and thus to pinpoint the gaps in service.

This information was obtained by speaking to the appropriate people at the County Department of Health, County hospitals, private hospitals, Los Angeles County Medical Association, Sheriff's Department-Narcotics, and known detoxification facilities such as those of the Veterans Administration and the Narcotics Prevention Project. Two other good sources were the Alcoholism Council and the Recovery House Association. The inventory is organized into discussions of each program area. The detoxification facilities in each program area were organized by type of government, i.e., county, state, and federal, and by private agencies.

DETOXIFICATION FACILITIES

I. Alcoholic Detoxification

A. Public Agencies

1. Los Angeles County Hospitals

(a) U.S.C. County General - Dr. Clyman
1200 N. State Street
Los Angeles 225-3115 x3677

44 detoxification beds for acute alcoholism
3-day average stay (if more send to Long Beach General)
$151/day

(b) Long Beach General - Dr. Fox and Dr. James
636-0784

30-40 beds for detoxification (mostly rehabilitation)
5 male wards and 1 female ward (20-25 beds each)
Take transfers from USC and nonacute cases
1-4 weeks (average 2 weeks)
$59/day

(c) Harbor General

No detoxification
Just screen patients and send to Long Beach General or County General
Have alcohol stabilization (used to have detoxification and rehabilitation)

2. County Health Department

- has 5 rehabilitation clinics for alcoholism
- all out-patient
- all detoxification but different than county

(a) 5205 Melrose Avenue 464-9121 x211
(b) 122 W. 8th Street, San Pedro 775-7111
(c) 2655 Pine Avenue, Long Beach 427-7421
(d) Pasadena

3. U.S. Government

(a) Veterans Administration, Brentwood - Dr. Lowenstein
478-3711 x5123

No alcohol detoxification (would have had one but for quake last year)
Do have 8-week in-patient care for those with previous history of alcoholism

(b) Veterans Administration, Long Beach
498-1313

Have alcohol rehabilitation clinic
Detoxification only in emergency

(c) Veterans Administration, Sepulveda

No alcohol program

(d) U.S. Naval Hospital
547-6721

Have an alcohol rehabilitation clinic and detoxification

4. State Hospitals

(State phasing out state hospitals, since cheaper to contract for services, e.g., with half-way houses)

(a) Camarillo State

Good alcohol program but do not have detoxification there (Have about 100 alcoholic beds - about 65 for Los Angeles residents)

(b) Metro State

Caseload too heavy to allow Los Angeles County people for alcohol detoxification

II. Drug Detoxification

A. Public Agencies

1. Los Angeles County Health Department - 8 drug clinics (out-patient drug detoxification at all 8)

(a) El Monte Health Center
11013 Valley Mall
El Monte 444-2558

(b) Florence-Firestone Health Center (federal money)
8019 Compton Avenue
Los Angeles 583-9031 x383

(c) N.E. Health Center Methadone maintenance)
2032 Marengo Street
Los Angeles 90033 225-5975

(d) Pacoima Health Center (Maintenance soon)
1330 Van Nuys Blvd.
Pacoima 91331 899-0231

(e) S.E. Health Center
4920 S. Avalon Blvd.
Los Angeles 90062 273-6145

(f) W. Health Center
1806 Lincoln Blvd.
Venice 392-4114

(g) W. Hollywood Health Center
621 N. San Vicente Blvd.
W. Hollywood 90069 278-6530

(h) Methadone Maintenance Headquarters
(Imperial Heights)
10616 S. Western Avenue
Los Angeles 754-2981

2. County Hospitals

(a) County General (USC)
225-3115

3 beds reserved for Narcotics Prevention Project (N.P.P.) for detoxification and some reserved also for Bricks (heroin) (won't say how many they have)

(b) Harbor General, Torrance - Dr. Diamond
x277

Have written contract with House of Uhuru and Compton Special Services Center
Drug withdrawal, on voluntary basis

- each has maximum bed usage of 10/mo. (not 20 though at any one time); if beds are full have other medical emergencies, drug detoxification patients given last priority and usually sent away and referred elsewhere.

(c) Rancho Los Amigos, Downey

Only detoxification for barbituates (no heroin - send to Metro)
31 detoxification beds (also used for observation, acute cases, and overdoses)
(27 beds for rehabilitation) - most referrals from County General and county health clinics

(d) Olive View, Sylmar - Dr. Pickens

Used to have 25 detoxification beds but were destroyed in quake. May get new facility in Sepulveda with detoxification beds.

(e) John Wesley

Research hospital - detoxification only for pregnant women with hepatitis who plan to delivery there later and also detoxification in emergencies.

(f) Martin Luther King, Watts

Opened March 27
Have no detoxification now but may have something soon to accommodate Bridge Back and others.

3. State Hospitals

(a) Metropolitan State
11400 S. Norwalk Blvd.
Norwalk 863-7011 x320

40-50 beds (detoxification heroin, mostly)
25 beds reserved for N.P.P. (EYOA)

- N.P.P. is only referral agency to Metro from Los Angeles County
- also take referrals from Orange County
- 10-day average stay for detoxification
- minimum age 16-18 years

(b) Camarillo State
Unit 113-Admitting Ward
Camarillo 93010 (805) 482-4671

- 18-1/2 years and up
- most people from Los Angeles County
- state pays 90% of tab (Short-Doyle Act)
- also stipulates only direct referrals from county mental health facility
- between July 1 and December 31, 1971, had 314 in drug programs (76.5% stayed for completion of detoxification - first 7 days)
- detoxification mostly with methadone (use valium, etc.)
- 184 people in program for first 3 months of 1972
- will have 55-bed detoxification program within a few months that will be separate from overall drug program

(c) UCLA - NPI - Dr. Ungerleider
760 Westwood Blvd.
Los Angeles 825-0511

5 beds (4 detoxification beds for heroin and 1 bed for barbituates)
22 slots for methadone maintenance
Detoxification period usually 6-1/2 days with methadone

4. U.S. Government

(a) Veterans Administration, Brentwood - Dr. Isabel
478-3711 x6127 and x4113

- no set number of beds for detoxification
- do have 150 on methadone maintenance, many who were detoxified there before going on maintenance
- not admitting any new patients
- detoxification in acute medical ward

- after May 15 will go to out-patient care, mostly, maintaining drug rehabilitation ward at VA mainly for heroin addicts for 2-week detoxification (now is 6 days)
- detoxification for everything
- supposed to admit only acute emergencies to detoxification ward, but bend this ruling to meet the needs of patients
- must be veteran with honorable or special discharge to be admitted (no dishonorable) (bill presently before Congress to change this ruling)
- refer new patients to places like N.P.P., Bridge Back, Bricks, Uhuru, PRC, free clinics since they all have reserved detoxification beds

(b) Veterans Administration, Sepulveda
894-8271 x436

Would not give out any information

(c) Veterans Administration, Long Beach
498-1313

Detoxification for drugs in psychiatric ward
No set number of beds

(d) U.S. Naval Hospital
Terminal Island
547-6721

- very little drug detoxification (mostly alcohol)
- no methadone
- must be or have been in Navy

B. Private Agencies

1. Kaiser Foundation Hospital (3 locations)

(a) 4900 Sunset Blvd.
Los Angeles 667-4011

(b) 1100-1050 W. Pacific Coast Highway - Dr. Merrick
Harbor City 90710 325-5111

(c) 13652 Cantera Street - Dr. Zimelman
Panorama City 91402

Alcohol detoxification only (no drugs) - only on out-patient basis with Antibuse, etc. (usually only 1-day detoxification and follow-up)
Must be Kaiser card holder

2. Parkwood Rehabilitation Center - Ted Wold
   11616 San Vicente Blvd.
   Brentwood 826-4621

   In-patient detoxification ward mainly for alcoholism (1 out of 3 have dual dependency) - do some drug detoxification but not for heroin (not licensed for methadone)
   8 detoxification beds ($75/day)
   22 rehabilitation beds ($35/day)

3. Edgemont Hospital
   4841 Hollywood Blvd.
   Los Angeles 666-5252

   Drug and alcohol detoxification in-patients
   Voluntary and $500 deposit
   No specified number of beds for detoxification

4. Alcoholic Detoxification and Treatment Center - Mrs. Wood
   (also called Southland Sanitarium)
   5750 W. San Vicente Blvd.
   Los Angeles 933-8255

   Alcohol only
   In-patient detoxification (also out-patient, 3 months)
   14 detoxification beds (72 hours, average); in-patient voluntary and high cost

5. Beverly Lake Hospital - Mrs. Price
   755 N. Fairfax Avenue
   Los Angeles 653-1741

   Alcohol only
   In-patient detoxification only - usually 2 days
   Small facility (6 beds) voluntary and high cost
   No rehabilitation - send elsewhere

6. Santa Monica Hospital
   1250 - 16th Street
   Santa Monica 451-1511

   Both alcohol and drugs
   No formal detoxification - only for emergencies

7. St. John's Hospital
   1328 - 22nd Street
   Santa Monica 829-5511

   Both alcohol and drugs, but mostly drugs
   No formal detoxification except in emergencies in hospital, although they have a mental health center at same address that has out-patient detoxification (up to age 18)

8. Alhambra Neuropsychiatric Hospital - Mr. Solare
   4619 N. Rosemead Blvd.
   Rosemead 286-1149

   Licensed to use methadone. Detoxification with drugs for alcoholism and drug abuse but treatment varies according to individual psychiatrist on case. Voluntary and high cost.

9. San Marino Sanitarium
   6812 N. Oak Street
   San Gabriel 681-2248

   Do some in-patient detoxification for both alcohol and drugs (not licensed to use methadone)

10. Los Encinas Psychiatric Hospital - Dr. Steve Smith
    2900 E. Del Mar Blvd.
    Pasadena 795-9901

    No formal alcohol detoxification except for emergencies, but have regular drug detoxification; 8 beds, for Pasadena Drug Treatment Center

11. Glendale Adventist Hospital
    1509 Wilson Terrace
    Glendale 91206 244-5684

    Both alcohol and drug
    Detoxification informally - hope to get government grant to act as formal detoxification facility

12. St. Luke Hospital
    2632 E. Washington Street
    Pasadena 797-1144

    No formal alcohol detoxification except for emergencies

13. Van Nuys Psychiatric Hospital - Dr. Younger, Dr. Eisenberg
    15220 Van Owen Avenue
    Van Nuys 787-0123

    Detoxification informally for both alcohol and drugs
    Not licensed to use methadone

14. Keeley-Bernadette Hospital - Dr. Wood
    (oldest alcohol hospital in world)
    1231 S. Alvarado
    Los Angeles 389-4181

    29 detoxification beds (3-4 days)
    Voluntary and high cost

15. Long Beach Sanitarium
1159 E. Pacific Coast Hwy.
Long Beach 591-5221

Alcohol detoxification (3-5 days)
5 beds
Voluntary and high cost

16. Memorial Hospital
2801 Atlantic Avenue
Long Beach 595-2311

Alcohol detoxification (average stay: 7 days)
14 beds
Voluntary and high cost

17. Signal Hill Hospital and Sanitarium
1600 Orange Avenue
Long Beach 591-0515

Alcohol detoxification (3-5 days)
10 beds
Voluntary and high cost

18. Golden State Community Mental Health Center
(together with Pacoima Memorial Lutheran Hospital)
Pacoima 896-1161

10 alcohol detoxification beds (average stay: 2 weeks)
10 drug detoxification beds (average stay: 2 weeks)

Reserve beds for El Projecto del Barrio, Valley Drug Clinic (2) and Cry-Help (1). Other beds reserved for youngsters coming in off street.

19. California Emergency Hospital
712 S. Pacific
Glendale 245-5131

Detoxification informally for both drugs and alcohol

20. Ingleside Lodge
7518 Hellman Street
S. San Gabriel 283-8342

Both drugs and alcohol
Acute patients
Detoxification informally
No methadone (use tranquilizors)

21. Rosemead Lodge Sanitarium
4620 Rosemead Blvd.
Rosemead 286-9048

Detoxification for both drugs and alcohol
Have methadone maintenance program for 79
12 detoxification beds reserved for N.P.P.
9 detoxification beds (in main building) for anyone
Voluntary and $225

22. Compton Foundation Hospital and Clinic
820 W. Compton Blvd.
Compton 537-3070

Detoxification for both (would not say how many beds)
Licensed for methadone
13 years old and up (minor with parental signature)

23. Suicide Prevention Center - Mr. Randell
Los Angeles 381-5111

Out-patient clinic - detoxification
Licensed for methadone
Dispense methadone (28 slots for methadone withdrawal)

24. Children's Hospital
4650 Sunset Blvd.
Los Angeles 663-3341

Detoxification only in emergencies

25. Los Angeles Free Clinic
Fairfax Avenue
Los Angeles 938-9141

Out-patient detoxification - no methadone (true for all free clinics although not related)

26. House of Uhuru
1807 E. 103rd Street
Los Angeles 778-5290

Would not give me information over phone
Have contract for beds at Harbor General

27. Bridge Back - Roy Evans and Joe Egana
6723 S. Avalon Blvd.
Los Angeles 971-2080

Had 5 detoxification beds at Bonair Hospital but not now - may get some at new Martin Luther King Hospital

28. Prevention Referral Center
6th and Sunset
Venice 392-5744

Have 4 detoxification beds at UCLA-NPI (3 for males and 1 for females)
24-hour emergency care
No longer have crash pad

29. Central City Bricks (Culver City Mental Health Center)
644 E. 35th Street
Los Angeles 232-2441 x27

Have contract for 2 detoxification beds at County General (heroin)

CRASH PADS

Crash pads, as such, appear to be a thing of the past. The Narcotics Prevention Project, Cry-Help, and the Central City Mental Health-Bricks programs all have residential facilities and will allow an occasional person to crash and "come down" there. However, they do not advertise. The Unattached Men's Center of the County Department of Public Social Services will provide vagrants (many of whom are alcoholics) with hotel vendor tickets.

However, most of the places earlier known as crash pads have either folded or become residential treatment facilities, because of the legal risks involved with such temporary and unspecific treatment. They also had trouble keeping drugs out of the facilities.

Staff morale was perhaps the biggest problem of all. It was not very gratifying to help someone clean up or come down from a drug on one day, and then see the same person return, under the influence, just a few days later. More stable and thorough treatment programs were needed.

INVENTORY OF PLANNING ACTIVITIES

This research was to delineate as clearly as possible the various planning arms within county government that are involved in research and/or planning in delinquency prevention, alcoholism, and drug abuse. We also asked for a description of the information coordination among these groups and a description of the plans currently being made. It was the hope of the project staff that understanding of planning and information coordination—or the lack of it—would illuminate the problems and possibilities related to these issues for the private sector. Here the two sectors are closely tied by funding, authority relationships to public agencies, and intention to work toward the solution of the same problems.

The report discusses and outlines the various planning arms of the county commissions and departments that are related to these issues, and their relationships to each other. These various organizations are filled with people of good intent, but their size tend to make them cumbersome and detracts from necessary communication and from possibilities for action.

Very little planning is going on in delinquency prevention. The Probation and Sheriff's Departments have small diversionary programs to prevent further delinquency, but they are held back by jurisdictional limitations from actual preventive programs.

The various health departments have recently merged, and this will have an effect on the attempts at coordination and planning already under way in the areas of drug abuse and alcoholism.

Although some private programs and agencies are involved with the task forces and departments discussed below, it seems that many others are staying away because of the confusion and lack of coordination that too often is one of the costs of large size.

DELINQUENCY PREVENTION

Key Groups and People

1. Department of Community Services (Dave Bisno/Francis Hollis/ Jerry Inglis)
2. Sheriff's Department (Lt. Cook/Ken Bayless)
3. Department of Human Relations (Herb Carter, Director/Julius Klein)
4. Probation Department (Millie Klein/Cal Hopkinson/Dick Newman/ Jack Fitz/ Kenneth Kirkpatrick, Director)
5. Delinquency and Crime Commission (Mrs. Millard, Chmn./Phil Wax)
6. Los Angeles Regional Criminal Justice Planning Board (Ronald Weber)
7. Urban Coalition (Jim Abernathy)
8. Juvenile Court (Judge Barrett)
9. Delinquency Control Institute (Bob Carter)
10. Teen Post (Bill Elkins)

Coordination of Information

The Department of Community Services, through its branch offices, maintains intraagency information and referral among its own staff and the communities in which they work. They also provide consultation to the Delinquency and Crime Commission and the Sheriff's Department. They also annually compile a directory of resources in this area that they have evaluated and found useful.

Among the various agencies mentioned in the report, there is no formal arm of information exchange and no key figures attempting to establish such an exchange, formal or otherwise.

Planning

As is true of other areas within the public sector, very little actual planning is being done in juvenile delinquency prevention. Most such resources and projects can be found in the private sector. A number

of CCCJ grants and other grants spread throughout the county are directed primarily to private groups.

Supposedly, within the public sector in the county the big problem is the lack of jurisdiction on the part of many county agencies. One of the few agencies having jurisdiction in matters of delinquency prevention is the Sheriff's Department, which has had an ongoing diversionary and resource development project since 1970.

The Probation Department, for example, cannot work with a youngster until he is within the criminal justice system. Dick Newman stated that the Probation Department would like to become more involved in an outreach or street capacity, as the Sheriff's Department is now, although to a smaller degree. He is presently trying to gain internal support from the Board of Supervisors, in an attempt to get the state legislature to extend the jurisdiction for county agencies other than law enforcement into the area of prevention, i.e., before a youth comes in contact with the criminal justice system.

The County Department of Human Relations also has a jurisdictional barrier, since it can proceed only in matters of explicit discrimination, which does not often apply to juveniles, unless a youth feels he was discriminated against by law enforcement officers.

The Delinquency and Crime Commission serves in a usual, figurehead capacity as do other commissions answering directly to the Board of Supervisors. It makes recommendations to the Board of Supervisors and to the Department of Community Services regarding public policy decisions, delinquency prevention projects, and programs administered and operated by local governmental (or nongovernmental) organizations, that is, those submitted for funding on a matching basis through the California Delinquency Prevention Commission to the Department of Youth Authority. But it does not have the necessary resources to do a planning job.

The Probation Department does have a program development arm, but, again, it does not have jurisdiction in this area. The Sheriff's Department only has its two representatives at the Department of Community Services and they also do not really have the resources to do any effective planning for delinquency prevention.

In terms of evaluation, the Sheriff's Department has conducted a brief pilot study at the East Los Angeles Station to evaluate the process for handling juvenile arrests. This also enabled them to evaluate the resource agencies currently available and to make recommendations relative to the type of resources that the juvenile officers feel are needed.

This study, although it utilized as a sample only 35 diverted youths, showed favorable results in 25 cases. The Sheriff's Department is currently in the process of attempting to evaluate the effectiveness of the resources and the programs; the evaluation, however, will be on a much larger scale. This evaluation will be a detailed analysis with a sample

of approximately 200. Their hope is to establish the effectiveness of the Department's program as a national model, specifically testing the concept of diversion. It is the largest diversionary program in the country, according to Lt. Cook. In two years they have diverted over 1,000 people from the criminal justice system to local community treatment centers for counseling and other services.

The statistical evaluation will be conducted by Dr. Klein of U.S.C., who is in the process of obtaining a $50,000 grant from the California Youth Authority and other sources to do the statistical design.

The Sheriff's Department is also proposing a major study to evaluate all of the County's resources to substantiate that they can and will provide the treatment, counseling, or other services indicated. The acceptable resources are now being compiled (by Community Services) into a directory for ready reference by the offices.

Other sources like EYOA and Model Cities are having an effect also in the area of prevention, in terms of receiving grants. EYOA has three different funded programs that apply to drug addicts. The County Model Cities program has five projects going. Most of the attempts by both of these agencies involve working with ex-offenders, and very little attention seems to be given to prevention programs in the school system or other parts of the community.

DRUG ABUSE

Key People

Key people involved in drug treatment in the public sector of Los Angeles County are Dr. Anderson; Dr. Hochman (Mental Health); Dr. Heidbreder and Dr. Hartman (Health Department); Dr. Epstein (Hospitals); Dr. Ungerleider (UCLA-NPI); and Doug Steele and Jeff Samson (CAO's Office).

Planning

Considering both the public and private sectors, the two most influential groups in Los Angeles County are the Narcotics and Dangerous Drugs Commission and the Interagency Task Force on Drug Abuse (which meets at the Department of Mental Health). The former is chaired by Dr. George Anderson and the latter by Dr. Joel Hochman. The Interagency Task Force is the more important of the two, acting as a workshop or sounding board for many of the drug abuse programs in the county, both public and private, and answers directly to the office of the Chief Administrative Officer (County) and the Drug Commission. The Task Force is the only agency in the public sector that the Narcotics and Dangerous Drugs Commission

recognizes as doing anything positive and constructive in Los Angeles County.

The biggest obstacle to planning is the usual lack of money. At the Task Force meeting on April 26, 1972 there was discussion of possible utilization of some proposed $1.5 million in new funds funneled from the federal government through the State Department of Social Welfare and Mental Hygiene. The proposed usage of funds is as follows:

$500,000	-	for half-way houses
$500,000	-	for walk-in and free clinics
$ 60,000	-	for diversionary programs
$ 50,000	-	schools and prevention programs
$180,000	-	for methadone maintenance and detoxification
$210,000	-	seed money for regional coalitions

If these funds are obtained they will be channeled through the Task Force, and would be the first funds received by the Task Force since its creation earlier this year. The money is not a large amount but is a good starting point. By next year a very large sum of money may come from HEW through the State Department of Rehabilitation to the counties. This may possibly amount to $30 or $40 million for Los Angeles County.

Research and Development

The Interagency Task Force has recently created its own research advisory panel, which is supposed to serve an evaluative function. It is not really functioning properly because of insufficient staff and money. The Steering Committee of the Task Force also is supposed to be serving as a research and development group.

By June 1, 1972 the Department of Mental Health was to submit a proposal to the CAO's office for money to retain a systems analysis agency called Dreams, Inc., for the Task Force. They would do a computer analysis of drug abuse programs in Los Angeles County. One of the possible outcomes of this analysis would be the creation of a central information bank for use by all local drug agencies.

On July 1, 1972 a merger of the various health agencies of the county was to officially take place (see the Alcoholism planning report). It appears that the effect of this merger on the Task Force will be minimal. The Task Force should remain the same in structure and be responsible for planning or at least serve as a workshop for the new coordinator of this multi-service agency.

ALCOHOLISM

Key People

1. Paul Hinshelwood (Alcohol Program Coordinator, Los Angeles County Department of Health)
2. Jim Davidson (Director of Los Angeles Alcoholism Council)
3. Tom Pike (Vice President, Fluor Industries; member Alcoholism Council, Alcoholics Anonymous Board, local and national National Institute of Alcoholism and Alcohol Abuse (NIAAA) Advisory Board)
4. Kathy Pike (Member of Alcoholism Commission)
5. Dr. Vernelle Fox (Long Beach General Hospital, Alcoholism Program)
6. Bob Leslie (CAO's Office)
7. Rena Billings (Mary Lind Foundation)
8. Dr. Monroe Epstein (Department of Hospitals)
9. Dr. Sampliner (Department of Mental Health)
10. Chuck Fletcher (State Department of Rehabilitation)
11. George Staub (State Department of Rehabilitation, Sacramento)
12. Warren Bennett (Alcoholism Safety Action Project)
13. Loren Archer (Coordinator of Alcoholism Program in State Deparmtnet of Human Relations)

Planning

The planning function on alcoholism has shifted within the public sector from the office of Paul Hinshelwood to a 3-man committee, composed of Hinshelwood, Dr. Epstein (Hospitals), and Dr. Sampliner (Mental Health). They meet regularly to do alcohol planning, although Dr. Sampliner was given the responsibility for writing a comprehensive alcohol plan by June 1, 1972. Also sharing in the planning role is Bob Leslie of the CAO's office.

The County Commission on Alcoholism functions as a figurehead committee, answering directly to the Board of Supervisors. The chief spokesman for the Commission is Kathy Pike. Paul Hinshelwood acts in the capacity of executive secretary of the Commission, and within his role as Alcohol Program coordinator may sometimes be perceived as a facilitator among the many diverse alcoholism groups in the county. His office is more or less responsible for coordinating information on services and resources within the county. Hinshelwood works closely with groups such as the Alcoholism Council in providing the necessary information, training, or services that they may desire, and also directing community groups, like Model Cities, toward the correct sources of obtaining grants for their own alcoholism programs. EYOA, for example, has two OEO-funded alcohol programs going in East and South Central Los Angeles, and when those programs expire on June 30, 1972 they are hoping to be refunded by NIAAA.

Although very little real planning is actually done in the county in terms of alcoholism, there are several developments that may definitely alter or change this situation somewhat. The major development is the merger of the County Departments of Public Health, Mental Health, Hospitals, and Veterinarian into one new County Health Service Department. To have the greatest influence over the many diverse groups involved in alcoholism, the coordinator of the alcoholism program after July 1 may possibly be directed by the CAO's office and within the present Alcoholism Safety Action Project headed by Warren Bennett, which now has a $6.5 million grant from the Department of Transportation. The rationale behind this move would be to stop the dissension between the County Departments of Public Health and Mental Health as to their influence over the program by placing the coordination of it higher up in the county hierarchy.

And since the present Alcoholism Commission was not set us as a planning body, a task force comprised of approximately 15 professionals may serve in an advisory capacity in terms of doing the planning for alcoholism. It would also be imperative, according to Jim Davidson, to include many citizens groups in considering planning needs so that there would be adequate representation throughout all parts of the county. This new task force may well be structured like Mental Health's present Interagency Task Force on Drug Abuse, i.e., subject to the authority of a County Commission on Alcoholism and including many alcoholism programs as its members. The Department of Mental Health also has an Interagency Health Task Force, but it is not functioning in the same capacity as the former in terms of meeting alcoholism needs.

Another possible development is the creation of a regional training center in Los Angeles. Jim Davidson is the chairman of the group promoting this idea, and he has a group of 41 people committed to forming a consortium in order to formalize this training center proposal. He did not have any idea when this center would be created, although he is very optimistic that the idea will become reality.

A third development that may mitigate the present lack of planning and development is the forthcoming Hughes grant for $915,000 (Public Law 91-616). A good part of these funds were originally supposed to be used for program planning and development, but the present alcoholism program has a $300,000 deficit in its MacAteer fund ($1.5 million), so this will be taken out first from the forthcoming funds. A good part of the remaining $615,000 will be used for administration, treatment program, possibly some prevention programs, and, it is hoped, for planning and development.

FEDERAL FUNDING SOURCES

A study was conducted to search out all of the federal programs that make money available for programs, facilities, staff, or equipment in the areas of drug and alcohol abuse and delinquency prevention. Included in the report are the funding patterns and priorities of these programs and an analysis of why certain programs have or have not been funded to their limit. The information is essential to discussions of the problems of obtaining federal funds and general availability of federal funds. The information was not available at any one location, but had to be obtained from a number of different agencies in Washington, D.C.

The Department of Labor (DOL) offers money for programs in the area of delinquency prevention. Money for programs, facilities, or staff in drug or alcohol abuse and delinquency prevention is offered by the Office of Economic Opportunity (OEO), Departments of Health, Education, and Welfare (HEW) and Housing and Urban Development (HUD), and the Justice, the latter through the Law Enforcement Assistance Administration (LEAA) (this report, however, excludes programs of the California Council on Criminal Justice (CCCJ)). The information in the report is organized by federal departments and includes the policies and procedures by which each program has been funded within Los Angeles County. The name of each project and the amount of funds it received was recorded.

In the last section of the research report is a discussion of why certain programs are funded at higher levels than others. Most programs were found to be funded to their limit except where another organization or group would provide matching grants which would not allow it to quality for the maximum amount. The report stresses that it is difficult to determine a limit to a given federal program, since the amount of funds depends so heavily on Congressional appropriations and on the need, poverty level, and population density of the area applying for the funds.

The report concludes that of the three program areas alcohol abuse receives the lowest funding priority. The diligence with which the funds are pursued as well as the actual merits of the program is a very important factor in obtaining federal funds.

OFFICE OF ECONOMIC OPPORTUNITY

Drug Programs

There are no drug programs in this region.

Alcoholism Programs

All to be transferred to HEW in July 1972.

Delinquency Prevention

Youth programs part of Community Action Agencies (CAA). Funds no longer earmarked for youth; rather, they come under the "local initiative" of each CAA. Act titles funded under Economic Opportunity Act, 1968, and continuing on a "continuing resolution." Total 1972 Fiscal Year, CAA in Western Region, $4,669,000, which includes all kinds of programs operated through CAA.

The following represents funds that the Community Action Programs (CAP) and CAA of each county in California have declared as going into youth programs.

Berkeley	$ 20,000
Butte County	10,000
Compton Willowbrook	150,000
Contra Costa County	122,000
E.Y.O.A. - Los Angeles	1,845,000
Fresno County	72,000
Imperial County	25,000
Kern County	48,000
Kings County	13,000
Long Beach	140,000
Madera County	10,000
Marin County	67,000
Monterey County	38,000
Napa County	10,000
Oakland County	198,000
Orange County	29,000
Pasadena	100,000
Rio Hondo	40,000
Riverside	44,000
Sacramento County	158,000
San Bernardino	46,000
San Diego	130,000

San Francisco	579,000
San Joaquin	40,000
San Luis Obispo	12,000
San Mateo	35,000
Santa Barbara	12,000
Santa Clara	82,000
Santa Cruz	14,000
Solano County	102,000
Sonoma County	58,000
South Alameda	42,000
Stanislaus County	14,000
Ventura	17,000

Funding level was determined by need as determined by OEO and by population density.

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

All HUD programs, etc. in the area of drug and alcohol abuse and delinquency prevention come through the Model Cities program. From Model Cities, Los Angeles City receives $26,000,000, Los Angeles County receives $8,100,000, and Compton receives $1,100,000. Amount of funding determined by population density and poverty level of the area.

Following is a breakdown of the kinds of programs in Los Angeles City.

Program	Total Funds	Matching Funds	Operating Agency
Career Opportunity Program	$ 75,585	$ 74,985	Los Angeles City Schools
U.C.L.A. Black College	154,000	131,000	U.C.L.A.
Narcotics Prevention Project	578,900	407,900	E.Y.O.A.-Narcotics Prevention Association
Vocational Rehabilitation of Drug Abusers	70,099	14,020	Department of Rehabilitation, State of California
Prevention and Treatment Center for Adolescents (help in emotional areas also)	292,633	226,804	Los Angeles County Health Department and South Health Center
Alcoholism Rehabilitation Clinic	334,334	134,334	E.Y.O.A. and South Central Multipurpose Health Service Center

Program	Total Funds	Matching Funds	Operating Agency
Bridgeback Center (Housing, Counseling for ages 16-25 in drugs)*	$286,375	$297,125	Bridgeback
Teen Post	63,000	63,000	Teen Post, Inc.
Vocational Rehabilitation of Drug Abusers	70,000	14,041 CCCJ-56,167	State of California, Department of Rehabilitation
Youth Coordinating Service (Recreation programs, etc.)	318,338	318,338	Salesian Boys Club
Wilson High School (Recreation and cultural facility)**	515,750	515,750	Los Angeles City School District
East 60th Street N.Y.C. Youth Acitivity Center***	105,345	48,495	Greater Los Angeles Urban Coalition
Crime and Delinquency Model Neighborhood Legal Center	422,513	407,513	Mexican-American Legal Association
Model Neighborhood 7th Step Project	229,936	179,960	7th Step Foundation, Inc.
Delinquency Intervention Adjustment Center	894,284	448,352	Los Angeles County Probation Department
Greater Watts Justice Center	299,826	244,088	Watts Neighborhood Law Office
Youth Street Council (Reach alienated youth)	121,581	113,111	Los Angeles City Department of Recreations and Parks
Youth Training and Employment Project	956,481	602,094 other OEO funds	United Community Efforts

* HEW is also adding $35,000 in money and $89,000 in in-kind personnel.

** Funds held up—use of money questioned.

*** $4,900 - Department of Interior; $51,950 in-kind personnel and travel.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Drug Programs

Mini-grant program; training in drug abuse and prevention education receives $10 million nationally (application enclosed). This program operated through the Office of Education. Funded under the Drug Abuse Education Act of 1970. Other programs in narcotics addiction and drug abuse are funded through NARB and NIMH (enclosed is item explaining authorizing grants, funding procedures, and application and award process for NARB and NIMH programs).

Delinquency Prevention

The Office of Education (OE) of HEW has a dropout prevention project—only 10-12 funded in United States because of lack of funds. Such a project in Oakland is funded for $500,000. Also under OE are the Talent Search, Upward Bound, and Special Services Programs which are treated as a group and coordinated on a regional basis.

Talent Search—Authorized by the Higher Education Act of 1965, Title IV, Section 408. Objectives: identify qualified youths having financial or cultural need with an exceptional potential for post-secondary education traing and encourage them to continue. Publicize existing forms of student financial aid. Encourage secondary school or college dropouts who have aptitude to finish school and go on to post-secondary programs. Objectives are met through grants and contracts of up to $100,000 per year from the OE to approved applicants. Only public and private nonprofit agencies may receive grants.

Upward Bound—Precollege preparatory program designed to generate the skills and motivation necessary for success in education beyond high school among young people from low-income backgrounds and inadequate secondary school preparation. Program began in June 1966.

Special Services—For Disadvantaged Students in Institutions of Higher Education Program authorized under the Higher Education Act of 1965, Title IV, Section 408. Offers special services for students with academic potential (enrolled at school that is a beneficiary of the grant) who by reason of deprived education, cultural, or economic background or physical handicap are in need of such services to assist them to initiate, continue, or resume their post-secondary education.

(Further information about these three programs can be obtained from the Application Information and Program Manual put out by HEW, OE, Bureau of Higher Education, Division of Student Assistance.)

Youth Development and Delinquency Prevention Agency, part of HEW. Authorized under the Juvenile Delinquency Prevention Control Act. Had a one-year extension which ran out in 1971; new legislation is needed to keep their programs alive. This is a funding agency; it funds delinquency programs creating alternatives for youth. Its aim is the development of all youth by creating access to socially acceptable roles for youth, thereby reducing their alienation. It also deals in areas of drug abuse. The agency receives $100,000 from the CCCJ for planning, and $10 million nationwide. Grants in Los Angeles are as follows:

To Los Angeles City Schools	$200,000
Children's Hospital	106,183
Community Justice Center (for training of ghetto youth)	80,000
Special Services for Groups, Inc.	24,623
Teen Post, Inc.	133,347
USC, Technical Assistance	188,055
USC, Training Act	35,337
Santa Ana (involves youthful deviants in groups—operated out of Probation Department)	249,967

DEPARTMENT OF LABOR

The Department of Labor (DOL) offers a number of programs in the area of delinquency prevention but none in the areas of drug or alcohol abuse. The delinquency prevention programs are the Neighborhood Youth Corps (NYC), Job Corps, and in a slight way the Concentrated Employment Program (the last concentrates more on adults). The NYC offers in-school, out-of-school, and summer programs. Ideal is to keep youths in school, get them back in school, teach them a skill, or give them work experience. Age group is 14 to 18. In 1971 NYC received $10,362, $410 for the out-of-school and summer programs for Los Angeles County. In 1972 NYC received $8,491,925 for the summer program. Figures for the in-school and out-of-school programs for 1972 are not yet available. In 1971 the prime contractors for the NYC programs were as follows:

1. Compton-Willowbrock Community Action Agency (E.Y.O.A. is the CAP agency)
2. Long Beach Commission on Economic Opportunity
3. Watts Labor Community Action Commission

4. E.Y.O.A. (received largest share)
5. Pasadena Commission on Human Need and Opportunity
6. Rio Hondo Area Action Council

Each contractor has a certain number of slots (slots are the number of children the contractor can handle), and each contractor receives more funds from DOL if they handle more slots. For 1972, funding was as follows:

Los Angeles City Schools (5,000 slots)	$2,125,000
Los Angeles County Schools (4,500 slots)	1,912,000
Catholic Archdiocese (1,000 slots)	425,000
City of Los Angeles (3,400 slots)	1,493,650
Compton Willowbrook CAP (940 slots)	391,500
Pasadena CAP, or the Commission on Human Need, (580 slots)	246,500
WLCAC (980 slots)	416,500
Total	$8,491,000 (about)

NYC programs funded under the Economic Opportunity Act of 1964 and the Manpower Development Training Act of 1962.

Job Corps—Takes disadvantaged youths out of their areas; attempts to make these youth employable. Ages they work with are 16 to 21. Funding is allocated by state. This year Job Corps received $200,000,000 nationally and California received approximately 10% of that, the California share being based on population, poverty index, and need. Could not ascertain what the authorizing act for Job Corps is; however, we do know that it was originally an OEO program. We would assume that now it is funded under the Manpower Development and Training Act. The DOL gives some of the Job Corps money to the state, which in turn doles the money out to private corporations or Job Corps centers or government agencies. Some of the money is given by the DOL directly to Community Action Agencies, private contractors, and Job Corps Centers. Part of the Job Corps program is funded directly by the DOL rather than through the state because the state cannot perform certain services wanted by the DOL; it may lack staff or necessary supporting services.

FEDERAL FUNDING LEVELS

The amount of money an agency receives from federal sources depends, first, on agency characteristics, such as the program area and the particular service(s) provided. It depends, second, on community characteristics, such as its size, the density and poverty level of its population,

and the urgency of the need of that community for the service(s) provided by the agency. It appears that problems of alcohol abuse have the lowest priority of the three program areas we are concerned with and consequently receives less funds than the others. Drug abuse and juvenile delinquency prevention services both seem to be of utmost importance and so they receive a very good share of the attention, but the amount of their funding of any particular agency also depends upon the size of its organization and its need for funds as determined by the funding agency. It seems that in some cases those programs in which there is more intense involvement on the part of both the participants and organizers receive higher funding. For example, whereas the city of Camarillo received $178,587 for a resocialization program for drug abusers, the city of Hawthorne received only $43,156 for a narcotics education resource center.

FACILITIES FOR THE TRAINING OF PARAPROFESSIONALS: SUMMARY

The intent of this study was to discover what types of educational facilities exist in Los Angeles County to train paraprofessionals to work in drug, alcohol, or delinquency prevention programs. Also, to assess the demand for these types of training and whether these demands are being met. The initial methodology was to look through the universe of agencies and determine a few that used paraprofessionals; calls were then made to all these, to see where their paraprofessionals had received training. All such places as universities and public and private hospitals that were felt to be possible sources of training were investigated.

Each training course or program was described in detail, including cost, length of time, number of students per year, how placed, demand, assessment of success of training, and whether it is a course or an entire program. The source of information in locating each program was also included. Certain very informal types of training were also described. Also included were lists of some of the existing training facilities outside of Los Angeles County, and current proposals for facilities within the County.

In assessing demand, the primary conclusion is that new courses need to be instituted, since the present demand for training is being met but the real need is not. Demand was assessed by seeing if whatever training programs were found were able to accommodate the demand for classes and if the employers' training needs were met. The real need is not being met, because many people who need the training that is available do not even know that is available. What usually happens when those who need training do not know that professionally-run courses are being offered is that instead they receive on-the-job-training. Many agencies seem to be using volunteers who have no or very incomplete training.

The problem is therefore twofold: more training facilities need to be developed and information about new and traditional training facilities needs to be made available to those who need the facilities.

Details of Findings

A. Training Programs in Los Angeles County That Are Open to Public

1. CARD, Counseling on Alcoholism and Related Disorders, course number 420.3, through UCLA Extension, is a three-quarter series, four units per quarter. Cost, $65 per quarter. Meets once a week, three hours each session. Lecturers provide information regarding techniques, sources of additional information, etc. Coordinator, Ralph Worden (825-5494).

2. Polytechnic High course (12431 Roscoe Blvd., Sun Valley) sponsored by the Alcoholism Council of San Fernando Valley. Cost, $1.25. Runs every ten weeks. Have guest speakers from Alcoholics Anonymous, courts, medicine; have films, group discussions, etc.

3. Alcoholism Council of Greater Los Angeles course for volunteers. No fee; is given twice a year for two full days. Is a crash course to accompany on-the-job training, teaches the ABC method of crisis intervention referral, bringing a person down, phone work, lectures, recognition of the problem through role playing, etc.

4. Delinquency Control Institute of U.S.C.

5. Narcotics Information Resource Center, Valley College, Van Nuys. Mr. Korn (781-1200, x341).

   (a) A course for elementary school teachers and nurses. Eight to ten sessions, meets weekly. Cost: $60. Has been given every quarter since 1969, to make trainees more sensitive to the early signs of drug abuse.

   (b) In the fall, will offer a noncredit, no-fee course of same format, for the community.

   (c) Is sponsoring the same course this summer, with the Valley Interfaith Council. No fee.

6. Long Beach General Hospital has a program with the Counselor Training Alcoholism for U.S.C. Research and Training Center to traing paraprofessionals at all levels, as the need arises. The program has been in existence only since December 1971. No fee. Duration depending on the needs of the participants. Next one, for Watts paraprofessionals, is one half a day per week. Each paraprofessional is assigned to an aide at the hospital, and will follow him around, do what he does, learn by doing. Also lecturers, staffing, interviewing. Then

paraprofessional will go to Long Beach Alcoholic Rehabilitation Center, and be assigned to one of their counselor groups. Don't advertise, but wait until contacted by agencies. Dr. Santoni (636-0784, x379).

7. Central City Community Health Center. Sue Winford (232-2441). They have a six-week training program; meets twice a week, on Monday and Wednesday from nine to twelve; is open to public. No fee. Have lecturers with knowledge and experience, as well as professionals. Trainees engage in role playing, learn all fundamental techniques. About eighteen full-time workers are going through the course to get training before doing counseling at the Center. Also get groups (usually of about twelve) who come occasionally for maybe a couple of sessions. Problem with drop-ins is that they attend one or two sessions and feel that they know it all. Now have three sessions per year, but want to increase this to four. Send out letters to solicit students.

B. Training Programs in Los Angeles County That Are Restricted to the Staff of the Sponsoring Agency

1. Probation Department. In-service training at their own Delinquency Control Center. People here have experience in the ministry, college programs, and/or community service.

2. Ex-Helps. Use paraprofessionals whom they train. Have trainees review all the information manuals two to three times; log in so many training hours before they can do phone work; attend course on Thursday, 7-10:30, each week. Lectures, discussions by professionals, ministers, etc. Also have a series of three eight-hour training sessions every four to five weeks, to update and verify training. Staff of about 40 people, all of whom trained there. For more information, contact lay director, Phil Madler. 934-4740 (home), or 385-3661 (office).

3. Pasadena Mental Health. A twelve-week course that meets once per week for one hour and forty-five minutes is offered two to three times per year. Teach the ABC method of crisis prevention, telephone work, etc. After the course, psychologists and psychiatrists donate their time to teach volunteers. Also, after the course, staff works four hours per week at the Center and starts taking other courses available (a total of thirteen in all, including ABC course). All are of same format; courses in interviewing, role-playing, counseling supervision. Course is restricted to people who work at the Center.

C. Training Programs Not in Los Angeles County

1. Hayward State College drug training center. Phone number (415) 582-4241. Cost, $54. (See article in October 1971 issue of California's Health, published by the State Department of Health).

2. Camarillo State Hospital Alcohol Abuse Program.

3. Schools in Arizona and Utah.

D. Proposals for New Facilities in Los Angeles County

1. Training center at U.C.L.A. similar to the one at Hayward, because something closer than San Francisco is needed; also because there is an unmet need for this sort of program. Would be a formal training center for drug abuse, two-week sessions, nominal cost. For more information, contact Judy Hoffman in Dr. Ungerleider's office (825-0293).

2. Alcohol program at U.S.C. Mr. Davidson of the Alcoholism Council of Los Angeles (380-0330) has particulars.

3. Interagency Task Force on Drug Abuse at the Department of Mental Health. Bill Prensky (937-2380). $200,000 has been made available by the National Institutes of Mental Health for a training facility.

4. Long Beach General Hospital. Dr. Santoni (636-0784, x379) is trying to set up a countywide program to train paraprofessionals in the field of alcoholism.

E. Other Sources

1. There are over 200 drug programs in Los Angeles. For information on these programs, write "Drug Abuse: A Directory of Community Services in California," prepared by the Department of Youth Authority, 714 "P" St., Sacramento, California 95814.

2. Occasional symposiums at various U.C. campuses.

3. Conference in July in San Diego on Drug Abuse. For more information, contact Florence Conger at Havenhouse (684-2169).

4. See the "Directory of Health, Welfare, Vocational, and Recreational Services in Los Angeles County," published by the Welfare Information Service, 621 S. Virgil Ave., Los Angeles, California 90005 (380-2913).

SUMMARY OF INSURANCE COVERAGE AND TREATMENT FACILITIES

Many treatment programs and sanitariums, especially those providing treatment to alcoholics, are underutilized, partly due to the cost to clients for the treatment. It was the intent of this research to determine trends in insurance coverage that might affect this underutilization, and to learn the kinds of coverage available to alcoholics and drug addicts and the eligibility requirements. The results were ex-ensive and in some respects promising.

Some insurance companies are beginning to liberalize the coverage available to alcoholics, but almost none makes coverage available for drug users. Coverage that does exist is found primarily in health plans and a very few automobile insurance company treatment plans for alcoholics. Of the large number of health insurance companies, only a small percentage offer any kind of coverage in these areas.

Existing coverage is almost exclusively available through group health plans with various kinds of special qualifiers that limit the number of people to whom coverage is available. Most of these companies consider alcoholism to be a disease or illness. About the only drug addiction coverage available applies to people who become addicted to prescription drugs or addicted to drugs and alcohol in combination.

Concerning driving and alcoholism, we find that there is little concern for curing the alcoholic driver. A few, very progressive comapnies do have small rehabilitation programs but the coverage is very expensive.

Because most health plans do not cover alcoholism or drug addiction, many patients are admitted to hospitals ostensibly for other reasons, but actually so as to be covered by their insurance policies (many secondary illnesses are associated both with alcoholism and drug addiction). Many hospitals that do specifically treat alcoholism refuse to deal directly with insurance companies; patients who have such coverage must make their own arrangements with their companies.

Insurance Coverage

The average alcoholic is a family-man or woman in the middle thirties with a good job, a good home, and a family. Less than 5% of alcoholics

are found on "skid row." And 50% of all fatal traffic accidents involve an alcoholic. These were the findings of a recent study by the National Council on Alcoholism, Inc., as reported in Business Insurance, January 4, 1971. It was determined in this study that alcoholism is treatable, and that effective business and industrial employee alcoholism programs show recovery rates of 65 to 70%. Education, early detection, and community treatment facilities were found to be the greatest forces operating at present to control and reduce alcoholism.

In view of these findings, a task force on insurance of the Advisory Committee to Alcoholism Services in Wisconsin studied the problem of coverage for alcoholism and made the following recommendations:

1. That alcoholism be covered to the extent of the basic policy in every health insurance plan operable in Wisconsin.

2. That insurance coverage be flexible enough to permit individualized treatment as determined by the hospital staff, and include both in-patient and out-patient care.

3. That insurance carriers be urged and encouraged to conduct educational programs for their staffs so as to develop better understanding of alcoholism.

4. That management and labor accept their responsibilities to work together with their health insurance carriers to provide comprehensive health services for the alcoholic employee.

5. That health and compensation carriers inaugurate insurance alcoholism programs, similar to safety engineering programs, designed for early referral and treatment of alcoholism in business and industry with the consequent reduction of economic losses due to alcoholism.

A few insurance companies have demonstrated, through their main offices, an interest in attempting to achieve the objectives mentioned above. These companies are Kemper, whose main office is in Chicago; Wasau in Wisconsin; and the Insurance Company of North America in Philadelphia. Full-time employees are retained by these companies to work on projects of rehabilitation and education of alcoholics and drug addicts. Recently a lot of pressure has been put on other insurance companies to follow the example of these three, and legislation along these lines is expected.

California has lagged far behind the east and midwest in legislation and treatment programs. While the trend is toward rehabilitation, courts, society, and insurance companies are slow in responding. Some companies exclude coverage for alcoholism and drug abuse, and others exclude certain facilities where these illnesses could be treated. The general outlook seems to be for more coverage for alcoholism and drug abuse by increasing numbers of insurance companies.

An insurance company spokesman mentioned that until several years ago even a person such as a social worker who worked to rehabilitate drug addicts or alcoholics would have been considered a bad insurance risk. There appears to be a trend toward insurance company recognition of rehabilitation programs (such as that of the Automobile Club of Southern California), in which a defendant in a drunk-driving charge, after having gone through the courts and been given credit for going through an educational and rehabilitation process, might be considered as a standard insurance risk by many companies.

At present, most people who have been convicted of driving under the influence of alcohol are shifted to special-risk insurance companies. Now, under more liberalized laws, a first offense may be reduced to a reckless driving charge. However, a second offense means automatic license suspension. If the offender has been insured with a company over a long period of time, a special arrangement might be made, possibly involving a 30% increase in insurance rates for three years. If the offender has had an insurance policy for only a year or two, it is most likely the company would ask to be relieved of the risk and that the person would be referred to a special-risk company.

There are twelve major insurance companies in California that carry the special-risk or nonstandard type of insurance. Five of the most prominent of these companies are the following:

Financial Indemnity Insurance Co.,
which asks no questions, takes most hard-core risks, and requires higher premiums than the other companies.

Mercury Casualty Co.,
which is more discriminating than the other companies.

Reserve Insurance Co.

Dairyland Insurance Co.,
which is the largest nonstandard auto insurance underwriter in the United States.

Wilshire Insurance Co.

The insurance rates of these special-risk companies may be as high as double those of other insurance companies. California is not a "field rate state," which means that there are no specific guidelines as to exactly how much of an increase in insurance rates these companies are allowed. The only qualification seems to be that they remain closely competitive in price with other special-risk insurance companies. There are guidelines for the State Insurance Commissioner to review, but no careful regulation is involved.

According to a spokesman for the Wilshire Insurance Co., the normal policy writings of the special-risk comapnies involve persons known to have had past experiences with alcoholism and drug abuse; there is an increased trend toward a definition of drug abuse as involving prescription drugs rather than hard-core narcotics (e.g., a person who has taken enough of a prescription drug to cause drowsiness while driving).

Another program to handle special-risk insurance is controlled by the State of California. Every company that writes automobile insurance in this state must participate in a special assigned-risk program which, after one offense, would cost the driver 70% more than a standard policy. Those persons having drivers licenses who cannot be insured by standard company policies because they are too young or old, or have a history of reckless or drunk driving, must apply through the State of California, which assigns them to one of the standard insurance companies for coverage.

The special-risk insurance companies mentioned above do not have to apply through the California assigned-risk program; thus they may charge more than the 70% increase specified to standard insurance companies by the assigned-risk program.

The following list of insurers shows their varied policies regarding coverage for alcoholism and, where applicable, drug abuse:

Automobile Club of Southern California

Drunk driving arrest (23-102) does not bar the person from obtaining insurance. According to Mr. Zaitz of the Automobile Club, while the drunk driver would be covered, his coverage would be considered on an overall basis including other factors such as number of accidents and whether or not it was a first offense. An insurance risk would not usually be taken within the first year after a violation for drunk driving, and would definitely not be considered with a background of narcotics use.

There is a special rehabilitation program under the direction of Paul Williams, regional safety consultant for the Automobile Club of Southern California. We were informed of this program in an interview with Ken Schonlau, who works with Mr. Williams on rehabilitation of alcoholics. For humanitarian reasons, as well as because it has been ascertained that one-half of all fatal accidents are caused by alcoholics, rehabilitation is essential. The public safety program allows for the removal of a drunk driving charge from his record, if an offender attends classes for rehabilitation.

One of the conditions for probation is attending classes in lieu of the $320 fine or five-day jail sentence. The program is called "Alcohol Counter-Measure School" and consists of a series of classes designed to expose the drinking driver to films and lectures concerning drinking and driving. Papers must also be turned in explaining what the person convicted was doing twelve hours before his arrest and what he plans to do in the future concerning this problem. He pays $20 for a four-meeting, ten-hour course that meets the provisions of probation. There is a maximum of forty people in the class at one time, and the approximate breakdown is 75% men and 25% women. 50% of these people are probably truly alcoholics. At the second meeting resources are suggested to help problem drinkers. The resources used depend on the individual and what his problem is. People from 18 to 60 years old and all walks of life are represented in this

program; they are not particularly "skid row" types. Surprisingly, it seems that a high degree of alcoholism exists within the clergy.

This rehabilitation program was developed in Phoenix, and after five years indications are that relatively few persons who attended the classes were involved in a repeat violation. It was tried for the first time in Southern California in El Cajon, then in Pasadena, and is now being tried in Santa Monica. Classes of this type are soon to be undertaken in Beverly Hills. (This would seem to be one of the most enlightened programs—rehabilitation and suggested treatment rather than punishment—that exists in this area.)

Mr. Williams went on to say that one major problem is the difficulty of determining when a person is under the influence of drugs or a combination of drugs and alcohol, and treatment and rehabilitation in these cases is especially difficult.

Blue Cross

Blue Cross pays nearly all contracts, including those involving nervous and mental disorders, with few exceptions. Claims will be paid in general, psychiatric, and county hospitals and in state (but not federal) institutions, but not in some special alcoholic treatment facilities, e.g., Parkwood. The reason given for excluding claims at special alcoholic treatment facilities is that alcoholics are not being given active treatment at these facilities but only "drying out." When care given to the individual comes under the category of treatment, it is covered in most standard group policies.

The individual policyholder must have filled out a complete health contract before being accepted as an insurance risk, so that the chances of an individual policyholder being an alcoholic or an addict are slight.

Crown Insurance Company

Crown is one of the very few companies with no exclusion clauses. Alcoholism is considered to be a disease, as is drug addiction. Alcoholism and drug addiction claims are treated the same as those for any other illness. The amount of coverage depends on the particular policy involved.

Equitable Life Assurance Society

On group cliams frequent or excessive use of alcohol would be considered. If use of alcohol was considered to be moderate, a policy would be issued at standard rates.

Once the person is insured, Equitable will pay for the amount of days spent in a general hospital whether the illness was alcohol-oriented or

not. Most standard group policies cover treatment for alcoholism or drug abuse in mental hospitals, depending on the terms determined by the employer involved. Treatment at special alcoholic treatment facilities would not be covered. Mr. Levy of Equitable specified that in individual policies alcoholism and/or drug abuse would most likely be excluded.

Insurance Company of North America

According to Mr. Gardner of INA, the trend in the insurance industry, under most group policies, is to exclude drug abuse and alcoholism in disability income insurance policies but not in life or health policies.

The Insurance Company of North America provides coverage for group claims in life or health policies; but the person would be covered only if he participated in an extensive rehabilitation program. This company hires registered nurses to advise (not care for) clients suffering from alcoholism or drug abuse about which facility would be advisable and available for rehabilitation, considering all the circumstances in each particular case.

John Hancock Mutual Life Insurance Company

Full coverage in a general hospital would be provided for alcoholism and drug abuse only under a group policy; however, psychiatric treatment would be excluded.

Kemper Insurance Company

The Kemper Insurance Company is a leader in the insurance field stressing the disease aspect of alcoholism. This company even has a rehabilitation program for alcoholism among its own employees.

Medical expenses incurred in the treatment of alcoholism are covered by the Kemper Insurance Group Health Plan, including income protection, in the same manner as treatment for any other illness is covered. In addition, where a supervisor or consultant requests an examination for diagnostic purposes by a physician, the company will pay the cost of such an examination.

However, hospital treatment for alcoholism is covered only in a general hospital and not in special alcoholism sanitariums and hospitals.

Medicare

Medicare coverage is automatic in California at the age of sixty-five and is provided by the Occidental Life Insurance Company. Coverage would include treatment for alcoholism and drug abuse if the patient is under the

care of a physician. There would be 80% coverage for a physician's services and payment for a 90-day stay in an acute-care facility; but out-patient care would not be covered.

Mutual of Omaha Insurance Company

All of the underwriting is done in Omaha, where each case is handled on its own merits. New policies do not exclude alcoholism.

Northern Life Insurance Company

This company runs an inspection report and will insure drug addicts and alcoholics, but, depending on the individual case, the client might have to pay a premium twice as high as that of the standard policy. If it can be ascertained that, regardless of the individual's past history, there has been no drug or alcohol problem within a year, a policy would be issued at the standard rate.

Union Labor Life Insurance Company

Many insurance policies are underwritten for unions. Each union has a contract written in accordance with its own wishes. Most group policies provide coverage for in-patient care in a general hospital (but not for out-patient care) for alcoholism and drug addiction.

California State Disability Insurance covers treatment for alcoholics; however, California State Employment Insurance does not. The recent trend is for many companies, such as McDonell Douglas Corporation and Hughes Aircraft Company, to cover their own employees in group insurance policies for alcoholism and drug addiction. Among the insurance companies that pay for alcoholism and drug addiction treatment in policies where specified by employers are Aetna, Connecticut General (provides insurance coverage for McDonnell Douglas), Confederation Life, National Postal Union, and Pacific Mutual.

It seems that individual policyholders are rarely covered for alcoholism and/or drug abuse. The individual may be covered indirectly if his physician enters him in a general hospital for treatment under the guise of his having another illness.

The general trend would seem to be for alcoholism and drug abuse coverage to be provided mostly in group insurance policies, where an employer pays higher premiums for this coverage. And coverage would be more for alcoholism than for drug addiction, as alcoholics seem better able to stay with a job long enough to qualify for group insurance, whereas drug addicts usually have difficulty remaining with a job long enough to do so.

According to Miss Van Vorden, private secretary to Dr. Jokichi Takamine (medical leader and authority on alcoholism), most drug abuse patients are not covered by insurance and must use welfare facilities. Referral of addicts for drug counseling is available at the Venice Drug Clinic and Tuumest. And the Veterans Administration Hospital, County-U.S.C. Hospital, and U.C.L.A. Hospital are drug resources.

According to Miss Van Vorden, most standard insurance companies will cover a claim for alcoholism, considering it to be an illness, but generally consider drug addiction to be self-inflicted and a mental disorder, and many companies will not cover claims for emotional and mental disorders.

There is an ongoing controversy as to whether or not alcoholism is to be considered an illness, according to the Los Angeles County Medical Association. More and more pressure is being applied by local governments to treat alcoholism as an illness. When this attitude is accepted, possibly through legislation, other companies, as well as those insurance companies that now consider alcoholism an illness, will revise their insurance coverage accordingly.

The general trend seems to be toward liberalization. Senator Harold Hughes of Iowa is leading the battle for recognition of alcoholism and drug abuse problems by insurance companies as illnesses. The efforts of Senator Hughes have resulted in nationwide hearings on alcoholism and drug abuse.

Dr. Jokichi Takamine made the statement (Los Angeles Times, April 12, 1972) that "There are 88 drug abuse programs and 52 alcoholism programs in Los Angeles County but no coordination between them." A similar situation would seem to exist in regard to insurance coverage for alcoholism and/or drug abuse and the special hospitals and sanitariums equipped to deal not only with detoxification but also with rehabilitation of alcoholics. Most insurance policies, even when coverage for alcoholism and drug abuse is provided, do not cover the sanitariums and hospitals that specialize in treatment of these illnesses.

The general future trend, however, is toward inclusion of alcoholism and drug abuse treatment in medical insurance policies, as insurance companies are being pressured from the government, employers, individual policy-holders, hospitals, and doctors to drop exclusion clauses pertaining to alcoholism and drug abuse; the basic reasoning being that alcoholism and drug abuse are illnesses which require medical treatment in hospitals the same as any other illnesses.

Treatment Facilities

Insurance coverage for alcoholism and drug abuse varies among general hospitals and sanitariums, just as it does among insurance companies, as follows:

Parkwood Rehabilitation Center

A spokesman for the Parkwood Rehabilitation Center in Brentwood (a special alcoholic rehabilitation facility) mentioned the fact that in terms of numbers of people involved, alcoholism is a greater problem than drug abuse. The largest population affected by drug abuse is adults using prescription medications, such as barbituates to excess. Teen-age drug abuse would follow, and then persons on narcotics. The latter are urgent problems not because of the numbers of people involved but because of the criminal aspect. Only in the last few years have treatment programs grown, and this growth is due mostly to government interest in helping to accelerate programs for rehabilitation of alcoholics and drug addicts.

Parkwood is licensed as a convalescent hospital, as distinguished from a general medical or an acute-care hospital. It is a 70-bed facility that treats all stages of alcoholic rehabilitation: (1) detoxification (withdrawal), which usually takes 2 to 5 days at a charge of $75 per day; (2) rehabilitation program, based on a 21-day format of patient activities at $35 a day; (3) follow-up and out-patient treatment at $20 a month. Parkwood follows an interdisciplinary approach to the treatment of alcoholism, combining treatment similar to that provided by Alcoholics Anonymous, social work, psychological testing and evaluation, vocational rehabilitation, and family services.

The cost to a patient going through detoxification and rehabilitation at Parkwood would be approximately one-half the cost of the same treatment at a general hospital; but most general medical hospitals are not equipped to handle treatment beyond the detoxification stage.

While treatment at Parkwood is predominately for alcoholism, treatment is available for people suffering from drug abuse (mostly for an overdose of prescription drugs) when it is combined with alcoholism. Approximately one out of three patients has a dual dependency, on prescription drugs as well as on alcohol. When drug abuse and alcoholism exist together the treatment is much longer and more difficult. No narcotics treatment program is available.

Treatment at Parkwood is available to those who have insurance coverage for alcoholism in a facility other than a general medical hospital or to those who can afford to pay themselves. At present there is no provision for handling charity patients.

Coverage for alcoholism is mainly in group policies where specified by an employer. Presently, the majority of hospitalization policies—group as well as individual—specifically exclude payment for alcoholism and drug abuse treatment in any facility; however some few insurance companies do not have exclusion clauses and will voluntarily include alcoholism treatment.

Very little insurance coverage is available to patients at Parkwood. As mentioned abose in the discussion of insurance companies, most coverage

for treatment of alcoholism and/or drug abuse is available only in general or acute-care hospitals—not in convalescent or hospitals that specialize in treatment of these problems. Thus, treatment in those facilities that are specifically to provide rehabilitation programs are the least covered by insurance.

The feeling is that more facilities like Parkwood are definitely required. General hospitals attempt to free their beds quickly and do not have the time or the staff to provide rehabilitation programs. Without rehabilitation the patient will be released just well enough to go out and start drinking again within a short time.

Due to the fact that most general hospitals are reluctant to admit alcoholics or drug addicts, and that the doctor's bill may not be covered by insurance if a patient is admitted for alcoholism or drug abuse, a physician might seek admittance for his patient for other reasons. At Parkwood an alcoholic is admitted as an alcoholic, which automatically excludes this facility from standard insurance coverage.

An example of the type of insurance that covers facilities such as Parkwood is the program that McDonnell Douglas follows. Included in the program is a full-time staff to administer an employee alcoholism program. Alcoholic employees are referred to Parkwood and other similar hospitals, and the patient's care is covered by McDonnell Douglas Employee Insurance. Some of the major aerospace companies are following this example.

Some characteristics of people treated at Parkwood are that usually they have been referred to this hospital by their families and physicians, and they are primarily middle-class working people whose primary adjustment problem is recovering from alcoholism.

Future plans for Parkwood include provision of beds for indigent patients, in conjunction with nonprofit organizations or federal, state, and county governments. Parkwood would assume some of the cost and attempt to work with the full range of the alcoholic population.

Other Facilities

Southland Sanitarium in Los Angeles is licensed for 14 alcoholism beds and currently provides alcoholic rehabilitation services. Admittance has been at an average of 25.5 patients per month since July 1971. No insurance cases are accepted. The patient must pay the hospital (later, if covered, he may be able to collect from his own insurance company).

At Briarwood Terrace in Encino, a facility for the treatment of alcoholism, a spokesman explained that coverage for alcoholism depends on the individual insurance policy involved. Group policies of Lockheed and

Pacific Telephone Company cover their employees for alcoholism and other illnesses beyond the standard insurance coverage, but not for drug abuse. Blue Cross is the only company that has honored an insurance claim for alcoholism at Briarwood Terrace. Other insurance companies might cover treatment at a general hospital but not at special alcohol treatment, convalescent, or extended-care facilities where it is most needed. Patients of Briarwood include TV personalities and business executives as well as middle-class working people.

At Berkeley East Sanitarium, an alcoholism treatment hospital, a spokesman stated that only private patients referred by doctors are accepted as patients, and they must make their own arrangements for insurance coverage. This sanitarium never deals directly with insurance companies.

A few facility in Santa Monica, Patrician Rehabilitation Hospital, is now patterning itself on the Parkwood model.

The best alcoholic rehabilitation program existing in Southern California is said to be found at Beverly Manor Hospital in Orange, California.

Another excellent facility of this type is Memorial Hospital in Long Beach. These latter three hospitals would all be excluded from coverage by those insurance policies which would cover treatment of alcoholism in a general medical hospital only.

While there are no alcoholism beds within a five-mile radius of Parkwood, alcohol detoxification is available at the following facilities: Alcohol Detoxification, which accepts private patients for the most part; insurance coverage is mostly through medicare, and payment must be made by the patient to Alcohol Detoxification directly and then handled personally with his insurance company. St. John's Hospital, where certified insurance coverage is accepted for room and board, depending entirely upon the type of coverage the individual has. Westwood Hospital, where coverage depends entirely upon the physician's diagnosis, the insurance company, and the type of policy involved.

LOS ANGELES LIAISON ASSOCIATION: SUMMARY

The intent of this research was to characterize the Los Angeles Liaison Assocation, its goals, intents, and chance of success. Very little was learned about the Association but it appeared to be a significant step in formulating a public-private planning mechanism for drug programs in the County. The method of seeking this information was to speak with the two persons who formed the Association and then with the members.

The problem was the inaccessibility of the two persons who formed the Association and the difficulty in obtaining a list of members. No one was willing to cooperate or to assist in any meaningful way. It appears that the Association, a nonprofit incorporated agency, actually originated in the County Administrator's Office. It is similar in purpose, though not in effectiveness, to the Los Angeles County Drug Task Force. The Drug Task Force is considerably more active and would have been a more worthwhile subject for a research project.

The stated purpose of the Association is to coordinate and upgrade the public and private agencies dealing with drug abuse and other health-related programs. The intended activities include training programs, program evaluation, development of personal relationships to facilitate referrals, and assistance in developing more stable funding sources. The Association wants to become involved in several issues including the licensing of programs by the State. Although the Association has tremendous potential it appears to have accomplished little. Two committees, the Committee for Emerging Groups and the Training Committee, were formed and appear to be active to some extent.

One reason for the inactivity has been a lack of financial resources, without which no coordinating agency can succeed. Those involved have not had the time or funds to organize and operate the Association as they would like to. Therefore, everything still appears to be in a state of conjecture and conceptualization. However, none of this explains the reluctance of those who have anything to do with the Association to talk about it.

SPECIAL SERVICES TO GROUPS, INC., AS A SPECIAL KIND OF LIAISON SERVICE

SSG provides a unique service to developing agencies in Los Angeles County. When a community group or person comes to SSG with a problem and a potential solution, SSG offers its assistance. This assistance first involves a survey of the community to determine the relevance and scope of the problem and to feel out the suggested solution. If the decision is made to help the group, a program is established by SSG to provide management, training, and consulting staff; the community provides the manpower.

The type of liaison service SSG provides is not between two ongoing agencies but between a potential agency and the management and administrative expertise it needs to survive. The data from both the select sample interviews and the questionnaire indicate heavy demand for this type of management and administrative advice, usually by newer and smaller agencies in all three program areas. SSG is therefore meeting a community need, but not to the extent to which it is demanded. The liaison also includes the community's financial resources available to the new agency, which it also desperately needs to survive.

SSG, after having set up the program in the community, allows it to operate freely without stringent controls. The projects are monitored and evaluated by SSG, and the agencies are only too willing to cooperate. The projects are then classified as research and action which makes them interesting to many people who learn from their successes and failures. Both the staffs and clients of SSG and its sponsored projects are multi-racial in an attempt to follow the recommendations of the Kerner Commission.

AN EXAMPLE OF (NEGATIVE) COMMUNITY PRESSURE

Recently a private crisis referral and counseling center was established within the city of Beverly Hills. A research report was submitted before the decision to open the center was made. There was a great deal of local resistance to the center because of its initial publicity as a "drug" program. This appeared to be a good opportunity to observe and analyze the dynamics and factors of community resistance often mentioned or encountered by other drug-related programs. Many of these problems center around residential treatment, which this is not, but most of the situational elements were the same. The results have proved interesting and helpful.

The report chronologically outlined the steps taken in proposing the center as well as identified key figures pro and con—city officials and interested prominent citizens.

The key issues were easily identified. The lable "drug" crisis center stimulated fear and friction, even though drug treatment was not to be one of the services provided. Although many in the community recognized the need for the center, no one wanted it "next door" or too close to a school. There were personality conflicts between the proposed director (and other leaders who were promoting the center) and some of the more conservative city officials. Timing was an important issue: the proposal came to the City Council just before an election that affected three council seats. Since some of the candidates were reluctant to state an opinion on the proposed center, the council postponed a decision until after the election, by referring the proposal to still another committee for further study. Thus the political climate was an important factor in the postponement of decision making.

An interesting additional factor was that the city never intended to provide funds for the center. In other words, the primary issue was whether or not to allow a building to be used for the purposes of the center, within the city limits of Beverly Hills.

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