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INVENTORYING AND PLANNING FOR ALCOHOLISM AND ALCOHOL ABUSE SERVICES IN THE MUNICIPALITY OF ANCHORAGE

July 14 -15, 1977

MUNICIPALITY OF ANCHORAGE

George M. Sullivan, Mayor

Department of Health and Environmental Protection

Robert A. (Bert) Hall, Director

INVENTORYING AND PLANNING FOR
ALCOHOLISM AND ALCOHOL ABUSE SERVICES
IN THE MUNICIPALITY OF ANCHORAGE

July 14 - 15, 1977

The contents of this report reflect the views of the author who is responsible for the facts and accuracy of the data presented herein. The contents do not necessarily reflect the official views or policy of the Municipality of Anchorage. This report does constitute the partial fulfillment of a contract between the Municipality of Anchorage and the Alaska Center for Staff Development.

A REPORT ON

INVENTORYING AND PLANNING FOR ALCOHOLISM AND ALCOHOL ABUSE SERVICES IN THE ANCHORAGE MUNICIPALITY

A MEETING HOSTED BY
MUNICIPALITY OF ANCHORAGE HEALTH DEPARTMENT

July 14 - 15, 1977

By
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Alaska Center for Staff Development
650 International Airport Road
Anchorage, Alaska 99502

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REPORT SUMMARY

Alcoholism and alcohol abuse continue as major problems within the Municipality of Anchorage to which a number of public and private agencies have focused services.

In an attempt to identify who is offering what services, to whom and what their respective target population is, the Municipal Health Department, Behavioral Health Division, hosted a meeting July 14 and 15, 1977, for individuals and agencies offering services in the alcohol field.

An inventory of services by service classifications, agency, or individual, was developed during the meeting. The inventory, incomplete at the conclusion of the meeting, was viewed as essential information to the community, and the participants recommended steps be taken to complete and verify the inventory.

Meeting participants identified a total of seven (7) services as lacking or insufficient to meet the needs of the people of the Municipality. All aspects of prevention were identified as the highest priority in needed services, and weighted considerably above the second and third priorities, early intervention, and aftercare respectively.

Some services currently offered were viewed by participants as being in excess or unnecessarily duplicated for the needs of the community. A total of four (4) general areas were identified during the meeting as candidates for further consideration as being excessive or duplicative in nature.

The meeting participants made six (6) recommendations for future action by the Municipality. The author of the report includes some observations concerning the process used during the meeting, conclusions based upon findings from the meeting, and recommendations for future action.

INTRODUCTION

Alcoholism and alcohol abuse continue to be one of the Anchorage Municipality's major problems. A number of agencies, both public and private, attempt to serve municipal inhabitants with alcohol problems or provide information, education, or guidance aimed at prevention of alcohol-related problems. Yet the alcohol problem continues to increase in spite of these efforts.

Sketchy information exists which accurately reflects the true scope of the problem in alcoholism and alcohol abuse. Thus, it is difficult to accurately describe the potential target population for agencies and their corresponding programs to provide prevention, treatment, and support services. Nevertheless, alcohol continues to gain in proportion as a causitive factor in death and related bereavement, monitory loss to industry and government, as well as the individual, crime, mental illness, child abuse, and failure in the educational system.

In an attempt to better identify what this larger potential target population is and how this population is being served, the Municipality of Anchorage Health Department hosted a meeting July 14 - 15, 1977. This report is an attempt to capture the more significant events, findings, and recommendations resulting from the meeting, in hopes that these will be useful in guiding our future.

BACKGROUND

During the spring of 1977, the Manager and staff of the Behavioral Health Division, Municipality of Anchorage Department of Health and Environmental Protection, examined the roles and responsibilities of their Division. A conclusion resulting from this analysis was the need to better identify the needs that could potentially be served through the resources of this Division. It was anticipated that some of the needs identified could be addressed directly by the staff of the Division. Other needs identified could better be served by delineating the scope of work needed to address the need, issuing Requests for Proposals (RFP's) and contracting with the most advantageous bidder to meet the identified need.

To identify those needs to be addressed, it was decided to hold three (3) basic meetings, one for drug abuse, the second for alcoholism and alcohol abuse, and the third for mental health. This report concentrates on the meeting for alcoholism and alcohol abuse.

On June 27, 1977, a letter from Dr. Helen Beirne, Behavioral Health Manager, was sent to 57 agencies, inviting them to send a representative to the July 14 - 15, 1977 meeting on Alcoholism and Alcohol Abuse, Prevention, and Treatment. A copy of the letter of invitation can be found in Appendix A, and a list of agencies invited can be found in Appendix B.

The Municipality of Anchorage contracted with the Alaska Center for Staff Development to assist with the planning and to conduct the meeting, and to provide this written report. Dr. Ronald Daugherty, Director, and Ms. Lynne Curry, Project Director for Substance Abuse Counselor Training of the Alaska Center for Staff Development were specifically assigned to conduct the contracted scope of work.

The meeting was convened at 9:00 A.M. on July 14, 1977, in the Fifth Floor Conference Room of the Municipal Health Building, 825 "L" Street, Anchorage. A total of 26 individuals attended all or a portion of the day and one-half meeting, representing 22 different agencies or Municipal divisions. A list is provided in Appendix C.

The meeting was facilitated by Dr. Ron Dougherty. As facilitator, he pinpointed the following meeting objectives:

1. To determine services currently being offered within the Anchorage Area for treatment or prevention of alcoholism or alcohol abuse.

2. To determine what services should be, but currently are not available within the Municipality for the treatment or prevention of alcoholism or alcohol abuse.

3. To develop recommendations for future action by the Municipality of Anchorage, Department of Environmental Protection, Behavioral Health Division.

A copy of the meeting agenda is available for reference in Appendix D.

PROCEDURES USED FOR COLLECTING DATA

Inventory. The data constituting the inventory of services currently offered was collected in two (2) ways. First, the letter of invitation was accompanied by an inventory form and a set of Service Classification Definitions to aid in explaining the major inventory categories. This inventory was to be completed by the agency representative and mailed back to the sender or brought to the meeting on July 14, 1977. A total of 25 of these inventories were returned.

Secondly, the entire first day and approximately one (1) hour of the second day of the meeting were devoted to recording data that corrected or supplemented data from the returned forms. To accomplish this, each major category and sub-category were discussed and verbal information sought from meeting participants and recorded on large wall charts. The resulting inventory can be found in the Findings section of this report.

Services Needed. On the second day of the meeting, participants were divided into small groups of three (3). They were asked to identify up to three (3) services that were non existent or in insufficient supply as to meet the needs of those in the Municipality with alcohol problems or individuals prone to develop such problems. In addition, they were to develop the rationale and supply any relevant data to substantiate this need.

Each small group then presented their list of services and justification to the total group. The resulting list from all groups was then revised to eliminate duplication or unnecessary overlapping. Each participant was then askeu to distribute 17 points on these needed services to indicate the weight of importance given each. No individual was to place more than 5 points on any one need area, but some need areas could receive 0 points if they desired. The resulting weighted needed service areas are reported in the Findings section of this report, page 14.

Services in Excess or Duplication. In a similar manner the same small groups of three (3) were asked to identify and verbally present up to two (2) services that appeared on the inventory that were excessive or unnecessarily duplicated by two or more agencies, in terms of meeting the Municipality's population needs. A list of these services appears in the Findings section of this report.

Recommendations. As a total group, participants were asked to identify specific recommendations they wished to make to the Municipality. The recommendations were recorded and can be found in the Findings section of this report.

FINDINGS

Inventory. The inventory of services currently provided in the Municipality for those having alcohol or alcohol related problems, or those with potential of having such problems, as provided by meeting participants, can be found in Appendix E.

The inventory is incomplete for a number of the agencies listed. It is also known that many private providers (physicians, psychologists, and social workers) service the alcohol using and abusing population in several capacities, but did not participate in person or in writing.

Services needed. Based upon the inventory of services currently provided and the professional judgement of meeting participants, the following areas of needed service exist in Anchorage with each need's weighted relative importance. The higher the rank order (one geing highest) and the larger the relative weight, the more urgent the need for this service in Anchorage.

Rank Order		Relative Weight
1.	Prevention (all aspects). Education (through additional, non-traditional alternatives), and youth (all), building on recognized, successful programs.	32
2.	Early intervention. Women's resource center (offering general resources), troubled employees, middle class treatment (out-patient).	21
3.	Aftercare for continued support (proposal for sheltered workshop, residential care).	20
4.	Staff training and continuing professional education.	19
5.	Youth resource center (comprehensive).	17
6.	Centralized (unbiased) diagnostic, evaluation, and referral center to independent, yet interrelated services.	12
7.	Decentralization of comprehensive community alcohol program.	11

Services in Excess or Duplication. Based upon the inventory of services currently provided and the professional judgement of meeting participants, the following services are thought to be in oversupply to people in Anchorage, and reduction of these services to the level of need might free some resources for use in other need areas.

1. Primary Services: Early detection and counseling. There appeared to be a wide range of agencies, mostly public in constitution, offering primary prevention, early detection, and counseling services. Most of these agencies were listed as providing preventive services for youth through information, education, and early detection services, and yet these services were the highest in priority of needed services. This would suggest that there is a need for better coordination, better definition of goals to be accomplished, and better evaluation of results.

2. Services provided to public inebriate. There appeared to be a degree of animosity relating to the expenditure of funds for the public inebriate which seemed out of proportion to that expended on the much larger population of middle income persons.

3. Number of hotlines. Recommend one hot line for the entire Municipality which would insure coordinated referral.

4. Appears to be duplication of some treatment services. Comments and behaviors displayed during the meeting indicated hostilities between participants and uncovered some apparent strong feelings about the quantity and quality of services being offered by some agencies in the Municipality.

Recommendations. Meeting participants made recommendations for future action as a result of this meeting. The following list describes them as they were made, in no priority order:

1. The Municipal Health Department form a task force to provide further guidance in pursuing the recommendations from this meeting, to make recommendations for providing services currently lacking or insufficient to meet the needs, and to identify ways to influence the reallocation of recources where excess or duplicative services exist.

2. The Municipal Health Department serve as the facilitator for convening a forum to explore legislative changes to further protect the rights of individuals and the community through expanded commitment proceedings with corresponding facilities and programs to accommodate these individuals.

3. The Municipal Health Department complete the services inventory begun in this meeting through the involvement of agency representatives not in attendance at this meeting and the verification of recorded services of those agency representatives.

4. The Municipal Health Department promote the use of resources for research to focus on problems in Alocholism and Alcohol Abuse with emphasis on the costs to society, business, industry, and government due to alcohol problems in the middle class population, women, and Alaska Natives.

5. The Municipal Health Department utilize resources to educate professionals from non-alcohol fields such as law, medicine, education, etc., in techniques and resources available to provide prevention and treatment assistance to those they serve.

6. As the Municipal Health Department implements the recommendations and priorities coming from this meeting, preference should be given to those activities which are no additional cost items or the reallocation of existing resources to meet the needs.

Process Outcomes. Based upon observations by the meeting facilitator, the following outcomes were noted regarding the process used for this meeting:

1. This process did not develop a comprehensive current inventory or services and agencies offering these services within the Municipality of Anchorage for those people with alcoholism or alcohol abuse problems or people with the potential of developing problems in these areas.

2. The timing of the mailing of invitations allowed too short a response time between receipt of the letter and the actual meeting, thus limiting attendance.

3. Terminology, particularly sub-categories, used in the inventory, was not defined precisely enough to permit the degree of accuracy desired for the inventory.

4. Representatives at the meeting lacked sufficient knowledge regarding some of the agencies and services to accurately provide inventory data.

5. In some cases, individual participants having knowledge of agencies and services remained in the meeting too short a time to be of significant value to the inventorying process.

6. The motivation of some participants degenerated over the span of time devoted to completing the inventory.

7. Participants were reinforced to announce their intention to participate in the meeting a very short time, give a brief synopsis of their organization's services, and leave.

8. The lack of a complete and refined inventory of services inhibited participants in making specific and detailed lists of needed services, and services in excess or duplication.

9. Comments and behaviors displayed during the meeting indicated hostilities between participants and uncovered some apparent strong feelings about the quantity and quality of services being offered by some agencies in the Municipality.

10. Meeting facilities and conveniences appeared to accommodate the meeting participants' needs very well.

CONCLUSIONS

Based upon the findings, the following conclusions seem appropriate:

1. Additional data will need to be collected using more precisely defined terms to complete an accurate and complete inventory of agencies and services providing assistance in the fields of alcoholism and alcohol abuse.

2. There is a wide range of agencies, mostly public in constitution, offering prevention and treatment services in the fields of alcoholism and alcohol abuse throughout the Municipality.

3. There exists a need for a directory of services in alcoholism and alcohol abuse that can be used for information and referral by various individuals throughout the Municipality.

4. There appear to be some services currently in need that, once started, could be fully or nearly fully self-sustaining financially. These services are primarily within the rehabilitation or sheltered type of services for those returning from more intensive services.

5. There exists a proliferation of agencies and personnel making diagnoses, providing information about other agencies, and making referrals. Thus, clients may get conflicting information from two or more servicing agencies. Clients may also go from agency to agency using up resources that might better meet their needs or the needs of others. Simplified and more efficient procedures appear to be needed in this area.

6. No one office or person is seen as the primary source of current information regarding alcohol and alcohol related services in the Municipality of Anchorage.

7. Insufficient detailed needs data exists to provide adequate justification for any agency, public or private, to pursue added fiscal support for new services. This same data deficiency makes management decisions aimed at better servicing the prospective client somewhat more difficult and ineffective.

8. The apparent strong feelings of some individuals working in the alcohol field regarding methods or techniques to be used in providing service or the competency of individuals providing services is counter-productive to cooperation among agencies to strengthen services.

9. Meeting participants would be more inclined to attend a similar meeting for the entire agenda if the inventory of services was completed or very nearly completed prior to the meeting.

10. Sufficient well-founded needs and recommendations emerged from the meeting to guide the Municipal Behavioral Health Division in some immediate decisions and to secure additional data for more long-range decisions.

11. In addition to the data collected to meet the needs identified for this meeting, a side benefit was an apparent improvement in communications and in interpersonal relations between those in attendance at the meeting.

12. Many agencies were listed as providing prevention services through information and education of youth, and, yet, this service was highest in priority of needed services, suggesting the need for better coordination, better definition of goals to be accomplished, and better evaluation of results.

13. The quality of many existing services needs to be improved. The data which substantiates quality should be maintained by all agencies and be available for public review, at least in all cases where public funds are used in part or in full.

14. The lack of coordination, realistic and data-based goal setting, and data-based evaluation suggests the need for staff improvement in these processes.

RECOMMENDATIONS

Based upon the findings and related conclusions, the following recommendations are set forth for consideration by the Behavioral Health Division of the Municipality:

1. All recommendations, priorities for needed service, and suggestions for excess or duplicative services coming from the meeting be considered with a written rationale for the Municipality's action on each item.

2. A model be developed to provide highly coordinated or centralized diagnostic, information, and referral services to all individuals regardless of age, sex, ethnic origin, religion, or chosen life styles. Such a model should provide a variety of options for individuals to become aware of and in touch with such services, and provide 24 hour phone and walk-in service. The model should provide a simplified, but systematic non-biased system for offering services or options of services and staff with competent individuals supplied with current information necessary to carry out their jobs. The implementation of this model should be promoted by the Municipality as feasible.

3. A centralized data bank be established with standardized data and the protection of human subjects which will provide more accurate and comparable information (including unit costing) assessing what has been accomplished and more significant information on the

target population. Such a data bank could be voluntary , and those who contribute according to specifications have access to the data bank. Such information, crucial to evaluating what is being done, and determining what yet needs to be done, is essential to accountability and securing new fiscal resources.

4. A model be developed for a program and facility to serve as a sheltered residential and day care aftercare unit. Such a unit should incorporate the sheltered workshop and sheltered employment concepts which would serve to make the unit self supporting. The Municipality should consider the feasibility of financing the planning and possibly the initial start-up costs of such a unit with the goal of it becoming self supportive. Such a unit might be able to serve those from drug abuse, those with mental health problems, as well as those needing alcohol services.

5. A plan be developed for offering two or three workshops annually over the next three to five years aimed at increasing the effectiveness of managers of local programs and agencies and increasing the competency of targeted counselor groups. Many of the problems in duplication of effort, lack of services, poor accountability, and poor service to the individual client are best addressed through increased competency of the personnel responsible for such problems. The Municipality could sponsor these workshops based upon a commitment from local program people to attend.

6. An assessment be made of local program needs for such technical assistance as evaluation design, third party evaluation, needs assessments, and planning techniques, developing a team approach. If sufficient need exists, provide local program personnel with directories and guidelines for acquiring such assistance and, if necessary, make provision for such assistance through the Municipality as a last resort.

7. The Behavioral Health Division begin a feasibility study with the Parks and Recreation Department of the Municipality to determine if and how a "Youth Resource Center Program" might be developed. Such a study should identify the options as to who or what agency could and should have responsibility for developing such a program aimed at prevention and early detection/intervention for youth.

8. An annual seminar be sponsored by the Municipality for all local program people in which the latest findings from research, proven service models from other localities, evaluation results and techniques, and a "Current Status of Services From Agencies in the Municipality " are presented and discussed.

9. The "Inventory of Services" developed during the July 14 and 15, 1977 meeting be completed and varified with all agencies listed. A form be developed for acquiring each agency's update on the Inventory, at least annually, and from this a directory of services be issued with annual supplements for update.

10. The Municipality sponsor data collection or identify existing data which would both promote and discourage legislation necessary to further protect the rights of individuals and the community through expanded commitment proceedings of the persistent inebriate. This data would then serve as the basis for convening the forum to discuss this topic.

APPENDIX "A"

Letter of Invitation

Municipality
of
Anchorage

POUCH 6-650
ANCHORAGE, ALASKA 99502
(907) 279-2511

GEORGE M. SULLIVAN,
MAYOR

DEPARTMENT OF HEALTH AND ENVIRONMENTAL PROTECTION
(825 "L" Street)

Many private and public providers of services in the Anchorage area are making an impact on the alleviation of problems related to alcoholism and alcohol abuse. These services cover many needs of the alcohol abuser but may leave many needs yet unmet. The Municipality is interested in joining forces with all private and public providers of alcohol services to better identify these needs and to explore alternatives in alcoholism treatment.

To begin this cooperative effort, the Municipality will be hosting a meeting July 14 and 15, 1977, beginning at 9:00 a.m., in the fifth floor Conference Room located at 825 "L" Street, Anchorage, Alaska.

It is hoped to accomplish the following:

1. to determine services currently being offered within the Anchorage area for treatment or prevention of alcoholism and alcohol abuse;

2. to determine what services should be, but currently are not available within the Municipality for the prevention or treatment of alcoholism or alcohol abuse;

3. make recommendations for alternative ways these added services could be provided.

To conserve your time in this meeting, it will be essential to gain some preliminary information concerning the services provided by your agency. A one-page inventory sheet has been enclosed for this purpose.

Please fill out this inventory sheet and mail it to my office prior to the meeting. If this is not convenient for you, bring the completed form to the meeting. A brief set of

"Service Classification Definitions" is also enclosed to aid you with the interpretation of terms used on the inventory sheet.

We look forward to receiving your program inventory and sincerely hope you can find time in your busy schedule to attend the meeting.

Your contribution to this effort is essential to making alcoholism and alcohol abuse services better serve the citizens of the Anchorage area.

Sincerely,

Helen D. Beirne, Ph.D.
Behavioral Health Manager

HDB: epw

Enclosures: 1 Inventory Sheet
1 Service Classification Definitions

SERVICE CLASSIFICATION DEFINITIONS*

PREVENTIVE: Education and activities aimed at 1) averting disease or its consequences, and 2) improving the healthfulness of the environment, the individual, and relationships conducted before the individual becomes involved with Alcoholism and Alcohol Abuse. Prevention is not a treatment intervention as are the other four service classifications.

Examples of activities are personal health awareness programs, support of alternatives to alcohol and alcohol education for non-users, community education programs.

PRIMARY: Early intervention given at the time when the client/patient first uses alcohol. Intervention is aimed at assisting the experimental alcohol user rather than the alcohol abuser. These are individuals whose alcohol use has not yet become a dominant influence affecting other areas of life -- e.g., school, job, family, and personal relationships, non-emergency treatment. Primary services may be ongoing.

Examples of activities are early detection, on-going services, and individual and group counseling for experimental alcohol users, hot lines, alcohol education for users.

SECONDARY: Services provided by a trained specialist (e.g., doctor, policeman, fireman, paramedic) for individuals in a life-threatening situation until that situation is under relatively effective control; short-term critical treatment, emergency care, usually 3 to 5 days duration.

Examples of activities are crisis intervention, critical care, detoxification, suicide intervention.

RESTORATIVE: Services provided after the crisis of critical portion of the episode has passed, to assist the individual in establishing a routine stabilized existence. Treatment in this classification is time-limited; the length of treatment will vary with the program, but does not have an end point at which time the client/patient is expected to re-enter the community.

Examples of activities are rehabilitation, limited duration therapy, short-term care, vocational rehabilitation.

CONTINUING: Services necessary to maintain the client/patient indefinetly, as opposed to restorative services which have a time limit.

Examples of activities are long-term alcohol care, long-term counseling, institutional care, life-long community based peer group supports, (e.g. Alcoholics Anonymous).

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*Service Definitions are those utilized by the State of Alaska, Health Systems Agency, (H.S.A.).

7-6-77 kjb

ALCOHOLISM AND ALCOHOL ABUSE PROVIDERS INVENTORY

NAME OF PROVIDER ____________________

CHECK SERVICES YOU PROVIDE	TO WHOM DO YOU PROVIDE THIS SERVICE	AGE RANGE	NUMBER OF PEOPLE
*PREVENTIVE			
[] 1. Health Awareness Programs.			
[] 2. Alcohol Education for Non-users.			
[] 3. Community Education Programs.			
[] 4. Alternative to Alcohol Use Program (Recreation, etc.)			
[] 5. ____________			
[] 6. ____________			
PRIMARY			
[] 1. Early Detection.			
[] 2. Individual Counseling.			
[] 3. Group Counseling.			
[] 4. Alcohol Education for Users.			
[] 5. Hot Lines.			
[] 6. ____________			
SECONDARY			
[] 1. Crisis Intervention.			
[] 2. Critical Care.			
[] 3. Detoxification.			
[] 4. Suicide Prevention.			
[] 5. ____________			
[] 6. ____________			
RESTORATIVE			
[] 1. Vocational Rehabilitation.			
[] 2. Limited Duration Therapy.			
[] 3. Medical Maintenance.			
[] 4. Short-term Non-Emergency Care.			
[] 5. ____________			
[] 6. ____________			
CONTINUING			
[] 1. Long-term Residential Care.			
[] 2. Long-term Counseling.			
[] 3. Institutional Care.			
[] 4. Long-term Medical Maintenance.			
[] 5. ____________			
[] 6. ____________			
REMARKS:			

7-5-77
epw

APPENDIX "B"

Agencies Invited

AGENCIES INVITED

1. Salvation Army Comprehensive Alcoholism Services
2. Studio Club, Inc.
3. Alaska Alcoholism Treatment Center
4. Family Resource Center
5. Phoenix House
6. Alaska Children's Services
7. Center for Alcohol and Addiction Studies
8. National Council on Alcoholism, Alaska Region
9. Anchorage Council on Alcoholism
10. Women's Resource Center
11. Anchorage Child Protection Association
12. Social Services Program, Cook Inlet Native Association
13. State Office of Alcoholism
14. Division of Vocational Rehabilitation
15. Alaska Labor and Management
16. Alaska Native Council on Alcohol and Drug Abuse
17. Alaska Youth Advocates
18. Alaska Hospital and Medical Center
19. Veteran's Administration
20. Providence Hospital
21. Alaska Care Center
22. Catholic Social Services
23. Alaska Cabaret, Hotel and Restaurant Association
24. Court System
25. Public Defenders Office

26. Alaska Center for Staff Development
27. Base Social Action
28. New Start
29. Open Door Clinic
30. Narcotic Drug Treatment Center
31. State Correctional Center Annex
32. Division of Social Services, State of Alaska
33. Anchorage School District
34. Suicide Prevention and Crisis Center
35. Alaska Baptist Family Service Center
36. Alcohol and Drug Control Office
37. Anchorage Community Mental Health Center
38. Future House, Inc.
39. Langdon Psychiatric Clinic
40. Metropolitan Community Church of Anchorage
41. Urban and Rural Ministry
42. Alaska State Troopers
43. Anchorage Police Department
44. Human Support Services
45. Emergency Medical Services
46. Nursing
47. Physical Health

APPENDIX "C"

Agency Representatives Attending

AGENCY REPRESENTATIVES ATTENDING

1. Sue Trice
   Anchorage Council on Alcoholism
   P.O Box 2972
   Anchorage, Alaska 99510

2. Bernard Segal
   Center for Alcohol and Addiction Studies
   2651 Providence Drive
   Anchorage, Alaska 99504

3. Samuel G. Cornell
   Commission on Youth
   600 West 6th
   Anchorage, Alaska 99501

4. Sr. Dorothy Forest
   Urban Ministry, Catholic Archdiocese of Anchorage
   P.O. Box 2239
   Anchorage, Alaska 99510

5. Emily McKenzie
   Anchorage Alcohol Safety Action Program
   941 West 4th
   Anchorage, Alaska 99501

6. Dennis Kelso
   State Highway Safety Planning Agency
   Box 42
   Anchorage, Alaska 99510

7. Lynne Curry
   Alaska Center for Staff Development
   650 International Airport Road
   Anchorage, Alaska 99502

8. George Barrel
   Alaska Native Commission on Alcohol and Drug Abuse
   750 East Fireweed
   Anchorage, Alaska

9. L.E. Brown, Sr.
   Anchorage Emergency Medical Services(Municipal)
   211 West 7th
   Anchorage, Alaska 99501

10. Dorothy Osborne
    Department of Health and Environmental Protection (Municipality)
    825 "L" Street
    Anchorage, Alaska 99501

11. Rita Schmidt
    Department of Health and Environmental Protection (Municipality)
    825 "L" Street
    Anchorage, Alaska 99501

12. Judy Hart
    National Council on Alcoholism - Alaska Region
    4510 International Airport Road
    Anchorage, Alaska 99502

13. Ardi Bury
    Salvation Army Comprehensive Alcoholism Services
    825 "L" Street
    Anchorage, Alaska 99501

14. Nancy Beck
    Community Health Nursing
    Department of Health and Environmental Protection (Municipality)
    825 "L" Street
    Anchorage, Alaska 99501

15. Bruce Garberding
    Cook Inlet Native Association Social Services
    670 West Fireweed
    Anchorage, Alaska 99503

16. William Hogg
    Veteran's Administration
    429 "D" Street
    Anchorage, Alaska 99501

17. Paul Jones, M.D.
    Veteran's Administration
    P.O. Box 1288
    Juneau, Alaska

18. Thomas Stoner
    Alaska Native Commission on Alcohol and Drug Abuse
    750 East Fireweed
    Anchorage, Alaska

19. Gavin Vilander
    Family Resource enter
    2311 Boniface Parkway
    Anchorage, Alaska 99504

20. Ed C. Stewart
    Department of Health and Environmental Protection (Municipality)
    825 "L" Street
    Anchorage, Alaska 99501

21. Barbara Hoffmann
Anchorage Council on Alcoholism
825 "L" Street
Anchorage, Alaska 99501

22. Marty Margeson
Task Force on Women and Alcoholism
2360 Homestead #A
Anchorage, Alaska 99507

23. Jeannine Lyerly
Alaska Area Native Health Service
A-MH
Box 7-741
Anchorage, Alaska 99510

24. Bill Stokes
Municipal Human Support Services
225 Cordova
Anchorage, Alaska 99501

25. Henrietta Nugen
Studio Club
546 East 15
Anchorage, Alaska

26. Margaret Wolfe
Department of Health and Environmental Protection (Municipality)
825 "L" Street
Anchorage, Alaska 99501

APPENDIX "D"

Meeting Agenda

ALCOHOL SERVICES MEETING
AGENDA

July 14, 15, 1977
Municipality Health Bld
5th Floor Conference
Room

Convene Meeting
(Hand in Providers Inventory)

Introductions:

Pair up with person next to you.

One minute for the person on right to tell you about themselves. (How you feel about being at this workshop). Now split pairs and do the same.

Everyone introduce the person who introduced themselves to you.

Purpose of Meeting:

1. To determine what services are currently offered in the Municipality for treatment or prevention of alcoholism and alcohol abuse.

2. To determine what services should be, but currently are not available within the Municipality for the treatment or prevention of alcoholism and alcohol abuse.

3. To make recommendations as to alternative ways these added services could be offered.

Preview Agenda:

Note: We will take as long as it takes to get the job done -- up to 2 days.

Ground Rules:

1. We are here to accomplish the objectives stated - I will chair the proceedings and keep us on the track (task) even if I need to be rude.

2. We are not here to evaluate each others' programs or services, but to find out what services truly exist for the client and how those services are made available.

3. There seems to exist major questions concerning what is an "ideal" program and I doubt this can be resolved during this two day meeting. Therefore, we will work towards an <u>orderly</u> concensus as to what services are lacking and what alternatives exist for offering these added services.

4. I will serve as the norm for communications in this group. If I can understand what you are communicating, everyone should be able to understand. I do not know your programs nor do I know the fields of Alcoholism and Alcohol Abuse.

5. We must deal with the areas of Alcoholism and Alcohol Abuse in a manner which is somewhat manageable. To do this we have chosen the "Service Classifications" as the major categories we will operate within - Preventive -- Primary -- Secondary -- Restorative -- Continuing
(Definitions handed out to those who did not bring theirs)
Review?

Description of End Products:

1. List of what is offered - by service classification

2. List of what services should be offered - by service classification

3. List of options for providing needed services

Alcoholism and Alcohol Abuse Inventory:

(Staff will take information from inventorys handed in and place on charts) ie., wall chart

Prevention

Services Provided	Providing Agency	Who Uses This Service	Age Range	# of People	Comments

Begin with Prevention Inventory of what is.

Read definition

Review what appears on chart and get questions answered

Others who should be listed on chart

Summarize

Primary Inventory of what is.

Read definition

Review what appears on chart and get questions answered

Others who should be listed on the chart

Summarize

Secondary Inventory of what is.

Same

Restorative Inventory of what is.

Same

Continuing Inventory of what is.

Same

What Should Be?

Groups of five (5) -

Come up with:

a. No more than 3 services that should be provided which appear to be insufficient or totally lacking within the inventory just completed.

b. Provide as much proof as possible that need exists for each of these services.

c. Identify one or two services that appear in the inventory that you feel is unnecessary duplication or unnecessary service and why you feel that to be the case.

Each group present their case to the total group.

After all groups have presented - total group discussion.

Review and test apparent concensus.

What are your priorities for these added needs - use value chip approach.

How Should These Services Be Provided?

Brainstorm by total group
(Categorize needed services by service classification and priority).

Vote on most appropriate alternatives

3 = 1st choice
2 = 2nd choice
1 = 3rd choice

Summarize

Next Steps:
Municipality plans for future action

APPENDIX "E"

Inventory

PREVENTIVE INVENTORY

SERVICE	PROVIDERS	AGES	# SEEN
Health Awareness Programs	Alaska Children's Services	12 - 18	
	Native Health Corporations	All	
	Anchorage Council on Alcoholism	9 - 70	
	Anchorage Commission on Youth	All (Primarily 0-22)	
	Center for Alcohol and Addiction Studies - University of Ak.	All (Primarily adult)	
	Municipal District Nursing	All	30 homes/day
	Veteran's Administration	All	
	Municipal Home Health Services	All	
	Open Door Clinic	All	
	Anchorage Drug Abuse Services	18+	
	Cook Inlet Native Association		
	Salvation Army Comprehensive Alcoholism Services	18+	
	Alaska Native Health Service	All	
	National Council on Alcoholism	All	
	Family Resource Center	Anyone requesting	
2. Alcohol Education for non-users	Anchorage Council on Alcoholism	9 - 70	
	Urban Ministry, Catholic Archdiocese of Anchorage	All	
	Alaska Native Commission on Alcohol and Drug Abuse	All	
	University of Ak. School of Nursing		
	U of A - Criminal Justice Center		
	Family Resource Center	All	22/month
	National Council on Alcoholism		
	Drinkwatchers (Beginning 10/77)		
	Alaska Native Health Service	All	
	Native Health Corporations		
	Alaska Children's Services	12 - 18	
	Veteran's Administration	all	
3. Community Education Programs	Anchorage Council on Alcoholism	9-70	
	Suicide Prevention and Crisis C'tr	9-65	
	Native Health Corporations		
	Anchorage Commission on Youth	All (primarily 0-22)	
	Center for Alcohol and Addiction Studies		
	Urban Ministry, Catholic Archdiocese of Anchorage	All	
	Alaska Native Commission on Alcohol and Drug Abuse		
	Church youth groups		
	APD, State Troopers		
	Cook Inlet Health Department		
	Family Resource Center	All	

PREVENTIVE

SERVICE	PROVIDERS	AGES	# SEEN
Community Education Programs, cont.	National Council on Alcoholism		
	Alaska Native Health Service	All	
	Alaska Labor and Management Employee Affairs, Inc.	16 - 65	
4. Alternative to alcohol use (recreation, etc)	Alaska Native Commission on Alcohol and Drug Abuse		
	Cook Inlet Social Services	18+	
	Community Services	18+	
	Youth Department	Primarily 13-18	
	Cook Inlet Manpower		
	Employment Assistance		
	Family Services		
	Native Health Corporations		
	Alaska Children's Services	12-18	
5. Teacher Training Program	Center for Alcohol and Addiction Studies	18+	
	Anchorage Council on Alcoholism	All	
	Center for Staff Development	18+	
6. Training	Center for Staff Development	15+	80+ ancillary/yr
	Anchorage Council on Alcoholism	18+	
	Cook Inlet Health Department	18+	
	Alaska Native Alcoholism Training Institute		
	Center for Alcohol and Addiction Studies	Adults	
7. Technical Assistance	Alaska Native Commission on Alcohol and Drug Abuse	18+	
	Veteran's Administration	18+	
	National Council on Alcoholism	18+	
	Family Resource Center		
8. Public Information Media and Publications	National Council on Alcohlism	All	
9. Community Organization - Program	National Council on Alcoholism	All	
	Veteran's Administration	18+	
10.Responsible drinking as alternative to alcohol abuse	Drinkwatchers (beginning 10/77)	18+	

SERVICE	PROVIDERS	AGES	# SEEN
Early Detection	Anchorage Council on Alcoholism	16 - 60	
	Urban Ministry, Catholic Archdiocese of Anchorage	All	
	Alaksa Division of Vocational Rehab	All	
	Court Alcohol Screening	Driving age	
	Veteran's Administration	All	584 in '76 - '77
	Alaska Labor and Management Employee Affairs, Inc.	12 - 70	
	Individual industries		
	Native Corporations		
	Salvation Army's Comprehensive Alcoholism Services		
	Family Resource Center (TLC)		
	Cook Inlet Native Association		
	District Nurses		
	Future House		
	Open Door Clinic	Primarily youth	
	Youth Advocates	Primarily youth	
	Private Providers		
	Schools	Primarily youth	
	Corrections		
	Junior Chamber of Commerce		
	Family Medical Centers		
	Community Mental Health Center	All	
	Alaska Native Health Service	All	
	Neighborhood Health Center	All	
	Postal Program (PAR)		
	Turning Point Boy's Ranch	Youth	
	Army DARE Center	Military	
	Air Force - Social Action	Military	
	McLaughlin Youth Center	Youth	
	Catholic Social Services	All	
	Booth Memorial Home	Youth	
	Alaska Children's Services	12 - 18	
Individual Counseling	Urban Ministry, Catholic Archdiocese of Anchorage	All	
	Division of Vocational Rehab.	All	
	Alaska Native Commission on Alcohol and Drug Abuse (as coordinator with RuralCAP)	All	
	Veteran's Administration	18 - 90	
	Cook Inlet Native Association	All - primarily Native	
	Salvation Army's Comprehensive Alcoholism Services	Adult	
	Alaska Labor and Management Employee Affairs, Inc.	12 - 65	

SERVICE	PROVIDERS	AGES	# SEEN
	Alaska Native Health Service	All	
	Catholic Social Services	All	
	Postal Program (PAR)	Adults	
	Turning Point Boy's Ranch	Youth	
	Air Force - Social Action	Primarily ad. Milit.	
	Army DARE Center	Primarily ad. Milit.	
	Mc Laughlin Youth Center	10 - 18	
	Family Resource Center	All	
	Studio Club	Adult	
	Youth Advocates	Youth	
	Private providers	All	
	Schools	Youth	
	Corrections	All	
	Junior Chamber of Commerce	Primarily adult	
	Alaska Children's Services	Youth	
	Booth Memorial Home	Youth	
Group Counseling	Urban Ministry, Catholic Diocese of Anchorage	All	Varies
	McLaughlin Youth Center	Youth	
	Veteran's Administration	18 - 90	(584 in '76 - '7
	Alaska Native Health Service	All	
	Youth Advocates	Youth	
	Private providers	All	
	Schools	Youth	
	Alaska Labor and Management Employee Affairs, Inc.	12 - 70	
	Corrections	All	
	Salvation Army Comprehensive Alcoholism Services	Adults	
	Studio Club	Adults	
	Alaska Children's Services	Youth	
	Turning Point Boy's Ranch	Youth	
	Air Force - Social Action	Primarily ad. Milit.	
	Army DARE Center	Primarily ad. Milit.	
	Mc Laughlin Youth Center	Youth	
	Postal Program (PAR)	Adults	
	Catholic Social Services	All	
	Open Door Clinic	Primarily youth	
	Cook Inlet Native Association	All - Native	
	Alaska Children's Services	10 - 18	
Alcohol Education for users	Urban ministry, Catholic Archdiocese of Anchorage	All	
	Alaska Native Commission on Alcohol and Drug Abuse(RuralCAP)	All	
	Veteran's Administration	18 - 90	(584 in '76-'77
	Salvation Army's Comprehensive Alcoholism Services	Adults	

PRIMARY

SERVICE	PROVIDERS	AGES	# SEEN
Alcohol Education for Users, cont.	National Council on Alcoholism	All	
	Anchorage Council on Alcoholism	All	
	Family Resource Center	14+	
	Cook Inlet Native Association	All	
	Women's Task Force	Primarily adults	
	AA, Alanon, Alateen	All	
	University of Alaska	All	
	Public schools	Youth	
	Drinkwatchers (beginning 10/77)	Primarily adult	
	Alaska Native Health Service	All	
	Alaska Children's Services	12 - 18	
	Alaska Labor and Management Employee Affairs, Inc.	12 - 70	
Hot Lines: (Emergency)	Suicide Prevention and Crisis Center	All	
	Salvation Army's Comprehensive Alcoholism Services	All	
	Open Door Clinic	All	
	AA, Alanon, Alateen	All	
	Anchorage Council on Alcoholism	All	
	Medical Services	All	
	Poison Control Center	All	
	Police (911)	All	
	Emergency Medical Service	All	
	Alaska Native Health Services	All	
	Air Force Hospital	All - military	
	Alaska Labor and Management	All	
	Employee Affairs, Inc.	12 - 70	
Information and Referral	Cook Inlet Native Association - Social Services and others	All	20+ per week
	Drinkwatchers (beginning 10/77)	All	

SECONDARY

SERVICE	PROVIDERS	AGES	# SEEN
Crisis Intervention:	Emergency Medical Service	All	
	Suicide Prevention & Crisis Cntr.	All	
	CINA	All	
	SACAS	All	
	Medical Services	All	
	Public Health Nurses	All	
	Private Providers	All	
	Open Door	All	
	Police	All	
	Home Health Aid	All	
	Clergy	All	
	Community Mental Health	All	
	Neighborhood Health Center	All	
	Abused Women's Aid in Crisis	All	
	Alaska Youth Advocates	All	
Critical Care (medical):	Emergency Medical Services	All	
	SACAS	18 years or older	
	Hospitals	All	
	Open Door	"	
	Public Health Nurses	"	
	Private Providers	"	
	Alaska Native Health Service	"	
Detoxifcation:	SACAS	18 years or older	
	Hospitals	All	
	AA	"	
	Private physicians (limited #)	"	
	Alaska Native Health Service	"	
Suicide Intervention:	Emergency Medical Service	All	
	Urban Ministry, Catholic Archdiocese of Anchorage	All	
	CINA	"	
	Open Door	"	
	Paramedics	"	
	Drug Central Intake	"	
	Abused Women's Aid in Crisis	"	
	Clergy	"	
	Policemen, Firemen	"	
	Suicide Prevention & Crisis	"	
	Alaska Native Health Service Hospitals	"	

SECONDARY

SERVICE	PROVIDERS	AGES	# SEEN
Transporation:	Emergency Medical Service	All	
	CINA (when possible)	"	
	SACAS	18 years or older	
	Police	All	
	Cabs	"	
	REACT	"	
	Abused Women's Aid in Crisis	"	
	FISH	"	

RESTORATIVE

SERVICE	PROVIDERS	AGES	# SEEN
1. Vocational Rehabilitation	Urban Ministry, Catholic Archdiocese of Anchorage	All	
	Veteran's Administration	18-90	
	Division of Vocational Rehab	Adults primarily	
	Human Support Services (Munic.)		
	Job Services	Youth and adults	
	Alaska Retarded Citizens Ass'n	All	
	Future House	Adults	
	Salvation Army Comprehensive Alcoholism Services work therapy	Adults	
	SACAS Transitional Care	Adults	
	Studio Club	Adults	
	Alaska Skill Center	Adults	
	Cook Inlet Employment Assistance	Adults	
	Manpower	Adults	
	Palmer Adult Camp	Adults	
	Eagle River Corrections	Adults	
	Alaska Labor and Management Employee Affairs, Inc.	16-65	
2. Limited Duration Therapy- non residential, out-patient	Veteran's Administation	All (18-90)	
	Cook Inlet Native Association	All	
	Family Resource Center	All	
	Salvation Army Comprehensive Alcoholism Services - Outpatient Unit	Adults	
	Studio Club	Adults	
	Alaska Clinic	All	
	Private Providers	All	
	Alaska Native Medical Center	All	
	Open Door Clinic	Primarily youth	
	Alaska Labor and Management Employee Affairs, Inc.	Primarily adult	
	Youth Advocates	10-18	
	Corrections	Adult	
	Division of Social Services(State)	All	
	Mental Health Clinic(Community)	All	
	Clergy		
3. Medical Maintenance	Hospitals/API	18+	
	Private providers	All	
	Neighborhood Health Center	All	
	Alaska Native Health Service	All	
	Veteran's Administration	18 - 90	

RESTORATIVE

SERVICE	PROVIDERS	AGES	# SEEN
4. Short-term, non-emergency care (Residential)	Alaska Native Health Service	All	
	Studio Club	Adult	
	Future House	Adult	
	Salvation Army Comprehensive Alcoholism Services - Transitional Care Unit, Short Term	Adult	
	Veteran's Administration	All, primarily adult	
5. Group Counseling	Family Resource Center	16+	
	Salvation Army - CAS	18+	
6. Individual Counseling	Family Resource Center	16+	
	Salvation Army - CAS	18+	
7. Non-service connected and service connected compensations	Veteran's Administration	18+	

CONTINUING

SERVICE	PROVIDERS	AGES	# SEEN
. Long-term residential (6 mo. +)	Salvation Army - Comprehensive Alcoholism Services	18+	Capacity 40
	Future House	18-40	15
	Studio Club	18+	
	Veteran's Administration	All, primarily adult	5/year
2. Long-term counseling	Cook Inlet Native Association	35-60	10-15/week
	Salvation Army Comprehensive Alcoholism Services	18+	Capacity 40
	Alaska Native Medical Services	35-50	10-15/week
	Private Prividers	All	
	AA, Alanon, Alateen	All	
	Mental Health Clinic (Community)	All	
	Cook Inlet Native Association	All	
	Veteran's Administration	All	
	Alaska Labor and Management Employee Association, Inc.	16+	
. Institutional care	Alaska Psychiatric Institute	10+	
	Correctional Institutions	18+	
	Quasi-institutions	18+	
	Nursing homes	18+	
	Veteran's Administration	All, primarily adult	
. Long-term medical Maintenance	Alaska Native Medical Center	All	
	Private providers	All	
	Public Health Nurses	All	
	Alaska Native Health Service	All	
	Veteran's Administration	18-90	
. Aftercare	Family Resource Center	All (9-67, primarily)	
	AA, Alanon, Alateen	All	
	Churches	All	
	Salvation Army Comprehensive Alcoholism Services	Adults	

The Salvation Army's
COMPREHENSIVE ALCOHOLISM SERVICES

DAVID G. BOYD, Captain
Director

CLARENCE WISEMAN
GENERAL

RICHARD E. HOLZ
TERRITORIAL COMMANDER

ARTHUR SMITH, Major
DIVISIONAL COMMANDER

July 15, 1977

To All Members
Advisory Board of Anchorage
Social Center Advisory Council

From: Roy Norquist, Chairman
Social Service Advisory Council Roy V. Norquist

re: FUNDING HEARING - ANCHORAGE MUNICIPAL ASSEMBLY

The Salvation Army Comprehensive Alcoholism Services contract covers a period of 15 months, October 1, 1976 to December 31, 1977. Because of the many funding sources it was divided into two budget cycles - October 1 through June 30 and July 1 through December 31st. We have been in a long series of negotiations on this and this is an update report.

Our staff and the Municipal Office of Management and Budget both prepared budgets that totaled out to within a thousand dollars of each other at $1,268,370 for this six months to present to the State. The State has offered $360,000 (5% increase) which left the budget $323,920 short. The only increases of program in the budget are two additional positions and increasing the Community Service Patrol from 16 hours daily to 24 hours.

In order to meet the State mandate that a balanced budget be presented by June 30th or lose the State funds for July (about $60,000) we reluctantly agreed to a budget of $1,020,058. To do this the following cuts have to be instituted:

1. Alpha Center would be closed on July 31st.
2. Anchorage Council on Alcoholism allocation would be cut from $25,000 to $12,5000.
3. Elimination of new positions and with a built in 10% vacancy factor in staff would save $69,000
4. Emergency Service Patrol kept at 16 hours operation
5. $80,000 added to Third and First Party payment revenue

We were unhappy with this budget as the level of service would be greatly reduced below the community expectation and the revenue source lacked credibility.

For the Municipality to receive the State Fund, it is necessary for the Assembly to formally accept them. It appears this will be on the Agenda of the Assembly, July 26th. Prior to this hearing, it was necessary for this to be reviewed by the Municipal Health Commission. They passed the following resolution on July 6th:

CONT:

P. O. Box 4-212 Anchorage, Alaska 99510 274-1693

FUNDING HEARING - ANCHORAGE MUNICIPAL ASSEMBLY - Cont:

"THE MUNICIPAL HEALTH COMMISSION RECOMMENDS THAT THE COMPREHENSIVE ALCOHOLISM TREATMENT PROGRAM BE APPROVED IN CONCEPT, AND THAT THE ASSEMBLY ACCEPT THE STATE GRANT MONIES FOR FY 77-78 CONTINGENT UPON THE MUNICIPALITY PROVIDING ADDITIONAL FUNDING TO SUPPORT THE ALPHA CENTER FUNCTION, 24 HOUR EMERGENCY SERVICES PATROL, STAFF EDUCATION AND TRAINING, PUBLIC INFORMATION AND EDUCATION, AND THE DELETION OF THE VACANCY FACTOR."

In further negotiation with the Municipality since then they have suggested the following additions to the $1,020,058 Budget be presented to the Assembly.

"1.	Restore Anchorage Council on Alcoholism Contract to $21,000.	$ 8,500.
2.	Reduce Vacancy Factor from 10% to 3% and eliminate $11,000 in administrative positions.	35,000
3.	Eliminate $40,000 from projected revenues	40,000
4.	Restore Training and Vacation accrual account	39,270
5.	Continue Alpha Center from August 1 - December 31 at 16 hours	55,000
		$177,770"

Although this is a good step, it still will give us a program below our current level of operation and cause some problems such as:

1. Closing Alpha Center 8 hours a day will put the public inebriate back on the street for that time each day. Since this programatically would be during the day, it would visibly compound the problem we have been trying to handle.

2. Four components of our C.A.S. operates 24 hours a day, 7 days a week. This, coupled with a very sparse staff, does not allow for any percentage of vacancy factor without hurting the program .

3. Our salary scale needs upgrading to attract the competent help we need and to hold those we have. In this budget period, funds will be needed to handle the first annual increases. As no funds are added for this purpose, we face greater morale and turn over problems in staff.

4. We can live with a continued 16 hour Community Services Patrol, but we will not be able to fulfill the community expectation of a 24 hour service.

Cont:

FUNDING HEARING - ANCHORAGE MUNICIPAL ASSEMBLY - Cont:

We are attaching a list of the Anchorage Municipal Assembly for your reference. We urge you to contact several of them by telephone or personal contact and present our concerns. For further information, contact me at 279-0514 or Major Smith at 276-2515.

We need your assistance now!.

ANCHORAGE ASSEMBLY MEMBERS

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Arlis Sturgulewski
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Anchorage, AK 99504 n/p

David Walsh
3104 Brookside
Anchorage, AK 99503 277-8622

file in Comprehensive program

OK

Minutes of Meeting
Crime Prevention Committee
8/18/77

Meeting was called to order by Chairman Frank Reed at 4:10 p.m.

Present were: Frank Reed; Adam Johnstone; Evelyn Phillips; Dr. Dexter from the Salvation Army Comprehensive Alcoholic Services; and Dean Ehrich of the Chamber Staff.

Purpose of the meeting was to discuss the recent cut back in the hours of operation of the Salvation Army's Walk-In Center for inebriates from 24 hours to 16 hours. Dr. Dexter explained that the Municipal Assembly had voted to cut back funds for that operation on recommendation of the Mayor. The effect of this cut back was to force the center to reduce its services both in the operation of the patrol which picks up persons incapacitated by alcohol and in the availability of the center to house these persons. Presently, the hours of operation for the pickup service and the Walk-In Center are between 5:00 p.m. and 9:00 a.m. During all other hours of the day, the inebriates must be put back on the street. Dr. Dexter emphasized that the other aspects of the Alcohol Treatment Program have not been affected by the budget cut. He estimated that a total of $16,000.00 would be needed to fund a 24 hour operation of the "pickup" and "walk-in" service for the balance of this calendar year.

Dr. Dexter also stated that the Anchorage Police Department had urged the Assembly not to cut back the Emergency Patrol Service because the presence of the inebriates on the street would create a problem for the police.

According to Dr. Dexter, the fund cut back was probably caused by the fact that certain funds anticipated to come from the state of Alaska were not forthcoming. Accordingly, he felt that the curtailment of the emergency service and the hours of the Walk-In Center was not because of any wish on the part of the city but. rather, because the necessary funds are simply not available.

Chairman Frank Reed requested that a further meeting on this subject be scheduled for Wednesday, August 24th at 4:00 p.m. and that Bert Hall of the Municipal Health Department be invited to discuss the matter with the committee.

There being no further business at this time. The meeting was adjourned at 5:10 p.m.

Bert Hall

COMPREHENSIVE ALCOHOLISM

TREATMENT PROGRAM

MUNICIPALITY OF ANCHORAGE

ASSEMBLY MEMORANDUM

No. ______________

Meeting Date:

From: Mayor

Subject: Salvation Army's Alcoholism Contract

Background

In May of 1976, during the final budget reviews for the transitional budget period of July 1 -- December 31, 1976, it was obvious that the existing system for delivering alcoholism services in Anchorage was a drastic failure. We lost our JCAH accreditation, the Board of Health was calling for major cuts, the agencies were unable to work cooperatively and there was an obvious shortage of funds to operate a comprehensive program -- although an acceptable one had been designed.

In June, 1976, programs were put on notice that there was no guarantee of continued funding beyond July 1; the Assembly authorized month-to-month contracts to continue detoxification services, a walk-in program and a half-way house. A Request for Proposals was developed and published. They were received and professionally evaluated resulting in the rejection of all proposals. A new RFP was designed and published and competing proposals received. Following similar reviews and much public input, a contract was approved and entered into with the Salvation Army to provide a major portion of the community's Comprehensive Alcoholism Services Programs. Attachment #1 is a copy of the Department's presentation to the Assembly last September outlining the project.

The priorities included in the RFP and supported by the State and local alcoholism advisory boards, the State Office of Alcoholism and the Assembly were aimed at the public inebriate and prevention by way of information and education. It was recognized that there was less government money available than in the past but still a comprehensive program requiring several new components was needed and desired. Subject to future funding, the Assembly authorized the Department to enter into a 15 month contract with the Salvation Army which included a budget only through June 30 and a provision to negotiate the final six-months budget by June 30 based upon availability of funds. Related levels of service included in the original contract would be re-defined accordingly.

The outpatient and aftercare programs including the drunk driving program, the information and education component through a subcontract with the Anchorage Council on Alcoholism, the Alpha Center and Long-Term Care were underway at the beginning of the contract period. Halfway house services were continued in the interim with Studio Club and later a transitional care facility was developed by the Salvation Army when a subcontract could not be satisfactorily negotiated.

The new system called for several major new components to be designed and established. Central Intake along with a related tracking system was begun immediately. A holding component was developed as state regulations were implemented and the facility was renovated. An Emergency Services Patrol was established in March following a long period of negotiating with the State for rules and guidelines required before State approval could be granted. Attachment #2 describes each of the components. attachment #1 reflects the most current statistics regarding the program.

Implementation Obstacles

It should be emphasized that Anchorage now has in place a complete, comprehensive program in spite of many obstacles, some of which were mammoth in size.

For instance, we had much less government money to use. The State grant was reduced by 4%; the Municipality's program received no NIAAA Public inebriate money, the Community and Regional Affairs Pipeline Impact money was eliminated. We balanced a higher budget reflecting increased costs by a combination of the following: elimination of higher overhead and duplication by dealing with a prime contractor instead of many groups; the infusion of $111,000 in cash and more value in-kind by the Salvation Army; and by using some of the local dollars that we had hoped to save for the final six months.

Another obstacle relates to the Woronzof facility which we expected would be available for use in the program. Its unavailability did not cost as much in dollars as it did in inconvenience. Fortunately, we were able to use space at 825 "L" Street which resulted in dual positive effects but we lost time in getting detoxification going. In a related area, the equipment held by former contractors took months of legal manuevers to obtain.

Another major obstacle related to the inability of the State to promulgate several regulations, some of which were required by law over three years ago. This delayed the holding facility, the Emergency Patrol and frustrated the total "approval" process. Developing a capacity to earn program revenues through Veteran's Administration, insurance, etc. has also been a long hard battle.

June 30 Status

By March, for the first time in the history of Anchorage, there was in place a complete, operational comprehensive alcoholism treatment program that we believe is beginning to prove its effectiveness, that meets our short range high priority of the public inebriate with some prevention/education, that we believe is capable of meeting all the State standards required by law and that can be the foundation for building alternative programs to meet more of Anchorage's serious alcohol abuse problems.

The program has been evaluated by the Department's evaluation team, by the Salvation Army and by Dr. Uwe Gunnerson, former Director of the Alcoholism Section of JCAH. The Department's early evaluation was completed in December and reflects many observations and recommendations, most of which have now been implemented. It is summarized as Attachment #3. The Salvation Army's evaluation was done recently and has not yet been received. Dr. Gunnerson's brief report is included as Attachment #4. We share Dr. Gunnerson's optimism and excitement.

Financial Reviews

Our contract provides for a review of funding and budgets following December 31, 1976 and June 30, 1977. We have met regularly with the contractor to review finances. When we looked at this year's first quarter closing figures it became obvious that we would be hard pressed to maintain the level of service, now a full program, unless more revenues were found.

A budget was developed for the final six months at the end of April in the form of an application to the State for grant-in-aid and Pipeline Impact funds for the period July 1, 1977 -- June 30, 1978. We requested that half be awarded through December 31 with the rest to be held for the next cycle.

It was our sincere belief that we would be able to demonstrate sufficient progress and management capability along with our documented need to generate a substantial increase in State support. In mid April, the State proclaimed that it would accept applications for no more than 5% above last year's award and they held fast! We challenged this but our application was returned and we had to re-submit. The final award was for the 5% increase and the same level of NIAAA Pipeline Impact dollars although we applied for double the amount. The final application was worked on until the last minutes and did not have prior Health Commission review so we agreed to not request Assembly approval until after Commission review, which we have done.

The State, in granting us the funds, required that we re-balance the budget and submit by June 30. We then met with the Salvation Army, completed final negotiations on the budget on June 30 and transmitted same immediately to Juneau. The adjustments in budget items and proposed revenues along with our rationale at the time are found in Attachment #4. In essence we revised the projected income figures downward and reduced $126,500 from the earlier budget submitted to Juneau. We have some anxiety with some of the final revenue figures. The results of the "cuts" are: require a 10% vacancy factor for personnel, reduce the subcontract with Anchorage Council by $12,500, close down Alpha Center on August 1 instead of September 1 and retain the Emergency Patrol at 16 hours instead of expanding to 24 hours. We also agreed to review and renegotiate if necessary on August 15 and finally on September 30.

It is important to note here that the move to balance the budget was required in the contract, represented fiscal accountability and was necessary in order to obtain the State grant. It is the only budget for which we have any fiscal responsibility or the Salvation Army has a level of service obligation. Attachment #5 describes the adjustments refelected in the budget balancing process along with our rationale at the time. It is "signed off" by both the Department and the Salvation Army on Page Six.

Subsequent to the negotiations required to balance the budget, the entire Comprehensive Alcoholism Treatment Program and its related application for State funds was reviewed by the Project Review Committee and the Health Commission itself. (Attachment #6.)

The Commission approved the concept of the Comprehensive Alcoholism Treatment Program and recommended the acceptance of State funds contingent upon the Assembly's appropriation of additional funds necessary to refrain from reducing the present level of services and beyond that to support the basic budget originally proposed to operate the program at the level of service defined in the original Request for Proposal.

With the assistance of the Office of Management and Budget, it has been calculated that the amount needed to support the Commission's recommendation would be \$287,610. (Their \$260,000 + \$27,000 to increase the Patrol to 24 hours.) Attachment #7 describes the costs per component and shifting some programs.

The Department and the Salvation Army have again re-evaluated the entire project and have jointly concluded that over \$100,000 of that amount could be reduced from the budget total without destroying the basic goals of the project.

The following items, therefore, reflect the highest priorities of items which should be restored if additional funds are available.

1.	Restore Anchorage Council on Alcoholism Contract to \$21,000.	\$ 8,500
2.	Reduce Vacancy Factor from 10% to 3% and eliminate \$11,000 in administrative positions.	35,000
3.	Eliminate \$40,000 from projected revenues	40,000
4.	Restore Training and Vacation accrual account	39,270
5.	Continue Alpha Center from August 1 - December 31 at 16 hours.	55,000
		\$177,770

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COMPREHENSIVE ALCOHOLISM

TREATMENT PROGRAM

PRESENTATION TO THE MUNICIPAL ASSEMBLY

SEPTEMBER 14, 1976

Mr. Chairman and members of the Assembly, I believe that we in Anchorage are on the threshold of one of the most exciting times in the history of providing alcoholism services in this community. Over the years, a lot of good people and organizations in difficult situations and with very limited resources have accomplished many good things. Alcoholism is Anchorage's number one health and social service problem. You have by your past action indicated a policy direction to respond to that problem. We believe that the following proposal reflects that policy.

We are here before you today to outline a war plan for the immediate future. We are here specifically to seek your continued concept approval for the overall direction that we believe you want to go; to seek your specific approval to submit the proposal we are about to describe to the State Office of Alcoholism for their concurrence, approval and funding; to seek the Assembly's approval to accept the expected state award and to contract with the Salvation Army for the provision of these services.

This presentation is designed to take less than 45 minutes and to be used in conjunction with the tables and charts which have been distributed. (Because of the complexity of the topic we are discussing, it is necessary that we raise certain questions in your minds during part of the presentation fully intending to answer as many of them as possible during later parts. It would be appreciated if we could go through the entire presentation and then respond to questions). We intend to bring you up-to-date by way of review on what has happened in recent years; to review the reasons why it has been necessary for us to fall back and regroup at this time; to share with you a general idea of the overall plan for a comprehensive alcoholism treatment program for Anchorage; to discuss the specific plan that we have as part one for the immediate

future, to share with you the proposal of the Salvation Army as it fits into that plan and to speak for just a few minutes about tne immediate future and the steps of implementation.

It was less than a decade ago that alcoholism was considered more of a crime than a disease and it has been only in recent years that government and the public have attempted to respond to this terrible disease with treatment instead of with penalty. During the past few years, there has been developed in this state a grant-in-aid program for providing dollar assistance to municipalities and programs around the state to assist in funding their local alcoholism programs. A good deal of money has been made available in recent years. Some of it has been spent well and some of it not so well. Table No. 1 shows that in fiscal year 1976, the state provided $943,900 and local government $346,600. In the year that we are now in, the state has set aside $796,500 and the Municipality has available, if we annualize the six-month figure in the transitional budget, $371,400. On the one hand, that is a lot of money. On the other hand, there is a tremendous amount of need yet to be met. Table No. 2 describes the recent history of the state grant-in-aid program to the Municipality for alcoholism programs. You will note that the total funds available for distribution statewide have increased over last year by 12.8% to a little over two million dollars. At the same time, the funds to be distributed to the Municipality from this source have been reduced by 4% from $713,000 to $687,000. Additionally, the state has an increase in available NIAAA pipeline impact funds of some $164,400. To date---- Anchorage has been advised that it will receive the same $109,500 as last year although the possibility exists that $60,000 more may be available.

Table No. 3 speaks to the total amount of funds available to the Municipality for the current year and compares them to last year. You will note in this table that in addition to a reduction in state grant-in-aid dollars set aside, that we no longer will be receiving the Community and Regional Affairs Pipeline Impact monies which accounted for $121,400 just last year.

A couple of conclusions ought to be made from the figures reflected in these tables. Number one, Anchorage is not getting as much of the share of the state pie as it was in the past and one of the reasons for this, I firmly believe, is that we just haven't done a good enough job with what we had. Second, of course, is the unavailability of state pipeline impact money although some of feel very strongly that the pipeline impact has continued even though the funding has ceased.

Table No. 4 will give you some kind of an idea of how the monies were expended last year from the serveral sources. Up until this past year, the state received applications directly from the programs, analyzed, reviewed, made its recommendations and allocations, and then made the money available through the Municipality for the program's use. This year there has been a change in that procedure. The Municipality is being looked to as the overall coordinator of the programs in the area and as such would submit a comprehensive program to the state and then the state would fund that program through the Municipality. In addition to the monies listed in Table No. 4 for the state funding, the Municipality provided direct services through its own personnel for outpatient treatment, the drunk driving program and administration. Chart A illustrates what services were provided last year, by whom, and how they have been or have not been inter-related.

Legislature and the State Office of Alcoholism and the desire of the Municipality to further develop this philosophy of local decision making and local control with the state providing the basic resources under certain parameter and local government making the specific decision of how those monies would be spent.

To this end and by way of another historical piece, there was a lot of work done by a lot of people including the mayor's Alcoholism Advisory Group along with our own staff who developed in cooperation with the state an extensive plan for the delivery of a comprehensive alocholism treatment program for the Anchorage area. This plan has been approved by the state and endorsed locally. Chart B describes that plan. In that plan, there are several program elements which have never been provided in the Anchorage area. We have not had a central intake component. We have not had a tracking system, We have not had an emergency service patrol. We have not had a holding facility. We have not had an effective long term care program.

Table No. 5 is a compilation of the dollar figures which were developed and proposed in the plan to the state to reflect the costs of implementing the comprehensive alcoholism treatment program for Anchorage. Budgets reflecting these figures were proposed through both the state and the local funding mechanisms. You will note that of the $1,192,000 requested of the state, only $796,500 has been set aside. Likewise on the local level, of the $665,700 hoped for, only $371,400 was budgeted. The obvious total expected funding of $1,857,000 was short by almost $700,000.

Now by reviewing the tables that you have seen, some preliminary conclusive judgments can be made. Number one, for the twelve-month state fiscal year that we are now in, we face a reduction of state dollars both in grant-in-aid and in pipeline impact monies at a time when we are recognizing a 15% increase in personnel costs among the programs that have been funded. Second, that in order to develop a comprehensive program for Anchorage, there are a number of components which need to be established which obviously means that we are going to have to redistribute the available resources if we are going to be able to accomplish anytning profound. Third, while there was a time in the past when the local government provided a little bit more than half of the total government dollars, there has been a reluctance to make local dollars available in spite of the seriousness of the alcoholism problem in our area.

The logical question for us to ask is why has this happned? What has caused us to fall back and regroup? There are three or four obvious reasons and a few more subtle. Last fall the State Office of Alcoholism did an evaluation on the programs in the Anchorage area, a copy out of that evaluation came the conclusion that our system was failing, that some dollars were not being well spent and that we were in danger of losing our accreditation if we did not take those necessary steps to develop the comprehensive program that was required and needed. I am advised by the State that the evaluation also contributed substantially to the reduction of state funding for the overall program and is further evidenced by the reluctance of the state to allow any state dollars to be spent presently for certain existing local programs.

A second major factor was the evaluation done by the Joint Commission on Accreditation of Hospitals which was done late in March of this year. The official notification of nonaccreditation was received on August 5th. However, the exit interview in March advised the Municipality that we were about to lose our accreditation and many reasons for that were provided in the preliminary evaluation report. While losing accreditation may not be the worst thing in the world, it certainly points out very clearly that we were not moving in the right direction in improving the management quality of our programs and developing the comprehensiveness and coordination which is both required and beneficial.

Our third reason for falling back and regrouping has already been spoken to in the recognition that there are less dollars available with which to work and we must, therefore, reassess how those dollars are spent. Another consideration has been that evidenced by the local Chamber of Commerce and the special committees which were established to look into the public inebriate problem and their continued demonstration of and interest in helping us solve that part of the alcoholism problem. Just yesterday, Bob Hartig, the Chamber's new President told me that Alcoholism was his number one priority. Another factor was the reaction of the statutorily created Board of Health which early in the budget cycle last spring made the recommendation that 30% of the local funding for the alcoholism program be cut out with the net effect being a reduction of the entire program since the local share is used in the match to get the 75% state funds. Still another, was the concern expressed by the mayor's advisory group on alcoholism who during the budget sessions on May 18th presented a resolution which spoke to either fully fund the comprehensive program with substantial additional local dollars, contract with a new non-profit group in a comprehensive way or have the monies put into a contingency fund until a whole new plan could be developed.

Finally, the Assembly by its action of May 20th made it very clear to me that we were given the mandate to reestablish our priorities and develop a comprehensive program which is both efficient and effective.

One of the proposals that seemed to make sense was the concept that the agencies providing the services under contract would get together and form a new corporation and submit a jointly prepared proposal. Many meetings were held with advisory boards and staff and some progress was made in this direction.

Let me add, at this point, that the department does not claim infallibility. We have made mistakes, lots of them. We have been accused of not giving technical assistance at certain times, of not getting additional resources, of getting too involved at some times and not getting involved enough at others.

Of course, we have erred but we have learned a lot from those mistakes. But somehow, I have to reject the notion that just because we made some mistakes or changed our mind when circumstances changed that we ought to continue doing a poor job of meeting a critical need.

Through a series of meetings between the Department, the Board of Health and the Alcholism Advisory Group it became obvious that there was common ground in developing a priority for the immediate short range future, specifically, the public inebriate. There were three main reasons for making this determination Number one, the public inebriate is a human being, a person for whom no comprehensive program has effectively been developed in the past but who instead has been more a part of a

revolving door program. Second, while the public inebriate is recognized as the tip of the iceberg, he is also that tip of the tip of the iceberg for whom public funds ought to be expended. Third, more of a practical political reality, we realize that if we did not make some dent in the public inebriate problem or the Fourth Avenue problem, then our ability to obtain resources for the other important alcoholism problems would not be there. The Grand Jury report just released speaks to this issue. In addition to this problem the public inebriate, it was recognized that we must always spend some of our resource for prevention and education.

In the above context, it became obvious that the way that we were spending our monies had to change. That if we were to have a short range high priority of the public inebriate in the framework of a comprehensive program which required us to establish additional new components that we could not continue to fund programs at the same level or necessarily in the same manner. With this in mind, in early June we advised those organizations with whom we had contracts that they had no assurance for continued funding beyond June 30th. We made the decision that the outpatient program we were providing directly was of a lower priority and established a schedule to phase it out as a direct service and include it in the contract.

We parted from our past practice of just negotiating with existing providers and went out with a public "request for proposal" through the Purchasing Department which was advertised in the newspaper. We received a number of proposals which we had evaluated through four different mechanisms and came to the conclusion that none were sufficiently responsive to the request so we recommended that this body reject

all of the proposals. During the interim period, with this body's concurrence and direction we have been funding the basic programs of detoxification/treatment, half-way house and walk-in center on a month-to-month basis. We then upgraded the request for proposal and went back out for new publication and received four proposals. Those were given an intensive evaluation in the same four mechanisms as the first group and the unanimous recommendation was that the proposal submitted by the Salvation Army was the best. We immediately entered into negotiations with the Salvation Army in an attempt to develop a proposal which would be both acceptable and approvable by both local and state entities.

We have gone just about as far as we can in finalizing those negotiations and would like to present at this time a summary of that proposal.

<u>Contractor</u>

The proposed contractor is the Salvation Army, Alaska Division. The Army has been providing humane services in Alaska since 1898 when Evageline Booth first arrived at Skagway. They are incorporated in four major headquarters of the United States, with the Western Region incorporated in the state of California. They are licensed to do business in the State of Alaska.

Over the years, the Salvation Army has performed numerous services to the Alaska puolic through contracts with local, state and federal governments in such areas as Day Care, Nutrition, Aging, Corrections, Vocational Rehabilitation and Alcoholism. They have met <u>all of</u> the provisions required by government in carrying out a contract relationship.

The Salvation Army has been active in Anchorage since 1941 and has built a fine reputation for effectively and efficiently providing services often under difficult circumstances. They have an enviable Social Service program and considerable <u>real assets</u> to bring to such a contract relationship.

In the specific area of alcoholism rehabilitation, the Salvation Army has been providing varying groups and types of services (with public and private funds) all over the United States including similar Comprehensive Alcoholism programs in about 150 communities including Honolulu, Denver, and Chicago. The Director of their Honolulu Comprehensive Alcoholism program spent a week here in Anchorage assisting them in the development of their proposal. That program is the only two-year accredited comprehensive alcoholism program recognized by the JCAH.

They are including in their proposal their reputation and credibility, their experience in rehabilitation and social services, their dedication to the people being served as well as a belief that they can accomplish something. Beyond that, the Salvation Army will be contributing a substantial amount of dollars, $111,000 in cash, their building at 8th and "C" Streets and their reputation for stretching the dollar as far as possible. Additionally, they will be involving their other assets such as vehicles, furnishings, etc. in different ways.

Their corporate headquarters are in Los Angeles but they do have and use effectively a local advisory board for the Anchorage programs and a specific advisory council for this program. We feel comfortable in dealing with this entity and have reason to believe that they can accomplish what they set out to do and would be the last to mismanage a program or walk out on a failing project leaving the Municipality to pick up the pieces or pay the bill.

Proposal

The Salvation Army proposes to provide the basic elements of Comprehensive Alcoholism Treatment Program for the Municipality.

Chart "C" describes the program as proposed. You will note that all of the components which we indicated earlier as comprising our plan for Anchorage are included.

Let me just outline briefly the plan.

1. An Emergency Services Unit which, when fully implemented, will include an Emergency Services Patrol or Community Patrol, a Holding Facility and an initial client contract point which they call "Alpha Center". The Community Patrol will function as a facilitator for entry of patients into a total care program. Controlling force will be used only in clearly identifiable life threatening situations. The patrol will work cooperatively with the Anchorage Police and the Emergency Medical Service of the Fire Department.

The Holding Facility will be a secured room specifically furnished to enable inebriated individuals to remain in the facility while they are considered a threat to themselves or others.

The Alpha Center will function as a collection and pick-up point for inebriated individuals wishing to be transported to detoxification and as a community outreach station enabling motivational counseling to occur at street level as opposed to providing welfare services.

Eventually, the program will develop to a point where existing state legislation regarding the public inebriate can be tested. The law, though never used in Anchorage, allows for a public inebriate to be picked up by a peace officer or a member of an approved Emergency Service Patrol, taken to his home or an approved medical or alcoholism treatment facility and held for a period not to exceed 48 hours or until no longer incapacitated. During that period and under certain circumstances, a court order can be obtained to hold the person for evaluation and treatment for five days and then for 30 day increments. The State is developing regulations for facilities and emergency patrols.

The use of such a tool or just the knowledge that it exists and can be used, will go a long way in eliminating the revolving door situation we have so much of at present.

2. The Detoxification Unit which will have available medical consultation, will be supervised by a Nurse Practitioner or Physician's Assistant and will have a registered Nurse on duty 24 hours a day, seven days. This unit will provide evaluation and supervision of individuals referred for non-hospital care for intoxification or withdrawal in an emphethetic environment with careful observation and supportive care. Daily monitoring and evaluation of the client's progress will be done jointly with both medical and clinical staff to assist the client on a daily basis to confront his life situation realistically and to develop a creative plan for immediate needs. Appropriate evaluation and referrals for other institutional, psychiatric or social services observed will be accomplished.

3. The Residential Services Unit will include four major functions:

(a) Short term treatment is designed for persons who need less than 40 days of residential care or who are unable or unwilling to undertake therapy in a long-term residential treatment center. It is a highly structured model with heavy emphasis on family and employment counseling and is designed primarily for persons who have available an intact family and/or community support system and who are willing to be involved in the treatment process. Included in this component is the evaluation which provides an on-going standard of self evaluation, therapist's appraisal and psychometrics to be collected throughout the entire program.

(b) Long term or extended care--designed for people needing over 40 days in a residential setting.

(c) Transitional care or halfway house services will be provided by preferably sub-contract with existing agencies such as the Studio Club or Phoenix House. Traditional halfway house services are defined as a community based facility with a peer group operation in a supportive non-drinking environment. The Salvation Army has established paramata for sub-contract compliance.

(d) Intake and Case Management includes the gathering of pertinent data, the initiation of a personal comprehensive treatment plan, the coordination of all treatment services on behalf of any client, monitoring and control for the entire case load.

4. After Care & Out-Patient Services will focus on three different client groups: persons completing treatment in any or all of the residential program components and who need continued assistance, support or treatment; out-patient services for those still able to fucntion in the community setting but who have identified themselves as having an addiction problem which they wish to alter and for whom the service is deemed appropriate; and court referrals or placements as a result of convictions involving alcohol and motor vehicles.

5. The Community Education Program will focus on raising the awareness of the general public on the causes, symptoms, typical progress and treatability of alcoholism. Much effort will be focused in the schools. This component will also seek to assist in the development and expansion of industrial alcoholism programs. These services will be provided through a subcontract with the Anchorage Council on Alcoholism.

6. The Administrative Unit will provide appropriate comprehensive, fiscal and program control and accountability systems. Existing models will be refined for this specific program. Additionally, the evaluation component will be established to monitor the effectiveness of all program components.

The Department will be the basic evaluation mechanism and provide on-going technical assistance and coordination with other alcoholism efforts within the state as well as develop additional opportunities and resources.

Budget and Control

The total budget for the nine-month period beginning October 1, for the Salvation Army program amounts to $1,129,771. Funds to support that come from the following sources:

A.	Salvation Army - - Cash - -	$111,150
B.	Third Party Payments - -	152,767
C.	Municipality of Anchorage - -	65,000
D.	State - - Grant-In-Aid - -	523,974
E.	State - - NIAAA - - (Pipeline Impact) --	169,100
F.	NIAAA - - Public Inebriate - - To be applied for	107,780

Additionally, the Salvation Army will be providing in-kind contributions such as their facility, rent free at 8th and "C", six vehicles, auxillary staff, etc., estimated to exceed $200,000 in kind.

Assuming that we are successful in being awarded the anticipated known state and federal dollars through June of 1977, then the only amount which would be included as "subject to appropriation" would be the $62,500 from the Municipality for the January 1 - - June 30, 1977 period. Currently included in the Department's proposed budget.

We requested proposals for the 15 month period beginning October 1, 1976 and would enter into a contract for that period with special provisions relating to availability of funds to be appropriated at a later date and for budget review and changes as appropriate before December 31, 1976 and July 1, 1977.

The Department has developed a new contract for use with all of its contractors. It responds to the many concerns which have been expressed in recent years especially in accountability and evaluation. The Salvation Army has agreed to the terms and conditions of that contract.

Facilities

The Salvation Army has indicated its willingness to provide its building at 8th and "C" for the project with free rent.

The present plan would provide, at that facility, residential rehabilitation for thirty men and eight women, appropriate lounges, recreation area and group treatment space, the Alpha Center, kitchen, dining room, chapel and some office space.

The third floor of the Old Community Hospital would house detoxification for 26-30 patients, short-term treatment for 18-20, the holding facility and appropriate lounges, recreation and therapy space.

The intake unit, case management section, facilities management, fiscal services and records and support services would be located in the Hospital basement.

Originally, the Salvation Army proposed using the Point Woronzof facility now leased by AATC. The Department and the Army were led to believe that the facility would be available for the community's public program. As it turns out, many of our negative concerns about the location of the Woronzof facility some 15 miles from the high priority public inebriate problem have been alleviated.

The Salvation Army and the Administration have been negotiating with the Community Hospital for space when they move to their new hospital next month. Consideration of the third floor for detoxification has been discussed for over a year and a half.

In the event that the hospital should not be available for some reason, the Salvation Army has explored several alternatives and has a contingency plan.

Time Schedule

There is unanimous concern shared by almost all involved in the alcoholism program concerning the time crunch. It is easy to accept the logical conclusion that we did the right thing in stopping what was recognized as a failing system; it makes sense to agree that we had to fall back and re-group in light of all that has occurred if we really mean to do a good job and stop spinning our wheels and wasting much of our resource. But at the same time, we are concerned because there are people who desperately need these services.

Following the instructions of this body, we deferred presenting the Municipality's amended application for state funds and this specific proposal until approved by the body. We have requested that the State Alcoholism Advisory Board reconvene September 20, next Monday, to hear our proposal. They have agreed that and if all is approvable before this body and the State, we can have a grant award next week and be into a contract before October 1.

The Salvation Army would then begin several services on October 1 including long-term care, transitional care, administration, fiscal, etc. By October 15, the Alpha Center, Emergency Services Patrol, Detoxification, Holding, Short-term Care and Community Education and Information would be off the ground. The remaining elements of Case Management and Central Intake would be operative by November 1st.

We would propose to continue the interim detoxification program with AATC until the Salvation Army is ready.

Summary

By way of summary, the Department has responded to the mandate of the Assembly and the specific concerns of the State Office of Alcoholism, the JCAH, the Municipality's Alcoholism Advisory Group, the State's Alcoholism Advisory Group, the Board of Health, the Chamber of Commerce, the public and most especially to its own charge to get services to people.

We have recognized that there is less resource with which to work, that there are elements of a CATP which need to be instituted for anything profound to occur, that the public inebriate would be the short range high priority, that we would have public education and prevention, that we would propose to do only that which we believe we can accomplish effectively and efficiently, and that we will have a system which is accountable and which can be effectively evaluated.

We realize that the proposal which we have submitted will not please everyone, expecially some who have been providing services for a long period under difficult times and with limited resources -- and to them we owe a debt of gratitude but we rest assured that the failure of our system demanded a redistribution of the resources, a sound overall plan, a clearly identified objective and a committment to get on with the business of working together to make the plan work and to obtain sober drunks.

ANCHORAGE DEPARTMENT

OF

HEALTH AND ENVIRONMENTAL PROTECTION

TABLE #1

HISTORY OF AVAILABLE FUNDS

FOR

LOCAL ALCOHOLISM PROGRAMS

YEAR	LOCAL $	%	xSTATE $	%	TOTAL
7-1-75 - 6-30-76	346,600	26.9	943,900	73.1	1,290,500
7-1-76 - 6-30-77	*371,400	31.8	796,500	68.2	1,167.900

* - Annualized (7-1-76 - 12-31-76 x 2)

x - Includes NIAAA and State Community and Regional Affairs Pipeline Impact Grants

OBSERVATION: Total Dollars Available Reduced By $122,600 9.4%

TABLE #2

HISTORY OF STATE GRANTS

TO MUNICIPALITY OF

ANCHORAGE

	1976 APPROPRIATION	1976 AVAILABLE ANCHORAGE	1976 %	1977 STATE APPROPRIATION	1977 AVAILABLE TO ANCHORAGE	1977 %
STATE GRANT	1,822,400	713,000	39.1	2,056,000	687,000	33.4
NIAAA PIPE-LINE IMPACT	347,600	109,500	31.5	531,000	[1]109,500	20.6
	2,170,000	822,500	37.9	2,587,000	796,500	30.8

OBSERVATIONS:

State Grant to Municipality reduced by $26,000 - 4%

Total State Grant Appropriation Increased by $233,600 - 12.8%

Total State Funds Increased by $417,000 - 19.2%

[1] - Possibility exists that additional $59,600 might be available to Municipality from this source.

ANCHORAGE DEPARTMENT

OF

HEALTH AND ENVIRONMENTAL PROTECTION

TABLE #3

FUNDS AVAILABLE TO MUNICIPALITY

FOR ALCOHOLISM PROGRAMS

	AVAILABLE 7-1-75 - 6-30-76	PROPOSED 7-1-76 - 6-30-77
STATE GRANT	713,000	687,000
STATE NIAAA - Pipeline Impact	109,500	109,500
STATE - CRA - Pipeline Impact	121,400	-0-
	943,900	796,500
Local Appropriated	346,600	*371,400
	1,290,500	1,167,900

* Annualized

Observations:

State Grant-In-Aid Reduced 4% by $26,000

State CRA Pipeline Impact Elimated $121,400

ANCHORAGE DEPARTMENT

OF

HEALTH AND ENVIRONMENTAL PROTECTION

TABLE #4

STATE ALCOHOLISM FUNDS USED
7-1-75 - 6-30-76

	STATE GRANT-IN-AID	STATE NIAAA - PI	STATE CRA - PI	TOTAL
ALASKA ALCOHOL TREATMENT CENTER	343,400	60,000	59,000	462,400
CME WALK IN CENTER	147,600	35,100	9,400	192,100
STUDIO CLUB	72,300	-0-	11,100	83,400
ALASKA COUNCIL ON ALCOHOLISM	61,200	-0-	5,000	66,200
SALVATION ARMY	20,000	-0-	-0-	20,000
TAHETA HOUSE	33,000	-0-	-0-	33,000
HEALTH DEPARTMENT	25,700	-0-	37,000	62,700
USED	703,200	95,100	121,500	919,800
ALLOCATED	713,000	109,500	*121,400	*943,900

NOTE * Figures Rounded

ANCHORAGE DEPARTMENT

OF

HEALTH AND ENVIRONMENTAL PROTECTION

TABLE #5

ORIGINAL PROPOSED PLAN TO FUND THE COMPREHENSIVE ALCOHOLISM TREATMENT PLAN FOR 12 MONTHS JULY 1, 1976 THROUGH JUNE 30, 1977

STATE RESOURCES		LOCAL RESOURCES	
ALASKA ALCOHOLISM TREATMENT CENTER	516,700	ALASKA COUNCIL ON ALCOHOLISM	24,400
SALVATION ARMY	131,700	CME - WALK IN CENTER	158,000
CENTRAL INTAKE	380,700	CENTRAL INTAKE	45,000
TAHETA HOUSE	74,700	STUDIO CLUB	66,900
MANAGEMENT	88,200	DEPT. BUDGET	371,400
	$1,192,000		$665,700
SET ASIDE	$ 796,500	BUDGETED	$371,400
SHORT	$ 395,500	SHORT	$294,300

TOTAL ESTIMATED COSTS	$1,857,700
TOTAL SET ASIDE OR BUDGETED	1,167,900
UNAVAILABLE FUNDS	$ 698,800

ANCHORAGE DEPARTMENT

OF

HEALTH AND ENVIRONMENTAL PROTECTION

TABLE #6

CURRENT FUNDING ANTICIPATED
FOR MUNICIPALITIES ALCOHOLISM PROGRAMS
7-1-76 - 12-31-76

FUNDS EXPECTED

STATE SET ASIDE:	$398,250
* LOCAL APPROPRIATION	210,710
TOTAL	$608,960

* Includes $25,000 By Emergency Ordinance of 8-24-76

OBLIGATED THROUGH 9-30-76

	JULY	AUGUST	SEPTEMBER	TOTAL
CME WALK-IN-CENTER	16,309	16,309	16,500	49,118
ALASKA ALCOHLISM TREAT-MENT CENTER	39,094	38,844	39,999	117,937
STUDIO CLUB	9,857	8,857	8,500	27,214
LOCAL EXPENDITURE	32,500	27,000	27,000	86,500
TOTALS	$97,760	$91,010	$91,999	$280,769

DISTRIBUTION OF ABOVE

	OBLIGATED	REMAINING
STATE FUNDS	150,804	247,446
LOCAL FUNDS	129,965	80,745
	$280,769	$328,191
Less Estimated Local Expense Through 12-21-76		61,500
Available for Contract Services 10-1-76 Through 12-31-76		$266,691

ANCHORAGE DEPARTMENT

of

HEALTH AND ENVIRONMENTAL PROTECTION

TABLE #7

ESTIMATED GOVERNMENT DOLLARS AVAILABLE FOR CONTRACTS
10-1-76 - 6-30-77

AVAILABLE FOR CONTRACTS 10-1-76 - 12-31-76		$266,691
January 1, 1977 THROUGH June 30, 1977		
STATE SET ASIDE	$398,250	
ESTIMATED LOCAL FUNDING (SAME LEVEL)	62,500	
TOTAL		$460,750
ESTIMATED TOTAL AVAILABLE 10-1-76 - 6-30-77		$727,441

NOTE:

OTHER POTENTIAL REVENUE NOT INCLUDED ABOVE:

1. Possible additional $59,600 NIAAA PIPELINE IMPACT MONIES NOT YET ALLOCATED.

2. Possible Transfer of NIAAA Public Inebriate Staffing Grant of $107,750 Now Awarded to ALASKA ALCOHOLISM TREATMENT CENTER.

3. Possible refunds from existing Contractors for Government Dollars not Expended.

"A"

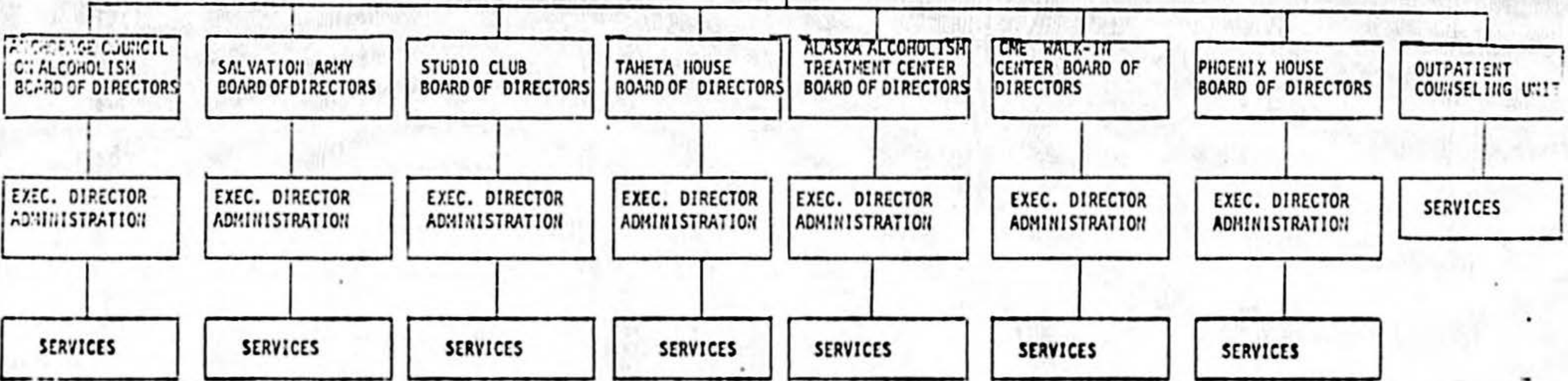
ANCHORAGE SEMBLY

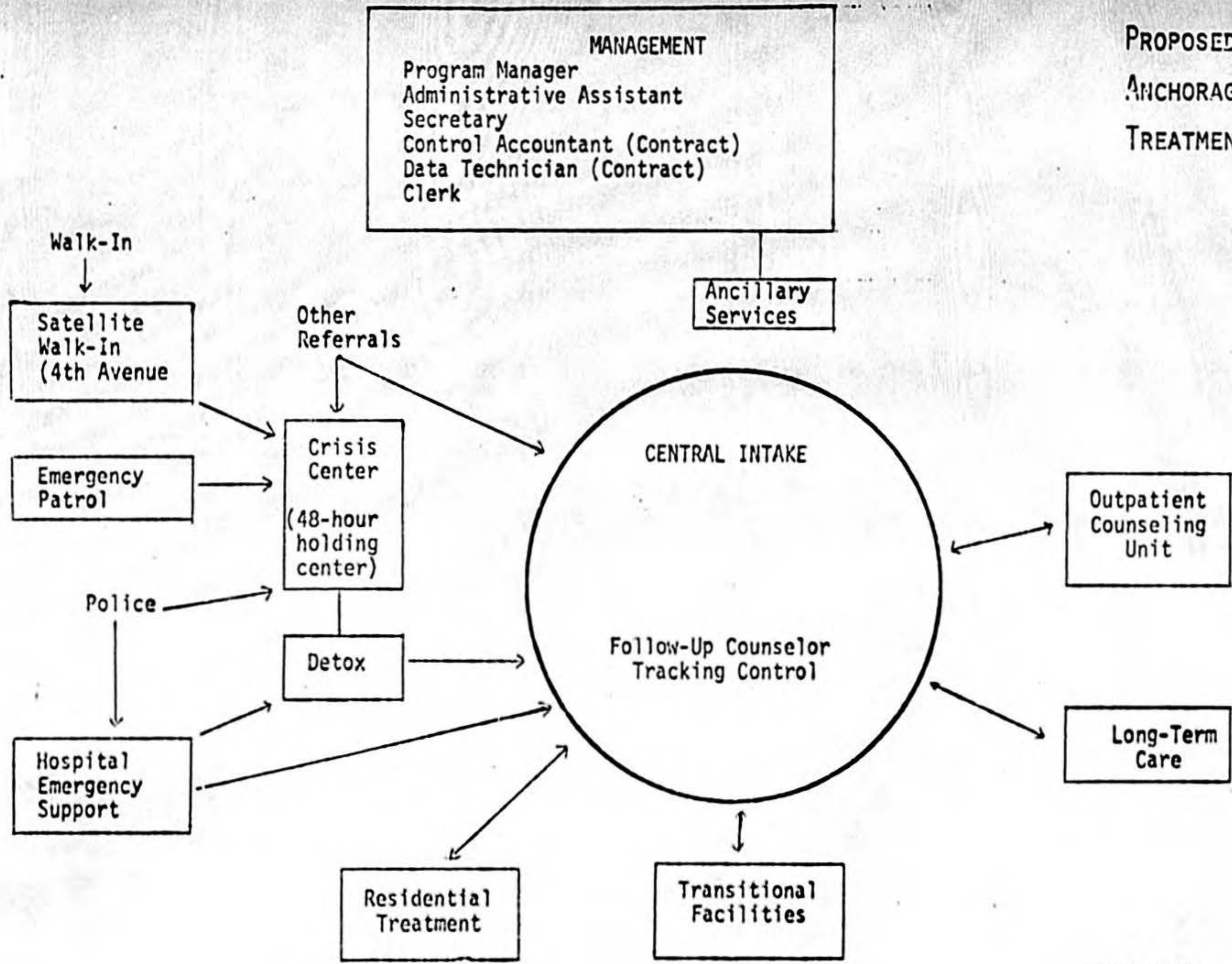
MAYOR OF ANCHORAGE

HEALTH AND ENVIRONMENTAL PROTECTION DEPARTMENT

BEHAVIORAL HEALTH DIVISION

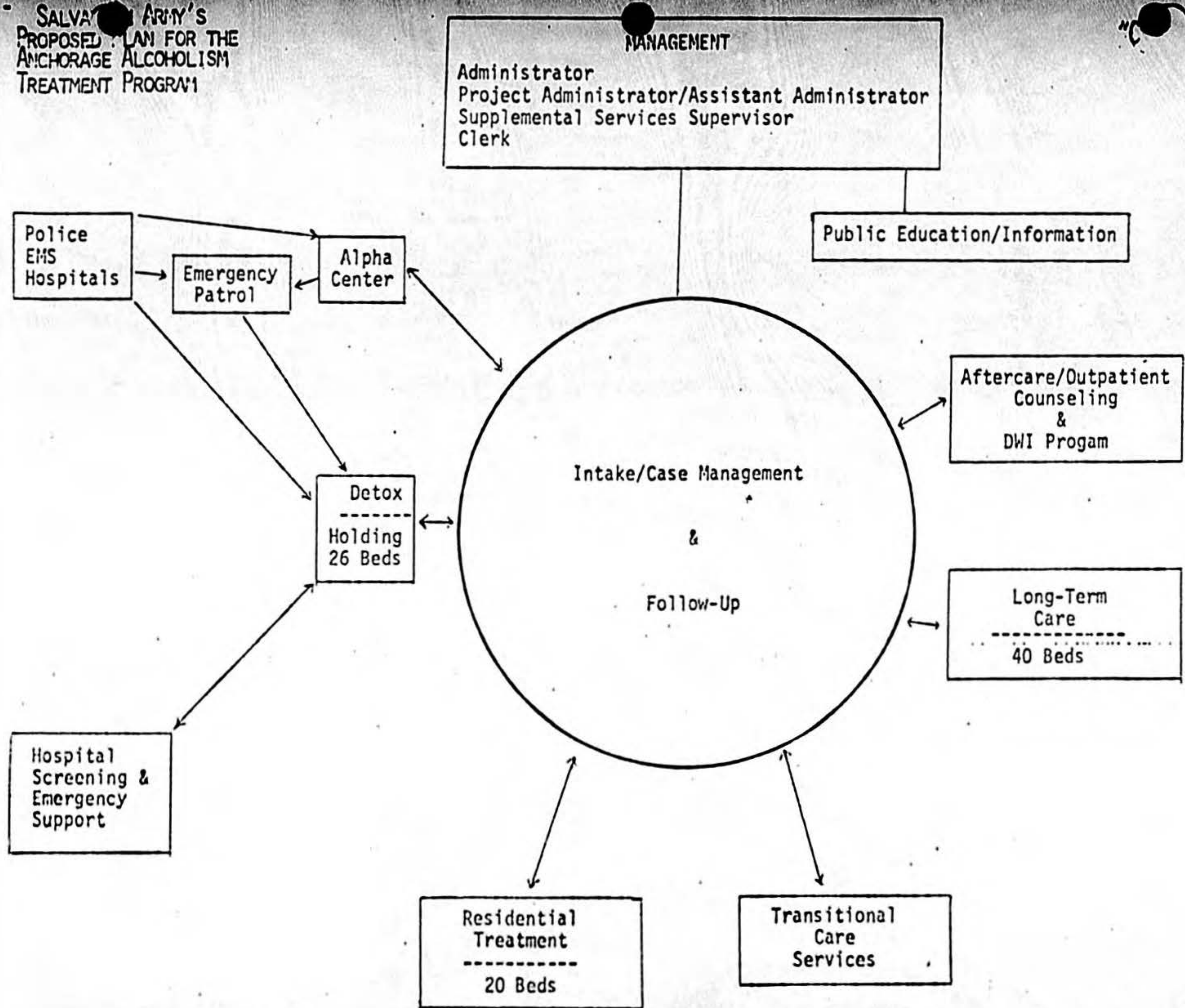
ALCOHOLISM PROGRAM MANAGER





PROPOSED PLAN FOR THE ANCHORAGE ALCOHOLISM TREATMENT PROGRAM

CHART "B"


SALVA ARMY'S
PROPOSED LAN FOR THE
ANCHORAGE ALCOHOLISM
TREATMENT PROGRAM
MANAGEMENT
Administrator
Project Administrator/Assistant Administrator
Supplemental Services Supervisor
Clerk
Public Education/Information
Police
EMS
Hospitals
Emergency Patrol
Alpha Center
Detox
Holding 26 Beds
Intake/Case Management
&
Follow-Up
Aftercare/Outpatient Counseling & DWI Progam
Long-Term Care
40 Beds
Hospital Screening & Emergency Support
Residential Treatment
20 Beds
Transitional Care Services

The Comprehensive Alcoholism Treatment System (CATS): The Comprehensive Alcoholism Treatment System has been developed over a five year period and is based on the experience gained during the community's attempt to treat alcoholism and alcohol abuse. The CATS has been designed to meet the standards set forth by the Joint Commission on Accreditation of Hospitals (JCAH). The CATS as designed has eight system components which can be graphically described as an umbrella as depicted in Figure 1, (see page # 6) as shown in Figure 1, the system components fall into four major groupings or interrelated service functions. The chart Figure 2 (see page #7) indicates normal patient/clients flow through the system.

Administration/Supportive/Services: This component is required by the Joint Commission on Accreditation of Hospitals and includes throughout the CATS the following functions: Governing Authority, Patients' Rights, Planning, Fiscal Management, Environment, Personnel, Evaluation, Patients' Records, Medication Control, Referrals, Dietetic Services and Research.

Information and Referral: This component embodies parts of two (2) of the Joint Commission on Accreditation of Hospitals service components. The two/JCAH components are 1) Outreach component designed to facilitate identification (within a target population) of persons and their families who have problems related to the use or abuse of alcohol, to facilitate procurement of alcoholism services, and to alert all public and private human service agencies who serve the same target population to the importance of early identification and easy access to the service delivery system. 2) Education service designed to convey on a regular and planned basis a philosophy that increases community understanding of the nature of the use and abuse of alcohol, its treatment and prevention, and the human and legal rights of the population at risk, as well as to inform the public of existing alcoholism resources and to gain public support for the development of additional resources.

Neither of these service components are required but, the Education service is strongly recommended.

Community Services Patrol: This component provides the twenty-four hour transportation support service as required by JCAH in the Emergency Care service component and provides direct outreach to the identified target population of 2,000 public inebriants in the downtwon area. The Community Services Patrol provides transportation/outreach to inebriant individuals either to their homes or to an approved/appropriate community facility.

Screening/Shelter/Protection-Detoxification: This component is not required by JCAH but, is composed of two (2) of the portions of Emergency Care and Inpatient Care. The Screening/Shelter/Protection program is a walk-in or receiving station for inebriated individuals who do not have homes or do not want to use other available resources. Screening involves an interview by a counselor to assess the possible readiness of the client to enter any other component of the CATS. Shelter means a place out of the weather and out of a bar away from alcohol. Protection refers to the safety of that shelter, so a person can relax or sleep without worrying about robbery or assualt. Individuals enter this facility either under their own power as walk-ins or they are transported to the facility by the Community Services Patrol.

The Detoxification program provides medical intervention that is designed to assist and support an individual through the process of removing alcohol from his/her system. In the Detoxification program an individual receives a full medical/social/psychological evaluation and a treatment plan is developed.

Short Term Care: This component is not required by JCAH but inbodies functions of the Intermediate Care service component. Short Term Care is an intense theraputic environment where a client receives counseling and other rehabilitative services.

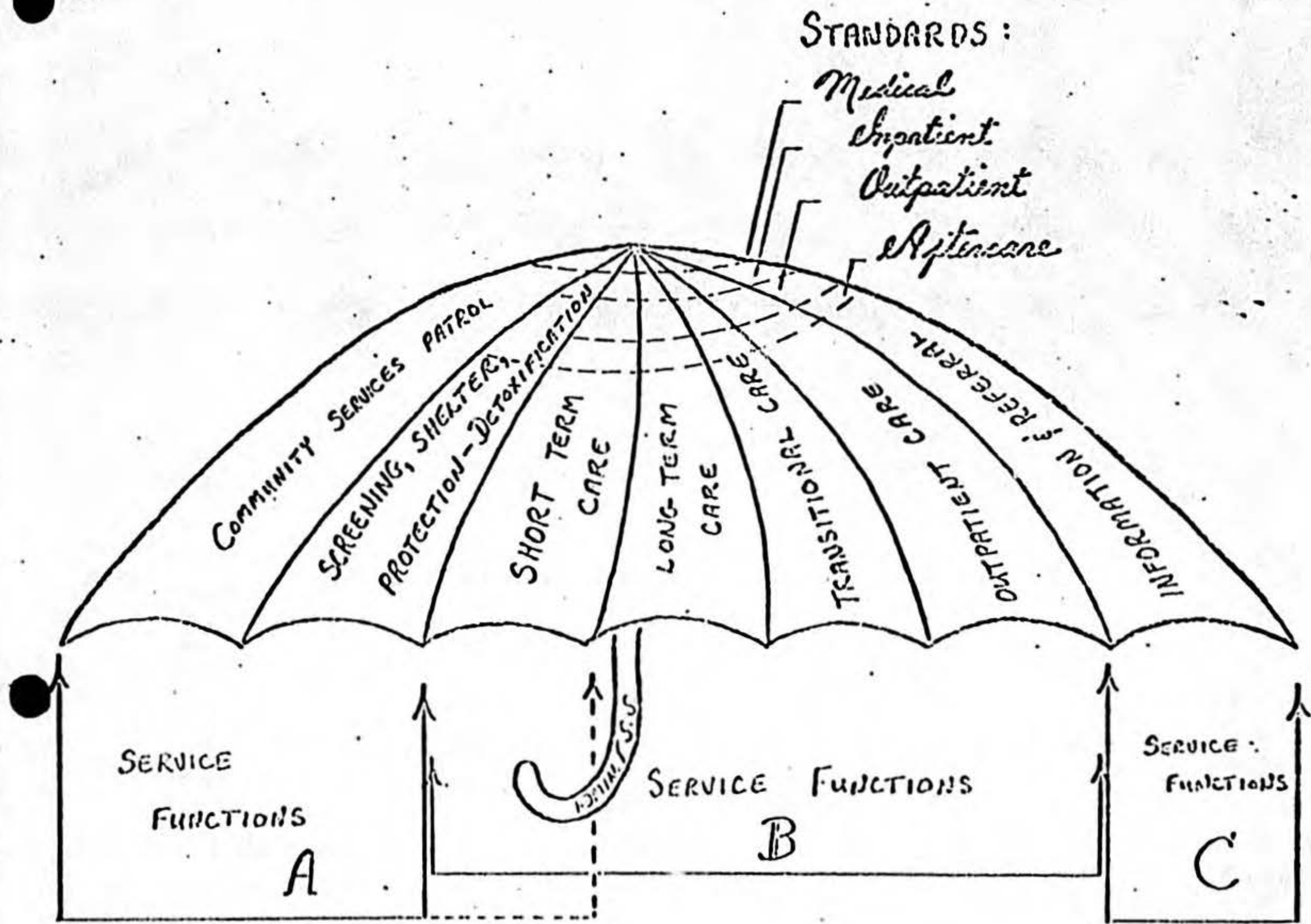
The program is residential and designed as a 30-45 day treatment program with a 16 bed capacity.

Long Term Care: This component is not required by JCAH but inbodies functions of the Intermediate Care service component. Long Term Care is of low to medium intensity providing counseling, vocational/work and other rehabilitative services. The residential facility has 45 beds and is designed for a 90 day minimum stay.

Transitional Care: This component is not required by JCAH. Transitional Care is the final component designed to meet all services recommended by JCAH as Intermediate Care service component. Transitional Care is a supervised living experience designed to support individuals in their return to full function. The facility has 14 beds and the program is designed for a 90 day minimum stay.

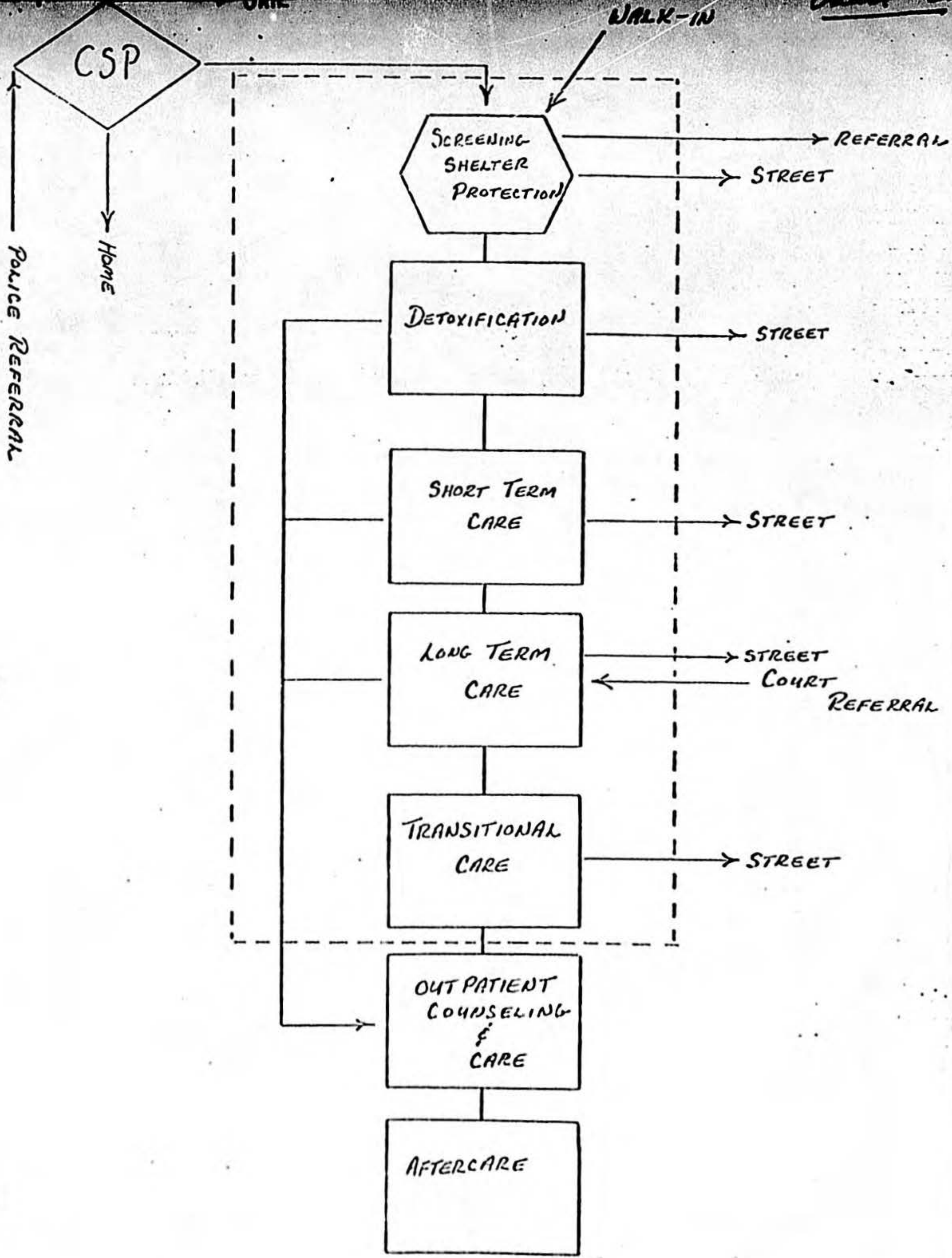
Outpatient Care: This component inbodies all the required functions of the After Care service unit that is required by JCAH. The outpatient section provides counseling and diagnosis for the individual and family that are affected by alcohol abuse. The counseling services include individual, family and group sessions. After Care provides care to patients who have progressed sufficiently through emergency, inpatient, intermediate and/or outpatient services to a point in their recovery where they will benefit from a level of continued contact which will support and increase the gains made to date in the treatment process. The central intake process occurrs in the outpatient component and consists of central record keeping and management, diagnosis, referral to the proper treatment component, and case review. Follow-up function is part of the Outpatient Care component and consists of statistically valid 6-12 month tracking and follow-up of a client after he leaves the CATS. The Drivers' Alcohol Information School is a series of classes for those who have been arrested for and convicted of Operating Motor Vehicle while intoxicated and are usually court referred.

Chart #1



A Comprehensive Approach to

Alcoholism


CSP
WALK-IN
POLICE REFERRAL
HOME
SCREENING SHELTER PROTECTION
REFERRAL
STREET
DETOXIFICATION
STREET
SHORT TERM CARE
STREET
LONG TERM CARE
STREET
COURT REFERRAL
TRANSITIONAL CARE
STREET
OUT PATIENT COUNSELING & CARE
AFTERCARE

Attachment #3

Municipality of Anchorage

835 "D" STREET
ANCHORAGE, ALASKA 99501
(907) 277-2675

GEORGE M. SULLIVAN,
MAYOR

DEPARTMENT OF HEALTH AND ENVIRONMENTAL PROTECTION
Behavioral Health Division
Alcoholism Section

Summary of the Technical Assistance and Review Team's Evaluation and Comments on The Salvation Army's Comprehensive Alcoholism Services. December 14, 1976

Attached you will find copies of the detailed comments by each surveyor as it pertains to the components that they reviewed.

Overall, the technical review team made several positive comments about the efforts of the staff to provide a quality comprehensive alcoholism system. However, there is a definite lack of written policy and procedures for the majority of the components which is reflected throughout the comments made by each of the surveyors. I would like to summarize some of these problems and point out some critical areas that need to be addressed as well as note some of the strong points that were found in the service delivery system.

Management and Support Services, Section A--Governing Authority. There seems to be a very clear and defined chain of command, as well as governing authority, rules and regulations that is kept primarily in the administrative section. There seems to be some question as to the chain of command as it relates on down within the ranks of the employees. Most of this detailed information is kept under the purview of the administrator and although the staff did not have copies available, there was some question as to whether there actually are copies available for the staff to review. There seems to be some need to clarify the distinction between responsibilities of the Administrator and the Program Coordinator. This has also shown up in the staff comments on who is responsible for making what decisions even though they are readily willing to indicate that the final authority rests with Captain Boyd. There does need to be some clarification of the responsibility for decisions and the delegation of responsibility and authority.

Patient's Rights. In the Detox Section, the patient rights seems to be very good, although there needs to be explained in their application for services that there are possibilities that detoxification is quite hazardous to the individual client's health, and this has not been explained and probably should be written into the initial intake format. There seems to be some question about the actual participation of the patient in his own treatment plan, and there does not seem to be written documentation specifically addressing this issue, let alone for the client to actually become involved in his own treatment.

Planning. There seems to be a great deal of planning going on. It is more or

less on a day-to-day, as needed basis, and needs to be further developed. Undoubtedly, the newness of the program serves to hamper these planning efforts, but some specific action should be written out in the planning areas of each individual component, as well as the overall program.

Fiscal Management. The evaluation team did not get into the fiscal management section, and it will be addressed at a later time.

Environment. There were several concerns throughout the environmental evaluation that dealt primarily with the Alpha Center of which we are all acutely aware. We indicate that there were several topics of discussion related to moving the Alpha Center up onto the first floor and there have been suggestions by the evaluation team that possibly the Alpha Center should be moved to another location. This will be worked out jointly with the Municipality, as it is a very serious concern, and one of our first priorities. There is some concern about the location of new clients coming in for screening and evaluation at Central Intake, who share the same waiting area as the patients in treatment. Certainly, with the addition of space and reorganization within Community Hospital, this can be alleviated.

Personnel. This is one of the most critical sections, and an area that we are quite concerned about. The detail of the personnel will be found with Margaret Wolf's comments and Andrew Linn's comments. Overall, there seems to be a very detailed and documented policy and procedure manual in personnel, although it lacks some very specific areas in affirmative action plans, employee review and evaluations, where the personnel files are kept, and they are not readily available to staff. We would like to discuss this further with the administration and review what the Hawaii Program has done in order to pass the accreditation standards, since the personnel manual is basically kept only for administrative persons.

Evaluation. There seems to be a periodic evaluation of personnel, although it is not reflected in the personnel files, and there seems to be some question as to the review and update of these evaluations. There is also a lack of training and education for the staff, as well and is not indicated in the personnel files.

Support Services. Patient Records--They seem to be fairly good towards the end of the program. Certainly, this is because additional information is picked up as a client moves through the system. However, in the Alpha Center, there is much concern over the fact that the clients' names and social security numbers are laid on the desk for everyone to see as the client enters and re-enters the Alpha Center. This needs to be looked at and perhaps another system devised, so there is better confidentiality maintained at this particular point. Detox seems to have a fairly good evaluation, and records system that is monitored fairly accurately by the staff and the physician. Certainly, Central Intake is doing a very find job in their evaluation of the clients and recommendations; however, there seems to be some lack of communication from Central Intake on to other components, and visa versa. This needs to be addressed in the staff so that there is the proper communication where the information is gathered, who is responsible for taking that information, and where clients are to go for their beginning evaluation. This was even uncertain in the Ouptatient Unit.

The Outpatient Unit has gotten off to a very good start. There need to be some policies and procedures developed that would be reflected the the patient's records. There needs to be further documentation throughout the whole system on the family treatment and what means are being utilized to include family in the alcoholism efforts and documentation of these efforts. Again, there needs to be specific documentation on the client's involvement in each component and in writing his own plan with the counselor.

Medication Control. Medication controls seem to be very good. There seemed to be a need for an updated Physician's Desk Reference, and also probably some individual staff training on side effects of various medications as it relates not only to Detox, but specifically to the Alpha Center as well as the Inpatient Treatment Program. Overall, this was a very strong section and seemed to be very good. There are a few other written comments in this area by Dr. Burst and Nancy Beck, Public Health Nurse.

* Referrals. This seemed to be a very weak area. It would indicate that some counselors have readily accessible information on agencies available in the community, whereas other sections are totally unaware of what is available in the community for further referrals and follow-up.

Dietetic Services. This area is severely lacking. We are aware that there has not been a consultant dietitian brought on contract and we feel this certainly needs to be done in the very near future. Again, we realize the staff limitations, as well as the space limitations, and hopefully, now that Community Hospital cafeteria may be rented to the Salvation Army, this can be further developed. The staff were very amenable to suggestions, and very cooperative, and we feel this area can be strengthened with relatively minor changes.

Research. Research is addressed specifically by Margaret Wolfe, but there need to be written guidelines to address the research area, and certainly is not one of our major concerns, but an area that should be looked into in the near future.

* Emergency Care. Again, it would seem that the Alpha Center needs to be reorganized physically so that it provides services a little bit more adequately. There probably needs to be some training specifically addressing the motivation of the client into treatment. There is not a clear understanding by the staff on whether they should be motivating these clients towards further treatment or merely monitoring the people as they come in the door.

Detoxification. Overall seems to be fairly good. There probably needs to be some allowance for private belongings to be locked in the closet. These physical modifications can take place at a later time, but is an area that we need to move towards for more privacy to the client. Training probably needs to be arranged to address some of the side effects of medication, specifically in the areas of detoxification as well as making the clients aware of the hazards of going through detoxification.

Central Intake. This seems to have the best written documentation on their evaluation and diagnosis, and client records, but there seemed to be some lack of communication with the other systems so that they understood the function of Central Intake and how it relates to their section and what kind of information

should be shared between these components. Again, a communication problem that could be addressed fairly readily.

Inpatient Care. Inpatient Care was just starting to get off the ground during the evaluation. There needs to be written documentation in this area of their component, how they relate to the other systems and communication of responsibility for their specific area of treatment as it relates to the overall client treatment plan. Again, an issue should be addressed about family involvement and some written organization for the treatment of family members.

Outpatient Care. Overall Outpatient has a very good program going. It is in the early stages of development and certainly could be expanded. There is a lack of written documentation, policies, and procedures, as well as planning efforts and with this improvement it can be a very functioning, very good unit. Aftercare is an area which is lightly touched upon. There does not seem to be the documentation there, and it is a critical area for accreditation standards that needs to be addressed. We are aware that not many people are moving through the System and coming out the other end, but in preparation for that, it would be better to plan for it now, rather than wait until after the people are moving out, to develop the documentation and follow-up of these clients as they leave the treatment system.

Consultation and Education. This area seems to be somewhat unorganized at this time. The documentation of their system and policies and written procedures were unavailable, although they had been presented in the past for documentation. There seems to be some lack of clarity as to the role of the Anchorage Council as it relates to the Salvation Army. They certainly have their own areas of responsibilities in the community and this needs to be defined in writing, from the Administration. They are assisting in the in-service training of the counselors and they need to become more involved in the system with specific areas of training that should be addressed. However, the bulk of the responsibility for this training should not rest on one person, but should be merely coordinated through that office.

Overall View. It would seem that the quality of services being delivered in the Comprehensive Alcoholism Services system is very good. Staff was very cooperative and immediately took recommendations and tried to implement those that could be done on the spot. There is a very serious lack of documentation for written policies and procedures. There is a very serious lack of personnel rules and regulations that are not available to the staff. There seem to be some areas of in-service training that need to be addressed very readily as they pertain to providing services in the emergency components. There needs to be better communication throughout the system so that each component understands what the other component is doing. This comes out in several different interviews with several different components and should be addressed as one of the first priorities. In light of the fact that most of the system has been in operation less than sixty days, there has been a tremendous amount of progress in the delivery of alcoholism services in the Anchorage Area, and the overall evaluation team's comments were very good in the areas of providing services. We hope to be able to come back in a few months and see many of these areas modified to provide the written documentation and communications that are necessary to improve the Program even further. We want to thank the staff of the Salvation Army and the Administration for the time they have given. It was, we feel, very rewarding to both parties, very enlightening, and hopefully, will prove to be the development of a quality Comprehensive Alcoholism Services system for the Anchorage Area as well as the State of Alaska.

Attachment #4

600 McCormick Street
San Leandro, CA. 94577
(415) 568-6800

RECEIVED
JUN 28 1977
ALCOHOLISM CONTROL

UWE GUNNERSEN
Director

MARK L. FELDMAN, Ph.D.
Associate Director

DATE: June 22, 1977

TO: Mr. Ed C. Stewart
Alcoholism Program Manager
Department of Health and Environmental Protection
Municipality of Anchorage
825 L Street
Anchorage, Alaska 99501

FROM: Uwe Gunnersen
Director
Human Services Horizons

SUBJECT: A BRIEF EVALUATION OF THE SALVATION ARMY C.A.S.

On May 20 - 24, 1977, I conducted a brief evaluation of the Salvation Army C.A.S. This program is under contract with your office to provide comprehensive services to alcoholic people in the municipality of Anchorage. In previous years, I had the opportunity to survey the consortium of diverse programs that used to be under contract to the Health Department. At that time, I was the Director of the Alcoholism Division of the Joint Commission on Accreditation of Hospitals, and my task was to provide some consultation and accreditation for the consortium. You will remember that utter and complete sense of futility that we experienced by the consortium's inability to benefit from consultation, and consequently, failing to achieve accreditation. I do, at this time, feel much more positive about the Salvation Army program. The various components of this program benefit from unified leadership and management, and the staff is working cooperatively for the benefit of clients.

My evaluation consisted of the following:

1. Interviews with key staff
2. Review of program documentation
3. Review of patients' records
4. Site visit to all facilities
5. Patient interviews
6. Participation in budget development
7. Summation conference

All of my findings have been verbally communicated to program staff and to you. This report, therefore, is not meant to recapture all details, but merely to give some of the more significant highlights of the evaluation.

I found the staff to be quite dedicated and generally competent. The medical staff needs to be upgraded and should, ideally, involve more of the medical community in Anchorage. The general competence of staff should be enhanced by in-service training that responds to identified deficiencies. This staff does not need another ready-made course or sequence of courses that are readily available. It does, however, need training in individualized patient assessment and evaluation, treatment planning, and aftercare planning. In addition, the staff should be capable of implementing utilization review and quality assurance mechanisms.

Program documentation is well under way and should meet with state approval. If JCAH accreditation is desired, some more conceptual work on criteria for admission to the various program components needs to be done. (JCAH accreditation at this time, however, would be premature because of inadequate on-going staff training and deficiencies in some of the physical facilities.)

Patient records generally need to be organized. They do not reflect individualized assessments and treatment plans. At present, patient records do not adequately reflect a therapeutic process with the patient, and are, therefore, useless as teaching tools, or as a basis for utilization review or quality assurance. If the program and the Health Department should be sued for negligence or malpractice, patients' records, with their present contents, would constitute a poor basis for any defense.

The facility housing the long term care and walk-in components are inadequate by national standards. Bunkbeds, crowded conditions, non-personalized environment, absence of privacy and a host of other obvious issues mitigates against this facility contributing to any therapeutic process. The walk-in center is simply too small to handle all the emergencies that are referred. It is my considered professional opinion that a large number of non-alcoholism emergencies are "dumped" into the walk-in center. The Health Department should consider a general receiving and referral facility that relates to a wide spectrum of crises and emergencies. This facility would not be operated by the Salvation Army, but would refer alcoholic patients to it. (It should also be funded by other than alcoholism funds.)

The program must also develop cost centers that permit accurate determination of costs per unit of service. This would not only expedite negotiations and contracts with third party payors, but would also provide much needed regionally prevailing rates to the HSA.

In summary, it can be said that the present contractor with the Health Department for provision of services to alcoholic people in Anchorage is performing a creditable job. Considering that the life time of the contract has been less than one year, and the contractor has experienced and overcome some severe start-up problems, it is amazing that the program has progressed this far. The above noted deficiencies can be readily corrected with appropriate and experienced consultation.

UG:fvl

Attachment #5

ANCHORAGE HEALTH DEPARTMENT
COMMENTS ON PROPOSED BUDGET REDUCTIONS
July 1 to December 31, 1977 ALCOHOLISM BUDGET
(SALVATION ARMY)

Attached are the Grant Work Sheet for the Alcoholism Grant for the period July 1, through December 30, 1977. This narrative is to point out some of the ramifications of the proposed changes and to solidify understandings between the Municipality and the contractor (the Salvation Army).

All changes listed are the result of negotiations between the Contractor and the Municipality and are to be reflected in the Grant Application. The existing contract between the Contractor and the Municipality shall be modified to reflect these changes.

NARRATIVE

The proposed budget expenditures submitted to the State of Alaska are $1,146,558.

Proposed Reduction No. 1 Alpha Center (\$18,000)

In the submission to the State of Alaska the Alpha Center (a walk-in center and drop-off point for the Emergency Service Patrol) was proposed to be operated for two (2) months. Discussions indicate that while there is dedication to finding suitable alternatives and some progress has been made, nothing has been solidified at this time.

This reduction envisions the phasing out of the Alpha Center immediately, resulting in a one month only operation. This further reduces the chances of finding suitable places to take the inebriated person. Without a place to take the person with alcohol abuse problems ("wet drunk") the contractor may violate the provisions of the State Statute on Alcoholism treatment.

The law states that a person with alcoholism or alcohol abuse problems must be taken home, an approved treatment facility or to jail. The choices are in that order. If the person has no home and there is no approved treatment (health) facility, or one that will accept them, the last choice is jail.

We can see some very real problems developing due to the already over-crowded detention facilities and the fact that these facilities are not now manned or geared to handle the "wet drunk". The existing excellent relationships between the law enforcement agencies, the Emergency Medical Services and the Contractor would be seriously impaired.

Current investigations indicate that there are several alternatives that could be developed.

1. Develop a "holding" facility for only those picked up by the Emergency Service Patrol

A part of the traffic in the "walk-in" center are seen as having Social Service type problems. Only a part of the people showing up at the center fit within the scope of Alcoholism Services. The walk-in center, in addition to providing a needed service, serves as a sorting/tracking point for those people who would benefit from Alcoholism services or some other type of Social Service. Also, the center serves to get a certain portion of the population off the street and out of sight. Therefore an alternative is to provide only a holding place where triage could go on.

2. Develop other agencies that may accept certain segments of the population-in-need

For instance, CINA could develop some alternative method or facility for the Native population that show up in the population-in-need. We see some tremendous problems relating to Civil Rights and discrimination when we suggest sorting out various ethnic (or other) groups for different or separate treatment alternatives provided by Public Funds.

3. Have some other Agency with adequate funding resources develop the Walk-in-Center

If we can reach agreement that the services rendered at the walk-in-center are predominately Social-Economic-Cultural related, with only a minor percentage of the problems being rue alcoholism or alcohol related, then it would seem that there is a responsibility for those agencies with Social Service funding to pick up the costs or to develop alternatives for the walk-in center.

To develop this alternative would take considerable time.

4. Combinations of the above

Undoubtedly there are additional sources that could be cultivated and there are other alternatives. However, the above are seen as the most realistic and are being vigorously pursued. In all probability, the final solution will be a combination these and other resources.

Proposed Reduction No. 2 Vacancy Factor (\$69,000)

The proposed budget as submitted has been characterized as "tight". This proposal envisions the managing of staff vacancies so that a total cash savings of \$69,000 may be realized. The worries that are attached to this reduction deal with the probable inability of staff to capture the projected revenues.

In the consideration of most service providers, services to people are of primary importance. If the choice is to hire a nurse or a billing clerk, the program manager will hire the nurse every time. Without adequate Administrative and fiscal help the probability of realizing projected potential revenues is seriously impaired. Considerable personal time must be spent in negotiating first and third party payment agreements.

Additionally, considerable time must be invested in contract and grant compliance issues in order to avoid audit exceptions, cash drain and loss of credibility at the funding source.

This reduction is seen as a total dollar reduction rather than as a percentage. The contractor must be given considerable flexibility in the application of the reduction. The staffing patterns currently adopted are seen as flexible with the following mutually agreed upon philosophy (or guideline) to be in effect for the first 45 days of the forthcoming quarter (July 1 to August 15, 1977) at which time the contract staffing patterns will be modified to reflect actual staffing patterns.

GUIDELINE

The primary concern of the Contractor and the Municipality is with the welfare and safety of staff and clients. Choices as to the hiring of staff and proposed unfilled vacancies will be directed towards this safety and welfare consideration, some times to the detriment of reporting and administrative requirements. If there is to be a major problem in reporting, missed deadlines for reports or in administrative affairs, then the Contractor is required to notify the Municipality in adequate time to seek acceptable solutions.

Proposed Reduction No. 4 The Anchorage Council ($12,500)

This proposed reduction is diametrically opposed to the stated desires of the Department. The function of the Anchorage Council on Alcoholism is to provide Information, Education and Referral. This falls well within the concept of "prevention" and, as such, supports one of the tenets of Public Health ("The role of the Public Health Service is to prevent-----").

However, the reduction has the lowest immediate impact upon the existing identified treatment part of the overall program. This effort is reduced to a funding level of roughly $20,000.

Proposed Reduction No. 5 Emergency Service Patrol ($27,000)

In the proposed budget is a requested funding level that would allow the Emergency Patrol to operate full time (24 hours per day). The reduction of $27,000 would cut back these services to 16 hours per day, the existing level of service, which seems adequate.

Proposed Revenue Source No. 1 (stated in application at $80,000)

Third Party Payments

Current analysis of Revenue indicates that the sources available to the contractor are:

Veteran's Administration	$12,000 month x 6 =	72,000
Other Third Party	2,800 month x 6 =	16,800
Current Generation Expected		88,800

Increases projected

Veteran's Administration	4,480 month x 6 =	26,800
Other Third Party	6,730 month x 6 =	40,400
		156,100

Discussion with the provider indicates that payments by the Veterans Administration could be increased considerably. Also, the discussions indicate that there are other third parties that could be cultivated such as the Unions, J.C. Penneys and Insurance Carriers as a fairly significant revenue source.

Concerns have been expressed in this narrative (Reduction #2) about the amount of Administrative and Clerical time that is necessary to capture these funds. Confidence in this potential revenue is strong as a funding plateau has not been reached.

Proposed Revenue Source No. 2 (stated in application at $59,000)

Food Service Agreements $59,000

The Food Service component of the proposal has built into it the costs of running a large food preparation service. There are existing agreements with other services of the Contractor (Meals-on-wheels, etc.) that guarantee the realization of this resource.

Proposed Revenue Source No. 4 (stated in application at $30,000)

Food Stamps and SSA, Title XIX $52,100

The latest figures indicate that these resources are generating the following:

Food Stamps	1,950/month x 6 =	11,700
Title XIX	3,400/month x 6 =	20,400
		32,100

Increases projected

Food Stamps	1,200/month x 6 =	7,200
Title XIX and XX	2,120/month x 6 =	12,780
		52,080

The increases projected are within the realm of possibility but are somewhat "softer" than other projected increases. The Title XIX possibilities must be cultivated and some effort must be invested into the agencies that handle food stamps and other Federal/State resources.

Proposed Revenue Source No. 5 (stated in application at $53,000)

NIAA Pipeline Impact Funds $53,000

These funds are assured (as much as possible) by the State.

Proposed Revenue Source No. 6 (stated in application at $74,100)

Salvation Army $74,100

Cash put up by Contractor.

Proposed Revenue Source No. 7 (stated in application at $125,000)

Municipality of Anchorage $125,000

Depending upon how the cash flow of the contractor balances at June 30, 1977, this amount is assured.

Proposed Revenue Source No. 8 (stated in application at $3,000)

Donations $ 3,000

This is a lower level estimate of cash donations.

Proposed Revenue Source No. 9 (stated in application at $3,900)

United Way $ 3,900

This revenue source is assured and is dedicated to the Anchorage Council of Alcoholism.

Proposed Revenue Source No. 10 (stated in application at $54,600)

In Kind $54,600

This is the value of the donated or pledged facility at 8th & C used for the Alpha Center and the Long Term Care component of the Treatment System.

There is also an impact on this resource due to the closure of the Alpha Center. What this would be is unknown at this time but, is estimated as a possible reduction of $8,000 to $10,000.

Proposed Revenue Source No. 11 (stated in application at $360,000)

State of Alaska $360,000

This amount is reasonably assured.

SUMMARY

The above budget and revenue projections are the best possible effort of the Municipality and the contractor reaching a negotiated agreement after some discussion. All parties realize that the proposal is not the best of all possible worlds but is the best utiliztion of the existing funds for the benefit of the Community.

Additionally, it is mutually understood and agreed that the projections of funding and program are subject to the availability of funds. This analysis must be on-going with a critical review and negotiation to the conducted during the first two weeks in October for the quarter ending September 30, 1977.

We are confident of developing and realizing additional sources of revenue. As (and if) these funds become available the priority to reinstate the services and budget cuts are as follows:

1. Vacancy Factor $69,000
2. Emergency Service Patrol 27,000
3. Alpha Center 18,000
4. Anchorage Council 12,500
5. Or combination of the above to reflect negotiated needs as these needs become more clearly identified.

Agreed + negotiated - June 30, 1977
Robert C. Hall, Director, Anchorage Dept of Health + Environmental Protection

Reviewed and understood - June 30, 1977
David R. [illegible], Program Director/acting Director The Salvation Army Comprehensive Alcoholism Services

Attachment #7

COSTS PER COMPONENT
BASED ON FULL SERVICE PROGRAM SIX MONTHS

COMPONENT	Personnel	Other	Total Raw Costs	Aver/Mo Cost	Income total	Net Raw total	Aver Raw/Mo
Emergency Services Patrol	75,690	13,750	89,440	14,910	000	89,400	14,910
Alpha Center	106,550	39,070	145,620	24,220	27,300	118,320	19,720
Detox	193,210	82,240	275,450	45,910	76,600	198,850	33,141
Short Term	40,340	63,810	104,150	17,360	48,940	55,210	9,201
Long Term	77,010	79,480	156,490	26,080	170,960	[14,470]	[2,410]
Outpatient Central Intake/ TCU	108,700	23,510	132,210	22,035	77,900	54,310	9,050
Information & Education	000	28,880	28,880	4,800	3,900	24,900	4,150
Administration	143,020	32,270	180,290	30,048	000	180,290	30,048
Fiscal	86,210	21,210	107,420	17,903	000	107,420	17,903
Totals	830,730	389,140	1219,870	203,310	405,600	814,270	135,710

*ESTIMATED COSTS FOR SHIFTING SPECIFIC PROGRAMS

ALPHA WALK - IN CENTER - Scheduled to be phased out by August 1

To re-instate - 24 hrs/day; 7 days/week	$16,200 x 5	Cost	$ 81,000
To operate - 16 hrs/day; 7 days per week	$11,000 x 5	Cost	$ 55,000
To operate - 8 hrs/day; 7 days/week	$ 4,000 x 5	Cost	$ 20,000

EMERGENCY SERVICES PATROL - Scheduled for 16 hrs/day; 7 days/week

To operate 24 hrs/day; 7 days/week	$ 3,500 x 6	Cost	$ 27,000
To operate 8 hrs/day; 5 days/week	$ 2,290 x 6	Save	$ 48,300
To eliminate entirely	$ 0	Save	$ 62,000

* Does not match exactly with above as reductions were based on earlier estimates.

Municipality of Anchorage

MEMORANDUM

DATE: July 12, 1977

TO: Mayor

FROM: Director, Department of Health and Environmental Protection

SUBJECT: History of State Funding for Local Alcoholism Programs

In response to your request, the following chart represents a history of State funding for local programs in the recent past.

State Fiscal Year	State Grant	Increase or Decrease	NIAAA Pipeline Impact	Increase or Decrease	State C & RA Pipeline	Increase or Decrease
1976	713,000	--	109,500	--	121,000	---
1977	687,000	-3.6%	105,800 +92,207*	-3.4% (+79% total)	-0-	-100%
1978	719,000	+4.7%	108,520	+2.5% (-84% total)	-0-	--

*NIAAA -- 1976 Carryover funds awarded in Spring of 1977

Total State funds decreased from 1976 to 1977 -6.3%
State grant increase between 1976-1978 +0.8%
NIAAA grant decrease between 1976-1978 -0.9%

Robert A. (Bert) Hall, Director

RAH/dg

cc: Doug Weiford

91-010 (4/76)

9.

STATISTICAL INFORMATION

Salvation Army Comprehensive Alcoholism Services
October 1, 1977 - June 2, 1977

The total number of clients served since the inception of the Salvation Army's Comprehensive Alcoholism Services is 1,200.

The total clients seen by ach component are as follows:

1. ALPHA CENTER

Total Different Clients..........1,436
Total clients served once only.... 140
Total Contacts...................4,067

2. DETOXIFICATION COMPONENT

A total of 417 clients have been served 700 times;of the 700 detoxes, 527 completed treatment and 173 left against medical advice. Average number of admissions 1.67.

3. CENTRAL INTAKE

April, May only have received 133 clients of which 107 were new assignments to treatment units.

4. SHORT TERM TREATMENT (TERRA FIRMA)

December - May
Total clients since inception....... 68
Clients completing treatment........ 32
Clients left against medical advice............................ 32
Total number still sober............ 26

5. LONG TERM TREATMENT (ARC)

Total clients since inception.............. 424
Average monthly bed count.................. 53
Clients left program with a plan........... 31
clients left program against advice........ 92
clients still in contract with program after discharge but still remaining sober....... 19
Average length of treatment................ 78

6. OUTPATIENT

Total clients since inception (October - May)..... 307
Clients discharged with plan..................... 49
New Referrals April & May........................ 115

7. TRANSITIONAL CARE UNIT

Total clients since inception (March - May)..... 29
Clients discharged with plan.................... 5
Average in treatment (capacity is 14)........... 12

STATISTICAL SUMMARY
of the Emergency Services Patrol

March through June, 1977

Since its inception on March 14, 1977, the Emergency Services Patrol has transported 1,868 clients. The highest month of service was April when 1,150 clients were transported. We have used the month of June as a sample of the percentage of clients transported to other facilities and where calls for transportation were received. This detail is as follows:

Sample Month - June, 1977

Total of 156 calls for transportation received:

Anchorage Police Department.......... 44 calls or 23%

Bars................................ 5 calls or 3%

Businesses.......................... 17 calls or 9%

Emergency Medical Services........... 1 call or .5%

Personal Residences.................. 7 calls or 4%

Emergency Services Patrol pick-ups...110 calls or 59%

Salvation Army Comprehensive
Alcoholism Services.................124 calls

Of the 337 calls for transportation, the clients were transported to the following:

Alpha Center........................151 clients or 45%

Detox (Medical Clearance)............ 45 clients or 14%

Hospitals (API, 5040th, Alaska
Hospital, Providence)...... 27 clients or 8%

ANS Hopsital......................... 60 clients or 17%

Personal Residence................... 13 clients or 4%

Salvation Army Comprehensive
Alcoholism Services................ 18 clients or 5%

Other............................... 23 clients or 6%

It should be noted that during April, the Patrol was receiving many requests primarily for informational purposes since it had just started operation in mid-March. Thus, June was used as the sample month, since it was the month that reflected the typical usage of the Emergency Services Patrol.

SALVATION ARMY COMPREHENSIVE ALCOHOLISM SERVICES --- GRADUATES*

Case #541: Client entered Detox in February, 1977, for normal seven day stay. Screened by Central Intake and accepted to Short Term for six weeks of intesified therapy. Graduated from Short Term and enrolled in Transitional Care Unit where he presently is engaged in job hunting with the Teamster's Union. This is the longest period of sobriety he has had in the past few years.

Cases #297 and #319: Husband and Wife who came to Detox in February, 1977. After normal stay in Detox, bed space was not available and clients stayed in hotel for a period of three weeks while checking daily for opening in program. Both accepted in Long Term Residential Treatment. Completed treatment with individual and couple therapy. Husband was transferred to Transitional Care Unit and Wife followed two weeks later. Husband has been working since Transitional Care Unit in April in kitchen of SACAS. Wife is going to take courses at the University and has applied at ANS Hospital for position as a Licensed Practical Nurse and is now doing volunteer work at CINA and peer counseling in SACAS treatment. During the course of treatment the Wife made an important decision and relinquished her children from a previous relationship. They are now legally adopted by their foster parents.

Case #443: Client was transferred to SACAS from AATC Detox in October of 1976. Client was accepted in Long Term and completed program and then transferred to Transitional Care Unit in March, 1977. Due to medical problems with his feet, client has not applied for work. He receives disability monies and is in-house worker for this unit at present. Client resolved problems with spouse while in treatment and is seeking supportive funds through food stamps and Social Security One to help himself.

Case #361: After having completed treatment, client was working as a truck driver for the Salvation Army. He relapsed and started a drinking period in April. In May, he re-entered Detox and stayed seven days. From there he entered Short Term and completed six weeks of treatment. He is now back at his old job and appears to be more aware of how to cope with problems than before. Client is presently seeking counseling in the Outpatient Unit.

Case #306: Entered Detox in December of 1976 and Short Term treatment. Was one of the first Transtional Care Unit clients in March. Client has left Transitional Care Unit on own and is working as a fiberglass worker in Anchorage.

*The above represents only a few of the clients that have graduated from the Salvation Army Comprehensive Alcoholism Services program. These cases were chosen at random, but are indicative of the types of clients served and the successes made.

Fourth Avenue regulars may be left out in the cold

by Rodger Painter

Anchorage

Fourth Avenue winos soon may be sleeping on the street again, victims of massive budget overruns in the municipal alcoholism program.

Employes at the Alpha Center, Anchorage's alcoholism walk-in center, have been notified that they'll be laid off on July 31. However, alcoholism officials say they are scrambling to piece together a proposal that keeps Alpha Center open at least part-time. They hope to submit it to the assembly within two weeks.

Some 2,000 persons can be considered part of the Fourth Avenue population during an average year, according to statistics gathered by Capt. David Boyd, director of the Salvation Army's Comprehensive Alcoholism Services. He estimates the normal population at any one time at 120.

A spokesman for the Anchorage Police Department said there is no alternative to Alpha Center and that its closing would create one "helluva problem" for officers.

Cost overruns in the first phase of the 18-month comprehensive services contract amounted to more than $100,000. The final six months of the program would cost $260,000 more than originally projected under the latest official proposal.

[illegible] merchants and the chamber of commerce led a public campaign to clean up Fourth Avenue, prompting the city to pull its diversified alcoholism services together into one program headed by the Salvation Army.

The comprehensive program has been plagued by problems since it started a year ago. The first phase of the program from mid-1976 to mid-1977 cost the city $170,000, which is $100,000 more than the original budget. But, the cost for the final six months will be still higher.

The budget approved by the assembly a year ago called for the municipality to contribute $125,000 for the final phase. But the city health commission last week adopted a resolution strongly supporting the concept of the comprehensive program and accepting state alcoholism funds contingent on the city funding the program at a full level of services. The budget the commission approved would have the municipality's share increased by $260,000 to a total of $385,000.

Alpha Center would be closed at the end of the month and the public information program cut in half under the budget the city administration submitted to Juneau for state aid.

Bert Hall, director of the municipality's Department of Health and Environmental Protection, has a strong interest in keeping within the $125,000 figure since he promised the assembly he would not come in with a request exceeding that amount. He now admits he may have made a mistake.

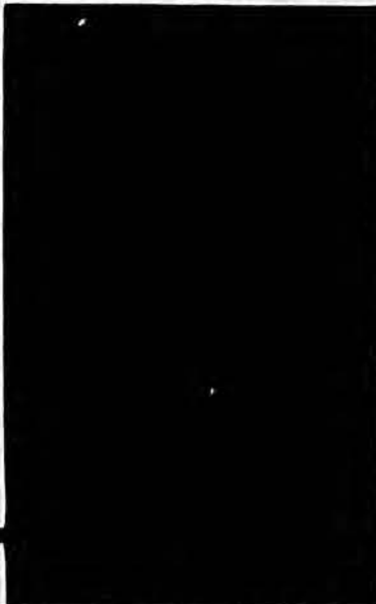
"We've GOT to prove to this community that you can have a good alcoholism program within limited resources," Hall said. "That's why I made the promise I did."

Hall sidestepped questions on whether he would have to break that promise, but he did indicate a compromise that would cut the $385,000 commission request was likely to emerge.

"My guess is some portion of Alpha Center will be retained," he said. The notice was given to employes, Hall said, to cover legal requirements in case the center is closed.

Alpha Center is the initial point of contact for the street drunk to Anchorage's alcoholism treatment program—the backbone of the attempt to clean up the human tragedy and business eyesore of Fourth Avenue.

Alpha Center—the street drunk's first contact with Anchorage's alcoholism program



Paul Piper, who helped put together the Salvation Army's Comprehensive Alcoholism Services, didn't want to talk about his resignation

Boyd said the center has been highly effective as a sc[illegible]ening point for the Salvation Army's treatment program. At least 21 persons identified as members of the hardcore Fourth Avenue population have been dry and "self-sufficient" for 60 days or longer because of Alpha Center, Boyd said. Another 13 patients in treatment are considered hopefuls, he said.

The *Advocate* spent a night at Alpha Center last March and a subsequent story outlined overcrowded, deplorable conditions (see *Advocate* March 17, 1977). Hall and Boyd admit the conditions at Alpha Center are "cruddy" but insist the small, sparsely furnished basement room meets government safety codes.

The *Advocate* article incorrectly said the center failed to meet state fire codes. Alpha Center does have two emergency exits, contrary to what the article reported. The legal occupancy load for Alpha Center is 55, not eight as a spokesman for the state fire marshal's office earlier told the *Advocate*.

Even Hall and Boyd concede that, despite meeting state and local safety codes, Alpha Center poses a real fire danger and is greatly inadequate as a sleep-off area for 55 people. However, it also is recognized by everyone concerned that Alpha Center is better than having 120 drunks sleeping in the streets at 20 degrees below zero.

There is no alternative to Alpha Center, said Chuck Betts of the Anchorage Police Department. Without some place to take homeless drunks all officers can do is to "keep them moving like a bunch of cowboys (herding cattle). That's ridiculous," Betts said.

The department spokesman said he didn't "even want to think about" what would happen next winter without a walk-in center.

Since the department would have to reinstate a foot patrol in the downtown area to handle the drunks, it appears likely the municipality will end up footing the cost of caring for the drunks even if Alpha Center is closed.

Hall said he had already "raped my budget" in trying to fund the alcoholism program and his staff was investing considerable time in trying to find alternatives to closing Alpha Center.. The budget figures will be juggled, corners cut and alternative funding explored until a satisfactory operating plan emerges, he said.

Underestimated personnel costs played a major role in the budget crunch, according to Paul Piper, who just resigned as coordinator of the comprehensive program.

A key factor in the Salvation Army's successful bid to land the 18-month comprehensive contract was its low salary range for personnel. Piper said he was having problems keeping the most qualified staffers and turnover was high in most phases of the program.

Piper declined to discuss his resignation, but Boyd said it was not demanded or [illegible] three other supervisors had submitted their resignations in sympathy with Piper, a move that could be viewed as a pressure tactic.

Also cited as primary reasons for the higher cost to the municipality were:

—A vicious squabble over shrinking funding sources between alcoholism and drug treatment programs remaining from the era of Lyndon Johnson's "Great Society." Among a long list of remaining problems is $70,000 in public inebriate funds tied up by the Alaska Alcoholism Treatment Center, which apparently is no longer handling adult alcoholism problems. Hall and Boyd say that money could be used to keep Alpha Center open.

—Less-than-anticipated revenue from the state, primarily because Gov. Jay Hammond's proposal to raise Alaska's alcohol excise tax failed to make it through the legislature."

—The inability of the staff to pursue "soft revenues"—such as billing and collecting from clients—when tied up by budget hassles, red tape and infighting with competing agencies.

The strong endorsement of the comprehensive program by the health commission was a boost to the chances for increased funding and a morale lifter for Hall and Boyd in the face of continued criticism. A favorable evaluation last month from a prominent national consultant also helped.

None of that impresses critics such as Leonard Nugen, director of the Studio Club, a private Anchorage halfway house that generally is considered one of the best alcoholism treatment programs in the state.

Nugen and the municipality failed to arrive at a mutually acceptable funding agreement for the Studio Club to contract for halfway house services under the comprehensive program. Nugen managed to obtain state funding anyway, and is turning down renewed approaches by the city.

"All the money's gone and all the big things they've promised to do haven't been done," Nugen said. "Before I go through that hassle again, I'll nail my door shut and there'll be no other treatment in Anchorage."

Boyd has a terse "no comment" on the situation, signaling that one of the major obstacles to treating Anchorage's alcoholism problem will be a difficult hurdle.

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WOMEN'S AND CHILDREN'S
SOCIAL SERVICE SECRETARY

TELEPHONE
279-0522

MAJOR MARIAN PECK
ADMINISTRATOR

THE SALVATION ARMY

Booth Memorial Home

MAIL ADDRESS
BOX 3-063
ANCHORAGE, ALASKA

3600 EAST TWENTIETH AVENUE
ANCHORAGE, ALASKA

June 24, 1977

Not knowing where to go,
running, running, running,
I have no one who cares
And I no longer care.

There seems to be nothing I can do,
but I really want
To try now,
Because I care.

I'm tired of going with no place to go;
It does me no good;
it does me much harm.
I finally realize that I do care.

And I'm out to find someone
who cares about me.

-Booth Resident-

Dear Gentleperson:

We are writing to bring you up to date on Booth happenings of 1976, and share some of our future plans for 1977.

Residents

In 1976, the Booth Memorial Home residential treatment program served a total of forty-six residents (fourteen girls were presently residing in the home in January of 1976). Of the thirty-two admissions, fourteen also participated in the maternity section of our program. So far in 1977, we have provided residential treatment for a total of thirty-six residents, twelve of whom participated/are participating in the maternity portion of our program.

In 1976, twelve residents returned home after treatment, three residents enrolled in boarding school in congruence with their goal of emancipation, six residents were referred to more structured settings, three ran away with no follow up contact, four were discharged to less structured settings (group home/foster home), and four are presently in placement. The average length of placement for non-pregnant residents for 1976 was one hurdred twenty-four days; the average length of placement for pregnant residents was seventy three days. Fifty-three percent (seventeen) of this population were Native. Seventeen members of this population were from outside the Anchorage area.

Services

The summer of 1976, through Title I ESEA funding, Booth Home instituted an in-house accredited school due to the demonstrated social and academic needs of our residents. This school year, in-house school continued with one full-time and one part-time teacher, and a full-time teacher's aide. In January 1977, it was supplemented by another Title I Grant providing reading tutors and various motivational activities.

On-going staff training in the house and within the community, we feel, is the foundation of program growth. Staff training has been widely expanded this year including utilization of outside resources for first aide course work, crisis intervention, psychomotor therapy, women in treatment, understanding mind altering drugs, abuse counseling, expanded constructive confrontation skills, understanding and use of problem solving and grief processes, and goal orientated behavior. We have developed, as a staff, a stronger staff orientation sequence. Due to your support, we have been financially able to assist them in their learning.

Two new roles have been added within counseling positions: activities coordinator and group leader. In addition to these, the Booth Home Advisory Council appointed a program review committee which has acted as a research and evaluation body for administrative staff this year bringing growth recommendations to the Advisory Council.

School

This summer the in-house school will be funded by the Anchorage School District with one full-time teacher, one student teacher, and one full-time teacher's aide. We will be expanding academic areas to include more science and physical education activities by loan of equipment from the District and the Whaley Center gym.

This summer will also bring summer jobs coordinated through federal funding and offering residents various levels of responsibility.

Maternity Education

The maternity education program continues its refinement. With support from the Public Health Service, we have utilized many new materials for discussions of child abuse and movies illustrating the alternatives and feelings within each. In addition, we have coordinated with the Women, Infants, and Children Program to further the nutritional awareness and health of our maternity residents. We continue to offer each girl the support of a labor coach for the time of delivery.

Activities

Through the hard work and planning of the activity coordinator of our counseling staff, we have expanded our recreational activities to include gym and pool usage, roller skating, bowling, theater arts, and various timely community activities. We are continuing to expand these and are open to suggestions.

Activities are varied from the Clam Gulch expedition (that was Booth in the Anchorage Times) to some beautiful International Dinners. One such dinner was put on completely by the residents to say "thank you" to the Zonta Club for thier financial support as Santa Claus and of the craft and reading programs this year.

Camping trips to Birchwood Camp, Homer, and Nancy Lake are planned for this summer. We are also hoping to coordinate scholorships with the YMCA and Camp Fire. We'll be doing lots of all-day outside activities.

Groups

Group education and therapy have been varied and enhanced by the addition of a group leader to our counseling staff. Groups have included body awareness, health education, and explorations of sexuality in addition to straight therapy and problem solving groups. Our next segment of groups will deal with career capabilities, alternatives, and lots of practice in "how to" (act in an interview, accept supervision, handle discrimination, use your talent for you), utilizing Strong Campbell testing, community resource persons, and field trips.

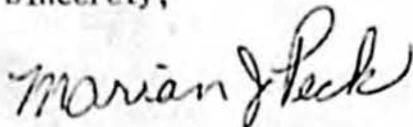
Residents also conduct their own policy making meetings, House Meeting, on Thursday nights and, through the support of counseling staff, are learning to plan and conduct various house activities as well as make concrete recommendations on program policy. One such recommendation now in operation is the incorporation of a long term resident into the orientation of a new resident.

* * *

In summary, we continue to serve our residents, your clients, and community with a purposeful program to build upon the strengths of each individual, accept her weaknesses and help her to learn more functional behaviors in order that she may be better able to attain her individual goals.

We invite you to come and visit us, take a tour of the facility, and talk with the staff and residents over a cup of coffee. Thank you for your continued support of our program.

Sincerely,



Marian J. Peck, Major
Administrator

THE SALVATION ARMY
BOOTH MEMORIAL HOME
P.O. Box 3-063
Anchorage, Alaska 99501

BOOTH PHILOSOPHY

Each adolescent woman is of worth by virtue of her own personhood. Each young woman has the ability, responsibility, and need to be an accepted, contributing member of her community. It is our goal, as a residential treatment program, to utilize and structure each day's events/relationships for the growth and learning of the individuals involved. Specifically, our goals are: to facilitate each resident's recognition and acceptance of herself and others as persons of worth; to help her learn to directly and appropriately ask for what she needs; to give her, in appropriate and helpful ways, the relationship of past and present experiences in terms of her own life processes; and, to teach her more functional, rewarding ones; to provide and encourage meaningful and varied relationships of male/female adults and peers; in total, to recognize and develop each individual's power in coping, growing, and directing her life situations.

We view dysfunctional and destructive behavior as the consequence of the individual's discouragement with herself within her life experiences, the most basic of these experiences being her relationships with family adults and, as an adolescent, with peers. Her perception of these experiences is developed from her perception of herself, her processes of dealing with relationships, and the various life situations she encounters. We serve the more discouraged adolescent woman who has not been able to cope with and/or be accepted by the constructive youth alternatives of her community (i.e., family, school, church, youth groups). We provide a residential treatment program in which she may, through being herself and living with others, gain a greater understanding of her own processes, learn more functional, rewarding behaviors, and recognize her worth as an accepted, contributing member of the Booth community. The development of a therapeutic environment is for and begins with the individual.

After an orientation of two weeks at Booth, an individual's treatment plan is completed. The goals of a treatment plan are established by the referring agency's social worker in conjunction with the goals as seen by the individual herself and her primary counselor and social worker here at Booth. Treatment goals are based on the individual's goals (both long-term and immediate) and deal with everything from education to personal growth areas to future living arrangements. Incorporated in a typical treatment plan are the resident's strengths and needs in each specific area expressed via her individual processes and their use, as well as clearly delineated helping techniques to aid in the attainment of the various goals by the treatment team.

Each month, treatment plans are reviewed and contracts (concrete steps to each goal) are drawn up between the resident and her primary counselor. Contracts are integrated with the level system by crediting contract completion with the largest number of points avaliable. Contracts are reviewed by the individual and her primary counselor weekly, and are modified as needed depending on the specific areas being emphasized at any given time.

Plans and contracts form the framework of treatment, and all members of the Booth treatment team work together to implement progress toward attainment of the individual's goals within all aspects of her daily functioning.

At Booth, we have a total living environment in which our young women can re-learn behaviors, and develop alternatives to unacceptable behaviors. Our goal is to build on the strengths of each individual by her interaction with her present environment, primary social systems, and the community at large.

The parameters of our agency include:

Knowledge of internal agency and referring agency structure, function, and purpose (i.e., type of custody of client, purpose of agency, type of services eligible for intra- and inter-agency/intercommunity communication and procedures) (i.e., perception and understanding of program goals) (i.e., perceptions of "how people learn").

Interpretation and understanding of legal/professional boundaries (i.e., licensing, sponsoring agency, advisory council, law, children's code).

A level-point system provides common expectations for all the young women in the house. For the facility it is a management tool by which house up-keep and daily routine are established and credited. For the residents it provides a standardized, predictable base from which to earn privileges and a concrete way of seeing individual progress through the program.

Booth offers an accredited in-house school program with a full-time teacher, one half-time teacher, and a full-time teacher's aide. Residents are expected to attend this program until Level III in the point system is reached and maintaintd for one quarter. This requirement allows time for a stabilization of behavior, at which time the individual will begin her re-entry into public school on a gradual basis.

Each girl is involved in two therapy groups each week. Defined as, "Where we deal with our feelings about each other, our parents, and staff", these groups provide each resident with caring feedback, an opportunity for expression of feelings, and a safe place to try out new behaviors.

Each Thursday evening, all residents, social work staff, and administrative staff meet to discuss and decide on house management procedures, activities, and other house problems. Girls chair the meetings themselves, new officers being elected every four weeks. Girls make recommendations as to changes in policy and deal with all-house situations of the previous week.

As Booth is an open facility, we endeavor to insure that the girls have frequent contact with the public. House activities such as bowling, movies, picnicing, skating, skiing, or camping are planned for four evenings a week. Girls have the option of participation or planning an alternative outing with friends. We are coordinating library use and attendance at extra-cirricular activities with East High School. Transportation is also provided for shopping trips twice each week.

Each girl has an individual log which is open to the resident and all staff. It includes staff daily progress notes, appointments, treatment plan, weekly level system, and a section for resident-staff written interaction. Each girl also has a file in which social histories, medical and psychological reports, and school evaluations are dept. These are available to the girl at appropriate times.

As mentioned previously, each girl has group twice weekly, also intensive counseling with her social worker, her primary counselor, as well as all staff on duty with whom the girl chooses to interact.

Ultimately, the helping process has as its parameters the following inherent, individual parameters of the individual client:

Self Image: The filtering system used to experience the world.

Role Perception/Script: Script in the system of program developed telling "Where I will end up?", and "What will be my satisfactions and frustrations from life?". "Am I a winner, loser, persecutor, victim, rescuer?"

There are a limited number of roles available to each person: female, friend, daughter, sister, worker, girl friend, student.

Primary Data Sources About Self Image: (Currently most valued information sources.)

Vary with age.

Parents and family were original. Currently sources are used by each person to provide data about self. To help a person alter their self image, they need to start getting data from sources which are not duplicates of the original. Know who a person listens to for what, then plan intervention/interruption.

Problem Solving/Decision Making Process:

When perceive self in a corner, how does the person go about getting out of it (e.g., play helpless and have someone else solve it; defer to person with most power; see what an "expert" says to do; jump based on old assumptions that I'm always wrong; run away, get sick)?

Goal Process:

Define the problem/individualize the person or situation.
Gather data.
Define alternatives.
Define ramifications of each alternative.
Choose alternative and implement.

Techniques for Expressing Feelings:

The verbal and non-verbal vehicles used to communicate most important ways to express feelings to another (i.e., voice tone, script, non-verbal) (e.g., anger, frustration, loneliness, satisfaction, caring, fear).

Techniques for Getting and Giving Strokes:

Verbal and non-verbal (e.g., physical proximity, illness, teasing/kidding, less noise, harsher noise, politeness, less resistance, touch, doing something with, doing something for, give room to retreat).

Perceived Sources of Satisfaction and Frustration:

Standardize the sources to be checked: peers, family, adults, male peers, work/vocation, recreation, creativity, school/learning, physical, spiritual.

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UNITED STATES GOVERNMENT

Memorandum

Received from Helen Burns 9/16/77

TO : Chief, Social Work Service (122) DATE: July 1, 1977

FROM : Program Planning Specialist (122A)

SUBJECT: Proposal for a no-cost community rehabilitation center (Sheltered Workshop - Residential Care Unit).

There is a definite need for an after-care unit in Anchorage which would serve a population of veterans in need of a structured environment and provide purposeful, directed activities of economic value to the veterans and community. It would also provide an attractive sheltered living arrangement. This would be a no-cost to agency situation. The population served would be those who have been in multiple rehabilitation programs and half-way living situations as well as in boarding homes, nursing homes and hospitals. The population would necessarily be limited, at the onset, to those who have individual income in small amounts such as VA pension, Supplemental Social Security income, State Welfare funds and/or small compensations from other sources.

The setting would be one of a live-in sheltered work-shop arrangement which would eventually become a producing unit of marketable materials manufactured by the individuals living in the facility and therefore sharing in the income derived from the sale of those commodities.

It is projected that social service agencies all have many clients they support, who are very possibly living in poor environments and do not receive the proper follow-up care, therefore becoming candidates for further rehabilitative or medical problems. The bulk of these clients are supported by monies from some source. Those monies might very well be directed toward their own self support, therefore returning a degree of integrity to them and possibly returning some to the main stream in time. I would establish a semi-permanent residence for those not able to return to regular community living.

The depth of talents and dormant skills in both alcoholics and other individuals who have become non-productive is often great. These individuals may not be utilizing any of their skills to any degree. They have sometimes lost many of their skills but may very possibly be able to regain some of them and put them into proper use in a sheltered work-shop living situation.

I will report here-in, facts in establishing such a unit.

Purpose is to fill a void which has been created by a lack of reinforcement in present rehabilitation programs and to serve a population of those in need which has not previously been properly done. We wish to prevent further disintegration of individuals from mental, physical and social incapacities. This will establish a method to maintain gains which individuals have made in previous rehabilitation programs and very possibly enhance those gains to a

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point where they can re-establish in the community. This method will attempt to stop the recycling of individuals entering the rehabilitation system and make a more purposeful use of monies spent by agencies toward rehabilitation. We wish to create an environment which is conducive to preventing development of dependencies and produce an attitude and environment which may very possibly do exactly the opposite. It will also alleviate much of the further costs of hospitalization. Built into the program would be a method to maintain and/or rebuild the family stability with a distinct possibility of re-establishing family and social relationships which very possibly might have been lost otherwise. In a sheltered workshop the clients would work on contracts which would afford them a percentage of the profits on each commodity sold, and therefore would maintain a feeling of productivity. Within the unit would be a native craft area wherein native individuals would be allowed to work on their individual items and thus sell them on the market for a proper price; and also afford a training area to enhance the inherent skills of many native men in the art and carving area.

The unit is a semi-self supporting unit with payment for care coming from the individual, SSI, possible VA, State Welfare, Office of Vocational Rehabilitation and/or the Municipality. Also native organizations may very well be able to have voluntary input, these would include BIA, CINA and other regional native corporations. Other possibilities in the future are direct grants, possibly from the State Legislature and several othersources.

In this type of unit volunteer help would be solicited from various agencies, such as Veterans of Foreign Ward, Disabled American Veterans, Alcoholics Anonymous and service organizations such as the Lions Club, Elks Club, Shrine, Salvation Army, Catholic Charities and Jaycees.

The recycling of individuals in rehabilitation programs has become an almost laughing matter, in that it appears many individuals receiving rehabilitation do nothing with what they have learned or gained after they leave the programs. A large void is in the employment area. No agency, to my knowledge, is doing a great deal about re-employing individuals which they have "rehabilitated" and they pay very little or no attention to their living arrangements. Therefore, the work which has been accomplished is by and large lost.

Most of the individuals placed in the unit, would be those which rehabilitation programs would find rather unacceptable. Those who have small incomes and are able to pay for their own care, would also be able to gain more income from the sale of whatever commodities would be made and sold in the unit. Those who do not have incomes would very possibly be able to pay for their own care from the income derived from the sale of their products.

In summary, the purpose of this report is to indicate a willingness and desire to estab ish such a unit to both enhance the Veterans Administration Programs and to assist other agencies in having some logical after-care for individuals who otherwise would not gain a great deal from whatever efforts are being made in their behalf by other agencies. It will require a great deal of cooperation between agencies and it will require, of course, a staff of individuals who are knowledgeable, willing and capable of using their innovative

abilities in a proper way. A further report of the physical structure, cost factors and staff requirements will be submitted.

WILLIAM V. HOGG

STAFF REQUIREMENTS

I. Resident Director

A. College graduate- Masters Degree/Social Sciences
B. Over 35 years of age
C. Capable of innovating- see job description.

II. Assistant Director

A. Degree- Social Science

III. Administrative Officer

IV. Vocational Training Staff

A. Public Relations- Sales and Promotion
Acts as salesman, ideaman and community liason.
B. Shop foreman (Supr.)
Runs wood shop and arts and crafts area
C. Vocational Rehabilitation Specialist
Planning projects and coordinating abilities with work.
D. Social Worker (SWA)
Acts as Counselor and advisor
E. Resident shift personnel
2 for each day shift & for swing. 1 for graveyard and 2 relief.

V. Cooks (2)

A. Chief cook
B. Assistant Cook

VI. Maintenance Staff

VII. Director of Volunteers (Non-paid)

VIII. Executive Secretary

PHYSICAL STRUCTURE - PROJECT CHUGIAK ELEMENTARY SCHOOL - TWO FLOORS

+ Has
- Has not

+ 1. Kitchen, Dining and Serving Capacity.
+ 2. Recreational (Multi-Purpose Room).
+ 3. Adequate Lavatory Facilities.
- 4. Needs Installation of Showers.
- 5. Needs Floor Tile Replacement - Upstairs and Downstairs.
- 6. Repairs to Stage.
+ 7. Has Adequate Office Space
+ 8. Nursing Station (Convert Front of Old Principal's Office or Use Existing Nurses Station).
- 9. Void of Furnishings.
+ 10. Occupational Therapy Area or Crafts Area in Old Kindergarden.
- 11. Emergency Lighting Needs Battery Replacement.
- 12. No Sprinkler System.
- 13. No Laundry Facilities.
- 14. Roof Needs Repair.
+ 15. Grounds are Spacious and Ideal for Outside Activities.
+ 16. Large Storeage Area.
+ 17. Heating Facilities are Adequate
- 18. Large Rooms Need Dividers for Living Area, Beds etc.
- 19. Inside Painting Necessary.
- 20. No Wheel Chair Access Ramps.