1991 Public Inebriate Plan

and

Data & Recent Research

Municipality of Anchorage
Department of Health & Human Services
Planning Office

July, 1995
MUNICIPALITY OF ANCHORAGE
PUBLIC INEBRIATE ALCOHOL TREATMENT PLAN

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Planning Office

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EXECUTIVE SUMMARY

A relatively small group of public inebriates has created more visible social and economic problems than any other group its size in our community. These problems are visible to all including the downtown merchant, the paramedic, the fireman, the police officer, and especially the residents of Downtown neighborhoods.

During the previous decade, the Municipality, in cooperation with other non-profit agencies, has devoted a substantial amount of resources addressing this problem. We now have a permanent location for Bean's Cafe. The Brother Francis Shelter has become an important service in our community. Shortened bar hours helped reduce the availability of alcohol. The Community Service Patrol is now available 24 hours a day, 7 days a week. And, the downtown urban renewal efforts begun by Mayor Knowles resulted in the geographic relocation of some of the population.

A considerable amount of money has been spent on a relatively small group of public inebriates. In 1989 the Municipality and other non-profit groups spent approximately $5,800,000 on providing services to the public inebriates. This amounted to approximately $15,600 per public inebriate per year.

Despite this previous effort, the public inebriate problem persists. Some say it is getting worse. The number of public inebriates may have doubled or tripled from approximately 90 individuals in 1978 to between 160 to 375 today. The visible impact of the public inebriate continues to plague certain parts of our community, particularly the Fairview and Downtown areas.

As available local resources to support all social services continue to dwindle, we must carefully examine our funding and service priorities and how we approach the problem of the public inebriate. Neighborhoods like Fairview have suggested the need for a new comprehensive look at services to the public inebriate.

The Mayor's Blue Ribbon Panel on the Public Inebriate was created in November 1989 in response to the need to develop a comprehensive plan. Its charge included responsibility for developing specific recommendations, acceptable to the community, to help resolve the continuing health, social service, legal, public safety and financial problems associated with the public inebriate.

During the 18 months the Blue Ribbon Panel has worked on the plan, a considerable amount of testimony concerning the nature and extent of the public inebriate problem in Anchorage has been received. Experts providing input included representatives from local businesses, the medical community, the court system, public safety officials, social service agencies, substance abuse treatment providers, elected and government officials, and residents of the affected areas in our community.
The recommendations contained in this Plan are founded on the following seven principles formulated by the Blue Ribbon Panel in response to public testimony:

- The current situation with alcohol abuse in our community is intolerable. Recognizing the critical nature of the extent of alcohol abuse in Anchorage by all segments of the population, the Panel issues a "call to action" to develop effective methods of reducing the negative impact of alcohol abuse.

- Current laws should be enforced more aggressively and utilized in conjunction with court ordered treatment to allow public inebriates to receive the medical care they need to ensure that their health and welfare are protected.

- Responses to the public inebriate problem should address better management of the problem (services and legal issues), and not rely solely on alcohol treatment as the means of reducing the adverse impacts of the public inebriate.

- Emergency services for the public inebriate should be minimal and humanitarian. They should be designed only to protect the public inebriate from being a danger to himself or others.

- Responses should help reduce the visibility of the public inebriate problem, and minimize the adverse impacts of the problem on the citizens of Anchorage and on the Anchorage business community.

- Opportunities should be available for all those who choose to enter treatment.

- A continuum of treatment should be available to those who choose to enter treatment.

Based on these principles, the Panel developed short-term and long-term responses to the public inebriate problem.

**Short-term Responses**

1. **Streamline involuntary commitment procedures and lengthen the permitted duration of commitment.**

In many cases, the public inebriate may be a danger to himself or others, thus requiring some type of protective custody. In addition, testimony received suggests that public inebriates or chronic alcoholics may be incapable of making reasoned decisions regarding long-term alcohol treatment or rehabilitation.

Legislation should be enacted amending Title 47 to be more workable for communities in their efforts to place public inebriates into treatment facilities, and to make it more useful as a tool for the police and the public.
2. **Public drunkenness should not be recriminalized at this time.**

The U.S. Supreme Court has ruled that public drunkenness is not a crime. Alaska Statute (Title 47) has been adopted as a means of managing the impact of alcohol abuse, including public drunkenness.

Public inebriates commit a wide variety of crimes such as trespassing, vandalism, etc. which could be grounds for their arrest. Existing ordinances and statutes should be more vigorously and aggressively enforced in lieu of recriminalizing public drunkenness.

3. **Maintain the Existing Sleep-off Center at the Brother Francis Shelter "Campus" until additional detox beds are available at Pt. Woronzof.**

In the long-run the existing sleep-off services should be eliminated and replaced by an expanded detox unit, located at Pt. Woronzof, and expanded Community Service Patrol (see long-term recommendations).

The existing sleep-off center needs to remain in operation until the additional detox units are available at Pt. Woronzof in early 1992. In the meantime the sleep-off in conjunction with the Community Service Patrol is necessary to provide the minimum level of humanitarian service needed to prevent death and needless suffering among the public inebriate population.

4. **Maintain State funding for a publicly supported detoxification services serving the Southcentral region.**

The elimination of the publicly funded detox program would have three major consequences. First, the resources of local hospital emergency rooms and public safety personnel would be severely taxed, diverting those resources from providing more appropriate and pressing services. Secondly, the absence of a detox program would eliminated the principle entry point into alcohol treatment and eventual rehabilitation. Thirdly, residents of smaller cities and villages within the Southcentral region with severe alcohol problems who come into Anchorage would not have access to needed detoxification services.

The existing detoxification facility at Pt. Woronzof is truly a regional service. A 1980 study conducted by the Department's Behavioral Health Division showed that only 27% of all clients who used detox services mentioned Anchorage as their place of residence. A more recent analysis of detox client records showed that 75% of all clients were from Anchorage. While these figures are significantly different, they nonetheless confirm the regional character of Anchorage's alcohol treatment services.
5. **Increase the visibility of law enforcement in areas frequented by public inebriates.**

The current laws are not being used effectively to solve the problems of the public inebriate. Attitudes were changed when the community began to look upon alcoholism as a disease. The effectiveness of existing ordinances and statutes could be enhanced through more vigorous and aggressive enforcement.

The Downtown Police Substation should be manned with additional police officers.

The Alcohol Beverage Control Board should be asked to focus additional attention on violations of provisions of Title 4 which prohibit the sale of alcoholic beverages to intoxicated persons.

**Long-term Responses**

6. **Eliminate Sleep-off and Replace it with an Expanded Detox Unit at Pt. Woronzof (10 to 30 beds) and an Expanded Community Service Patrol.**

The expanded Detox Unit, located at Point Woronzof, would work in tandem with the expanded Community Service Patrol to replace the existing Sleep-off Center. In order to move the sleep-off to Pt. Woronzof, an additional van will be needed to transport public inebriates to the expanded detox facility. The extra van is needed in order to maintain continuous coverage of the Core Skid Row area while the other van makes the 40 minute round trip to Pt. Woronzof.

Only 16 hours of coverage by the second van is needed since the number of public inebriates picked-up between 3:00 a.m. to 11:00 a.m. is small enough to be handled by one van.

The 30 bed detox unit would be staffed by trained technicians. Public inebriates would be held at the unit for up to 48 hours instead of the average length of stay of 6.5 hours at the existing sleep-off facility located at the Brother Francis Shelter "campus". There is a 48 hour limit under the protective custody provisions of AS 47.37.170.

The existing sleep-off center operated by the Salvation Army Clitheroe Center should be maintained at its current location in the "campus" area until the expanded detox units are available in early 1992. The number of detox beds should be re-evaluated after six months to determine if additional beds are needed.
7. **An additional 40 long-term alcohol treatment beds should be funded.**

The number of public inebriates has increased dramatically within the last ten years, yet the number of treatment beds has remained relatively static. According to the Salvation Army approximately 30 beds are needed in order to eliminate its current waiting list. The remaining ten beds are needed to handle the increase in the number of admissions through increased involuntary commitments and other criminal referrals.

The establishment of a 90 to 180 day long-term treatment facility in Anchorage is needed to provide an alternative to the traditional 21 to 28 day treatment program. With longer treatment length, the chances of complete recovery are greatly enhanced.

8. **Develop a Centralized Drop-off/Triage Center in the Downtown Area.**

A frequent theme of testimony received by the Blue Ribbon Panel suggests that centralizing services for the homeless public inebriates in a "campus" setting creates incentives for the public inebriate to continue a public drunk lifestyle. The sleep-off center contributes to this problem because it allows the drunk to sleep-off the effects of alcohol and continue his or her drinking activity.

A long-term solution to this problem, if funding permits, is to convert the existing sleep-off center to a centralized Drop-off/Triage Center. The new Center would serve as a holding station where public inebriates would await transportation to the Detox Unit at Pt. Woronzof.

The Drop-off/Triage Center should be staffed by trained, non-medical technicians who would provide a brief evaluation of the inebriate and determine the appropriate destination (i.e. a hospital emergency room, home/family, sleep-off, API or other appropriate facility). The length of stay should be short, and not exceed approximately 4 hours, depending on the transportation schedule.

Within the framework of applicable law, the incapacitated public inebriate could be transported from the Drop-off/Triage Center to the Detox Unit at Pt. Woronzof (described below), a hospital emergency room, home/family, jail, or other appropriate treatment facility.

9. **Take an aggressive position against alcohol abuse in our community.**

The current situation is intolerable. A "call to action" should emphasize the critical nature of the extent of alcohol abuse in Anchorage by all segments of the population.
The Panel supports efforts to educate the citizens of Anchorage about the serious consequences of the irresponsible use of alcoholic beverages. Programs such as Anchorage Partnership Program should be supported by both private and public sources.

10. **Establish an adequate and predictable funding base for programs for the public inebriate.**

The public inebriate program is not solely an Anchorage problem, but is regional and statewide. This suggests that funding should come from a variety of sources, including the Municipality of Anchorage, the Alaska Area Native Health Services, the State of Alaska Division of Alcohol and Drug Abuse (ADA), and Native Regional Health Corporations.

Since most of the clients served by public inebriate programs experience some type of psychosis, mental health trust fund money should be available for funding these programs.
PURPOSE AND USE

According to Title 47 of the Alaska State Statues, the State of Alaska is responsible for the delivery and planning of alcohol services. In the past, the State has given little attention in its planning efforts to the problems posed by the public inebriates. Since this is a problem which seriously impacts many businesses and residents of Anchorage, the Municipality has felt compelled to take on this task itself.

Recently the Municipality initiated a study of alcohol services for public inebriates in Anchorage through the Mayor's Blue Ribbon Panel on the Public Inebriate. The Panel discovered during the course of its investigation that the problems of the public inebriate cannot be dealt with piecemeal and that a comprehensive approach to the problem needs to be adopted.

Other Substance Abuse Planning Efforts

The following document is a comprehensive plan for treatment services to the public inebriate. There are, of course, other substance abuse and homeless problems which this community faces which are at least as serious as the public inebriate problem. Other task forces are already working on some of these issues.

The Partnership for a Healthy Anchorage will soon be formed in order to implement a four-year $1,550,000 grant from the U.S. Department of Health and Human Services, Office for Substance Abuse Prevention. (Note: Official notification of grant award is expected in July.) The purpose of the Partnership is to enhance the city's alcohol and drug abuse prevention programs. The Partnership's activities will compliment this Plan which is primarily a treatment services plan and does not address prevention issues.

The Mayor's Homeless Task Force is currently working on housing issues which affect the public inebriates. Their work will also compliment this report by providing input on the non-alcohol related services (e.g., food and shelter) needed by public inebriates.

The Purpose of the Public Inebriate Services Plan

The following Comprehensive Alcohol Services Plan identifies the extent of the public inebriate problem in Anchorage as well as addresses the range of alcohol services needed to solve the problem. In the past, too much attention was focused on the location of a sleep-off center. In order to successfully rehabilitate public inebriates a continuum of care which emphasizes long-term treatment needs to be available.

The Comprehensive Alcohol Treatment Services Plan recognizes that a substantially greater commitment is needed by both the
Municipality and the State. If adequate resources are available to implement the plan the lives of the public inebriates will be substantially improved and the impact of the public inebriate on city residents will be substantially reduced as well.

The entire plan probably cannot be implemented immediately. As a result, various parts of the Plan may be implemented separately as the money becomes available.
DESCRIPTION OF TARGET POPULATION

Characteristics of the Population

Skid Rows in the United States:

A review of the literature regarding demographic characteristics of the chronic public inebriate (CPI) from different areas of the United States revealed very similar profiles (Aaronson, Dienes, & Musheno, 1978; Breakey et al., 1989; Roth & Bean, 1985).

Most studies report that the CPI population in the United States is predominantly male (90% or more). Approximately two-thirds are between the ages of thirty and sixty years. The same proportion are reported to be of ethnic backgrounds other than Caucasian (specific nationalities were different for each area). Several large cities reported Blacks comprise 40 to 60%, and Hispanics approximately 14% of the homeless group. This group has little income. Many have little education; a significant portion (36 to 67%) have not achieved the equivalent of a high school diploma. Many of these people report themselves as veterans; numbers from forty to almost seventy percent have been cited.

Socially, this population is at the bottom of society's hierarchy. They are considered by many researchers to be grossly undersocialized and alienated from mainstream society. Most are estranged from their families. Approximately half are divorced, a third never married, and it is estimated that almost two-thirds have children. Interestingly, many report being homeless in a cyclic pattern, periodically reestablishing contact with family or friends, thereby "getting off the street." However, most do not have a stable support network outside of the street community. A vast percentage (as high as 92%) reported having been jailed in the past. These people generally have poor occupational or vocational skills, further reducing their chances of improving their state of poverty.

Chronic public inebriates also suffer from an increased number of health problems, especially if there are preexisting disease conditions (i.e. diabetes or high blood pressure). Alcohol is known to exacerbate and intensify health problems in addition to causing them. This is a population that is frequently victimized physically and emotionally as well as socially.
Anchorage's Skid Row Population in 1978:

The Center for Alcohol and Addiction Studies of the University of Alaska Anchorage performed a descriptive analysis of the Skid Row population in downtown Anchorage in 1978. The Center estimated that there were approximately 560 to 700 Skid Row persons residing in Anchorage at the time of the study. Of this number only 90 were considered to be chronic public inebriates.

Overall analysis of the descriptive characteristics of Anchorage's Skid Row population in the 1987 study indicated the existence of lifestyle behaviors generally consistent with other urban Skid Row areas, but with some notable differences. Alcoholism was found to be prevalent, as was a marginal relationship with the larger society. A certain segment of the overall population was composed of working men with relatively regular sources of income. In addition, the population also included those with somewhat more intermittent sources of income, as well as those with no visible means of support.

The 1978 study also reported on employment status and agency utilization. It was concluded that those who were unemployed, abused alcohol, and had poor health utilized significantly more public agency resources. It stated, "those who had neither steady work or unemployment compensation benefits seemed to be the most socially debilitated. They were more likely to sleep on the street, be broke, be in poor health, drink more heavily...and drink on the street". The support system for this population is poor, and the study reasoned that people migrated to the Fourth Avenue area to drink or be with friends. It was even mentioned that this area is considered a "forced alternative for both residence and recreation" for some, such as those who travel to Anchorage for employment to support families who live elsewhere.

There are three notable differences between the findings of the 1978 Anchorage study and the previously cited national which makes the Anchorage Skid Row population unique.

First, Anchorage has a fairly young population compared to other states. The Center for Alcohol and Addiction Studies reported a majority (60.1%) of the CPI population to be between the ages of 26 and 45 and only about 20% were over 45 years old. Second, Anchorage has a significantly higher percentage of women in this group; 19% as opposed to the 8% or less reported by other researchers. The third unique characteristic involves the ethnic mix of Anchorage's Skid Row population. It was reported that in 1978 57% of this population was Native, 40% Caucasian, and 3% Black/Asian. This is quite different from the stereotypical older Black man often depicted in the national media.
Anchorage's Current Public Inebriate Population:

In 1989 and early 1990 at the Salvation Army Diagnostic Screening Center collected a substantial amount of information on Anchorage's public inebriate population (Salvation Army: Diagnostic Screening Center [SADSC], 1990). In this study, initial screening interviews were conducted on 502 clients utilizing sleep-off services. It should be noted that the interviewers rated almost 70% of the individuals to be inebriated at the time of the interview.

<table>
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<th>Characteristic</th>
<th>United States</th>
<th>Anchorage 1978</th>
<th>Anchorage 1989</th>
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<tr>
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<td>32%</td>
<td>40%</td>
<td>29%</td>
</tr>
<tr>
<td>Native</td>
<td>NA</td>
<td>57%</td>
<td>67%</td>
</tr>
<tr>
<td>Black</td>
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<td>3%*</td>
<td>3%</td>
</tr>
<tr>
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<td>Marital Status</td>
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<td>Other</td>
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<tr>
<td>Education</td>
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<tr>
<td>Less Than H.S.</td>
<td>45%</td>
<td>45%</td>
<td>20%</td>
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<tr>
<td>High School</td>
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<td>38%</td>
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<td>Some College</td>
<td>29%</td>
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<td>Veteran</td>
<td></td>
<td></td>
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<tr>
<td>Yes</td>
<td>35%</td>
<td>44%</td>
<td>31%</td>
</tr>
<tr>
<td>No</td>
<td>65%</td>
<td>56%</td>
<td>69%</td>
</tr>
</tbody>
</table>

* Includes Asians

** Nation figures are not available for this age distribution. However, approximately 60% of the Skid Row population in the United States is between the ages of 30 and 60.
The Salvation Army data reveals that some of the characteristics of the public inebriate population has changed substantially since the 1978 study (see Table 1). The ethnic composition shows several changes since 1978. The proportion of whites decreased from approximately 40% to 29% while the proportion of Alaska Natives increased from 57% to 67%. According to Segal (1991), the changes in the ethnic composition of this group is due to a large degree to the economic situation in Alaska over the past few years. The depression caused by the decline in oil prices caused many people to leave the state. This out-migration consisted primarily of transient and seasonal workers, largely white, who tended to frequent the 4th Avenue area when unemployed. On the other hand, Native Alaskans, who are less mobile than the white transients are less likely to leave the state. Native Alaskans are also more likely to seek employment in Anchorage during bad economic times.

The education level of the street population has risen since 1978. The number of those with less than a high school education is down to 20% from 45%. This probably reflects changes in the high school education system, particularly in the Bush, rather than any significant change in the types of persons inhabiting the 4th Avenue area.

The Salvation Army data also revealed fewer numbers of veterans, as well as those divorced or separated, but over half of the new data shows individuals who have never married. On the other hand, the percentage of the public inebriate population who are women is still several times the national average (17% versus 8%).

**Drinking Behavior of Anchorage's Public Inebriate Population:**

Extensive information is available on the drinking habits of the public inebriate as a result of statistics collected by the Salvation Army's Diagnostic Screening Center (DSC). According to an analysis of this data by Dr. Bernie Segal, professor at the University of Alaska, Anchorage, drinking habits varied significantly depending on the demographic characteristics of the individual. In general, males drank more heavily than females as measured by their average Blood Alcohol concentration (BAC). Drinking occurred across all age groups, but those between 25 and 54 years drank most heavily. This level also was prevalent among people between 55 and 64 years but to a lesser extent.

The relationship between ethnicity and alcohol consumption was particularly revealing. All groups had members who drank heavily, but there were proportionately less heavy drinkers among Blacks, Hispanics, Asian-Pacific Islanders and Others. Alaskan Natives and American Indians showed the highest levels of drinking (see figure 1). Based on a Chi Square test of significance, it was concluded that there is a relationship between drinking patterns or levels of alcohol consumption and ethnicity.
Figure 1

ETHNICITY AND BAL WITHIN BAL GROUPS

According to Segal (1991), one factor that may contribute to the excessive drinking behavior of Alaskan Natives, is the urban environment itself. Studies contrasting urban and rural American Indians have found marked differences in drinking behavior between members of these two communities. Urban dwellers were found to drink more heavily and to have a lower rate of abstainers when compared to rural counterparts.

Graves (1971) concluded that the increased drinking behavior among urban American Indians might be explained by the fact "that their preparation for successful, unstressful urban living is far poorer and that heavy drinking is a way of coping with feelings of personal inadequacy and failure by temporarily escaping from them."

Heavy drinking has resulted in Alaska Natives using emergency services at a higher rate that other ethnic groups. Alaska Natives accounted for 67% of the total Community Service Patrol clients in 1989 and 77% of the total pick-ups.

**Public Inebriate Population Estimates**

Exact enumeration of the public inebriate population is extremely difficult due to this group's tendency to move frequently. However, the question of size is a prerequisite for developing estimates of the need for alcohol services.

The report entitled "A Descriptive Analysis of the Downtown Anchorage Skid Row Population", prepared by the Center for Alcohol and Addictions Studies, University of Alaska, Anchorage, estimated that there were approximately 560 to 700 Skid Row persons residing in Anchorage in 1978. Of this number only 90 were considered to be chronic public inebriates.

The number of public inebriates has increased substantially since this earlier study was conducted. It is estimated that 160 to 375 chronic public inebriates currently live in Anchorage. This is an increase of two to three times the number of public inebriates estimated to live in Anchorage in 1978.

The above estimate is based on statistics collected by the Salvation Army Diagnostic Screening Center (DSC). For the purposes of our estimate, chronic public inebriates were defined as those who show up at the DSC more than 10 times during the year with an average Blood Alcohol Concentration (BAC) of 0.1. Any definition of chronic public inebriates based on number of visits to the DSC and average BAC is bound to be arbitrary. However, the above definition is justified to the extent that those who visit the DSC less than 10 times a year are probably either transients passing through Anchorage or binge drinkers who periodically drink to excess. Those that average a BAC of less than 0.1 were considered to be more moderate drinkers who exhibit at least some control over their drinking behavior.
Out of the 1,783 different individuals served at the DSC in 1989, 159 were admitted more than 10 times with an average BAC greater than 0.2 and an additional 215 clients were admitted more than 10 times with a BAC of between 0.1 and 0.2 for a total of 375 public inebriates.

The number of chronic public inebriates serves as a good estimate of the need for emergency alcohol services since they are expected to be the most frequent users. However, most of the public inebriates are expected to use the emergency alcohol care services at least once during the year.

**Location of Public Inebriate Population**

According to the 1989 Community Service Patrol (CSP) logs, approximately half of the public inebriates currently picked up by the patrol are centered around the liquor store on 13th and Gambell. The other half are picked-up on 4th Avenue between A St. and G St. The number of inebriated persons picked-up in the residential neighborhood east of Ingra was surprisingly small considering that the CSP patrols the area on a regular basis. The residential area to the west of the liquor store on Gambell, on the other hand is heavily impacted by public inebriates.

A further investigation of the CSP records revealed that the closure of liquor stores is the most important factor influencing the pattern of the public inebriates pickups. According to the analysis, the closure of the Safeway store on 9th Ave. and Gambell Street in August 1987 was the main impetus for the increased activity of the public inebriates in the area around 13th Ave. and Gambell. Prior to the closure few public inebriates were picked-up in this area. Apparently, their alcohol needs were being met by Safeway and there was little reason to travel the extra 4 blocks to the Oaken Keg Store next to Carrs Grocery Store.

According to testimony provided by Dr. Dennis Kelso to the Mayor's Blue Ribbon Panel on the Public Inebriate, "the closure of package stores in the downtown area has enlarged the area affected by the public inebriate to include the liquor stores on Gambell near 12th and 13th." Dr. Kelso also suggested that the relocation of package stores on Gambell (in Fairview) may modify the pedestrian traffic pattern of the public inebriate.
THE USE AND EFFECTIVENESS OF EXISTING SERVICES

Summary of Alcohol Treatment System

Figure 2 identifies the continuum of care needed to comprehensively deal with the public inebriate problem. These services are functionally related to one another in as much as each component must be in place in order for the system to work effectively. The following paragraphs describe how the system works together. Each service is then described in more detail later in this section.

The Municipality of Anchorage has been funding the Community Service Patrol program for 13 years. The program is designed to pick-up public inebriates who are incapacitated by alcohol and in danger to themselves or others (AS 47.37.170 b).

In order for the CSP to be effective, there must be a place available to drop-off public inebriates who are incapacitated. At the present time the CSP van deposits 69% of their clients at the existing sleep-off (between July 1989 and Feb. 1990).

Clients who have a dangerously high level of alcohol in their body or who may gave other serous medical problems are taken to the hospital for screening or treatment.

Clients are taken to jail to be held for a maximum of 12 hours if they are violent or when no other health facility is available. Clients are usually taken to jail when the sleep-off or detox are at capacity.

The purpose of detoxification is to assist persons who are statutorily incapacitated until they are no longer incapacitated by alcohol as defined by statute and can make a rational decision with regard to their need for treatment.

The detox unit serves as the primary point of entry for those addicted to alcohol, including the public inebriate, into comprehensive treatment and rehabilitation services. While they are at detox, clients are encouraged to enter a long-term treatment program. Without detoxification, public inebriates are not sober enough to make the choice to seek treatment.

The role of detoxification in initiating rehabilitation through referral to long-term care facilities and other social and health care services in the community has been seen as critical (Annis 1979). Without these additional services, the Community Service Patrol and Sleep-off Center would result in an even faster revolving door and more rapid physical deterioration of public inebriates.
Figure 2
Continuum of Alcohol Services

Community Service Patrol

Hospital Jail

Drop-off/Sleep-off

Detoxification

Treatment Programs
Involuntary and Involuntary

Other Treatment Programs

Dual Diagnosis

30-60 Day Residential

Long-Term Care

Transitional Living

Walk-In

No Treatment Bean's BFS Home

Anchorage Police Department
Treatment is the next step in the continuum of alcohol services. It does not do any good to detox someone if there is not enough treatment beds to accommodate those who want to continue into treatment. The Mayor's Blue Ribbon Panel on the Public Inebriate has recommended that a long-term treatment program be established in the Anchorage area. This would not only provide needed bed space but also provide an alternative to the traditional 30 day treatment program for clients who have recently ended a long, heavy drinking binge.

One of the long standing bottlenecks in the continuum of alcohol services is the lack of transition and aftercare facilities. Recovering alcoholics need time to reenter society gradually and build positive relationships without substance abuse. With no place to go treatment clients often return to their old lifestyle.

**Community Service Patrol**

**Description of Existing Program:**

The purpose of the Community Service Patrol program is to protect public inebriates from the elements, victimization, reduce the disruptive impact of the public inebriate on the community.

State law requires persons incapacitated by alcohol be picked up and transported to a safe location such as homes, the sleep-off center, hospitals, Brother Francis Shelter, or Bean's Cafe. The CSP primarily responds to requests for assistance from businesses, the Anchorage Police Department, the Native Medical Center, and the Fire Department. When not engaged in a call, the CSP routinely patrols a core area bounded by 15th street on the south, L Street on the west, Orca Street on the east, and Whitney Road on the north.

Currently, one van is operated 24 hours per day, 365 days a year. There is a minimum of one Emergency Medical Technician I (EMT I) and one driver on duty at all times.

The Municipality of Anchorage has been funding the Community Service Patrol program for 13 years. The program was operated by the Salvation Army for the first 12 years. A new contractor, Allvest, Inc. was selected in July 1989. The current cost of the CSP contract is $325,000 per year.

**Use and Effectiveness of Existing Program:**

The Community Service Patrol picked-up an average of 1,041 persons a month between April 1990 and March 1991. During this time the number of clients picked-up ranged from a high of 1,288 a month to a low of 754 a month.
American Indians and Alaskan Natives constitute the largest percentage of clients served by the CSP (see Table 2). The percentage of Native Alaskan's pick-up by the CSP increased from 77.3% last year to 85% this year. Females represent nearly 19% of the clients and males 81%. Most of the individuals picked-up by the CSP (72%) were between 20 and 45 years old and 28% were over 45.

<table>
<thead>
<tr>
<th>Race</th>
<th>White</th>
<th>Black</th>
<th>Native</th>
<th>Hispanic</th>
<th>Asian</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent</td>
<td>14.0%</td>
<td>0.6%</td>
<td>85.0%</td>
<td>0.2%</td>
<td>0.1%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Table 3 shows that the sleep-off center is the most frequent destination of the Community Service Patrol. Nearly 86% of the clients transported by CSP end up there. The second most frequent destination is the local hospitals.

<table>
<thead>
<tr>
<th>Destination</th>
<th>Sleep-off</th>
<th>Brother Francis Shelter</th>
<th>Hospital</th>
<th>Jail</th>
<th>Beans Cafe</th>
<th>Home</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>10,666</td>
<td>322</td>
<td>962</td>
<td>119</td>
<td>83</td>
<td>291</td>
<td>50</td>
</tr>
<tr>
<td>Percent</td>
<td>85.4%</td>
<td>2.6%</td>
<td>7.7%</td>
<td>1.0%</td>
<td>0.7%</td>
<td>2.3%</td>
<td>0.4%</td>
</tr>
</tbody>
</table>

In August, 1987, the Alaska Supreme Court, in the Busby vs Municipality of Anchorage decision, held that the statute requiring persons incapacitated by alcohol to be taken into protective custody was intended to benefit and protect the health of such persons. The court's decision appeared to support the obligation of law enforcement to place persons in protective custody. The Community Service Patrol relieves the burden placed on local law enforcement by the Busby decision. Without the CSP, local correctional facilities would be severely crowded.
Sleep-off Center

Description of Existing Program:

The Salvation Army has been operating a sleep-off facility on a site adjacent to Brother Francis Shelter since January 1989. Funding for the program was originally provided by a grant from NIAAA under the Steward B. McKinney Homeless Assistance Act. Since the NIAAA funding expired in the fall of 1990, the operation of the sleep-off has been funded by a combination of Municipal and State money.

The present facility was assembled out of five donated modular units formerly used at a pipeline construction camp. It was opened on January 6, 1989 with a temporary building occupancy permit that has since been extended twice. The current permit expires on December 21, 1991.

The existing sleep-off center serves four purposes: 1) as a shelter for persons too inebriated to care for themselves, but not so ill as to require medical treatment, 2) as a shelter to protect public inebriates from the elements and from victimization while intoxicated, 3) as the major entry point into a full continuum of alcohol treatment and rehabilitative services, and 4) as a means to reduce the disruptive impact of the public inebriate on business and the community.

The sleep-off does not provide medical care or detoxification. When inebriated clients have recovered from the effects of intoxication and can reasonably function again, they generally leave the facility.

Some public inebriates arrive at the sleep-off with medical problems or are severely intoxicated. In either case, they require medical attention. These clients are referred to hospital emergency rooms at Providence, Humana or the Alaska Native Hospital.

The operator of the facility is selected through an RFP process. The current yearly operating budget is approximately $350,000 and is funded through a combination of Municipal, Indian Health Service and State Division of Alcohol and Drug Abuse (ADA) revenues.

Use of and Effectiveness of Existing Program:

As a NIAAA research program, an extensive amount of information is available on the sleep-off's operation. (Note: The sleep-off center was originally called the Diagnostic Screening Center or DSC.) During 1989 1,783 individuals (22,544 duplicated) were admitted into the facility and utilization ranged from an average of 95/day in February to 53/day in August.
The majority of the clients entered the facility 10 times or less (accounting for 75.3% of the client entries, see Table 4. and Figure 3.), while close to 3% of the clients came in over 100 times during the year. However, this 3% accounts for approximately 25% of total admissions.

The mean age of sleep-off clients was 37. Alaskan Natives were the heaviest users of the facility both in terms of percentage of individuals (64%) and percentage of entries (76.7%) (see Tables 5 and 6). Males account for 81% of the users and women account for 19% (Figure 4). Over 82% were homeless (Table 7).

The Center for Alcohol and Addiction Studies at the University of Alaska, Anchorage conducted an in-depth survey of over 500 DSC clients between January 1, 1989 and August 31, 1989. The following statistics are derived from their research:

- Over the 8 month period, the average blood alcohol content of clients was 0.185, with a range of 0.005 to 0.505.
- 27% of the clients were transported to the facility by the Community Service Patrol, 5% by the Anchorage Police Department, and 63% were walk-ins. Of these, 73% came in staggering.
- 85% of the clients were intoxicated, 1% were determined to be under the influence of drugs other than alcohol, and 2% were determined to be under the influence of both alcohol and other drugs.
- 84% of the unduplicated count were reportedly homeless, with no claimed residence.

The survey also revealed that almost 60% of those interviewed did not consider Anchorage their home. The homeless statistic is particularly significant because it verifies that a large proportion of people served by the DSC are not Anchorage residents.

The location of the sleep-off at the "campus" site is convenient for a number of reasons. Not only is it close to the core area frequented by the public inebriates but it is adjacent to shelter services which are also utilized by the drunks when they are sober.

According to Table 8, the primary destinations of clients leaving the sleep-off are Brother Francis Shelter and Bean's Cafe. The sleep-off allows these services to more effectively fulfill their purpose. Without the sleep-off or an alternative place to take drunks, Brother Francis Shelter would be unable to function normally due to their tendency to disrupt others who are trying to sleep.
Table 4

Use of DSC By Frequency of Visits

<table>
<thead>
<tr>
<th>Count</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>700</td>
<td>39.2</td>
</tr>
<tr>
<td>213</td>
<td>11.9</td>
</tr>
<tr>
<td>119</td>
<td>6.7</td>
</tr>
<tr>
<td>139</td>
<td>7.8</td>
</tr>
<tr>
<td>173</td>
<td>9.7</td>
</tr>
<tr>
<td>162</td>
<td>9.1</td>
</tr>
<tr>
<td>128</td>
<td>7.2</td>
</tr>
<tr>
<td>103</td>
<td>5.8</td>
</tr>
<tr>
<td>46</td>
<td>2.6</td>
</tr>
</tbody>
</table>

Figure 3

Number of DSC Visits By Percent
January to December, 1989

Source: Salvation Army
CLIENT CHARACTERISTICS

N = 1,783 (Unduplicated)

Table 5

<table>
<thead>
<tr>
<th>Age</th>
<th>Count</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 - 24</td>
<td>200</td>
<td>11.2</td>
</tr>
<tr>
<td>25 - 34</td>
<td>574</td>
<td>32.2</td>
</tr>
<tr>
<td>35 - 44</td>
<td>510</td>
<td>28.6</td>
</tr>
<tr>
<td>45 - 54</td>
<td>260</td>
<td>14.6</td>
</tr>
<tr>
<td>55 - 64</td>
<td>109</td>
<td>6.1</td>
</tr>
<tr>
<td>65+</td>
<td>130</td>
<td>7.3</td>
</tr>
</tbody>
</table>

Total 100.00

Mean Age = 37 years

Table 6

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Count</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alaska Native</td>
<td>1143</td>
<td>64.1</td>
</tr>
<tr>
<td>Caucasian</td>
<td>483</td>
<td>27.1</td>
</tr>
<tr>
<td>American Indian</td>
<td>55</td>
<td>3.1</td>
</tr>
<tr>
<td>Hispanic</td>
<td>22</td>
<td>1.2</td>
</tr>
<tr>
<td>Black</td>
<td>42</td>
<td>2.4</td>
</tr>
<tr>
<td>Asian</td>
<td>2</td>
<td>.1</td>
</tr>
<tr>
<td>Pacific Islander</td>
<td>2</td>
<td>.1</td>
</tr>
<tr>
<td>Other</td>
<td>34</td>
<td>1.9</td>
</tr>
</tbody>
</table>

Total 100.00

Table 7

<table>
<thead>
<tr>
<th>Residential Status (Self-Reported On Entry)</th>
<th>Count</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homeless</td>
<td>1469</td>
<td>82.4</td>
</tr>
<tr>
<td>From out of town</td>
<td>97</td>
<td>5.4</td>
</tr>
<tr>
<td>Rents/Owns</td>
<td>83</td>
<td>4.7</td>
</tr>
<tr>
<td>Staying w/ family</td>
<td>64</td>
<td>3.6</td>
</tr>
<tr>
<td>Staying w/ friends</td>
<td>40</td>
<td>2.2</td>
</tr>
<tr>
<td>From out of State</td>
<td>9</td>
<td>0.5</td>
</tr>
<tr>
<td>Unknown</td>
<td>21</td>
<td>1.2</td>
</tr>
</tbody>
</table>

Total 100.00

Source: Salvation Army
Table 8

<table>
<thead>
<tr>
<th></th>
<th>BFS</th>
<th>Beans</th>
<th>ANS</th>
<th>APD</th>
<th>Street</th>
<th>Detox</th>
<th>Humana</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>3,100</td>
<td>4,272</td>
<td>284</td>
<td>106</td>
<td>3287</td>
<td>117</td>
<td>43</td>
<td>579</td>
</tr>
<tr>
<td>Percent</td>
<td>26.3</td>
<td>36.2</td>
<td>2.4</td>
<td>0.9</td>
<td>27.9</td>
<td>1.0</td>
<td>0.4</td>
<td>5.0</td>
</tr>
</tbody>
</table>

Initially the sleep-off serves as a place for the Community Service Patrol or the Police to drop off public inebriates while they are intoxicated. Others walk in. Once they are sobered up, the public inebriate is then in a position to make a decision regarding detox and treatment.

The operation of the existing sleep-off facility is highly unsatisfactory. Few if any public inebriates are rehabilitated as a result of the current sleep-off center services. According to sleep-off center statistics less than 1 percent of the clients actually end up in a treatment program. The center doesn't even do a very good job of sobering them up since many are released while still technically drunk (the average BAC upon exiting the facility is approximately 0.1).

Many experts in the field believe that sleep-off as it is presently operating makes the public inebriate problem worse by enabling continued drinking. This is because the sleep-off presently allows the inebriate to come and go at will. Thus they are able to use the facility to sleep-off the effects of alcohol and return to drinking. The average length of stay at the sleep-off is 6.5 hours.

The long range plan addresses these problems through the replacement of sleep-off services with an expanded detox and Community Service Patrol. Less seriously intoxicated clients would continue to use homeless shelter services.

Detoxification Services

Description of Existing Detoxification Programs:

The Salvation Army Clitheroe Center Detoxification Unit currently provides acute alcohol detoxification as well as intervention services in a modified medical setting. Staff controls the immediate medical and psychological complications resulting from both an excess of alcohol in the bloodstream and the body's response to withdrawal from repeated overdoses of alcohol. Nurses and technicians monitor the detoxification process and provide medical services as needed 24 hours per day. Licensed Physician's Assistants are on the unit on a daily basis. The PA's perform physical examinations and prescribe medication as necessary and deliver medical services. All medical services are performed in compliance with the sponsoring physician's who is on 24 hour call.
The Detoxification Unit personnel provide brief situational and motivational counseling, crisis referral services and alcoholism and drug abuse education. The unit has 12 available beds for both men and women. The average length of stay is three to five days. A medical screening is required within 24 hours prior to admission to the Detoxification Unit. The screening can be obtained through a private doctor, clinic or hospital emergency room or by the PA on duty at Detox.

All services are based on the client's ability to pay. The Veteran's Administration and some insurance companies will cover the cost of treatment when applicable. The total yearly operating costs will be approximately $450,000 and will be funded through a combination of Municipal, Indian Health Service and State ADA revenues. This unit is small. It has half as many beds as 10 years ago while the population using the services has probably tripled.

**Regional Character of Detox Clients:**

A 1980 study conducted by the Department's Behavioral Health Division showed that only 27% of all clients who used detox services mentioned Anchorage as their place of residence. A more recent analysis of detox client records showed that 75% of all clients were from Anchorage. The difference is likely due to how the question was phrased. While these figures are significantly different, they nonetheless confirm the regional character of Anchorage's alcohol treatment services.

The regional character of the problem was echoed by the participants of the "Mega" meeting, held in Anchorage in October, 1989. The minutes of the meeting contained a proposal to have Native Regional Health Corporations and ANHS to share in the funding responsibilities with the Municipality of Anchorage and the State of Alaska.

**Use and Effectiveness of Existing Program:**

There are differing opinions about how to define success of detoxification programs. Robins (1988) wrote, "The primary reason for existence of a detoxification unit is to help the client safely through an episode of acute intoxication caused by alcohol and the detoxification staff should consider themselves to have been successful when they have safely seen a client through withdrawal."

Another widely used measure of detox success is the rate of referral to treatment facilities. Sparadeo et al. (1982) stated that the only appropriate measure of the success of detox services is referral rate. This statement is justified given that detox serves as the primary point of entry for those addicted to alcohol, including the public inebriate, into the continuum of comprehensive treatment and rehabilitation services. When public inebriates have sobered up enough to
leave the sleep-off Center, they may do so. However, while they are at the detox center, clients are encouraged to enter a long-term treatment program. Without detox services public inebriates are not sober enough to make the choice to seek treatment.

Using either definition to evaluate most programs can be discouraging. Authors report referral rates from 8-100% (Annis, 1979; Finn, 1985; McCarty et al., 1987: Sadd & Young, 1987; Shandler & Shipley, 1987), but only about one third who are referred actually present for treatment (Smart, Gray, Finley, & Carpen, 1977). In addition, less than 50% of those who enter treatment actually finish their program (Finn, 1985). A similar success rate was found in Anchorage (Segal 1991).

A significant proportion of resources are being drained by a small number of repeat detox clients. Richman and Neumann (1984) reported that 47% of clients comprised 24% of the readmits. Eleven Percent (11%) of clients used 40% of the detox bed days according to McCarty et al. (1987), and Annis (1979) reported a 70% readmission rate within two years.

The Salvation Army reports similar recidivism rates in their detox program. According to a survey conducted by the Salvation Army in 1989, 57% of those individuals who entered the Clitheroe's detox program had previously entered the detox program sometime during their drinking careers.

Sparadeo et al. (1982) found that those referred by police, those with higher blood alcohol levels (BAC), and older clients with only one detox admission were less likely to accept referral. On subsequent admissions, however, neither referral source nor BAC affected acceptance. Also of interest is an increased tendency among those detoxed two to five times to accept referrals (Sparadeo et al., 1982) and that a longer detox tended to increase referrals.

It appears from the above data that a short stay in a detox center not would, in itself, have any lasting effect on the majority of chronic alcoholics. Therefore, in order for detox to have any lasting effect, it is important that the client remain at the facility for as long as the State of Alaska protective custody laws permit.

**Effect of Defunding Detox**

The Municipality of Anchorage had been funding the Detoxification services through the Salvation Army since the mid 1970's. In June 1989, the Department of Health and Human Services announced the termination of local detox funding due to a substantial decline in available local revenues and state law requiring the state to pay for these services (AS 47.37.130). As a result of the withdrawal of local funding detox was not available for a six month period from July to December 1989.
In order to assess the impact from the closure of detox, the Municipal Health and Human Services Department entered into a contract with the University of Alaska's Center for Alcohol and Addiction Studies. The resulting study sheds some light on the need for detox and its role in the overall alcohol treatment system. It should be noted, however, that data from the Alaska Native Hospital was not analyzed even though it was the only one most likely to be impacted.

In summary, the impact of the elimination of detoxification services has had the following effects:

1. There was no significant difference in the number of admittance or BAC of those using the DSC before and after the elimination of Detox funding.

2. No change in the number of referrals from DSC to Humana and Providence Hospitals

3. No change in APD calls.

4. An increase in the number of CSP transports to hospitals was noted for July, 1989.

5. The time spent by the Providence Hospital ER with alcohol-related cases increased from an average of 1.7 hrs. per case in June to 3.6 hrs. for July and August.

The most significant finding involves the increase in the length of time spent by hospital emergency rooms treating alcohol related cases. According to emergency room staff, these increased service demands (the number of public inebriates seen and the amount of time each one spent in the ER) reduced the amount of available resources for routine emergencies.

Another important impact resulting from the withdrawal of detox services involved the number of referrals to the treatment facilities. According to data obtained from the State of Alaska Division of Alcohol and Drug Abuse (ADA) Management Information System, the lack of detox apparently caused a significant decrease in the number of admittances in the Salvation Army Intermediate Care Unit which can be directly attributable to the lack of referrals from the detox unit (see Table 9). The intermediate care unit experienced a 29% drop in clients after detox funding was cut. The reflection programs experienced a similar 31% decrease in the number of clients served.
Table 9
1989 Client Summary
Salvation Army Residential Treatment Program

<table>
<thead>
<tr>
<th></th>
<th>Detox Jan-June</th>
<th>No Detox July-Dec</th>
<th>Difference</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intermediate</td>
<td>296</td>
<td>211</td>
<td>85</td>
<td>-28.7%</td>
</tr>
<tr>
<td>Reflections</td>
<td>137</td>
<td>95</td>
<td>42</td>
<td>-30.7%</td>
</tr>
<tr>
<td>Total</td>
<td>433</td>
<td>306</td>
<td>127</td>
<td>-29.3%</td>
</tr>
</tbody>
</table>

Detox is a major referral source for the Salvation Army treatment programs. During the period Jan. to July 1989 the Salvation Army Detox unit referred 74 clients to the Intermediate Care Unit. This represented approximately 25% of the total number of Intermediate Care Unit clients during this period. The Detox unit also referred 25 or 18% of the total number of clients treated in the Reflections program.

The number of intermediate and long term treatment clients referred from the Salvation Army Detox Unit represent a significant proportion of the clients served by the treatment programs.

The above finding corroborates public testimony received by the Mayor's Blue Ribbon Panel on the Public Inebriate that stated that detoxification is the first step in the rehabilitation of public inebriates. Treatment cannot begin until the alcoholic has been successfully detoxified. During the detox process, the client is motivated and counselled to receive needed treatment.

**Estimated Need for Detoxification Services:**

Three different methods were used to estimate the number of publicly funded detox beds required by a regional alcohol treatment system:

The NIAAA method is based on the estimated number of persons suffering from alcohol addition.

The application of the San Diego model of sleep-off and detoxification services assumes a minimal approach with services available only to those who choose to enter treatment.

Historical Anchorage detox beds present a picture of the bed need prior to the growth of private sector detoxification services.
NIAAA Method

A formula developed by the National Institute on Alcohol Abuse and Alcoholism (NIAAA), Special Project Branch, estimates that a total of 18.5 publicly funded detox beds will be needed in Anchorage in 1990. This figure was calculated based on the following premises:

- that 10% of Anchorage residents (23,000) are alcoholics (per an estimate from ADA);
- that 12% or 2,760 of those alcoholics will seek treatment at some time during the year (per the NIAAA);
- that 60% of those seeking treatment (1,656) will need detox services for an average of 4 days (per the NIAAA);
- that 6,624 detox bed days or 18.15 beds (6,624/365) will be needed in Anchorage;
- that there is an 85% occupancy rate for detox beds (per the NIAAA);
- that one-fourth of all clients using publicly funded detox services are from outside of Anchorage;

The San Diego Model

Detox services in San Diego are available to those alcoholics who express a strong need to seek treatment. Their program provides 16 publicly funded detox beds for a population of about 1,000,000. This would translate to 4 beds for Anchorage's population of 218,000. This method does not include the impact of non-Anchorage clients on local detox services.

Anchorage Historical Data

The Salvation Army Detox Unit is the primary provider of detox services to low income persons in Anchorage. Based on Salvation Army records dating back to 1984, 7,536 cases were seen up to the end of 1988, averaging three to five days. During this time frame an average of 1,256 cases a year were admitted, which corresponds to an average of 105 cases per month.

For the past few years, Anchorage has maintained 10 modified medical detox beds in a social setting at Point Woronzof funded by the Municipality of Anchorage.
Table 10
Summary of Detox Bed Need Calculations

<table>
<thead>
<tr>
<th>Method</th>
<th>Total Beds</th>
<th>Private Beds</th>
<th>Publicly Funded</th>
</tr>
</thead>
<tbody>
<tr>
<td>NIAAA</td>
<td>28.5</td>
<td>10</td>
<td>18.5</td>
</tr>
<tr>
<td>San Diego</td>
<td>NA</td>
<td>NA</td>
<td>4</td>
</tr>
<tr>
<td>Historical</td>
<td>NA</td>
<td>NA</td>
<td>10*</td>
</tr>
<tr>
<td>Estimated Need (Voluntary Admits Only)</td>
<td>18.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated Need (Involuntary plus Voluntary)</td>
<td>30</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Approximately two and one half beds have historically been funded by the Veteran's Administration (VA).

Since the Municipality intends to utilize protective custody, the high estimate of 30 detox beds should be used. This may be an underestimate since the NIAAA methodology used to arrive at it is based on a nationwide alcoholism rate and the Municipality of Anchorage has one of the highest incidences of alcoholism in the country.

Social vs Medical Detoxification:

According to Sadd and Young (1987), the medical model is utilized by approximately two-thirds of the detoxification programs operating in the United States. This model includes extensive use of physicians, nurses, and psychiatric personnel. It also utilizes medications to relieve the symptoms of withdrawal. Average length of stay in a medical detox program ranged from 1 to 15 days (Finn, 1985; Hayashida et al., 1989; Sparadeo et al., 1982).

Studies cited by the Finn (1985) and Sadd and Young (1987), which evaluated rates of completion of medical model detoxification programs focusing on the chronic public inebriate, reported very low results. This type of program is the most expensive of the different options to operate, and can be from two to ten times as expensive as the social settings model (discussed below), according to Hayashida et al. (1989), McCarty, Mulligan, and Argeriou (1987) and Sparadeo et al. (1982).

The medical model detox has several advantages which at least partially offset the above problems. First, it may be more humane since it relieves the pain associated with detoxification. Second, it is easier to encourage voluntary detoxification if a medical model is available. Third, medications provided through the medical model may prevent seizures and brain damage.

Social setting detoxification programs concentrate on providing supportive care, instead of administering medication to assist the client through the withdrawal period. It also emphasizes counseling and client safety. Most social detox programs are near or affiliated with a hospital or other emergency medical
care in case a client should require admission. Naranjo et al. (1983) stated that 85% of clients can be safely detoxified without drugs, and the "standardized supportive care used by us can be applied in a variety of clinical settings with minimal medical supervision," and "is feasible in routine nursing care." Other studies reported significantly lower percentages of clients requiring hospitalization, ranging from 1.4 to 5% (Hayashida et al., 1989; Richman & Neumann, 1984; Shandler & Shipley, 1987; Sparadeo et al., 1982; Whitfield et al., 1987). The average length of stay ranged from two to eight days. All references confirmed that social detox is much cheaper to operate than the medical type.

Modified medical, outpatient, and partial inpatient are three other types of detox. Modified medical is simply a combination between medical and social detox. The Salvation Army currently operates such a detox program at Pt. Woronzof.

Outpatient programs provide care at scheduled visits between the client and counselor. The treatment may be social in focus or medical, and may have group as well as individual alcohol counseling. The partial inpatient model requires the client to attend the program all day during the week, and go home at night. It is felt that none of these options would be appropriate to the chronic public inebriate population because of a lack of housing and the poor compliance record demonstrated by this population.

In conclusion, social detox has a major advantage over medical detox in terms of lower costs. Sadd & Young (1987) also reported a tendency for socially detoxed clients to commit to higher levels of treatment (i.e. long-term versus only Alcoholics Anonymous). Nevertheless, modified medical detox is still needed for an important segment of the public inebriate population.

**Treatment Programs**

**Description of Existing Programs:**

**Salvation Army Intermediate Care Unit**

The Salvation Army currently operates a 26 bed Intermediate Care Unit at Pt. Woronzof. This facility offers a four to eight week residential alcoholism and drug abuse treatment program. The highly structured treatment program offers individual and group counseling with an emphasis on skill-building, problem solving and the development of long-term support. Groups and classes in addiction, stress management, problem solving and the development of long-term support. Groups and classes in addiction, stress management, problem solving, grief resolution and self-awareness are provided. Alcoholics Anonymous meetings are held in-house several times per week.
Clients are expected to participate in all structured activities. This includes four and one half hours of group work and three hours of classes per day as well as individual counseling sessions. The client is required to attend six AA meetings per week. It is also expected that the client will work through the first five steps of the AA step process.

The SACC treatment philosophy asserts that short-term residential care is only the first part of a client's progress towards long-term sobriety. All clients who complete the ICU treatment program are referred to continued treatment either in continued residential care or on an outpatient basis. Clients are referred to the Transitional Care Unit, the Outpatient Unit, or Aftercare counseling.

**Salvation Army Extended Track Program**

The Salvation Army used to operate a 12 bed extended care track program for the chronic alcoholic with psychosis. In 1990, this was converted to a program for alcoholics with chronic mental illness. Depending on individual client needs, the program varies from three to six months. This program provides treatment services to those for whom short term residential or outpatient treatment has proven to be unsuccessful.

The treatment program is based on the treatment structure of the Intermediate Care Unit; however, due to the longer treatment time, programming is more comprehensive. Special emphasis is placed on learning and practicing sober living skills, cross-cultural issues, and learning from past failures at treatment. A grant from the Federal Office for Treatment Improvement provides additional mental health counseling and intensive case management.

Upon completion of the Extended Care Track all clients are referred to aftercare in order that their treatment advances and sobriety be maintained.

**Salvation Army Reflections: Residential Treatment for Women**

Reflections is a specialized residential treatment program for women who are experiencing problems with alcohol and other drugs. It is a 28 day program with 12 beds and special accommodations so the small children can accompany their mother when necessary.

The intensive 28 day program consists of individual counseling, therapy groups and educational groups. Narcotics Anonymous and Alcoholics Anonymous meetings are held in-house weekly. Counseling emphasizes the stressors inherent in the role of the modern woman and how those stressors and role expectations can reinforce her negative coping behaviors such as substance abuse and other unhealthy dependencies.
After completion of the Reflections program the client may continue her treatment in aftercare at the Outpatient component.

The Alaska Native Alcoholism Recovery Center

The Alaska Native Alcoholism Recovery Center, operated by the Cook Inlet Tribal Council, provides a 26 bed intermediate residential treatment facility and aftercare services. Not all of the beds are available for the treatment of low-income public inebriates, however, since only 12 out of the 26 beds are funded by the State Division of Alcoholism. The facility is located in the Mountain View area of Anchorage but serves the entire State.

The target group is composed of Native alcoholics, alcohol abusers, and drug abusers who are in need of and will benefit from ANARC's 60- to 90- day residential program, followed by a long-term program of aftercare outpatient counseling.

Salvation Army Outpatient Counseling Unit

The Salvation Army Outpatient Counseling Unit is a treatment program for individuals with alcohol and/or drug related problems. This component is designed for clients who are unable to attend residential treatment or whose treatment does not require intensive residential treatment.

Treatment usually consists of individual and group counseling sessions. Group sessions include therapy and educational groups.

This treatment method is usually not appropriate for homeless public inebriates who can not be relied on to attend outpatient counseling sessions.

Nugen's Ranch

Nugen's Ranch is currently the only long-term alcohol treatment program available in the southcentral area. It provides inpatient treatment for the revolving door chronic alcoholic in a work farm setting. Treatment generally last from 6 months to two years.

This facility has a capacity of up to 38 beds.

Akeela House

Akeela House is a 43-bed long-term treatment program which uses the therapeutic community treatment modality within which to provide services. The majority of Akeela House clients are polydrug users although approximately 20% cite alcohol as their primary problem.
Most of the Akeela House clients have reached a state in which their social and psychological health have been drastically impaired or destroyed through addiction. Clients enter the Akeela House treatment program voluntarily, from the criminal justice system, or through referral from other agencies and treatment programs throughout Alaska. Like other traditional therapeutic communities, treatment at Akeela House is phasal in nature and ranges from as few as three months to as long as eighteen months. A client first enters Candidacy, lasting for 14 to 21 days, then advances to Intermediate (Primary) Residential Care for up to seven months. Aftercare services are provided for those determined ready to begin more intense contact with the larger community and may last up to six months.

**Use and Effectiveness of Treatment Programs:**

Research has been generally pessimistic about the potential for successful rehabilitation of the homeless alcoholic (Shiply et al., 1989). According to Riley et al. (1987), "treatments for alcohol programs with demonstrated enduring effectiveness do not exist, regardless of treatment orientations or treatment goals." This opinion was supported by the findings of Smart et al. (1977), who found no significant difference among halfway houses, farms, or nonresident programs, and program completers showed no improvement over non-completers. Smart et al. (1977) cited that only about 20% of clients improve after treatment, and that there is no difference in recidivism rates among programs.

According to Breakey (1987) lack of success in the long-term treatment of public inebriates is attributable to the following factors:

a. the distrust of authority and disenchantment with service providers,

b. a transient population who fail to keep appointments and who turn up unexpectedly,

c. complicated cases which involve a multiplicity of needs, and

d. the obstacles provided by alcohol abuse and dependency.

Some of the factors identified with "success" or improved functioning were: drinking behavior; legal involvement; vocational, social/interpersonal, emotional, and physiologic functioning (Daley, 1989; Malla, 1987; Ornstein & Cherepon, 1985; Pomerleau & Adkins, 1980). Polev, Lea, and Vibe (1979) wrote, "Positive treatment outcome is associated with marital and occupational stability, higher socioeconomic status, higher IQ and better education, social skill, later onset of heavy drinking, no court convictions, fewer prior treatment..."
involvements, level of motivation, and length of abstinence in the year prior to treatment. Conversely, negative outcome is associated with lower socioeconomic class, social isolation, occupational and marital instability, poor motivation, history of dropping out of treatment, severity of illness, arrest history, and psychopathy."

Homeless patients are particularly treatment resistant. The reality of the situation is that the prognosis is often extremely poor especially for the chronic public inebriate population (Breakey, 1987). Robins (1988) reported a 13 to 40% dropout rate.

A recent study conducted by UAA professor Bernie Segal analyzed the success rate of the Salvation Army Intermediate Care Unit. Of a total of 65 cases, 50.8% completed the 28 day program with a third of these cases referred to an aftercare program (either outpatient treatment or to a VA counselor).

Of course, completion of a treatment program does not mean that the client will automatically achieve long-term sobriety. The best measurement of the effectiveness of a program is the percent of clients who remain sober after treatment. According to the Salvation Army approximately 50% of the clients who complete its alcohol treatment programs are sober after 6 months.

Testimony received at public hearings conducted by the Blue Ribbon Panel from the criminal justice system and alcohol treatment providers suggests that there exists a significant shortage of alcohol treatment facilities in Anchorage.

There is currently a 1-5 month waiting period for entry into the Salvation Army Intermediate Care Unit depending on the emergency nature of the referral. A total of 84 persons were on the waiting list as of April 1991.

Persons desiring to enter the Reflections program must currently wait 1-2 months although the wait has been as long as 4-6 months in the past. A total of 11 persons were on the waiting list as of April 1991.

There is currently a 2-3 month waiting period for applicants to the program operated by the Alaska Native Alcoholism Recovery Center with between 20-25 persons on the active waiting list.

**Transitional Care**

**Description of Existing Programs:**

**Salvation Army Transitional Care Unit**

The Salvation Army Transitional Care Unit is the "half-way house" component of the Salvation Army clitheroe Center (SACC). Currently 20 beds are provided.
The primary treatment program of the unit is the delivery of supportive services. The purpose of the TCU is to provide safe and supportive environments for the client while he or she begins the process of reintegration into the community. While clients are attending TCU it is expected that they will be either employed or seeking employment. The clients are expected to do their own cooking and house cleaning, as well as participate in weekly group therapy sessions, SACC Outpatient Counseling and Alcoholics Anonymous meetings.

New Dawn

The Alaska Women's Resource Center's New Dawn Program is a ten bed Halfway House for women recovering from drug and/or alcohol abuse. They provide long-term aftercare for women who have completed treatment programs such as Reflections at the Salvation Army or other short term treatment programs. Women can live at New Dawn for up to a year while they learn how to deal with the devastation that substance abuse has caused in their lives. The safe, supportive, structured environment allows women to maintain their treatment gains, develop a drug free lifestyle, improve birth outcomes for their children, reduce the negative impact of maternal drug/alcohol use, and improve parenting skills for the attainment of a healthy positive family unit.

Services include information and referral, crisis intervention, group and individual counseling, abuse victim support, job readiness though the Career Options Program, health information and counseling, pregnancy and health education, career and confidence development clinics, and alcohol treatment.

The Use and Effectiveness of Existing Programs:

Alcoholism is one of many problems experienced by chronic public inebriates. A hierarchy of needs beginning with food, clothing, shelter, and medical care was cited by several authors as more important (at least initially) than alcoholism therapy (Robins, 1988; Shandler & Shipley, 1987). Another study (Breakey, 1987) identified the following needs of the public inebriate: affordable housing, financial assistance, employment, recreation and social activities, food, alcoholism treatment, supportive counseling, money management, interpersonal skills, and storage for possessions).

Many of the needs identified in the national studies mentioned above were also identified as important by Anchorage's public inebriate population. In the study conducted by the Center for Alcohol and Addiction Studies (1978) public inebriates reported desiring help with food, clothing and jobs.
In order to fully rehabilitated and integrated public inebriates into the larger community other problems besides alcoholism must be addressed. Halfway houses, which provide alcoholics with the skills and information needed to cope with these other problems are, therefore, an important component of the alcohol treatment system.

There are only two publicly funded halfway houses for alcoholics operating in Anchorage at the present time. The New Dawn Program is the only halfway house specifically design for women in Alaska. In FY90, New Dawn provided services to 30 women, 20 of whom were mothers; during this period 14 children lived at New Dawn with their mothers. Most of the women and children utilizing the facility are homeless and poor. 40% of the residents are Alaska Natives. The waiting list is between eight to twelve weeks.

There is currently no waiting list at the Salvation Army Transitional Care Unit.
ADDITIONAL SERVICES REQUIRED

Methods of Increasing Entry Into Treatment

The Mayor's Blue Ribbon Panel on the Public Inebriate concluded that additional effort needs to be focused on increasing the number of public inebriates who enter treatment.

There are a number of alternatives which may be used to attain this objective. Table 11 shows the involvement with the legal system of all those admitted to a state funded alcohol program in fiscal year 1988 and 1989. The table suggests that 37% to 39% of all those admitted to state funded alcohol programs had no involvement with the criminal justice system. Of those who did, the largest proportion are there as a condition of probation or parole (31.6% in both years). Involuntary commitment accounts for a surprisingly small proportion of all admissions, 155 in 1988, 145 in 1989.

Table 11
Admissions to State Funded Alcohol Treatment Programs
By Legal Status, 1988–1989

<table>
<thead>
<tr>
<th>Legal Status</th>
<th>1988</th>
<th>1989</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Pct</td>
</tr>
<tr>
<td>No Involvement</td>
<td>3,870</td>
<td>36.8</td>
</tr>
<tr>
<td>Referred Prosecution</td>
<td>258</td>
<td>2.5</td>
</tr>
<tr>
<td>Deferred Sentence</td>
<td>375</td>
<td>3.6</td>
</tr>
<tr>
<td>Probation/Parole</td>
<td>3,319</td>
<td>31.6</td>
</tr>
<tr>
<td>Involuntary Commitment</td>
<td>155</td>
<td>1.5</td>
</tr>
<tr>
<td>Furlough</td>
<td>1,106</td>
<td>10.5</td>
</tr>
<tr>
<td>Other</td>
<td>172</td>
<td>1.6</td>
</tr>
<tr>
<td>Unknown</td>
<td>1,255</td>
<td>11.9</td>
</tr>
<tr>
<td>Total</td>
<td>10,510</td>
<td>100%</td>
</tr>
</tbody>
</table>

Public inebriates are most likely to utilize involuntary commitment to enter treatment. As a result, the majority of this section will focus on this alternative.

Involuntary Custody and Commitment:

State law permits persons to be placed in protective custody while incapacitated if they are a danger to themselves or others (AS 47.37.170). However, this law only allows the person to be held in protective custody for a maximum of 48 hours. Testimony received by the Blue Ribbon Panel suggests that public inebriates or chronic alcoholics need to be sober for at least 3 to 5 days in order to detoxify and be capable of making reasoned decisions regarding long-term alcohol treatment or rehabilitation. Thus, in order to make protective custody an effective alcohol treatment tool, the time period for protective custody needs to be lengthened.
The Panel also supports legislative action amending AS 47.37.180, the involuntary commitment law for alcoholics. The law needs to be streamlined to make it more workable for communities in their efforts to place public inebriates into treatment facilities.

Constitutional due process requirements will prevent substantial streamlining of the law. Still, some steps can be taken to remove unnecessary obstacles such as extending the time period for a doctor's certificate and allowing the doctor to testify by phone.

In addition, State law should be modified to provide legal assistance to family members of an alcoholic needing commitment and are unable to afford it.

Some of the pros and cons regarding involuntary commitment include:

a. ACLU suggests that least restrictive alternatives should be tried first, and that civil commitment, if used, must be balanced against the public inebriate's civil rights of privacy, liberty and due process.

b. Some people assert that drunk only benefit from treatment when they are ready to enter it. They believe involuntary commitment is ineffective if the client is not ready to enter treatment, resulting in low success rates.

c. The involuntary civil commitment procedure is more expensive than voluntarily entering treatment but is probably the least expensive way to require treatment.

d. Involuntary commitment will only work if there are enough residential beds to meet the demand.

Deferred Prosecution, Deferred Sentencing, Probation, and Furlough:

Besides involuntary commitment, five other tools are available to increase the number of public inebriates who entry treatment.

1. Deferred prosecution can be used when an individual commits a crime, the individual is caught and the facts are clear to everyone including the offender. Following an arrest by a police officer a municipal or state prosecutor offers treatment in lieu of prosecution. Crimes are typically minor.
2. **Deferred sentencing** requires a trial either before a magistrate or a jury and conviction. The offender can either be convicted, plead guilty, or not contest the allegation. The judge may withhold sentence as part of a plea agreement pending the successful outcome of treatment.

3. **Probation** allows a person who has gone to trial and who has been convicted of a criminal offense to live in the community under supervised conditions. The court imposes a sentence which does not involve confinement. Persons involved in probationary action often have committed important criminal offenses related to their alcohol problem, but not so serious as to mandate confinement as a form of punishment.

4. **Parole** applies to cases where the court imposes a sentence which does involve confinement. The status of the offender is changed from "in custody" to "on parole" when (and if) the state's parole board decides that the offender merits release back into the community. There has been a demonstrated severe history of drinking abuse which warranted the initial confinement. The offender has been rehabilitated to the point that a return to the community will not risk a return to substance abuse.

5. **Furlough** involves cases where an individual is convicted of a crime and is sentenced to jail. Alcohol treatment can occur while in jail, either in the facility or at a treatment center off-site.

According to the Anchorage Police Department, public inebriates often commit a variety of crimes including tresspassing, disorderly conduct, indecent exposure, and liquor violations (see Table 12). As a result, it is possible to utilize the court system in order to require public inebriates to seek the help that they need. Since most of the crimes committed by public inebriates involve misdemeanors, deferred prosecution and deferred sentencing are probably the most effective with respect to increasing the number of public inebriates in treatment. Probation, parole, and furloughs are not appropriate solutions to the public inebriate problem since they primarily apply to more serious crimes.
Table 12
Alcohol Related Crimes - 1988

<table>
<thead>
<tr>
<th>Offenses</th>
<th>No. of Offenses</th>
<th>% of Total</th>
<th>Cost to APD</th>
<th>Percent Alcohol</th>
<th>Related to Alcohol</th>
</tr>
</thead>
<tbody>
<tr>
<td>Property</td>
<td>10,591</td>
<td>17.7%</td>
<td>$6,533,203</td>
<td>14%</td>
<td>$914,648</td>
</tr>
<tr>
<td>Sex Offenses</td>
<td>333</td>
<td>0.6%</td>
<td>221,465</td>
<td>29%</td>
<td>64,225</td>
</tr>
<tr>
<td>Indecent Exposure</td>
<td>136</td>
<td>0.2%</td>
<td>73,822</td>
<td>29%</td>
<td>21,408</td>
</tr>
<tr>
<td>Liquor Misc.</td>
<td>30</td>
<td>0.05%</td>
<td>18,455</td>
<td>100%</td>
<td>18,455</td>
</tr>
<tr>
<td>Liquor-Minors</td>
<td>70</td>
<td>0.1%</td>
<td>36,910</td>
<td>100%</td>
<td>36,910</td>
</tr>
<tr>
<td>Drunkenness</td>
<td>1,162</td>
<td>1.9%</td>
<td>701,304</td>
<td>100%</td>
<td>701,304</td>
</tr>
<tr>
<td>Disorderly Conduct</td>
<td>4,516</td>
<td>7.5%</td>
<td>2,768,306</td>
<td>100%</td>
<td>2,768,306</td>
</tr>
<tr>
<td>Disturbance (Family)</td>
<td>1,355</td>
<td>2.3%</td>
<td>848,947</td>
<td>48%</td>
<td>407,495</td>
</tr>
<tr>
<td>Detox</td>
<td>772</td>
<td>1.3%</td>
<td>479,840</td>
<td>100%</td>
<td>479,840</td>
</tr>
<tr>
<td>Child Abuse</td>
<td>351</td>
<td>0.6%</td>
<td>221,465</td>
<td>40%</td>
<td>88,586</td>
</tr>
<tr>
<td>Suicides</td>
<td>27</td>
<td>0.05%</td>
<td>18,455</td>
<td>64%</td>
<td>11,811</td>
</tr>
<tr>
<td>Suicides Attempted</td>
<td>148</td>
<td>0.2%</td>
<td>73,822</td>
<td>64%</td>
<td>47,246</td>
</tr>
<tr>
<td>Vandalism</td>
<td>2,560</td>
<td>4.3%</td>
<td>1,587,162</td>
<td>25%</td>
<td>396,790</td>
</tr>
<tr>
<td>Non-Criminal Commits</td>
<td>1,574</td>
<td>2.6%</td>
<td>959,680</td>
<td>100%</td>
<td>959,680</td>
</tr>
<tr>
<td>Accidents</td>
<td>7,649</td>
<td>12.8%</td>
<td>4,724,576</td>
<td>10%</td>
<td>472,458</td>
</tr>
<tr>
<td>Tresspassing</td>
<td>807</td>
<td>1.3%</td>
<td>479,840</td>
<td>20%</td>
<td>95,968</td>
</tr>
<tr>
<td>DWI</td>
<td>709</td>
<td>1.2%</td>
<td>442,929</td>
<td>100%</td>
<td>442,929</td>
</tr>
<tr>
<td>Total*</td>
<td>59,826</td>
<td></td>
<td>$7,928,059</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Total offenses in 1988 other than homicide, forcible rape, and aggravated assault.

Source: Anchorage Police Department.


Drop-off/Triage Center

The Drop-off/Triage Center is the lowest priority among the recommendations for expanded alcohol services. This partly reflects the hope that the expanded detox and Community Service Patrol will take care of the emergency alcohol services needs of the public inebriates.

The primary difference between the Drop-Off/Triage Center and the Sleep-off Center which it replaces is that there are no beds at the Drop-off/Triage Center. It is only meant to serve as a short-term, usually not more than four hours, holding facility to permit efficient transportation to the 48 hour medical stabilization unit.
The idea of a drop-off/triage center in the downtown area is not new. One of the original recommendations proposed by the Mayor's Blue Ribbon Panel on the Public Inebriate included a suggestion that public inebriates be dropped off at a centralized drop-off/triage center near the Brother Francis Shelter and wait there for transportation to a longer term holding center Medical Stabilization Unit at Pt. Woronzof.

The Drop-off/Triage Center will also be operated 24 hours a day and will be located at either the current "campus" site or on the site of the 7th Avenue jail. The "campus" location would require a new building probably constructed on the same portion of the site as the proposed sleep-off center. The 7th Avenue site would utilize existing space currently used to store Municipal records.

A physician's assistant or nurse would screen the clients at the facility to ensure that the patient was not in any physical danger prior to transportation to Pt. Woronzof.

Expanded Detox and Community Service Patrol

The expansion of the Detox Unit from 10 to 30 beds would work in tandem with the expanded Community Service Patrol to replace the existing Sleep-off Center. In order to move the sleep-off to Pt. Woronzof, an additional van will be needed to transport public inebriates to the expanded detox facility. The extra van is needed in order to maintain continuous coverage of the Core Skid Row area while the other van makes the 40 minute round trip to Pt. Woronzof.

Evaluation of Expanded Detox Unit Option:

In order to adequately evaluate the Sleep-off versus Detox/CSP options the objectives of the program must be clearly stated. The following objectives have been at one time or another adopted by either the Municipal staff or the Mayor's Blue Ribbon Panel. The objectives are followed by a discussion of how well each option meets them.

Objective #1: Protect public inebriates from harm to themselves and others.

This represents the minimum humanitarian objective of the sleep-off center. Meeting this objective also helps the city to avoid lawsuits.

The primary drawback to using the Detox/CSP option is that potential sleep-off clients are not likely to voluntarily go to the sleep-off center. Users want to continue their drinking activity. A trip to Pt. Woronzof will disrupt that pattern. Public inebriates may attempt to avoid the community service patrol and resist getting into the van.
As a consequence, the Drop-off/MSU option would not meet this objective as well as the current Sleep-off site which allows public inebriates to come and go at will. However, since sleep-off is available the likelihood of a civil suit is diminished.

**Objective #2: Reduce the impact of public inebriates on the Downtown businesses and the Fairview and South Addition communities.**

This objective is met by getting as many drunks as possible off the streets for as long as possible. This could be met by keeping a lot of drunks off the street for a short period of time or by keeping fewer number of drunks off the street for a longer period of time.

Holding public inebriates at Pt. Woronzof will have a net positive effect on Downtown businesses or nearby communities. The present facility operates at only 57 percent capacity even though it is usually at capacity every night. This is because it is almost empty during the day. By adding 20 more beds to the Detox facility at Pt. Woronzof, an average of 11.8% more people would be removed from the community because it will be full most of the day and night. Thus, the decrease in the number of public inebriates held (from 100 to 20 per night) is more than compensated by the increase in the length of time they are held (from 6.5 hours to more than 24 hours).

**Table 13**

**Sleep-off Bed Utilization**

<table>
<thead>
<tr>
<th>Length of Stay</th>
<th>Occupancy Rate</th>
<th># of Beds</th>
<th>Actual Bed Utilization</th>
<th>% Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leave at Will (Present Policy)</td>
<td>57% *</td>
<td>30</td>
<td>17</td>
<td>-</td>
</tr>
<tr>
<td>24 hr. Hold</td>
<td>90% **</td>
<td>20</td>
<td>18</td>
<td>+5.8%</td>
</tr>
<tr>
<td>48 hr. Hold</td>
<td>95% **</td>
<td>20</td>
<td>19</td>
<td>+11.8%</td>
</tr>
</tbody>
</table>

* Based on 1989 Sleep-off Center data.  
** Estimated, assumes fewer will use a program which interrupts their drinking activity.

**Objective #3: Increase the number of public inebriates undergoing treatment.**

The sleep-off facility should be a means of referral for alcohol treatment facilities. Otherwise it is nothing more than a drunk hotel.
As previously mentioned, the present system result in only a 1 percent referral rate. The advantage of transporting public inebriates to Pt. Woronzof is that clients currently undergoing treatment could be used to motivate those at the sleep-off facility to enter treatment. This interaction is not practical at other locations.

**Objective #4: Minimize operating and capital cost.**

The cost of operating the existing 30 bed Sleep-off Center is approximately equal to the cost of operating the expanded Detox/CSP program. It currently cost $345,000 per year to operate the sleep-off center at the "campus" site.

**Long-term Treatment Facility**

The Municipality of Anchorage needs additional long-term treatment beds to cope with the increase in the number of chronic public inebriates.

A total of 24 beds is proposed for this new component. Twelve of these beds are available for immediate occupancy utilizing excess capacity at the Salvation Army Pt. Woronzof facility. The hiring of two treatment counselors and one vocational counselor would complete the staffing for this component.

A separate facility constructed adjacent to the Salvation Army facility will house the additional 12 beds. Staffing would be more intensive for this facility requiring evening, night and weekend coverage in addition to the normally required counseling staff.

Treatment planning for the 180 day or longer program could focus on vocational and self-esteem building skills combined with a slow paced substance abuse treatment regimen based on the 12 Step model. Vocational counselors will conduct weekly job seeking and role playing sessions. Interviewing skills, and resume development will be practiced. Enhance self-esteem will be promoted by craft and recreation programs and by encouraging clients to engage in volunteer community service projects. A weekly native oriented session will be conducted for native clients to assist them to regain their respect for their cultural heritage.

The experience of the recent NIAAA Homeless Substance Abuse Grants throughout the country has demonstrated the need for intensive case management for this group of clients. The Case Manager along with the vocational counselors will assist clients to develop money management skills, coordinate community service projects, work with employers for job development and apprentice programs, and during the aftercare phase, assist the clients to secure stable and sober housing.
Involuntary Commitment is an integral part of the long-term treatment concept. Without some motivation from involuntary commitment or the criminal justice system (deferred sentence, deferred prosecution) most of those in need will probably choose not to go to such a facility for an extended stay. We must streamline the legal process for requiring them to go before it is worth establishing and funding such facilities.

**Alcohol Free Living**

One of the weakest points in the continuum of alcohol treatment services is in the area of transitional housing. In order to be effective, the treatment system must include programs which aid the client in his attempt to reenter the community after he has learned how to stay sober.

One program which is worthy of further examination is alcohol free living. The Oxford House movement is one of the most successful examples of alcohol-free living in the United States.

Oxford Houses are a self supporting group homes. They are democratically run "ruled by a group conscience". There is no house manager. Houses typically revolve officers, including a president, a vice president, secretary, treasurer and common offices.

Oxford House residents characterize their living situation as a homelike environment similar to a college fraternity or sorority. No counseling or professional services are provided. Oxford house residents maintain that they are not a treatment center but a group of people living together by choice to promote their own recovery. They subscribe to the twelve step alcohol recovery process promoted by Alcoholics Anonymous.

The average length of stay in an Oxford House is about one and a quarter years. A typical length of stay however, is about two years. The difference between the mean and the mode is the extremely short length of stay of clients who fall off the wagon or the early weeding out of residents who are not suitable for the house. This length of stay is contrasted with the typical halfway house length of stay which is approximately six months.

The securing of houses for recovering alcoholics is a delicate process. Houses must be near public transportation, grocery stores, and services. Treatment programs must be near enough so that patients who are still in treatment can attend treatment programs. Count decisions and changes in Federal law make it illegal to discriminate against individuals with a disability. Recovering alcoholics fall into this category. This may invalidate local Quasi-Institutional designations which require a conditional use permit.
IMPLEMENTATION PLAN

This section outlines a 3 phase process of transforming the present public inebriate treatment system to the one proposed in long range plan.

I. PRESENT SYSTEM - Public Inebriate System Through April 1, 1991

A. CSP

1 van; 24 hours, 7 days a week operation

B. Sleepoff

30 beds; 24 hours, 7 days a week operation.

Note: Building is temporary, it does not have an occupancy permit for sleepoff after December 21, 1991 and the program does not meet current zoning codes.

C. Detoxification

7.5 publicly funded beds and 2.5 self pay beds for a total of 10 beds. A van is available to transport from sleepoff to detoxification.

D. Residential Treatment

Some existing intermediate care beds are used to treat Public Inebriates. However, usually clients need a longer term of treatment. This is generally not available.

Some are referred to Nugen's Ranch, a long term care facility, but the agency is reluctant to accept criminal and involuntary commitments.

II. TRANSITION PLAN - Public Inebriate System April 1 Through August 30, 1991

A. CSP

Expand the Community Service Patrol to 2 vans; one operating 24 hours a day and the other operating 16 hours a day.

B. Sleepoff

Start converting this unit to a dropoff/ triage center by moving the drunkest most chronic clients to detox whenever there is space. Operate 16 hours a day, 7 days a week by closing from 4 am to noon. This time period is the slowest because liquor cannot be sold between 2 am.
and 10 am. The present building meets all fire codes. This new program meets the B-3 zoning requirements, the land is presently zoned B-3.

C. Detox

Expand this service by 10 beds for a total of 20 beds. Some operating funds will come from money saved from elimination of a sleepoff shift. An additional $93,500 in operating funds will be needed and could come from the State Division of Alcohol & Drug Abuse (ADA). No additional capital funds will be needed.

The program will require the drunkest most chronic clients be held as long as legally possible. When there is any unutilized bed space, the drunkest and most chronic clients will be transported from sleepoff to this unit for detoxification. Clients will be held in protective custody for as long as it is medically appropriate or as long as legally possible, whichever is the shortest time. This cannot exceed 48 hours, AS 47.37.170(b) & (d) and AS 47.37.260(9).

In accordance with the statutory provisions contained in AS 47.37.180, upon proper application an administrator in charge of an approved public treatment facility may approve an application for emergency commitment. Upon approval of an application for emergency commitment under AS 47.37.180, the administrator shall file a petition for involuntary commitment under AS 47.37.190. An involuntary commitment into residential treatment for up to 90 days may follow (AS 47.37.190 -.200).

D. Residential

Begin a 12 bed, 90 - 180 day long-term treatment program with operating funds provided by the ADA. Clients may be civil commitments from detox. Continue to maximize use of all other residential treatment programs using civil commitment and voluntary means.

III. LONG TERM PLAN - to start August 30, 1991 or soon after

A. CSP

Continue the operation of two shifts.

B. Drop Off/Triage Center

Close Drop Off Center.
C. Detoxification

Expand Detox to 30 beds when needed

A new wing would be added to the existing Point Woronzof building.

D. Residential

Long term treatment will be expanded to 42 beds by building a 30 bed residential facility using modular units. Capital funds would come from the state and Operating funds will come from the ADA.
Data and Recent Research
## Municipality of Anchorage
### Department of Health and Human Services
#### Division of Social Services

### Transfer Station Statistics

**BY ADMISSIONS**

July - December 1992

### Gender (N=5151)

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<thead>
<tr>
<th>Gender</th>
<th>Count</th>
<th>Percentage</th>
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<tr>
<td>Female</td>
<td>944</td>
<td>18.3%</td>
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<tr>
<td>Male</td>
<td>4207</td>
<td>81.6%</td>
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</table>

### Ethnicity (N=5144)

- Caucasian: 743 (14.4%)
- African-American: 47 (0.9%)
- American Indian: 147 (2.8%)
- Athabascan: 505 (9.8%)
- Tlingit: 199 (3.9%)
- Haida: 23 (0.4%)
- Yupik: 1013 (19.6%)
- Aleut: 510 (9.9%)
- Inupiat: 1661 (32.2%)
- Hispanic: 56 (1.1%)
- Asian: 3 (0.1%)
- Other: 237 (4.6%)

### Birthplace (N=5126)

- Anchorage: 392 (7.6%)
- Foreign: 104 (2.0%)
- Outside: 772 (15.1%)
- Rural Alaska: 3756 (73.2%)
- Urban Alaska: 102 (2.0%)

### Native Regional Corporation (N=5144) (3823)*

- Not a Shareholder: 1321 (25.7%)
- AHTNA, Inc.: 105 (2.0%)
- Aleut Corporation: 143 (2.8%)
- Arctic Slope: 257 (5.0%)
- Bering Straits: 875 (17.0%)
- Bristol Bay: 430 (8.4%)
- Calista Corporation: 580 (11.3%)
- Cook Inlet Region: 398 (7.7%)
- Chugach Alaska: 60 (1.2%)
- Doyon, Limited: 155 (3.0%)
- Koniag Corporation: 29 (0.6%)
- NANA Regional: 508 (9.9%)
- Sea Alaska Corp.: 268 (5.2%)
- 13th Regional: 15 (0.3%)

### Residence (N=5148)

- Homeless: 4564 (88.6%)
- Staying w/ Friends: 107 (2.1%)
- Staying w/ Family: 188 (3.7%)
- From out-of-town (in Anch. less than 2 wks): 68 (1.3%)
- From out-of-state: 2 (0%)
- Renting (including hotel): 190 (3.7%)
- Other: 29 (0.6%)

### Medical Clearance Obtained (N=5062)

- Yes: 240 (4.7%)
- No: 4822 (95.2%)

### Condition on Arrival (N=5157)

- Unassisted Walking: 104 (2.0%)
- Staggering: 5052 (98.0%)
- Unconscious: 1 (0%)

### Breath Alcohol Content (BAC)

- Average on Arrival: 240 (N=4622)
- Average on Depart: 125 (N=5072)

### Condition on Departure (N=5131)

- Unassisted Walking: 4789 (93.2%)
- Staggering: 342 (6.7%)
- Unconscious: 2 (0%)

### BAC on Arrival (N=5169)

- 0-99: 170 (3.3%)
- 100-199: 1261 (24.4%)
- 200-299: 2726 (52.7%)
- 300-399: 981 (19.0%)
- 400-499: 28 (0.5%)
- 500+: 3 (0.1%)
Brought to Transfer Station (TS) by (N=5154)

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<td>AST</td>
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<td>Walk-In</td>
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Destination when Leaving TS (N=514)

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<tr>
<td>Bean's Cafe</td>
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<td>Walk Out</td>
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<td>Jail</td>
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<td>0.4%</td>
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<td>74</td>
<td>1.4%</td>
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<tr>
<td>Other (family)</td>
<td>162</td>
<td>3.1%</td>
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* figures calculated without the "Not a Shareholder" category
PREDICTORS OF HOMELESS PERSONS
PURCHASING ALCOHOL BEVERAGES

(B. Parker, M. Huelsman, D. Fisher, G. Reynolds, & A. Chouhdrey)

Objective: Substance-using homeless are reported to have higher average income than non-substance users. This study modeled the predictors of alcohol purchase in the last 30 days by homeless individuals.

Method: The Municipality of Anchorage conducted a survey in 1992 of 310 homeless individuals across 8 sites. Sampling was proportionately stratified by sex and location. Questions asked included sources and amount of income, types and amounts of expenditures, and number of agency contacts during the preceding 30 day period. Analysis was performed using logistic regression with diagnostics.

Results: 176 of the respondents, or 57%, reported purchasing no alcohol during the previous 30 days. The balance reported spending between $5 and $1,998 on the beverage. The mean was $79.60. Respondents who purchased alcoholic beverages were more likely to have: used the local sobering station, purchased tobacco, used the local soup kitchen, purchased a hotel room, and spent money on a station, purchased tobacco, used the local soup kitchen, purchased a hotel room, and spent money on a category called other (60% of the expenditures in this category were for clothing, gifts, bills, or debts).

Conclusion: Respondents were likely to use the emergency shelter and food services even though they had, during the same 30 day time period, funds for less critical uses, including purchasing hotel rooms. For some individuals, emergency shelter and food services appear to be subsidizing alcohol purchase.
SUPPORTIVE HOUSING PROGRAM FOR ALCOHOLICS IN FINLAND AND ALASKA. Mäkelä RP, A-Clinic Foundation, Fredrikinkatu 20 B 18, FIN-00120 Helsinki, Finland; Huelsman MD, Municipality of Anchorage, P.O.Box 196650, Anchorage, Alaska 99519-6650; Aarnio A, Viinkankahti Shelter, Hatunpäävaatatie 19, FIN-33100 Tampere, Finland.

The social policy and housing programs for homeless alcoholics were compared between two northern cities (Tampere, Finland; Anchorage, Alaska), similar in size and climate. Both cities have contended with a rural to urban migration, and serve clients who often are shy and unaccustomed to urban life. Both cities have the same costs for providing social services and both must contend with a citizenry who don't want shelters and other homeless programs in their neighborhood.

In Tampere, a voluntary supervised housing program has been developed during the last 10 years which invites chronically homeless alcoholics to rejoin society by providing them skills and support needed to live in one of 20 single person apartments scattered throughout lower middle class neighborhoods. The program is limited to local citizens and includes a coordinated system to charge clients for all emergency and other services they receive.

In Anchorage, the focus has been on large shelters, a large soup kitchen and other free services. With the help of volunteers the services are functioning well providing emergency support. However, they undermine personal responsibility and support a skid row counterculture.

The Finnish supportive housing model may be practicable also in other U.S. Cities. The pilot program will begin in late 1995 in Anchorage.
A 14-Year Comparison of Alaska Homeless

G. Reynolds (1), M. Huelzman (2), D. Fisher (1)
W. Parker (2), J. Jones (2), H. Beirne (2)

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Abstract

A 14-Year Comparison of Alaska Homeless

To show the changes over time of the rapidly increasing homeless population, the Municipality of Anchorage conducted a survey in 1992. This survey replicated Kelso et al (1978). 310 homeless individuals were interviewed across 9 sites. Sampling was proportionately stratified by sex and location. There were no significant differences across the two studies in marital status, gender, employment status, and substance abuse. There were recent increases in the number of Whites, Blacks, number of recent arrivals, use of agencies for shelter rather than residential hotels, and low income. Therefore, the current homeless population is more mobile, poorer, and more dependent upon social agencies.
A 14-Year Comparison of Alaska Homeless
G. Reynolds, M. Huelsman, D. Fisher, W. Parker, J. Jones, H. Beire

Introduction

The problem of homelessness continues to plague American cities and most of the literature addresses psychological problems, mental illness and substance abuse as causes of homelessness. Recently, however, as homeless populations continue to grow and the type of individuals who find themselves homeless deviates from the traditional "Skid Row" inhabitant to include families and children, a closer look at the economics of homelessness has occurred (1). Anchorage, Alaska, has experienced problems with a growing homeless population as well as its own financial problems. First surveyed in 1978 (2), the population was estimated at that time to be around 700. Current estimates show that figure has doubled since 1980 (3). The Health and Human Services Department of the Municipality of Anchorage, Alaska, conducted a survey of homeless individuals between November 1991 and January 1992. This survey was intended to identify characteristics of the homeless population as a means of determining whether existing shelters were meeting the needs of the homeless. It was also intended to act as a basis on which policies for public expenditures on services for the homeless could be formulated (4).

Material and Methods

Trained interviewers surveyed 310 individuals at nine sites located within the Municipality of Anchorage. The sites were the
Brother Francis Shelter and the Rescue Mission, two shelters primarily serving individuals; McKinnell House, Clare House, the Abused Women’s Aid In Crisis, and Family Shelter, shelters primarily serving individuals with children; Eagle Crest and Abbott Loop, transitional programs; and Bean’s Cafe, a soup kitchen. The Diagnostic Screening Center (DSC), a non-treatment facility operated by the Salvation Army from January 1989 through June 1992 (therefore in operation at the time of this survey) took in intoxicated individuals based on blood alcohol screening levels (5). It was not specifically included in the survey. However, because the DSC did not serve meals, Bean’s Cafe was surveyed as a way to sample those individuals whose blood alcohol levels were high enough to gain admission to DSC, as well as to sample other homeless individuals who might not be staying in any of the public shelters, but who relied on Bean’s Cafe for meals. Participation in the survey was voluntary and approximately 50% of the clients in each program were interviewed. Sampling was proportionately stratified by sex and location.

The survey questions included demographic characteristics, reasons for homelessness, alcohol and drug abuse, as well as contact with the social welfare and criminal justice systems. The survey built on the most recent previous study of the homeless population in Anchorage, conducted in March 1978 by the State of Alaska Department of Health and Social Services and the Center For Alcohol and Addiction Studies of the University of Alaska Anchorage (2). Several of the questions asked in both surveys were identical. Others, while they attempted to elicit
similar types of information regarding such things as alcohol and other substance abuse problems and how respondents spent their money, were asked in ways that made direct comparisons difficult.

Results and Discussion

There were no significant differences across the two studies of the homeless individuals surveyed in marital status, gender, employment status and substance abuse. Similar proportions of respondents were single, divorced, separated and widowed, as well as similar proportions of males and females. The difference between the two proportions of gender between the two surveys was not significant \((z=0.10, N=509)\).

Self-reported problems with alcohol and substance abuse were also not significantly different \((z=0.56, N=351)\). However, it should be noted that this comparison was between two questions which were not worded in the same way and the this finding should be interpreted with caution. (In 1992, the question asked was, "Have you ever had an alcohol or drug problem?" while in 1978, the question asked was, "Is your drinking a problem?")

Employment rates have remained fairly constant over the past 14 years, with a few more individuals reporting employment in 1978 than in 1992. These proportions were also not significantly different \((z=1.15, N=511)\).

Differences were found in the racial composition of the homeless population. There were recent increases in the number of whites and blacks in the 1992 homeless population, and a decrease in the number of Alaska Natives \(X^2(3, N=507) = 33.859\),
For purposes of analysis, racial groups used were white, black, Asian and Alaska Native. It should be noted that the data in the Alaska Native category was grouped together as both studies used breakdowns of finer shades of ethnicity in this category (i.e., in 1992, subcategories of Yupik Eskimo, Inupiat Eskimo, Athabascan Indian, Tlingit Indian, Haida Indian, Tsimshian Indian, American Indian, Aleut; in 1978, subcategories of Eskimo, Aleut and Other Indian).

Both surveys asked where respondents slept the night before being interviewed. In 1992, a significantly greater proportion of those surveyed slept in agency shelters and fewer slept on the street or lived in apartments, cheap hotels or boarding houses than reported for 1978 \( \chi^2(2, N=514) = 109.745, p=.000 \). Three categories of shelters were used: (a) agencies or primary shelters; (b) the street, which included abandoned buildings and cars; and (c) residential living quarters, which included hotels, apartments, rooming houses.

The increased use of shelters may be due in part to the 240 beds which were added when the Brother Francis Shelter opened in 1983. This was followed more recently by the Rescue Mission increasing its total available beds from 20 to 100. A decrease
in the supply of low cost residences is also partly responsible for the decline in the use of residences. According to recent estimates (6), 1,000 low cost residences (cheap apartments) were eliminated in the mid 1980’s.

The comparison between the two surveys also revealed that the current homeless population is more transient than in the past. Respondents in 1992 were significantly more likely to have resided within the Municipality of Anchorage for less than one year than they were in 1978, $z=2.76$, $p<.01$.

However, it should also be noted that there was no statistically significant difference in whether the two groups had relatives living in Anchorage, $z=1.41$, $p<.01$. This could be explained by the fact that Anchorage is the urban hub of the State of Alaska, with an influx of persons arriving either from "the bush" (rural Alaska) or from out of state seeking employment. It is possible that while the homeless population have themselves been residing within the Municipality of Anchorage for less than one year, the reason they moved was to follow other family members currently living there. This is supported by a majority of the 1992 respondents' answers to the question, "What are the main reasons you became homeless?" Over 16 percent identified "traveled to Anchorage and became homeless as the main reason for current homelessness.

After adjusting for inflation, the 1992 homeless population earned significantly less income than that of 1978, although a similar number overall were employed [$X^2(5, N=515) = 31.756$, $p=.000$].
Attempts were made in both surveys to determine percentages of income spent on alcohol and other drugs, as well as a variety of other items such as food, clothing, rent, tobacco and transportation, however, the wording of the questions made it difficult to obtain a meaningful comparison. On three items, alcohol, tobacco and transportation, a comparison possible. Responses were adjusted for Consumer Price Index (CPI) differences across the 14-year period and a t-Test Procedure on all three items were significant: \( t(345) = 4.6337, p = .0001 \) on dollars spent in the last thirty days on alcohol; \( t(513) = 7.5761, p = 0.0000 \) on dollars spent in last 30 days on tobacco; and \( t(513) = 5.1482, p = 0.0000 \) on dollars spent in last 30 days on transportation. The 1992 homeless, though earning significantly less income than the 1978 homeless, spent significantly more on these three items.

The 1992 homeless population was better educated than that surveyed in 1978. While those respondents who had completed at least a high school level education remained almost the same, there was a significant difference between the two studies in the education levels at the high and low end, that is, more of the homeless had received some education beyond the high school level in 1992 than in 1978. Also, in 1978, a greater proportion had not completed high school, while this group was a smaller percentage of the overall number surveyed in 1992 [\( \chi^2(2, \)
Questions concerning respondents contacts with the social service and criminal justice systems were asked of both the 1992 and 1978 homeless. Respondents replied to contact with four entities ("During the last 30 days how many times did you have contact with...") that included welfare, police, court, and jail. Proportions having contact with welfare were not significant between the two groups (z=1.53, N=517). However, differences between proportions were significant with respect to all three of the others, police, court and jail.

Two other variables, status as a veteran and possessing special job training, also provided significant differences, the 1978 homeless population being significantly more likely to have been veterans and to have had special job training or skills.

Insert Table I about here

Conclusion

Between the two surveys, it was found that no significant differences were found in the gender, marital status, employment status and self-reported substance abuse. Significant differences were found in the ethnicity of the two groups, where respondents slept the previous night, mobility, and the amount of income earned and how that income was spent on tobacco and transportation. Significant differences were also found in number of contacts with police, the courts, and jail across the studies.
These findings that the 1992 homeless population is more dependent on social agencies, poorer and more mobile than the homeless population surveyed in 1978 has policy implications for the continued provision of public shelters for homeless individuals. The loss of low-cost housing in the form of residential hotels and cheap apartments that occurred in Anchorage, with the construction of public shelters to take their place, could be said to have contributed to the high percentage of homeless persons using the shelters. This observation, combined with the substantially lower income and substantially higher percentages of income spent on other items (tobacco and transportation), lends itself to the conclusion that if people are not forced to pay for housing out of their own pockets, what income they do have will be spent elsewhere if they can count on shelter being provided for them. It is possible that public shelters have created their own clientele, those who use the shelters rather than their own resources or their families and relatives.

With respect to the lower frequency of contact with the courts, jail and police in the 1992 responses, it is possible that shelters lower the number of problems the homeless have with the justice system. Further research is necessary to determine how and why this is occurring and what the impact is on the surrounding community.
References


Acknowledgements

Maggie Corey, Bob Eaton, Jerry Butler, Maureen Dursi, M. Karina Grundahl, Don Bettis, Hilary Morgan, Laurita Hefner, George Laurito, Theodore Thomas, Rosemary Pagano, and Harry Wakefield.
Homeless Ethnicity Comparisons 1978 and 1992

$\chi^2(3, N=507) = 33.859, p = .000$
Where Subjects Slept Comparisons - 1978 and 1992

![Bar chart comparing the percentage of respondents who slept in different locations in 1978 and 1992. The locations are Agency, Residential, and Street. The chart shows a significant increase in the percentage of respondents sleeping in residential areas in 1992 compared to 1978.]
Homeless Income Comparisons 1978 and 1992

$\chi^2(5, N = 515) = 31.756, p = .000$
Homeless Comparisons 1978 and 1992
Obtained Value of Z

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Table I
CITY POLICIES REGARDING ALCOHOLISM AND HOMELESSNESS IN THE NORTH

Finland, a country with some 5 million inhabitants, lies between the roughly same latitudes as Alaska, but on the opposite side of the globe. There are no high mountains in Finland, but the climate is probably quite similar. In wintertime, the temperature is typically mostly between 0 and -10 degrees Celsius in the south and between -10 and -20 degrees in the north of Finland.

Recorded consumption of alcohol in present-day Finland is at more or less the same level as in Europe on average, i.e. 6.8 litres of absolute alcohol per inhabitant per year (1993). During the past two years consumption has slightly decreased. Before that, there was a period of very sharp growth from 1969 to 1974 as a consequence of the liberal alcohol policy and liberal attitudes among the general public; a plateau period from 1975 to 1984; and a period of slight increase from 1985 to 1990. It has been estimated that in Finland there are between 250 000 and 400 000 heavy drinkers, 50 000 to 80 000 alcoholics, 10 000 people who are dependent on medical drugs (this is an increasing problem), 5000 users of alcohol substitutes, 2000-3000 cannabis users and 1000-2000 users of "hard" drugs.

In the autumn of 1993, according to official statistics, there were in the whole Finland about 2600 totally homeless people (living in first-stage shelters or outdoors), about 2600 people living in different institutions and about 6700 people living with friends or relatives. If compared with the figures one year earlier, the total decrease in the number of homeless people was 9 % (in institutions 21 %). The unemployment rate in the country is now in excess of 20 % (about 500 000 people).

Twenty-four year’s perspective

My first encounter with alcohol problems and homelessness dates back to 1970 when as a young psychiatrist I started my first alcohol research project (together with the social policy researcher Lasse Murto) in my home town Tampere. With a population of around 175 000, Tampere is the second largest city in Finland (after the Greater Helsinki Area) and also Scandinavia’s largest inland city.

The number of lonely, homeless and alcoholized men had increased in all
larger Finnish cities towards the end of the 1960's owing to a period of high unemployment (not as high as the present crisis) and the introduction of the retail sale of low-toxic alcohol substitutes.

My first job in that research project was to do a medical examination on more than one hundred homeless alcoholics, most of them sleeping rough even during the winter. They were dirty, foul-smelling and had many musculoskeletal, respiratory, digestive, liver and neurological diseases. One of the most visible psychic features of these men was their low self-esteem. They had no confidence in their own resources, and they did not believe that someone might actually care for them and would be willing to help them. Most of them had at some point received detoxication or other treatment in psychiatric hospitals or institutions for alcoholics. About half of the men were on a disability pension. They had no organized health care system, only a first-stage shelter in a run-down building, a former creamery.

I also read foreign literature, including books from North America, and discovered that all western countries had their own skid-row or homeless alcoholics with all the related social and health problems.

During the course of the research project, a better, barrack-like first-stage shelter was built for our alcoholics, and the municipality of Tampere hired me to arrange weekly consulting hours in the shelter. A nurse started to visit the shelter twice a week. I worked there until 1979, but virtually the same health services have been available even since then.

Over these more than twenty years, the situation of homeless alcoholic men in Tampere has changed very considerably. Today, only very few of them sleep rough in the winter. For drinking men and women, there is a new shelter with good facilities. During abstinent periods, they can live in one of five half-way homes, and more stable persons can rent a cheap apartment from the municipality of Tampere. When we now meet homeless alcoholics on the street or in treatment facilities, they are no longer as dirty, foul-smelling or somatically ill as they used to be earlier.

In the metropolitan area of Helsinki and its environs, the housing situation is not as good, so that both local people and foreign tourists visiting our country may still run into really miserable drunken men, and sometimes women, in the streets and parks of central Helsinki.

The social and health care organization in Finland

Before I continue with the subject of homelessness, I would like to say a few words about the general features of Finnish social and health care systems, which also provide treatment and rehabilitation services to alcoholics and other substance abusers.

Male mortality is higher in Finland than in many other industrial countries; life expectancy at birth is currently 71 years. Among the main reasons for premature deaths are accidents, intoxications and suicides,
which are often connected with heavy drinking.

The Act on the Welfare for Alcoholics and Drug Addicts, enforced in 1987, attaches special importance to primary-level social and health care services. These services are available throughout the country for all citizens and at a low cost. Every municipality has its own health centre (which is sometimes shared with small nearby municipalities), which also offer round-the-clock walk-in health services. Primary-level social services are also available in all municipalities. Some of the biggest municipalities are divided into smaller units with their own health and social care teams (nowadays, the two separate teams are often organized under the same administration). Many major employers have organized occupational health services for their employees.

In all of these primary services, there are many possibilities to be in contact with early-phase heavy drinkers and more serious substance abusers, as well as with homeless people.

We also meet heavy drinkers in specialized hospitals. Two years ago, a one-day survey was conducted at the University Hospital of Tampere for all inpatients and outpatients (Seppä & Mäkelä 1993). According to self-reports and the physicians’ opinions, 25 % of the male and 11 % of the female patients were regarded as heavy drinkers. Heavy drinking was most commonly associated with psychiatric and surgical disorders, but it occurred in all specialties. We concluded that all patients in all clinics should be questioned about their drinking habits so that the staff could make early interventions and take other preventive steps in the relevant cases and possibly recommend continued treatment. It is important to stress here that only a few per cent of these hospital patients met the diagnostic criteria of true alcohol dependency (including homeless alcoholics), but their health and life situation were at risk because of alcohol use.

The network of specialized services in Finland consists of outpatient units (A-Clinics, youth clinics), detoxification centres, rehabilitation institutions, and housing services. The services are subsidized by the local municipalities, which in turn get part of their money from the government. The total number of personnel engaged in these services is around 1400 in the whole country. In addition to these professional services, there are many self-help groups (Alcoholics Anonymous, A-Guilds) as well as religious groupings.

In earlier years there was a greater tendency than nowadays to use statutory measures, including involuntary treatment. Today, short involuntary measures are used only in psychotic cases and very rarely when the person is violent towards his family or other people.

Educating health care professionals for the treatment of substance abuse problems

In recent years the organization I represent, the A-Clinic Foundation (which is a non-governmental, non-profit private organization that
maintains many outpatient and inpatient facilities in Southern Finland), has started to give increasing weight to the medical perspective to support our earlier, more traditional social work orientation. In 1991, in the context of our Substance Abuse and Health Project, we started work to plan training courses for the medical staff working at municipal and occupational health centres as well as in hospitals. We have received a generous three-year grant for this project from the Finnish Slot Machine Association. (Finns are avid Lotto, pools and slot machine players.)

We found that the educational needs of the medical staff were greatest in issues related to the therapeutic relationship and the motivating interview. In other words, even experienced health care professionals feel insecure and incompetent in their everyday job of meeting and talking with patients. Perhaps the course of the "dependency disease" and the behaviour of the substance abuse patient are not consistent with the accepted and "legitimate" course of a medical disease; perhaps alcohol and drugs are still surrounded by many myths which block the normal skills of the medical staff.

One of the most important efforts in our project has been the development of networks of cooperation between different social and health care facilities. On the one hand, we need to have primary-level social and health care teams to assume responsibility for all the needs of a certain target population, including substance abuse problems. On the other hand, substance abuse treatment requires special expertise, just as other specialties within the fields of medicine and social work. The intention is to develop our A-Clinics into regional "resource centres" which are both medically and socially oriented and which can provide treatment and rehabilitation for more serious and chronic cases and also organize education, supervision and consultation for primary-level outpatient teams, hospitals, and the staff of the shelters and half-way homes for substance abusers.

Attitudes towards homelessness

There are many discriminating mechanisms which tend to label homeless people as representing "a certain type". Homelessness is not seen only in terms of not having a place to live in; at the level of attitudes, homeless people are also associated with certain personal problems (problems with mental health, alcohol, criminal background, invalidity etc.). In Finland, homeless people are more or less automatically assumed to be alcoholics (or even alcoholics using alcohol substitutes), even though in actual fact only 30-60% of homeless people are alcohol or other substance abusers.

At the same time, the term "alcoholic" itself has very bad connotations; for many Finnish people, the word is associated with "homeless elderly men hanging around the railway station or hiding in stairways or scrap vehicles and drinking windscreen cleaner" rather than with the 1-2 % of the population who have alcohol dependency but who live a perfectly normal social life, or with the 10-20 % of the population who drink so much that they might be causing harm to their health. These attitudes
are injurious to all prevention and treatment efforts for substance abusers, but particularly for homeless alcoholics who now carry the worst imaginable label.

According to Juhila (1992), municipal housing, social and health authorities have to choose from two two strategies: One is hopelessness, implying the definition of the homeless as permanently incapable of living an independent life. Therefore it is pointless to allocate decent housing to them because they will fail there in any case! The other strategy is one of apparent optimism towards rehabilitation. Through a process of change and growth the "disease of alcoholism" can be cured. Even so some people may be regarded as being beyond recovery and beyond rehabilitation. The shortcomings here are thought to be those of the homeless individuals rather than the rehabilitation organization!

City policies: Tampere as a case in point

The alcohol policy plan of the city of Tampere (1991) is based on the following premises: "The purpose of social policy is to provide all people decent living conditions and sufficient basic security. Special attention must be given to improving the living conditions of poor people. Groups at high risk include single men and multiproblem families. It is suggested that the availability of high-standard rented accommodation be increased and that the standards of dilapidated dwellings be improved. It is also suggested that, in addition to general housing measures, special steps are taken to resolve the housing problems of socially deprived substance abusers, e.g. by means of decentralizing their dwellings to different parts of the city".

The housing programme adopted by the city of Tampere for the years 1993-1998 is in a sense a realistic paper. The earlier version of that programme wanted to eradicate homelessness altogether from Tampere by the year 1995. Because there are continuously some 400-500 homeless people in Tampere (20-60 of whom sleep rough), the new programme is content with achieving an essential reduction in the number of homeless people. And indeed the numbers have been slowly decreasing year by year, in spite of the ongoing economic recession.

In this housing programme it is really difficult to specify the share of alcoholics. In some tables the title "homeless people" is synonymous with "substance abusers", in another table there are separate rows for both titles. Perhaps the planners have tried to be neutral and unprejudiced but the outcome is rather confused. It would seem that there are enough rehabilitation institutions, half-way homes and first-stage shelters (a total of 200-250 beds with a capacity utilization of only 60-70 %), but too few supported dwellings and entirely independent cheap apartments. It has been recommended that the same apartments, buildings or blocks should not be used permanently for the accommodation of the same special groups to help avoid stigmatization. Intensified cooperation among the social, health and housing authorities is also strongly recommended.
I recently had the opportunity to interview the director of the same first-stage shelter where I started my career in this field. During the last twenty years, he said, two important changes have taken place. First, there are far more rented apartments available for homeless alcoholics than previously (although not yet sufficiently). The situation has improved most notably during the economic recession (!) as rents have gone down and the social and housing authorities have noticed that supported, independent housing is a much more cheaper alternative to the municipality than institutions, shelters and police arrests. Second, attitudes towards rehabilitation have become more positive because the more systematic co-ordination between the social and housing (and partly health) authorities has yielded better outcome figures than earlier. The main drawback in the present situation is that proper treatment and rehabilitation measures for substance dependencies is now receiving insufficient attention. In our shelter, the staff consists mainly of social workers. A part-time psychiatric nurse is available for somatic and psychiatric nursing; and a physician’s services are now available in the nearby health centre or A-Clinic.

Homeless alcoholics in the Greater Helsinki Area

During the past few years, most Finnish studies on homelessness have been carried out in Helsinki, where the situation remains worse than anywhere else in the country: more than half of the homeless in Finland live in the Greater Helsinki Area. Tapanainen (1989) estimated that during the winter of 1986, there was about 100 people in Helsinki who had been sleeping rough for at least one year; around 10 % of them were women. They lived outside the city centre in "camps" consisting of 3-5 tents or other self-made shelters. Many of these people were actually in paid employment because the labour market situation at the time was very good. The consumption of alcohol in these camps was lower than among men living in the shelters arranged by the municipality. Most of them did not want to live in shelters because they felt that the shelters are too restless and that they would have to give up their freedom and independence and submit to what was regarded as humiliating control. However, almost all would have wanted to live in rented accommodation.

After a follow-up period of three and a half years, about 40 % of these people were still sleeping rough; 40 % lived in a rented apartment (as a consequence of the municipality’s active rehousing programme); and 20 % had died. Quite a high mortality!

Using the method of participant observation, the sociologist Jouni Kylmälä (1991) found that there are two main types of homeless alcoholics in Helsinki. First there are the middle-aged or elderly men who have moved into the metropolitan area from the countryside years ago, who have unassured manners and who are very shy of all people, including the authorities. The second type are younger people who were born in the city, who are more visible in the street, and who take advantage of existing social and other services.
The share of the police in housing alcoholics has decreased quite dramatically in recent years. In the biggest police shelter of Helsinki, the number of people arrested each year because of public drunkenness was around 70,000 during the 70's, around 40,000 at the end of the 80's, and 26,000 in 1992. This has become possible with the increase in other shelter types and the more tolerant attitudes of other people (as well as the police).

Conclusions and recommendations

During the last twenty-five years the situation of homeless alcoholics in Finland has improved considerably, at least in Tampere and many other smaller areas, but to some extent in the Greater Helsinki Area as well. This might be explained by the following factors:

1. The attitudes of the authorities and the general public in Finland towards the homeless and alcoholics have become more neutral and tolerant. The homeless and/or alcoholic people have been treated more "normally" when they have sought help from social, health and housing authorities. Arrests for public drunkenness have also decreased. At the same time the ability of these people to cooperate has increased respectively.

2. In the 1970's, an increasing number of shelters, half-way homes and other institutions were established. Then, towards the end of the 80's, supported and independent housing arrangements were developed, in addition to institutions. And finally, during the recession years of the 90's, the number of institution beds has been decreased by some 20%; days spent in institutions have dropped by as much as 50%. At the same time, outpatient services should have been increased, but this has happened only partially and in some municipalities.

3. The working methods of our treatment organizations have improved and developed. Now, we can design more individualized, comprehensive (somatic, psychic, social) and realistic treatment plans and use the expertise of different professionals together with self-help groups and accept short-term and more modest goals. (Overly ambitious goals, such as life-time abstinence, tend to cause unnecessary frustration among all parties).

However, there are still a number of problems that need to be overcome:

1. We authorities and treatment personnel lack effective means for motivating single, middle-aged men to embark upon a process of rehabilitation for changing their way of living when they are unemployed, when they miss their family contacts and have chronic illnesses, in addition to their alcohol or other substance dependency and poor housing situation.

2. The Finnish social and health care organization is bureaucratic, sectorized and humiliating: dropping out of the system is all too easy if
the individual has many different kinds of problems and if he is not very persistent and submissive in seeking help. In particular, health care staff in hospitals and health centres still have much to do to change their pessimistic and moralistic attitudes.

3. The present trends in the development of Finnish health services away from centralized regulations towards more locally adapted models based on the rules of market economy, can have disastrous effects for marginalized groups of people (such as homeless alcoholics).

4. Because of the extremely high level of unemployment in Finland today, occupational integration of the recovering alcoholics is now nearly impossible.

5. If total alcohol consumption starts to climb again (after the possible end of the economic recession and Finland’s decisions concerning the European Union), all alcohol problems will also begin to increase again. We will see a new wave of chronic, sometimes homeless alcoholics in Finland.

I would like to end my presentation by noting that, in my own personal experience, neither alcoholism nor homelessness are permanent forms of existence. We professionals and authorities should encounter those people just as normally and neutrally as our other clients and patients, and offer them a real opportunity for social and health well-being. Their goals may differ from our opinions, but we have to respect their personal views. Sometimes they will succeed, sometimes fail. In one of my first research reports in 1972 I said: "The leading principle in the treatment policy (for homeless alcoholics) should be to give repeated pushes to activate and help the possible trials to return back to society". I sincerely agree with these words even today.

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