National Institute on Drug Abuse

SERVICES RESEARCH REPORT

Nonurban Drug Abuse Programs:

A Descriptive Study

ARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service
Alcohol, Drug Abuse, and Mental Health Administration

The Services Research Reports and Monograph Series are issued by the Services Research Branch, Division of Resource Development, National Institute on Drug Abuse. Their primary purpose is to provide reports to the drug abuse treatment community on the service delivery and policy oriented findings from Branch sponsored studies. These will include state-of-the-art studies, innovative service delivery models for different client populations, innovative treatment management and financing techniques, and treatment outcome studies.

This report was produced under a contract of the National Institute on Drug Abuse (Contract No. 271-75-4045) to BRX, Incorporated, McLean, Virginia and the Institute for Research, Reston, Virginia.

DHEW Publication No. (ADM) 78-636
January 1978

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, D.C. 20402

Stock No. 017-024-00708-1

PREFACE

Throughout the late 1960s and early 1970s, Federal agencies dealing with the problem of drug abuse focused their attention almost exclusively on urban areas. However, there was increasing concern expressed that drug abuse in rural settings was a different phenomena from that encountered in the cities.

A study was initiated by the National Institute on Drug Abuse (NIDA) to provide a description of the structure and functioning of a sample of rural or nonurban programs and, in addition, to describe some of the innovations developed within these programs to deal with the uniquely rural aspects of the drug problem they confronted. This report, based on that study, is intended to share the concerns and the initiatives of rural program planners, administrators, and staff with their colleagues.

Special thanks are due to the Directors and staffs of the nonurban drug programs visited for their cooperation in making this study possible.

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CONTENTS

LIST OF TABLES

NONURBAN DRUG ABUSE PROGRAMS:

A DESCRIPTIVE STUDY

INTRODUCTION

In 1974, the Directors of several Single State Agencies expressed their concern that, while data was being amassed concerning urban drug abuse programs, there was little information concerning rural programming (Hesse 1974). It was their feeling that the rural drug abuse problem was different than the urban one and deserved separate attention.

This view was elaborated in a 1975 survey of eight selected rural drug abuse programs conducted by the Perth Amboy General Hospital (New Jersey Division of Narcotic and Drug Abuse Control). The survey explored several important areas of difference between rural and urban drug programs, and suggested that aspects of the drug problem and the responses to that problem varied between rural and urban settings. Although this preliminary study revealed relevant data on rural problems and the characteristics of rural drug abuse programs, its findings and implications were limited by the time and sampling constraints under which it was conducted.

As a followup to the New Jersey study of eight programs, the Services Research Branch of the Division of Resource Development, National Institute on Drug Abuse (NIDA), decided to initiate an enlarged study. Since the Bureau of Census definition of "rural" was not used in the selection of programs for the study, the alternative term "nonurban" has been used in this report. The study was designed to collect data on the structure and functioning of a large sample of nonurban programs and to collect descriptive information with regard to creative initiatives in nonurban programming.

It is important that the descriptive nature of the study be emphasized. The study did not contrast urban and nonurban programs, nor did it formulate or test hypotheses. Nor do the programs selected constitute a representative sample of nonurban programs. As will be described, the site selection procedures favored programs that were believed to be the more successful ones in nonurban areas.

The specific objectives of the investigation were:

1. To study current systems for implementing prevention programs and delivering drug abuse treatment services to nonurban areas.

2. To identify those elements within existing delivery systems which impede and which facilitate the delivery of effective prevention and care to the nonurban drug abusers.

3. To describe innovative elements, ideas, or practices discovered in nonurban programs.

Structure of the Report

This report will begin with a description of the METHODOLOGY used in conducting the study, followed by a selection on FINDINGS. The last section of the report, PROGRAM CAPSULES, contains brief sketches of initiatives designed to extend or enhance services.

METHODOLOGY

Definitions

As the study was being initiated, it became clear to both NIDA staff and the research team that the definition of rural used by the Bureau of Census--towns with populations of 2,000 or less--would severely restrict the scope of the study and exclude most of the programs of interest. Therefore, it was decided that programs would be eligible for study if they served clients residing in towns of 25,000 or less, regardless of where the programs were headquartered. To avoid confusion with the census definition, it was decided that the broader term of "nonurban" would replace the word "rural" for purposes of this study.

Design Overview

The study employed a two-wave survey of nonurban drug abuse programs. In Wave I, 59 programs from all parts of the U. S. were visited to obtain basic descriptive data on the program and the community. In Wave II, 20 of the original 59 programs were visited again to gather additional data and to examine those program elements which might prove useful to other nonurban drug abuse service units.

Program Selection Procedures

In the sampling approach used, an effort was made to identify the universe of nonurban drug abuse programs. Next, that universe was narrowed to a candidate list of 200 programs. Finally, 59 program sites were selected. The following paragraphs summarize this selection process.

To compile a master list of existing nonurban drug abuse programs, all Single State Agency Directors and State Education Directors were contacted by letter and asked to identify and recommend possible study sites. In addition, all HEW Regional Drug Abuse Program Coordinators and Office of Education Training Center Directors were contacted for suggestions. Other sources used to compile the master list were NIDA nonurban grants and contracts, nonfederally funded nonurban drug abuse treatment programs, and programs known to the Office of Education.

Once this master list of programs was compiled, a candidate list of 200 programs was developed. This list reflected two major sampling concerns which carried through to final site selection: namely, to strike a balance between treatment and prevention programs, and to have geographical representation. In addition, each program on the candidate list was recommended by more than one source as appearing to be successful.

The majority of the programs available for study were outpatient drug free, although a special effort was made to seek out and include methadone maintenance and therapeutic community programs. While such programs are prevalent in urban areas, they appear infrequently in nonurban settings.

Based on these various criteria, 59 programs were finally identified for site-visits and for inclusion in this study. These programs were visited at two different times during the contract study, as described below.

Both treatment and prevention programs selected for study were drawn from all regions of the country (table 1). The Midwest supplied the largest number of programs (19), followed by the Southeast (12) and the Southwest (10). The large majority of programs visited were classified as treatment only (26) or treatment/prevention combinations (26). Only seven programs were classified as solely prevention.

Community Size and Population

The populations served by the program were spread across a median catchment area of 5,000 square miles, often described as having poor roads and adverse weather conditions. While a cross-section of ethnic groups were represented in these communities, including Hispanic (9.6 percent), black (5.6 percent), and Indian (1.4 percent), the vast majority were white (82.6 percent).

The population density of the areas in which programs were located was highly variable, but typically low (table 2). The average density was 64.6 persons per square mile, with a range from .67 persons per square mile to 357.4.

Data Collection Procedures

Wave I site visits were conducted by research staff from January 1976 to July 1976; Wave II site visits from March 1976 to October 1976. During Wave I, programs were visited for a period of two to four days, depending upon program size (client volume, number of satellites, etc.) and complexity. Wave II visits were made for a period of two to three days. Data were collected in semi-structured interviews with the program director and/or designated staff member. During Wave II visits, staff also interviewed several key individuals in the community to gather additional data and to

TABLE 1

TYPE OF PROGRAM BY REGION

Region	Treatment	Prevention	Treatment/Prevention	Total
Northeast	3	0	4	7
Southeast	7	1	4	12
Midwest	6	1	12	19
Southwest	7	2	1	10
Northwest	1	1	3	5
Far West	2	2	2	6
TOTAL	26	7	26	59

TABLE 2

POPULATION DENSITY OF COMMUNITIES SERVED

Persons Per Square Miles	Number of Programs*
0-10	15
11-25	7
26-50	12
51-100	10
101-200	8
201-400	4

*Missing data on three programs.

corroborate information collected in the program.

The Wave I report form included the following information:

- General program information and history
- Demographic information from client records
- Service components
- Staff activities and development
- Program organization
- Transportation
- Finances.

The site-visit teams used a five-point scale to rate programs on such aspects of programming as quality of records, staff development, quality of service components, management procedures, linkages with other community agencies, etc. These ratings were used primarily to select Wave II sites.

The Wave II form was designed to 1) provide documentation on potentially promising program capsules; 2) provide additional details on community-program relationships and linkages; and 3) fill in gaps in the Wave I data.

Implications of the Methodology

By design, the sampling strategy used was oriented toward a purposive selection of programs, based on program type, location,

and reputed effectiveness; it did not employ a random selection of programs or clients within carefully defined strata. Therefore, there is no effort made to describe programs sampled as representative of a nonurban population. The study was descriptive, not evaluative. It cannot provide conclusive evidence that any particular approach was more effective than any other.

Despite these limitations, the programs selected for study do depict some of the dynamics and problems of the nonurban setting and offer suggestions for program initiatives.

FINDINGS

PROGRAM TYPE

As stated previously, the majority (52) of programs were either treatment (26) or treatment/prevention combinations (26). Seven programs provided prevention services only.

Of these program types, 33 delivered services to alcohol and drug clients; while 26 programs delivered services exclusively to drug abusers (table 3).

TABLE 3

PROGRAM TYPE BY PROBLEMS ADDRESSED

Problems Addressed	Crim. Justice & Treatment	Treatment/Prevention	Prevention	Total
Drugs Only	11	14	1	26
Primarily drugs, include some alcohol clients	11	6	4	21
Alcohol and Drugs Separate Components	1	2	2	5
Primarily alcohol, but accept drug clients or have a drug service component	3	4	0	7
TOTAL	26	26	7	59

Program Settings

The most prevalent treatment setting was outpatient drug-free (N=45), a finding which parallels that found in the New Jersey survey. There were three programs classified as residential treatment; two programs classified as inpatient (detoxification); and two programs classified as outpatient methadone (table 4).

Methadone maintenance, detoxification, and residential care services were rare in nonurban areas, as compared to urban areas. (The two methadone maintenance programs studied were the only two such programs identified as serving nonurban communities.) This finding is difficult to interpret. Either there is a relatively low volume of nonurban clients in need of these approaches to treatment, or those in need have migrated to urban areas where the services they seek are available.

Staff Size and Caseload

Most of the programs were small. The majority had fewer than 10 paid staff members (median staff size is seven), and only six program staffs exceeded 20 members.

The mean client load for treatment programs was 89; residential and inpatient programs averaged 20.7 and 20.6, respectively.

Program Funding

The average amount of funds received by the programs for fiscal year 1976 was $128,803, although a majority received under $75,000. Funding for individual programs ranged from $13,000 to over $1 million, with the Federal and State Governments the major funding sources (mean = $107,109). Only one program in the study sample of 59 received no Federal or State money.

Funds from client fees, Title XX, and other third-party reimbursements comprised the next largest source of support (mean = $39,937).

TABLE 4

PROGRAM SETTING

Outpatient Drug-free	45
Residential	3
Inpatient Detoxification	2
Outpatient Methadone	2
Prevention	7
TOTAL	59

Only 16 programs received money from one or more of these third-party sources. Virtually all fee schedules were based on a sliding scale adjusted to the clients' incomes; however, since most clients were able to pay only minimal amounts, little revenue was generated from such fees.

Local funds were received by 38 programs, but in dollar amounts this yielded the smallest amount of funds (mean = $17,973). It is often difficult for programs to obtain local contributions from the community and the local government because of the small local tax base in nonurban areas which are typically economically poor. This problem also inhibits obtaining funds from State and other local sources, which usually require matching funds from the community.

CLIENT CHARACTERISTICS

Thirty-nine programs classified their clients as primarily nonopiate multiple drug users. Six programs reported that a majority of their clients were primarily heroin users, while the remaining seven programs treated alcohol abusers. (The seven programs remaining out of the total of 59 were prevention programs.) This supports an earlier study (Services Research Report: "An Investigation of Rural Drug Abuse Programs," NIDA 1976), which found that 8.1 percent of the clients seen in rural programs reported heroin as their primary drug of abuse, as compared to 65.7 percent of urban clients.

Primary Drugs of Abuse

The primary drugs of abuse among outpatient drug-free clients are shown in table 5. The most common primary drug category is marihuana, followed by amphetamines, alcohol, and barbiturates/sedatives/tranquilizers.

If one disregards the client with a primary problem of marihuana abuse, the most prevalent primary drug problem among nonurban treatment clients in this sample is amphetamine abuse. The Ns in the results presented below varied as a function of the availability of the data. Moreover, because the vast majority of the treatment programs in the sample were outpatient drug-free programs, the detailed presentation of client data is confined to the available data from the outpatient programs.

Data usually were derived from treatment caseloads current at the time of the site visits. In instances where current data were not available, data derived from previous monthly or yearly (1974-1976) averages were used. All data analysis was based on raw data and total client Ns were derived by summing across all programs for which data were available.

Client data from alcohol programs with very few drug clients were omitted from all analyses. Also, caseloads in alcohol service components were not included. When interpreting these data, one must be mindful that the drug use category is based on the drug used most frequently. This schema was the only way in which most programs maintained data. However, the reader is reminded that programs reported the vast majority of their clients were multiple drug users, rarely confining their use to a single substance.

Age by Primary Drug of Abuse

Table 6 displays the current age of clients by primary drug of abuse for the eight programs from which these data were available. Most programs maintained data on primary drug of abuse and age separately; only eight programs had combined this data. Based on this sample, an analysis of the age data

TABLE 5

PRIMARY DRUGS OF ABUSE IN OUTPATIENT
DRUG-FREE TREATMENT POPULATIONS

Primary Drug	% of Clients	N
Marihuana	33	514
Amphetamines	20	315
Alcohol	13	203
Barbiturates/Sedatives/Tranquilizers	12	191
Heroin/Other Opiates	10	153
Hallucinogens	7	117
Inhalants	2	26
None	4	67

Note: Total Client N=1586 (based on data from 16 programs).

alone (raw totals) reveals that the nonurban clients are quite youthful--62 percent are under 21 years of age, while only 4 percent are over 35 years of age. The age trends detected in this sample parallel those found in the earlier NIDA study.

This table indicates differences in drug abuse patterns among age groups. Most clients under 14, and 30 percent of the 14 and 15 year old clients, are not using drugs; they are referred primarily by the criminal justice system for truancy, petty theft, etc. This finding suggests that, in this age group, the selected nonurban programs are treating behavior disorders rather than substance abuse alone.

Clients from 14 through 19 use marihuana and amphetamines for the most part, with some barbiturate and heroin use apparent in the 19-20 group.

For clients in the 19-35 year old range, the pattern is distinctly different. Among these clients, heroin is predominant, with amphetamines a close second.

Clients over 35 tend to abuse alcohol, barbiturates, sedatives, and tranquilizers.

Thus, according to the data from these eight programs, amphetamine and marihuana use characterize the teenaged clients; barbiturates and heroin use increase in the young adults; use of alcohol, barbiturates and other sedatives characterize middle age.

Summary Client Profile

Additional characteristics of outpatient drug free clients are displayed in table 7. The majority of clients are males who are either employed or in school and for whom the treatment experience is their first. Sixty-two percent of the clients have a history of arrest and 32 percent are referrals from the criminal justice system.

In the three residential treatment programs (total client N=62), 45 percent of the clients are primary amphetamine abusers, 18 percent are primary users of barbiturates and other sedatives, 16 percent are primary users of marihuana, and 14 percent are primary opiate users. The majority (85 percent) of these residential clients are males; 57 percent of the clients were referred by the criminal justice system.

Two of the programs in the sample operated short-term inpatient facilities within a community mental health center. Most clients in those programs are users of multiple non-opiate drugs. Sixty-five percent are males; 25 percent are criminal justice referrals.

The two methadone maintenance programs studied treated mostly Mexican-American heroin abusers, who tended to be poor and unemployed. The majority of these clients are male (88 percent) and are voluntary admissions.

TABLE 6

CURRENT AGE OF CLIENTS BY PRIMARY DRUG OF ABUSE
FOR OUTPATIENT, DRUG FREE TREATMENT POPULATIONS

Client Age	PRIMARY DRUG OF ABUSE											Total No. of Clients
	No Drug Use	Heroin	Other Opiates/ Synthetics	Alcohol	Barbiturates	Other Sedatives/ Tranquilizers	Amphetamines	Cocaine	Marihuana/ Hashish	Hallucinogens	Inhalants	
Under 14	73%(16)	0	0	0	0	0	4%	0	14%(3)	4%(1)	4%(1)	22(100%)
14-15	30%(21)	3%(2)	1%(1)	3%(2)	7%(5)	0	18%(13)	0	16%(11)	11%(8)	11%(8)	71(100%)
16-18	7%(17)	2%(5)	2%(5)	2%(4)	10%(24)	5%(13)	22%(56)	1%(4)	28%(67)	13%(35)	5%(13)	243(100%)
19-20	2%(2)	12%(11)	1%(1)	4%(4)	14%(13)	3%(2)	34%(31)	4%(4)	13%(12)	12%(11)	0	92(100%)
21-25	4%(6)	23%(34)	6%(9)	4%(6)	12%(18)	3%(4)	20%(30)	1%(2)	11%(16)	14%(21)	2%(3)	149(100%)
26-35	3%	30%(26)	7%(6)	1%(1)	14%(12)	5%(7)	23%(20)	2%(2)	7%(6)	3%(3)	1%(1)	87(100%)
36-45	12%(2)	6%(1)	6%(1)	44%(7)	12%(2)	19%(3)	0	0	0	0	0	16(100%)
Over 45	0	0	8%(1)	38%(5)	8%(1)	46%(6)	0	0	0	0	0	13(100%)

*Total Client N = 693 (based on data from 8 programs).

TABLE 7

ADDITIONAL CHARACTERISTICS OF
OUTPATIENT, DRUG-FREE CLIENTS

	% of Clients
Unemployed (not in school)	41
Employed or in school, G.E.D. or vocational training program	59
First treatment experience	66
History of arrest	62
Male	68
Nonvoluntary CJS referral	32

It should be noted that residential and methadone maintenance programs appear to be rare in nonurban America; they were included in the sample only because a concerted effort was made to find examples of these treatment approaches.

Program Services

Table 8 displays the types of services found among the 59 programs visited. As is apparent from the table most programs offered more than one service.

Virtually all of the types of drug abuse treatment and prevention services existing in the urban setting can be found in nonurban programs. In general, program staff reported that differences occur in the balance among types of services provided and that modifications are sometimes made in the treatment approaches to reflect specific nonurban needs.

Prevention

As with the drug abuse treatment services provided in nonurban areas, community and school-based prevention activities tended to mirror those found in urban communities. Nonurban program staff reported that gaining entrance into school systems to provide direct treatment services (e.g., counseling) to students is difficult. Drug abuse program staff characterized school personnel as more comfortable with drug education curricula and teacher training components than with school-sponsored intervention and treatment activities.

PROGRAM STRUCTURE AND OPERATION

In an attempt to provide a range of services to either large geographical areas or dispersed populations, nonurban programs have developed a variety of organizational structures differing from the unitary program structures seen in many urban programs. These alternative structures include the establishment of multiple facilities, affiliation with community mental health centers, and membership in "umbrella" organizations.

Multiple Facilities

A number of programs operate secondary and ancillary facilities which are staffed on a full or part time basis. Twenty-six of the 59 programs have multiple facilities to serve substance abusers. Table 9 presents the number of programs having secondary and ancillary facilities. Secondary-service facilities are program-operated facilities providing one or more services on a full-time basis. The secondary-service facilities are located away from the main or primary-service facility and may not offer the range of services provided in the primary-service facility. Ancillary facilities provide services on an ongoing part-time basis. An ancillary facility may offer the same or fewer services than a secondary facility. Both secondary and ancillary facilities are often referred to as satellites and are usually located throughout the target area. Twenty-six (46 percent) of the 57 programs for which data are available operated more than one facility.

TABLE 8

PROGRAM SERVICES

Service	Program N
Individual, Outpatient Counseling	45
Family Counseling	26
Offender Counseling	6
Criminal Justice Diversion	27
Crisis Intervention/Referral	13
Residential Care	3
Inpatient Detoxification	2
Outpatient Methadone Maintenance	2
Community Presentations/Workshop	30
Alternatives to Drug Abuse	21
In-Service Teacher Training	17
Law Enforcement Personnel Training	7
School-Based Drug Education Rap Sessions	10
School-Based Problem Solving Groups	5
Parent Education Courses	9

TABLE 9

NUMBER OF PROGRAMS HAVING SECONDARY AND ANCILLARY SERVICE FACILITIES

Secondary Service Facilities		Ancillary Service Facilities	
No. Programs	No. Facilities	No. Programs	No. Facilities
40	0	33	0
4	1	8	1
7	2	2	2
2	3	4	3
1	4	3	4
1	5	2	5
1	8	1	7
1	14	1	11
		1	16
		1	21
		1	25

*based on data from 57 programs.

The typical service model consists of rotating drug counselors who provide service at the satellite clinics on a regular basis (e.g., one afternoon at each clinic). Larger drug programs sometimes have designated staff whose primary function is to travel regularly among the satellite clinics. Another plan in use by several of the programs visited is to hire part-time drug abuse staff who are residents of the communities in which the satellite mental health clinics are based. According to those program directors favoring this approach, it eliminates the time and expense of staff travel between service sites and increases community involvement in the program's services. However, if a counselor is from the immediate community, anonymity and objectivety can cometimes be lost if client and counselor have known each other previously and the potential client may be hesitant to come to the agency for help or may be less than candid in his/her communications.

The purpose of the satellite clinic delivery system is to extend services to clients within the catchment area who might otherwise be unable to undergo counseling on a regular basis because they lived far from the program's primary site.

Although the concept has gained wide acceptance, there are also certain problems experienced by programs with part-time satellite operations. A substantial amount of staff time is tied up in traveling to and from ancillary sites. This decreases the amount of time available for working with clients and, as a direct result, the cost per client served at ancillary satellite sites is greater. Also, it is often necessary to tightly schedule counseling sessions to allow for staff travel time to and from the site. This "stacking" of clients is a hardship on counselors and may affect the quality of service. Another problem that occurs with satellite operations is that professional communication among counselors and supervision suffers because counselors are dispersed and often work alone. This isolation decreases the opportunities for case consultation and other important day-to-day interchange necessary for staff motivation and professional growth.

Community Mental Health Centers

A second method for reaching a limited number of drug clients while reducing the cost of separate facilities is affiliation with an existing community mental health center (CMHC). Twenty-five (42 percent) of the 59 programs studied in this project were affiliated with CMHCs.

CMHC affiliated drug programs vary in the degree of their integration with the mental health delivery system as indicated by several characteristics: (a) whether or not they are physically located within the mental health center; (b) whether they have additional service delivery facilities located outside the mental health center complex; and (c) the extent to which drug clients receive specialized services or receive the same services as other mental health clients.

As can be seen in table 10, there are 12 drug programs affiliated with community mental health centers which are physically located within the CMHC facilities and have no additional separate facilities. In these 12 programs, all treatment units are self-contained and staffed by drug specialists. Drug clients are usually not integrated with mental health clients for services.

Six programs housed one drug outpatient unit within the center and located an additional unit or other program components in a separate facility; in five programs, all program services were housed separately from the CMHC. Although these programs function as physically independent entities, administration and oversight reside with the CMHC itself.

Drug clients were integrated with mental health clients for service in only two of the 25 programs.

The following advantages of integration with the mental health delivery system were reported by the mental health affiliated programs included in this study:

- Drug programs enjoy a professional treatment image and enhanced credibility because of their inclusion in a recognized mental health center.
- The stigma of drug abuse tends to be reduced through the association of drug treatment with other "people helping" services provided by the CMHC.
- Paraprofessional staff can benefit from the experience and skills of CMHC staff through participation in their training programs and case conferences.
- Programs have accessibility to psychiatric evaluation, therapy services,

TABLE 10

INTEGRATION OF MENTAL HEALTH CENTER AFFILIATED PROGRAMS

How Integrated	Type of Program			
	Treatment	Treatment/Prevention	Prevention	Total No. Programs
Program housed within CMHC. Separate drug unit	8	4	0	12
Outpatient unit housed within CMHC. Additional facilities separately located	2	4	0	6
Drug clients integrated with MH clients--no special services	2	0	0	2
All drug program facilities housed separately from CMHC	1	3	1	5
TOTAL	13	11	1	25

and specialized consultants on an almost immediate basis.

- Mental Health can provide matching funds.
- The drug program located within the mental health delivery system inherits an already established client care and client recordkeeping system.

Three disadvantages reported by CMHC affiliated drug staff were:

- While identification with a CMHC may be positive in terms of community acceptance, it may also represent a trading of stigma. Potential clients may not want the association with "mental disorders" or emotional problems.
- Integration with mental health services may weaken the specialized treatment function of drug staff.
- The recordkeeping system to which the program falls heir may be unnecessarily complex and not suited to a drug program's needs.

Umbrella Administration and Combined Service Approach

Two other approaches to multifacility organization are the use of an umbrella administration and the use of a combined service approach. Only two programs studied used either one of these approaches.

The umbrella administration that was located consists of a central office and affiliation of seven local guidance clinics covering a five county area. Although each clinic exists as a separate organization, the central board consists of two representatives from each clinic. The central office offers a wide range of administrative, technical, fiscal, and other advisory services to the member clinics. Grant management, administration, employee benefits, government funding solicitation, and information/data systems are some of the more significant functions performed by the central office personnel, which results in considerable economy and time savings for the various clinics.

In the combined services approach, there is a central intake unit which performs the initial client assessment and programming and coordinates the various services to which the client is referred. Whereas the umbrella organization provides similar services to different populations in different locations, the combined services agencies provide different services (e.g., alcohol treatment, probation counseling, mental health services, etc.) to one population

and one area. This prevents duplication and fragmentation of services. In addition, the one central intake unit and central coordination of client case-management allows for integrated services specifically designed for each client.

While the umbrella and combined services approaches received favorable reports from their participating agencies, high costs ($140,000-$200,000 annually) and resistance to cooperative efforts were cited as substantial obstacles to their establishment and operation.

MAJOR PROGRAM PROBLEMS

The problems discussed in this section came both from responses to the direct open-ended question regarding the major problems the program had encountered in its history and from the specific mention of problems as respondents described particular facets of program operation. Results from the open-ended question are displayed in table 11.

The majority of programs reported that lack of acceptance from the community was their major problem. The number of responses in this category illustrates both the concern with community support and the level of resistance encountered.

Obtaining funding was cited as a serious problem by 20 programs. Although approximately half of the programs studied charge client fees, these contribute only a small amount to the program's funding base.

Many of the programs cited lack of staff experience and poor management as significant problems. Sixteen of the programs visited reported that poor management was a problem. Twelve programs reported that there was little supervision from the director, that there was little sense of authority regarding accountability, and that the quality of counseling suffered from lack of supervision and case management.

As noted above, most of these programs had small staffs. Five programs reported that they had major problems due to understaffing. With small full-time staffs, programs in these areas rely heavily on the use of part-time staff and volunteers or filled positions through the Comprehensive Employment and Training Act, Public Service Employment Program (CETA/PSE).

Sixteen programs reported difficulty in hiring experienced staff members. Low salaries, undesirable locations, and lack of opportunities for personal development and career advancement were suggested as causes.

Another problem reported by the majority of programs was lack of training funds to pay for travel and outside consultants. In this same vein, a number of programs reported that there were no training resources available within their areas.

As noted above, the lack of acceptance from the general community and/or from community agencies was the most frequently cited problem by nonurban drug programs. This lack of acceptance was often seen as stemming from denial of a drug problem by the community, by apathy, or by resistance to the establishment of treatment activities. Programs often began operations with less threatening prevention/education activities combined with concerted public relations efforts.

Transportation was expected to be a major problem, yet only eight programs volunteered that it was. Although in many cases there were immense distances between satellite facilities, most programs served the population within a ten-mile radius of either the primary or satellite facility. It should be noted that many programs had no strategies or funds to support transportation pools or outreach efforts to those people living beyond the ten-mile radius from the facility. Outreach was usually confined to the immediate service area.

The Federal Funding Criteria

As shown in table 12, 36 of the drug programs stated that they were covered by the Federal Funding Criteria (FFC); 11 more were covered by State standards which supersede the FFC. Eight of the program directors interviewed openly stated that they were in noncompliance with the FFC; 22 of the 36 programs covered by the FFC reported having problems in meeting the criteria. Some directors are misinformed and do not realize they can obtain exemptions to the FFC; others are aware of the process but consider the paperwork too bothersome. Many of the programs have applied for and received exemptions, and others have requests pending.

The major problems stem from the Federal Funding Criteria requirement for physical examinations, urine screenings, and extensive laboratory tests, generally viewed by treatment program staff as unnecessary for the drug abusers who are not addicted and who are usually in outpatient, drug-free treatment modalities. There has been a change in these requirements since the study was conducted.

TABLE 11

MAJOR PROBLEMS REPORTED BY PROGRAMS

Major Problems	Program Type			
	Treatment N=24	Treatment/Prevention N=25	Prevention N=7	Total N=56
External				
Lack of acceptance from the general community	14	14	5	33
Lack of acceptance from community agencies	15	16	3	34
Lack of referrals to program	6	4	1	11
School system resistance	2	5	2	9
Funding	5	11	4	20
Transportation	4	4	0	8
Local political problems	1	4	1	6
Other miscellaneous external problems	4	4	4	12
Internal				
Understaffing	3	2	0	5
Lack of staff experience	7	7	2	16
Poor management	8	6	1	15
Other miscellaneous internal problems	7	5	1	13

TABLE 12

PROGRAMS COVERED BY THE FEDERAL FUNDING CRITERIA AND STATE STANDARDS

	Treatment	Prevention	Treatment/Prevention	Total
Programs covered by the FFC	19	2	15	36
Programs covered by the FFC and reporting problems with FFC	11	1	10	22
Programs covered by State Standards	17	2	20	39

Laboratory testing for clients in outpatient programs who orally use amphetamines, sedative/hypnotics, inhalants, marihuana, cocaine (nasal), hallucinogens and opiates (excluding methadone programs) is now to be performed at the discretion of the program physician.

Other criteria, difficult to meet because of the small staff size of many nonurban programs, include the hours of operation and amount of counseling time per client per week. Meeting the matrix requirements is often reported as difficult by nonurban programs--matrix slots cannot always be filled and if funds are reduced, outreach and other services must be curtailed.

SUMMARY OF FINDINGS

The findings from this study confirm the New Jersey and NIDA studies in suggesting that the nonurban drug abuse treatment client is different from his/her urban counterpart. The clients of nonurban treatment programs are typically young, with marihuana, amphetamine, and alcohol problems predominating.

The types of services delivered by nonurban programs are generally the same as those in urban areas, with modifications to meet particular nonurban needs.

The majority of the programs in nonurban areas are outpatient drug-free. Residential and methadone maintenance programs are rare.

Twenty-six of the programs visited have satellite facilities in order to deliver services to clients geographically dispersed within their catchment area.

Although 25 of the 59 programs studied were affiliated with CMHCs, the majority of them function as separate units either housed within or located outside the mental health facilities.

Major problems reported as adversely affecting service delivery were lack of community acceptance, difficulties in obtaining funding, and internal problems involving staffing and poor management.

Study Implications

The study suggests that the types of nonurban drug abuse problems which most frequently require attention are different from the urban ones and do require flexible responses from the Federal Government. The exemption process of the Federal Funding Criteria allows for such flexibility and nonurban programs should be encouraged to use the system.

The study indicates that the responses to the nonurban problems have varied from the efforts that have been developed to deal with the abuse problems in the urban areas. What follows in the next section are some examples of creative ways in which some nonurban administrators and staffs have dealt with the complexities of their local drug abuse problems and limited resources.

PROGRAM CAPSULES

The rural study revealed that programs use a number of solutions to problems in an effort to maximize paid staff time, respond to hard-to-reach clients, and generally confront the obstacles involved in nonurban programming. The program capsules which follow are not intended as nonurban models or guidelines. They do constitute brief descriptions of existing program practices which other nonurban program staff might find helpful.

TRANSPORTATION

In many nonurban areas, particularly those served by satellite facilities, public transportation may be inadequate or unavailable. This means that many clients are unable to receive treatment with the frequency dictated by their problem or, in some cases (e.g., the adolescent too young to drive), may not be able to participate in prevention, treatment, or rehabilitation services at all.

Program Capsule: Volunteer Transportation Pool

To reduce this problem, one program visited during the study established a volunteer transportation pool. The pool consisted of a large group of community volunteers who used their own cars to drive neighbors to and from the program.

The program administrator recruited the drivers through personal requests made to local civic organizations and to the PTA. By creating a large pool, each volunteer carried a reasonable driving load, a factor which assured a firm commitment to this voluntary effort. Moreover, the program reimbursed each volunteer for mileage incurred while driving clients, a feature which makes this service attractive and feasible for its participants.

When the pool started, the program administrator took responsibility for organizing drivers and riders. As the program matured, a volunteer assumed the role of transportation coordinator. Now the pool operates

independently, providing a needed service cost-effectively and without draining valuable staff time for administrative duties and supervision.

PUBLIC INFORMATION

Many nonurban programs consist of a one to two person staff whose time must be carefully allocated to meet client needs. Yet, there is a need within their communities to provide consistent drug abuse information on a regular basis to a dispersed population with whom staff contact is necessarily minimal. In addition, staff in such circumstances need to learn more about the concerns of the community in order to guage more accurately the nature and extent of the local drug abuse problem.

Program Capsule: Drug Column

To resolve this problem, two nonurban programs each initiated a question and answer column in their local high school newspapers to disseminate accurate drug information and to answer questions about drugs and behavior. The keys to the column's effectiveness seems to lie in its integrity and format. Prior to beginning the column, approval was obtained from the school principals involved. At that time, the authors explained that some of the issues raised would be controversial but, to respond to students' needs, it was essential to answer these difficult questions fully, although not sensationally. With the principals' endorsements, the columns discuss those sensitive subjects (drug effects, sex, etc.) which concern the student population.

Anonymous questions are accepted, so that strict confidentiality is preserved. The question and answer format enables the authors to respond to problems directly and professionally. The emphasis is on straightforward discussion in which the facts speak for themselves.

While no solid measures of column effectiveness exist in either of the two programs using this approach, interest in the column, as evidenced by the number of questions received, remains high. Once reader response is stimulated, their questions provide the framework for each article, and often one question will require the entire column to answer.

This approach is viewed so positively in the two communities visited that the concept has been expanded to a drug/alcohol abuse and parenting column for the local newspaper.

INFORMAL INTERVENTION

Since there is a shortage of formal social service agencies in many nonurban areas, opportunities for intervention may be lost, especially for that segment of the population which is not involved in school or the traditional civic or social organizations.

Program Capsule: People Helpers Workshop

To expand the number of informal intervention and referral points in a small community, the drug prevention component of a community mental health center developed a People Helpers Workshop to educate barbers, hairdressers, bartenders, waitresses, and others who may work in a situation where they are in contact with people with substance abuse problems.

Working with the local Jaycees, the drug component organized potential "people helpers" into a volunteer planning committee to devise an informal intervention plan to reach people in need. Based on the kinds of problems raised by the committee, the drug component designed a five-session workshop for people helpers to improve skills in:

- Understanding the effects of drug and alcohol
- Basic counseling/empathetic listening
- Identifying appropriate local resources for help with specific problems
- Understanding the legal questions involved in intervention
- Recognizing when a patron's problem is so severe that immediate assistance is required.

Each workshop lasts for two hours and is offered one evening a week for five weeks. The workshop is free of charge and since it uses a community building (charges are paid by the Jaycees) and recruits volunteer specialists to supplement the drug staffs' resources, the cost to the drug component is minimal. While no formal evaluations have been conducted, the response from the participants has been enthusiastic.

INSUFFICIENT STAFF

Many drug abuse programs suffer from limited funding and staff availability. For drug programs in small towns and rural areas, locating specialized staff or supporting

the additional clerical positions necessary to meet requirements for new sources of revenue can be especially acute.

Program Capsule: Program Staffing Through CETA Funds

A valuable source of staff for nonurban drug abuse programs are Public Service Employee monies (Title VI of the Comprehensive Employment and Training Act: CETA).

The Public Service Employment program is designed to provide public service jobs to the unemployed. Funds are awarded to State and local governments--to the CETA Prime Sponsor--who, in turn, can supply them to virtually any public service agency to hire staff for one year. Although funds are limited, several drug abuse programs across the Nation have used these funds to support staff at medium and lower level positions, particularly in the clerical area. While funds are awarded only to governments serving populations in excess of 100,000 people, several counties may form a consortium to become eligible for the funds. Programs interested in pursuing this source of support should contact the chief elected official in the area--the governor, mayor, chairman of the County Board of Supervisors--or the CETA Prime Sponsor directly.

Program Capsule: Retired Senior Citizens

An especially interesting aspect of one program was a State-supported component called Seniors-at-Work. These older citizens work 20 hours per week and are paid $200 per month. In order to be eligible for this program, an individual must be 55 years of age or older and retired. Programs visited used seniors to provide services useful in the rehabilitative aspect of the treatment regimen and in the daily operation of the program. Seniors served as bookkeepers, accountants, and fundraisers, and trained clients in auto and machine repair, accounting, typing, and other skills useful in obtaining employment.

Program Capsule: Use of VISTA Volunteers

Vista volunteers were recruited by an outpatient counseling program to provide tutoring services to clients interested in obtaining a high school graduate equivalency diploma (GED). The program could not afford to hire additional staff to provide ancillary educational services; therefore, it turned to Vista. The volunteers selected offered help to learning-disabled clients, as well as more traditional, remedial tutoring in math.

Program Capsule: Volunteers in Corrections

Volunteers in Corrections (VIC) is a nonprofit organization dedicated to the rehabilitation of substance abuse offenders. The primary goal of VIC is the prevention of crime through the reduction of the pressures which may lead parolees and those on probation into criminal activities. The program is staffed by trained volunteers who establish a support-friendship relationship with an assigned client for the term of his/her probation or parole and provide services such as employment placement and assistance in finding recreation-social alternatives. The clients served by VIC have all had drug or alcohol charges or convictions.

This local Volunteers In Corrections program exists within a coordinating agency for substance abuse service agencies.

The core staff of volunteers is managed by a coordinator who, under the direction of the State Department of Probation and Parole, screens, trains, and assigns citizens from the community to supervise and counsel on a one-to-one basis those adults placed on probation or parole by the courts. There are currently 154 volunteers involved in VIC, some of whom are professionals who are able to provide counseling services to clients. The services the volunteers are equipped to perform include:

- Counseling
- Assistance in obtaining employment, housing, legal aid, recreational and social alternatives
- Help with personal financial management.

The VIC program had a $28,000 budget for 1976, which includes approximately $9,000 donated in-kind in the form of ACTION and CETA workers. The primary funding comes from a State LEAA grant. Office space and telephone service is provided to VIC by the coordinating agency of which it is a part. Volunteers In Correction has been in existence for over four years and is accepted and approved by adult and juvenile courts and probation and parole officials.

COORDINATING LOCAL RESOURCES

In rural as in urban communities, there are a number of substance abuse clients who need and/or are served by the variety of social service and criminal justice agencies.

Often, these clients must visit several locations to receive services and, more critically, the agencies providing help may be unaware of the clients' multiple-program involvement or, if aware, may be unable to coordinate these services into one meaningful rehabilitation plan because of logistical problems or differences in approach. Focusing treatment under these conditions is difficult and valuable resources are wasted in duplicated intake and counseling hours.

Program Capsule: One-Door Combined Services

One nonurban substance abuse program decided to capitalize on the "limitations" of its location to institute one-door, combined services for its clients. Since the total number of clients was low and there were only a small number of public and private social service and criminal justice agencies, the substance abuse program promoted the concept of pooled rather than separate services.

Briefly, the objectives of the combined service were to:

- Coordinate all services needed by the substance abuser
- Cooperatively develop one comprehensive treatment plan
- Designate one primary staff person to oversee total case coordination and followup.

Since each service available (alcohol, mental health, probation, etc.) was established in its own facility, the one-door program opted for a central intake location where representatives of each contributing agency could participate in screening, diagnosing, and formulating an individual treatment plan for each client. Because numbers of clients are relatively small (an average of 250 per month), joint intake not only improved the initial client evaluation and determination of the primary problem area, but it meant that representatives from several agencies could staff a case if the client required it. Thus, a client's treatment team could consist of a substance abuse counselor, a psychologist from a private mental health agency and a probation office, if appropriate.

The one-door combined services project is both independent of any one agency and embedded in all of them. It operates under the auspices of an advisory board comprised of a representative from each participating agency. A percentage of each agency's budget is allocated to the service and the board pools these funds and then redistributes them to support the one-door project.

By staffing a central intake unit with staff from each agency, the agencies avoid individual hiring of costly specialists. For example, since the mental health service contributes a psychologist, the substance abuse program does not have to hire one. Also, because the psychologist is involved in screening, evaluation, and treatment plan development, cross-agency coordination is built in at the very beginning, so the treatment plan is comprehensive and focused on providing the client with the maximum concentration of interest.

In addition to meeting the clients' direct needs for assistance, the one-door project compiles a single intake form and maintains central case files which contain complete program and client activity records. Not only does this function reduce and remove a significant portion of the recordkeeping burden from each agency, but it enables the advisory board to examine centralized case records and hold agencies accountable for client progress.

The combined services probject has been evaluated by its State Law Enforcement Planning Commission. The Commission concluded that the project had met its objectives for comprehensive client treatment plans and central case files. Morever, it noted that the demand for services was increasing and that "the multiagency approach properly coordinated does foster new and innovative methods of dealing with the problems at hand." Finally, the evaluation concluded that the one-door combined services project was "client-oriented, not agency-oriented." Providing the client with the best possible services to assist in overcoming his/her substance abuse problem has been the prime objective, overriding the "turf protection" tendencies usually so prevalent in bureaucratic organizations.

SCHOOL-BASED PREVENTION

In a number of nonurban areas, young people live several miles from one another or from traditional sources of supervised recreational activity and concomitant opportunities for role modeling, decisionmaking and developing sound judgment in a peer group situation (e.g., Scouts, church followship, etc.) Prevention efforts, other than the public information variety, are difficult to mount because they cannot reach sufficient numbers of youth to justify their cost. Despite

this, however, nonurban areas believe there is a need to provide prevention-related programs aimed at these youth, whose use of alcohol and drugs appears to be increasing.

Program Capsule: Teacher Workshops

In a small town in the Southeast, a prevention program is addressing the problems underlying drug abuse through a series of innovative workshops for teachers, with the idea that the consolidated school system offers the one common contact point for the area's widely dispersed youth population and teacher-training is the most cost-effective vehicle for assuring that tools helpful in working through problems will be communicated to students on a regular basis.

The primary goal of the teacher workshops is to prevent drug abuse by helping young people achieve a more positive self-concept. Teachers are trained through 20 or 30-hour workshops, in the subject areas of self-esteem, communication skills, coping skills, values clarification, and decisionmaking, to increase their personal self-esteem and to learn to use techniques useful in helping students raise their self-esteem. The teachers, who range from elementary to high school teachers, are taught to integrate these techniques in the normal curriculum and to understand how their intelligent use can increase teacher effectiveness. The workshop sessions are described as "intensive participation sessions" and use specially designed materials for the community's population, which is largely working class.

Following attendance at the workshops, teachers participate in a one-year project designed to assist them in implementing newly learned skills in their classrooms. The teachers receive technical assistance from the drug program staff throughout the year, including followup training, classroom observation, and identification of problems.

An inducement for teachers to encourage their participation has been built into the program. By successfully completing the workshop series, teachers receive renewal credit toward their certification requirements from the local community college.

Conducting the workshop program requires about 26 hours of staff time on a weekly basis: eight hours for actual workshop participation, eight hours of workshop planning and organization, and two hours for teacher/principal consultation. The annual cost of the teacher workshops is approximately $23,500, which includes staff salaries, overhead, and supplies. This workshop program is funded primarily by the State, with a substantial contribution from the United Fund. In addition, the program has a contract with the community college and receives funds for offering the workshops.

The program staff has found that the most effective way to sell the program is to work directly with the principals and superintendents, rather than the school district staff.

The program staff uses two primary strategies to gain cooperation of the schools. The first is to use personal one-to-one contact on the school principal level and the second is to call on the program's advisory board. Both appear to be effective in this community, as indicated by the program's three-year history of operation and support.

In terms of impact, program evaluation results show an increase in both the teachers' and students' self-esteem as a result of the workshops, but no measure of increase or decrease in drug abuse among the students is available.

Program Capsule: Community School

Disturbed by a survey depicting high rates of drug and alcohol use among its elementary and secondary school students and reports that truancy and vandalism were on the rise, a rural community decided to operate an alternatives program for all members of the community using the facilities and resources of the local school system.

The objectives of the Community School Program are:

- To provide youth with recreational and learning experiences outside the school-day activities
- To stimulate and promote community interest in its youth through involvement in program planning, implementation and participation
- By offering youth alternative activities, ultimately to reduce drug abuse in youth.

The Community School serves as an alternatives program to compensate for the lack of recreational and learning experiences outside of the schoolday activities for youth in the community. The alternative activities are held at one of the local schools, which is

open specifically for the Community School Program on weekday evenings, weekends, and summers. The School Board has also provided buses to transport students to the alternative activities.

The activities of the Community School have included intramural sports, welding, fly-tying, sewing, crocheting, movies, swimming, skating, a metric class, typing, bowling, a Mexican-American dance, fishing trips, liquid embroidery, and exercise classes. The Director of the program will try to find an instructor for any activity requested by the students or community; if the activity attracts enough response, it is continued. A full monthly schedule is made up by matching what young people want to learn with what is available in the community. Classes are offered from 7 p.m. to 9 p.m. week-nights; sports and outings are offered on the weekends.

The activities are conducted by instructors who may be teachers, community members, or work-students from a local college who have skills which they are willing to teach in return for a small payment. The project is supervised and coordinated by two half-time staff with masters' level degrees in education and guidance and counseling. Other assistance is provided by community school teachers and administrators on a volunteer basis.

The Community School is attended by students of all ages in the school district. Every Wednesday night, Community Night, school drop-outs and other community members are welcome to participate in the activities. It is estimated that the program is reaching and involving 10-20 percent of the out-of-school community members. Other youth groups are also involved in the program. These include the Student Council, Brownies, and Girl Scout groups, who often act as leaders for outside trips, camp retreats, etc.

The Community School staff also operate a National Youth Sports Program during the summer, which is funded by a grant from HEW Community Services through a local college in the town. The grant was awarded because of the success of the Community School program and has adopted the project objectives. The purpose of the sports program is instructive rather than competitive, and is directed at youth between the ages of 10 and 18 from low-income families. The sessions last six weeks and involve 100 young people, who receive professional instruction in athletic skills, half an hour of counseling each day, two free meals per day, and free health care.

While no formal evaluation has been conducted yet, police, faculty, and school board members attribute a reduction in vandalism, drug abuse and other self-destructive behavior in the community to the schools' leisure time activities.

Program Capsule: Jobline

Jobline is a free employment placement and referral service for adolescents (13-17 years of age) which views useful work as an activity that raises self-esteem and provides the jobholder with a sense of achievement. Jobs provided are part-time and include such activities as library aides, store clerks, landscape assistants, mothers' helpers, handymen, etc.

Jobline is headed by a CETA-funded vocational counselor who coordinates a staff of 11 community volunteers who, in turn, operate the placement service and solicit jobs from employers. Each volunteer works one three-hour shift and attends a two-hour training session each week for three months. They are trained in communication, interviewing, and counseling skills. Problem areas in working with volunteers--such as shift-to-shift transfer of information and placement follow-through--and possible program changes are openly discussed in weekly meetings. The Jobline Coordinator oversees placement performance and maintains program continuity. In addition to placement, the program offers job readiness counseling as well as periodic classes on long-term vocational goals.

As jobs become available, an applicant will be called and referred to the potential employer. Applicants are encouraged to come by the office or phone regularly and are placed in an inactive file if no contact has been made for 30 days. Each youth referral is followed up by a staff phone call to see how the youth performed on the job. If any problems have arisen, the youth is recalled for additional counseling and/or training until the situation improves.

Jobline does not set rates for jobs beyond requiring the minimum wage: salaries are negotiated between the employer and employee. Jobline does not charge a fee to either applicants or employers. After each job is completed by a Jobline client, an evaluation form is filled out by the employer and signed by the employer and employee. The worker is rated in areas such as quality of work, attitude, punctuality, and dependability. In addition, a thorough followup is performed

for each position filled. The Jobline staff call the employer after each job is completed and this subjective report becomes part of the clients' record and is reviewed each time the client is referred for another job.

The annual cost for the Jobline service includes the coordinator's salary ($8,400), which is paid by CETA funds, and a few hundred dollars for advertising and incidental expenses. This low cost is possible because the Jobline office is housed within a drug prevention program facility. Currently, Jobline has an active applicant list of 300 and interviews approximately 180 new people each month. To date, jobs generated through the program have brought about $1,500 per month to the community's youth.

Program Capsule: Youth Placement Services

In one midwestern community, prevention and intervention services are offered in the form of a youth work program which is accepted by parents and youth, provides a needed service to the community, and enables troubled youth to be identified for help by experienced counselors in a nonthreatening environment.

The youth work program operates on two levels. First, in response to the lack of employment opportunities for majority youth, it offers young people modest salaries to do odd jobs and necessary chores for local elderly and handicapped persons. Second, work services incorporate vocational training and personal counseling sessions to identify youth with problems and work toward concrete behavioral goals within the employment framework.

The goals of the youth employment program are:

- Provide teenagers with paid, temporary employment, making available to them skills which they can carry into the work world
- Provide those working youth with nonthreatening personal counseling, as needed
- Give elderly and handicapped persons the help they need to maintain their self-sufficiency and allow them to stay in their own homes.

The aim of the program is to provide junior and senior high school students and some court-referred youth with paid temporary work. In this sense, the program parallels the Jobline service described above. The work involves either doing odd jobs for the elderly or handicapped in the community or working for city departments in community improvement activities. The youth are paid the minimum wage by the program.

Unlike Jobline, though, the program is interested in identifying youth with problems that can be addressed and resolved through short-term individual and family counseling. For this reason, the work program is budgeted to employ 56 young people a year, with 12 participants at a time working for a five-week period. Should a youth be particularly enthusiastic about the work, the program will put him/her in touch with an elderly or handicapped person who can individually and privately pay for the work. Youth involved in the program come from every economic strata except low-income (low-income youth are covered through an area-wide Manpower Program). The staff aims to provide work for a cross-section of youth--from honor roll students to court-referred drug users. They attempt to have an equal distribution of males and females and an equal number from each of the community's four schools.

During the five-week period, each participant is given an exposure to the working world and is involved in a weekly work group meeting and a twice-weekly individual counseling session. In addition, depending on issues which might surface during the work experience, the counselor will casually meet with the youth at the jobsite and explore concrete steps for tackling the problem at hand. Since the quality of relationship that exists between youth and parents is often identified as a major causal factor in the problems expressed on the job, the program counselor will attempt to involve parents in the counseling effort. Because the counselor is identified with the work program and not the substance abuse or mental health center, the approach to parents is easier. Discussion can be initiated within the context of the work situation and problems described concretely in terms with which the parent is familiar. The program reports that parents seem less intimidated and hostile when broached in this way and are more amendable to working out family conflict situations. In some cases, five weeks of combined work and counseling are insufficient to address the youth's problems. Then, the work/counseling period is used to encourage child and parents to seek indepth help via the substance abuse program or mental health center. Again, the referral seems more acceptable if received from the work counselor and youth are identified prior to serious

school or legal problems (e.g., expulsion, arrest).

The services of the youth work program have been advertised to the elderly and handicapped in the community through their churches, radio advertising, local newspapers, and by word-of-mouth. The elderly need only to call the program to arrange to receive a young person's help.

The work program is funded by a HUD community Development grant. The program's annual budget is $15,200, which pays for the Work Counselor's salary and the participant's wages. The program is housed within the community library building, which supplies its space rent-free.

When the program started, some citizens were suspicious of it, fearing they would be assigned hardcore drug users from the drug program. To alleviate these fears, the work counselor contacted prospective employers personally to explain the program. In addition, to avoid future problems of this kind, the work program was given its own telephone number to disassociate it from the drug program. Another minor problem concerned employer's unrealistic expectations regarding job performance. This issue was and continues to be resolved through the counselor's intervention in an employer/employee session where expectations are keyed to skill and experience.

While no formal evaluation of the youth employment service has been conducted, subjective reports from the participants, employers, parents, and community members indicate that the program is useful and beneficial to both employers and employees. Employers are asked to fill out reports two or three times during the five-week work period, citing the progress they have observed in the youth. At the end of the employment period, they complete an evaluation form describing their satisfaction with the work performed and the program itself. The majority of these evaluations have been positive.

Parents and youth are also asked to complete evaluation forms regarding their experiences with the work program and the youth are given a followup survey a few weeks after their participation. Results indicate that both groups believe the experience to be useful in terms of skills acquired and improved attitudes and understanding between parents and children.

MAXIMIZING HOTLINE OPERATIONS

Hotline operations were encountered frequently during the rural study. Many had experienced the high staff turnover and eventual decline in use and effectiveness common to 24-hour telephone services. Yet, in the nonurban setting, the hotline may be the singular contact point for emergency services. In addition, a hotline can be used for expanding an innovative service delivery system. Therefore, they take on an importance which they might not have in urban areas where there are a variety of crisis intervention options. For this reason, a nonurban hotline ideally should function consistently and responsibly; cover a large territory; handle a wide variety of calls; be able to provide a link to onsite emergency service, if required; and retain a cadre of committed volunteers over a relatively long period of time.

In reality, no single program accomplished all of these objectives, but several had devised new techniques or creatively used existing resources to enable the hotline to respond to their scattered communities' diverse needs.

Program Capsule: Live-in Worker/Bridge System

In one western community, night coverage has been provided through the hiring of a live-in worker who resides in the hotline facility (a house located in a residential neighborhood and equipped with a kitchen, etc.). In this case, the live-in worker is always a work-study student in the sociology department at a nearby university. The live-in worker must be in the facility from midnight to 8 a.m., Monday through Friday, to answer all calls, aid walk-in clients, and determine the need for and dispatch outreach teams. He/she also attends all training sessions and staff meetings and help maintain the recordkeeping system. Each worker is with the center for one year, working five nights per week for $200 per month and a room. The university funds 80 percent of this salary. Two couples from the community alternate, covering weekends during the same timeframe on a voluntary basis. The worker can be a senior or graduate student and can receive up to four credits of college work for this internship. Since the hotline uses many of the students from the sociology department as volunteers, the staff is continually screening and looking for a replacement for the next year from the existing volunteer staff.

The same hotline operation has add-on telephone capabilities which enable the staff to relay any call to staff members who are not there at the time or to professional resource people in the area. The phone add-on system is called a "Bridge System." It allows the hotline to take any incoming call and transfer it to another phone within the community. In this way, the hotline can utilize the expertise of staff and volunteers who are not on duty.

Program Capsule: Outreach Teams

Outreach teams attached to the hotline in one community provide emergency assistance, crisis intervention, referral, and general information to those who cannot or will not come to the center. Crisis situations are handled by special teams who have undertaken extensive training in a specific problem area. The outreach teams are currently trained to handle drug overdoses, suicide attempts, rape attacks, and serious emotional trauma. The teams are made up of volunteers and paid staff members, and designated people are on call all of the time. The hotline averages 15 outreach calls a month.

The outreach teams are activated by a call to the hotline. The volunteer on duty first determines the nature and severity of a situation and then dispatches the appropriate team.

The drug outreach team is made up of three or four people per emergency and responds to any overdose or drug-related crisis. The team works closely with the local hospital to assist with patients with emergency drug abuse problems.

In the event of a suicide call, the hotline person on duty determines if it is a hoax call and, if not, if the caller needs help to come to him/her. Approximately half of the callers will indicate a need for a team for assistance. If guns or other weapons are mentioned in the call, the police are contacted to accompany the team. The suicide outreach team normally consists of two or three people, with at least one male and one female on the team.

The rape outreach teams consist of three people, two women and one man, who are trained to provide medical assistance, legal advice, counseling, and transportation. The male is included on the team to guard against the chance that there might be a set-up for an attack on a female-only team coming to provide assistance. The rape victim is asked if she would like to talk with the male member of the team or not.

The rape outreach teams are trained to deal with the problem by getting the pertinent facts about the rape, notifying the victim of her rights both medically and legally, and trying to secure all the evidence that might be necessary if the victim decides to prosecute. The team will make arrangements with a doctor or hospital for immediate medical attention and is trained to deal with the immediate psychological problems that may be caused by the rape attack.

The outreach teams are backed up and supported by the local drug program staff and three local doctors. They receive extensive training in their specialized area, and in advanced first aid. The training is conducted at a nearby university and the hotline facility, using films and video tapes as the primary training tool.

Program Capsule: Tele-Care

To combat staff boredom during the slow morning hours and to provide volunteer staff with a sense of satisfaction and relationship, one hotline instituted a Tele-Care program. This service uses one telephone line to contact elderly and shut-in area residents to check on their well-being, offer services and provide friendly conversation to combat lonliness. Approximately twenty-five people are signed up for this service and receive daily phone calls at a specified time during the morning hours. The elderly and shut-ins enroll voluntarily in the program, which they learn about primarily through hospitals, public health agencies, and physicians.

Through the hotline, several other community agencies have become involved in the Tele-Care program. Meals-on-Wheels can be activated by the hotline, transportation or errands will be provided to Tele-Care enrollees by a local church group, and reduced taxi rates are available as well.

The application for Tele-Care requests information regarding the person's nearest neighbor, a relative or friend's name and address, church affiliation, and name of pastor and physician. If no answer is received on the Tele-Care call, an appropriate person is called to check on the shut-in or elderly person.

Program Capsule: Cooperative Services with Local Agencies

To maximize utility and fulfill a need shared by several nonurban communities, one hotline coordinates social services for the area's transient population. The system works as follows: Any transient (usually a migrant farm worker) who appears at any agency for assistance to obtain food, lodging, or travel expenses is referred to the hotline. The person in need them visits the hotline and the staff or volunteer verifies the need for services and provides the caller with a coupon which enables him/her to receive the required service without any exchange of money.

The hotline has the flexibility to complete a coupon for food at a specific store or gas at a specific station. It has the authority to provide up to five gallons of gas, one meal at a cafe, and one night at a hotel. Migrant farm workers with families can also receive up to $35.00 in cash, depending on their situation. If any services beyond these are necessary, the hotline staff contact the appropriate agency by phone to receive authorization for additional expenditures. Some of the participating organizations which provide money, food, or lodging are the Salvation Army, Community Services, Governor's Manpower Council, Seventh Day Adventists, and the State Social and Rehabilitation Services.

Not only is this service useful to the participating community agencies, since many requests are made before or after normal working hours, but it maximizes the use of hotline staff time, as well.

Program Capsule: WATS Line/Call Diverter Installation

One midwestern hotline covers a large catchment area with a substantial portion of prospective callers in the long-distance rather than local call range. Moreover, the communities served are on a party line system, a circumstance which interferes with caller privacy.

To eliminate these problems, a WATS line was purchased which enabled all county residents to call into the hotline center directly and at no cost to them. To assure 24-hour coverage and confidentiality, two call diverters were installed which automatically channeled hotline calls from the center to a volunteer's home. This was achieved through the addition of two new telephone lines which gave each volunteer a private line. Volunteers were then reimbursed the cost differential between a party line and a private line telephone.

This hotline is budgeted at $7,000. This includes $6,000 for the WATS line installation and $1,000 for volunteer private telephone line reimbursement and miscellaneous office supplies.

CONCLUSIONS

Since many nonurban communities have few of the traditional ancillary services, circumstances have impelled drug programs to reexamine their use of existing resources. Schools have extended their hours and scope to include post-school enrichment activities for parents and children. Hotlines have modified their roles and evolved into full service organizations which supplement existing resources. Because public transportation is scarce and population pockets are widely dispersed in many areas, drug abuse programs have joined efforts with rescue squads and hospital emergency services to improve the delivery of crises intervention services.

Certainly, such nonurban realities as the need for satellite units and multiservice facilities and the lack of accessible support and training resources complicate the delivery of drug abuse services. Nevertheless, as the program capsules demonstrate, these problems can be resolved with some imagination. As a result of these efforts to capitalize on community strengths, a number of nonurban programs have translated the themes of citizen involvement, voluntary action, and community alternatives to drug abuse into significant program elaboration and development.

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PUBLICATIONS

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☆ U.S. GOVERNMENT PRINTING OFFICE: 1978—260-943:1160

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