40 SCOMM 6: SENATE SPECIAL COMM. ON ALCOHOLISM 1977-78

Public Law 93-959 maximum training is two years.

The Direct Employment Service at Mauneluk is similar to the services provided by an employment agency, but with a few exceptions. Mauneluk Association will act as an agency to place eligible applicants into employment, statewide, for employers desiring specific employees. In addition the service will provide transportation to the job site and a travel allowance. In addition a living stipend is maintained as well as funds for special clothing and tools, as needed, until the receipt of the individual's first paycheck.

Eligibility for Direct Employment service includes: 1) anyone of one quarter Native blood and 2) the applicant must be at least eighteen years of age.

The factors taken into consideration for the successful applicant include both pre-departure counseling and counseling, with a referral service, at the job site.

The Apprenticeship Program allows individuals who qualify to earn money while learning a specific skill or trade. The Apprenticeship program is a system designed to develop skilled craftsmen (i.e., journeymen) through a specified period of time.

In general the program for training and developing a skilled craftsman is provided through an agreement between the contractors and unions, in the several divisions of the construction industry in Alaska, the Mauneluk Association and, at times, the State of Alaska.

The term of Apprenticeship for the construction industry ranges from two to four years. Apprentices attend classes of related technical instruction supplementing their training on the job to give them a comprehensive understanding of the theoretical aspects of their work. Usually the classes are held during the Winter and slack seasons for construction work. In the classroom setting, the Apprentice learns the basic theories of their trade on the job and under the direction of a skilled journeyman, they learn its practice.

No charge is made for the classroom instruction. However some trades require code manuals, or textbooks which are utilized constantly by journeymen. A nominal charge is made for such essential materials.

Each Apprentice signs an Apprenticeship agreement with the joint Apprenticeship Committee which is composed equally of contractors and union representatives. This agreement is registered with the Bureau of Apprenticeship, U.S. Department of Labor, which also awards certificates of completion to apprentices upon successful completion of training

Qualification and requirements for the Alaska building and construction Apprenticeship and training programs vary according to the particular trade desired. On the average the required minimum age is eighteen and a high school diploma or equivalent is necessary. Certain training will require testing and between three to sixteen weeks of classroom training per year. The starting wage varies between $8.35 and $12.85 per hour which is between 50% and 100% of a qualified journeymens day. Of course the above information varies per Apprenticeship trade, but there are over twenty-five trades to choose from if all fields are open.

The interested individual is urged to visit Annie Loon at Mauneluk Association and discover the full range of information available. What could be better than "earning while learning?"

# Acts of Congress

## Indian Health Care Improvement Act

Earlier this year Dave Stewart worked as a Special Projects officer for Mauneluk Association in Washington, D.C. as the result of a two month contract drafted through the mechanism of a Public Law 93-638 (P.L. 93-638) Grant. The function of the special project encompassed P.L. 94-437, the Indian Health Care Improvement Act, which with Dave's legal background allowed him to "observe, provide input and report on the process through which the development of regulations for the act were undergoing." While in Washington he visited certain agencies, private institutions and tribal groups to determine their individual philosophy concerning the act and to also gather information about the actual appropriations that are to be allocated through it.

Dave Stewart reports that "P.L. 94-437 was an act of Congress which was passed in response to the conditions of health care among the Native Americans. As part of the trust responsibility of the United States Government, it is in definite need of improvement.

The health standards are substantially lower for the native populations than for the rest of the country. Death rates are higher and health problems occur at a considerably greater frequency. As such P.L. 94-437 addresses the conditions of the health care delivery system presently provided to Indians and Alaskan Natives.

To better understand the Indian Health Care Improvement Act a little historical information will provide a more meaningful perspective. Originally the Health needs of Native Americans were cared for through the Bureau of Indian Affairs (BIA). In the early 1950's the responsibility for health care delivery to Native Americans was transferred from the BIA to the Department of Health, Education and Welfare (HEW) which the Public Health Service (PHS) is under. The Indian Health Service (IHS) within the PHS, is the agency now with prime responsibility for health care delivery to the Indians and Alaskan Natives.

The IHS received its authority to provide health services from the Snyder Act of 1921. This Act did not specify any specific responsibility for the IHS as it exists now. Rather it was primarily an appropriations vehicle stating in general terms that Congress could appropriate money to meet the health care needs of the Native American people. As such the Snyder Act was an authorization and each year at appropriation time, the act gave Congress the power to appropriate money for the upcoming fiscal year (FY) to meet the needs of what IHS provided. As can be noted Congress must make an "authorization" to "appropriate" money to fulfill the purpose of an Act.

P.L. 94-437 is also an Act of authorization and, as such, it does give Congress the authority to appropriate money for Indian health care and the other needs of the IHS as were listed under the vaious sections of the act.

The Act as it was first passed does establish some substantial levels of funding, but one must remember this is only an authorization and requires that appropriations be made through the appropriations process in Congress. Though it may appear that Congress did commit a large sum of money with P.L. 94-437, in reality the act commits no dollars at all and another action of Congress is required to allocate money

(Continued on Page 16)

## INDIAN HEALTH CARE . . .

(Continued from Page 15)

for the six titles included with the legislation. It should also be noted that the legislation itself did encompass several areas that the IHS did have prior authority for under the Snyder Act.

Coming out of P.L. 94-437 are basically six sections. These sections are titles, I-VI, which address a variety of issues dealing with health care improvements for Indians and Native Americans. Title VI was designed to allow the IHS to conduct a study concerning the feasibility of establishing an American Indian School of Medicine which would provide a health professional school exclusively for Indians and American Natives. Though this is now in the study phase it is felt that the school will unlikely be established because a sufficient number of schools already exist and there are numerous vehicles to allow Native Americans to obtain a medical education with financial assistance in the forms of scholarships, grants and awards from the BIA and IHS. It is anticipated that the study now underway will be completed sometime this fall.

Title V extends the authority of the IHS by providing authorization for funding to conduct programs for urban (i.e., city dwelling) Indians and Native Americans. Presently the appropriations process has no dollars to conduct this phase of the Act. Also as far as Alaskan interests are concerned this title is of no effect because the IHS is responsible for providing health care services to the State's Native population as a whole.

Title IV of this Act is to establish a new method for obtaining funds for the IHS. This section will allow the IHS to bill HEW for health services provided to Indians and Native Americans, through the IHS, to eligible clients under the Medicare and Medicaid programs. Medicaid is the State system for providing health care to those citizens who are financially unable to manage the cost of health care services. This program is primarily financed by the Federal Government with the State as the administering agency. As it is established under the Medicaid section, the Federal Government, through HEW, will reimburse the State 100% for the billed cost of the services rendered by the IHS.

Medicare is the health insurance system provided by the Fereral Government for those citizens who are retired or over sixty-two years of age. It provides for the cost for elderly citizen's health care.

The thrust of Title IV is to enable the IHS to receive funds from HEW for services rendered to Indians and Native Americans, as citizens of the United States, for the Medicare and Medicaid programs. The funds received by the IHS from Medicare and Medicaid must be utilized to improve and upgrade the IHS hospital facilities to a level set by the Joint Commission on American Hospitals. This is the primary organization se ng standards for individual hospital accreditation. Presently the IHS has forty-nine hospitals of which approximately twenty-six meet the standards for accreditation. All of the IHS hospitals in Alaska are accredited. As such any money received under either reimbursement program could not be spent in Alaska. Therefore these funds would apply only to the lower forty-eight where accreditation does not presently exist.

Title III is a section to authorize Congress to appropriate money for facilities construction. This is designed for those areas lacking specific types of

**Dave Stewart, a Special Projects Officer at Mauneluk, visited Washington, D.C. to gain knowledge concerning P.L. 94-437 and filed this report with the editor.**

facilities or lacking in health care facilities altogether. It also budgets money for sanitation facilities (e.g., water and sewage treatment). Presently sanitation facilities are received through other appropriations. An example of this is the Kotzebue Water Project and those in other villages within our Region which are under PHS construction. As with other sections of this act prior authority does exist and thus P.L. 94-437 provides a duplication or overlapping authority (e.g., Snyder Act of 1921). Again this is an appropriations phase of the act and does not necessarily guarantee any monies will be spent or that authorized levels will be met. For example, for the upcoming FY-78, Title III authorized $118 million for construction of facilties and sanitation projects, but in the appropriations process only $24 million was allocated. So Title III, as the facilities construction section of the Act, authorizes levels for FY-78 through to FY-80, but it will remain a year to year issue as to how much will actually be appropriated.

Title II is the Health Services portion of the Act. This section was designed to provide funding for more health professionals to improve the IHS Manpower force. For FY-78 $14 million is authorized which should provide more doctors, nurses, dentists, health technicians and the like. The appropriations process established $4 million which is entirely for the transfer of mature National Institute of Alcohol Abuse and Alcoholism (NIAAA) projects to the IHS. There is one NIAAA project in Alaska, which is the Upper Tanana Regional Council on Alcoholism, to be transferred in FY-78. In essence the IHS will have administrative responsibilties for these projects. At the present they will also have funding control over these programs, but no review and evaluation of these programs is to occur for some time.

Title I is the Indian Health Manpower Section. This is a new program providing explicit authority to the IHS which they did not have before. This section provides for several phases encompassing Health Education. It authorizes substantial funds for education for anyone within a medical or health professional school. In exchange for getting a scholarship, grant or award, under this section, one must in return work for the IHS or in an area mainly serving Indians and Native Americans for a specific period of time. There is also a section to provide training to those individuals already working for the IHS. For example, one may attend workshops or conferences to improve their health care skills or to obtain more health care services information.

In addition Title I provides a section for compensatory education for Indians and Native Americans. As interpreted by the IHS this will provide financial assistance encompassing three areas. It will provide funds for these individuals who have gained entry into a health professional school, but who have subsequently had to drop out due to a deficiency in their prior education (e.g.,

lack of mathematics, basic or advanced sciences, etc.) and must gain compensatory education in order to re-enter the school. The compensatory education portion of this act is also for those who have gained an undergraduate degree at the four-year college level, and who desire to continue the education in the health professions, but who need "supplemental" education in order to gain entry into a health professional school. This would include remedial education in the basic sciences, mathematics and the like. Thus, one could obtain financial assistance to further their educational goals. The last aspect of the compensatory education section is designed for those with high school education who desire education in an allied health profession school and need to meet the basic requirements to gain entrance to such an institution.

The Major section of Title I is a grant program to provide funding to agencies under "Grant Projects" attempting to "locate and identify Indians and Native Americans who have potential as career health professionals". This would include the whole range of health careers from the village health aides to medical technicians to surgeons. This particular aspect of the title is not an IHS program, but a grant program which will be contracted out to other organizations across the country. It will also allocate funding for programs to encourage and assist Indians and Native Americans to enroll or gain necessary training to attend health professional schools. This particular program is presently appropriated at $900,000.00 for FY-78 and is the only phase of P.L. 94-437 that is not providing money to the IHS, but rather other agencies both private and public.

In conclusion P.L. 94-437 the "Indian Health Care Improvement Act" is only an authorization Act by Congress, it does require Congress to meet annually to appropriate money as seen fit. In many ways it can be considered a superfluous act because it duplicates already existing authority granted by other Acts of Congress. In order for this Act to be effective it is going to require a concerted effort on behalf of Indians and Native Americans across the country to make Congress realize the nature of Health care issues for Native people, as this is a part of the trust responsibility of the United States Government. It remains to be seen, as the entire Act runs its course of seven years, what will be accomplished through P.L. 94-437. Time will be the test of Congress' sincerity in appropriating the needed funds.

This act represents an opportunity to upgrade and improve health services bringing them up to the standard levels enjoyed by the rest of the American society. Presently Indian and American Native health care on the whole is deficient and substandard when compared to what the average American society experiences.

As a whole the State of Alaska is now better off than other States, with large Native populations, served by the IHS. Out hospital facilities are accredited and health care is improving, but it still does remain to be seen what the P.L. 94-437 really will mean as time provides the avenues for the complete saga of Native American health care.

## Comments...

# Unwritten Honor Code Still Survives

Remember when we used to live at a slower pace and folks had more time for one another to talk and listen? There are so many good things of life to remember. Today is your moment to remember good things in life.

I remember when we used to leave the houses unlocked. We never had to be afraid to leave camp tents and cabins unlocked because no one bothered them unless in an emergency.

A few weeks back I was in Pt. Hope and the unwritten honor system was brought back to my memory, I thought the unwritten honor system was also a forgotten virtue of the past, but there on a lonely stretch of beach at Pt. Hope I saw the honor code was still alive.

That one day as I walked the beach I saw a piece of driftwood lying over another piece of driftwood making the form of a "T", if you ever see wood laying over other pieces of wood one should honor that claim of someone else. It used to be almost a sacred thing to see. Remember to honor that claim because it might be one of your elder friends' claim.

**Tommy Ongtooguk, a Consumer Education Specialist at Mauneluk, offers his innovative and provocative comments to the Mauneluk Report.**

Perhaps next time we will remember more good things of life that have allowed Eskimos to survive for thousands of years.


## MAUNELUK REPORT

The *Mauneluk Report* is published approximately every seven (7) weeks beginning with Vol. 1, No. 1 issued in mid May, 1977. Circulation is 3,800. The Report is compiled at the Mauneluk Association, in Kotzebue, Alaska, under the editorship of R. W. Frampton. Photographs by T. M. Ongtooguk, R. W. Frampton, and others as credited. Articles submitted by Mauneluk staff. Graphics by R. W. Frampton. Typesetting and printing by the Lettershop, Fairbanks, Alaska. Information herewithin may be utilized by other non-profit organizations. Please advise the editor of the *Mauneluk Report* and credit the Mauneluk Association for any visual and written materials copied or disseminated.

# Editor's Notes...

## ITEMS OF INTEREST

We at the Mauneluk Association are attempting through a continuous effort to improve our ability to inform and to up-grade the well being of Alaska Native people within the NANA Region. We encourge the readers of this News Letter to raise constructive questions concerning our programs and to provide suggestions and recommendations for improvements of our programs and projects. Please forward your ideas to: Editor, Mauneluk Report, P. O. Box 256, Kotzebue, Alaska 99752

We will make sure the appropriate staff members will receive your ideas.

In each issue of the *Mauneluk Report* we carry a general "Comments" column. If you have an item of interest, a question, or thoughts you feel others should see please write to us, at the above address, and we'll attempt to share what you have to say with others of our NANA Region.

## The Next Report

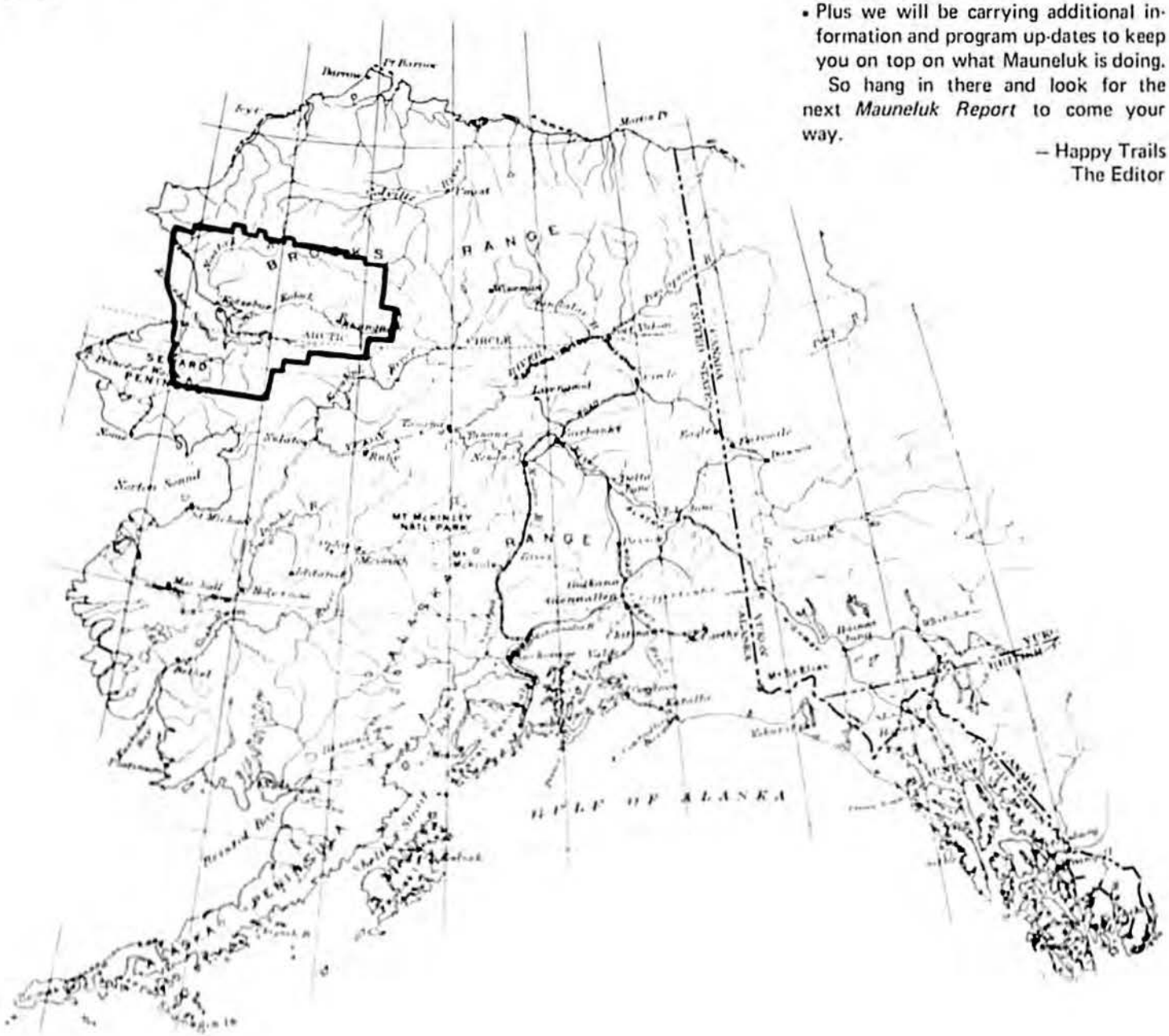
In approximately seven (7) weeks the third issue of seven (7) *Mauneluk Reports* will be resting in your mail box.

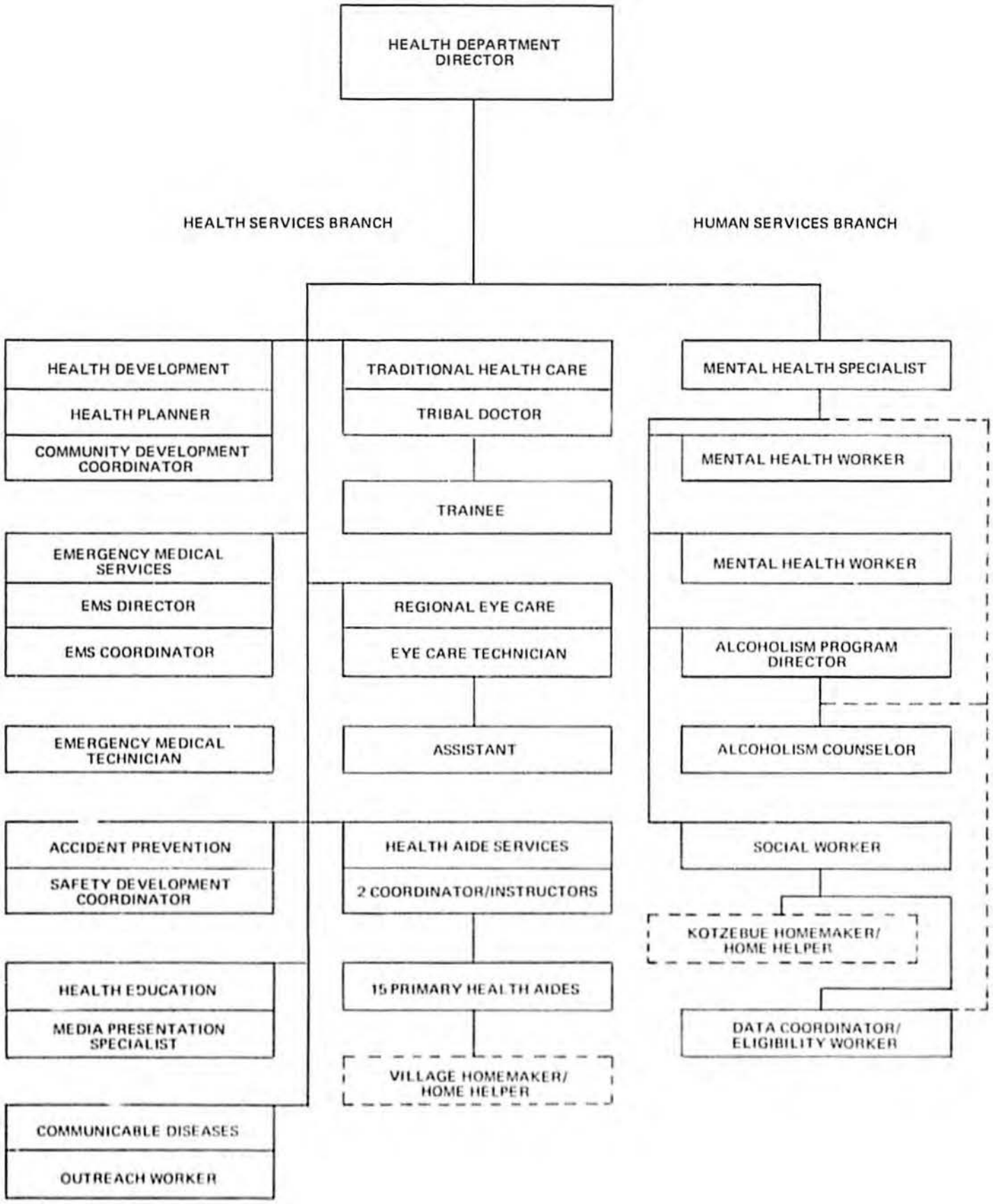
Our next issue will highlight on:

- An interview with Mary Schaeffer, Vice President of Management and Planning at Mauneluk. She will inform us on the office of Native American Programs (ONAP), what the office is and what it means to the residents of the NANA Region.
- We will also interview with Della Keats, the Tribal Doctor, and how her expertise with "Traditional Eskimo Health Care Techniques" aids many individuals throughout the region.
- We will be informed about the Federal Safe Water Act of 1972.
- Plus we will be carrying additional information and program up-dates to keep you on top on what Mauneluk is doing.

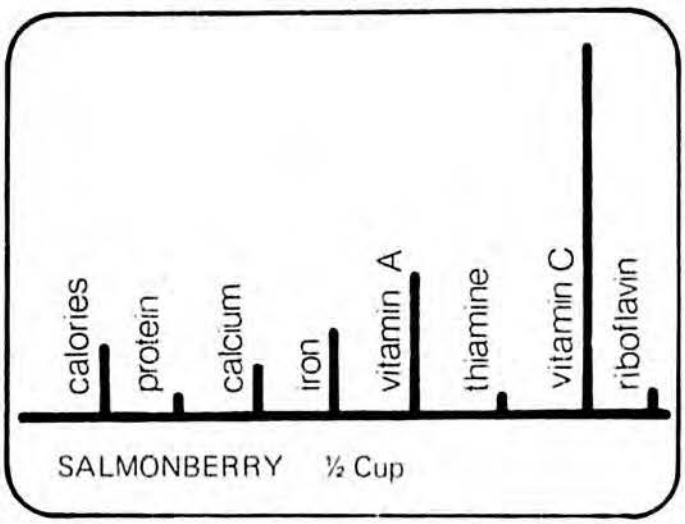
So hang in there and look for the next *Mauneluk Report* to come your way.

– Happy Trails
The Editor

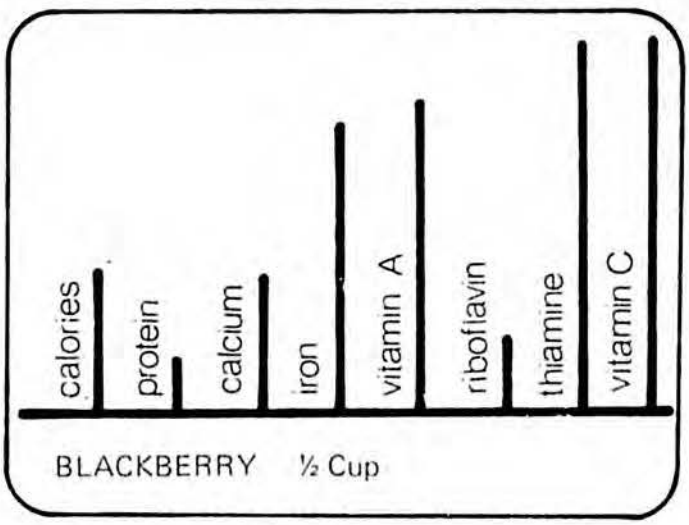



HEALTH DEPARTMENT DIRECTOR
HEALTH SERVICES BRANCH
HUMAN SERVICES BRANCH
HEALTH DEVELOPMENT
HEALTH PLANNER
COMMUNITY DEVELOPMENT COORDINATOR
EMERGENCY MEDICAL SERVICES
EMS DIRECTOR
EMS COORDINATOR
EMERGENCY MEDICAL TECHNICIAN
ACCIDENT PREVENTION
SAFETY DEVELOPMENT COORDINATOR
HEALTH EDUCATION
MEDIA PRESENTATION SPECIALIST
COMMUNICABLE DISEASES
OUTREACH WORKER
TRADITIONAL HEALTH CARE
TRIBAL DOCTOR
TRAINEE
REGIONAL EYE CARE
EYE CARE TECHNICIAN
ASSISTANT
HEALTH AIDE SERVICES
2 COORDINATOR/INSTRUCTORS
15 PRIMARY HEALTH AIDES
VILLAGE HOMEMAKER/ HOME HELPER
MENTAL HEALTH SPECIALIST
MENTAL HEALTH WORKER
MENTAL HEALTH WORKER
ALCOHOLISM PROGRAM DIRECTOR
ALCOHOLISM COUNSELOR
SOCIAL WORKER
KOTZEBUE HOMEMAKER/ HOME HELPER
DATA COORDINATOR/ ELIGIBILITY WORKER

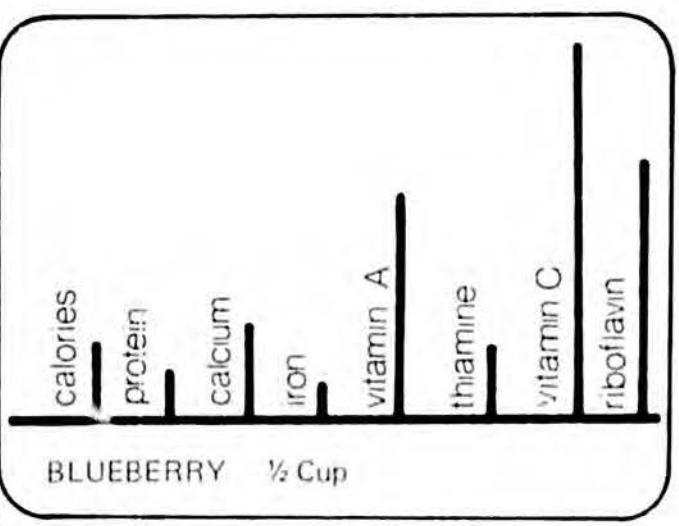
# Food Value For Good Health



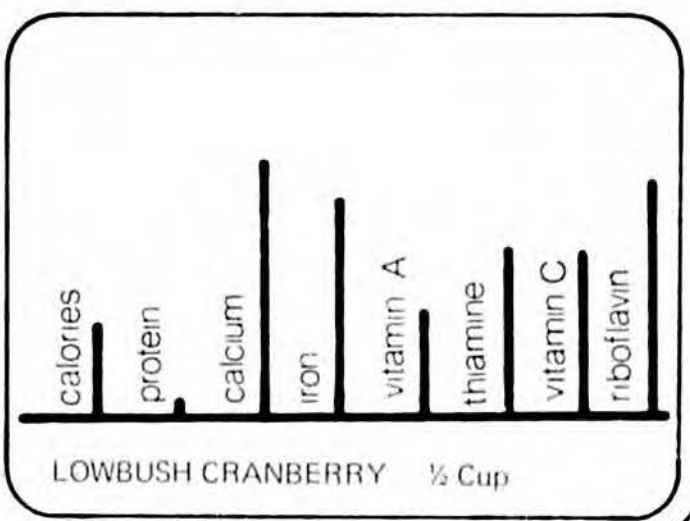

SALMONBERRY ½ Cup




BLACKBERRY ½ Cup




BLUEBERRY ½ Cup




LOWBUSH CRANBERRY ½ Cup

**Mauneluk Report**
**Mauneluk Association, Inc.**
**P. O. Box 256**
**Kotzebue, Alaska 99752**

**.S. Bulk Rate**
**PAID**
**Permit No. 208**
**Fairbanks, Ak.**

**To:**

# SCOMM

#6:40

THE

# RESIDENTIAL ALCOHOLISM REHABILITATION PROGRAM

A COMMUNITY PROJECT

Merwin A. Kiel
306 West 8th St.
Juneau, AK
99801

# THE RESIDENTIAL ALCOHOLISM REHABILITATION PROGRAM

During the past eleven years the Association of Halfway House Alcoholism Programs of North America has grown into a viable, productive organization dedicated to the recovery of alcoholics throughout the continent. Furthermore, halfway houses, their programs and significance to the comprehensive alcoholism programs, have grown in prestige and credibility. We are no longer just a place for recovering alcoholics to live until they can return to their families or obtain some sort of job, until they can be out on their own again. We are an integral part of the rehabilitation of the recovering alcoholic; of the Whole Person.

In these days of rising costs, increasing number of persons seeking help with alcoholism, and the decreasing amount of public monies available, it is imperative that we search for a less expensive way to furnish professional help for more alcoholics who desire sobriety and need help to attain and maintain it. The Residential Rehabilitation Program in a halfway house setting, is one way in which this can be accomplished. This program, especially, is advantageous for smaller communities. They should be large enough to have a hospital or inpatient health facility and have access to offices to other Health and Social Service agencies that can provide special services to the client as an in-kind contribution to the program.

Although costs will vary somewhat in different areas, the expenditure of money for a client to receive treatment in a hospital based thirty-day program is about the same as a seven-day hospital detox plus a four-month residential rehabilitation program. And, the client will pay a good portion of this himself. The Halfway House concept is the ideal basis for the Residential Rehabilitation Program. In this environment the alcoholic can make the transition to sobriety by adhering to the in-house program and utilizing all of the community resources designed to help each individual according to his or her needs.

This paper is an outline of the complete program; organization, personnel qualifications, program technique, administrative procedures, funding for and by the client, and the path of recovery from detox to his or her emergence as a fully adjusted, self-sustaining, and responsible "Whole Person". For simplicity, the client will be referred to as male.

in this paper

One of the primary reasons for interjecting this program with the Halfway House program is the lack of readily available primary treatment at a comprehensive treatment center. Most of the treatment centers are located in or near the large metropolitan communities and travel to these centers is often a problem: It is difficult to get the client there. Oftentimes the client does not want to leave his locale. And, in many cases this is for the best; this is where the client will live as a sober person. His family, or sometimes his culture, does not approve of sending him so far away. But, the client must have a semi-protective environment in which to concentrate on his problem of alcoholism. He must be able to learn the value of honesty and to confront reality. This is where it is!

Another reason to utilize this type of program is the comparative ease in operating the Aftercare Program. Although the Aftercare Program has been thoroughly discussed and agreed upon, by the client and the counselor, it is difficult to follow up on it by long distance communications. Continued proximity of the client does not assure a successful aftercare program, but it helps. And, Aftercare is one of the most important phases in the continuum of care for the recovering alcoholic.

Of course the main attraction of this type of program, as the primary community effort to combat alcoholism, is money. Primary treatment in a hospital setting is expensive; up to a hundred and fifty-dollars per-day or more in some areas. The Residential Rehabilitation Program can operate at a cost one quarter to one sixth of this, again depending on the locale. Third-party payments are available for accredited rehabilitation facilities. Furthermore, after the first two-to-four weeks, the client can be working and paying a major portion of the cost of his treatment. Recovery from alcoholism takes a lot of time and effort, and the client must be made aware of this and be able to accept that fact.

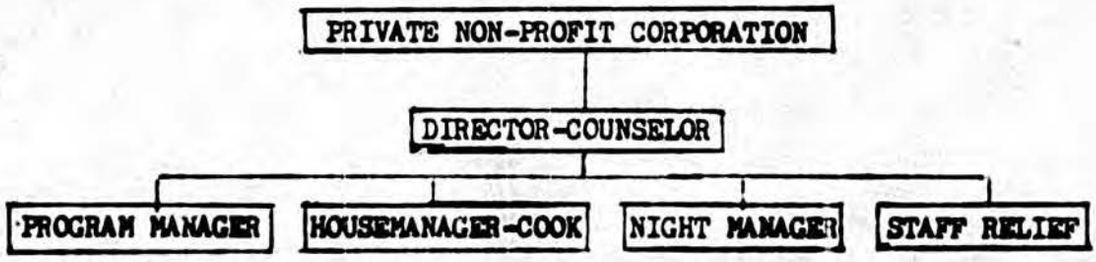
One such program operates with twenty-one percent of the budget coming from the State Office on Alcoholism as its share of the federal funding of programs. Eleven percent comes from the community, thirteen percent is generated within the program in the form of in-kind services, and the remaining fifty-five percent is derived from the clients and third party payors; the clients paying over half of this themselves.

Each community will have to research the funding possibilities and put together the best combination for both immediate and long term goals. A sample budget is attached to this paper.

The basis of this program is a private non-profit corporation. This type of operation, unhampered by local, state, or federal civil service regulations, is better suited to meet the needs of the individual client, and the personnel, than is a government operated facility.

The physical plant should be able to feed and house twelve to fifteen clients plus two live-in staff members. Space for administration and program activities, such as individual counseling and group therapy, should be in the same building, but can be located in another facility if necessary.

The Board of Directors should be comprised of local persons interested in the community and its growth; and, able to give some of their time to creating policy and monitoring the efforts of the staff. It is well to have representation from the business, banking, educational, legal, and accounting fields of the community. The table of organization will show the Director-Counselor reporting to the Board of Directors and the Program Manager, Counselor House Manager-Cook, Night Manager, and Staff Relief person responsible to the Director.




Personnel job descriptions are as follows:

DIRECTOR-COUNSELOR: The Director is responsible for the daily administration of the facility; implementation of policies and practices approved by the governing body; preparation of budgets for approval, and control of all financial matters pertaining thereto; prepare written reports as required by the governing body and the Office of Alcoholism; handle details of agreements with other community agencies in accordance with policies and procedures; develope an in-service training program; planning and negotiating needed modifications to buildings and grounds of the facility to meet Codes and Standards of the State and Community; recruitment, hiring, and training of subordinate personnel and volunteers; create public relations with the community at large; individual and group counseling.

PROGRAM MANAGER: Will perform individual and group counseling; maintain all client records and statistical data needed for preparation of required reports; establish a Personal Recovery and Aftercare Program for each client; maintain communications with staff of other agencies according to the needs of each client.

HOUSE MANAGER-COOK: Will verify the performance of client-assigned household duties and cleanliness of the facility; prepare menus and meals; maintain inventory of food and supplies; compute cost of food and supplies consumed each month and submit this report to the Director.

NIGHT MANAGER: Maintain discipline and security within the facility from the end of the working day until curfew.

STAFF RELIEF PERSONS: Serve preplanned meals during the Cook's time off; perform security checks during the Night Manager's time off.

As previously stated, the program is based on honesty and reality. It begins with the Board of Directors and the personnel, and continues with the client. He begins his at the Detox unit. of the medical facility.

The client arrives at the Detox unit by any one of a number of referral sources; the police, his family, an AA friend, his minister, or even by himself. His length of stay in the Detox unit will be from three to seven days depending upon the severity of his withdrawal. During this period of time the client will be given a complete physical examination, monitored continously for withdrawal symptoms, and interviewed at least three times by the alcoholism counselor.

Through the medium of these sessions the counselor can determine what further treatment is most likely to attain the desired solution to the client's problem. It may be to return home, participate in AA and outpatient counseling, or it may be to go to a major hospital with a primary treatment program. In many cases the long term residential rehabilitation program will be the most expedient. Criteria for entry into the program will be — the client's need for help with his alcoholism problem and his desire to put forth whatever effort is necessary to overcome it.

When he enters the residential rehabilitation program, he is interviewed by the Director first. During this interview the Director will try to ascertain what needs of the client it will be necessary to address so that he may have access to all of the available help to straighten out his life. This is the meaning of rehabilitation for the WHOLE PERSON.

The Director explains the house rules, the house duties, and the schedule of therapy to the client. Agreements as to behavior and causes for termination will be discussed and signed. The resident schedule, concerning group therapy one-to-one counseling with the program mananager, AA meetings, church schedules and other pertinent activities will be fully explained and a copy given to the resident client. Not the least important item to be discussed is the payment for these services.

When the Director is finished with the intake interview, the client is introduced to the house manager; assigned a bed, shown the facilities, and, in general, acquainted with the idea of group living. He is assigned a household duty, instructed as to the meal times, and instructed to report to the program manager the next morning.

During the first two-to-three weeks the client's time will be absorbed with the program. Didactic activities such as lectures, films, audio tapes, and discussions will be programed for the mornings of each workday. One-to-one counseling, studying, personal needs, and interviews with other agencies will consume the rest of his time. It is during this time that the Personal Recovery Program of each client can be developed. By observing the client and comparing counseling notes from interviews, the Director and the Program Manager will have an idea of what services the client can best use to meet his needs for help in his recovery and attaining the reality of being a self-sustaining, responsible, tax paying citizen.

The Director should maintain a good working relationship with all of these social service agencies. They can furnish in-kind services for the clients as w@ll as some funding for his stay at the facility. The Mental Health service, the Marital clinics, and the Family and Childrens Services all provide a service needed by some of the clients. The Veterans Administration and the Department of Vocational Rehabilitation can often furnish both needed services and third-party payments. The local welfare office and the employment office are also a source of services and revenues. With a good relationship with these services and other private sources of community help, such as the Elks and Lions clubs, the Director can be very instrumental in setting up the first appointments for each client so that he may be d'rectly responsible for his own change in his character and style of living. The client is the person that must put forth the effort to attain this goal.

If the client has marital or family problems, the Director should help him get the first interview with a marriage counselor, family relations counselor, pastor, or other available special counseling service for this problem. When the client has his mind at ease as to what he can or cannot do about his family relationships, he is in a much better position to concentrate his energies on his own problem of alcoholism. If his family problem is not attended to in the beginning of his program, he will be too occupied with anxiety and fear to be of much help to himself. The entire program is designed on the "Here and Now" concept of living; What he is, where he is, where does he want to go, and how does he get there.

Dr. William Glasser, Founder of the Institute for Reality Therapy, developed this therapy based on the three R's, right and wrong, reality, and responsibility. Reality Therapy is a concept of relearning to live that is a very useful tool for the Residential Rehabilitation program. It does explore the regression of the person's lifestyle, and although it is well to review this, the client has been there, and it does not accomplish a whole lot to spend too much time on this. Rather, it is more profitable to spend time with him on the positive aspects of this program. The Concepts of Reality Therapy, is available in book form, workshops, and video tapes from the Institute.

Although the program is designed for the voluntary client seeking help, most of the persons that come are coerced into it in one way or another. Referrals come from the courts and the hospitals; In many cases the client has a choice of taking treatment for alcoholism or losing his job. For some, it is the last desperate attempt at survival. But, however the client enters this program, if he stays for a minimum of thirty days, he is going to get something positive from it.

About fifty-percent of the admissions will be short term residents, mostly due to violations of the house rules. If these clients needed to be there in the first place, they will be back. And, they should not be refused readmittance if they meet the criteria for entry. The clients that stay in the program for a period of four-to-twelve months, depending on the individual, will have an excellent probability of remaining sober and productive. For many, it will be their second or more attempt for sobriety and a rational life.

Data on one program that has been in operation for over a year indicates that the short term client's average length of stay is twenty-two days and long term client's length of stay is one-hundred and fifty-three days.

Fees to be charged the client will vary somewhat, depending on the client's ability to pay and third-party payors. In no case should the fee be lower than it would cost him to maintain himself elsewhere in a sober and comfortable manner. These charges will have to be based on the local economy and be seriously considered when preparing the budget.

This is a community project. The only way it will be able to operate is with the complete cooperation, social encouragment, and financial support of the community it is to serve. This means that the business, political, and social leaders must be willing to give both time and money towards its establishment and maintenance; It means they must help in finding a facility, even a small one to start with; They must help in funding research, public and private; and, especially, help in recruitment of the right personnel to manage it.

The residence and program just described is a domain for learning; unlearning and relearning a way of life. A phrase often heard in our society is: " Oh, he will never sober up." In this business, we NEVER SAY NEVER.

## SAMPLE BUDGET

### By Percentage of Total Budget

| | % | % |
|---|---|---|
| **Personal Services:** | | |
| Staff Salaries | 37.2 | |
| Staff In-Kind | 13.0 | |
| Fringe Benefits (14.5%) | 5.4 | |
| | | 55.6 |
| **Travel:** | | |
| Fare, Tuition, and Per diem | 1.2 | |
| | | 1.2 |
| **Contractual Services:** | | |
| Communications | 1.0 | |
| Rent | 14.4 | |
| Utilities | 1.4 | |
| Professional Services (Auditor) | 1.4 | |
| Local Transportation | 0.4 | |
| Maintenance | 0.8 | |
| Insurance | 0.8 | |
| Building Repairs | 3.0 | |
| | | 23.2 |
| **Commodities:** | | |
| Food | 15.4 | |
| Fuel | 1.8 | |
| Supplies | 1.2 | |
| Equipment Replacement | 0.4 | |
| | | 18.8 |
| | | 100.0% |

Based on an occupancy of twelve clients per day. (75%)

PLEASE NOTE: THE FOLLOWING PAGES WERE TREATED AS A UNIT IN THE ORIGINAL DOCUMENT.

Gastineau Manor

Juneau, Alaska

306 W. 8TH STREET 99801 PHONE (907) 586-3684

## The Program

Gastineau Manor has a fully functioning program designed to aid the rehabilitation of the recovering alcoholic. The staff consists of the Director, Counselor, Housemanager, Cook, and night manager. The last three positions are client-staff who have attained their sobriety and are maintaining it at Gastineau Manor.

We are part of a network of social services in Juneau and use the services of Mental Health, Vocational Rehabilitation, Adult Learning Center, Manpower Services on a regular basis, as well as continual group therapy at ACA.

A client must be sober when applying for residence and program at Gastineau Manor. It usually takes a few days to overcome the pains and results of withdrawal from alcohol and after that the client starts on the regular program: group therapy, individual counseling, AA, and attendance at weekly behavior modification lectures. In two or three weeks the counselor and the client develop a Personal Recovery Program (PRP). Each PRP is developed according to the abilities and needs of each client.

It takes many months for an alcoholic to be reconditioned to live without using alcohol to relieve the pains and frustrations as he has in the past. About fifty-percent of our admittances stay less than thirty days and about all they learn from that stay is facts about alcohol and alcoholism. The clients that stay and work on their program for a period of six months or more usually learn to live a productive and socially integrated life without the use of alcohol. Whatever the period of time the client stays, he will learn at least one thing "It Can Be Done".

Gastineau Manor
Juneau, Alaska
386 W. 8TH STREET 99801 PHONE (907) 586-3536

# POLICY MANUAL

## INTRODUCTION

Gastineau Manor, Juneau, Alaska is a Residential Rehabilitation Facility for adult male and female alcoholics without restriction as to race, national origin, or religious belief, provided they meet the criteria set forth herein.

The goals of the Gastineau Manor are to provide a supportive home substitute in an atmosphere conductive to living without alcohol or the use of drugs other than prescribed medication for a physical condition. A home-like and relaxed atmosphere, counseling, the use of community health facilities, the sharing of tasks required to operate the home, and programs designed to assist residents in living without chemical comforters; the attainment of economic stability through work or job training; and resocialization outside the resident's drinking envirement, are all methods toward the final objective of return to full community living as a productive and stable citizen.

## APPLICATIONS FOR RESIDENCY

Admission shall be by referral from physician, medical facility, alcoholism treatment center, or social agency. Priority consideration of application will be given to persons completing, or who have completed inpatient treatment for alcoholism and/or discharged with medical approval from a hospital having an alcoholism treatment program.

All referrals will be made to the Director and screening will be conducted by him in coordination with the referring agency or person.

Final decision to admit an applicant is the responsibility of the Director.

Persons who have been addicted to "hard stuff" opiates or their chemical equivalents, are not eligible.

No person will be admitted as a resident who is under the influence of alcohol or drugs. No detoxification or medical treatment will be conducted at Gastineau Manor.

CONDITIONS OF RESIDENCY

The applicant voluntarily requests admission.

He agrees to participate in the Gastineau Manor Program, by an initial minimum self-commitment of thirty days and to follow through with continual program and Aftercare Plan as agreed upon by client and program manager.

He agrees and understands that no maximum limit is imposed, but is entirely a matter between the Program Manager, any therapist involved in his treatment, and himself.

The applicant must be employable, or if impaired, such impairment prognosed as tempory and he is receiving, or is eligible for his disability assistance.

The cost of residence at the Gastineau Manor is the first responsibility of each resident in the use of his funds.

The House is not responsible for the personal property or funds of the resident, or loss or theft thereof.

That property left by any resident who terminates for any reason will be held, by the house, for 30 days only, and then disposed of in the best interests of the house.

Each resident authorizes the Resident Manager to search his personal property if the Manager suspects that the resident has intoxicants or drugs in his possession.

He agrees to follow all House Rules and to perform such duties as may be assigned to him in addition to maintaining the cleanliness and neatness of the room to which he is assigned.

TERMINATION

The following are causes for termination of residency:

Drinking beverage alcohol.

Use of unprescribed medication, or prescribed medication in excess of the dosage.

Failure to follow the House Program.

Unexplained overnight absence.

Non-payment of fees and charges at specified time.

Any conduct that is prejudicial to the good order of the House, the due consideration for others, or to accepted social behavior. Such conduct includes but is not limited to:

Uncleanliness of person or assigned sleeping area.

Inability to get along with other residents and to show them due consideration.

Failure to cooperate in maintaining the cleanliness and good order of other parts of the House and grounds.

In every case, except drinking or the use of drugs, as described, the Director will make every effort to avoid termination and find an acceptable solution to the problem, if possible.

The Director or in his absence, his designated assistant, is solely responsible for carrying out the policies established.

Approved by: Gastineau Manor Board of Directors

Date: 13 June 77

Gastineau Manor
Juneau, Alaska
306 W. 8TH STREET 99801 PHONE (907) 586-3536

## HOUSE RULES

1. NO intoxicants or intoxicated persons allowed on premises.
2. NO weapons or explosives allowed on premises.
3. NO SMOKING IN BED.
4. Residents will be fully clothed in the downstairs area of the House.
5. All residents will sign IN & OUT book when leaving and entering residence.
6. All residents will be out of bed at 7:00 A.M.
7. All beds and living areas will be made up and cleaned by:
   8:00 A.M. Weekdays
   9:00 A.M. Sundays and holidays.
8. Each resident will perform HOUSEKEEPING ASSIGNMENT each morning BEFORE leaving or at assigned time.
9. Attend ALL meetings and classes unless excused by the manager.
10. CURFEW is 11:00 P.M. unless prior arrangements have been made with Manager.
11. GUESTS may visit in the living room at times set by the Manager.
12. NO long distance phone calls can be made except in special circumstances cleared by the Manager in advance of said call.
    Arrangements for payment of tolls should be made at this time.
13. All residents are expected to know these rules established for the protection and guidance of al concerned. Any questions regarding the interpretation of these rules are delegated to the Director and the Board of Directors.

I understand the above rules and will abide by them.

Date:_____ Signed_____

Witness_____

Gastineau Manor
Juneau, Alaska
306 W. 8TH STREET 99801 PHONE (907) 586-3836

## DAILY SCHEDULE

### Weekdays

| | |
|---|---|
| ------7:00 AM | Get up,dressed and ready for breakfast. |
| 7:00--9:00 | Breakfast, clean personal area, household duties. |
| 9:00--11:00 | Group Therapy as scheduled. |
| 11:00--12:00 | Free Time |
| 12:00--1:00 PM | Lunch |
| 1:00--5:00 | Individual counseling and/or appointments with other agencies as scheduled; MHC, OVR, PHS, Basic Ed, etc.. |
| 5:00--6:00 | Dinner, Household duties. |
| 6:00--11:00 | Free Time, AA, and other activities. |
| 11:00------- | Curfew. |

### Special Compulsory Meetings

| | |
|---|---|
| Wed., 8:00 PM | Gastineau Group AA |
| Sat. 9:00 AM | House Meeting: |

A. Discuss house rule infractions.
B. Behavior Modification lecture.
C. Personal Problems to be discussed with Director.

### Sundays & Holidays

| | |
|---|---|
| Mornings: | Prepare own breakfast. |
| | Church |
| | Other Activities. |
| 4:30 PM | Sunday Dinner. |

I understand the above schedule and will personally abide by same during my stay at Gastineau Manor.

Signed_____

APPENDIXX B

Gastineau Manor
Juneau, Alaska
306 W. 8TH STREET 99801 PHONE (907) 586-3536

## HOUSE DUTIES

EVERYONE:

Daily: Make beds, hang up clothes, clean ashtrays, bring trash down.

Weekly: Vacuum room, dust furniture and woodwork, clean mirrors etc...

ASSIGNED DUTIES:

1. 1st floor; clean ashtrays, dust floors and woodwork, straighten tables.
2. Vacuum 1st floor rugs.
3. Clean 2nd floor bathroom.
4. Vacuum 2nd floor hall and stairs.
5. Clean 3rd floor bathroom, vacuum hall and stairs.
6. Set up table for breakfast.
   - 6A. Same for lunch.
   - 6B. Same for dinner.
7. Clean table and do dishes after breakfast.
   - 7A. Same for lunch.
8. Clean table, do dishes, and clean kitchen after dinner.
9. Sweep basement, clean washer and dryer, etc..
10. Clean office and vacuum rug.
11. 1st floor washroom and toilet.

If any duty assigned to you conflicts with your work schedule, please see the Manager so that exchanges may be arranged. This work must be done to keep the house clean and a place that we are proud to live in.

THE DIRECTOR

Gastineau Manor

Juneau, Alaska
99801

306 W. 8TH STREET

PHONE (907) 586-6806

July 1, 1977

CLIENT FEE SCHEDULE

This General Schedule of Client Fees is based upon net income less payments of family or child support, if any.

| | |
|---|---|
| $ 0. to 385.00 per month. | Client keep $35. and pay the rest. |
| 385. to 450.00 " " | $350. per month |
| 450. to 500.00 " " | 375. " " |
| 500. to 600.00 " " | 400. " " |
| 600. to 800.00 " " | 450. " " |
| Over 800.00 " " | 500. " " |
| All Third-Party Payers | 500. " " |

Each individual fee will be assessed by a careful evaluation by the Director and the client of his assets, income, and obligations.

APPROVED: GASTINEAU MANOR BOARD OF DIRECTORS.

Gastineau Manor
Juneau, Alaska
99801
306 W. 8TH STREET
PHONE (907) 586-6636

# THE DEPARTMENT OF HEALTH AND SOCIAL SERVICES

## WANTS YOU TO KNOW THAT

## YOU MAY NOT BE DISCRIMINATED AGAINST

## ON ACCOUNT OF RACE, COLOR, OR NATIONAL ORIGIN

## ACCORDING TO THE CIVIL RIGHTS ACT OF 1964

*It is the policy of the Department of Health and Social Services that no person shall, on account of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under federally assisted programs administered by or in behalf of the Department.*

Any person may file a complaint of discrimination on account of race, color, or national origin on behalf of himself or another person with the Department of Health and Social Services division, separate office or program director who administers the program under which discrimination was expressed (see list inside brochure);

and/or

the Department of Health and Social Services
Civil Rights Coordinator
Pouch H-02
Juneau, Alaska 99811

and/or

the State Commission for Human Rights
520 MacKay Building
338 Denali Street
Anchorage, Alaska 99501

and/or

Signed _____

Witness _____

Date _____

## HOUSE POLICY

### Visitors, Phone, Mail, Clothing

1. You may have visitors. They are welcome to the House if they are sober and interested in your welfare and recovery. Please confine your visits to the ground floor. You may invite them to a meal at the House occasionally, upon prior approval of the Director or the Counsellor. If you have visitors of a professional nature, please introduce them to the staff if possible.

2. You may use the phone in the front hall, or receive calls here, subject to the usual rules of courtesy and time.

   A. Clear long-distance calls with the Director and make arrangements to pay for them.

   B. Do not be selfish about telephone time.

   C. Log all long distance calls on the telephone log-sheet.

3. You are encouraged to write letters. No one will want to see them or to censor them. If you do not have a stamp, see the Director; arrangments can be made. Paper and envelopes can also be obtained from the Director.

4. Clients will be expected to dress at all times with due consideration for the rights of others and for ordinary politeness and the demands of good taste. Each client shall provide his own clothing, which will be kept clean and neat, using the laundry facilities at his disposal.

5. Personal belongings may be kept in each client's room, and decorations in good taste are allowed. Articles used for personal hygiene and grooming may be kept adjacent to your sleeping area. If you do not have what you need, talk to your counsellor and arrangements may be made.

6. Lockable storage spaces will be provided for bulky or excess baggage or belongings.

7. Staff persons are expected to respect your right of privacy. Violations may be brought to the attention of the Director.

8. Should you need a barber or beautician and cannot afford one, the Counsellor or Director will arrange for one.

9. Do not play stereos, TV sets, or radios when others may be disturbed.

10. You are encouraged to use the leisure time provided to you in the schedule in some progressive and useful way. If you do not know what recreational activities are available, consult the counsellor or the Director.

11. Please make yourself familiar with the fire-alarm button locations (near each door) and read the posted instructions on the Bulletin Board.

# "WHAT THE ALCOHOLIC DOES FOR HIMSELF..."

by Robert V. Seliger, M.D.

HE MUST

BE CONVINCED from his own experience that his reaction to alcohol is so abnormal that any indulgence for him consititutes a totally undesirable and impossible way of life.

BE COMPLETELY SINCERE in his desire to stop drinking once and for all.

RECOGNIZE that the problem of drinking, for him, is not merely a problem of dissipation, but of a dangerous psychopathological reaction to a (for him) pernicious drug.

CLEARLY UNDERSTAND that, once a man has passed from normal to abnormal drinking, he can never learn to control drinking again.

COME TO UNDERSTAND that he has been trying to substitute alcoholic fantasy for real achievement in life, and that his effort has been senseless and absurd.

RECOGNIZE that freeing himself from alcohol is his own personal problem, which primarily concerns himself alone.

BE CONVINCED that at all times, and under all conditions, alcohol produces for him not happiness, but unhappiness.

COME TO UNDERSTAND that the motive behind his drinking has been some form of self-expression, some desire to gratify an immature craving for attention, or to escape from unpleasant reality in order to get rid of disagreeable states of mind.

UNDERSTAND THAT alcoholic ancestry is an excuse, not a reason for abnormal drinking.

TRY TO ACQUIRE a mature sense of values and learn to be controlled by his judgement instead of his emotions.

REALIZE THAT IN stopping drinking he should not regard himself as a hero, or martyr, entitled to make unreasonable demands that his family give in to his every whim and wish.

BEWARE OF unconsciously projecting himself into the role of some character in a movie, book, or play who handles liquor ..... "like a gentlemen".., and of persuading himself that he can--and will--do likewise with equal impunity.

LEARN the importance of eating--since the best preventive for that tired nervous feeling which leads to taking a drink is good eating habits; and that alcoholics should not hesitate to carry chocolate bars or other candy with them, at all times if necessary, to eat between meals and whenever they get restless, jittery, or tired.

LEARN HOW to relax naturally, both mentally and physically, without the use of the narcotic action of alcohol.

LEARN TO avoid needless hurry and resultant fatigue by concentrating on what he is doing rather than on what he is going to do next.

NOT NEGLECT care of his physical health, which is an important part of his rehabilitation.

CAREFULLY FOLLOW a daily self-imposed schedule which, conscientiously carried out, aids in organizing a disciplined personality, developing new habits for old and bringing out a new rhythm of living.

REALIZE that any reasonably intelligent and sincere person who is willing to make a sustained effort for a sufficient period of time, is capable of learning to live without alcohol.

AVOID the small glass of wine-i.e., the apparently harmless lapse--with even more determination than the obvious slug of gin.

NEVER TO BE SO FOOLISH as to try to persuade himself that he can drink beer.

NEVER TO BE SO CHILDISH as to offer temporary boredom as an excuse to himself for taking a drink.

CLEAR HIS MIND of any illusions that alcohol sharpening and polishing his with and intellect.

LEARN to be tolerant of other people's mistakes, poor judgement and bad manners without becoming emotionally disturbed.

LEARN to disregard the ill timed or inappropriate advice--and other questions--of relatives and friends without becomming disturbed emotionally.

RECOGNIZE ALCOHOLIC DAYDREAMING about past "good times", favorite bars, etc., as a dangerous past time to be inhibited by thinking about reasons for not drinking.

LEARN TO WITHSTAND success as well as failure, since pleasant emotions as well as unpleasant ones, can serve as "good" excuses for taking a drink.

LEARN to be especially on guard during periods of changes in his life.

NEVER RELAX his determination or become careless, lazy, indifferent, or cocky in his efforts to eliminate his desire for alcohol.

NOT BE DISCOURAGED by a feeling of discontent during the early stages of sobriety but must turn his feelings into incentives for action which will legitimately satisfy his desire for self-expression.

NOT DROP HIS GUARD at any time, but especially during the early period of his reorganization, when premature feelings of victory and elation often occur.

UNDERSTAND that, besides abstinence, his real goal is a contented and efficient life.

APPRECIATE the seriousness of his re-education and regard it as the most important thing in his life.

REALIZE that most people seeking psychological help for abnormal drinking are above average in intellectual endownment, and that while drinking means FAILURE, abstinence is likely to mean success.

NEVER FEEL THAT ANY of these commandments are in any way inconsequential, or secondary to business, play or what not; and he must conscientiously observe everyone of them, day-in and day-out.

PLEASE NOTE: THE PRECEDING PAGES WERE TREATED AS A UNIT IN THE ORIGINAL DOCUMENT.

# DESIGN RECOMMENDATIONS FOR ESTABLISHMENT OF AN ALCOHOLISM SERVICE DELIVERY SYSTEM IN THE CITY AND BOROUGH OF JUNEAU

Prepared For:

THE CITY AND BOROUGH OF JUNEAU
155 South Seward Street
Juneau, Alaska 99801

Prepared by:

Human Services Horizons, Inc.
600 McCormick Street
San Leandro, California 94577

Uwe Gunnersen, M. A.
Director

Mark L. Feldman, Ph. D.
Associate Director

## I. BACKGROUND

On May 15, 1975, the Assembly of the City and Borough of Juneau, Alaska adopted a resolution creating an Alcoholism Advisory Board (Serial No. 311). This Advisory Board was mandated by a Comprehensive Staffing Grant that had been awarded to the City and Borough of Juneau by the National Institute on Alcohol Abuse and Alcoholism. The resolution further reflected the concern of the Assembly about alcoholism, by recognizing "alcoholism and alcoholism rehabilitation as a primary health concern in Juneau" and charging the Advisory Board with recommending "changes in local ordinances which will emphasize treatment of alcoholism as a social disease, rather than a crime".

It is our understanding that the intent of this resolution was carried out in a reasonably satisfactory fashion by the Alcoholism Central Agency (ACA), until the agency was forced to vacate its quarters at the St. Ann's Building. As the new quarters on the second floor of the police station were never well suited for an emergency care program, this escalated the considerable dissension already existing between ACA and other community service providers and interest groups. The situation was further complicated by the Alaska State Office of Alcoholism which conducted an extensive programmatic evaluation from which the State concluded that ACA was not operating in correspondence with State guidelines for alcoholism programs. Consequently, the State withdrew funds from the operation of ACA.

State withdrawal of funds necessitated a severe curtailment of services, making it impossible for the program to maintain even minimal compliance with the regulations of its federal comprehensive staffing grant. This withdrawal of funds further encouraged municipal authorities to scrutinously review the complex circumstances surrounding the operation of the program and make a decision as to their commitment to alcoholism service delivery. Concern over compliance with the Charter of the City and Borough of Juneau (which mandates attention to the alcoholism problem) motivated municipal officials to apply to the State Office of Alcoholism for a planning grant to design an alcoholism service delivery system. The newly designed system would be an attempt to integrate existing community services and all funding sources for the purpose of developing a comprehensive approach to the problem of alcoholism in Juneau. The planning grant was awarded on April 5, 1977 and Human Services Horizons was engaged to provide impartial consultation.

The following report is the result of the work done by Human Services Horizons on behalf of the City and Borough of Juneau. The report consists of a description of methodology, an assessment of program status, design recommendations, concluding remarks and an appendix. The report emphasizes those variables generally found to have the most significant impact on alcoholism service delivery.

## II. METHODOLOGY

Pursuant to the above considerations, Human Services Horizons' representatives, Uwe Gunnersen, M. A. and Mark L. Feldman, Ph. D.,

arranged to arrive in Juneau on the evening of April 16th. Upon arrival, the consultants were met with telephone messages from a number of the principals involved in the recent controversy over alcoholism services. These calls were returned and arrangements were made to meet these individuals later in the week.

On April 17th, contact was made with the State Alcoholism Coordinator, Mr. Robert Cole. Meeting in Mr. Cole's office, the consultants had an opportunity to review State alcoholism program regulations and the State's evaluation of the Alcoholism Central Agency. At the same time, the State's evaluation of Gastineau Manor was also reviewed. Mr. Cole made himself available to answer all questions relative to these evaluations and consequent State funding decisions. Further, Mr. Cole provided additional relevant data on legislation and corresponding policies and procedures impinging upon service delivery and funding.

A brief meeting with City Manager, Mar Winegar and Administrative Assistant, Kevin Ritchie took place on the morning of April 18th. At this time, an interview list was prepared and arrangements for initial interviews were made. Following this meeting, census data was obtained to supplement other data already provided by the planning department. This data was subjected to preliminary analysis such that its interpretation would facilitate more meaningful interviews.

The remainder of the consultants' activities from April 18th to April 24th consisted of interviews and site visits. Interviews were conducted with all principals connected with alcoholism

service delivery, including community figures, present and former program staff and directors, state and municipal officials, law enforcement officials and the alcoholism Advisory Board. Site visits were conducted at ACA, Gastineau Manor, the Southeast Regional Correctional Institution (SERCI) and Bartlett Memorial Hospital.

Interviews and site visits were conducted with the aid of a systems review form specially designed for this purpose (see Appendix). This form facilitated relatively consistent data gathering and sharing between consultants and among those being interviewed. Moreover, it facilitated systematic retrieval of all information as needed.

As the State Office of Alcoholism had already completed a thorough evaluation of the individual activities taking place within the alcoholism program, the consultants chose to verify, through document review, the veridicality of this evaluation. Once validation of such crucial areas as patient record keeping and aftercare was accomplished, emphasis was placed on reviewing the characteristics of the total system, rather than the individual parts. Systemic emphasis necessarily required a review of the mutual impact of the program components upon each other and the civic and service community, with whom their transactions occur.

The systemic approach necessitated identification of those complex interacting forces (e.g., laws, regulations, limited resources, funding inequities, interagency relationships, etc.) that developed and continue to shape the existing arrangements

for service provision. Once these forces had been identified, the decision facing the consultants was characterized by two alternatives: 1) accept the existing set of relationships and build onto them, or 2) identify undesirable factors and associated causes in the present system and initiate a program to alter the system by changing or eliminating key variables.

## III. ASSESSMENT OF PROGRAM STATUS

In choosing items for validation of the evaluation conducted by the State Office of Alcoholism (SOA), it was determined that the ACA operations manual and supporting documentation, as well as patient records and documentation of aftercare services, would be most appropriate. Clearly, these items related directly to the quality of patient care and programmatic accountability and responsibility. Thus, they would serve to indicate the reliability of the SOA evaluation. The necessary documentation was obtained from program files, municipal files, SOA files and from the former program director, Linda James.

The ACA operations manual and supporting documentation were, at best, incomplete. There was a marked absence of a statement of service philosophy. Goals and objectives were not prepared in an operational fashion capable of being measured. The statements of methodology were overly cryptic and, as such, wholly inappropriate to an operations manual. Similar statements can be made of most items in the operations manual, including the job descriptions which are, at best, confusing. The supporting documentation of program operations did not adequately verify

actual delivery of services and failed to include either administrative or clinical accountability mechanisms. Consequently, the assumption of appropriate responsibility by any staff member remains subject to conjecture.

This latter conclusion is clearly supported by our review of ACA patient records. The most positive statement that can be made about these records is that they are incomplete and inappropriate. The most glaring problem is the notable absence of individualized treatment plans. Even the few treatment plans that occasionally show up in the records are so inadequate as to be useless. There is no assessment of individual needs and no associated individualized strategy for meeting these needs. Judging from the nature of recorded progress notes, it is our belief that an individualized therapeutic process does not occur. The progress notes do not document implementation of a strategy that assures delivery of appropriate and necessary service. Moreover, the progress notes do not indicate the extent to which assessed needs are being met, an oversight which is unforgivable. Indeed, it is difficult to determine from the records whether much of anything therapeutic occurs, at least anything of a well-conceptualized, structured nature.

The lack of appropriate documentation of therapeutic activity becomes even more evident in light of the absence of aftercare records and, for that matter, an aftercare mechanism. Aftercare should consist of a second assessment of need conducted at a point where the client has achieved maximum benefit from the program and must begin to rely upon his own resources assisted by occasional monitoring and support from the program. The aftercare

assessment of need must be used to formulate an individualized aftercare plan designed to control recidivism through behavioral strategies to support and extend gains made in the treatment process. Aftercare is the first line of defense against recidivism. Unfortunately, evidence of aftercare is virtually non-existent in the records.

Our conclusions regarding the operations manual, patients records and aftercare clearly substantiated the conclusions of the SOA evaluation. We, therefore, deemed it unnecessary to further question this evaluation and accepted the veridicality of its findings. Following this validation, it was our considered opinion that the ACA was incapable of complying with the national standards of treatment quality established for alcoholism programs by the Alcoholism Division of the Joint Commission on Accreditation of Hospitals (JCAH), a circumstance that would render ACA incapable of securing third party reimbursements for service. It was further our opinion that the City Manager's assessment of our task as a patch-up job on an already functioning program was clearly inaccurate. ACA, as we found it on April 16 - 24, might have charitably been called a loose aggregate of minimal services, but not an alcoholism program. Clearly, the task was not to upgrade an existing program, but to make recommendations for a system of alcoholism service delivery to meet the needs of the City and Borough of Juneau.

Resolution of the majority of the problems will depend in part on locating an alcoholism services coordinator with sufficient skill and experience to attend to them. The alcoholism services

coordinator must be a human services professional with at least a masters degree in a major human service discipline. The coordinator should be qualified to receive an appropriate state license and should be capable of providing professional supervision and training to a staff having lesser qualifications. Further, the coordinator should have five years of direct treatment experience. Three years of experience should have been in an alcoholism setting, with at least two years in staff supervision and one year in administration. In addition, the coordinator must have worked in settings similar or comparable to the treatment setting being proposed for the City and Borough of Juneau. These qualifications should not be unduly comprised for salary considerations, as this position is the pivotal one for the future of alcoholism services in Juneau.

With policy guidance from the City Manager, the alcoholism coordinator must take immediate action to:

- Develop a revised operations manual in accordance with the JCAH accreditation manual for alcoholism programs.
- Prepare a cogent, logical statement of treatment philosophy that justifies treatment modalities, is tied to a set of operationally-defined, measurable programmatic goals and objectives and serves as the basis for an integrated program of services.
- Revise all job descriptions such that all tasks, duties and responsibilities are

clearly stated in terms of expected measurable performance.

- Revise entire patient record system. This is a task of significant proportions, requiring methodical preparation of forms that facilitate accountable recording and monitoring of therapeutic processes. Record system development must also be accompanied by <u>extensive</u> staff training that goes beyond forms completion to strategies for the actual preparation and recording of therapeutic treatment plans, progress notes and aftercare plans.

Implementing the above recommendations will probably require extens ve policy guidance, as many former policies will have to be mo ified and new policies generated. Assistance with these policy matters is clearly a role for the new Alcoholism Advisory Board. This Advisory Board, as per City and Borough of Juneau resolution, (Serial No. 311) was established, in part, "to formulate specific recommendations to the Assembly and to the City and Borough Manager on municipal legislation, policies, and programs which emphasize treatment and prevention of alcoholism and public drunkeness, rather than imprisonment or levy of fines". Other duties of this Board pertain to consultation "with the director of the alcoholism program in matters pertaining to data collection, research, agency coordination, planning, program development, project formulation, facilities and budget, as it

relates to alcoholism, public drunkeness, drug abuse and other similar and related health and social problems".

Unfortunately, the mechanisms by which this was to be accomplished were never made clear. We believe, therefore, that prior to assisting the City Manager in locating an appropriate alcoholism services coordinator and supporting the efforts of this coordinator, the Alcoholism Advisory Board should seek Assembly approval to amend its by-laws to reflect the following modifications:

- Regarding Section I of the by-laws, one member of the Assembly should serve as an ex-officio member of the Alcoholism Advisory Board and establish liasion between the Board and the Assembly. The alcoholism services coordinator and the police chief should also serve as ex-officio members of this Board, providing regular information on program operations and needs.
- Regarding Section IV of the by-laws, there should be at least one Native American representative on the Alcoholism Advisory Board.
- Regarding Section VII, the alcoholism services coordinator should not serve as Board secretary, but should provide agenda and supporting material to the Board secretary, who will be responsible for

the duties indicated in the present by-laws.

- Regarding Section VIII, the Board chairman should have the authority, with the consent of the Board membership, to appoint non-Board members to Board committees for a period of time sufficient to accomplish the task(s) of the committee.
- All Board policy and procedure recommendations should be extracted from the minutes and transmitted to the Assembly via its liasion member. Assembly responses to all Board recommendations should be requested in writing and held by the secretary as documentation of Board activity.
- All Board recommendations should be accompanied by a request that the Assembly's designate, the City Manager, carry out all approved recommendations within thirty (30) days, unless otherwise specified, and maintain documentary verification of continuing implementation. The thirty day implementation period, if the City Manager chooses, can be used to initiate appeals procedures consistent with due process.

Throughout its deliberations, the Alcoholism Advisory Board must be mindful of the mutual responsibilities of the community

and the service delivery system. The service delivery system must operate at and for the convenience of the community. The system's raison d'etre is no other than to meet the community needs which called it into being. When the system fails to meet the demands of the community and, instead, functions primarily for its own perpetuation and advancement, it is no longer a legitimate recipient of those public funds derived from the community and federal tax base.

On the other hand, the lay community must not make demands without first determining system impact, the ultimate reflective effect on service delivery and the ratio of positive to negative outcomes. Further, community representatives must be willing to rationally negotiate terms for exchange of services and money and engage in mutual problem-solving, such that the interdependent and necessarily collaborative nature of the community-provider relationship is emphasized. In this manner, the planning process can be more scientific than political, based more on community need than power and influence. None of this, however, can be accomplished without a constant two-way flow of objective, goal-directed, solution-oriented communications. The primary goal of the Alcohol Advisory Board should be to see that this process does not breakdown.

Consistent with the Alcohol Advisory Board's role as liaison between the community and the service provider is the Board's obligation to assure that available services correspond to community needs. It is our understanding that in the past, determination of need was left entirely to the service provider. For a variety of

reasons, not the least of which is potential conflict of interest, an objective assessment of need should never and can never be prepared by a provider. Where providers are allowed to define public need, they are open to accusations of concentrating on furthering their own interests. For the sake of community-provider harmony, assessments of need should be mandated and monitored by the Alcohol Advisory Board to assure broad community input regarding the range, distribution, cost and quality of services.

In the interest of illustration, we have initiated a limited assessment of need for the City and Borough of Juneau. Though this assessment lacks the community input of a thorough study of alcoholism incidence and prevalence, it should prove to be relatively informative and reality centered. Developed by Parker Marden[1], this approach utilizes incidence data culled from national surveys[2] in conjunction with City and Borough census data to yield a probability estimate of problem drinkers by age and sex. It should be noted that whereas it is often difficult to specifically define the characteristics of a problem drinker, the national surveys upon which the incidence formulae are based rely on self-reports of clinically observable and validated indicators of problem drinking, as such, the findings correlate highly with more direct measures of problem drinking (e.g., the Jellenik

---

1 Marden, Parker, "A Procedure for Estimating the Potential Clientele of Alcoholism Service Programs", Division of Special Treatment and Rehabilitation Programs, National Institute on Alcohol Abuse and Alcoholism, Washington, D.C. 1974.

2 Cahalan, D., I. H. Cisin, and H. M. Crissley, American Drinking Practices, Rutgers Center of Alcohol Studies, New Brunswick, New Jersey, 1969.

formula[3]) and tend to yield highly conservative results. Summaries of the computational findings can be found in figures 1 and 2.

The incidence computations indicate a probability of 685 adult male and 168 adult female problem drinkers, as per 1970 population estimates. Census population estimates for 1975 put these figures at 817 and 203, respectively, while population projections for 1980 put these figures at 989 and 246, increases of better than 45%. The census data upon which this assessment was based does not normally include the skidrow public inebriate who is generally thought to increase these figures by approximately 5%. Using the 1975 population estimates, then, we can make an initial estimate of approximately 1,071 problem drinkers of which 95% are non-skid row drinkers.

It should also be noted that these estimation procedures exclude youth and severely underestimate minorities. Though there is a dearth of probability data on youthful problem drinkers, we can make some rough estimates based on available data. Youth aged 15 - 19 represent roughly 42% (7,332) of the population of the City and Borough of Juneau and were responsible for roughly 40% of the alcohol related offenses in 1975 and 33% of the alcohol related offenses in 1976.[4] These figures would indicate a high level of problem drinking, if not alcoholism . However, to

---

3 Jolliffee, N. & E.M. Jellinek "Vitamin Deficencies and Liver Cirrhosis in Alcoholics", Quarterly Journal of Studies on Alcohol, II (1941), pp. 544-583.

4 Data obtained from Criminal Justice Planning Agency, Juneau, Alaska.

FIGURE 1

ESTIMATION OF POTENTIAL CLIENTELE FOR ALCOHOLISM SERVICES IN THE CITY AND BOROUGH OF JUNEAU

Probabilities for Problem Drinking Among - Adult Males

| Age | 1970 Census | Problem Drinkers |
|---|---|---|
| 20 - 29 | 947 | 235 |
| 30 - 39 | 1008 | 165 |
| 40 - 49 | 885 | 154 |
| 50 - 59 | 679 | 86 |
| 60 - 69 | 371 | 43 |
| 70 + | 117 | 2 |
| TOTAL | 4007 | 685 |
| Estimated Increase for 1975* | 4808 | 817 |
| Estimated Increase for 1980* | 5818 | 989 |

* Based on data from Planning Department, City and Borough of Juneau

FIGURE 2

ESTIMATION OF POTENTIAL CLIENTELE FOR ALCOHOLISM SERVICES IN THE CITY AND BOROUGH OF JUNEAU

Probabilities for Problem Drinking Among - Adult Females

| Age | 1970 Census | Problem Drinkers |
|---|---|---|
| 20 - 29 | 995 | 20 |
| 30 - 39 | 955 | 76 |
| 40 - 49 | 806 | 55 |
| 50 - 59 | 610 | 12 |
| 60 - 69 | 355 | 4 |
| 70 + | 126 | 1 |
| TOTAL | 3847 | 168 |
| Estimated Increase for 1975* | 4616 | 203 |
| Estimated Increase for 1980* | 5585 | 246 |

* Based on data from Planning Department, City and Borough of Juneau

complicate matters, it is generally accepted that law enforcement authorities prefer not to arrest youth, particularly middle class youth, for alcohol related offenses and generally choose to accompany the youthful offender home. Consequently, the figures for alcohol related offenses by youth tend to be underenumerations. If for purposes of conservative estimation one assumed that only 3% of the city's youth, aged 15 - 19, engaged in problem drinking (roughly half the conservative 6% figure for the adult population), we could estimate an additional 220 problem drinkers and increase the earlier total of 1,071 problem drinkers to 1,291.

Because census data for minorities is traditionally under-enumerated, we have very little to go on for estimation purposes. However, it is notable that Native Americans were responsible for approximately 44% of alcohol related offenses in 1976. As Natives comprise only 15% (2,671) of the population of the City and Borough of Juneau, these criminal justice statistics would indicate (barring racially motivated incidents) a high level of problem drinking.[5,6] On the basis of the ratio of percent of alcohol-related crime to the percent of population, one might conservatively estimate a probability of problem drinking roughly double that of the rest of the adult population (a very conservative figure according to law enforcement authorities). This would yield a 12% probability of problem drinking among the Native American population. Therefore, our previous total figure for the

---

5 Ibid.

6 Data obtained from State of Alaska, Department of Labor and SEALASKA statistics.

City and Borough of Juneau could be increased by 321 to 1,612 problem drinkers.

Another confounding variable i our estimation process is the apparent increased consumption of alcohol in Alaska over that in the lower forty-eight. As of 1975, Alaska's rate of per capita annual consumption was 57% greater than the nation's - 4.54 compared to 2.90 gallons of absolute alcohol per person.[7] Whereas there is not necessarily a correlation between increased consumption and alcoholism, recent epidemiological research does indicate that the rate of alcoholism increases at roughly the same rate as consumption.[8] Therefore, we might assume that as the problem drinking estimation procedures used above were based on a rate of consumption prevalent in the lower forty-eight, these same procedures have probably severely underestimated problem drinking in the City and Borough of Juneau. If we increase the present estimate by 57% to allow for increased consumption and concomitant expected increase in alcoholism, the total estimate of problem drinkers increases to 2,531.

Experience has shown that on the average, problem drinking tends to reach physically and socially destructive levels within a ten year period, indicating that approximately 10% of the total number of alcoholics might surface in any one year. For the City and Borough of Juneau, then, one could estimate approximately 253

---

7 Data obtained from the Annual Supplement to the Alaska State Plan for the Reduction of Alcoholism and Alcohol Abuse, State Office of Alcoholism, Juneau, Alaska.

8 Ibid.

alcoholics surfacing each year over a ten year period. Of those surfacing, only about 5% (13) will be skid row public inebriates. There is, of course, a cumulative effect over the years as population increases and people migrate in and out of the area. The problem cannot be interpreted as time bound; it is as perpetual as the consumption of alcohol.

In spite of the availability of this very basic needs data indicating a high incidence of alcoholism among the working population, youth and Native Americans, most of the service and fiscal resources in the alcoholism service delivery system are designed to meet the need of the skid row public inebriate; not the individuals who comprise the tax base upon which the system rests. Moreover, those services available to the public inebriate are insufficient and of relatively poor quality. To make matters worse, services have become so minimal as to threaten the ability of law enforcement officials to comply with the requirements of the Uniform Alcoholism and Intoxication Treatment Act (A.S. 47. 57.010 - .270) which decriminalizes public drunkeness and requires that police facilitate entry of the public inebriate to a detoxification facility, rather than arrest the individual. Further, services are of such low quality as to significantly increase the likelihood of the municipality eventually being charged with malpractice due to the negligent delivery of services.[9]

---

9 This is not to say that the staff is intentionally providing low quality service. Rather, it is our opinion that they are performing to the best of their present capabilities. However, relative to professionally accepted levels of service delivery, their performance is insufficient. The staff clearly needs extensive, additional, on-going in-service training to increase their competencies and capabilities.

Having reviewed needs and available resources, the remainder of this report identifies the highest priority services to be delivered and outlines a system for their delivery. The system recommendations include suggested staffing patterns and cost estimates for personnel. Estimates of capital needs and expenditures, as well as costs for equipment and supplies, are beyond the scope of this report and can be most adequately assessed following an extensive survey and cost/benefit analysis of available facilities (mobile and stationary).

## IV. PROGRAM RECOMMENDATIONS

The Alcoholism Central Agency is the recipient of an eight year declining Comprehensive Staffing grant. This grant provides funds only for staff salaries and requires local matching funds in the following proportions:

| Year | Federal Share | Local Share |
|---|---|---|
| 2 | 80% | 20% |
| 3 | 75% | 25% |
| 4 | 60% | 40% |
| 5 | 45% | 55% |
| 6 | 30% | 70% |
| 7 | 30% | 70% |
| 8 | 30% | 70% |

At the present time, ACA is in its 5th year of federal funding, which means that in the remaining life of the grant, the City and Borough of Juneau must raise 70% in local funds to receive 30% of staff salaries. This, of course, ties a substantial amount of local funds into salaries, at a time when there is great need for

adequate facilities and related support services.

The present status of the federal grant requires submission of a continuation application. The deadline for submission has been extended to July 1, 1977 (verified 5-10-77) and could possibly be extended another 30 - 60 days. We feel, however, that ACA will find it difficult, if not impossible, to meet the grant regulations, which require ACA to document on-going provision of five essential services.

These five services are described as follows:

1. Emergency Service: Provides immediate evaluation and care to alcoholics who may be acutely intoxicated, in immediate need of medical attention, or in need of emergency assistance for psychiatric or social problems. These services must be available on a 24 hour basis 7 days a week. Hospital facilities must be available, as needed, for treating the medical emergency needs of alcoholics. These services must be well-publicized and accessible, and must be coordinated with other components of the alcoholism program.
2. Inpatient Service: Provides on a 24 hour a day basis, a wide range of medical and psycho-social treatment, including, but not limited to, individual, family, and group therapy, chemotherapy, A. A. activities; and occupational and recreational activities. The need for this

service in each individual case must be evaluated for its continuing appropriateness and must be adequately documented.

3. Intermediate Care Services: Provides a wide range of treatment, counselling, and rehabilitative services for persons not requiring inpatient care. This service is customarily provided in a therapeutic milieu, such as a halfway house. The services, whether on a 24 hour basis, or just day or night care, must include physical, social and vocational attention.

4. Outpatient Services: Provides essentially the same services as the inpatient service, but on an ambulatory basis. Must take into account the patient's family situation.

5. Consultation and Education: Consultation is the provision of case and program assistance by qualified, experienced personnel to a variety of human service agencies, other community agencies, and individuals, including schools, courts, police, clergy, welfare workers, physicians, public health nurses, etc. Education promotes the prevention of alcoholism, attempts to charge public attitudes toward alcoholism, and stimulates public support and participation in planning for new or improved alcoholism services.

At this time, ACA is clearly not in compliance with the requirements for adequate emergency services, nor does it have an inpatient service. It provides outpatient services in an unplanned, limited fashion and does not have sufficient staff capability or training to provide consultation and education. These services should have been well established and extensively documented during the past five (5) years under the Federal Comprehensive Staffing grant. To expect these services to be developed and implemented by July 1, 1977 would be utterly unrealistic and a foolish expenditure of time and effort.

One of our concerns, however, has been to preserve the funds allocated to the City and Borough of Juneau in the federal staffing grant. This was exhaustively discussed on May 10, 1977 with Mr. Johnny Whitlock of the National Institute on Alcohol Abuse and Alcoholism (301/443-2070). At that time, Mr. Whitlock indicated that his office would consider converting Juneau's present Comprehensive Staffing grant into a Special Project grant. This would mean: 1) no decrease in federal funding over the next two years, and 2) no local matching funds required (freeing local funds for broader program use, including capital expenditures). Most important, however, is the fact that alcoholism services funded by a Special Project grant do not have to be comprehensive in nature, but rather are expected to address the <u>unique</u> needs of a particular community or population group. Such a conversion, then, should provide additional flexibility in addressing the problem at hand.

Clearly, community needs for alcoholism services abound, but

they are going unmet. The social and economic costs of the problem increase exponentially with each passing year. The longer the community refrains from meeting these pressing needs, the more difficult it will be to recover from what will surely become a problem of crisis proportions. At the present time, the variables needing immediate attention are already so many as to be beyond the current capability of ACA or any other community service provider. And, merely splitting the tasks among a number of different groups will only serve to further fragment and complicate the issues by encouraging factionalism, territoriality, self-interest and loss of control over public funds.

The situation must be brought under control immediately. The multitude of variables must be whittled to a manageable size. Whatever system is developed, only the highest priority services should be addressed at this time. Program expansion to meet other unmet needs should be forstalled until such time that the program achieves some measure of stability and success and is capable of delivering service in a responsible and accountable fashion.

At the present time, it is our opinion that the most pressing community need is the effective interface of the alcoholism service delivery system with the law enforcement system. Such an interface has been mandated by the "Uniform Alcoholism and Intoxication Treatment Act" (A.S. 47.37.010-270) and acknowledged by law enforcement agencies, the business community, health service agencies and the community-at-large as a rational attempt to deal with the problems of alcoholism. However, there is, in fact, no alcoholism service delivery system with which the police department

can safely interface and, thus comply with the decriminalization of public drunkeness.

As is the case in most areas of the country, limited financial and treatment resources have made implementation of the Uniform Act extremely difficult. Policemen frequently have to spend unreasonable amounts of time away from their shifts searching for a facility willing to admit the intoxicated person or waiting for a facility to decide on whether the intoxicated person should be admitted. With the curtailment of the emergency and sleep-off services of ACA, this problem has worsened significantly, leaving law enforcement authorities in a quandry as to how or whether to comply with the law and what the costs will be of keeping an officer away from the duties of his shift, as he tries to comply with the Uniform Act.

The failure of the municipality to provide adequate detoxification and treatment facilities, particularly crisis facilities is itself, a denial of the major impact of alcoholism, as one of the primary public health problems of this age. The crucial social significance and enormous potential of the Uniform Act is being violated through daily compromise. This is an intolerable situation that a caring and concerned community should not allow to continue. Therefore, it is our belief that initial efforts to restructure a service delivery system should emphasize an organization that will facilitate implementation of the Uniform Act.

The key component in this service delivery system should be an emergency service capable of <u>receiving</u> acutely and severely

intoxicated individuals. The emergency service facility should be located near Bartlett Memorial Hospital to facilitate immediate no-decline medical evaluation and, if necessary, intervention and treatment. In view of the limited physical facilities in this area, the emergency service could be located in a double-wide trailer which accommodates at least fifteen beds and has two (2) hour fire walls. It is our understanding that in the coming fiscal year, the State Office of Alcoholism may have funds for such capital expenditures. This should be discussed with the State Alcoholism Coordinator.

Entry to the emergency service facility should be characterized by a careful, systematic triage process that determines which clients are in need of immediate medical attention, those that need to be seen by a physician for possible admission to the hospital and those that can be safely admitted to a holding/sleep-off unit. The triage process should also be such that alcoholics can be differentiated from alcohol abusers and thus identified for psycho-social intervention specific to the level of their illness. The protocol for the triage process should be conducted in accordance with a detailed checklist of physical and psycho-social criteria, such that the conduct of the entire process can be documented for accountability purposes. Moreover, the physicians at Bartlett Memorial Hospital should participate in the development of the triage criteria and in the initial training of those nurses or emergency medical technicians who will utilize the criteria. Documentation of the training and development process, as well as physician agreement and participation, should be maintained by the Alcoholism Services Coordinator.

The holding unit of the emergency care service should be the triage entry point for all individuals. All triage entry documentation should be prepared here. The holding unit should consist of five (5) beds structurally separated from the remaining ten (10) beds of the emergency care facility. Admissions to this holding unit, when deemed appropriate by the triage officer, should be limited to individuals brought in by either the police or the crisis van. Walk-ins attempting to use the facility as a skid-row sleep-off should be turned away, as this defeats the purpose of the facility. An attempt at appropriate referral of such individuals should be made.[10]

Individuals should be maintained under constant, close observation and attention in the holding unit until such time as further disposition can easily be determined. If at any time during the initial observation period an individual develops symptoms which meet the triage criteria for medical examination and treatment, he must be immediately transferred to the hospital emergency room. If, following the sleep-off period, no significant symptoms or additional symptoms have developed, the emergency service staff should make every possible attempt to motivate both alcoholics and alcohol abusers to enter the non-medical detoxification unit (10 beds) of the emergency services facility. If a client insists on leaving without the benefit of detoxification, he should be

---

10 If no such referral facility has been established, it is suggested the city encourage the churches or other voluntary organizations to embark on such a charitable enterprise as have similar groups throughout the United States. However, this type of enterprise must be developed cautiously and with considerable safeguard, as many such efforts have failed by becoming threats to civic well-being due to the congregation of drunks.

asked to sign a release form and left to his own devices.

Clients entering the non-medical detoxification unit will typically be held for 3 to 5 days, depending upon physical and psycho-social needs. During this period, the client should be monitored carefully by nurses and other support staff. All dietary and immediate hygiene needs should be attended to. Moreover, appropriate referrals for medical, dental, vocational, housing and social welfare needs must also be completed. Throughout this period, also, if the client develops symptoms which meet the triage criteria for medical intervention, he must immediately be transferred to Bartlett Memorial Hospital. Close proximity to the hospital should not only facilitate transfer of clients, but should also facilitate sharing of basic support services such as dietary, housekeeping, laundry, etc.

As early as is practicable, each client in the non-medical detoxification unit should be provided some basic alcohol and health education, as well as some minimal consultation regarding immediate needs. Further, staff should have sufficient training to provide motivational counseling to these clients. Motivational counseling should encourage clients to seek either further treatment, if in fact they are alcoholics, or to participate in lectures and/or other didactic, educational activities, if they are alcohol abusers. Upon discharge from the non-medical detoxification unit, a discharge and aftercare plan should be developed for each client. All clients should be encouraged to participate in either the outpatient or intermediate care services. Those alcoholism clients discharged from the hospital should be returned to the emergency care facility for development of an aftercare plan and for

appropriate referral.

The emergency care services should be supported by outpatient services that facilitate continuity of care and treatment. The outpatient services could, if necessary, remain at the present ACA location. However, a location on a ground floor and away from police headquarters would be more desirable. The outpatient services should provide individual, group, and family counseling. A very basic alcohol/health education curriculum should be provided for clients only.[11] Moreover, an active, structured day care program should be made available for referrals from the emergency service, Gastineau Manor and other human services providers, as well as appropriate self referrals.

The outpatient service should perform an assessment of need for all outpatient clients. The assessment of need should be used to develop measurable therapeutic goals and objectives, the accomplishment of which is monitored in detailed progress notes. As client status changes, needs should be reassessed, and new therapeutic goals and objectives should be developed. When a client has been referred from emergency services, his discharge summary and aftercare plan should be consulted to assure continuity of treatment. Furthermore, when clients are under treatment with other providers (e.g., Gastineau Manor, mental health agency, etc.), some attempt must be made to coordinate therapeutic services. Upon discharge from outpatient services, a discharge and aftercare

---

11 This is not to include those convicted of OMVI violations. Education for these individuals will be discussed later.

plan should be prepared for all clients. Such plans should take into account medical, dental, vocational, psycho-social and public welfare needs.

Intermediate care services are a valuable adjunct to this service delivery system. At the present time, these services are being capably provided by Gastineau Manor. We see no reason why Gastineau Manor should not continue providing these services. We have, however, carefully read the SOA evaluation of Gastineau Manor and are concerned that Gastineau Manor be held responsible for immediately correcting the deficiences noted in the evaluation. Particular concern is expressed with regard to the documentation of patient records and accountable delivery of services. We further suggest that Gastineau Manor residents utilize the counseling and education services provided by the outpatient program, as this would be more in the interests of cost-effectiveness, than would hiring additional counseling staff.

Finally, we would like to stress, or rather insist, that each each of these program service components not overlook (as has been the case) aftercare. As noted earlier, aftercare is the first line of defense against recidivism. It consists of behavioral strategies for client self-care with some minimal program support and monitoring. The aftercare plan should review the client's short and long range needs and objectives and should outline strategies that enable the client to assume responsibility for himself, accomplish current objectives and generate new ones. All aftercare plans should include provisions for review and revision with the assistance of program staff.

In summary, the City and Borough of Juneau, with the assistance of the Alcoholism Advisory Board and an Alcoholism Services Coordinator, should operate an emergency service in a physical plant located in absolute proximity to Bartlett Memorial Hospital. There should be an affiliation agreement with the hospital for "no-decline" medical back-up, and for the sharing of basic support services. In addition, the municipality should provide an outpatient service program and, with the assistance of the Gastineau Manor Board of Directors, an intermediate care program. All services would provide for treatment and aftercare continuity.

The municipality should curtail all but the above mentioned activities. The Gastineau Council on Alcoholism should receive funds for 1-1/2 staff persons to develop an information and referral service, to operate the financially self-sufficient alcohol information school for OMVI convictions, to cooperate with the State's efforts to develop occupational programs, to develop a speaker's bureau and to aggressively provide public education. The municipality is encouraged to provide office space to the Council (perhaps with the outpatient program) to facilitate Council activities. This decision is based on the fact that the above listed prevention and education activities are not and will not become reimbursable by third party payors, who may eventually assume a significant role in supporting the program. Therefore, it is unwise to burden a direct service with these Council activities. Furthermore, Councils on Alcoholism have historically provided these "indirect" services well and, in the instance of occupational programs and OMVI schools, have avoided charges of conflict of interest that to which direct service programs could be

subject.

The Alcoholism Advisory Board should lend support to plans by the State Office of Alcoholism to develop a Southeast regional inpatient treatment program. It is our understanding that negotiations are being conducted to create such a program at the Mt. Edgecomb facility. This facility could receive clients who need more intensive and long term treatment than the municipality can cost-effectively offer. We further recommend that the Alcoholism Advisory Board support the concept and eventual development of a much needed domiciliary care facility that accepts clients from all over the State. Such a facility would receive the most chronic, "burnt-out" alcoholics who have lived beyond rehabilitation and need to be habilitated with some human dignity. This would also remove a burden from the community-based alcoholism service delivery system, which primarily emphasizes rehabilitation.

PROPOSED STAFFING PATTERN[12]

Administration

| | | |
|---|---|---|
| Alcoholism Services Coordinator | $ 25,000 | |
| Secretary | 12,000 | |
| Data Analyst/Client Records Clerk | 12,000 | |
| Clerk-Steno | 11,000 | |
| Subtotal | | $60,000 |

12 Salaries are estimates and may have to be adjusted to reflect customary local pay scales.

**Emergency Service**

| | | |
|---|---|---|
| Supervisory Nurse | $ 16,000 | |
| Staff Nurse | 14,000 | |
| Staff Nurse | 14,000 | |
| Emergency Medical Technician | 13,000 | |
| Emergency Medical Technician | 13,000 | |
| Emergency Medical Technician(50% time) | 6,500 | |
| Crisis Van Driver/Aide | 6,500 | |
| Subtotal | | $ 83,000 |

**Outpatient Service**

| | | |
|---|---|---|
| Senior Counselor | $ 14,000 | |
| Counselor | 13,000 | |
| Counselor | 13,000 | |
| Counselor | 13,000 | |
| Subtotal | | $ 53,000 |
| TOTAL | | 196,000 |
| Fringe Benefits 18% | | 35,280 |
| GRAND TOTAL | | $ 231,280 |

**DISTRIBUTION OF STAFF SERVICES**

**Administration**

| | | |
|---|---|---|
| Alcoholism Services Coordinator | 20% | $ 5,000 |
| Secretary | 50% | 6,000 |
| Data Analyst/Client Records Clerk | 100% | 12,000 |
| Clerk-Steno | 50% | 5,500 |

**Administration** - cont'd

| | | | |
|---|---|---|---|
| Subtotal | | | $ 28,800 |
| **Emergency Service** | | | |
| Alcoholism Services Coordinator | 40% | $ 10,000 | |
| Supervisory Nurse | 75% | 12,000 | |
| Staff Nurse | 100% | 14,000 | |
| Staff Nurse | 100% | 14,000 | |
| Emergency Medical Technician | 100% | 13,000 | |
| Emergency Medical Technician | 100% | 13,000 | |
| Emergency Medical Technician | 50% | 6,500 | |
| Senior Counselor | 50% | 7,000 | |
| Counselor | 50% | 6,500 | |
| Secretary | 25% | 3,000 | |
| Clerk | 25% | 2,750 | |
| Crisis Van Driver/Aide | 100% | 6,500 | |
| Subtotal | | | $ 108,250 |
| **Outpatient Services** | | | |
| Alcoholism Services Coordinator | 40% | $ 10,000 | |
| Senior Counselor | 50% | 7,000 | |
| Counselor | 50% | 6,500 | |
| Counselor | 100% | 13,000 | |
| Counselor | 100% | 13,000 | |
| Supervisory Nurse | 25% | 4,000 | |
| Secretary | 25% | 3,000 | |
| Clerk-Steno | 25% | 2,750 | |

Outpatient Services - cont'd

| | |
|---|---|
| Subtotal | $ 59,250 |
| TOTAL | $196,000 |
| Fringe Benefits 18% | 35,280 |
| GRAND TOTAL | $ 231,280 |

## V. CONCLUDING REMARKS

Having reviewed also the manner in which municipal alcoholism services interface or, for that matter, do not interface with other human services (municipal and otherwise), it is our opinion that the City and Borough of Juneau has tended to administer human services as though they were a collection of atomistic units having neither orderly nor systematic contact with each other. Such discrete treatment of individual services implicitly denies the mutual impact service providers necessarily have upon each other and the civic community, with whom their transactions take place. Administration of human services must recognize these services as a systematically interrelated group of entities whose intensity of relationship with one another, as well as the social environment, is such that a change in one generally has an impact on the rest. We, therefore, recommend that following resolution of the current crisis in alcoholism service delivery, the municipality establish a Department of Human Services designed to assure that the total human services systems is in correspondence with the needs of the community, the policies of the Assembly

and the exigencies of efficient and effective interface.

A Department of Human Services for a municipality the size of the City and Borough of Juneau could, at least initially, be run by a qualified human services professional supported by a secretary. Consistent with the principles of effective planning a coordinator of human services would prepare a coherent, comprehensive human services plan and budget that cuts across disabilities and special population lines to respond to assessed needs of the community. Such a plan would include proposed cross utilization of services and personnel, cross funding, comparison of program priorities and evaluation and monitoring mechanisms designed to assure accountability for public funds. Upon consideration and approval by the Assembly, the comprehensive plan would be implemented by the human services coordinator for the best benefit of the people of the City and Borough of Juneau.

We are cognizant of the fact that most of our recommendations for alcoholism services, as well as a Department of Human Services, would require some additional expenditure of funds. It could be argued that the municipality can ill afford such additional expenditures. However, so long as the municipality provides for the delivery of services to alcoholic people, these services must be delivered in a responsible and accountable fashion. To do otherwise is to invite the eventuality of legal action based in charges of negligence, a circumstance which could also lead to considerable expenditure of additional funds. The municipality's liability for the conduct of its alcoholism services is indisputable. Contracting with a private agency will not absolve the

municipality of this liability. Rather, the municipality remains vicariously liable for negligent conduct on the part of all its contractors. We, therefore, recommend that the Assembly temper its cost considerations with acknowledgement of its responsibility and liability, as well as the greater public good.

WORK PLAN*

| Task | Implementation by: |
|---|---|
| 1. Consultants Report | May 19 |
| 2. Obtain grant application for special project from SOA | May 20 |
| 3. Develop application for special project | May 20 |
| 4. Advertise for Alcoholism Services Coordinator and Secretary | May 20 |
| 5. Revise by-laws and procedures of Alcoholism Advisory Board | May 20 |
| 6. Submit special project application to NIAAA | May 31 |
| 7. Negotiate Emergency Care trailer with SOA - involve hospital | June 1 |
| 8. Negotiate location of trailer - involve hospital | June 1 |
| 9. Negotiate location of Outpatient facility | June 3 |
| 10. NIAAA site visit | June 10 |
| 11. Employ Alcoholism Services Coordinator and Secretary | June 14 |

| Task | Implementation by: |
|---|---|
| 12. Negotiations with Gastineau Council on Alcoholism | June 15 |
| 13. Negotiations with Gastineau Manor | June 17 |
| 14. Negotiations for sharing of support services with hospital | June 20 |
| 15. Final arrangements for delivery of trailer | June 21 |
| 16. Alcoholism Services Coordinator and Secretary on duty | June 30 |
| 17. Orientation of Coordinator | July 1 |
| 18. Revision of staff job descriptions | July 5 |
| 19. Advertise for all staff vacancies | July 7 |
| 20. Develop program philosophy and operations manual | July 8 |
| 21. Obtain fire and health department approval of all facilities | July 13 |
| 22. Negotiate "Uniform Act" arrangements with Juneau P. D. and State Troopers | July 18 |
| 23. Employ all staff | July 28 |
| 24. Staff Orientation | July 29 |
| 25. Prepare emergency care facility | August 1 |
| 26. Prepare outpatient care facility | August 1 |
| 27. Develop interim patient records system | August 5 |
| 28. Develop triage criteria - involve hospital | August 8 |

| Task | Implementation by: |
|---|---|
| 29. Training with triage staff - involve hospital | August 12 |
| 30. Staff training for interim patient records system | August 15 |
| 31. Commencement of services | August 17 |
| 32. Revise patient record system | August 24 |
| 33. Develop monitoring, evaluation and accountability mechanisms | August 31 |
| 34. Obtain outside, impartial evaluation of program operations | September 30 |

# APPENDIX

# INTERVIEW FORM

## ALCOHOLISM SERVICE SYSTEM REVIEW

## THE CITY AND BOROUGH OF JUNEAU - JUNEAU, ALASKA

Subject: _____ Date: _____

Title: _____

Address: _____

Prior Involvement: _____

_____

Service Description:

---

Comprehensiveness (program/system - continuum, necessary resources, services)

Optimal circumstances:

Gap:

---

Compatability (program/system - duplication, overlap, sequencing, transition)

Optimal circumstances:

Gap:

---

Operation (program/system - collaboration, integration, attitude, communication, distribution of power - influence):

Optimal circumstances:

Gap:

Client Access (identification and service delivery):

Optimal Circumstances:

Gap:

---

General Information (program environment, personnel, records, referrals, etc)

---

Community Relationships:

---

Miscellaneous:

HSH
HUMAN SERVICES HORIZONS, INC.

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

UWE GUNNERSEN
Director

MARK L. FELDMAN, Ph.D.
Associate Director

# CORPORATE CAPABILITY

Human Services Horizons, Inc. was established to enhance the delivery of health and social services to alcoholic people and their families. A research and consulting firm specializing in the application of multi-disciplinary systems analysis methods and techniques to the study and solution of problems in the design, development and evaluation of alcoholism programs and service delivery systems, Human Services Horizons is committed to the aid of the great numbers of socially stigmatized, and unidentified problem drinkers who, because of economic or geographic disadvantages, are in need of increasingly unavailable and frequently ineffective treatment services. Toward this end, Human Services Horizons is actively engaged in applied research for the design and testing of better models, procedures and criteria for treatment processes and practices, as well as prevention, identification and aftercare. Ongoing design, testing, evaluation and redesign are characteristic of all our efforts and demonstrate a commitment to constantly improving the efficiency and effectiveness of all projects with which we are associated.

Having considerable individual and collective experience in alcoholism treatment, programming and administration, Human Services Horizons staff has provided technical assistance to local, state and federal government agencies, private industry, local health care systems, hospitals, alcoholism service providers, community and non-profit organizations. As a result, HSH staff specialists are able to handle problems ranging from those of small treatment programs to those of the complexity of major industrial and governmental systems.

The experience and on-going interests of Human Services Horizons staff has contributed to the development of both theoretical and tested solutions in such areas of proficiency as:

- Program planning, development and evaluation
- Staff training and development
- Occupational Health programming and treatment
- Aftercare services

- Patient record systems
- Development and implementation of quality assurance mechanisms
- Reimbursement and third party relations
- Management contracting and consultation
- Ambulatory care
- Service utilization
- Public health education
- Health systems planning, integration, review and evaluation
- Consumer activism and conflict management
- Environmental impact
- Policy analysis and evaluation
- State of the art assessments
- Treatment environments
- Management information systems

Human Services Horizons maintains that effective problem resolution requires that those persons who implement a decision also make the decision; that the role of the consultant is to develop feasible alternatives that facilitate maximally effective decision-making and strategically sound and expedient actions. Therefore, HSH staff for each project is carefully selected according to their specialized experience in the identified problem area. A rapid practical solution at minimum cost is the goal of each project.

Recognizing that systems interactions for even the most isolated and simple problems can produce undesirable results by generating, through resolution, unforeseen new problems, Human Services Horizons utilizes systems analysis to identify interactions and facilitate thorough problem formulation, analysis and solution. HSH staff approach all situations systematically by:

- Defining needs clearly and operationally
- Developing feasible objectives and evaluative criteria