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IMPLEMENTATION EVALUATION OF A SOCIAL DETOXIFICATION PROGRAM

by

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Tim Slaven, M.A., C.A.S.

Doctoral Candidate

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TABLE OF CONTENTS

Page

LIST OF TABLES v

LIST OF FIGURES vi

Chapter

1. INTRODUCTION 1

PURPOSE 1

RATIONALE 1

PROGRAM BACKGROUND 2

GOALS AND OBJECTIVES 4

ASSUMPTIONS AND LIMITATIONS 6

2. REVIEW OF THE LITERATURE 8

ALCOHOLISM AS A SOCIAL DEVIANCE 8

PUBLIC INEBRIATE 14

CRIMINAL JUSTICE RESPONSE 19

DETOXIFICATION 28

3. METHODOLOGY 55

DESIGN OF THE STUDY 55

DATA COLLECTION PROCEDURE 62

ANALYSIS OF THE RESULTS 65

4. RESULTS 67

RESULTS OF GOALS AND OBJECTIVES 67

RESULTS OF IMPLEMENTATION EVALUATION 84

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TABLE OF CONTENTS
(continued)

Page

PLANNING AND IMPLEMENTATION. 89

SUMMARY OF FINDINGS. 98

5. CONCLUSIONS. 103

OVERVIEW OF THE STUDY. 103

EVALUATION 106

FEASIBILITY FACTORS. 107

COMMENTS 113

REFERENCE NOTES 115

REFERENCES. 117

APPENDIX. 129

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LIST OF TABLES

TABLE PAGE

1. Follow-up Comparison of N.I.P. and Jail Group on Arrests for Public Drunkenness. 76

2. Follow-up Comparison of N.I.P., Jail Group and a National Group on Drinking Days Per Month. 81

3. Follow-up Comparison of N.I.P. Jail Group and National Group on Working Days Per Month 83

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LIST OF FIGURES

FIGURE PAGE

1. Research and Evaluation of Public Inebriate Programs 34
2. Goals and Objectives. 57
3. Bed Utilization 72
4. Source and Disposition of Referrals 74
5. Public Drunkenness Arrests. 78
6. Implementation of the Norfolk Inebriate Program 90
7. Summary of Results of the Goals and Objectives. 99

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ABSTRACT

IMPLEMENTATION EVALUATION OF A SOCIAL DETOXIFICATION PROGRAM

Thomas M. Slaven

Old Dominion University, 1983

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While cities across the United States are attempting to revitalize their central business districts, the presence of the public inebriate remains one of the most neglected urban problems hampering redevelopment efforts. An evaluation of the implementation of a social detoxification program was conducted to monitor planning, initial staffing, training, building community linkages, impact on the criminal justice system, and changes in clients' working and drinking behavior. Public Drunkenness arrests, and working and drinking behavior were measured at intake, three month and six month follow-up with a sample of clients undergoing detoxification, a comparison group of individuals jailed but not detoxified, and a national comparison group of individuals undergoing detoxification in similar programs. The local detoxification clients exhibited no significant change in arrests for public drunkenness or reduction in drinking days per month. However, the detoxification group made a significant increase in the working days per month and an improvement in living accomodations at six month follow-up. Social detoxification programs can be effective if 1) police utilize

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detoxification centers, 2) detoxification is perceived as initial care with counseling focusing on assessing appropriateness for alcoholism rehabilitation and, 3) clients are referred to a variety of social service agencies. For those clients not appropriate for treatment, programs may have an effect if intervention addresses housing and employment issues.

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Chapter 1

INTRODUCTION

Purpose

In October of 1981, the Norfolk Community Services Board contracted with the Old Dominion University Urban Research and Service Center to provide an implementation evaluation of the Norfolk Inebriate Program covering the first six months of program operation. The purpose of the evaluation was to provide decision-makers monitoring and impact information on the success of implementing a social detoxification program, its impact on the criminal justice system and changes in clients' drinking and working behavior. The evaluation results will be used to make the adjustments necessary to insure that the program is implemented as designed and improving the lives of Norfolk's public inebriates.

Rationale

Men and women drinking on the corner of city streets, sleeping in doorways and panhandling passers-by has been called "the most critical dilemma for contemporary urban human service systems" (Reiger, 1979). Thus far, efforts at urban redevelopment and revitalization of downtown business districts have not adequately addressed this economic, social and criminal justice problem.

Howard Bahr has coined the public inebriate "the most stigmatized subculture in America today" (Bahr, 1973). Public inebriates are the most visible victims of alcoholism, but comprise only three to five

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percent of all alcoholics (NIAAA, 1978). Even the alcoholism field has ignored these most visible alcoholics in its attempt to raise alcoholism to a respectable, treatable disease. Although the American Bar Association, the American Medical Association and the World Health Organization have identified alcoholism as a disease, the alcoholic on the street, until very recently, has had only two alternatives; incarceration or "soup and salvation".

Norfolk, Virginia is one city that is attempting to attract investors, homeowners and shoppers back to the central business district, while at the same time making an effort to intervene in the lives of those chronic, public inebriates who voluntarily desire help.

Program Background

In January of 1978, the Virginia State Crime Commission and the Virginia Department of Mental Health and Mental Retardation began investigating the feasibility of enacting the Uniform Alcoholism and Intoxication Treatment Act, Public Law 91-616, 91st Congress, December 21, 1970 (Note 1).

The Uniform Act is model legislation drafted by the National Conference of Commissioners on Uniform State Laws, and has been recommended by the National Institute on Alcohol Abuse and Alcoholism for enactment by all states. Currently, 30 states have enacted the key elements of the legislation. The Uniform Act is based on the philosophy that alcoholism is a disease and that alcoholics and public inebriates should not be subjected to criminal prosecution, but rather should be provided treatment.

If completely enacted, the Uniform Act would decriminalize public

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drunkenness and forbid any local unit of government from enacting and enforcing any regulation or ordinance making public intoxication an offense punishable by criminal or civil penalties. The Act also requires the establishment of a statewide system of comprehensive treatment facilities, and a critical review of all involuntary commitment procedures.

Also during 1978, when the Commonwealth was considering the Uniform Act, the Norfolk Chamber of Commerce developed a plan of action for the revitalization of downtown Norfolk. As part of this effort, the Downtown Norfolk Development Corporation (DNDC) was created to oversee the redevelopment of Granby Mall. A committee of the DNDC, the Physical and Social Environment Committee, began seeking ways to provide social services to the homeless, unemployed inhabitants of Granby Mall. A subcommittee of the Physical and Social Environment Committee adopted as their focus the public inebriate population of Granby Mall. This subcommittee presented a position paper to the DNDC in January of 1979 recommending the development of a detoxification facility for medically indigent alcoholics (DNDC, Note 2).

These state and local activities aimed at helping the public inebriate converged two years ago when the Department of Mental Health and Mental Retardation set aside $100,000 of the FY-1981 budget to fund a public inebriate detoxification demonstration project in Norfolk. This program was to test a mental health alternative to incarceration as part of the larger question of decriminalizing public drunkenness through implementation of the Uniform Act (P.L. 91-616). Although public intoxication has not been decriminalized in the Commonwealth of Virginia to date, H.B. 1599 was passed during the 1979 Virginia General Assembly

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authorizing the police and courts to transport public inebriates to court-approved detoxification centers in communities where such centers existed and to reduce public drunkenness to a Class 4 Misdemeanor (Guest, Note 3).

A non-medical, social detoxification center provides a homelike, supportive setting where alcoholics can go through withdrawal without the use of drugs. Instead of being staffed by nurses and physicians, the center is staffed by counselors, often recovering alcoholics trained as Emergency Medical Technicians. Currently there are approximately 60 such programs operating in the United States.

Through the appropriation of $60,000 by the Norfolk City Council and $4,000 by the Downtown Norfolk Development Corporation, $100,000 was awarded the City of Norfolk by the State Department of Mental Health and Mental Retardation to develop a social detoxification center with a budget of approximately $164,000.

The Norfolk Inebriate Program (N.I.P.) has been designed to serve the medically indigent alcoholic and public inebriate in the City of Norfolk. N.I.P. has twelve beds and provides a safe and sheltered environment for intoxicated persons who do not require hospital treatment for medical or psychiatric problems (City of Norfolk, Note 4).

Goals and Objectives

Since this study is a program evaluation, measurable objectives will serve as hypotheses regarding expected outcomes. The problem statement is: What is the effect of a social detoxification program on arrests for public intoxication, jail bed days, drinking behavior and employment for public inebriates?

The following are the Goals, Objectives and Additional Evaluative Questions agreed upon by the Board and Staff of the Norfolk Community

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Services Board which will be used to measure the success of the implementation of the Norfolk Inebriate Program:

Goal 1.0: To provide social detoxification services to chronic alcoholics.

Objective 1.1: To identify and refer five percent of the medically indigent alcoholic population to the Norfolk Inebriate Program by September 15, 1982.

Objective 1.2: To provide 72 hours of social detoxification to 70 percent of those persons found appropriate for services by September 15, 1982.

Objective 1.3: To refer ten percent of those persons detoxified to rehabilitation or intermediate care by September 15, 1982.

Objective 1.4: To identify the number of referrals, client characteristics and source of referral both in and out of the program.

Goal 2.0: To reduce the burden on the criminal justice system by reducing the arrests and incarcerations of public inebriates.

Objective 2.1: To reduce public drunkenness arrests by 25 percent by September 15, 1982.

Objective 2.2: To reduce the number of jail bed days used by public inebriates by 75 percent by September 15, 1982.

Goal 3.0: To positively impact the drinking behavior and employment success of chronic alcoholics.

Objective 3.1: To improve the rates of abstinence for chronic alcoholics served in the Norfolk Inebriate Program.

Objective 3.2: To improve the rate of employment of chronic alcoholics served in the Norfolk Inebriate Program.

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Additional Evaluative Questions:

1. What are the person's reasons for self-referral? Why did they stay or why did they leave? What were the most desirable and least desirable aspects of the program? (Client Reaction Form)

2. How frequently were beds available in the community to serve the alcoholism treatment needs of the client?

3. How appropriate is the location and physical characteristics of the facility for housing the program?

4. What level of paramedical training is necessary for the program staff?

5. What transportation systems were utilized and were these adequate to meet the needs of the client?

6. What is the cost effectiveness of NIP as compared to arrest and confinement?

7. What planning and policy issues addressed over the last three years affect the implementation of the program?

Assumptions and Limitations

Initial estimates of the size of the program's target population have been based on police arrests, incidence of medical indigency and the Merden Prevalence Index. The Merden Prevalence Index (Appendix A) identifies occupational categories with the highest rates of medical indigency and estimates the rate of alcoholism for each occupational category in a geographical area. Based on this formula, the target population was identified at 4,603 medically indigent alcoholics in Norfolk, Virginia. This number is consistent with public drunkenness arrest data and the Eastern Virginia Health Systems Agency, Inc.

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methodology for estimating the incidence of medical indigency. While the number of skid row type people frequenting Granby Mall has been determined to be 100 to 300 individuals (DNDC, Note 2), the Norfolk Inebriate Program is designed to meet the social detoxification needs of medically indigent alcoholics throughout the city.

This study is primarily an implementation evaluation of a pilot demonstration project although outcome information is gathered. Since the evaluation was funded for only the first six months of program operation, the focus has been on monitoring the implementation of the Norfolk Inebriate Program (N.I.P.). Outcome data on arrests, jail bed days, drinking behavior and working days has been gathered at intake, three month and six month follow-up.

The short time span for evaluation, the difficulty following-up on this population and the short period of time clients are involved in the program (72 hours) have all been identified in the literature (Emerick, 1974) as limitations affecting evaluations of detoxification programs. Being aware of the complex issues surrounding services to the public inebriate, attempts have been made to develop an evaluation methodology that can be applied to this or other programs to measure the impact of social detoxification on client behavior and the criminal justice system.

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Chapter 2

REVIEW OF THE LITERATURE

Alcoholism as a Social Deviance

More than 100 million Americans drink alcoholic beverages and eight to ten million of these adults can be classified as problem drinkers or alcoholics. The National Institute on Alcohol Abuse and Alcoholism estimates that 25 percent of problem drinkers are white collar, 30 percent are blue collar, and 45 percent are professional or managerial. The chronic public inebriate and skid row alcoholic are not characteristic of the problem drinking population at large, since only 3% to 5% of all alcoholics reside on skid row.

Alcohol plays an important role in half of the nation's highway fatalities, half of its homicides, and one third of all suicides. The economic costs due to alcoholism have been estimated at well over 40 billion annually in lost work time, health and welfare services, and property damages. Despite these costs, the per capita consumption of alcohol in 1978 was the highest since the 1850's (NIAAA, 1978).

The skid row alcoholic is one of several categories of deviants including homosexuals, drug addicts, prostitutes, delinquents, the mentally ill and the mentally retarded. All these groups have in common "behavior which is considered deviant by our society" (Bahr, 1974). Deviant situations seem to arise when people who are in a position to impose their judgements find other people's behavior

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unsettling. In developing the process of deviance, Suchar states that the specifics of these reactions may vary considerably from strong moral outrage to feelings of distaste or even pity. Common to all of these situations, however, is a process of social typing in which those who feel threatened seek to avoid deviant persons and negate the conditions which they find objectionable (Suchar, 1978).

Probably the most dominant theory of deviance today is "Labelling Theory" also known as "Societal Reaction Theory". This has been a controversial theory especially as it applies to alcoholism and the skid row alcoholic. Edwin M. Lemert (1951), one of the most influential people studying social role violation, believes that deviation is the outcome of culture conflict, and that society's reactions to deviation vary in intensity. Lemert defines the deviant person as one whose self-concept is shaped by the behavior engaged in, its social visibility and the influence of the societal reaction. He believes that deviance identity is crystallized by the person's vulnerability to the reactions of society (Lemert, 1951). Howard Becker (1963) proposed one of the most widely used definitions of deviance as a catagory of subjective evaluation:

> Deviance is not a quality of the act the person commits but rather a consequence of the application of rules and sanctions to an offender. The deviant is one to whom that label has successfully been applied: deviant behavior is behavior that people so label (Becker, 1963, p. 278).

Becker describes deviance as an evaluation made by an individual about someone else's or his own behavior or identity. Those on the margin of society, particularly those who have little power and few resources, are those who are least able to resist a deviant label and are therefore most likely to be channeled into a deviant role.

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Critics of labelling theory have attempted to question this theoretical position especially in terms of alcoholism. Leigh and Robins (1980) believe that labelling theory is not sufficient to provide a complete sociological description of the development of alcoholism in the person. Robins sites studies that have been done on predictors of later deviant acts. The best predictor of any specific later deviant act seems always to be early deviant behavior, and the specific nature of that early deviant behavior seems to be rather unimportant (Robins, 1980). For example, a history of alcoholism in the family continues to be a potent predictor of alcoholism in the offspring even when the child does not live with the affected parent (Godwin, 1973). Robins states that being poor, urban, undereducated, and in an ethnic group of low social status are strong predictors of alcoholism along with family history and the person's own prior behavior. Also, all forms of deviance seem to drop off with age whether or not the person has ever been labelled. Robins strongly believes that labelling theory is not the sole explanation for deviance and believes that predictors of deviance provide a much stronger basis for explaining the intractability of alcoholism. Alcoholism, like other forms of deviance, is better predicted by early anti-social behavior of a nonspecific type than by any social characteristic (Calahan and Roane, 1974).

A great number of sociologist believe that alcoholism is well suited to Labelling Theory. In fact, the most common labeller of the alcoholic is often a member of his own family. Studies of social problems associated with heavy drinking (Calahan and Roane, 1974; Robins, 1968) consistently show that family complaints are the most common problem associated with drinking which occurs before problem

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drinking is detected by employers, police or doctors. Rather than being over eager to label, official agencies often aid in the denial of alcoholism. In hospital and emergency room records, alcoholism is not diagnosed unless the patient fulfills the stereotype of the "bowery bum" or has no medical or surgical problem that could serve as an alternative diagnosis. Also, death certificates grossly under report alcoholism as a cause of death (Blain, 1963).

The difference between an alcoholic and a heavy drinker usually depends on the frequency of intoxication and the degree to which intixication interfers with role performance. However, the difference between an alcoholic and a skid row type person has more to do with qualitative characteristics such as the limited resources and powerlessness of the individual, the social distance between the labeller and potential labellee, tolerance level of the community, and the extent to which the deviant behavior is visible (Robins, 1980). The majority of alcoholics are not visible to society unless they are of the skid row type or have come in contact with officials through an arrest such as a drunk driving charge.

It appears that while some authors believe that alcoholism is not consistent with labelling theory, the subcategory of the skid row alcoholic tends to fit well with the parameters described in labelling theory. But, alcoholism is only one aspect of the skid row person that is stigmatized. Skid row is also a highly visible sector of general poverty. The focus on a particular sector of single, homeless, poor persons distinguished by repeated public drunkenness arrests, and imprisonment has been sharpened when labels such as public inebriate, habitual drunken offender, and skid row or homeless alcoholic are

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are involved. All these terms in some sense reflect the interest of groups concerned with either the punishment, rehabilitation or social control of these persons (Archard, 1972).

Historically, the most popular view of alcoholism has been that of a moral failing, and treatment has most often taken the form of attempting to persuade someone to change their ways. The first medical scientist to explain alcoholism not as a moral failing but as a disease process was Dr. Benjamin Rush, signer of the Declaration of Independence and widely recognized as the most famous American physician of the 18th century. But the first acceptance of alcoholism by the medical community came with Dr. Lesley Keeley, who in 1879 set up institutes and sanitariums throughout the country to treat inebriates with what he called "bicloride of gold". This treatment came to be known worldwide as the "Keeley Cure". Keeley institutes were the forerunners of psychiatric and social treatment models that exist today (Alcoholism, 1982).

In the early 1930's, Alcoholics Anonymous (A.A.) was founded in Akron, Ohio, by Dr. Bob Smith and Mr. Bill Wilson. This self-help group is based on 12 steps and 12 traditions for the recovery from alcoholism with the key being total abstinence from alcohol. A.A. identifies alcoholics as individuals who have an "allergy" toward alcoholism. They believe that alcoholism cannot be cured, but can only be arrested through not drinking again (Alcoholics Anonymous, 1953). Rather than resisting the label of alcoholic, A.A. encourages individuals to take on the identity of an alcoholic as a means of recovery.

Theories regarding the causes of alcoholism are varied and run from biochemical, to environmental, to psychological reasons concerning

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the make-up of the person and how he becomes an alcoholic. Many authors have focused on the individual's family orientation as an important factor in determining later behavior. Clienbell in his book Understanding and Counseling the Alcoholic (1968) described that the chronic alcoholic's history is one of a doting mother and a stern father. The father is typified as one who inspired respect and displayed inconsistent tendencies of severity and indulgence, thus producing in the child a feeling of insecurity and helpless dependence. Jackson and Connors (1953) have found that parents of alcoholics have different attitudes about drinking when compared to parents of non-alcoholics. The authors found that alcoholics most frequently came from homes in which one parent, usually the father, drank. Moderate drinkers most often came from homes of non-drinking parents or homes where both parents drank socially or moderately.

The two major characteristics of alcoholics are excessive drinking and the apparent inability to stop drinking once started. Rohan (1975) has specifically investigated the quantitative aspects of alcohol use among hospitalized problem drinkers. He analyzed the self-report daily maximum intake of patients and found that maximum consumption levels varied from 22 to 56 drinks a day. Warner and Cutler (1975) defined loss of control as "consistently becoming more intoxicated than intended." The authors have suggested that loss of control is experienced by many drinkers, not necessarily those who are pathological drinkers. Associated with loss of control is the tendency to display drunken behavior when intoxicated. They believe that drunken behavior is more dependent on environmental keys such as time, place, and social atmosphere.

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In reports of psychological studies of alcoholics, these additional characteristics have been repeatedly mentioned: a high level anxiety in interpersonal relationships, emotional immaturity, ambivalence toward authority, low frustration tolerance, grandiosity, low self-esteem, feelings of isolation, perfectionism, guilt, and compulsiveness. These characteristics are not the result of prolonged excessive drinking but are present in many alcoholics before they begin excessive drinking. Also, many of these characteristics persist long after sobriety has been achieved (Archard, 1972).

The availability of alcohol in our society, consumption rates and social attitudes toward drinking and drunkenness, have a great deal to do with the symptoms of alcoholism. Cultural attitudes toward alcoholism which deal with will power, rather than sickness, probably contribute to the perpetuation of addiction once it is established. Probably no other group most characterizes these symptoms and characteristics as the skid row alcoholic, surely the most visible victim of alcoholism and the focus of our inquiry.

Public Inebriate

The National Association of State Alcohol and Drug Abuse Directors (NASADAD) has developed a profile of the urban public inebriate as typically a 45 year-old white male, unemployed with nine years of education, divorced or never married, homeless, receiving no public assistance, and having a prior arrest for drunkenness or a prior admission to a treatment program or detoxification center. NASADAD confirms the estimate that this population constitutes three to five percent of the nation's problem drinkers, or 300,000 to 500,000 persons (NIAAA, 1982). This

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profile has been supported in evaluations by Turner (1979), Makoujvola (1980), Feeney, et al. (1978), Annis (1979).

In discussing the skid row alcoholic and the public inebriate, the terms are often used interchangeably. The skid row alcoholic is a sub-population of alcoholics and skid row people in general, while the public inebriate is a person drunk in public or arrested for public drunkenness. But to understand who is the public inebriate, we must examine the traditional skid row man. The term "skid row man" is characterized by homelessness, low income, heavy use of alcohol and the use of various skid row institutions. While homelessness is the dominating theme of most scientific investigations concerning skid row, Nimmer believes that it is really "disaffiliation" or a lack of social attachments which best characterize this population (Nimmer, 1971).

Skid row persons generally fall into four categories: highly mobile workers, working residents, residents employed part-time, and the homeless unemployed (NIAAA, 1981). Each type has different needs and different characteristics. The stereotype skid row person has been seen as the homeless, unemployed type. This group has the most severe medical and social needs and the desire for alcoholism treatment is low among this group.

Nimmer (1971), Baker (1973), Blumberg (1965), and McSheehey (1979) have all characterized the skid row alcoholic as male and white. The number of blacks have increased in recent years and tend to be younger than the white skid row man. Although popular opinion holds that there are large numbers of doctors, lawyers and other professionals on skid row, Nimmer states that the great majority are "poor lower-class men who have failed to rise along the social structure" (Nimmer, 1981).

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Bahr (1973) believes that the skid row person is stigmatized as derelict since he occupies several stigmatized deviant statuses at once. He has problems of health and sanitation. He is presumed to be a bad character, dependent on welfare or charity, aged, impoverished and possibly an alcoholic (Bahr, 1973). NIAAA (1981), Bahr (1973) and Blumberg (1966) have estimated that 80 percent of the skid row population engage in drinking, however the rates of alcoholism range from 30 percent to 50 percent among this group.

Although poverty and homelessness are visible characteristics of skid row alcoholics, the main distinguishing feature of the skid row man is his powerlessness. Bahr explains that powerlessness is a consequence of freedom from social ties. The skid row man rarely gets his way in encounters with others. Blumberg (1978) suggests that stigmatization is also part of his powerlessness. If one has little power, his contribution to society is seen as minimal.

While the skid row person best characterizes the public inebriate, the Fourth Special Report to the U.S. Congress on Alcohol and Health (1980) is quick to point out that the widespread creation of detoxification centers has identified a different population. The detoxification centers have come in contact with public inebriates who do not fit the stereotype of the homeless, unemployed skid row alcoholic. The public inebriate, as opposed to the skid row man, is more likely to be a working person who in the past would have been taken home to "sleep it off" or to a hospital emergency room. Morrissey and Schucket (1978) have identified the diversity of persons now being admitted to non-hospital detoxification centers, however, their findings indicate that the majority still appear to be socially disrupted, inner city alcoholics (NIAAA, 1981).

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Pittman and Gorden (1958) reported on a sociological study of 187 public inebriates who they defined as "low bottom" alcoholics who are constently in and out of jail as a result of repeated drunkenness arrests:

> Our study has shown him to be the product of a limited social environment and a man who never attained more than a minimum of integration in society. He is and has always been at the bottom of the social and economic ladder: he is isolated, uprooted, unattached, disorganized, demoralized and homeless, and it is in this context that he drinks to excess. . . he is the least respected member of the community. (Pittman and Gorden, 1958, p. 152)

Most cities in the United States have one or more sections where the skid row person and public inebriate is concentrated. However, with urban renewal, the typical skid row section of town has changed since skid row was first identified in the 1800's. At that time, concentrations of facilities came to be known as "skid rows" from the skid ways on which lumberjacks in the Northwest transported logs. In Seattle, the lodging houses, saloons, and other establishments were on both sides of the "skid road" running from the top of the ridge down to the mill. The term "skid road" was applied to the community of homeless men who frequented the establishments and worked as lumberjacks. The term was later transferred to urban enclaves of homeless men and became "skid row" (Bahr, 1973).

Typically, the term skid row refers to a district or several districts of a city where there is a concentration of substandard hotels which charge low rates and cater to men with low incomes. These hotels are mixed in with numerous taverns, employment agencies for unskilled labor, restaurants serving low cost meals, pawnshops, secondhand stores and missions that provide a free meal, lodging and often mandatory religious services. These areas are often located near the central

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business district or transportation facilities such as a waterfront, freight yard or trucking depot (McSheehey, 1969).

Although skid row is often seen as a section of a city, Spradley (1970), Blumberg and Shipley (1978) portray skid row as less of a place and more of a human condition. Spradley believes that a subculture of urban alcoholics exists in our cities. He points out that the culture of poverty and urban nomads is similar in that individuals are socialized into both subcultures by the prejudice and discrimination of the larger society, specifically by police, courts, and the jail. Judges often reinforce the mobility of urban nomads by issuing lighter sentences to those who promise to leave town.

Blumberg, et. al. (1966) in describing skid row as a human condition, states that skid row-like conditions stretch throughout the slums and suburban areas of all cities. People of skid row have counterparts in other parts of the city, and many people who resemble skid row residents live elsewhere.

A major point of disagreement among sociologists is the proportion of homeless, skid row men who are actually alcoholic. Spradley (1970) and Larew (1980) believe that there are no more alcoholics among skid row's men as there are among other segments of the population. If this were so, it would average ten percent of the population. However, in a study conducted by Strauss with Salvation Army residents, it was found that 80 percent of the population related experiences of long and painful histories of excessive drinking (Strauss, 1946). While the truth must rest somewhere between these two extremes, it appears clear that this area of study is filled with stereotypes and misconceptions which seriously hamper effective understanding of the problem.

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The most visible institutions that have attempted to respond to the needs of the homeless public inebriate have been the missions, specificcally the Salvation Army. While these institutions have been criticized for contributing to the problem, they have been in many cases the only agencies willing to work with this population. The Salvation Army has been providing care for the alcoholic for over 100 years and serves 50,000 annually. Moos, Mehrenand, and Moos (1978) conducted one of the few evaluations available of a Salvation Army Alcoholism Treatment Program, published in the Journal of Studies on Alcohol. The program evaluation found a significant improvement in clients six months after discharge. The treatment program included vocational rehabilitation, psychotherapy, and recreational therapy. It appears from the evaluation of Moos, et. al. (1978), Warden (1982), and Steel (1970) that the Salvation Army programs are far from the stereotype of a hard sell evangelist trying to force religion on the clients. However, the program directors do admit that attendance at chapel is a mandatory part of the program. While the Salvation Army appears to provide a highly structured theraputic rehabilitation program, the other religious-oriented missions differ greatly in their services. Most all large cities will have urban churches offering a hot meal or sandwiches. Some require attendance at religious services as a prerequisite to food and others merely provide charity, asking nothing in return.

Criminal Justice Response

Public inebriates and skid row people are labelled as deviant by our society and are thus treated as being unworthy of respect. The missions offer help, but the police and courts are assigned the

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responsibility of enforcing society's values and laws. Although society has labelled the middle class alcoholic as deviant, the middle class drinker is less likely than the lower class drinker to come in contact with police officers. Since it is highly undesirable to have people sleeping in alleys and doorways, police are charged with the task of "getting them off the streets."

According to the National Coalition for Jail Reform (NCJR), one of every three misdemeanor arrests in the United States is for public intoxication. The cost of arresting, booking, jailing and trying the public inebriate is over $500 million per year (NIAAA, 1982). Life for many public inebriates is a revolving door between arrest, jail, courtroom and the street. The National Institute of Alcohol Abuse and Alcoholism (1982) estimated that the average person arrested for public intoxication has been arrested 12 times before. The time and effort invested in jailing public inebriates limits law enforcers' ability to respond to violent crimes (NIAAA, 1982).

Pittman (1974), in his study of the interaction between skid row people and law enforcement officials, concludes that police develop an approach to skid row as "preventing a deteriorated situation from deteriorating further." Police are more concerned with keeping the peace and using the law as a resource. So, the policeman uses arrest as a means of resolving problems rather than a means of solving a particular crime. Rather than attempting to control skid row through a "reign of terror," police often offer paternalistic indifference to those who break the law peacefully (Wilson, 1978). Pittman believes that this attitude further compromises the person's individual rights, since the skid row resident is percevied as not deserving of equal protection under the

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law, nor is he deserving of equal enforcement of the law.

In a study of court sanctions on chronic drunkenness offenders, Stub and Lovald (1969) concluded that punishment does not serve as a deterrent to future encounters with the police and the courts. In the Minneapolis skid row district, the authors found that regardless of the number of arrests, court fines had a greater deterrent effect than jail sentences. Longer periods of time between arrests were identified when offenders were given fines rather than jail sentences. Also, they concluded that once a person is officially labelled deviant through arrest and court action, the likelihood of additional encounters with the police is increased. Pittman (Note 4) and Blumberg et al. (1965) described the skid row man as having low verbal ability, low socioeconomic origins and poor educational background. He feels considerable hostility but is unable to express himself verbally until the situation becomes unbearable and then he is likely to get drunk. The skid row man knows that drunkenness is socially disapproved, therefore getting drunk serves as an act of hostility. This passive hostility "now you've driven me to drink, what are you going to do about it?" encourages the skid row man to exploit social welfare organizations and the jails as a resource when all else fails in the dead of winter (Pittman, et al., 1965).

While Pittman characterizes the skid row man as manipulating the system in a passive manner, Burr (1970) summerizes the same process quite differently:

> Such a person is inextricably caught in the cycle of intoxication, arrest for being publicly in that condition, conviction, confinement, release, and return to the street where, because of his complete lack of control over his drinking, the cycle begins again. This cycle has become so common that the number of arrests for public intoxication is higher than that for any other offense. (p.55)

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Once a person is arrested and brought before the judge, each case is decided on its individual merits. Yet the drunk court operates on the assembly line process. Sometimes groups of men are sentenced at once and other decisions may average as little as 30 seconds per man. Since most men plead guilty to the charge of public intoxication, the judicial treatment depends on the person's physical appearance, social position and arrest record (Bittner, 1967).

Pittman and Gorden (1958) believe that while an isolated arrest without jail may have little influence on the person, the psychological impact of the continual process of arrest and incarceration on the individual causes the resources of the person to be further weakened and the development of the institutionalized offender occurs (Pittman, 1958). But administrators and attorneys believe that it is simply a matter of time before public inebriates file suit against local governments, alleging improper jailing and treatment, with large financial penalties being sought. Already, numerous lawsuits have been lodged against local governments alleging civil rights violations (Monell vs. City of New York, Owens vs. City of Independence, Mo. (from Reiger, 1979). Nimmer states that "beyond these growing numbers of suits, medical care in local jails is getting increasing attention, as is the suicide rate among the public inebriate population." These factors will most likely put very strong financial pressures on localities to find alternatives to jail for public inebriates (Nimmer, 1971).

Bahr (1974), Nimmer (1971) and Blumberg (1965) have criticized criminal sanctions and the process applied to this population. They view the criminal justice system's treatment of the public inebriate as "improper regulation of public morals in the absence of harm to

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identifiable victims." The argument most often heard in court decisions is that the criminal justice system is providing social services in the form of protection, however, the quality of services is poor and no medical care is provided. The process neither deters the men from deviant acts nor provides opportunities for them to obtain rehabilitative services. In fact, it has been indicated that the criminal and social lable attached to skid row conduct reinforces the deviancy (Pittman, Note 4).

In order to justify the decriminalization of public drunkenness and the development of alternative programs such as detoxification centers, municipalities have assessed public drunkenness arrest data. In a comprehensive study of alcohol-related incarceration in Birmingham, Alabama, Sumrall and Fulk (Note 5) found that 65 percent of all arrests were alcohol-related during the 30 day period of the study, and all but 20 arrests were for Drunk in Public (D.I.P.). Also the authors found that 22 percent of their sample had been arrested for D.I.P. over ten times and two percent had been arrested over 50 times. The authors concluded that the treatment of problem drinkers and those with alcohol-related problems in the judicial system reflects the general community attitudes toward public intoxication, whether the attitudes are paternalistic, enforcement-oriented, treatment-oriented or laissez faire. In Birmingham, a paternalistic approach to coping with the intoxicated persons has resulted in a large amount of time occupied with maintaining the problem drinker in the reoccurring pattern of arrests, jail and re-arrest (Sumrall and Fulk, Note 5).

Much of the incentive for developing alternative methods for handling the public inebriate have come from decriminalizing public

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drunkenness. In the early 1970's, the Uniform Alcoholism and Intoxication Treatment Act was proposed to replace the criminal process and reduce the burden on the criminal justice system. This policy advocated the transfer of the public drunkenness problem from the criminal justice system to a therapeutic system. The Uniform Act states that alcoholics and intoxicated persons may not be subject to criminal prosecution because of their consumption of alcoholic beverages. Rather, these people "should be afforded a continuum of treatment in order that they may lead normal lives as productive members of society." Adoption of the Act makes it possible for states to receive Federal incentive grants to provide public inebriate services (NIAAA, 1982).

The debate over decriminalization has gone on for over ten years as evidence has accumulated regarding the effect of decriminalization. At the heart of the debate is the issue of punishment vs. rehabilitation and the disease concept of alcoholism. In two landmark cases in 1966, Easter vs. District of Columbia and Driver vs. Hinmant, the courts held that public drunkenness for the alcoholic is involuntary and, therefore, not subject to prosecution. In the Driver case, the court vacated the plaintiff's two year sentence for public intoxication as cruel and unusual punishment. However in Powell vs. Texas, the Supreme Court was not convinced of the "disease" argument regarding alcoholism. Their opinion was that the behavior may indeed be voluntary in many instances. Powell vs. Texas slowed the national reform movement somewhat but in 1968, the American Bar Association and the American Medical Association urged the adoption of comprehensive legislation which would both decriminalize public drunkenness and require the creation of local treatment facilities for alcoholic persons (Regier, 1979).

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In 1970, the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act (Public Law 91-616) was enacted which led to the establishment of the National Institute on Alcohol Abuse and Alcoholism (NIAAA). NIAAA was to assist states and localities in formulating effective treatment programs, sponsor alcohol research and generally serve as a national clearinghouse on decriminalization and acohol rehabilitation efforts. Tied to this Federal initiative, the National Conference of Commissioners on Uniform State Laws drafted the Uniform Alcoholism and Intoxication Treatment Act 1971 for the subcommittee on Labor and Public Welfare of the United States Senate (Note 1).

As of this date, the Commonwealth of Virginia has not adopted the Uniform Alcoholism Act. However, the 1979 Virginia General Assembly passed H.B. 1599 authorizing the police and courts to transport public inebriates to court-approved detoxification centers in communities where such centers existed and reduce the charge of public drunkenness to a Class 4 Misdemeanor (Guest, Note 3). In 1981, as a result of a three year study by the Virginia State Crime Commission, $250,000 per year for three years was awarded to the Department of Criminal Justice Services to begin developing a system of social detoxification programs throughout the Commonwealth.

This system included the establishment of 24 hour-a-day detoxification facilities throughout the Commonwealth. Transportation of the public inebriate to the detoxification center would be the responsibility of local law enforcement officers, private citizens, or the detoxification facility. If the inebriate was not appropriate for admission or refused admission to the facility, he or she would be arrested and jailed as long as he was considered a threat to himself or to others

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(VSCC, Note 6). The Commonwealth of Virginia did not decriminalize public drunkenness but set up a system of detoxification programs throughout the state with passage of H.B. 407.

But decriminalization of public drunkenness has been an extremely controversial policy. Kurtz and Regier (1975) believed that decriminalization affects only a portion of skid row persons since the disease model is more related to the larger portion of alcoholics. Regier and Kurtz said that the disease model is not well suited to the needs of the chronic public inebriate. It assumes a willingness of the alcoholism and medical fields to accept the skid row alcoholic.

Regier and Kurtz (1975) criticism was primarily directed at the poor fit between the skid row alcoholic and the medical model. Warren (1976), in support of Kurtz and Regier's hypothesis, states that:

> Although the chronic public inebriate looms large in the motivation for the Act, he may benefit little since he will be a poor patient in several important respects: He is indigent, a low status individual, and potentially repulsive to other patients, donors and legislators (p. 208)

This point of view has been supported by an evaluation of decriminalization conducted in Massachusetts in 1980. Daggett and Rolde (1980) studied the response of the police to decriminalization by analyzing public inebriate, drunkenness and disorderly arrests 18 months after the change. The authors found a 27 percent increase in the number of drinking related jail cell detentions and concluded that the diversion of inebriates to detoxification centers occurred only to a minimal degree. According to Daggett and Rolde:

> Public Drunkenness and similar laws (e.g., disorderly conduct) have always been used in a broadly discretionary way by the police in their role as agents of social control to deal with various situations regarded as annoying or troublesome. Drunkenness per se was never the real reason for the arrest:

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> in fact, some who were arrested were not drunk, and many who were drunk were not arrested. The essential point is that all of these people were arrested because of something about their behavior, or their appearance, to which police felt obliged to respond. That is why, even after drunkenness was decriminalized, the police function of social control was unchanged (p. 42)

Daggett and Rolde (1980) explain that due to the low motivation of this population for treatment, physical deterioration and the criteria for admission of most detoxification programs (no assaultive behavior or medical problems), few police case public inebriates meet the admission requirements (Daggett and Rolde, 1980).

While Kurtz and Regier felt that the care of the skid row person would eventually fall back to the criminal justice system, Warren (1976) believes that with deliberate training of medical care personnel to deal with the unconventional behavior of skid row alcoholics and with redefinition of expectations to a more realistic level of prognosis, decriminalization could succeed. Chafetz (1976) believes that decriminalization would affect more than "skid rowers" since it would reduce the stigma of all alcoholic persons as morally weak rather than ill. Chafetz explains that the disease model was advocated "becuase it was a symbolic mechanism of communication, familiar and unfrightening in its acceptability" (Chafetz, 1976). However, Chafetz did agree with Kurtz and Regier that the alcohologists' desire for a more respectable professional identity motivated them to support the disease concept. Also he agreed that professionals recruit clients who fit their treatment in perference to adapting their programs to unresponsive clients (Chafetz, 1976).

Blumberg (1976) suggests that persons found drunk in public but not skid row like in their lifestyle, may receive the maximum assistance from

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detoxification facilities. In time, detoxification may prevent public inebriates from drifting into skid row like conditions through arrests and "official labelling." Decriminalization will not eliminate police involvement, but turn police officers into referral agents.

It appears that there is no clear consensus as to whether decriminalization or diversion programs will reduce arrests and jail bed days for public inebriates. It may be too early to tell. Also, there is probably no entirely satisfactory solution to the problem since it has been defined by long-term conflicts in norms and interests. The real test of decriminalization may lie in the effectiveness of detoxification programs to identify and treat the public inebriate.

Detoxification

As a result of decriminalization of public drunkenness in some states and the burden of the public inebriate on the criminal justice system, detoxification centers have developed over the last fifteen years. These facilities are normally located in population centers, housed either in general hospitals, adjacent to long-term alcohol rehabilitation facilities or free-standing.

Detoxification is the process of becoming sober by the removal of chemical toxins from a person's body either with the aid of sedatives or using no drugs. Length of initial care can last from one to six days depending on the physical condition of the client, drinking history, and the amount of alcohol consumed. Detoxification protects the person from experiencing a medical emergency such as delirium tremens, seizures, and malnutrition.

Detoxification centers have been modelled on the "sobering-up

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stations" in operation in several Eastern European countries since the 1950's. The first detoxification center in the United States opened in St. Louis in 1966. In Canada, an experimental detoxification center, operated by the Addicition Research Foundation of Ontario, opened in Toronto in 1968. Over 100 detoxification centers are now located in many states across the U.S. and in several Provinces of Canada (Annis, 1979).

Depending upon a number of factors, safe detoxification may take place in either a medical or a social setting, and the management of withdrawal may involve either medical or psychosocial procedures or a combination of the two. Patients showing severe withdrawal symptoms require the close medical supervision and management available in an inpatient hospital setting. Also, patients with alcohol-related or non-alcohol-related complications may require detoxification in a medical setting regardless of the severity of withdrawal symptoms. It has been suggested that social setting detoxification may be the treatment of choice for persons experiencing either mild or moderate withdrawal (NIAAA, 1981).

O'Brient (1974) Tatham (1969) and Riebe (Note 7) have developed similar social detoxification models with the following components and characteristics:

1. Although the majority of alcoholic clients do not need immediate medical intervention, residential detoxification programs must have hospital affiliation to provide 24-hour, 7-day-a-week medical back-up.

2. Specially trained staff is an essential component in residential detoxification programs. The staff must be familiar with all existing community resources. They must have the ability to work closely with intoxicated individuals and have an understanding of the withdrawal sysptoms and complications associated with alcohol use.

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3. The environmental milieu is an important element of the residential detoxification program. The maintenance of a quiet, positive atmosphere is essential to facilitate detoxification without drugs or medical intervention.

4. Emergency care for alcoholics does not necessarily mean emergency medical care. All alcoholic people should have a complete physical examination as part of the recovery process.

5. Referral must be viewed as a primary goal of residential detoxification programs. Every client entering a residential unit should be offered information pertaining to referral resources available to meet basic needs and to provide ongoing recovery opportunities. Detoxification should be viewed as a time interval to prepare the client for referral.

6. Recidivism will occur in residential detoxification programs. Although the majority of clients will not be chronic repeaters, some will require multiple admissions. It is unreasonable to expect some individuals, who have been chronic alcoholics for many years, to make a complete change in life style after one admission to a residential detoxification program (O'Brient, 1974 p. 236-257).

In addition to these components of social detoxification identified by O'Brient, Tatham and Riebe have pointed out the need for a multi-agency system approach (NIAAA, 1982). In a discussion of California's detoxification and treatment programs for public inebriates, Charles G. Stribling, of the California Department of Alcohol and Drug Programs says:

> Alcoholism is only a part of the wide range of problems affecting this population. Most skid row residents have reasons other than alcoholism for being there - such as mental illness, escapism, availability of cheap food and housing, or rebellion. The assumption that all skid row people are alcohol or drug abusers is mistaken. Agencies must deal with the poverty-related problems of this population first (NIAAA, 1982 p. 5).

In an evaluation of the Southern Ontario Detoxification Centers, Ogborne and Clare (1979) and Annis (1979) also concluded that detoxification should be seen as only one of a range of services available

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to the public inebriate. Ogborne and Clare believe that the detoxification centers and other agencies designed to serve the police-case alcoholics should be valued for their humanitarian functions and be recognized as contributing to the long-term care and management of their clients.

Ontario's Detoxification Centers have been the subject of a thorough evaluation by the Addictions Research Foundation. Ontario has found that on some occasions a public inebriate may be taken to a police station, charged and even sentenced to jail while on other drinking occasions he is escorted to a detoxification center and not charged (Annis, 1979). In Ontario, Canada, 95 percent of the public inebriates admitted to hospitals appeared to need nothing more than a calm, anxiety-free, home-like milieu in which to become sober (Annis, 1976, 1979; Smart, 1977, 1978). Bahr has identified five advantages to social detoxification centers: (1) the stigmatizing effects of involvement with criminal law are avoided; (2) the "medically-oriented" detoxification center is more sanitary and humane than the drunk tank; (3) para-professional medical help is available with a minimum of expense or red tape: (4) law enforcement agencies are freed to devote their resources to more serious crime; and (5) there is a chance for referral and the potential for rehabilitative therapy (Bahr, 1973).

However, Vincent D. Pisani (1977) points out some disadvantages of non-medical detoxification. Pisani claims that detoxification programs which last two to three days may find the client appearing stabilized after only a few days, however, the acute phase often continues for a minimum of seven to ten days after withdrawal. There are many hidden medical and emotional problems which often go undetected and unattended in social, non-medical detoxification centers. Pisani believes that

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for these reasons the treatment of alcoholics should remain in the medical system where a complete continuum of care is available and close follow-up is provided (Pisani, 1977). The contention that detoxification should take place in a medical setting has also been supported by Hamilton, et al. (1975) in his evaluation of the Edinburgh Detoxification Project in Edinburgh, Scotland.

One of the critical problems in the treatment of alcoholism has been a critical shortage of scientific evaluations of detoxification programs. While there has been an increase in program evaluations of alcoholism treatment programs over the last ten years, evaluations of detoxification programs are few and far between. Bahr explains that programs for the homeless usually have a low funding priority because homeless men, and especially the chronic police-case alcoholic, are thought to have little promise for rehabilitation in comparison to other segments of the community (Bahr, 1973). Evaluations, when funded, have been added to treatment programs as an afterthought rather than being established as an integral part of the program. When this is done the results have often been a poor evaluation with no baseline information, no comparison groups and a general lack of adequate controls.

While there is little evidence that any one method of rehabilitating chronic inebriates has been successful (Slone, et al. 1975), there is evidence that some methods are more detrimental than others. Incarceration, for example, remains the most common "treatment" for public inebriates although it is universally considered an ineffective aid to rehabilitation. Insight therapy is still the most widely used method of treating alcoholics. This is not because it is shown to be effective but because it is preferred by most clinicians. In fact

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success in treatment has been related not to the type of treatment but to the clients motivation, desire for help and his/her social and psychological stability (Blum and Blum, 1967). As a limited objective, a simple rest or diversion has been shown to be more effective than "a traumatic attempt to break down defenses and reveal interpsychic truths" (Bahr, 1973).

Figure 1 provides a framework for describing the most relevant evaluations which have been performed of public inebriate programs in North America and Europe. Some evaluations use randomized control groups with follow-up, others merely provide descriptive data of clients. In reviewing the evaluations, it appears that the more rigorous the evaluation design, the less favorable are the conclusions. Overall, the poorly designed evaluations tend to produce favorable results.

Pittman (1969) believes that abstinence, as a criterion for success, is an unreasonable expectation when evaluating a detoxification program that often lasts only 72 hours serving a chronic alcoholic population with a long history of alcoholic drinking and multiple arrests and hospitalization. Lowe and Thomas (1977) explain that abstinence can be misleading if not evaluated in relation to other rehabilitation goals such as physical health, social and psychological adjustment and vocational functioning. The authors suggest that programs should aim for a reduction of drinking while concentrating on family adjustment, occupational effectiveness and social adequacy.

When analyzing the thirty studies described in Figure 1, eleven studies reported results in terms of abstinence. Smart, et al. (1977), Smart (1978), Ogborne and Wilmot (1979), Gallant (1973) found no significant relationship between a specific treatment, such as outpatient,

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Author/Year	Program	Components	Variables	Type of Evaluation Research	Significant Findings
Gallant, 1973	Comparison of three treatment approaches for the chronic alcoholic court offender, New Orleans, Louisiana	Number of subjects: 210 Type: Compulsory outpatient treatment, compulsory inpatient and outpatient treatment and voluntary outpatient treatment Method: Clients randomly assigned to three treatment groups Problem: Is compulsory inpatient treatment more effective than other approaches?	One year follow-up: (self-report data and court records) -Arrests/jail -Duration of clinic contact -Drinking patterns Intake and follow-up: -Psychiatric Evaluation Profile (PEP)	Impact	Only 17 subjects available at follow-up. 6% of original sample of 210 were rated as successes (37% mortality) (no criteria for success provided). Compulsory treatment showed no superiority to other treatment approaches, the success and failure groups were identical.
Hamilton, Aitken, Griffith, Ritson, 1975	Edinburgh Alcoholism Detoxification Project Edinburgh, Scotland	Number of subjects: 100 Type: Medical detoxification Length of stay: Seven days ($\bar{X}$=3.2)	Client descriptive information Medical evaluation Number of court appearances Arrests	Process	Treatment group showed a 76% decrease in court appearances. 50% police referrals, 30% self-referrals.

Figure 1

RESEARCH AND EVALUATION OF PUBLIC INEBRIATE PROGRAMS

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Author/Year	Program	Components	Variables	Type of Evaluation Research	Significant Findings
Hamilton, Aitken, Griffith, Ritson, 1978	Edinburgh Alcoholism Detoxification Project Edinburgh, Scotland	Number of subjects: 100 Type: Medical detoxification Length of stay: Seven days ($\bar{X}$=3.2)	Client descriptive data Arrests Treatment	Impact	Detoxification should be carried out in a medical environment with medical and nursing staff trained in psychiatry. No difference in duration of abstinence between treatment and control group or in amount of alcohol consumed. 36% reduction in public inebriate convictions for treatment group.
Hamilton, 1979	Edinburgh Alcoholic Detoxification Project Edinburgh, Scotland (court referred)	Number of subjects: 100 Type: Medical detoxification Court referred convicted public inebriates randomly assigned to detoxification and control group	Intake and one year follow-up of treatment and control group on: -Number of days abstinent -Drinking episodes -Number of days hospitalized -Drinking habits -Accommodations -Employment -Quality of life	Impact	Detoxification groups showed significant improvement in accommodations and quality of life. Detoxification group exhibited no significant difference in alcoholism or episode of drunkenness although their periods of abstinence were longer than the control group.

Figure 1 Continued

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Author/Year	Program	Components	Variables	Type of Evaluation Research	Significant Findings
Wilson, White and Lange, 1978	Health Services Center, Alcoholism Treatment Unit, Winnipeg, Providence of Manitoba, Canada	Number of subjects: 90 Type: Inpatient treatment program specifically designed for skidrow persons Length of stay: 21 days Number of beds: 24 Procedure: Clients evaluated and randomly assigned to treatment program or similar comparison program.	Client descriptive information Post treatment drinking behavior Self-administered questionnaire at intake and 5, 10 and 15 month follow-up covering 16 dimensions	Impact	The comparison programs effected greater short term changes but the difference between the effects of treatment conditions disappeared with time. The nine item questionnaire accounted for 50% of the variance in prognosis as measured by the amount of drinking at discharge. 26% of both groups exhibited at least three months of abstinence at follow-up.
Ogborne and Wilmot,1979	Outpatient Counseling Service for Skidrow Alcoholics, Toronto, Ontario, Canada	Number of subjects: 40 -20 experimental group and 20 matched control group Type: Outpatient counseling Length of stay: Six months Problem: What is the effect of six months of outpatient counseling for skidrow alcoholics (weekly meetings)?	Self-report data: -Accommodations -Employment -Drinking -Arrests	Impact	Only ten clients were seen weekly, these were matched with ten from the control group but the sample size was too small for statistical comparison. No information to demonstrate involvement with outpatient counseling had a lasting effect on drinking or life style.

Figure 1 Continued

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Author/Year	Program	Components	Variables	Type of Evaluation Research	Significant Findings
Smart, 1978	Ontario Detoxification Centers (12), Canada	Number of subjects: 174 Type: Social detoxification Length of stay: Unknown Problem: Which referral agencies are most effective in reducing readmission to detoxification?	Number and disposition of referral Number arriving at referral source Number completing treatment Number of readmissions to detoxification	Process	35% of referrals arrived at post-detoxification treatment facility. No difference in improvement later for half-way house, hospital and non-residential programs. Type of referral does not relate to improvement.
Annis and Smart, 1978	Ontario Detoxification Centers, Toronto and Hamilton, Canada	Number of subjects: 522 Type: Social detoxification Problem: What has been the post-detoxification experience of clients six months after treatment in terms of arrests for public drunkenness, readmissions to detoxification and admission to treatment facilities?	Follow-up self-report data on: -Employment -Drinking -Residence -Arrests -Detoxification treatment	Process	At six month follow-up: -82% report heavy drinking -53% not arrested -52% readmitted to detoxification -10% confirmed referrable Most men were arrested and jailed after detoxification rather than referred again to detoxification. Repeat admission not related to increased likelihood to accept referral.

Figure 1 Continued

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Author/Year	Program	Components	Variables	Type of Evaluation Research	Significant Findings
Annis, 1979	Ontario Detoxification Centers, Canada -13 detoxification centers -17 half-way houses	Number of subjects: 8000 Type: Social detoxification Overview of Ontario evaluations	Client descriptive profile Arrests Readmissions Treatment referrals	Process	40% police referrals in (11% in two largest cities). 70% of all admissions readmitted within two years. 10% showed up for referral out, of those: -37% entered residential treatment (2.8 weeks for six months program) -23% entered outpatient treatment Detoxification was serving a broader population than had been involved in the criminal revolving door. Some communities showed a decrease in arrests others did not. Changes in the number of arrests were not related to the number of drunkenness events. Greater leniency of police and courts was observed. The coexistence of public drunkenness offense and detoxification centers created highly discrepant responses from police on different occassions.

Figure 1 Continued

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Author/Year	Program	Components	Variables	Type of Evaluation Research	Significant Findings
Annis, 1979 Continued					Retention in post-detoxification treatment a major problem. Detoxification plays a minor role in integrating men into the health care system.
Annis and Liban, 1979	Ontario Half-way Houses, Canada	Number of subjects: 70 -35, experimental group (entered half-way houses), 35, comparison group (did not enter half-way house) Type: Half-way House Length of stay: Six months -Subjects matched on accommodations, employment, arrests and jail time, and months of outpatient treatment Problem: What are the effects of half-way houses on client's arrests and drinking episodes?	Client characteristics Drinking episodes	Impact	Men staying over two months in half-way houses, and men who did not enter half-way houses, were just as likely to return to heavy drinking. More limited humanitarian goals involving long-term, care-giving services are more realistic for meeting the needs of chronic public drunkenness offenders.

Figure 1 Continued

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Author/Year	Program	Components	Variables	Type of Evaluation Research	Significant Findings
Smart, Finley, and Funston, 1977	Detoxification Center Toronto, Ontario	Number of subjects: 114 Type: Social detoxification Length of stay: Unknown Number of beds: 20	Success of post-detoxification referrals at six month follow-up	Impact	31% police referrals in. 42% refused referral out. 60% referred out actually arrived. Those refusing treatment showed a significant increase in detoxification readmissions. Outpatient treatment seems to have the same effect as does residential treatment.
Ogborne and Clare, 1979	Bon Accord Farm Residential Rehabilitation Program, 75 miles south of Toronto, Canada	Number of subjects: 50 Type: Rural Residential Rehabilitation Program Number of beds: 24 male Problem: What is the effect of residential rehabilitation on detoxification readmissions for skidrow alcoholics?	One year follow-up on detoxification readmissions	Impact	Detoxification admissions increased following admission to residential rehabilitation (3.7 at intake, 7.2 at follow-up, [p 0.00001]). Rate of detoxification admissions after program are unrelated to length of stay.

Figure 1 Continued

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Author/Year	Program	Components	Variables	Type of Evaluation Research	Significant Findings
Kern and Schmelter, 1979	Nassau County Medical Center, Mineola, New York	Number of subjects: 189 Type: Alcoholism inpatient treatment Length of stay: 28 days	Client descriptive data Monthly follow-up at six months on total abstinence for the month Alcohol-related arrests and hospitalization	Impact	42% of subjects were abstinent for the entire six months of follow-up. Race (white), fewer hospitalizations and fewer arrests accounted for 27% of the variance in abstinence. Monthly contacts for follow-up increase involvement in after care and drinking behavior.
Moos, Mebren and Moos, 1978	Salvation Army Alcoholism Treatment Program, Palo Alto, California	Number of subjects: 97 Type: Inpatient, non-medical alcoholism treatment Length of stay: Six months Number of beds: 65 Long term recovery program includes: -Mileau therapy -Individual/group therapy -Community meetings -Sunday worship services -Religious counseling -Educational lectures and films -Alcoholics Anonymous	Client descriptive data Measure at intake and follow-up on: -Alcohol consumption -Behavioral impairment -Physical impairment -Rating of drinking -Hospitalization for alcoholism -Abstinent post-months -Occupational functioning -Social functioning	Impact	The inclusion of jobs and worship in treatment contributes to significant improvements in occupational, psychological and behavioral functioning. Active involvement of the client in the program is the most important factor in improvement. Clients exhibited statistically significant improvement on seven of nine outcome variables at follow-up.

Figure 1 Continued

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Author/Year	Program	Components	Variables	Type of Evaluation Research	Significant Findings
Moos, Mebren and Moos, 1978 Continued		-Vocational rehabilitation -Spot jobs in community	-Psychological well-being -Social climate -Program participation		
Whitfield, 1978	Detoxification Centers in Springfield, Illinois, Jacksonville Florida and Mount Vernon, Illinois	Number of subject: 1,114 Type: Social detoxification using vitamins Length of stay: Two to eight days	Close medical monitoring Client descriptive data Sobriety at two year follow-up (no randomization or control group)	Impact	Clients do as well in non-drug detoxification as do clients administered seda-tives and minor tranquilizers. Only two days are required for the acute detoxification period.
Randall, 1970	City of Houston Health Department, Opportun-ity House, Houston, Texas (designed specifically for the chronic police case public inebriate)	Number of subjects: 367 Type: Therapeutic community/intermediate care Length of stay: 26 days Number of beds: 45 Activities: -Alcoholics Anonymous -Vocational Rehabilitation	Client descriptive information Arrests	Impact	Client group exhibited a 48.3% reduction in arrests comparing number of arrests one year prior to program and number of arrests one year after program. 13% reduction in total public inebriate arrests ten months after program operation.

Figure 1 Continued

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Author/Year	Program	Components	Variables	Type of Evaluation Research	Significant Findings
National Institute of Alcohol Abuse and Alcoholism, Program Analysis and Evaluation Branch, HHS, 1980	An Evaluative Report of NIAAA Public Inebriate Programs for Fiscal Year 1980	Number of subjects: 22,497 Type: Detoxification and intermediate care Date represents 19 NIAAA-funded Public Inebriate Programs	Client descriptive information Referral in/out Employment Drinking behavior	Process/ Impact	Self-referral (32%) major source of referral in, (5% police). 72% of client reported abstinent at self-report follow-up (180 days). 51% decrease in drinking days at follow-up. 18% increase in employment at follow-up. 31% referred out to alcoholism treatment. 30% loss of subjects at follow-up.
O'Briant, 1975	Residential Detoxification Center, Stockton, California	Number of subjects: 5,959 Type: Social detoxification Length of stay: Unknown Number of beds: 20	Descriptive client information	Process	95% of alcoholics can be detoxified without medical intervention. Many admissions may be necessary before client accepts referral to ongoing services. 49% self, family friend referral in. 36% police referrals in. Must have medical backup.

Figure 1 Continued

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Author/Year	Program	Components	Variables	Type of Evaluation Research	Significant Findings
O'Briant, 1975 Continued					Staff must have some medical training and know community resources. All clients should be offered a referral at discharge.
O'Briant, 1976	"1335 Guerrer Street," San Francisco, California	Number of subjects: 99 Type: Social detoxification Length of stay: Four to six days Number of beds: 20	Descriptive client information Length of last drinking episode Family contact Family drinking history History of with-drawal symptoms Medical pathology Percentage of clients admitted but requiring medi-cal care	Process	41% of clients reported no contact with family in the last year. 44% reported at least one family member had heavy drinking history. None of the clients examined required medical care.
Turner, 1979	St. Vincent's Hospital and Medical Center, Keller Hotel, New York, New York	Number of subjects: 140 Type: Unstructured half-way house -Outpatient voca-tional counseling -Community meetings -Alcoholics Anonymous	Length of sobriety Length of stay in program Employment Self-report infor-mation on contacts with family and friends	Impact/ Process	A significant factor affecting the chance for recovery is the ability of the skid row alco-holic to form and sustain a relationship with someone. Need to work is a major fac-tor in recovery.

Figure 1 Continued

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Author/Year	Program	Components	Variables	Type of Evaluation Research	Significant Findings
Turner, 1979 Continued		-Antibuse -Supportive sober environment Length of stay: Six months			There appeared a significant relationship between one or more years of sobriety and employment and a sustained relationship with at least one family member or friend.
Berns, 1974	Denver General Hospital, Denver Detoxification Unit, Denver, Colorado.	Number of subjects: 1,683 Type: Medical detoxification Length of stay: Five days Number of beds: 23 Drug therapy used for sedation, nausea, hallucinations and Werniche-Korsokoff Syndrome Antibuse Group counseling	Descriptive patient information Referrals in and out Readmissions (for 12 month period)	Process	58% referrals from self, relative or friend. 4% referrals from legal agencies. 56% accepted referral for treatment after discharge (no follow-up). 28% accepted no referral for treatment after discharge. 80% of patients were admitted only once in the year (16% two admissions).
Ross and Adams, 1977	Community Mental Health Center, Female Detoxification Unit, Washington, D.C.	Number of subjects: 4,595 Type: Medical detoxification Length of stay: 72 hours Number of beds: 21	Number of admissions and multiple admissions over a four year period.		68% of female patients admitted did not return during the year and did not show what has been called a "revolving-door" of reoccurring admissions.

Figure 1 Continued

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Author/Year	Program	Components	Variables	Type of Evaluation Research	Significant Findings
Feeney, 1976	The Alcoholic Clinic, Washington, D.C. Outpatient services for skidrow alcoholics which includes medical relief, recreation, occupational therapy, social case work, group therapy and individual psychotherapy.	Number of subjects: 100 -Random selection of police referred clients and 50 volunteer clients Type: Outpatient counseling Problem: Are there significant differences between volunteer and police case clients?	Clinical interviews regarding: -Client descriptive data -History of alcoholism -Arrest records -Alcoholic reactions -Diagnostic classifications	Descriptive	Police case public inebriates: -30% diagnosed psychotic -48% in need of institutional care -94% judged poorly motivated for treatment -76% reported no family, no work and no job prospects. -84% had less than two dollars at discharge from jail -22% chronic brain syndromes The police case alcoholic whose intelligence is average or low, whose motivation to change is poor or nonexistent and who has no social or monetary resources seems to have little chance for recovery under outpatient treatment.
Makoujuola, 1980	Manchester Detoxification Program, Manchester, England (specifically designed for police referrals only)	Type: Medical detoxification and treatment Length of stay: Zero to two years Activities: -Detoxification -Individual therapy	Client descriptive data Referrals in and out Readmissions	Process	78% police referrals (considered low due to transportation problems and persons refusal to participate in detoxification treatment). 50% stayed under three days. 12% referred out (no follow-up) to treatment.

Figure 1 Continued

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Author/Year	Program	Components	Variables	Type of Evaluation Research	Significant Findings
Makoujuola, 1980 Continued		-Occupational therapy -Alcoholics Anonymous -After care			44% sent home. 29% readmissions. 46% homeless.
Kane, 1981	Martin Luther King, Jr. Health Center, Alcoholism Unit, Burrough of South Bronx, New York, New York	Number of subjects: 409 Type: Outpatient alcoholism treatment (program served Blacks and Hispanics only)	Client descriptive data Drinking behavior Arrests Work history	Process	Descriptive information on program activities, no client follow-up, no control group.
Guban and Reading, 1975	Mt. Carmel Guild Social Service Center, Paterson, New Jersey	Number of subjects: 620 Type: Detoxification, rehabilitation and half-way house Length of stay: Ten days	Client descriptive data Recidivism rate	Process	Claimed a success rate of 75%, but no data to support claim. (no follow-up, no control group)
Cook, 1968	Rathcoole House, London, England	Number of subjects: 34 Type: Half-way house Length of stay: Three to six months	Client descriptive data Arrest record Psychiatric assessment Relapses Work history	Process	Residents free from physical disorders inspite of prolonged alcohol use. Personality disorders found in all cases. Only 12 men stayed three months or longer. Men were too eager to find work and rushed into inappropriate jobs.

Figure 1 Continued

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Author/Year	Program	Components	Variables	Type of Evaluation Research	Significant Findings
Cook, 1968 Continued					Relapse appears inevitable. Clients need more directive structured program rather than supportive measures.
City of Alexandria, 1981 (unpub lished internal evaluation)	Alexandria Alcoholism Services, Detoxification Program, Alexandria, Virginia	Number of subjects: 751 Type: Social detoxification Length of stay: Four to six days Number of beds: Six	One year evaluation report	Process	19% police referrals, 32% self, 42% readmissions. Average length of stay four and one-half days. Averaged 38 clients per month.
Pittman, 1973	St. Louis Detoxification and Diagnostic Center, St. Louis, Missouri. (police referrals only)	Type: Social detoxification Length of stay: Seven days	Client descriptive data Criminal justice interface	Process	Oldest and best known detoxification program in the United States, began 1966. Success of program based on location near to where public drunkenness arrests are made for police incentive for referral. Benefits in reduced criminal justice time offset by increase in costs of medical facilities.

Figure 1 Continued

inpatient, detoxification or half-way house, and reduction in drinking. Also Annis and Luban (1979) found no relationship between length of stay in treatment and sobriety. However Turner (1979) and Moss, et al. (1978) indicated a positive relationship between programs that include vocational rehabilitation and sobriety.

Mandell (1979) suggests that alcoholics who stop or moderate their drinking do not necessarily improve in other areas of functioning, especially not in their vocational or marital adjustment. However, Emerick (1974) has concluded that a reduction in drinking is usually accompanied by a favorable change in other areas of social functioning. Drinking behavior can be used as a measure, not identical with other measures of social performance, but sufficiently positively correlated with other measures to allow reasonable inferences. Costello (1976) believes that some measure of drinking behavior is probably the only impact measure that is of common interest to all evaluators of alcoholism treatment efforts over both the short and long run.

Reduction in arrests for public drunkenness has been the other impact measure most often sighted in the evaluations [Annis (1979), Annis and Smart (1978), Gallant (1978), Ogborne and Wilmot (1979), Hamilton, et al. (1975), and Hamilton et al. (1978)]. Detoxification programs have been developed by most communities to remove the public inebriate from the criminal justice system. However, detoxification programs have yet to demonstrate a major impact on arrests. Daggert and Rolde (1980) and Annis (1979) actually found an increase in arrests and jail cell detentions after decriminalization. Randall (Note 7) reported a 48 percent reduction in individual arrests for clients admitted to a detoxification program in Houston, Texas and reported a

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13 percent reduction in total public drunkenness arrests for the entire city ten months after program operation. Of the eight studies reporting the percentage of referrals from police to detoxification, the lowest was four percent in Denver, Colorado (Berns, 1974) and the highest was 78 percent of all referrals from police in Manchester, England (Makoujvola, 1980).

The other variable sighted in seven of the evaluations is readmission into detoxification programs. Readmissions ranged from 30 percent to 70 percent of all clients. O'Brient (Note 8) and Smart (1977) conclude that several admissions are sometimes necessary before a client accepts a referral for further services. Correspondingly those clients refusing further treatment show a significant increase in detoxification readmissions. O'Brient suggests that programs with a high readmission rate would have a correspondingly high percentage of clients accepting and following through on a referral for further help. However, Annis and Smart (1978) disagree with these findings. They report that repeat admissions were inversely related to the likelihood of accepting a referral for further help. Annis (1979) has concluded from evaluations of 13 detoxification programs throughout the Providence of Ontario, Canada, that detoxification plays a minor role in integrating alcoholics into the broader health care system.

A major problem affecting evaluation results of alcohol programs is difficulty with loss of subjects at follow-up. Not only is there the problem of finding this transient population, but there has been no generally agreed upon time interval for length of follow-up. Lowe and Thomas (1976) explain that short follow-up intervals may risk that observed changes are temporary, while longer follow-up periods may

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reflect client changes not directly related to alcoholism treatment. Moss and Bliss (1978) have found that patients who are harder to locate have poorer treatment outcomes, even after length of time between discharge and follow-up has been controlled. As the period of follow-up increases, the proportion of patients abstinence decreases (Mandell, 1979). Mandell (1979) has reported nonresponse rates at follow-up ranging from 20 percent to 40 percent of the sample.

Closely related to problems in follow-up of clients is the validity of self-report data once the person is found. Annis (1979) found high response agreement at reinterview on demographic items such as age, citizenship and marital status, while items assessing social functioning and drinking patterns showed less agreement. Self-report of drinking behavior has low reliability, not because the person is lying necessarily, but because heavy drinkers and alcoholics are not able to accurately estimate how much they drink over a period of time. Alcohol interferes with memory functions including the ability to remember the amount consumed. Annis and Leban (1979) suggest that if official records are used such as arrest data, no subjects are lost to follow-up.

An additional methodological problem in many alcoholism program evaluations is the lack of a control group, comparison group or even an attempt at matching subjects. Of the thirty studies reviewed in Figure 1, five used a control group, and one study employed a comparison group. Studies that attempt to attribute improvement in clients due to treatment must have comparison or control groups that provide information about the normal rates of discontinuing alcohol abuse in the target population. Hamilton (1979), in his evaluation of the Edinburgh Alcoholic Detoxification Project, randomly assigned habitual drunken

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offenders to a detoxification group or a control group. At one year follow-up after treatment, the detoxification patients were found not to have improved in regards to their episodes of drunkenness, however their periods of abstinence were longer. Also significant improvements were noted in accommodations and self-reported quality of life.

Wilson, et al. (1978) also employed random assignment in evaluating a hospital-based inpatient program for the rehabilitation of chronic skid row alcoholics. At five month follow-up there was a significant difference between the inpatient and comparison group in alcohol use, general adjustment and self-concept, these differences dissolved at 15 months follow-up. Wilson, et al. (1978) findings support Mandell's previous work on follow-up. The longer the follow-up, the less evident the impact of treatment. Hamilton and Wilson, et al. (1978) supports the conclusion that permanent abstinence is not necessarily a feasible criteria for success. Longer periods of abstinence may be a more valid criteria for the chronic public inebriate.

Gallant, et al. (1973) also used randomization when comparing three different treatment approaches for the chronic police case alcoholic in New Orleans. Baseline and one year follow-up information was collected on arrests and days of imprisonment, duration of clinic contact, socioeconomic status and degree of change in drinking patterns. Self-report data on criminal justice contact was double-checked using police data for verification. The authors found no difference between groups on any of the variables and claimed that the compulsory inpatient group showed no superiority over the other treatment approaches. The authors drew these conclusions while admitting "that of the 210 subjects, only seventeen were available for evaluation and ratings

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upon follow-up at one year." The authors do not explain such a large loss of subjects when participation in two of the three comparison groups were supposed to be enforced by probation officers.

While the three studies by Hamilton (1979), Wilson, et al. (1978) and Gallant, et al. (1973) all have conceptual flaws, they stand out from the other studies in their attempt to design a rigorous evaluation. Annis and Smart (1978), Annis and Lebon (1970), Ogborne and Clare (1979), Smart, et al (1977), Smart (1978), Annis (1979) and Ogborne and Wilmot (1979) have all evaluated various aspects of Ontario's aggressive attempt to divert the chronic police case public inebriate into rehabilitation. While these studies covered six years of program operation at 12 detoxification centers and 16 half-way houses, only two studies employed a comparison group. Ogborne and Wilmot (1979) matched 20 treatment subjects with 20 comparison group subjects on characteristics typical of skid row alcoholics. In measuring the effect of outpatient counseling, the authors concluded that they were unable to demonstrate that involvement with the counselor had any lasting effects on drinking or criminal justice contact.

In summary, the analysis of evaluations have pointed out positive outcomes for poorly designed studies and negative, or no difference outcomes for the better designed studies. Only those studies that have been well designed have been discussed, although even those highlighted could have been improved upon. Miller, et al. (1969) believes that the results of most alcoholism programs evaluated are all threatened by selection factors. Miller, et al. states that:

> there appears to be a vast number of persons with drinking problems, so that any particular treatment program with room for only a finite number of cases, has to "select" its

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> patients, and this typically results in a non-representative sample (p. 472).

Miller identifies 12 factors each representing an elimination of potential subjects and each step introducing possible bias. The steps are: varying definitions of alcoholism, case selection from special populations, reputation of the treatment program, refusal of referral, rejection of applicants, failure to show up for treatment, exclusion of certain subjects from the study, dropouts during treatment, living or moving beyond feasible follow-up distance, deaths, inability to trace cases, and refusal to participate in follow-up study. What we are left with is threats to internal validity of many studies due to history, mortality, and selection. The subjects who are treated and followed-up end up being the least dysfunctional, highly motivated persons who may improve or not improve irrespective of treatment.

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Chapter 3

METHODOLOGY

Design of the Study

The development of detoxification centers throughout the United States has been due in large part to the adoption of a social policy which advocates the transfer of the public drunkenness problem from the criminal justice system to a therapeutic system based upon the disease model of alcoholism. This study evaluates the partial implementation of this social policy in Norfolk, Virginia. Virginia is developing detoxification centers for the diversion of public inebriates throughout the state while still maintaining public drunkenness as a Class 4 misdemeanor.

The evaluation is divided into two major areas. The first area is the Goals and Objectives of the Norfolk Inebriate Program which were developed by the staff and membership of the Substance Abuse Committee of Norfolk Community Services Board. These are both process and impact measures for the first six months of program operation. The second area is made up of additional evaluative questions designed by the Norfolk Community Services Board. These questions address specific implementation issues important to starting a new untested program. The last additional evaluative question is the descriptive implementation question anaylzing the planning process and background from which the program was developed. The evaluation design was reviewed and approved by the Old Dominion University Human Subjects Review Committee.

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This evaluation has been designed to improve on the methodology of other evaluations discussed in Chapter 2. Multiple measures of a variable such as public drunkenness arrests, and multiple sources of data have been used when possible. Abstinence as an outcome measure has been reported as the number of drinking days in the last month. Employment has been measured as working days in the last month.

Rossi (1979) and Weiss (1979) state that the program should have clear, well-defined and well-articulated goals and specific, measurable objectives. The impact evaluation should measure the degree of change in the individuals exposed to the intervention. Impact evaluations focus on the attainment of the goals and objectives while implementation evaluations focus on the means of attaining these goals (Patton, 1978). Under ideal circumstances, a randomly assigned control group is preferable, this evaluation is conducted in a setting which does not provide an opportunity for randomization. Therefore, one comparison group will receive an alternative version of the program and the other group will receive no rehabilitative program.

The Goals and Objectives listed in Figure 2 indicate that Goal 1.0 involves monitoring issues which include descriptive data collected at intake, discharge and follow-up from all clients admitted to the Norfolk Inebriate Program (N.I.P.). Subjects for the study were indigent chronic alcoholics and police-case public inebriates found appropriate for admission. The criteria for admission was a Blood Alcohol Content of .10 to .35, no signs of medical emergency, a desire to get sober and a willingness to follow the program's rules and procedures.

Goal 2.0 measures the impact on the criminal justice system. This requires arrest data for public intoxication and jail bed days used by

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Goals and Objectives		Measure	Research Design	Data Collection Procedure
Goal 1.0:	To provied social detoxification services to chronic alcoholics.			
Obj. 1.1	To identify and refer 5% of the medically indigent alcoholic population by Sept. 15, 1982.	Number of referrals ÷ M.I.A. population (4603 persons).	Monitoring/ Descriptive	NAPIS and background data on target population.
Obj. 1.2	To provide 72 hours of social detoxification to 70% of those persons found appropriate for services by Sept. 15, 1982.	Number staying at least 72 hours ÷ number admitted.	Monitoring/ Descriptive	NAPIS - DMH 570, 571
Obj. 1.3	To refer 10% of those persons detoxified to rehabilitation or intermediate care by Sept. 15, 1982	Number of referrals to treatment ÷ number staying at least 72 hours.	Monitoring/ Descriptive	NAPIS - DMH 570, 571

Goals and Objectives

Figure 2

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Goals and Objectives		Measure	Research Design	Data Collection Procedure
Obj. 1.4	To identify the number of referrals Client characteristics, & source of referrals both in and out of the program.	Number of referrals, admissions, source of referral, disposition of referral, length of stay and client characteristics.	Monitoring/ Descriptive	NAPIS - DMH 570, 571
Goal 2.0:	To reduce the burden on the criminal justice system by reducing the arrests and incarceration of public inebriates.			
Obj. 2.1	To reduce public inebriate arrests by 25% by Sept. 15, 1982.	Individual arrests for public intoxication for NIP clients and a comparison group, 90 days before and 90 days after intervention.	Non-equivalent control group, pre-test/post test design.	Self-report and computerized arrest data. (statistics: Analysis of Covariance)

Figure 2 Continued

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Goals and Objectives		Measure	Research Design	Data Collection Procedure
Obj. 2.2	To reduce the number of jail bed days used by public inebriates by 75% by Sept. 15, 1982.	Monthly jail bed days for public intoxication.	Time series graphs.	Monthly reports from City Jail.
Goal 3.0:	To positively impact the drinking behavior and employment success of chronic alcoholics.			
Obj. 3.1	To improve the rates of abstinence for chronic alcoholics served in the Norfolk Inebriate Program.	Self report at intake, 3-month and 6-month follow-up, number of drinking days in the last month.	Non-equivalent control group, pre-test/post-test design.	Self report at intake, 3-month and 6-month follow-up using Client Reaction Form.
Obj. 3.2	To improve the rate of employment of chronic alcoholics served in the Norfolk Inebriate Program	Self report at intake, 3-month and 6-month follow-up, number of working days in the last month.	Non-equivalent control group pre-test/post-test design.	Self report at intake, 3-month and 6-month follow-up using Client Reaction Form.

Figure 2 Continued

public inebriates in Norfolk.

Individual arrests for public drunkenness have been gathered from N.I.P. clients and a comparison group of subjects arrested and jailed but not undergoing social detoxification. Self-report data has been collected from subjects to compare with actual arrest records of the Norfolk Police Department. Utilizing a release of information from subjects, public drunkenness arrests for N.I.P. clients and a comparison group were analyzed by comparing pre-program arrests (six months prior to intake) with post-program arrests (six months after discharge). For Objective 2.1, self-report and police records are used as multiple sources of data for individual arrests. By correlating these two sources of data, the validity of self-reported arrests can be better determined.

Goal 3.0 measures the impact of N.I.P. on individual clients. Self-report data was collected at intake from all clients admitted March 15, 1982 to April 15, 1982 and again at three-month and six month follow-up. Of the intake and follow-up information gathered, drinking days and working days in the past month have been compared at intake and at follow-up with two comparison groups. One group is composed of clients from 17 federally-funded detoxification programs in 1978. The other comparison group is made up of individuals arrested and jailed for public drunkenness but not exposed to the Norfolk Inebriate Program.

The evaluation literature on alcoholism treatment programs offers a variety of measures to determine improvement in drinking behavior. Since abstinence has been shown not to be a realistic goal for a detoxification program serving a chronic population, drinking days in the last month has been selected as a more sensitive measure of change in drinking behavior. This measure, as well as working days, has been used

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for the last seven years by the National Institute on Alcohol Abuse and Alcoholism in evaluating Federally-funded alcoholism programs and reported in the Annual Special Report to the U.S. Congress on Alcohol and Health.

The pretest, post-test, non-equivalent control group designs used in this study measure the effectiveness of the program when compared to (1) similar clients in similar detoxification programs and (2) local individuals arrested and jailed but not going through detoxification. This local comparison group of indigent chronic alcoholics and police-case public inebriates not admitted to N.I.P. were interviewed initially in the Norfolk City Jail. While this design provides both a local and national comparison group, these are not true control groups since the nature of the program precludes random assignment of subjects. The local comparison group is composed of individuals jailed for public drunkenness. These subjects were matched with N.I.P. clients on sex and income. The threats to the validity of this study include the interaction effect of testing, selection/maturation interaction, difficulties with follow-up and self-report bias.

The "Additional Evaluative Questions" are the implementation issues that have been identified by the Norfolk Community Services Board and staff as critical information to aid in improving the N.I.P. program. Question #7 directly addresses the background planning process. This implementation evaluation draws upon models developed by Morris and Fitzgibbon (1978), Patton (1978), and Parlett and Hamilton (1975). The descriptive context from which the program began spans a period of time from October 1978, when the Chamber of Commerce proposed a program for the Granby Mall derelict, to March 1982 when the Norfolk Inebriate Program (N.I.P.) began to accept clients.

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The evaluation of program implementation has become a major focus of evaluations. Evaluators recognized that comparison of actual program outcome with desired outcomes gave decision-makers very little information on which to act. Parlett and Hamilton (1975) use the term illuminative evaluation to mean a "method of description and interpretation rather than measurement and prediction". The purpose of illuminative evaluation is to study how the program evolved, how it operates, and how it is influenced by various community situations. Illuminative evaluation is qualitative in nature and deals with subjective interpretation of events and stages of implementation.

Chase (1979), approaches implementation from the program manager's point of view. He points out that major obstacles arise when the program managers need to share authority and maintain a high degree of coordination with other bureaucratic and political actors such as the criminal justice system. Malcolm Feely (1979), in an implementation analysis of a pre-trial release program found that the cooperation of the courts and jail were central to the ultimate success of the program. Cooperation with police and corrections seems a critical step in implementation and one particularly relevant to the diversion of police case public inebriates into detoxification programs.

Data Collection Procedure

In order to measure to what extent the objectives have been accomplished and to address the additional evaluative questions, the following sources of data were used:

1. Client self-report data as reported on the National Alcohol Programs Information Services (NAPIS) (DMH 570, 571).

2. Client Reaction Form (self-report).

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3. Comparison Group Form (self-report).

4. Criminal justice data; monthly arrests and jail bed days for the charge of public drunkenness.

5. Criminal Justice Data; individual arrests for Drunk in Public.

6. Personal Observation.

7. Program Documentation.

8. Client Records.

9. Interviews of staff, clients, and police officers and community leaders.

The NAPIS management information system (DMH 570, 571) gathers client self-report information. Form DMH 570, Inintial Contact Form was completed by the counselor during the intake interview. The counseling staff at the Norfolk Inebriate Program collected all intake information and the evaluation team collected the follow-up data (Client Follow-up Form). Since the evaluation covers a period of time from March 15, 1982 to September 15, 1982, only those clients served from March 15, 1982 to April 15, 1982 were followed at three and six months after detoxification. The NAPIS information provides measurement data for Objectives 1.1 to 1.4, as well as other information on client history and descriptive data to better describe specifically the target population.

To measure the accomplishment of Objective 2.1, individual public drunkenness arrest data has been collected from a sample of individual clients and a comparison group of subjects. With signed releases of information, self-report data was compared with computerized police arrest records for individual public drunkenness arrests to ascertain the validity of the self-report data. In addition, there are two

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sources of individual arrest data, self-report and computerized police arrests records for both the detoxification clients and comparison group.

Objectives 3.1 and 3.2 have been tracked using the Client Reaction Form and Client Follow-up Form for N.I.P. clients and the local comparison group. The National Institute on Alcohol Abuse and Alcoholism provided client characteristics and statistics on working and drinking days in the past month. These measures plus other information regarding transportation, reason for admission and client's perception of the program were gathered from N.I.P. clients by the program staff at intake and by the evaluators at three month and six month follow-up through individual interviews. Clients and local comparison group participants were randomly assigned to the two evaluators for follow-up. The local comparison group was composed of individuals arrested and jailed for public drunkenness. The evaluators were permitted to interview these persons in the holding cell prior to their hearing at the Norfolk General District Court. Clients were asked to participate in the study, sign the appropriate release and provide information on their number of working days in the past month as well as current living arrangements. Also they were asked to report the number of public drunkenness arrests for the past six months in order to measure Objective 2.1.

The additional evaluative questions are listed in Chapter 1. Question 7 is the illuminative implementation evaluation question previously discussed. This provides an analysis of the activities over the last three years which have led up to the beginning of N.I.P. program operations. This data was collected from interviews with key community people, program documentation, minutes from the Downtown

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Norfolk Development Corporation and subcommittees, minutes from the Norfolk Community Services Board, observation notes, and a log of all meetings with staff. Data for the cost comparison, Question 6 was collected from program budgets, police data, jail information and the City of Norfolk, Department of Human Resources.

Analysis of the Results

Descriptive data illustrated through tables, charts and graphs are used to analyze Goal 1.0. Both individual and monthly arrests for public drunkenness and jail bed days used by public inebriates are the measures for Goal 2.0. Since there were few post program observations for monthly public drunkenness arrests as well as many non-quantifiable variables affecting arrests (season, political pressures, publicity, judicial procedures, police turnover), the impact of N.I.P. on arrests will be evaluated based on individual arrest data. The Pearson Product Moment Correlation was used to help estimate the validity of all self-reported information used in the study by measuring the relationship between self-reported arrest data and individaul arrest data retrieved through the police computer.

Public drunkenness arrests, drinking behavior, and employment was compared for N.I.P. clients and the previously described comparison groups. Mean scores and standard deviations are computed by analysis of variance and analysis of covariance for repeated measures to determine not only if a change occured for both groups from intake to follow-up, but more importantly, if there is a statistically significant difference between the groups at follow-up. Analysis of covariance was employed when individual arrests, and drinking and working days for the

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groups differed significantly at intake. Since subjects were not randomly assigned to groups, analysis of covariance adjusts follow-up scores when a statistically significant difference exists between intake scores between groups. When intake scores did not differ analysis of variance was used.

The "Additional Evaluative Questions" address implementation issues and rely primarily upon description and interpretation. The analysis of these questions is based upon the needs of the Norfolk Community Services Board, previous implementation evaluations and multiple sources of data. Gathering information on questions such as the adaquacy of transportation and location and comparison of costs provides decision-makers critical information to aid in making program adjustments during the first year of program operation.

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Chapter 4

RESULTS

This chapter will describe the results of the evaluation as measured by the objectives and will address additional questions identified as significant by the Norfolk Community Services Board. The Board, the Norfolk Inebriate Program staff, and the evaluator determined the actual criteria by which to measure the success of the Norfolk Inebriate Program (N.I.P.).

Results of the Goals and Objectives

Goal 1.0. To provide social detoxification services to chronic alcoholics.

Objective 1.1. To identify and refer 5% of the medically indigent alcoholic population by September 15, 1982.

Results. As of September 15, 1982, 374 persons were referred to N.I.P., or 8% of the estimated medically indigent alcoholic population. Therefore, this objective was accomplished. (This population has been estimated to be 4,603 by the City of Norfolk Community Services Board.)

Discussion. In planning the program, the Board and staff of the Norfolk Community Services Board decided that if 5% of the population of medically indigent alcoholics could be identified and referred to the program during the first six months, that would serve as a significant measure of the program's ability to impact this target group.

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Various reports developed by the City of Norfolk identified the "skid row", Granby Mall group to be between 100 to 300 persons. It was difficult to reach agreement on the description of persons in the target population. While the City was concerned primarily with removing the homeless males from Granby Mall, the Commonwealth of Virginia was interested in funding a demonstration project which would serve the entire City of Norfolk. Since the Granby group was a small proportion of the target group, program planners decided that N.I.P. would be available to all medically indigent persons in Norfolk requiring detoxification services. Expanding the target group placed the program implementors and local funders at cross purposes. City Council believed they were funding a program to help "clean up" Granby Mall, while program planners were interested in helping the alcoholic regardless of his location within the city.

However, data shows that the Granby Mall inhabitant was provided services. In the first six months of program operation, 26% of the persons detoxified gave the street or Union Mission as their place of residence. To determine the exact number of medically indigent alcoholics in Norfolk, the Norfolk Community Services Board employed The Merden Prevalence Index. The Merden Prevalence Index is derived from demographic and population data based on the degree of alcoholism among occupational catagories. These occupational categories are then broken down by distinct geographical areas. Given this formula, the number of medically indigent alcoholics for the City of Norfolk was estimated at 4,603. (See Appendix A.) Based on these estimates of the target population, the program was successful in serving 8% of Norfolk's medically indigent alcoholic population.

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Objective 1.2. To provide 72 hours of social detoxification to 70% of those persons found appropriate for services by September 15, 1982.

Results. This objective was not accomplished since, as of September 15, 1982, 197 of 297 persons (66%) admitted to the program received at least 72 hours of detoxification.

Discussion. This objective measures the program's ability to voluntarily keep individuals for at least 72 hours of detoxification. While some individuals require a longer stay, 72 hours was believed to be the standard period of time for removal of the chemical toxins from the body. Therefore, it was imperative to provide as much encouragement and persuasion to keep people voluntarily at the site. On many occasions, the evaluators found the staff not interacting with clients and not providing the therapeutic milieu that would encourage clients to remain in the program for the duration of detoxification.

Many clients were not interested in staying three days and, if admitted during the evening, would merely sleep over and leave the next morning. While this type of behavior was expected of the chronic alcoholic, the individuals staying for a short length of time should have been off-set by those who stayed beyond 72 hours. The program may have been more successful in keeping residents the full length of detoxification (72 hours) had clients' assessement of needs begun immediately upon admission with more client-counselor contact. There appeared to be a lack of structured programming leaving little for residents to do during the day except wait for the evening AA meeting. Soberity and AA involvement was stressed with little emphasis on non-alcohol concerns such as employment and housing. These are basic needs, and if these needs were

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responded to, they could possibly have served as the incentive for clients to desire a sober lifestyle.

Objective 1.3. To refer 10% of those detoxified to rehabilitation or intermediate care by September 15, 1982.

Results. As of September 15, 1982, 21% (63 persons) were referred to rehabilitation or intermediate care. Therefore, this objective was accomplished.

Discussion. The program has two main purposes: to provide detoxification for clients and to refer them to helping resources in the community. This objective assessed the staff's ability to persuade appropriate individuals who appeared motivated to enter inpatient alcoholism treatment programs or half-way houses. The 21% rate of referral to inpatient or residential treatment is one of the most outstanding accomplishments of the program and illustrates the ability of the staff to identify and help motivate alcoholics to continue treatment. It is important to note that only 20 to 30% of the clients served were actually public inebriates. The majority of clients were medically indigent or employed alcoholics. Therefore, the individuals referred to treatment were probably more motivated than a population of police or self-referred public inebriates might have been. Many of those entering treatment at N.I.P. during the first six months of the program were AA referrals. These were people who had been helped by AA members for many years and who were open to on-going treatment once they had been detoxified.

Objective 1.4. To identify the number of referrals, clients characteristics, and source of referral both in and out of the program.

Results. Below is the descriptive information which

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summarizes the characteristics of the population:

Number Referred:	374
Number Admitted:	297
Multiple Admissions	92 (31%)
Number Referred to Treatment:	63 (21%)
Bed Utilization Rate:	41%

<u>Discussion</u>. The average N.I.P. client was 44 years old, single, with an average education of 10 years of schooling. The sex and racial breakdown (85% male, 15% female; 87% white, 13% black) is consistent with the literature on other public inebriate programs in that the target group is comprised of predominately white males with black females being the distinct minority.

Figure 3 points out that bed utilization steadily increased throughout the evaluation period. The bed utilization rate was estimated based on 12 available beds and a three-day stay for each client. Using these criteria, a maximum of 120 clients could be served in a period of 30 days. A bed utilization of 41% is considered low since the majority of beds were empty at any one time. Underutilization was a result of the lack of police referrals and poor public relations. The program offered no orientation for community agency personnel on the purpose and goals of N.I.P.

Because of the stigma of alcoholism, the numerous misconceptions about the disease and the community's response to the public inebriate, there must be a strong emphasis on community education, public information and community organization. In the case of N.I.P., there were only superficial attempts to impact community attitudes or to facilitate a referral network into the program.

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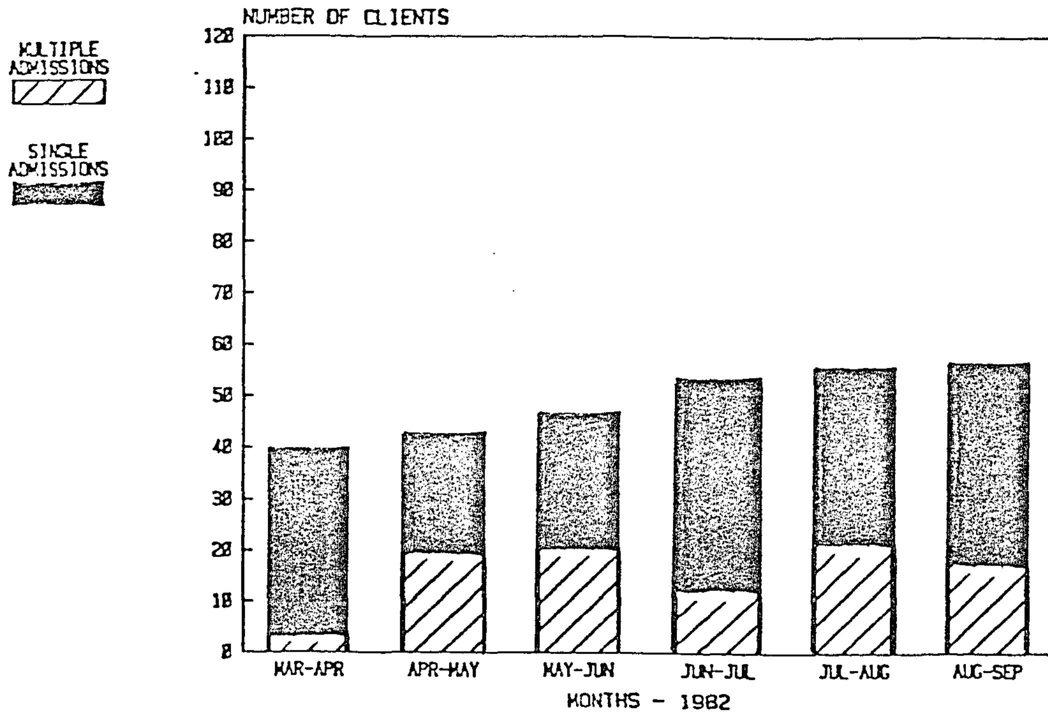

Bed Utilization

Figure 3

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Figure 4 identifies both the source of referral and disposition of referrals. Alcoholics Anonymous (23%) was the major source of referral into the program. Although the police did not have approval for official police diversion until August 5, 1982, police referrals made up 8% of the population and may have comprised a much larger percentage of referrals had police diversion been accomplished earlier in program operation.

The active involvement of Alcoholics Anonymous was unique to a social detoxification program. In other evaluations, A.A. has not played the active volunteer and referral role that it has in this program. The relationship with general hospitals, (10% of referrals), especially emergency rooms, was a continuing problem since the medical staff often referred inappropriate persons, i.e. those individuals requiring medical care. These inappropriate referrals were often the result of the hospital staff's reluctance to treat and admit alcoholic patients for medical detoxification or other illnesses. Advocacy, education, and appropriate referral of clients between the general hospitals and N.I.P. will require ongoing attention.

Figure 4 (Disposition of Referral) illustrates that people receiving no referral after detoxification accounted for the largest percentage of clients (36%). While 23% of all clients received an outpatient referral, only a third ever showed up for their appointment. Also there was no way to insure if AA referrals (9%) actually began attending AA meetings. Only those referred to inpatient, half-way house and general hospital could be confirmed. Therefore, there is documentation of only 26% of those referred actually following through on a referral to a rehabilitation program. Referrals relate directly to the size of

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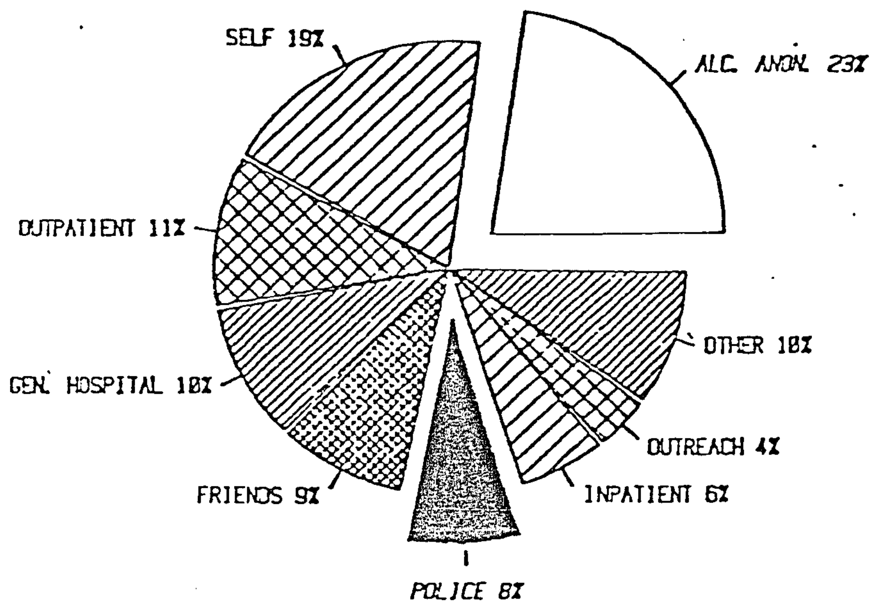

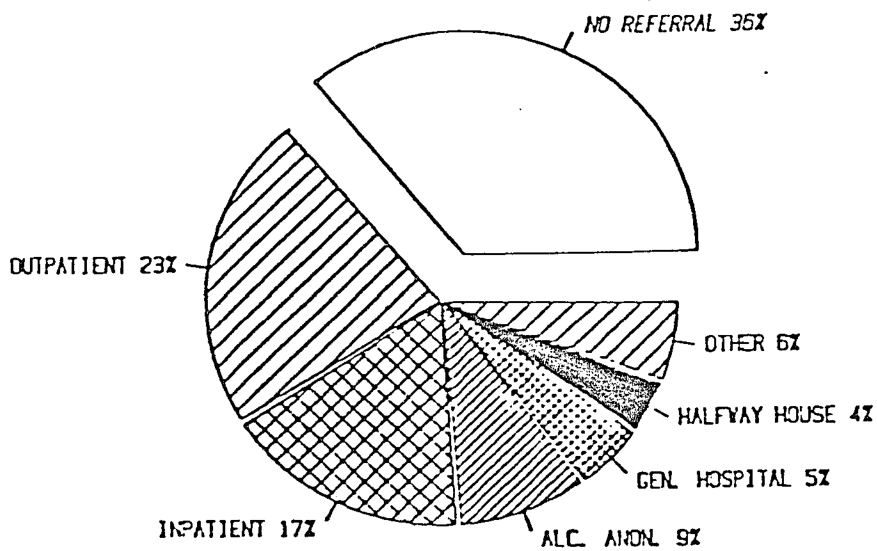

Source and Disposition of Referral

Figure 4

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the facility and bed utilization. Twelve beds are needed if there are multiple referral sources, police diversion from all precincts in the city, and adequate incentives for individuals to return on their own if they require further detoxification. For this chronic population, it often takes three or four detoxifications before the person is sincerely motivated to begin a program of recovery.

Individuals leaving the program with no referral made up the largest section of discharges. While the program was quite successful in referring people for alcoholism treatment, 36% of the clients left the program with no referral. Social detoxification must be more than a funnel into in-patient treatment and N.I.P. should refer to a variety of helping resources. The counseling staff must be exposed to training in non-alcohol related community resources to insure that as many individuals as possible have one or more referrals at discharge. For the most part, during the first six months of operation, individuals were referred to alcoholism treatment or not referred at all.

Goal 2.0. To reduce the burden on the criminal justice system by reducing the arrest and incarcerations of public inebriates.

Objective 2.1. To reduce public inebriate arrests by 25% by September 15, 1982.

Results There was a 26% decrease in police-reported individual public drunkenness arrests for N.I.P. clients six months after the program began. The jail comparison group experienced a 100% increase in arrests for the same period of time. The analysis of variance ($F = 2.9$, $p < .096$), do not support the accomplishment of the objective when follow-up numbers are compared by groups (Table 1).

Discussion. In order to determine the validity of self-

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Table 1

Nine Month Follow-up Comparison of N.I.P. and Jail Group

on Arrests for Public Drunkenness

		Oct. 1981-Apr. 1982			Apr. 1982-Oct. 1982		
Group	*n*	$\bar{X}$	S.D.	F	$\bar{X}$	S.D.	F
N.I.P.	20	2.7	3.3		2.0	3.1	
				.35(N.S.)			2.9(N.S.)
Jail	19	.5	1.0		1.0		1.0

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report data, self-reported public drunkenness arrest data was correlated with the police computerized records. A positive, non-significant relationship, (r = + .39), was found, indicating that police-reported arrests and client-reported arrests were in agreement 15% of the time. Therefore, the validity of self-report data is questionable.

While there was a difference in public drunkenness arrests at follow-up for the detoxification group and the jail group, the results were not statistically significant and were inconsistent. Either clients were public inebriates who were arrested continuously or they were blue collar alcoholics who were not visible to the police. Since the program initially admitted persons solely on their degree of intoxication, a wide range of individuals entered the program. While few public inebriates entered the program, the few that were admitted accounted for most of the arrests. The typical referral at the beginning of the program was referred by a friend or acquaintance of members of Alcoholics Anonymous.

N.I.P. was not easily accessible to either the street person or police officer in the First Precinct. Police perceived few incentives in either driving twelve miles round trip outside of the district or increasing the risk of the public inebriate becoming sick in the cruiser.

Although the evaluation and program began March 15, 1982, it was not possible to collect the necessary data to measure the impact of N.I.P. on total monthly arrests for public intoxication. The police did not begin diverting police-case public inebriates until six weeks before the end of evaluation. However public drunkenness arrests were tracked monthly for the cities of Norfolk and Portsmouth and are displayed in Figure 5.

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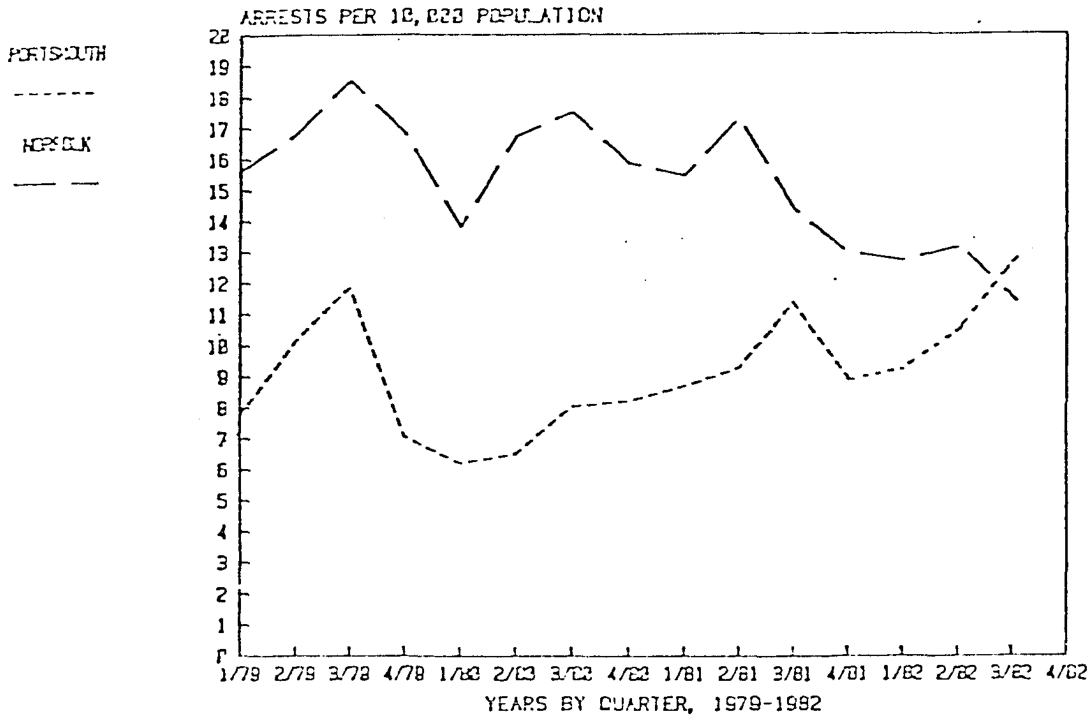

Public Drunkenness Arrests

Figure 5

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The results of this evaluation are consistent with the literature as few public detoxification programs have yet demonstrated an impact on monthly arrests for Drunk in Public (DIP). Monthly changes in D.I.P. arrests for Norfolk and Portsmouth are related to the differences in arrest priorities of the police chiefs, influence of City Council, number of calls for service, number of felonies, season, and mean temperature for the month. Political and administrative issues have been reported in the literature as most directly influencing D.I.P. arrest data. Also, police officers have indicated that, regardless of the existence of a social detoxification alternative, officers will continue to arrest and jail the disruptive public inebriate since his behavior precludes his admission to detoxification. Appendix B compares Drunk in Public arrests, felonies, and misdemeanors for the City of Norfolk by quarter for January 1979 to July 1982. While regression analysis indicated that felonies accounted for 54% of the variance in D.I.P. arrests, nonquantifiable factors such as arrest priorities for the month remain the major variables affecting monthly changes in arrests for Drunk In Public.

<u>Objective 2.2</u>. To reduce the number of jail bed days used by public inebriates by 75% by September 15, 1982.

<u>Results</u>. As of September 15, 1982, the number of monthly jail bed days used by public inebriates was 41% lower than the same time last year. According to officials at the Norfolk City Jail, beginning July 1982, persons arrested for public drunkenness with no other pending charges could be released on their own recognizance four hours after arrest. This change in policy during the evaluation period reduced jail bed days at approximately the same time police diversion to N.I.P. took place (August 5, 1982). Therefore this policy change and delayed police

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diversion affect the interval validity of measuring the impact of N.I.P. on monthly public inebriate jail bed days. The results, therefore, do not support the accomplishment of this objective.

Discussion. Due to the small number of post-program observations and the major change in jail policy described above, it was impossible to measure the influence of a social detoxification program on jail bed days. While jail bed days have shown a downward trend over the last three years, (Appendix C), this trend appears to have no relationship to the planning and implementation of the social detoxification program.

Goal 3.0. To positively impact the drinking behavior and employment success of chronic alcoholics.

Objective 3.1. To improve the rates of abstinence for chronic alcoholics served in the Norfolk Inebriate Program.

Results. When a sample of N.I.P. clients are compared to the national comparison group at intake and again at six month follow-up, the N.I.P. clients showed an 18% reduction in the number of drinking days per month, while the national comparison group showed a 51% reduction in number of drinking days. At three months follow-up the jail comparison had a greater reduction in drinking days per month (48%) compared to N.I.P. clients (38%). There was no significant difference at intake on number of drinking days for the three groups and analysis of variance on follow-up of the same variable did not show a significant difference between groups. Therefore, the results do not support the accomplishment of this objective.

Discussion. Table 2 shows that both the clients in the national comparison group and clients in the jail group showed a greater

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Table 2

Follow-up Comparisons of N.I.P. Jail Group and a

National Group on Drinking Days Per Month

		Intake			3 months			6 months		
Group	n	$\bar{X}$	S.D.	F	$\bar{X}$	S.D.	F	$\bar{X}$	S.D.	F
N.I.P.	26	16.4	11.4		10.1	11.9		13.5	13.1	
				1.4			.20			
Jail	18	11.4	10.1		5.9	7.4		—	—	
				.05						3.2
National	27	15.5	11.2		—	—		7.5	11.1	

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reduction in drinking days than did N.I.P. clients. There are several factors which may explain these results. First, there is the questionable validity of self-report data.

Another important factor that affects interpretation of results is the variance in drinking days. N.I.P. clients either abstained from alcohol entirely after detoxification, or resumed previous drinking behavior within several months after detoxification. The data from Navy personnel included in the jail comparison group affected the comparibility of groups since they were at sea during three month follow-up, and under enforced abstinence from alcohol. These Navy personnel were included in the sample to improve the comparability of the jail and N.I.P. clients in terms of age and occupation and their follow-up drinking behavior was not indicative of police case public inebriates or chronic alcoholics. The results are consistent to other evaluations in that detoxification does not appear to show any significant impact on later drinking behavior of clients. The chronic alcoholic group, their many non-alcoholic needs, the strong counseling focus on total abstinence, and the short length of treatment (72 hours) may explain these results.

Objective 3.2. To improve the rate of employment of chronic alcoholics served in the Norfolk Inebriate Program.

Results. N.I.P. clients exhibited a 16% improvement in days worked per month when compared to the national comparison group ($F = 5.9$, $p < .01$). The differences in working days between N.I.P. clients and the jail groups were almost statistically significant ($F = 3.96$, $p < .053$). Since the number of working days at intake between the jail and N.I.P. group were significantly different, analysis of covariance was necessary to adjust follow-up scores at three months. The results,

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Table 3

Follow-up Comparison of N.I.P., Jail Group
and a National Comparison Group
on Working Days Per Month

		Intake			3 Months			6 Months		
Group	n	$\bar{X}$	S.D.	F	$\bar{X}$	S.D.	F	$\bar{X}$	S.D.	F
N.I.P.	26	6.7	11.5		5.1	10.3		8.0	11.3	
				10.1			3.96			
Jail		14.8	9.6		11.7	11.9		—	—	
				1.7						5.9*
National	27	1.9	6.4		—	—		2.0	5.8	

*$p < .05$

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therefore support the accomplishment of this objective (Table 3).

Discussion. These results reflect the characteristics of the group during the first six months of N.I.P. Clients were often blue collar workers and not homeless, unemployed chronic alcoholics and many were employed or had the opportunity for periodic work. In many cases, subjects either worked full time and reported 21 to 30 working days a month or were unemployed. N.I.P. provided clients with medical screening, an opportunity to detoxify, and the ability to return to work sober. Although changes in drinking behavior and quantity of alcohol consumed could not be accurately assessed through the drinking days measure, the clients appeared better able to resume employment. They may not have altered their drinking pattern over a six month period, but they were able to improve the number of days worked. Consistent with the literature, N.I.P. failed to improve individual or monthly public drunkenness arrests or actual drinking behavior, but the program did contribute to the clients' ability to return to work.

Results of Implementation Evaluation

In addition to designing the Goals and Objectives, the Norfolk Community Services Board developed the list of additional evaluation questions to address specific implementation issues. These questions addressed such issues as client satisfaction, availability of treatment beds, appropriateness of the physical site of the facility, staff training, transportation and a cost comparison of detoxification as opposed to arrest and incarceration of public inebriates.

What are the person's reasons for referral? Why did they stay or why did they leave? What were the most desirable and least desirable aspects of the program? (Client Reaction Form)

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The results of the "Client Reaction Form" (Appendix D), completed by all clients at intake, indicated that 84% of all clients reported coming to N.I.P. to get help or get sober, and 55% arrived by private automobile. The reported reason for leaving was the completion of detoxification. Clients identified the most desirable aspect of the program as the accepting, friendly staff (50%) and the least desirable aspect of the program as the lack of activities or the lack of air conditioning. The final question on their present living accomodations was asked at intake and again at six month follow-up. The results indicated a 10% reduction in persons reporting living on the street.

How frequently were beds available in the community to serve the alcoholism treatment needs of the clients?

Sixty three clients (21%) were referred on to alcoholism rehabilitation. Only 14% of the clients stayed longer than 72 hours at N.I.P., although clients could stay in the facility for as long as 96 hours before the program standards required a full physical. During the first six months no clients were refused treatment elsewhere, and only 3 clients were refused detoxification at N.I.P. due to full occupancy.

How appropriate is the location and physical characteristics of the facility for housing the program?

In general, the location is appropriate for referrals from the Ocean View and 2nd Police Precinct area. N.I.P. is adjacent to public transportation and 1 1/2 miles from the 2nd Police Precinct. In August 1982, a survey (Appendix E) was conducted of the police officers in the 2nd Precinct who had made referrals of public inebriates to N.I.P. during the month. When asked about the location and time involved in a referral, the officers said the location was appropriate for their precinct

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and estimated a 10-minute time savings when compared to an arrest. The distance of N.I.P. from the Granby Mall, (four to six miles), and 1st Police Precinct has been a factor in the lack of police referrals from the downtown area and the low number of self-referrals who gave a downtown address. This has contributed to the program's failure to impact the Granby Mall homeless, male population. Both City Council and the Downtown Norfolk Development Corporation had as a primary objective the removal of the public inebriate from the downtown shopping area. By moving the location of N.I.P. out of the downtown area, the accessibility of the program for the police and inebriates was greatly reduced and contributed to non-attainment of that objective.

What level of paramedical training is necessary for the staff?

Thus far, the staff have responded well to medical emergencies, and with the back-up of the paramedics there have been no deaths. The specialized two-day training in detoxification procedures provided by the Medical College of Virginia, Richmond, Virginia and the six-week Emergency Medical Technician Training provided by the City of Norfolk prepared the staff to monitor vital signs and respond to medical emergencies.

What transportation systems were utilized and were these adequate to meet the needs of the client?

The program purchased a station wagon and liability insurance in July of 1982 which aided in jail and outreach worker referrals, as well as transportation for discharged clients referred for further help. Prior to this time, staff's private automobiles were used for transportation of clients.

What are the costs of the Norfolk Inebriate Program when compared

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to arrest and confinement for public inebriates?

The methodology employed in comparing costs is similar to measuring cost effectiveness since the comparison is between different methods of dealing with the same population; i.e., police-case inebriates. While the criminal justice objective is peacekeeping and law enforcement, the purpose of a social detoxification program is one of initiating rehabilitation.

This evaluation covers the first six months of program operation during which time only 8% of all admissions were police referrals and no estimate is made of the reduction in monthly public drunkenness arrests for police referrals. It will probably take more than six months to implement a large scale police diversion effort, reach full bed utilization and significantly reduce criminal justice costs.

In a straight cost comparison, it must be realized that not every admission to the Norfolk Inebriate Program is a police-case inebriate nor is every arrest and incarceration a N.I.P. eligible client. While it is possible to divide N.I.P. costs by the percentage of police referrals, it is difficult to determine the exact percentage of those persons arrested who would be eligible for N.I.P. The police admit that the majority of arrests are either persons causing a disturbance or requiring medical attention, both of these being criteria that would make the intoxicated person ineligible for social detoxification.

Due to the problems with police diversion and the short-term scope of the evaluation, conclusions can only be regarded as hypothesis at this point. While specific methodologies (Hertzman and Montigue, 1977; Rundell and Paredes, 1979; Jones, 1979; Swint and Nelson, 1977) have been developed for estimating long-term benefits of alcoholism rehabilitation,

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these cannot be applied to a social detoxification program whose only purpose is to keep the person 72 hours and refer to other helping resources. Measuring the economic and social benefits of clients' long-term sobriety would be ascribing benefits to detoxification which are really benefits of alcoholism treatment. We caution that the program's merit not be based solely on these cost comparisons since many of the benefits of detoxification are not quantifiable in monetary terms at the present time. Since N.I.P. clients are at the lower socio-economic levels with many having extremely poor employment records, it is difficult to develop any clear method of measuring long-term productivity as a result of 72 hours of detoxification. Following is a summary of costs with the complete description of how the costs were determined is included in Appendix G.

Summary of Costs:	Yearly	Per Person Per Day
Detoxification =	$179,000	$41 to $100
Arrests =	$100,132	$21
Jail =	+ 92,024	+22
Arrest & Jail =	$192,132	$43

A cost-benefit analysis was not conducted since many of the benefits of detoxification are not quantifiable. These benefits include access to medical screening, the treatment of acute alcoholism, the opportunity for ongoing treatment of alcoholism, exposure to AA, an alternative to medical detoxification, safer alternative to jail and exposure to community resources. From the summary of costs, N.I.P. will only be cheaper if the program is run continuously at full utilization; and if there is maximum police diversion, police costs will become a cost of detoxification less time savings for a referral.

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Planning and Implementation

The results of Goals and Objectives and additional evaluative questions for the first six months of program operation can best be understood by examining the planning process and context from which N.I.P. originated. A chronological list of implementation events is provided in Figure 6.

N.I.P. began its development simultaneously on a state and local level in 1978. The Commonwealth of Virginia desired to address the partial decriminalization of public drunkenness through the development of court-approved detoxification centers. On the local level, the Norfolk Chamber of Commerce developed the Downtown Norfolk Development Corporation whose goal was the revitalization of the central business district. Part of this effort was to effectively deal with the rehabilitation needs of the chronic police-case public inebriate and to remove them from the business district.

For approximately four years previous to this time, the Virginia State Crime Commission had been meeting in committees to deal with the overcrowding of jails due to alcohol-related crimes. The State was interested in developing several demonstration sites for social detoxification programs in order to determine the effectiveness of diverting individuals from a criminal justice system to the rehabilitation system.

In 1980, the Norfolk Community Services Board received verbal communication from the Virginia Department of Mental Health and Mental Retardation (DMHMR) that the Commonwealth had earmarked $125,000 for a Public Inebriate Demonstration Project in the City of Norfolk. The State requested that the Norfolk Community Services Board set up a meeting with local legislators, the Downtown Norfolk Development

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Pre-adoption phase

April 1978	Director of Human Resources, City of Norfolk recommends the development of detoxification program.
July 1978	Norfolk City Manager, reports on economic and environmental overview.
October 1978	Downtown Development Committee and the Norfolk Chamber of Commerce receives a report on Downtown.
November 1978	Norfolk Chamber of Commerce develops the Downtown Norfolk Development Corporation.
April 1979	"Granby Mall Action Plan", Downtown Plan Study Team, Department of City Planning.
May 1979	Virginia State Crime Commission develops the Public Inebriate Task Force to look at the extent of the problem and possible decriminalization of public drunkenness.
November 1979	Position Paper: Downtown Norfolk Development Corporation, which outlines a detoxification and rehabilitation program.
May 1980	Virginia Department of Mental Health and Mental Retardation developed a statewide detoxification model.
June 1980	Virginia Department of Mental Health/Mental Retardation (DMH/MR) verbally communicates to Norfolk Community Services Board (NCSB) that $125,000 has been earmarked for a public inebriate program for Norfolk.
October 1980	NCSB develops a preliminary program outline for a 72 hour social detoxification program called the Norfolk Public Inebriate Project (N.I.P.)

Implementation of the Norfolk Inebriate Program

Figure 6

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November 1980	"Action Plan: Norfolk Inebriate Program", Submitted to DNDC by O.D.U. Urban Research and Service Center.
December 1980	DNDC Resolution #55 pledges $4,500 in funds toward N.I.P.
December 1980	Program outline and budget for N.I.P. forwarded to DMH/MR.
December 1980	ODU's Research and Service Center provides detailed program design for N.I.P. with NCSB generated Goals and Objectives.
December 1980	Site selection begins.
December 1980	NCSB meets with City Council to discuss status of project and local matching funds.
December 1980	NCSB staff employs preliminary outline and O.D.U. Action Plan to develop detailed program design which is approved by NCSB.
January 1981	Eastern Virginia Health System Agency recommends shifting the funds to maintaining the Alcoholism Unit at Eastern State Hospital rather than N.I.P.
January 1981	EVHSA submit report describing a methodology for estimating the incidence of medical indigency.
February 1981	NCSB and Norfolk Office of City Planning develop site selection criteria and three proposed sites for N.I.P.
February 1981	NCSB receives letter from the Commissioner of MH/MR stating that due to local delays and no commitment of local funds, state funds were withdrawn for current fiscal year.
March 1981	DNDC continues to request Council for commitment of local funds for project.
May 1981	Norfolk City Council approves local matching funds of $60,000 for N.I.P. and total funding now available effective July 1, 1981.

Adoption phase

July 1981	Site selection process continues.
July 1981	Advocacy groups discuss with the coordinator of N.I.P. and staff the importance of active police involvement and cooperation at this point in program development.

Figure 6 Continued

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August 1981	Current site found but zoning problems delay site approval.
October 1981	Supervisor and staff hired.
November 1981	NCSB reorganized and the Substance Committee disbanded, resulting in a loss of committed and informed advisory board.
November 1981	Chairman of the Substance Abuse Committee, NCSB, term of office ends resulting in a loss of key Board leadership.
November 1981	Staff receives training in Counseling Skills, Emergency Medical Technician Training, Evaluation and Program Operations.
November 1981	Delays in opening due to site preparation to meet zoning, health and state licensing.
January 1982	Substance Abuse Coordinator resigns.
January 1982	Coordinator of N.I.P. responsibilities added to the duties of the Director of Local Alcohol Services.
February 1982	Virginia General Assembly appropriates $250,000 to Department of Criminal Justice Services to set up social detoxification programs throughout the state.

Implementation phase

March 15, 1982	Opening Day. No arrangements in place for police referrals, N.I.P. is understaffed due to an illness and one resignation.
April 1982	Staffing remains a major problem, diffusion of roles and job descriptions. Staff complain of lack of leadership.
April 1982	Staff calls precinct to discuss procedures for police referrals. The police are upset as no procedures are yet in place.
April 1982	Meeting held with NCSB staff and Virginia Department of Criminal Justice Services to discuss future funding of N.I.P. through Criminal Justice.
May 1982	N.I.P. does not meet state certification requirements and is given one month to comply.
June 1982	Court Order issued which approves the diversion of public inebriates by police to N.I.P.

Figure 6 Continued

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June 1982	Counseling Supervisor resigns. Board decides to further expand the Director of Norfolk Alcoholism Services duties as part-time supervisor of N.I.P.
August 1982	Police procedures finalized and police pick up and diversion begins.
September 1982	Only police from 2nd Precinct referring public inebriates. Granby Mall police officers have yet to utilize the program.

Figure 6 Continued

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Corporation, and representatives from the Criminal Justice System to begin discussing a state-supported detoxification program for the City of Norfolk. After requesting such a meeting, three months elapsed before DMHMR was ready to meet with local officials.

The Norfolk Community Services Board approved a program design and budget of $165,000 for the proposed Norfolk Public Inebriate Project in October 1980. This program design described seven treatment phases including outreach, detoxification, residential rehabilitation, medical care, and follow-up. Based on this preliminary program design, the Downtown Norfolk Development Corporation on December 3, 1980, pledged $4,500 in funds to help finance such a facility. Several weeks later, the Norfolk Community Services Board met with Norfolk City Council to discuss the local matching funds of $60,000 necessary to begin such a project.

At this same time, the Commonwealth of Virginia began a process of deinstitutionalization, to shift clients and resources from state institutions to the community. This effort called for the closing of the Eastern State Hospital's Alcohol Rehabilitation Unit. While this was regarded as a separate issue by the State, it further intensified the acute need for local rehabilitation of alcoholics. However, some people involved on a local level confused the defunding of Eastern State Hospital with the funding of the public inebriate program. The Executive Director of the Eastern Virginia Health Systems Agency (also a member of the Norfolk Community Services Board) objected to Eastern State Hospital's pending closing. As Director of the Health Systems Agency, he went on record opposing the closing of Eastern State Hospital and recommended that the City of Norfolk relinquish the approximately

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$100,000 for a public inebriate program in order to keep the Alcohol Rehabilitation Unit open at Eastern State for the next fiscal year. These statements were interpreted by DMHMR as a lack of committment on the part of Norfolk for the public inebriate project which led to further delays in funding the program.

The Fall of 1980 was characterized by confusion and uncertainty. State officials reported that delays in funding the program were because no formal proposal had been submitted by the City of Norfolk. However, the Community Services Board indicated that no written formal committment of dollars had been communicated to local officials with which they could then secure matching funds. In addition to these delays and misunderstandings, the Site Selection Committee never met although their job was to review the criteria and approve particular sites for the location of the program. The Committee was provided with three proposed sites for the public inebriate facility. However in late February, the Community Services Board received notification that due to the delays in funding and the misunderstanding between the local decision-makers and the State, the funds were lost for Fiscal Year 1981.

A budget and grant application was submitted in May of 1981 and $60,000 was approved by City Council to help fund the project. Local and State funds were available July 1, 1981, but due to delays in site selection and preparation, the program did not begin until March of 1982. It took approximately two years to secure the funds and eight months to find a site and prepare it for clients.

Site selection began again in July, 1981. Members of the Chamber of Commerce and City Council insisted that the location be as far away as possible from the downtown business district. This preference made it

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necessary to look at areas some distance from Granby Mall which resulted in making police referrals more difficult.

Late in 1981, several personnel and organizational changes took place that had an influence on the project. The Norfolk Community Services Board was reorganized around functional categories rather than disabilities and the Substance Abuse Committee was abolished to be replaced by a Program and Services Committee which would oversee all programs of the Norfolk Community Services Board. This action disbanded a group of Board members who had served as the "Board of Directors" of the Norfolk Inebriate Program. This committee had developed the Goals and Objectives of the program and were closely involved in every stage of development. This organizational shift diffused the Board's committment to the program and put budgetary decision-making in the hands of the Finance Committee which was not familiar with client's needs and program characteristics. These changes happened a few months before the program was to open and left N.I.P. with no leadership group who was closely involved and seriously committed to overseeing the implementation of the program.

While the committee reorganization of the Board created a leadership void, the most serious change was the departure of the Substance Abuse Coordinator. The Coordinator had sole administrative responsibility for securing the funds, designing the program, providing community liason, and staffing. The review of literature points out that when significant individuals depart at this critical point, or when others are assigned the job of implementation, delays often occur which result in a much different product than originally designed. The continuity of both Board and staff leadership is critical to the effective

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implementation of a program. With N.I.P., both the Board and staff leadership changed completely two months before opening day.

On March 15, 1982, the program officially opened and began accepting clients. However, no arrangements had yet been made for the diversion of public inebriates from the criminal justice system. Some preliminary discussion had been held with the Chief of Police, but there was no court order or procedure for the diversion of police case inebriates to the Norfolk Inebriate Program. The Board and staff greatly underestimated the sensitivity and difficulty in initiating the police diversion of public inebriates. Since the implementors lacked familiarity with the realities of police routines, it was assumed that police referrals would naturally take place.

When interviewed, police planners indicated a feeling of being divorced from the planning process and indicated that their knowledge of the program was only from reading the newspaper. A program which required the close cooperation of the Police Department was planned and implemented without their involvement. On August 5, 1982, procedures were finally in place for the diversion of police-case public inebriates. As of September 15, 1982, the end of the evaluation period, only 24 police referrals had been made to the Norfolk Inebriate Program.

During the six month evaluation period, monthly evaluation reports were communicated to the Norfolk Community Services Board in addition to ongoing dialogue with the staff and administrators. The evaluator also functioned in the role of change agent by providing the staff literature on police involvement, court orders and procedures from other jurisdictions, liason with the police planners, and suggestions on media exposure and staffing. Since a time line for the implementation of various stages

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of the program was never developed, it was difficult to judge whether the program was being implemented in a timely fashion.

Summary of Findings

From the beiginning, the various delays were encountered by both the Department of Mental Health and Mental Retardation and the Community Services Board in securing the dollars necessary to begin the social detoxification effort. The chronological listing of events (Figure 6) points out a lack of communication and a misunderstanding regarding the development of the program design and the basis on which funds were granted to begin the program.

The lack of police involvement from the early stages of planning created implementation delays and the failure to attract the target population. Prior to accepting clients, there were only superficial arrangements made and no letters of agreement with the courts and police. Not accomplishing this important pre-program planning activity led to only 8% police referrals to N.I.P. and detoxification of a predominantly blue-collar population. The lack of close cooperation with the police has been cited in previous literature as a major problem with criminal justice diversion programs and is supported in this study.

An important element of the program design that was not accomplished was the Multi-Agency Linkage System, although planners of N.I.P. were aware of the important linkages that were necessary with other community agencies. Only at the end of the evaluation period had informal linkages developed with housing, social services, and rehabilitation agencies.

Figure 7, summarizes the results of the Goals and Objectives. Clients exhibited no significant change in arrests for public drunkenness

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Goals and Objectives		Measure	Outcome	% Accomplished
Goal 1.0.	To provide social detoxification services to chronic alcoholics.			
Obj. 1.1	To identify and refer 5% of the medically indigent alcoholic population by Sept. 15, 1982.	Number of referrals ÷ M.I. population (4603 persons).	8% admitted	100%
Obj. 1.2	To provide 72 hours of social detoxification to 75% of those persons found appropriate for services by Sept. 15, 1982.	Number staying at least 72 hours ÷ number admitted.	66% remained	94%
Obj. 1.3	To refer 10% of those persons detoxified to rehabilitation or intermediate care by Sept. 15, 1982.	Number of referrals to treatment ÷ number staying at least 72 hours.	21% referred	100%

Summary of Results of Goals and Objectives

Figure 7

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Goals and Objectives		Measure	Outcome	% Accomplished
Obj. 1.4	To identify the number of referrals, Client characteristics, & source of referrals both in and out of the program.	Number of referrals, admissions, source of referral, disposition of referral, length of stay and client characteristics.	377 referrals 297 admitted 92 readmissions 63 referred to alc. treatment 41% bed use rate	
Goal 2.0.	To reduce the burden on the criminal justice system by reducing the arrests and incarceration of public inebriates.			
Obj. 2.1	To reduce public inebriate arrests by 25% by Sept. 15, 1982.	Individual arrests for public intoxication for NIP clients and a comparison group, 90 days before and 90 days after intervention.	26% decrease	100%

Figure 7 Continued

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Goals and Objectives		Measure	Outcome	% Accomplished
Obj. 2.2	To reduce the number of jail bed days used by public inebriates by 75% by Sept. 15, 1982.	Monthly jail bed days for public intoxication.	41% decrease	54%
Goal 3.0.	To positively impact the drinking behavior and employment success of chronic alcoholics.			
Obj. 3.1	To improve the rates of abstinence for chronic alcoholics served in the Norfolk Inebriate Program.	Self report at intake, 3-month and 6-month follow-up, number of drinking days in the last month.	38% decrease, 3 mth.(NIP) 18% decrease, 6 mth.(NIP) 48% decrease, 3 mth.(Jail Compariosn group) 51% decrease, 6 mth., (National Comparison group)	
Obj. 3.2	To improve the rate of employment of chronic alcoholics served in the Norfolk Inebriate Program.	Self report at intake, 3-month and 6-month follow-up, number of working days in the last month.	16% increase, 6 mth.(NIP)* 21% decrease, 3 mth.(Jail Comparison group) 5% increase, 6 mth., (National Comparison group)	

*Statistically significant, $p < .05$

Figure 7 Continued

or reduction in drinking days per month. However, N.I.P. clients made a significant increase in the working days per month and an improvement in living accomodations at the six month follow-up (10% reduction in clients living on the street).

Social detoxification programs can be effective if detoxification is perceived as initial care and if counseling focuses on assessing non-alcoholic needs and motivation and appropriateness for further alcoholism rehabilitation. For those clients who do not need to be referred for treatment, programs may have a positive effect if the intervention addresses housing and employment needs.

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Chapter 5

CONCLUSIONS

Overview of the Study

The Norfolk Inebriate Program (N.I.P.) was intended to intervene in the lives of public inebriates and provide 72 hours of non-medical, social detoxification to persons voluntarily seeking help. The purpose of this evaluation was to monitor the implementation of N.I.P. and measure the impact of the program on client arrests, and drinking and working behavior. Members of the Norfolk Community Services Board hoped that clear goals and objectives and close monitoring would lead to the successful execution of the project and insure on-going funding.

The objectives were never utilized by staff as guideposts for the program and the goals of N.I.P. seemed unrelated to how various groups perceived the purpose of the program. City Council and the Chamber of Commerce wanted to remove the derelict from Granby Mall. The Commonwealth of Virginia wanted to implement quasi-decriminalization of public drunkenness. Program administrators had as their objective an entry into treatment for medically indigent alcoholics, and the clients merely wanted shelter. It appears that the clients' viewpoint was closest to the actual function of N.I.P. - a place to get sober for anyone who asked for shelter.

Another problem was that program planners were not around to direct the implementation of N.I.P. Planning was divorced from execution

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through the departure of critical staff and Board members. Therefore, those charged with implementation inherited the program objectives and never really used the evaluation plan to guide the execution of the program.

During the planning and early implementation of N.I.P., four major constraints were presented. The first constraint was the community's emotional reaction to public inebriates. Not only were tax dollars being used to treat alcoholics, but citizens were funding a program for a population of people who had visible health and hygiene problems, were poor, aged, visually repulsive, often homeless and did not appear to be motivated to improve their condition. These multiple stigmatizing conditions directly affected the type of program developed, the location of N.I.P., and cooperation with other agencies.

A second major constraint was the specific definition of the target group. Because of the location, level of police involvement, and decision-makers' expectations there was never a real consensus as to whom the program was to serve. The City of Norfolk defined the target group as all alcoholics. At the initial planning stage, the program was perceived as a rehabilitative response to the Granby Mall derelicts, but was later expanded to serve the police-case public inebriate. Once the mental health system became the implementor, the definition further expanded to address the needs of the medically indigent, (insurance poor), alcoholics. However, when implemented, the target group to be admitted, became anyone who was drunk.

The third constraint was the physical location of N.I.P. It was too far away from Granby Mall and not designed to specifically address the needs and concerns of the police. In the first six months of program

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operation, the program served a few Granby Mall residents and police-case public inebriates, but no special efforts had been taken to target any of these groups. The confusion as to who was to be served and the failure to attract public inebriates affected the impact measures of the evaluation more than any other constraint.

The fourth constraint related to a confusion among staff and clients as to who was responsible for administration of the program. The Substance Abuse Coordinator for the City of Norfolk resigned one month prior to opening day and was not replaced. Then six weeks after the program opened, the Supervisor of N.I.P. resigned - she also was not replaced. Rather than filling these positions, the Norfolk Community Services Board elected to expand the duties of the Director of Norfolk Alcohol Services to supervise N.I.P. as well as function as Substance Abuse Coordinator for Norfolk.

This decision resulted in a void in both program administration and staff supervision. The absence of a full-time supervisor in this new, untested program forced the staff to make day-to-day programmatic decisions as new situations arose. The staff were unsure as to whom they were accountable. This eventually created dissension as selected staff members, at various times, were given managerial responsibilities but without authority. For example, one counselor was asked to oversee the documentation of the other counselors but was given no new title, salary increase or other symbol of authority. Also the staff were unable to interpret program policy or be assisted in understanding the intent of policies since the designers of N.I.P were no longer available.

The first six months of N.I.P. offered no signs of removing homeless males from Granby Mall due to the program's location and minimal

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police referrals. Public Drunkenness arrests continued to be made primarily for disruptive persons who were inappropriate for detoxification. Although the program findings indicate that drinking behavior did not improve, many clients were helped. Sober clients came back to visit, work as volunteers and attend evening AA meetings. While these former clients had been sober for only a short time, they achieved sobriety through N.I.P. and returned to work or entered rehabilitation.

In spite of the numerous planning and implementation problems, eight of the ten objectives developed by the program designers were achieved. Additionally, N.I.P. clients exhibited an improvement in living accomodations and a statistically significant improvement in working days per month.

Evaluation

A variety of limitations were encountered in the evaluation of N.I.P. This study had the limitations previously identified in the literature review such as the lack of random assignment to control groups, client selection bias, loss of subjects at follow-up and the validity of self-report data. In addition this study supported previous research which identified the failure of social detoxification efforts to affect client drinking behavior or arrests for public intoxication. Other detoxification programs (Daggert and Rolde, 1980; Annis, 1979; Berns, 1974) which were planned to reduce alcohol consumption and divert this "revolving door" client out of the criminal justice system exhibited no more success than Norfolk's efforts.

Follow-up efforts proved to be especially challenging and resulted in some unanticipated limitations. Due to the six-month evaluation

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period, only clients served during the first month of program operation could be followed-up at three and six months. Those clients who were located at follow-up were those who had stable social supports, home ownership, or a job. People with these supports were relatively easy to contact but also tended to be individuals who had a greater prognosis for recovery, hence a small and biased sample (Miller et al. 1969).

Due to the poor validity of self-reported data, the small number of clients located during follow-up, the high variance of arrests, working and drinking data, the impact measures lacked statistical significance for all but working behavior. In this evaluation, measures usually applied to a rehabilitation program's success such as arrests, employment, and subsequent alcohol use were modified and applied to a detoxification program. Because of intervening variables such as within group variance, difficulty with follow-up, and selection bias in sampling, it is questionable whether changes in alcohol consumption and arrests are meaningful indicators of the success of detoxification efforts. It appears that detoxification alone can not be expected to impact client behavior. Only if detoxification is viewed as the initial care component of alcoholism treatment can we expect lasting results.

Feasibility Factors

Since there are a variety of barriers that may prevent the successful implementation of a social detoxification effort, collecting information early in the planning process will provide indications of the feasibility of implementing a program. There are very real dangers in devising a program that looks good on paper but overlooks practical realities. Making an effort to identify and describe implementation problems

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can help decision-makers in deciding if a social detoxification program is really the best alternative for their community. The relative importance of these feasibility factors depends on the local situation.

The following feasibility factors bring together the common themes identified in the literature review and evaluation results.

<u>Cooperation and participation of community agencies</u>. Regardless of the nature of the community, the cooperation of the police force and courts is critical to successful execution of a social detoxification effort. Police and judges have seen human service programs come and go with the same client eventually ending up back in their hands. Therefore, any diversion program must be perceived by the police and courts as their program to solve their problems. Police and judges must be included at the earliest stages of planning and development of diversion procedures.

The cooperation of hospitals, especially emergency rooms, is very important. There must be a sharing of referrals and paramedic back-up between the detoxification program and the hospital. Not all inebriates who present themselves at emergency rooms require medical treatment, and many people referred to social detoxification centers are at risk for seizures. So, there must be medical detoxification beds available for indigents. This can only be accomplished through education and the development of cooperative agreements with hospitals.

The third group of agencies with which to work cooperatively is the social service agencies serving the indigent population. This includes the welfare department, state office of vocational rehabilitation and employment services, Salvation Army, Goodwill, and housing offices. Traditionally, these agencies have been resistant to serving the

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alcoholic because of his or her appearance, lack of motivation and poor prognosis for recovery. Having a few resources for many needy people, these agencies usually place the alcoholic at the bottom of their priorities. Planners and staff must work persistantly at educating case workers on alcoholism, presenting success cases and instilling the belief that alcoholics can recover. It is important that program staff focus on the client's non-alcohol related survival needs. Food, housing and employment must be addressed in order to develop the necessary supports that will help clients desire the satisfaction of higher order needs such as recovery from alcoholism.

Definition and identification of the target population. Agreement as to who comprises the program's target group is a critical issue that must be resolved prior to beginning detoxification services. Will the program serve only homeless inebriates, police-referred inebriates, medically indigent alcoholics, or all people seeking services? Will the program serve only males? What will be the extent of intake assessment in determining if a person is appropriate for admission? If these questions are not clearly addressed by all concerned parties, it is impossible to move to the closely related issue of attracting the target group to a voluntary detoxification program.

A program may fail to attract the target group if parameters of "who is appropriate" are not agreed on by all. Once the target group is agreed upon by staff and board members, referral sources can be identified and asked to participate as Advisory Board members. Finally, specific admission criteria should be determined. These criteria should include measures of Blood Alcohol Content, (B.A.C.), blood pressure, temperature, pulse and the use of a severity assessment scale.

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Instruments such as the Severity Assessment Scale, Total Severity Assessment Schedule, and the Glasgow Coma Scale have been used in various programs to determine the incidence and severity of withdrawal symptoms. Such an assessment scale will help determine the client's appropriateness for non-medical detoxification.

Location of the detoxification program. Many residential neighborhoods are resistant to having alcohol, drug, mental health, and mental retardation programs in their neighborhoods. Zoning approval must be obtained which often involves public comment through a series of hearings. Therefore community attitudes and residential characteristics may cause a site to be inappropriate or difficult to secure.

Proximity to both the target population and police headquarters is critical. There are trade-offs involved when city council or the chamber of commerce demands the program to be some distance from downtown in order to reduce the visibility of inebriates. Few self-referrals and voluntary re-admissions will be generated the greater the distance of the program from the "skid-row" area. Police will have few incentives to refer if the program is some distance away from the point of arrest or the police station. In order to be effective, the program must be closely adjacent to either the police station or the area where many of the public inebriates are located.

Program model and the community. After assessing the extent of the problem, the target population and community characteristics, program planners must decide which program alternative is most appropriate. It may be decided that social detoxification is not the appropriate design. Other alternatives may involve a shelter for the homeless, contracting for medical detoxification beds with local hospitals, a

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half-way house, or a treatment program which would include detoxification with up to thirty days of residential care. The 72 hour social detoxification model provides very little time to address the many needs of this chronic population. If a program is put in place for medical indigents without appropriate follow-up care such as alcoholism treatment, social services, housing, employment and half-way beds, then very little impact will be made on this client population.

Public support for alcoholism services. This question speaks to the availibility of funds at present and in the future to support detoxification efforts. Is the public inebriate a priority concern in the face of tight revenue constraints? How reliable are the present sources of funds? Will the program require a levy or a bond issue approval? These are all questions that must be addressed since detoxification for indigents cannot expect to generate much self-support through client fees or third party payments. Some fees should be charged, but these will never substantially contribute to agency support. Many states have funded detoxification programs through legislated designated taxation on liquor sales and license fees. Regardless of the funding sources, economic constraints and recessionary conditions have made for fierce competition for public funding of human services. The development of new programming such as social detoxification may be impossible if on-going funding is not insured.

Legal issues. The development of detoxification programs in the United States has been closely linked to the adoption of the Uniform Alcoholism and Intoxication Treatment Act. Thus far 33 states have enacted provisions of the Act which decriminalize public drunkenness and make care for the public inebriate the responsibility of the health

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care system. Diversion of public inebriates can be simplified if the state has implemented decriminalization. If the state has not decriminalized public intoxication or has implemented only certain provisions of the Act, police may not be able to transport public inebriates directly to the detoxification program without a court order. Even if program planners have developed cooperation with the police, police officers may not be able to use the facility if the state has not decriminalized or a court order issued for the diversion of public inebriates.

Personnel. In addition to possessing counseling skills and knowledge of alcoholism, personnel in many states have developed certification and licensing requirements for social, free-standing detoxification programs which require staff to be certified as Emergency Medical Technicians (EMT). A program must either pay to train their staff or hire persons already trained as EMT's. If the program must train their staff, it will require both time and money. If previously trained EMT's are hired, they may not have the counseling skills and alcoholism knowledge necessary to work with public inebriates. Also tasks such as meal preparation, cleaning and general maintenance require neither EMT nor counseling skills. These tasks can often be performed by clients and a house manager who is hired specifically for this purpose.

Alcohol related problems. The stigma of the deviant condition of the "skid row-like" person and lack of acceptance of alcoholism as an illness create probably the greatest barriers to alcoholism programming. Homeowners resist having a program in their neighborhood. Family members suffer guilt and shame and hence cover up drinking problems. Emergency room physicians are reluctant to treat or admit the homeless alcoholic because he or she is seen as hopeless, poor and unmotivated

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to remain sober. The appearance of these people, their lack of motivation, and their denial of a drinking problem often fosters a lack of compassion and tests the public sector's willingness to respond to this dependent population.

Comments

The feasibility factors just discussed identify the major themes of the evaluation as well as the practical barriers to implementation. These barriers can be overcome by developing a close link between the planning and implementation process and outlining a clear achievable strategy for identifying this target population. In the case of N.I.P., the planners were not the implementors, police cooperation was not insured, and the site location was too far away from the police or inebriates. Above all, there was no clear agreement on the characteristics of the target population.

If the goal is to provide services to the skid row alcoholic and remove him from the criminal justice "revolving door", the state must first decriminalize public drunkenness and establish a clear public policy regarding the public inebriate. On the local level, planners must arrange for complete diversion and have a variety of services in place including a general shelter, indigent treatment and half-way house beds. The location must be accessible to police and clients, and the program staff must be able to respond to the non-alcoholic needs of clients.

Thus far, much of the development of detoxification services has occurred without heavy reliance on research. Programs have continued to make the same mistakes and have not clearly anticipated the many barriers

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discussed in this evaluation. The need to develop clear outcome criteria for detoxification remains an important issue for further research. Since social detoxification is a very short-term initial care component, the goals must be limited since long-term impact on this chronic population may be quite unrealistic in a 72 hour program.

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Appendix A

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Method of Estimating Alcohol Detox and Rehabilitation Beds
Needed for the Medically Indigent

In order to focus on the medically indigent (i.e. those without either personal or third party resources to pay for treatment), the Director of the Norfolk Alcoholism Services Program, Mr. Walter Gallop, and the Norfolk Community Services Board's Substance Abuse Coordinator, Mr. Al Brewster met. At times during the process there was a need for an estimate to be based on clinical experience, rather than empirically based data. Where we have estimated based upon experience it is indicated. We would appreciate any feed-back you may have as to the validity of our estimate.

STEP I

We flagged occupational catagories from the Marden printout which in our judgement would be composed of the medically indigent and which we knew from experience were the type of occupations which our medically indigent clients reported.

For Norfolk we flagged the following occupational categories. Your area may differ significantly (e.g. a rural area might flag Row 10 Farm Laborers):

		Totals
Row 5	Craftsmen, Foremen	2,520
Row 8	Laborers except Farm	842
Row 11	Service Workers including Private Household	604
Row 12	Unemployed	189
Row 17	Female Craftsmen	19
Row 20	Female Laborers	16
Row 23	Female Service Workers	354
Row 24	Female Unemployed	59
		4,603

(1) The Marden Formula does not include approximately 35% of the working population 16-64 years of age who are not in the labor force, nor does it include the Military labor force. Consequently the Marden data tends to underestimate especially in urban military areas.

Appendix A

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"Estimated" Norfolk Population of
Medically Indigent Problem Drinkers = 4,603

4,603		
x .12	"Estimate" seeking treatment per year	(2)
552.36		
x .60	"Estimate" in need of Medical Detox	(2)
331.41		
x 4	Average days Detox	
1,325.64	Patient days in Detox	

1,325.64 ÷ 328.5 (90% of a year) = 4.03
403 Detox Beds @ 90% utilization

331.41	
x 17.87	Average length of stay (LOS) in Post-Detox Residential Program (3)
5,922.29	patient days

5,922.29 ÷ 328.5 (90% of a year) = 18.02

18.02 Post-Detox Non-Medical Residential Beds
@ 90% utilization

(2) While these percentages are estimates based on clinical experience, it should be noted that identical percentages were included in Tidewater Psychiatric Institute's Certificate of Need Application #VA-1210. In that application they cite the National Institute of Alcoholism and Alcohol Abuse "planning guidelines" as the source for the percentages, however as of this date no more specific reference is known.

(3) Based upon personal communication with Mr. Don Rooney, USPHS who reports LOS as 23.58 days - 4 days detox = 19.58 days rehab and Chris Faia ESH who reports LOS at 20.16 days - 4 days detox = 16.16 days Rehab or 17.87 X LOS.

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STEP 2 Actual Admissions Over Past Two Years

United States Public Health Service Hospital	Eastern State Substance Abuse Unit
CY 79 - 26	FY 79 162
CY 80 69 (Projected: 55 as of 9/25/80)	FY 80 145
2 95	2 307
47.5 $\overline{X}$ over 2 years	153

153
47.5
200.5 Actual $\overline{X}$ Admissions

200.5 Actual $\overline{X}$ Admissions
x 4 Average days Detox
802 Patient days in Detox

802 ÷ 328.5 (90% of a year) = 2.44
2.44 Detox Beds @ 90% utilization

200.5
x 17.87 Average LOS in Post-Detox Residential Program
3,582.93 Patient days

3,582.93 ÷ 328.5 (90% of a year) - 10.90

10.90 Post-Detox Non-Medical Residential Rehabilitation Beds @ 90% utilization

(3) Based upon personal communication with Mr. Don Rooney, USPHS who reports LOS at 23.58 days - 4 days detox = 19.58 days Rehab and Chris Faia ESH who reports LOS at 20.16 days - 4 days detox = 16.16 days Rehab or 17.87 $\overline{X}$ LOS.

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STEP 4

We know that the Marden formula underestimates the population of problem drinkers. On the other hand our manipulation of the Marden data may have overestimated the number of medically indigent problem drinkers. We also know that for a variety of reasons actual admissions to USPHSH and ESH may not be accurate predictors of need. For instance we don't have statistics on how many people were turned away from these hospitals because they didn't have room or how many received treatment for their addiction through public emergency rooms in general hospitals or were hospitalized and detoxed while receiving care for other ailments.

In summary neither the Marden based estimate nor the use of actual admissions data will cover all the variables that should be covered when trying to project the need for medically indigent alcohol beds. However, we must begin the planning process somewhere and there appears to be no other alternative data source. Therefore we suggest as a starting point splitting the difference between the two data sources to obtain a reasonable estimate of the bed need for planning purposes. As programs are developed to meet the need, consideration should be given to keeping data on the number of eligible clients who may be turned away because no beds are available.

The following combination of actual admissions and Marden projections provides the best estimate of medically indigent alcohol beds needed in Norfolk as of this date:

4.03 Detox Beds Based on Marden Formula
2.44 Detox Beds Based on Actual Admissions
6.47

6.47 ÷ 2 = 3.23 Estimated Norfolk Detox Beds @ 90% utilization

18.02 Residential Beds Based on Marden Formula
10.90 Residential Beds Based on Actual Admissions
28.92

28.92 ÷ 2 = 14.46 Estimated Norfolk Post-Detox Non-Medical Residential Beds @ 90% utilization.

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Appendix B

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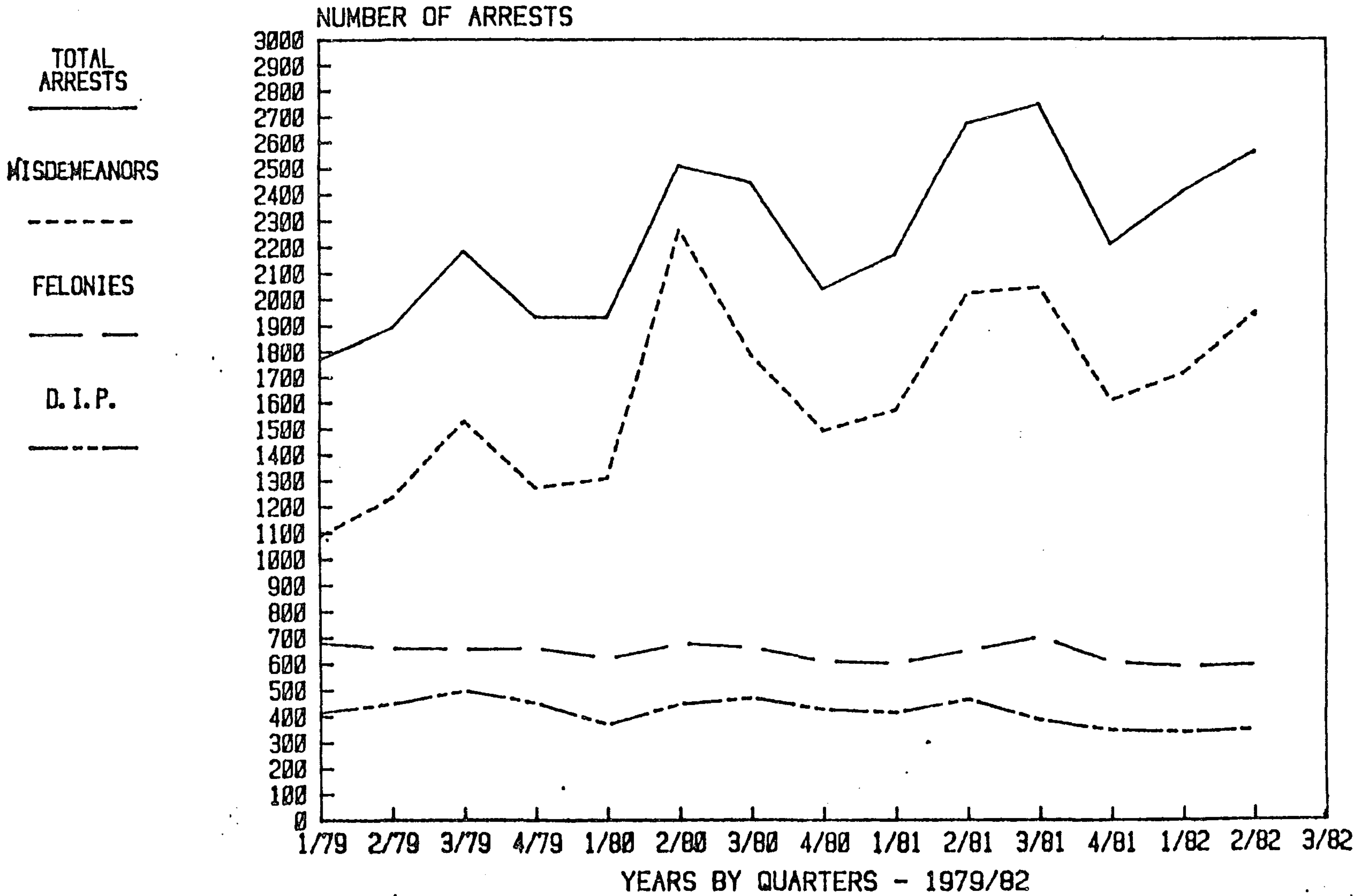
Appendix B



Appendix C

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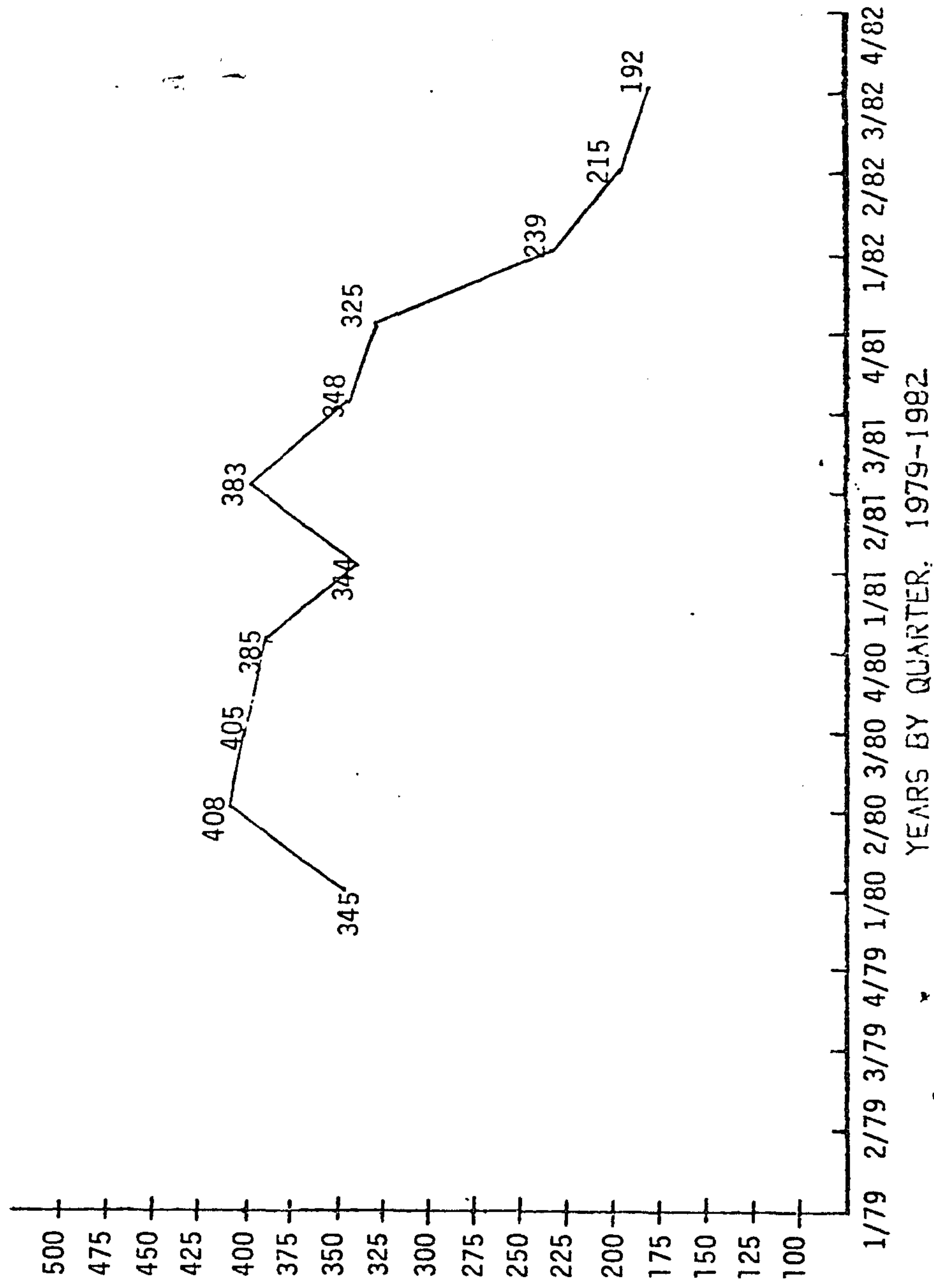

Appendix C

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Appendix D

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NORFOLK INEBRIATE PROGRAM

CLIENT FOLLOW-UP FORM (AEO-4)

NAME: ______________________ DATE: ______________

ADDRESS: ______________________ CASE NO.: ______________

______________________ PHONE: ______________

1. What did you think were the most desirable aspects of the program?

01	safe warm place to flop	06	a place to get sober
02	accepting a friendly staff	07	all the above
03	alternative to jail	08	______________
04	AA	09	______________
05	food	10	______________

2. What did you think were the least desirable aspects of the program?

01	safe warm place to flop	06	a place to get sober
02	accepting a friendly staff	07	nothing to do
03	alternative to jail	08	nothing
04	AA	09	Nurse
05	food	10	______________

3. Please describe your present living arrangements.

01	private home with family	06	street
02	apartment with family	07	apartment with friend
03	apartment alone	08	______________
04	single room	09	______________
05	Union Mission	10	______________

4. Approximately how many days did you drink during the last 30 days? __________

5. Approximately how many days did you work during the last 30 days? __________

6. Number of public drunkenness arrests in the 3 months prior to N.I.P. __________

7. Number of public drunkenness arrests in the last 3 months. ______________

8. Were you referred for further help at discharge from N.I.P.? ______________
   If so, where? ______________________ Did you go? ______________
   number of days ________ If you did not go for services, why? ______________
   ____

9. What has happened in the last 3 months? (complete on back)

NOTE: PLEASE MAKE SURE THE PERSON SIGNS THE RELEASE(S) OF INFORMATION ON BACK.

Appendix D

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Appendix E

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NORFOLK INEBRIATE PROGRAM

POLICE OFFICER SURVEY

Officer's Name:______________________ Date:__________

Precinct:______________________ Badge No:______

Client's Name:______________________ Case No________

When you transported a public inebriate to the Norfolk Inebriate Program:

1. Was the staff cooperative and courteous? Yes___ No___

   Comments:____

   ____

   ____

2. How does the time involved compare to an arrest?

   a) Took more time than an arrest ____

   b) Took less time than an arrest ____

   c) About the same time involved ____

3. Are you likely to use the N.I.P. program again? Yes___ No___

   Comments____

   ____

   ____

4. How could the N.I.P. program improve operations to facilitate more police referrals?

   ____

   ____

   ____

5. Is the location appropriate for the detoxification? Yes__ No___

6. Other comments: ___________________________________

   ____

   ____

Appendix E

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Appendix F

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Appendix F

Source of Referral

I. Objective 1.4 (cont.)	1st Month 3/15 to 4/15	2nd Month 4/15 to 5/15	3rd Month 5/15 to 6/15	4th Month 6/15 to 7/15	5th Month 7/15 to 8/15	6th Month 8/15 to 9/15	Total 1st 6 Mo. of N.I.P. 3/15-9/15
B. <u>Source of Referral</u>							
1. A.A.	33%(11)	38%(16)	30%(14)	19%(10)	14%(8)	14%(8)	23%(67)
2. Friends	11%(4)	21%(9)	2%(1)	15%(8)	5%(3)	5%(3)	9%(28)
3. Police	3%(1)	2%(1)	------	2%(1)	13%(7)	25%(14)	8%(24)
4. Church	6%(2)	------	------	------	------	------	.7%(2)
5. Norfolk Alcohol Services	6%(2)	5%(2)	17%(8)	13%(7)	7%(4)	5%(3)	9%(26)
6. VA Hospital	6%(2)	------	------	------	------	2%(1)	1%(3)
7. Community Mental Health Center	6%(2)	------	------	2%(1)	4%(2)	------	2%(5)
8. Social Services	3%(1)	------	------	------	------	------	.3%(1)
9. Family	3%(1)	------	------	------	------	------	.3%(1)
10. Media	3%(1)	2%(1)	2%(1)	4%(2)	------	2%(1)	2%(6)
11. Jail	3%(1)	------	------	2%(1)	2%(1)	------	1%(3)
12. Tidewater Psychiatric Institute	3%(1)	2%(1)	------	------	2%(1)	------	1%(3)
13. Alcohol Recovery Center of VA	3%(1)	------	------	------	------	------	.3%(1)
14. Serenity Lodge	------	------	------	4%(2)	------	------	.6%(2)
15. Flynn Home	------	2%(1)	------	4%(2)	2%(1)	2%(1)	2%(5)
16. Norfolk General Hospital	9%(3)	14%(6)	4%(2)	2%(1)	7%(4)	5%(3)	6%(19)
17. DePaul Hospital	------	5%(2)	------	2%(1)	------	7%(4)	2%(7)
18. Peninsula Psychiatric Hospital	------	5%(2)	------	------	------	------	.6%(7)
19. Salvation Army	------	2%(1)	------	------	------	------	.3%(1)
20. Alcohol Safety Action Program (Persons convicted of Driving while intoxicated)	3%(1)	------	2%(1)	------	------	------	.6%(2)

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I. Objective 1.4 (cont.)	1st Month 3/15 to 4/15	2nd Month 4/15 to 5/15	3rd Month 5/15 to 6/15	4th Month 6/15 to 7/15	5th Month 7/15 to 8/15	6th Month 3/15 to 9/15	Total 1st 6 Mo. of N.I.P. 3/15-9/15
B. <u>Source of Referral</u>							
21. Self	------	------	38%(18)	2%(12)	29%(16)	16%(9)	19%(55)
22. ARC (U.S. Navy)	------	------	2%(1)	2%(1)	------	------	.6%(2)
23. Outreach (N.I.P.)	------	------	2%(1)	6%(3)	7%(4)	5%(3)	4%(11)
24. Riverside Hospital	------	------	------	2%(1)	2%(1)	2%(1)	1%(3)
25. Union Mission	------	------	------	2%(1)	2%(1)	2%(1)	1%(3)
26. Comprehensive S.A. Program, Va. Beach	------	------	------	------	4%(2)	------	.6%(2)
27. Portsmouth Alcohol Services (o/p)	------	------	------	------	------	2%(1)	.3%(1)
28. Employer	------	------	------	------	------	2%(1)	.3%(1)

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Disposition of Referral

I. Objective 1.4 (cont.)	1st Month 3/15 to 4/15	2nd Month 4/15 to 5/15	3rd Month 5/15 to 6/15	4th Month 6/15 to 7/15	5th Month 7/15 to 8/15	6th Month 8/15 to 9/15	Totals 1st 6 Mo. of N.I.P. 3/15-9/15
C. <u>Disposition of Referral</u>							
1. No Referral	24%(8)	42%(18)	32%(15)	41%(22)	47%(25)	19%(11)	36%(107)*
2. Norfolk Alcohol Svs. (o/p)	21%(7/0)	12%(5/0)	28%(13)	22%(12)	13%(7)	16%(9)	18%(53)
3. Flynn Home, Portsmouth	9%(3)	7%(3)	2%(1)	6%(3)	2%(1)	2%(1)	4%(12)
4. VA Hospital, Hampton	9%(3)	2%(1)	9%(4)	2%(1)	13%(7)	16%(9)	8%(25)
5. Riverside Hospital, Newport News	3%(1)	------	------	2%(1)	------	------	.7%(2)
6. Serenity Lodge, Chesapeake	3%(1)	2%(1)	4%(2)	------	------	------	2%(6)
7. Alcohol Recovery Center of VA	3%(1)	------	------	2%(1)	------	------	.6%(2)
8. Peninsula Psychiatric Hospital	3%(1)	------	------	------	2%(1)	------	.6%(2)
9. Private Physician	3%(1)	------	------	------	------	------	.3%(1)
10. Employer	3%(1)	------	------	------	------	------	.3%(1)
11. Friend	3%(1)	------	------	------	------	------	.3%(1)
12. Eastern State Hospital	3%(1)	5%(2)	2%(1)	2%(1)	2%(1)	2%(1)	2%(7)
13. Alcoholics Anonymous	------	13%(6)	4%(2)	7%(4)	9%(5)	18%(10)	9%(27)
14. DePaul Hospital	------	5%(1)	2%(1)	6%(3)	------	7%(4)	3%(9)
15. Chesapeake General Hospital	------	2%(1)			------	------	.3%(1)
16. Peninsula Alcohol Svs. (o/p)	------	2%(1)	------	------	------	------	.3%(1)
17. Norfolk General Hospital	------	2%(1)	2%(1)	------	2%(1)	4%(2)	2%(5)
18. Tidewater Psychiatric Institute	------	2%(1)	------	------	------	------	.3%(1)
19. Chesapeake Substance Abuse Services (o/p)	------	2%(1)	2%(1)	2%(1)	------	------	1%(3)

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I. Objective 1.4 (cont.)	1st Month 3/15 to 4/15	2nd Month 4/15 to 5/15	3rd Month 5/15 to 6/15	4th Month 6/15 to 7/15	5th Month 7/15 to 8/15	6th Month 8/15 to 9/15	Total 1st 6 Mo. of N.I.P. 3/15-9/15
C. 20. Social Services	------	------	------	------	------	------	------
21. Portsmouth Alcohol Svs. (o/p)	------	------	4%(2)	2%(1)	------	2%(1)	1%(4)
22. James Institute (Eastern Shore)	------	------	2%(1)	------	------	------	.3%(1)
23. ARC (U.S. Navy)	------	------	2%(1)	------	------	------	.3%(1)
24. Union Mission	------	------	2%(1)	------	------	------	.3%(1)
25. Portsmouth Naval Hospital	------	------	2%(1)	------	2%(1)	2%(1)	1%(3)
26. CBN	------	------	------	2%(1)	------	------	.3%(1)
27. Virginia Beach Substance Abuse Services (o/p)	------	------	------	4%(2)	5%(3)	4%(2)	2%(7)
28. CMHC	------	------	------	2%(1)	------	------	.3%(1)
29. Police	------	------	------	------	2%(1)	------	.3%(1)
30. Salvation Army	------	------	------	------	2%(1)	4%(2)	1%(3)
31. Other	------	------	------	------	------	2%(1)	.3%(1)

*AMA(17)

Appendix G

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Detoxification and Criminal Justice Costs

Detoxification costs

a.	N.I.P. Annual Budget	$	168,000.00
b.	Administrative costs		11,000.00
	10% of Community Services Board Executive Director's time at $30,000 = $3,000.		
	30% of Community Services Board Substance Abuse Coordinator at $24,000 = $8,000.		
	Annual Detoxification Costs	$	179,000.00
	Cost Per Day	$	490.41
	Cost Per Client Per Day at 100% utilization	$	40.87
	Cost Per Client Per Day at 41% utilization*	$	100.08

c. Other Costs Not Monetarily Computed

(1) Lost cleint salary/productivity while in detoxification

(2) Opportunity costs of revenue not available for other disabilities or other public programs.

(3) Costs of police diversion to N.I.P, opportunity costs of not responding

*Bed utilization for first six months of program operation

Appendix G

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to other crimes or time involved in

excess of normal arrest. (police costs)

Police Costs

a.	Police officer salaries*	$10,894,012.00
	number of officers	÷ 446
		$ 24,426.04
	Estimated working hours per year	÷ 2,000
	Cost Per Officer Per Hour	$ 12.21
b.	Police estimate one hour to pickup, transport, book public inebriate and return to duty station.	
c.	Drunk in Public Arrests, 1981	4,824
	x Cost per officer per hour	x 12.21
		$ 58,901.04
	70% of time, two officers are involved	x 1.70
	Police Cost Per Year	$ 100,131.76
		÷ 4,824
	Police Costs Per Person Per Day	$ 20.76

d. Police Expenditures Not Monetarily Computed:

(1) Calls for service (officer's time, 15 minutes) that did not result in an arrest.

*City of Norfolk, FY 82 Annual Budget

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(2) Opportunity costs of officer's time which could be diverted into law enforcement or other more productive activities.

(3) Automobile expenses.

Jail Costs

a. Norfolk Jail, Annual Budget*	$ 3,945,024.00
less administrative costs	- 154,432.00
	$ 3,790,592.00
less judicial costs (costs not related to public inebriates	- 154,432.00
	$ 3,255,932.00
pro-rated administrative costs ($3,255,932 ÷ 3,790,592 = .86)	$ 154,432.00
	x .86
	$ 132,811.52
	$ 3,255,932.00
	+ 132,811.52
	$ 3,388,743.52
	÷ 365
Cost Per Day to Operate Jail Less Judicial Cost With Pro-rated Administrative Costs	$ 9,284.23

*City of Norfolk, FY 82 Annual Budget

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Cost Per Day to Operate Jail Less Judicial Cost With Pro-rated Administrative Costs	$	9,284.23
b. Average Number of Inmates/Day	÷	424
Cost Per Inmate Per Day	$	21.90
Public Inebriate Jail Bed Days, 1981	x	4202
Jail Cost Per Year for Public Inebriates	$	29,023.80

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Autobiographical Statement

Thomas M. Slaven was born in East Liverpool, Ohio on January 7, 1947. He received a Bachelor of Science in Business Administration from Bowling Green State University in 1969 and a Master of Arts in Counseling from Ball State University in 1973 and a Certificate of Advanced Study from Old Dominion University in 1979.

Mr. Slaven is a Licensed Professional Counselor, Substance Abuse Specialist in the Commonwealth of Virginia and a Certified Alcoholism Counselor in the State of Ohio. He has published a study entitled "Evaluating Professional Education in Drug Use and Abuse," Journal of Drug Education, Volume 10, No. 4, 1980; and presented a paper entitled "Training Bartenders in Alcoholism Prevention" at the National Alcoholism Forum, April 1981.

Mr. Slaven is a member of the National Alcoholism Professional Society, the Association of Labor and Management Administrators and Consultants on Alcoholism, Past President of the Substance Abuse Program Directors of Virginia, and a member of the Honor Society of Phi Kappa Phi.

He is currently employed as Executive Director of the Trumbull County Council on Alcoholism, Inc. in Warren, Ohio. He previously was Executive Director of the Tidewater Council on Alcoholism in Norfolk, Virginia and has held a variety of positions and assignments over the last ten years in mental health and alcoholism treatment, evaluation and college teaching.

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