A DESCRIPTION OF THE DETOXIFICATION SERVICES IN GREATER VANCOUVER AND A CONSIDERATION OF FACTORS WHICH DETERMINE POLICY FORMULATION

by

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B.App.Sc., University of British Columbia, 1943

A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF
MASTER OF SCIENCE

in

THE FACULTY OF GRADUATE STUDIES
Department of Health Care and Epidemiology

We accept this thesis as conforming
to the required standard

THE UNIVERSITY OF BRITISH COLUMBIA
September, 1978

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ABSTRACT

The Alcohol and Drug Commission of British Columbia, under the jurisdiction of the Ministry of Health, is establishing a province-wide system of care for the alcohol or drug dependent person in the province. The services which are being developed encompass those of detoxification, personal counselling, rehabilitative treatment, and prevention.

The detoxification services which are being set up throughout the province serve as a main entry point into the system of care. These detoxification centres supply therapeutic care in a crisis intervention mode for men and women who are or have been severely intoxicated and are in a condition of present or impending withdrawal from a specific addictive chemical. In this condition, the individual is in a state of health crisis. Within a detoxification centre remedial and custodial care is given to prevent the person from progressing into a more serious condition of ill health. Most of the clients who are admitted to a detoxification centre have a history of lengthy alcohol and/or drug abuse and, therefore, the illness occasioned by the chemical abuse is frequently complicated by the presence of other health abnormalities. There can be little argument that the presenting condition of the client warrants health care intervention. What kind and how much care to supply is one of the primary concerns of the Alcohol and Drug Commission planning committee as they seek to develop services which are responsive to client and community concerns.

The Alcohol and Drug Commission of British Columbia has established through their research department that there are large numbers of alcohol dependent persons within the province, possibly 70 to 80 thousand; so that a service demand exists which merits the establishment of this specific health service. The form of service developed through the years has been influenced by the attitudes and beliefs held by both the professional health service personnel and by the lay public. These attitudes and beliefs relate to theories about the aetiology of the condition of alcoholism as demonstrated by the alcoholic. Most of the opinions group themselves into

the three broad categories of i) "disease" origin theory, which proposes a genetically determined susceptibility to the chemical; ii) personality defects theory, which sees the person as a moral weakling with this specific form of self-indulgence; iii) social learning theory which attributes the development of the condition to behaviour learned through the social conditioning of his culture.

The philosophy held by the health care planners of this province would seem to be that of accepting a combination of the disease theory and the social learning theory. Based upon these attitudes, they have developed services which are humanistic in their efforts to create a service which is available to all citizens in need. Balanced with this concept is that of instituting preventive measures which are of an educational nature to attempt some change in the cultural habits of the drinking population of our province. The Commission has also to be aware of the large segments of the public who do not share such views and so strive to tailor their services to prevent undue criticisms of being soft-hearted and paternalistic to persons who the citizenry view as being unworthy members of society.

The detoxification services have been established in six centres in the province. The two centres in Greater Vancouver, Pender Street Detox, and Maple Cottage Detox, are directly funded services of the Ministry of Health, while the other units are funded indirectly through non-profit organizations. All of these units have followed the directives of the Alcohol and Drug Commission to present a socially oriented therapy rather than a medical-pharmaceutical therapy. The rationale for this policy decision had been derived from the observations of the effectiveness of such a mode as demonstrated in detoxification centres in Ontario and California. The identifying characteristic of the "social model" of detoxification therapy, is the minimal use of medication and medical intervention. Emphasis is given to behavioural techniques for the relief of withdrawal symptoms which are chiefly related to conditions of emotional stress. Close monitoring of the client's physical condition is maintained so that, if a client condition arises which demands professional attention, then such care is promptly accessed. The supporters, planners, and service deliverers recognize that crisis intervention only would be a short-sighted goal for the treatment of this highly recidivistic illness. Therefore, a second prime goal of the detox unit is to attempt to motivate the affected individual towards rehabilitative treatment. Outpatient coun-

selling services, residential treatment centres, and half-way houses have been established to provide on-going services. A further component of the system of care is the Client Monitoring System which has been designed to record demographic information of the clients and provide a potential for feed-back for the providers and planners.

As the detoxification centres have been set up throughout the province, problems have arisen which are related to the varying interpretations of the policy of using a social rather than a medical model of service. The restrictions upon medications vary from no medications (other than life-support prescriptions), to that of a restrained administration of tranquilizers. Physicians' services vary from daily attendance to that of infrequent consultation. The client care in all units has maintained satisfactory levels of safety and effectiveness. The problem areas which have been identified are associated with the selection and training of personnel. It has become evident that there is a need for training programs which are designed to provide the health care workers with competencies relevant to their practice. The recruitment of female workers does not present a problem since health care service is a common field for their education and practice. However, for male workers, the man-power pool is much more constrained. This situation would be improved if career programs could be developed which would provide for lateral and vertical mobility. The Alcohol and Drug Commission in their program of staff development offer a number of courses for educational enrichment and they are studying the desirable components of a basic core educational course for its service personnel.

Detoxification services in Greater Vancouver have served over 10,000 persons in the last four years and there is the valid expectation that this usage will expand. New service units established where community need is indicated will enable maximum entry into our system of care for the alcohol dependent.

The methods used in this study are those of literature search, participant observation, and review of the records of the Maple Cottage Detoxification Centre.

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ACKNOWLEDGEMENTS

I wish to thank the members of my Committee, Dr. Anne Crichton, Dr. C. J. C. Mackenzie, and Dr. Thomas Storm for the guidance and assistance they gave me during the development of this paper.

I am appreciative of the help of Dr. Carl Stroh of the Alcohol and Drug Commission for his review of my bibliography.

I should also like to acknowledge the assistance of the Alcohol and Drug Commission, PatrGilchrist, the administrator of Maple Cottage Detoxification Centre, Ed Birkenthal, administrator of Pender Street Detoxification Centre, and my fellow staff members.

I wish to express my gratitude for the support and encouragement of my daughter, Anne Mercer, who has assisted me with the organization of this paper and is responsible for transcribing it into its final form.

INTRODUCTION

During three years of working at two detox units in Vancouver, I have become interested in trying to organize my observations and impressions into a report which could define the service which is provided within them and to discuss the perceived goals and desired outcomes. I have found that references to detoxification units are sparse in the vast amount of literature which has and is being written about alcohol consumption and its attendant problems in our society. I shall try therefore, to present a description of the service as I see it, and to suggest the issues which are of concern to those of us who are working in the field.

A major issue within the field of alcohol detoxification currently, is that of treatment focus. Should the service be one of medical and pharmaceutical emphasis or should it be one of a bahaviour-oriented focus (psychosocial emphasis). The adoption of one or other of these foci depends upon the philosophy of treatment which is accepted by those persons who shape the program. This philosophy develops from an acceptance of certain theories regarding the condition called alcoholism, and the beliefs that it may respond favourably to treatment. Whichever position is held, differing treatment policies and practices evolve.

The Alcohol and Drug Commission Act of 1973 does not impose any regulations of the service to alcohol dependent persons in British Columbia. It indicates the Government is interested in developing adequate services to fulfill community needs. The change in government which has occurred during the years to the present has not made any observable change in the intent of the Act. The only change has been to return the services to the Ministry of Health from the Ministry of Human Resources. The philosophy and attitudes which are expressed by the Alcohol and Drug Commission, therefore, reflect those developed by the members of the Commission. The Commission has sought community input and has supported research to give direction to policy determination. I have reviewed some of the literature to discuss past and current theories which influence the generation of the

attitudes and beliefs surrounding the alcohol dependent person. From my personal experience, I have described the service rendered in a detoxification unit to illustrate the problems which arise in daily practice. As these problems become evident, compensatory responses can be developed if the supporters of the alcohol program endorse an attitude of flexibility and do not feel that once a policy is written, it is final.

It should be noted that the word "detoxification" is used commonly in English and many American sources, but a newer term, "detoxication", has become one of increased usage in Canadian writing and speech among the people who are working in the field of alcohol rehabilitation. It is the word used by the Alcohol and Drug Commission of British Columbia in its literature. I have used the word "detoxification" in this paper because it is probably more familiar to the reader. The only time the term "detoxication" will be used is when there is a direct quote from official sources. Probably the word "detoxication" was developed as a parallel form to "intoxication".

I shall use the masculine forms of the personal pronouns throughout to denote male or female.

CHAPTER ONE

DETOXIFICATION SERVICE

"What is a detox centre?" (detox = detoxification centre)

"What do you do there?"

These two questions are the ones most frequently asked of detox workers by persons unfamiliar with the service. Humourously, the answer might be, "We wash 'em up, wring 'em out, and lay 'em out to dry".

The staff of a detox centre find some difficulty in detailing their service tasks. It is, in many ways, easier to say what a detox is not!

A detox:

- is not a psychiatric nursing unit.
- is not a restraining custodial prison.
- is not a "drunk tank".
- is not a "hangover haven".
- is not a counselling sanctum.
- is not a transient hostel.

An alcohol detoxification centre is a place where residential care is provided for those persons who are and have recently been intoxicated by reason of their having ingested alcohol in amounts large enough to produce a distressful condition which, when they stop drinking alcohol, is called "withdrawal". It is, in essence, a crisis centre. This withdrawal period induces symptoms of anxiety, tremors, diaphoresis, anorexia, diarrhoea, insomnia, epileptiform seizures and, in its more severe form, hallucinations, which may lead to a condition called delerium tremens (D.T.'s). This latter condition is rarely seen in a full-blown state, but visual and auditory hallucinations occur occasionally. The epileptic-like seizures ("rum fits") occur frequently enough so that all staff of a detox unit must be competent to provide the care required. In Maple Cottage Detox, since December, 1977 to July, 1978, there has been an average occurrence of two seizures a week. Close surveillance of a client's general condition during

the first 24 hours of withdrawal is followed by supervision and encouragement of the client's re-establishing normal patterns of eating and sleeping. When a client has rested sufficiently, the staff talk to him about the situation he now finds himself in, relative to his drinking habits. During these conferences, which may involve more than one staff member, efforts are made to direct the client towards entering a rehabilitative program. It is during these conversations, at the beginning of an episode, that clients frequently demonstrate a refusal to recognize that any problem exists. As one ex-client remarked when reminiscing about his road to sobriety, "Hell, I never had any problem drinking, I had a problem stopping!"

REFERRAL ROUTE

Many clients come to the detox centre by way of self-referral. When asked how they had learned about the service, they will reply, "From friends", "From A.A." (Alcoholics Anonymous), "From my landlord", or just, "Oh, somebody in a bar or beer parlour told me."

Other referral sources are physicians, social service workers, alcohol counselling services, alcohol rehabilitation centres and hospital emergency wards. The initial contact regarding the prospective client is usually by telephone. Very few clients arrive unannounced at the door of the Maple Cottage Detox, chiefly because the unit is situated in the grounds of the Woodlands School, so, its more secluded position precludes "walk-in street traffic". Pender Detox, however, being situated adjacent to the skid-row area of Vancouver, has frequent callers. A practice has developed over the years to discourage the admission of unannounced patrons because frequently there will be no "admitting" bed to receive them. It is the practice of both units to designate the beds nearest to the unit office area as "admitting beds", so that those clients requiring close surveillance are near at hand to the staff's working place. Newly admitted clients usually occupy these beds for at least 12 hours and longer in the case of those who have a history of having had seizures during previous withdrawals. Therefore, most agencies, institutions and physicians who are familiar with the detox services, will phone to inquire about "bed space" before sending along a client.

TABLE I : REFERRALS to MAPLE COTTAGE DETOX
December 7, 1977 - July 31, 1978

Total Admissions: 892

Male = 702 (78.70%); Female = 190 (21.30%)

REFERRAL SOURCE	NUMBER	PER CENT
Physician	48	5.38%
Hospital	127	14.24%
Self	311	13.87%
Family	100	11.21%
Friends	40	4.48%
A.A. (Alcoholics Anonymous)	90	10.08%
Alcohol & Drug Commission Services	7	0.78%
Narcotic Addiction Service	8	0.90%
Other Detox	13	1.46%
Out-patient Counselling	20	2.24%
Treatment Centre	28	3.14%
Half-way House	20	2.24%
Recovery Home	2	0.22%
Social Agency	1	0.11%
Social Service	20	2.24%
Health Services	3	0.34%
Police	17	1.91%
Courts	5	0.56%
Clergy	3	0.34%
Native Court Workers	2	0.22%
Employer	15	1.68%
Miscellaneous	3	0.34%
Not Recorded	9	1.01%
	892	99.99%

ADMISSION PRACTICE

In another part of this paper, reference has been made to an "open door" admission policy. This phrase, "open door", means that there are few limitations to entry such as in some detoxes which are conceived as being available only to clients who are being referred by the police department. The term "open door" does not mean "open latch".

There are a few stipulations regarding acceptable clients. Firstly, the client must not be brought to the unit under duress. When a request is received "Can you lock him up so that he can't get to a bottle, and make him do something about his drinking?", the staff member states that the detox unit is a place of voluntary admission and that there are no constraints possible if a person wants to leave. Secondly, the client must be ambulatory or, if in a wheelchair, able to transfer himself from chair to bed, or chair to toilet, and able to transport himself within the unit. A third consideration is whether the client had been recently discharged from one of the detoxes in the Greater Vancouver area. To prevent a "revolving door" usage by clients, a system of information exchange has been established between the detoxes for client discharges of the previous 24 hours. In addition to this 24 hour period, the staff look at the requesting person's record of usage of detoxes through the previous two to three months. If the client has had three admissions in this period, with no observable effort at rehabilitation, he may be refused entry. A problem arises for the intake worker if this situation exists, and the client is in real need of detoxification service. In this circumstance, the staff member will accept the client on a 24-hour assessment basis. As soon as the client has regained his sobriety, he will be advised that the unit does not operate as a "bed and breakfast" resource and that the door is open!

The Alcohol and Drug Commission have endorsed, by a recent directive, a policy which empowers the staff of a detox to ask a client who has used the detox services frequently, to sign a "limitation of service" contract. This "limitation of service" contract states that the client, herein signing, will not apply for service within the following three months. The names of these clients are recorded and the limitation of service is honoured by all three detoxes.

After the first 24 hours (critical period) the client is encouraged to

re-establish normal patterns of living. The most important factor in his recovery is to attain adequate levels of nutrition. Most of the clients are mal-nourished and exhibiting vitamin deficiency. Therefore, well-balanced meals, and mega-vitamins are the basis of the remedial therapy. The client is encouraged to be responsible for the care of his bed unit and for the laundering of his personal clothing, for which purposes a washer and dryer are available.

Information about rehabilitative resources in the community are given to the client and every effort is made by the staff to encourage him to accept a referral to one of them. Group discussions are held daily about subjects relating to the problems surrounding alcohol abuse. Some of these presentations are of special films or there may be a lecture-type by a staff member. Group discussions usually follow this structured delivery and participation by all clients is encouraged. The staff give unobtrusive direction in the leadership of these groups to prevent the occurrence of "drunk-a-logues" wherein the lurid details of past drinking bouts would be aired to the group. Otherwise, the staff members, when able, sit in the groups on a peer basis with the clients to enhance the clients' appreciation of their acceptability. Quiet occupations such as reading, card games, jig-saw puzzles, and T.V. watching are provided for in the lounge. However, more physically active recreations are more difficult to plan. Space is one restriction, and the poor physical condition of the clients imposes further constraint. The requests for shuffle-boards and stationary bicycles are being considered at Maple Cottage. One client suggested setting up a dart board!

A detoxification centre may be visualized as a crisis intervention centre and a therapeutic community. Emergency care is provided as required but the work of establishing a humanistic environment wherein the client is encouraged to consider his rehabilitation needs is the prime focus of staff endeavours.

LENGTH OF STAY

The average length of stay for a client in the Vancouver detoxification centres has been approximately three days. Pender Detox for the year 1976-77 averaged 66 hours, which figure was matched by Maple Cot-

tage Detox during its first six months of service. From past experience, the staff had observed that most clients had regained sufficient physical and emotional stability within a 72-hour period to be able to return to their homes, or to enter a rehabilitative treatment program. The clients who accumulated hours over 72 tended to be those whose detox episode bridged a week-end, during which time most residential treatment programs do not admit new clients. To maximize the probability of the client's entering the referral target, he may be retained in the detox until a direct transfer would be possible. This "holding" function has to be used with discretion to avoid abuse of the service. One of the difficulties which arise is that it rapidly becomes "street knowledge" as to what is the accepted length of stay for a client, and the clients who plan to use the service consider the allowable number of hours as a "right". In July, 1978, Maple Cottage had started to hold clients up to 7 days, while completing plans for rehabilitation. To the astonishment of several staff members, a recent client, when asked about his plans following discharge, said, "Well, I won't be leaving until Thursday, when my five days are up, so I have plenty of time to think about them."

A result of adopting a more flexible attitude to length of client stay is that the staffs' perception of their role of crisis interventionist may change to take on further aspects of counselling roles. Such a change may be rooted in a desire to increase their status by an assumption of therapeutic counselling roles which they perceive as being more prestigious.

The government of British Columbia, in its "Alcohol and Drug Commission Act of 1973", does not restrict the amount of service to be given to an alcohol dependent person. The Act simply defines an "alcoholic as a person who suffers from the illness of alcoholism", and empowers the Alcohol and Drug Commission to operate programs for these persons. The type of program, and rules of usage are developed by the Commission. The per diem rate for a detoxification bed in the Pender and Maple Cottage Detoxes is approximately $45.00, so that care must be exercised to ensure en equitable distribution of the service to the persons in need in the community. This task of monitoring the service usage is a responsibility of the detox personnel and is exercised daily. Each staff member is instructed to assess each client individually as to need for nurture and rehabilitation plans, and to make his decision for discharge accordingly.

REFERRAL TO REHABILITATIVE RESOURCES

The second purpose of a detoxification unit, following the surveillance of a client's detoxifying process is to direct him into the most appropriate treatment resource(s) required for his rehabilitation. The Alcohol and Drug Commission have been active in promoting the development of these resources throughout the province. A list of these resources is included in the Appendix. In the detox units the staff members discuss with clients their plans for rehabilitation and appraise the reality of such plans in view of the client's general condition and family situation. If the client expresses his desire to continue with further treatment, the staff will contact the designated agency. Plans for the client's entry will then be made. It is the responsibility of the client to provide his own transportation to the treatment centre. The staff member sends a referral form to the agency with the expectation that the agency will return information about the clients' progress during the rehabilitative program, to the detoxification unit.

CHAPTER TWO

GENERAL DISCUSSION OF ALCOHOLISM: THEORIES OF CAUSATION, DEFINITIONS, IMPLICATIONS

"Throughout history, alcoholic beverages have been consumed by members of almost all cultural groups for religious, social or recreational reasons. The extent to which alcohol has been integrated into Western society is readily illustrated by its universal availability at private clubs, public drinking houses, athletic events, and business functions. Social gatherings are often organized specifically for drinking; for example, the cocktail hour and wine-tasting party. Perhaps more than any other single substance, alcohol has been woven into our social fabric and significantly influences our life style.

"While alcohol consumption is a common and accepted practice, surprisingly little is known of its consequences, from chronic and unrestrained intake. For most addicted individuals there are deleterious social, economic, marital and vocational effects resulting from chronic inebriation." (Tarter, 1976.)

"It is obvious that there can be no alcohol problems without alcohol, but a preoccupation with the alcohol problem and the propensity to define it as simply drinking too much for the circumstances, ignores the pervasive influence of alcohol in Canadian society. Many people become dependent on alcohol because of social and occupational acceptabilities or pressures, and use alcohol at levels that are hazardous to health. However, it is quite unrealistic to tar with the same brush the pathological personality who uses alcohol to vent his hostilities on society, the lonely person who nightly seeks the support of tavern associates and drives home impaired; the member of the minority culture who drinks to escape social degradation and economic disadvantage, or because his group perceives drunkenness as desirable; the young person who uses alcohol along with the automobile as a means of acting out or asserting manliness, or simply because it is "cool"; the housewife who drinks because she feels she is no longer needed by her family or society; the successful and respected business or professional person who copes with stress and pulls her or himself together, at least for a while, by taking frequent nips through the day; the Saturday night binger who harms nobody but himself because he gets drunk at home, or at the home of friends, and never drives after drinking; and the down-and-outer whose homes are jails, detoxification centres and skid row in a revolving door fashion. Nor is there an inevitable down-hill course from respectability to shame where the person with a problem hits bottom and is ready for the cure." (Health Canada,

"Alcohol Problems in Canada", 1976.)

This excerpt from a national report on alcoholism, illustrates the variety of people in a community who may be potential clients for a detoxification centre. There is the implication at the end of the paragraph that detoxification centres are for down-and-outers. If this is the expectation of those who set up such centre, where do all the other persons go for needed detoxification service? The problems which arise from alcohol abuse are experienced by individuals in all segments of the community, therefore, such treatment services should be of general availability.

THEORIES AND DEFINITIONS OF "ALCOHOLISM" AND "ALCOHOLICS"

Disease Theory

In 1960, Jellinek, a pioneer in the scientific analysis of alcohol use and abuse, pointed the way toward a study of the alcoholisms, in his typology, which consisted of five types. Drawing on the Greek alphabet, Jellinek called these types of alcoholism, Alpha, Beta, Gamma, Delta, and Epsilon.

Jellinek based his typology on several underlying dimensions. The first of these is a dimension involving psychological versus physiological dependence. Alpha alcoholism is thought to be a matter of pure psychological dependence on alcohol, whereas Gamma and Delta alcoholisms are believed to involve increased tissue tolerance, adaptive cell metabolism, and physiological dependence, evidenced by the appearance of withdrawal symptoms on the cessation of drinking.

A second underlying dimension in Jellinek's types concerns inability to abstain from drinking versus loss of control over drinking. The Delta alcoholic cannot abstain from drinking whereas the predominant feature of Gamma alcoholism is loss of control over the drinking. These two concepts seem closely related but are distinguishable. The Delta alcoholic is the so-called steady-state drinker, one who has learned to regulate dose and frequency so that an even "glow" of intoxication is maintained throughout the day. The Gamma alcoholic shows some evidence of ability to abstain on given occasions but cannot control the intake of alcohol once the drinking has started. Gamma alcoholics were thought by Jellinek to be

the most prevalent type in American society and also the most commonly found type among the members of Alcoholics Anonymous.

Jellinek's final dimension, physical health versus disease, seems the least satisfactory of his efforts to develop a useful typology of alcoholism. His fifth type, Beta alcoholism, is characterized by nutritional deficiency disease associated with alcoholic drinking. But, since physical diseases, either dietary in origin or linked directly to high levels of alcohol consumption, are common in all types of alcoholism, Beta alcoholism is most readily distinguishable as an independent type. (Wallace, 1977.)

Jellinek has influenced our thinking with regard to the progression of alcoholism. His model of disease progression consists of a linear process involving four phases.

Phase I, the pre-alcoholic phase, is characterized by the use of alcohol to relax and to deal with the everyday tensions and anxieties of life. Unfortunately, continued drinking for these purposes leads to a gradual increase in physiological tolerance for the drug, and the person must drink larger quantities and more frequently to achieve the same subjective effects.

Phase II, the early alcoholic phase, is ushered in by the experience of a blackout - a brief period of amnesia occurring during or directly after a drinking episode. Early alcoholism is characterized by the following experiences: (1) further blackouts, (2) sneaking of drinks, (3) growing preoccupation with drinking and drinking situations, (4) defensiveness about drinking with attendant increased rationalization of it, and (5) feelings of guilt about drinking, resulting in the increased use of denial as a defense mechanism.

In Phase III, the crucial phase, frank addiction is thought to occur. Physiological dependence is now clearly in evidence and the person shows loss of control over his drinking. Job loss, marital conflict, separation and divorce, general interpersonal difficulties and increased aggressive behaviour are apparent. The individual becomes willing to risk everything he has struggled for to continue drinking.

Phase IV alcoholism is the chronic phase of the illness. It is at this point that the alcoholic experiences many of the horrors associated with alcoholism as it is traditionally understood. Advanced liver disease may appear in the form of alcoholic cirrhosis of the liver. Polyneuropathy,

cardiomyopathy, pancreatitis, hypertension, tachycardia, central nervous system damage, anemia, muscle and bone disease, skin diseases, and oral cancers may occur either singly or in varying combinations. With abrupt termination of drinking (withdrawal), the person may experience frightening hallucinations, violent tremors, severe agitation, paranoid episodes, and a host of other psychiatric symptoms. Severe depressions, manic acting out, a pervasive sense of futility and hopelessness, suicidal thoughts and impulses, panic episodes, dread, and self-loathing are commonly encountered in the later stages of alcoholism.

Although Jellinek's typology is of definite interest and value, it does not resolve the problem of variability among alcoholics in a satisfactory manner. The categories suggested by Jellinek are neither precisely defined nor sufficiently independent. For example, while psychological and physiological dependence are surely involved in alcoholism, both are likely to be present in varying degrees in the majority of alcoholics. It is, in fact, difficult to imagine the development of physiological dependence in a given drinker without the development of psychological dependence as well. (Wallace, 1977.)

Today, there has been considerable deviation from Jellinek's conceptual framework, but his work remains as an outstanding contribution to the development of studies of the condition of the alcohol dependent person and the condition of "alcoholism".

As Tartar and Superman (1976) point out, his influence was, and is, substantial in that his "alcoholism model", and his conceptions were assimilated and accepted by the public, and, in particular, by self-help groups such as Alcoholics Anonymous. These persons conceptualize alcoholism as a progressive disease which, if left untreated, grows more virulent, more uncontrollable, year by year. An important corollory of this belief is that alcoholism is a <u>treatable</u> disease, and that it can be arrested.

Multi Causation Theory

Brent Q. Hafen of Brigham Young University Health Sciences Department, (1977), speaks of alcohol as a disease in the broadest sense of the word, referring to the fact that it produces a disabling condition which is progressive in nature and is manifested as a syndrome with interrelated

biological, emotional, social, spiritual and behavioural aspects. He quotes Mark Keller, of the Center of Alcohol Studies at Rutgers University, N.Y., for an authoritative definition:

> "Alcoholism is a chronic disease or disorder of behavior characterized by the repeated drinking of alcoholic beverages to an extent that exceeds customary dietary use, or ordinary compliance with the social drinking customs of the community and which interferes with the drinker's health, interpersonal relations, or economic functioning." (Keller, 1972.)

Behavioural Disorder Theory

Donald Goodwin, writing in 1976, defines alcoholism as a behavioural disorder. The specific behaviour that causes problems is the consumption of large quantities of alcohol on repeated occasions. The motivation underlying this behaviour is often obscure. Max Glatt, interestingly, had written in the Nursing Times, (1975) that the person's loss of the ability to choose "when" he is going to drink, "where" he is going to drink, and "how much" he is going to drink are the significant behavioural characteristics of an "alcoholic".

Addiction Theory

A definition of precision but considerable complexity is presented by Greenblatt and Slader, (1975):

> "For hospital physicians, the term alcoholism is applied to three distinct conceptual entities:
>
> A. A pathological psychosocial behavior pattern, characterized by deteriorating function in occupation, family and citizenship, resulting from excessive alcohol ingestion. Its basis is the alcoholic's inability to resist the craving for alcohol despite the obvious adverse psychological sequelae.
>
> B. A drug addiction of the classic type. Cessation of alcohol ingestion is followed by a withdrawal syndrome subjectively unpleasant enough to perpetuate continued alcohol use.
>
> C. A medical disease with certain characteristic sequelae, such as cirrhosis, nutritional disorders, and neurological damage."

These authors say further that if all three of these entities co-exist, "alcoholism" is easy to recognize, but, they add, they do not necessarily co-exist. The emphasis in their article is to view alcoholism primarily as a drug addiction, and to discuss the approach to therapy of the

withdrawal syndrome. This presentation is of particular interest to the workers in a detoxification unit because most of the clients whom they serve demonstrate varying degrees of the withdrawal syndrome.

The National Council on Alcoholism has taken a step toward settling the legal and medical question of whether alcoholism is a disease and what are the variables necessary for labelling a person an alcoholic. A fourteen man committee of the Council has compiled a set of criteria which are designed to put the diagnosis of alcoholism on a standardized basis. These guidelines are presented in Appendix I of this paper.

Deviant Behaviour Theory

A view which has been expressed more recently by writers in the field (Hafen, 1977) considers alcohol abuse as deviant behaviour manifestation. Hafen draws heavily upon Robert Merton's concepts of anomie and anomia to suggest that herein may be the sociological and psychological processes which give rise to the deviant behaviour. This theory of deviant behaviour proposes that there are three main reasons for social concern about alcohol; (a) the intrinsic properties of alcohol as a drug over which one may lose control, (b) the symbolic or cultural traditions attached to drinking which permit relaxation of social and personal controls, and (c) the widely held view that alcohol use is associated with socially undesirable behaviour.

Therefore, Hafen goes on to say, that viewing alcoholism as deviant behaviour would represent the alcoholic person as someone who, through a set of circumstances, becomes publically labelled a deviant and is forced by society's reactions into playing a deviant role. This theory of deviancy as related to anomie has the implication that any therapies relating to its amelioration must consider, not just the individual's personality, but also the effect of the social and cultural pressures which impinge upon him. The dissonance in our society's values and practices, as described by Robert Merton, may well be at the root of an individual's using alcohol as a coping mechanism to quell his anxieties and frustrations.

Labelling Theory

Attitudes to Alcoholics and The Labelling Process

In North American culture, alcoholism and alcoholics are frequently

perceived as being deviant from the prevailing norms of acceptable behaviour. In many instances, this deviant characteristic is negatively valued so that it bears with it a stigmatization. Despite a popular myth of the "jolly old drunk", as personified by the late W. C. Fields, most people do not like drunkards.

The philosophy of the public and private agencies providing service for alcohol addicted persons generates attitudes which shape the policies of these services. These philosophies are the outgrowth of the perceptions held by the providers or supporters of the services as to the causation of alcohol addiction. As Max Glatt (1969) says:

> "The man on the street has usually regarded alcoholism as a weakness of character; the moralist sees it as a vice; the law represents it as a crime; the psychiatrist as a symptom of underlying personality difficulties; the sociologist as a social problem; and possibly many clergymen as a sin. The conceptions may be seen to encompass that of disease (medical), loss of control over drinking (psychological), conformity to social norms (sociological), and acquisition of drinking habits by following precepts of others (learning theory). The consequences of the acceptance of one or more of these concepts are wide ranging. Therefore, it may be realized that a researcher within this field of designing treatment programs for persons with alcohol-related problems is beset with a bewildering number of variables, not the least of which is his or her own conception of causality."

Cutler and Storm (1973), in their study of three B. C. cities examined the attitudes of doctors, nurses, social workers and clergy towards alcoholics. They found that as a group, doctors saw alcoholics as being deceptive, unreliable, and undisciplined, compared to their other patients. They expressed the most negative feelings among the professionals, and they were also the least optimistic about the effect of the counselling attempts. The nursing group surveyed, defined alcoholism in terms of the disease concept and almost half of them found alcoholics to be more belligerent and aggressive than other patients. The social workers adopted a more varied definitional approach and saw, as troublesome characteristics, the problems relating to poor self-image and the frequent involvement of other complications. The clergy emphasized personal weakness, a feature of the formerly popular 'moral model' of alcoholism. (Cutler, 1973.)

Halleck, in the Politics of Therapy, p. 114, observes that:

> "When an individual is given a medical label, society is encouraged to believe that his behavior cannot be controlled; a non-medical label, on the other hand, leads society to assume that

> an individual can control his behavior. Thus, a heavy drinker may be thought of as imprudent or obnoxious; however, once we call him an alcoholic, we assume that he cannot control his drinking."

When he is cast in the 'sick role', a patient assumes a role which is perceived as being deviant, and carries with it powerful expectancies. These expectations not only take hold of the mind of the perceiver, but of the perceived person as well. (Wolfensberg, 1972). So the disease model generally implies that a deviant person, (the alcoholic), is a 'sick' patient who, after 'diagnosis' is given 'treatment' or 'therapy' for his 'disease' in a 'clinic' or 'hospital' by 'doctors' who carry the primary administrative and human management responsibility, assisted by a hierarchy of 'paramedical' personnel and 'therapists'; all this hopefully leading to a 'cure'. There often exists a pessimistic preoccupation with the issue of curability because of the perceived 'chronicity' of the condition. Wolfensberger goes on to quote Parsons and Fox (1958) to say that this 'sick' role carries with it special demands and privileges. The privileges include exemption from normal social responsibilities and a recognition that the condition is not the individual's fault. The demands of the role are that the individual must want to get well or, at least, better, and must seek suitable and appropriate remedy for his condition. A further hazard of this role for those who work with deviant persons is spelled out by Thomas Szasz. He says that to call people "sick" is a strategic "tagging process facilitating their shipment out of the social order." He stresses that it is a moral and political act, not a medical act.

Freidson (1965), in his discussion of "Disability as Social Deviance", says that the issue of personal responsibility is a critical dimension of the label connotation because, he suggests, it bears closely on the moral identity of the person concerned, and on the obligations others may feel to him.

> "It makes a great and real difference when the cause of deviant behaviour is seen to lie in deliberate choice rather than in accident, inheritance, infection, or witchcraft. When the individual is believed to be responsible for his deviance, some form of punishment is likely to be involved in the way others respond. When he is believed not to be responsible, permissive treatment, instruction or therapy is used in his management."

This status inequality is noted by Geiger (1975), when quoting R. N. Wilson (1963), that "to be a patient is to be a man but not quite a man, to be human without the full responsibilities and privileges of humanity."

Once a person is perceived as being unable to control his deviant actions and he is labeled "sick", society views him with ambivalence; on one hand there is a solicitous regard for his welfare, yet at the same time, he is seen as being an inferior person and the community feels justified in imposing restrictions upon him and in rejecting or ignoring whatever he might try to say. Freidson, (1965), points out that in the area of drugs, a man who uses alcohol or other drugs to excess may be overwhelmed with all sorts of personal and social difficulties and still maintain a respectable role in society. However, once he is labeled an "alcoholic" or "addict", he is cast into an entirely different role -- he is viewed as a person who is diseased. Some people will pity him, but a sizable number will fear or scorn him. Under certain circumstances, he could lose many of his rights, even though his use of the drugs or alcohol doesn't hurt anyone but himself.

Freidson also discusses another facet of the problem when he speaks of the dimension of "prognosis", namely whether the deviance is believed to be "curable" or "hopeless". He suggests that this dimension bears on the management of treatment. He says that,

> "Since the management of all forms of deviance requires some form of segregation, the question becomes the quality of segregation. In "curable" cases, segregation is likely to be temporary and not far removed from community life. In "incurable" cases, it is likely to be permanent to the point of being banishment from the community."

While such considerations do not influence the detoxification treatment per se, they do influence the directions in which the detox staff look for a referral for the 'chronic alcoholic' following the detoxification.

The labeling of persons with alcohol drinking problems as "alcoholics" with either a moral deviancy or a disease deviancy tag, have implications beyond just the individual themselves. The service providers themselves and their organization can assume, in the eyes of the community and other workers, a deviant aspect, which will cause them to be devalued. This lowering of employment status may be more evident when the staff of the alcohol treatment service units are comprised of several ex-alcoholics. As this devaluation is perceived, the staff or organization may strive to emphasize the "disease" theory of alcohol dependency, since it is less stigmatizing than that of moral deviancy.

As Ehur (1971), remarks, the labeling approach highlights the sig-

nificance of conflict elements in definitional processes to show the basically "political" nature of deviance.

DEFINITIONS

Perry, et al, (1970), presents a useful summary of current thinking about alcohol dependence, in the following statements:

> "(1) Alcohol dependency may be characterized as a biopathology inherent in the body chemistry of the individual, which, once triggered off by the psychological events in his life space, sets up a physiological dependency on alcohol which follows a course of deterioration and organic disintegration in much the same manner as any other organic disease.
>
> "(2) Alcohol dependence may arise intrapsychically. The alcohol dependent may have a particular psychological predisposition which develops as a result of interaction with family members during growth and development. Certain psychosocial events acting upon this predisposition trigger off a psychodependence upon alcohol. The individual does not necessarily become physiologically dependent upon alcohol.
>
> "(3) Alcohol dependence may be viewed as social in nature, and conditioned by the norms and values of society. The alcohol addict is seen as an individual who cannot make the choices and decisions necessary to negotiate among the overlapping and conflicting standards set by society governing the use of alcohol.
>
> "(4) Some consider the problem as involving all these causal systems. In other words, the alcohol dependent is defined as an individual with an organic potential for dependency upon alcohol coupled with a particular psychodynamic personality structure, who is unable to cope with particular social and emotional demands in his milieu and is deaf to society's conflicting standards regarding alcohol use."

Perry concludes to say that from a survey of the current literature there are four major schools of thought which provide the theoretical framework for the understanding of and therapies for the alcohol dependent person. These are: psychoanalytic, sociological, physiological and social learning.

TABLE II: IMPLICATIONS OF THEORIES FOR TREATMENT AND STAFFING

THEORY	CLIENT ROLE	TREATMENT FOCUS	TREATMENT CENTRE	STAFF
Disease or Genetic	Patient - Passive role	Medical - Pharmacological	Hospital	Professional
Addiction	Patient - Passive role	Medical - Pharmacological	Hospital or Clinic	Professional
Deviant Behaviour	Deviant person - Passive role	Medical Pharmacological Custodial Punitive Stigmatization	Hospital Clinic Special restrictive housing	Professional Paraprofessional Custodians
Behavioural Disorder	Client role - Self-determining role	Behaviour management Minimum medical and pharmacological intervention Life-style change	Non-institutional social setting	Paraprofessional (ex-alcoholics) Occasional input by professionals
Multi Causation	Some "patient" aspects but also "client" role - Self-determining role as well as recipient role	Moderate medical - pharmacological Life-style change	May be associated with a hospital or May be a social setting	Professionals in administration and supervision and consultive roles Paraprofessionals form most of staff - include ex-alcoholics

CHAPTER THREE

THE CHALLENGE TO PUBLIC HEALTH

The physical, mental and social health problems associated with the use of beverage alcohol in Canada are of serious proportions and the indicators available suggest that their magnitude is growing. It is obvious that Canada requires co-ordinated mobilization of resources at the national, provincial and local levels in order to prevent or reduce the costly burden of these problems on our country.

From the viewpoint of public health service planning, it is important to know how many alcoholics there are within our society in order to appreciate the extent of the problems and to plan adequately for its treatment and prevention. However, it is not easy to measure alcoholism directly. The most familiar index is Jellinek's Estimation Formula:

$$A = \frac{P\ D}{K}\ R$$

which is based on rates of death due to cirrhosis of the liver. The elements in the formula are the following: A is the total number of alcoholics alive in a given year; D is the number of deaths from liver cirrhosis reported in that year; P is the percentage of such deaths attributable to alcoholism; K is the percentage of all alcoholics with complications who die from liver cirrhosis, and R is the ratio of all alcoholics to alcoholics with complications. (Cutler, 1974).

Schmidt and de Lint, (1968), estimate the prevalence in Ontario using four different methods and bases: the death rate due to cirrhosis of the liver, the suicide rate, the death rate attributed to alcoholism, and consumption of alcohol. The four estimates are roughly the same; the number of alcoholics in Ontario for 1965 varies from 118,800 to 136,800. In another paper, Schmidt used the Jellinek formula to estimate the prevalence of alcoholism for the Canadian provinces in 1961 - reproduced in Table 1

of C.L. Boydell, 1972, p. 264 .

In 1974, Ron Cutler, a consultant to the Alcohol and Drug Commission and Director of Research, Alcoholism Foundation of British Columbia, estimated that there were approximately 29,300 alcoholics in metropolitan Vancouver area. He based this on a provincial alcoholism rate of 3.8% of the adult population using the Jellinek formula, and applied it to the projected metropolitan Vancouver adult population (20 and older) for 1974. (Cutler, 1974, p. 3). Boydell, et al, in 1972, in reviewing the studies of Schmidt and de Lint concluded that the estimation of alcoholism prevalence from consumption data would seem the most practical, since all the necessary data are relatively easy to obtain. This approach to prevalence estimates is supported by the Health & Welfare study of 1976, and it suggests that current consumption patterns may be the best indicator of alcohol-related problems such as cirrhosis.

This report shows that there has been an appreciable increase in the per capita consumption of alcohol in all of Canada. With reference to British Columbia, the per capita consumption of persons over 15 years increased from .88 gallons to .94 gallons in 1970, representing a 6.8% increase. It is of interest at this point to consider the implications of a study of "Drug Use Among Vancouver Secondary School Students" in 1970 and 1974, by John S. Russell, and Marcus J. Hollander. Their data shows that the percentage of students currently using alcohol increased from 62.9% in 1970 to 72.8% in 1974, a 10% increase. Of the students studied, 59.9% were 14 years of age and younger, representing 16,800 drinkers not included in the adult population base. These individuals would not have been included in the calculations of the national figures reported previously. The study was done on a 10% random sampling of 28,000 secondary students in Vancouver and the findings generalized to refer to this total population. It is of concern, therefore, to note that 70% of these 28,000 or 19,600 students used alcohol 21+ times in the 6 months preceding the 1974 survey. Ten per cent of these student drinkers could become heavy drinkers, so that at least 330 more persons could be at risk of developing alcohol related problems which will seriously affect their adult lives. It can be predicted that many of them will become users of our health and welfare resources at a relatively early age.

Another group of "at risk" individuals which merits brief discus-

sion is that comprising the children of alcoholic parents, singly, or paired. This group may be prone to develop abusive alcohol drinking habits because of the environmental and behaviour modeling in the home. Indeed, such is the argument often put forward for the high incidence of drinking at an early age which is often seen in the native Indian people.

But the "risk" to the children of alcoholic parents is rather that of their deprivation of care and nurture. Margaret Cork, in her article "Forgotten Children", (1969), reports on her study of 115 of such children, who were drawn from middle class, upper class and some lower class families. She said that the implications from her study were great. These children had experienced feelings of being unwanted and unloved, and had heightened anxieties about security and external relationships. She found that their attitudes to life had been distorted because of the ideas they had acquired from their parents. They reflected an isolation which could predictably cause them to develop anti-social characteristics which lead to alienation from their society. These children may, by reason of their early exposure to the drinking habits of their parents, and by their development of deviant attributes be highly susceptible to becoming alcoholics.

The Research Department of the United Way of Vancouver in 1974 prepared a set of figures to illustrate probable population changes in Metropolitan Vancouver. By the year 1990, they predicted a marked increase in the adult age groups, 30 years and over, in which population most of the persons with alcohol problems are to be found.

Geriatric studies have suggested that the "senior citizen" (65 + years), is a person who may experience situations of stress such as a diminished sense of worth, termination of employment and fewer interpersonal relationships. All of these factors may well lead to his falling into a state of anomia from boredom and loneliness. (Clinard, 1964). Such conditions are prime reasons for these persons to turn to alcohol consumption for the solace of its anaesthetic properties. For the aged habitual heavy drinker, there are few resources in the community. Rehabilitative treatment centres have difficulty formulating their admission policies for such individuals. The reasons for rehabilitating them do not appear as imperative as for younger alcoholics. The motivations of job retention and family re-integration are not valid, so vague encouragements to "live as long as you can" are

often put forward in an unbelieving manner. The individual himself may also seem so deeply sunk into apathy that he shares the outlook that there is no reason to keep on going. In the present detox services, there has been a growing awareness that the number of older clients, male and female, has been increasing. They present special problems for referral after the acute stage of detoxification has been handled. For example, if these seniors have been using the long-term care residential services prior to their admission to our units, these doors may be closed for their return. Recently, I asked one of the regional directors if thought had been given to such individuals and he said, "No, we have too many other concerns at present." However, he also indicated that within the residential intermediate care service programs, alcoholics were not wanted. From this brief look at population groups from adolescents to seniors, it is evident that more specific attention must be given to treatment approaches to the needs of people with alcohol problems throughout the life cycle. (Pattison, 1976).

CHAPTER FOUR

CLIENTELE AND ADMISSION POLICIES GENERAL DISCUSSION

In much of the literature relating to planning programs for alcohol dependent persons, emphasis is given to the problem of client identification. It would seem that the chronic alcoholic is the target person. But, as mentioned in an earlier chapter, there is great difficulty in determining this specific population. Beigel, et al, 1974, in discussing comprehensive planning for comprehensive community alcoholism, stresses the need for a prevalence survey to identify a potential population at risk. His observations were based on a prevalence survey in Pima County, Tucson, Arizona, where a task force attempted to identify and contact alcoholics and their families who were associated with community agencies, primarily because of a drinking problem. These researchers theorized that these contacts provided the information about that segment of the total alcoholic population which might be characterized as the "visible" problem drinkers. The task force contacted 200 agencies which included law enforcement agencies, courts, hospitals, churches, mental health clinics, welfare and social service agencies, Indian agencies, adult and juvenile parole and probation officers and nursing homes. The task force identified 5,160 visible problem drinkers within Pima County, of a total population of 351,000. The overwhelming percentage (91 per cent) of visible problem drinkers identified were men. Pima County used the demographic and socio-economic data gathered in this survey to guide their planning for the location and staffing of services and justified their locating emergency detoxification services away from the general hospital emergency rooms. The data, since it was directly related to the agency sources, would enable a future effectiveness measure of the alcohol problem in terms of the other agencies' continued contacts with the clients. However, there was the recognition that the problem of delineating the non-visible problem drinker remains a puzzle.

The task force emphasized that there should be an active effort to seek out these individuals through a careful assessment of such caretaking resources as physicians, clergymen, industry, labour unions, and schools. They quoted an unpublished report of J. O'Dowd and T. R. McCabe, Tucson, 1970, in which was reported that the ratio of non-visible problem drinkers to visible problem drinkers has been estimated as 3.5 to 1. (Beigel, et al, 1974).

Cutler and Storm, in their survey of drinking practices in three British Columbia cities, 1973, found many variations in drinking practices, but were not able to describe predictive variables which would denote "problem drinkers" necessarily. I think that we can accept the fact that most of the probable clients for a detoxification centre are individuals within a community who have not been identified as such. They do not wear labels "alcoholic", "alcohol dependent", or "problem drinker", as open-sesame tokens for the opening of a detoxification service door.

The program description manual of ADC, B. C., June, 1977, provided guidelines for detox referral as follows: (p. 11)

> "The Appropriate Client for Detox is:
> An individual intoxicated or in a state of withdrawal due to alcohol or drugs who:
> 1. Comes from the geographical area for the facility;
> 2. Does not require emergency medical treatment;
> 3. Is willing to accept a referral.
>
> It is preferable if client:
> 1. Has a behavioural change potential;
> 2. Can utilize the referral system.
>
> Do not refer clients who are:
> 1. Obviously suffering from a psychiatric disorder;
> 2. Show signs of violence or disruptive behaviour;
> 3. Require emergency medical treatment."

Ed Birkenthal, the Pender Street Detox Administrator, has added a further criterion to the above. He says, in an unpublished report "Treatment of a Chemical Dependency Within A Detox Facility", February, 1978:

> "Ideally, an individual who has become part of the "revolving door" syndrome is not an appropriate client for a detoxication facility. (This is based on the assessment of the staff. Multiple admissions, refusal to accept appropriate referral for further treatment, etc., would constitute ineligibility). In reality, you have to provide service to these clients on a limited basis."

These guidelines which are applicable for detoxification services in

Vancouver are relatively non-restrictive in so far as they do not specify that the client must fit the category of public drunkenness offender (PDO). The requirement from the ADC list, "Is willing to accept a referral", leads one to query when the question is asked of the client. There is the implication that the "gate-keeper" of the detox says, "Will you take a referral for on-going treatment?", and, if the client does not answer affirmatively, the door does not open. Such is not the actual practice, but frequently, the intent is there and a non-conforming client may be admitted grudgingly. When the referral rate for post-detoxification clients is held to be an important measure of the detoxification process, then it is highly desirable to have clients who will fulfill this expectation.

Ron Cutler, in his report of 1974, "Detoxication: A Plan for Vancouver", suggested: (p. 3)

"TARGET POPULATION

The target population for whom further detoxication facilities are to be planned include individuals who are:

(a) in a state of acute intoxication
(b) in a state of acute withdrawal due to chronic dependency on alcohol
(c) experiencing acute drug reactions
(d) in states of withdrawal due to chronic drug dependency (excluding heroin dependency)"

His main population search had been directed at the Skid Row area, and was motivated by the problems presented by the hard core drunkenness offenders who were overloading the justice system and the welfare foles.

In Ontario and California, the perceived population for detoxification services is those persons who because of their drinking behaviours place great strains upon the criminal justice system. So, the goals of the Sacramento Detoxification Center Study of 1973-74, clearly spell out this emphasis:

"(1) to reduce public inebriate arrests by 50 percent over a 12 month period;
(2) to reduce correctional costs over a 12 month period."

The report of this study said that a third goal was inherent in the proposal for the program. It related to the provision of detoxification and referral services. However, this direct treatment goal was not specified when the contract with the California Council on Criminal Justice (CCCJ) was drawn up with the Alcohol Program Management for funding purposes.

The clientele served were arbitrarily selected by reason of their impact, financial and nuisance, upon the providers of health and welfare agencies.

The Sacramento detoxification center was located in a completely remodeled building that had been previously used as a warehouse. It was geographically located near the central downtown area within nine blocks of the main police pickup area for public drunkenness arrests.

The admission policy allowed the detoxification center to admit any individual who wants or needs help with an alcohol problem and/or those brought in involuntarily by the police for public drunkenness. During the year of study, (1973-74), 72 per cent of the 5,319 total admissions were involuntary. Ninety per cent of these were brought to the center by the police. The balance of the admission, 28%, were voluntary.

At the same time that the Sacramento study was being undertaken, another Detoxification Study was being conducted in San Mateo County, California. Its program goals were of a general public service nature to include:

(1) improved service for handling inebriates;
(2) increased cost efficiency for handling public inebriates;
(3) involvement of community agencies in services for public inebriates;
(4) demonstration of the value of involvement of volunteers and paraprofessionals (especially, recovered alcoholics in the program).

The specific goals in relation to improved services the first year were stated to be:

(1) completed referrals for after care services for 75 percent of admissions;
(2) reduction of the recidivism by 25 percent; (baseline measure not clear)
(3) 100 percent case finding and treatment of physical pathology;
(4) maintenance of withdrawal symptoms (such as seizures) to a level at or below symptoms experienced in hospital treatment.

This San Mateo detoxification unit was situated in a wing of the Crystal Springs Rehabilitation Hospital, located approximately four miles west of downtown San Mateo City. The Admission Policy for this unit was open to voluntary and involuntary admissions. Between October 15, 1973 and April 15, 1974, a little less than one-third of all admissions were in-

voluntary police cases, so the largest proportion of admissions was by self-referrals or social agency referral.

ONTARIO

In Ontario, in 1968, a Task Force on Detoxication was empowered to study the problems of handling drunkenness offenders with the view to making recommendations for the kind and number of detoxification, half-way houses and long-term care facilities which would need to be established.

The main recommendations, submitted in 1969, were that detoxification centres should be established in large centres and that police should be empowered to take inebriates to them after arrest and in lieu of laying charges. Toronto was to have a large detoxification centre of 125 beds, with arrangements with suburban hospitals. A multi-service centre was to take care of diagnosis and referral to residential treatment facilities and, in particular, to inexpensive "self-help units".

These recommendations were not immediately implemented because legislation enabling the police to take drunk arrestees to designated detoxification "in lieu of laying an information in respect of contravention", on being intoxicated in public place, had to be designed. To give the police the discretionary power, the Liquor Control Act (Bill 101) was amended by the Ontario Government in 1971. The Ministry of Health was empowered to set up detoxification centres while the Ministry of Community and Social Services was charged with the development of half-way houses. An Inter-departmental Committee on Chronic Drunkenness Offenders had been set up in January, 1972; they submitted recommendations for the detoxification half-way house system. They proposed that rather than one large unit of 125 beds, several smaller units of not more than 20 beds per unit be established. They also recommended that detoxification facilities be established for areas having at least 1,000 public drunkenness arrests per year. The Committee's recommendation that statutory authority be provided to forcibly detain patients in detoxification centres for up to 24 hours was not accepted by the Government.

The objectives of the detoxification half-way house programs was clearly to provide "care and rehabilitation for the chronic liquor offender".

For this reason, the centres were to be established where the concentration of such arrests occurred. The Hon. A. F. Lawrence, speaking in the Ontario House in 1971, said that definitely, since the units were limited in number, there would be "no hangover havens", and that the programs, at least initially, would be unable to deal with "non-chronic drunkenness offenders", who might wish to commit themselves voluntarily to such centres. The program was established specifically as an alternative to jail for drunk police arrestees who had previously been involved in the criminal revolving-door system.

The Californian studies have been quoted because they have been recently conducted and they are on the west coast of North America. The Ontario report was examined because the Ontario Detoxification programs have been consulted in the planning for service development in British Columbia. The reported success of the non-institutional model as set up in Ontario led to the Alcohol and Drug Commission of British Columbia choosing this model for their detoxification services.

CHARACTERISTICS OF DETOX ADMISSIONS
SACRAMENTO STUDY, 1972 - 73

Total admission in $7\frac{1}{2}$ months = 5,319

1. 72% of admissions involuntary police admissions
2. 60% of clients arrested for public drunkenness
3. clients all male
4. clients mostly single, unattached, living alone
5. 65% of clients unemployed
6. 50% of clients unskilled labourers
7. most arrests apprehended in skid row area
8. recidivism high - 45% of persons represent 77% of all admissions
9. referral rate for treatment low - 18% for involuntary admissions; 25% for voluntary
10. program operated at overflow - there were approximately 300 arrests monthly for whom there were no available beds at the detox

SAN MATEO STUDY

Total admissions for 6 months = 859

1. 33% of admissions were involuntary police admissions
2. clients were 79% male and 21% female
3. 40% of clients - ages 25 - 44
   28% " " ages 45 - 54
   68% " " ages 25 - 54
4. 46% of clients separated or divorced
5. 75% of clients unemployed
6. 30% had had public drunkenness arrests
7. 26% of clients were repeaters
8. referral rate to other treatment: 17% for involuntary admissions; 26% for voluntary admissions
9. detoxification unit was usually not full

ONTARIO TASK FORCE STUDY

Total admissions over 2 years at 13 detoxes = 8,112 male
613 female

1. arrested for drunkenness last year:
   males 48% of 8,112 = 3,894
   females 50% of 613 = 307
2. a large portion of admissions had stable home and social relationships
3. successful referral rate from detoxes - was approximately 10% for first admissions. The referral rate on second and subsequent admissions decreases.
4. recidivism - over a two year period, 70% of all admissions were readmitted at least once.
   - In a study by Annis and Smart, 1976, it was found that within a 6 month period 52% of admissions had two or more admissions and 20% had four or more.

VANCOUVER, PENDER DETOX

Total admissions 1976 - 1977: 2,031

1. very few police referrals
2. 55.7% had no previous admissions
3. of first admissions: 68% males, 32% females
4. referrals: 15.3% - recovery home facilities
   13.7% - out-patient counselling
   Overall referral referral rate (accepted some type of referral such as A.A.) = 63%

NEW WESTMINSTER, MAPLE COTTAGE DETOX

Total admissions 1977 - 1978 (first seven months): 1,342

1. 46% had no previous admission
2. of first admissions: 69% males, 31% females
3. referral rate (including A.A.) - 64%

TABLE III: CLIENT CHARACTERISTICS - MAPLE COTTAGE DETOX
December 8, 1977 - September 12, 1978

CHARACTERISTIC	NUMBER	PER CENT
Sex		
Male	46	76.67%
Female	14	23.33%
Age		
0 - 29	6	10.00%
30 - 44	23	38.33%
45 - 59	25	41.67%
60 +	6	10.00%
Life-Style		
Alone	39	65.00%
With Partner	21	35.00%
History of Problem Drinking		
0 - 2 years	6	10.00%
3 - 9 years	17	28.33%
10 - 19 years	14	23.33%
20 + years	23	38.33%
Educational Level		
Public School	45	75.00%
High School Grad. +	15	25.00%
Main Income Source of Past 12 Months		
Job	25	41.67%
U.I.C.	6	10.00%
Pension	6	10.00%
Spouse	5	8.33%
Welfare	18	30.00%
Current Employment Status		
Employed (includes housewives)	19	31.67%
Unemployed	35	58.33%
Retired	6	10.00%
Occupation (as told to interviewer)		
Unskilled Labour	14	23.33%
Skilled Labour	21	35.00%
White Collar	7	11.67%
Management	3	5.00%
Professional	3	5.00%
Retired	6	10.00%

DISCUSSION OF TABLE III

A representative sample of 60 admissions has been selected in six groups of 10 consecutive admissions. These groups are distributed from December 7, 1977 to September 12, 1978. I chose these groups of admissions to show the increased rate of admission.

GROUP	DATES	DAYS
A	Dec. 7/78 - Jan. 3/78	25
B	Jan. 24/78 - Jan. 31/78	8
C	Apr. 5/78 - Apr. 9/78	5
D	Jun. 26/78 - Jun. 30/78	5
E	Aug. 19/78 - Aug. 23/78	5
F	Sep. 9/78 - Sep. 12/78	4

The purpose of setting up this Table of Characteristics was to show that the clients who have come to the Maple Cottage Detox exhibit a range of characteristics. If a detoxification service is to be restricted to vagrant males, with a long drinking history, then a large number of persons will be neglected. The Ontario Detoxification Centres have had this specific clientele as their target population, and, as mentioned previously, consider their program a failure because other persons have filled their beds. There are only 6 beds set aside for women in Toronto. In Vancouver, there are at least twice that number, some of which are used interchangeably to ensure maximum bed utilization.

The age distribution shows that most of the clients fall in the age group of 30-59 years. These are normally the years of highest productivity. Efforts to assist these individuals to overcome their problem of alcohol abuse would appear to have value in that the economic state of both the individual and the community could be improved if all citizens functioned at independent levels. This portion of the table also shows that there are 20% of the clientele who fall outside of this age group. This percentage represents a section of the community who also require detoxification service.

The chronicity of the condition of "Problem Drinking" is indicated by the reported history of 90% of the sample that they had had 3 or more years of such alcohol abuse. The definition of "problem drinking" was explained to clients to indicate their drinking habits which interfered with

their social functioning. There may have been some uncertainity in their reporting but generally their answers did indicate their habit of drinking large amounts of alcohol frequently throughout the time span noted.

The Main Income Source for the past twelve months shows that the clients are not all "welfare bums". Welfare assistance is reported by 30%, with an additional 10% on U.I.C. This 40% represents public support, with an additional 10% being pension recipients. The remaining 50% of the clients were self-supporting individuals.

The Current Employment Level shows a different distribution to the Income Source, and may reflect the effect of the person's drinking habits upon current job situations. Of the 58% unemployed, hopefully some may be returned to the work force.

The Educational Level indicates a preponderance of clients had achieved less than high school graduation. This observation, coupled with that of "Occupation", which shows 58% of the clientele to fall within the labouring categories, would support the practice of using paraprofessional staff who also tend to fall within these levels, as being congruent in life experiences.

Of the 60 clients reviewed, only 5 indicated no fixed address which can be related to a wandering, vagrant living style synonomous with the "skid-row drunk". Undoubtedly, several of the addresses given by the clients were for rooming houses, or downtown hotels, but at least they indicated that the person had a specific residence. In Maple Cottage Detox most of our clients come from Burnaby, Coquitlam, Surrey and Richmond where there are fewer transient-type accommodations than in Vancouver.

This table of Client Characteristics is a brief review of some of the characteristics of the clientele of Maple Cottage Detox. When the analysis of our first six months of operation is available from the Client Monitoring System, a more detailed examination of the clients will be possible.

DISCUSSION

A consideration of the preceding outline of characteristics of the clientele of the Sacramento, San Mateo, Ontario centres and Vancouver detoxes, leads to the recognition that there are fundamental differences in the populations which are served. These differences stem from the philosophy of service goals which are stated by the supporters of these services. The Sacramento Study, San Mateo Study, and the Ontario Task Force Report make similar recommendations which would restrict the detoxification services rendered in special units to the public drunkenness offenders only. The Ontario report states that to spend public monies on providing detoxification beds to those segments of the population who occasionally drink to the point of intoxication and appear drunk in public would be prohibitively expensive and totally unjustified since their personal resources of family and friends could be utilized for their care. (Task Force II Report). Dr. Martha Sanchez-Craig, reviewing this report, states that the Task Force in its summary reported a failure of the Ontario Detoxication system to meet its objective of servicing the public drunkenness offenders with the purpose of reducing their involvement with the criminal justice system, and also failing to rehabilitate a significant number of the PDO's through residential treatment programs. She recommends an overall objective be "To provide care to all public inebriates and rehabilitation only to those who have the physical and psychological structures required to achieve rehabilitative goals and the motivation to get involved in a program of rehabilitation." She says that the main purpose of the detoxification facility will be to remove the public inebriate from the street and care for him or her temporarily in an alcohol free setting. She suggests that "detoxication centres should be used (almost exclusively) by chronic public inebriates" and advocates that Recommendation #1 in the Task Force II Report ought to be implemented. This recommendation reads, in part, as follows:

> ...that admission to a detoxication unit be reserved primarily for chronic drunkenness arrestees who are largely lacking in other support systems.
> (Craig-Sanchez, 1977)

The American studies observed that their detoxification services partly met their objective of decreasing the involvement upon the criminal justice system, but that there seemed to have been minimal rehabilitation

of the chronic drunkenness offenders. They reported that diversion to a detoxification centre did not make a difference in the long-term condition of persons who would otherwise have gone to jail. (Sacramento Study and San Mateo Study).

The Ontario Task Force II Report was even gloomier in that it reported that when the skid row inebriates were asked about their experiences in using the detoxification services, 54% of the respondents stated that their recent health was worse than it had been a few years ago. Only 11% said that their health was better. This general appraisal of their health was substantiated by policement and administrators of skid row services. The implication was that being freed from incarceration threats (or reality), the skid row inebriates have more time at large to drink and fewer interruptions of drinking sprees. (Task Force II Report).

This perceived failure of detoxification services in specific locations is the result of the goal of servicing being restriced to a specific population, the chronic drunkenness offender. If a goal of serving the wider community is accepted, then detoxification services can be viewed as a special service within the public health system. Such a view is the one which prevails in British Columbia. Certainly, when the magnitude of the potential population at risk of alcohol problem involvement is appreciated, this breadth of service focus would seem to be logical. Detoxification units provide one of the chief routes of entry to rehabilitative treatment for the alcohol dependent person. If entry to the services is broadly based, then the possibility of contacting persons before the dependency has developed into irreversible chronicity, is much more positive. The exposure of the alcohol dependent person to the therapeutic community of a socially-oriented detox may provide the stimulus for his /her seeking help. The costs of such a community wide service will of necessity be higher than those of a restricted chronic-inebriate population focus. The challenge will be to contain costs without reducing equity of access for all citizens in need.

If detoxification services are conceived as being principally for skid-row chronic alcoholics, there is the great danger of dehumanizing the service. Because this population is easily judged to be comprised of social deviants, the providers of health care service can compartmentalize them into an impersonal service situation in which the clients receive authoritarian treatment. Such a focus for detoxification service delivery also en-

ables a health care system to limit its delivery of service to the wider community needs. It is obvious that a successful means of containing costs is to narrow the eligibility for service. Since the chronic skid row alcoholics comprise a small percentage of all alcohol dependent persons, restriction of service to this group negates the concepts of equity of access for all citizens. Such a restriction also inhibits preventive and rehabilitative measures because this specific group have been shown to be the most resistant to treatment and have the highest rate of recidivism.

Detoxification services in B. C. register more admissions then other services within the alcohol service system, as shown by the table prepared by Marcus Hollander, 1977, so they are a key focal point for case finding. For this reason also, an open-door policy for admissions is advocated. This public contact function could be intensified if, as an adjunct to the service, an aggressive outreach service could be developed. It is conceivable that an experienced detox worker could be available for home visits to assess clients as to their condition to determine whether their detoxification might be safely handled at home or whether they require hospitalization or to be brought to the detoxification centre. Working possibly with A.A. members, counselling and encouragement for post-detoxification treatment could be given. There is no such service with existing detox services in the provinces. The only service which resembles this is that provided by the Downtown Community Health Society which has a health care team making home visits within the Strathcona District of Vancouver.

In summary, recommended policy would be to preserve equity of service and to promote maximum contact of alcohol dependent persons, so that detoxification units serve all segments of the community. Geographically, it is advantageous to have the centres located where there are concentrations of probable alcoholics such as skid row areas, but, in addition, other centres may well be situated to serve more suburban areas. As community acceptance and utilization of the service expands, small units could be established to serve more distinct areas. Areas of reasonably high population density such as Richmond, Whalley, Coquitlam, Maple Ridge, and North Vancouver can be seen to be logical regions for such service development. Ease of access together with local service identification would promote utilization. In addition, the involvement of local

citizens to provide ancillary services of a voluntary nature could be promoted.

CHAPTER FIVE

DETOXIFICATION TREATMENT EMPHASIS

A second policy decision which is of major concern to planners is that of the treatment focus for the detoxification service. Should the service be medically, i.e., hospital oriented, or should it be non-medically, more socially oriented. In Ontario, the services which have been developed have turned from that of hospital-based, medical-pharmacological emphasis, to that of a non-medical, therapeutic-community focus. This model which demonstrated its effectiveness as far as detoxification is considered, has been adopted for many of the services developed in other parts of Canada, as well as in a few centres in the United States. The Addiction Foundation of Ontario from its studies had concluded that medical intervention was not the essential ingredient of a detoxification service. Rather, it was reasoned, the emphasis should be upon the early introduction of the client to self-responsibility for behaviour change. Only by a reversal of previous attitudes and behaviours could an individual hope to reduce his dependency upon alcohol and reduce the resultant problems in his living. Therefore, the client should not be encouraged to see himself as a "patient". With less emphasis upon sickness, persons admitted to the detoxification facility are less likely to adopt a sick role. From surveys of clients of detoxification units, it had been observed that most of them recover their sobriety without serious health complications. Whereas, much of the literature describing the physical signs and symptoms of intoxication and subsequent withdrawal, mention alcoholic seizures and delerium tremens in considerable detail, almost invariably, the comment is made that these symptoms occur infrequently. Other evidences of ill health such as malnutrition, liver disease, cardiac and other complications are seen also, but again, only in a small percentage of the clients. It would appear logical then, to plan the service for the more uneventful detoxification episode, with provisions being made to handle the other less com-

mon manifestations. Such thinking led to the adoption of the non-medical or social setting model as the model of choice. The emphasis in such a centre is placed on a quiet, positive atmosphere, with minimal drug use and medical intervention. As George Dominick, a director of an Alcohol and Drug Specialty Unit in Atlanta, Georgia, writing in 1976, said, the rationale of this model of a detoxification unit as developed by the Addiction Research Foundation of Toronto in 1969, seems to be based on a philosophy of care which is sensitive to life style, crisis orientation and the genuine need for identity of the alcoholic. He points out also, that medical examination or attention is not ruled out, but that it is only used as needed. Of interest in his article is his report of the centre established by Dr. O'Briant in 1974, in Stockton, California. This facility was established as a demonstration unit to test out the feasibility of the non-institutional model advocated by the Addiction Research Foundation. The objectives of this unit were to:

(a) develop a social setting detoxification center for alcoholic persons;
(b) develop a facility which will serve as a starting point for referral to recovery programs and community resources;
(c) establish a model of treatment without some of the problems inherent in traditional medical and judicial approaches to the alcoholic person;
(d) demonstrate the model of treatment to the community, service agencies, professional groups, and to other communities;
(e) demonstrate that this model of treatment can provide detoxification at a lower cost than the established detoxification methods.

At the end of the two years' operation, then centre had had nearly 6,000 admissions, with an average monthly rate of 248. The recidivism rate was approximately 50%, but still less than was experienced in other more traditional centres for public inebriates. Dr. O'Briant reported that over the two years, community agency referrals increased, and police referrals declined. From his observations of the Toronto programs and his own program at Stockton, Dr. O'Briant is of the opinion that 95% of alcoholics can be detoxified without medical intervention. From this experience he drew up several guidelines for persons working with this non-medical model:

(a) social setting detoxification programs must have hospital affiliations.

(b) special training for staff in recognizing withdrawal symptoms and stages, knowledge of community resources, and an understanding are essential;

(c) referral is the primary goal and each person must be appraised of community resources;

(d) multiple admissions are expected, but chronic repeaters will not form the majority of clients.

The other two American studies which I have mentioned previously, the Sacramento and the San Mateo studies, both advocated the social setting model for detoxification services. The main reason for their supporting this model appeared to be that of economy. Indeed, the San Mateo model recommends the removal of the centre from the hospital environment because it was thought that it was such association which escalated the costs. However, both of these studies reported that the delivery of detoxification service itself was satisfactory in the setting. Both studies recommended the social model as preferable over the medical model. It must be emphasized again that these two studies had provided for the provision of medical care and supervision when it was deemed necessary for the safety of their clients.

In Vancouver, the Alcohol and Drug Commission has studied these reports and has instituted the policy of using the social model, rather than the medical model for the service direction of its detoxification centres. Within these units every effort is made to "humanize" the health care service being delivered. Recognition of the individual worth of each client is encouraged by the removal of barriers of status, creed or race. Peer relationships are fostered between staff members and between staff and clients. In several instances, clients have expressed astonishment at the prevailing atmosphere of friendliness and acceptance which they experienced during their stay at the detox units. It seemed to me a rather sorry commentary upon their other social relationships that they should find this acceptance of themselves so remarkable.

In summary, there is justification from demonstration studies that the social model for detoxification centres be chosen over the institutional or medical model.

CHAPTER SIX

DEVELOPMENT OF DETOXIFICATION SERVICES IN GREATER VANCOUVER (AND B. C.)

In March, 1967, the first serious proposal for the development of a detoxification centre was proposed by the "Action Sub-Committee" of the Special Joint Committee on Skid Row problems of the City of Vancouver. Many groups of persons had become concerned with the problem of what to do with the "skid-row drunks" and with their revolving interaction with the agencies on the "institutional loop". (Cutler, 1974). The repetitive movement of individuals from the street to the lockup, to the court, to the jail and, finally, to the street again, produced nothing but mounting frustrations within the service providers. The clients themselves showed little change in their life style which encompassed habitual drinking and search for minimal life-sustaining inputs. These chronic alcoholics who, it is estimated, comprise only 3-5% of all alcoholics in society, are the highly visible ones. Especially during our spring and summer months when the weather is reasonably temperate, the skid row drunk can sleep off his inebriation under the most minimal shelter. Consequently, recumbent, dirty, odoriferous bodies could be seen in many corners of our downtown area. However, when the development of the downtown area into "Gastown" began, this was not the landscaping design element that was desired. During the seven years, 1967 - 1974, numerous articles and proposals were written advocating a direct attack upon the problem of servicing these skid-row drunks, thereby cleaning up the area. During this time, Ron Cutler reports that more than 100,000 arrests were accommodated in the drunk tank of the city gaol. At this time, the Salvation Army, in its Cordova Harbour Lights Hostel, operated a twenty-five bed hostel where care was given to drunk and destitute males. Admission to this service was on a first-come, first-served basis, and the underlying purpose was that of religious salvation. There were also, at this time, several "flop-houses"

where nightly accommodation could be purchased for 25¢. Space could be reserved in these residences during the morning, and, having thus reserved a roof for the night, the individual could proceed to spend the rest of the day in pursuit of alcoholic beverages and /or some free food.

For the other segments of society with alcohol and drug related problems and /or psychiatric disorders, Dr. Ross MacLean's Hollywood Sanitarium in New Westminster offered sanctuary and treatment and admitted approximately 1,000 patients annually. With the situation in the downtown area becoming unacceptable to the City Council and other agencies, as an interim measure, the government took over the facilities of the Harbour Lights Hostel to set up the Cordova Detoxification Centre in 1972. This centre was under the jurisdiction of the Department of Health and was staffed by a resident physician, registered nurses, and male attendants, some of whom were hospital-trained orderlies, and some were experientially-trained by their own experience of being recovered alcoholics.

The Hospital Insurance Plan did not recognize alcoholism as an actual illness so that when persons needed hospital care for their condition, they were admitted under a diagnosis relating to the medical manifestations of complicating conditions. These would be described as "gastritis, "neuritis", "nervous disorder", "malnutrition". Many "acute" beds in general hospitals were thus occupied for the treatment of alcoholics. The provision of "detoxification" beds outside the hospital would therefore free these hospital beds for more appropriate usage.

The Alcohol and Drug Foundation, a lay group of interested individuals had long been active in the study of alcohol and drug problems and the provision of outpatient counselling services in Vancouver and the province, and had proposed many plans for the development of a comprehensive system of care for alcoholics. The board members of this organization served as consultants to the government in the formulating and direction of its plans.

On April 17, 1973, the Legislative Assembly of the Province of British Columbia passed the "Alcohol and Drug Commission Act", which empowered the Commission to do the following:

(a) operate programs, or enter into agreements with any department of Government, hospital, agency, university or person to operate programs, for studying, researching,

diagnosing, treating, rehabilitating, counselling, following-up, caring, or providing other services for alcoholics or drug users.

(b) provide financial or other assistance to any person or organization mentioned in clause (a).

(c) conduct or arrange and fund programs for the dissemination of information about alcoholism and drug abuse.

In June of 1973, seven Commissioners were appointed to serve at the pleasure of the Lieutenant-Governor in Council. Several of the Commissioners had had active membership with the Alcohol Foundation of British Columbia and the Alcohol Foundation of Ontario.

During its first year of operation the Commission concentrated on obtaining an overview of the situation in British Columbia regarding drug use and abuse. They set forth at this time a set of objectives upon which to base their planning and identified eight priorities for the year.

The priorities were:

(1) the development of preventive programs for young people;

(2) the creation of a detoxification system throughout the province;

(3) the establishment of special counselling services for native Indians;

(4) the opening of a Clinical Treatment and Training Centre;

(5) the standardization of maintenance programs;

(6) the organizing of impaired driver training courses;

(7) the further support of health educator programs;

(8) the development of a comprehensive job-related dependency program.

At this time, the Cordova Detoxification Unit was the only directly funded detoxification service in the province.

In 1974, the Alcohol and Drug Commission was removed from the Department of Health to that of the Department of Human Resources, and the Vancouver Resource Board accepted the responsibility for administering the Vancouver operations of the Alcohol Foundation and the Narcotics Addiction Foundation programs. Funding and program direction for these two latter services continued to be through the Alcohol and Drug Commission. During this year, dissatisfaction had been expressed at the traditional in-

stitutional model (medical model) of detoxification care with its emphasis on medically oriented therapy and preservation of the "patient" role for the individuals served. The planners perceived that there was little change in the recurring pattern of admission - detox stay - discharge - drinking - re-entry. They perceived that for many, the detoxification centre was a place where the individuals could come over and over again when their money ran out, and the need for withdrawal arose. None was forced to withdraw without medication, and thereby face the consequences of their behaviour. Apathy, lack of desire to socialize, and an unwillingness to suffer any discomfort that could be alleviated by medication were noticeable. Transference of dependency from one sedative to another was obviously being practised, despite the efforts of the staff to keep medication to a minimum. (Annual Report, A.D.C., 1974, p. 12). After consultation with knowledgeable people outside of British Columbia, (notably, Ontario, where an effective detoxification system was already in effect), the Commission chose the "psycho-social" model, which emphasized communication between staff and client. The goal of this therapy was to help the individual make responsible choices about his or her future and to guide the client into further treatment programs when appropriate. In the annual report of this year the Commission stated:

> (1) The detoxification centre should provide a protective environment for persons recovering from the effects of acute chemical intoxication.
>
> (2) It (the detoxification centre) will accept chemically intoxicated persons from police, hospitals, and other sources. (It) will assess the individual's condition, and refer to the designated medical setting providing medical back-up to any person too ill to remain in the centre. It will provide an average length of care of 72 hours per patient. (ADC, Annual Report, 1974)

The Commission states that one of its goals is to establish a "detoxification" system for the whole province. (ADC, Annual Report, 1974).

The Commission involved the officials of the general hospitals in Vancouver, Victoria and Prince George with the detoxification planning and emphasized that the planning was for a community-wide population, not only the skid-row alcoholic, but also for the middle class housewife on tranquilizers and barbiturates and for those who form the largest population at risk - the alcoholics whose drinking patterns have seriously affected their social functioning. (ADC, 1974).

The report suggested that to service this wider population the detoxification units should be relocated away from the skid row area. It was hoped that such an environment change would encourage more use by the larger non-skid row population of alcohol dependents in the community. Plans were begun for the removal of the detoxification unit from the Cordova Street site where the premises seemed incongruent with the new focus of treatment. These Cordova quarters were crowded, dingy, and were for male clients only. The sleeping, lounging, and dining areas were all in one large room. The new location, while only six blocks distant, at the corner of Pender and Abbott streets, did provide a less depressing facade and a greatly enlarged living space. Gone would be the back-alley entrance, dimly lit and rank with garbage and occasional recumbent bodies. This alley had been a most unlovely access route for incoming clients and had occasioned much anxiety to the staff members arriving for night shift.

Planners at this time were also discussing the establishment of a second detoxification centre for the China Creek area of east Vancouver, at Keith and Seventh Streets. It was proposed that this second unit should have twenty-two beds and have a drop-in capacity. It would provide fourteen beds for men, and the remaining eight beds would be arranged so that they might be used for either men or women.

In June, 1974, a new administrator, Ed Birkenthal, was appointed to the Cordova Detox and, under his direction, the unit changed its treatment focus from that of the medical model to that of the psycho-social model. The most visible indicator of this change was the staff's changing from their wearing uniforms to their wearing civilian clothes. Blue jeans and casual wear, worn by male and female staff members conveyed a sense of a relaxed, non-institutional milieu. The new non-medical emphasis of the detox did not rule out all medications. The unit operated with standing orders for Valium 10mgm. prn, and Dilantin 100mgm. stat, for clients admitted with a history of seizures. Chloral hydrate 500mgm. was routinely given at bedtime. The practice of having a physician on the unit daily, was discontinued and for medical examination, the clients were sent up to the Downtown Community Health Service. The staff assessed the clients as to their need for a check by the doctor, and sent most of the arrivals during the preceding 24 hours along to the clinic. It is interest-

ing to note that there was a marked increase in referrals to the hospital emergency department following the change-over. There had been 56 such referrals, January - June, 1974, and this jumped to 151 referrals, July - December 30, 1974. In spite of the cramped quarters, in 1974 the Cordova Detox handled 2,470 admissions. Its operating budget for this year was $181,913. (ADC Annual Report, 1974).

The non-medical emphasis was reflected in the hiring policy adopted at the beginning of 1975. At this time, the first female staff member who was not a Registered Nurse was brought on to the staff. Her classification was that of Orderly I. As a result, there were shifts which were staffed only by Orderly categories. The staff member who carried the unit supervisory responsibility during these shifts, filled the senior position by reason of seniority of service within the detox. These staff members were affiliated with the BCGEU, (British Columbia Government Employees Union). The other women on staff were members of RNABC, (Registered Nurses Association of British Columbia). It may be realized that a situation had arisen which created grounds for dissatisfaction because there was a salary differential between the two categories, and on those shifts where there was no RN, a lesser professionally trained person performed the same duties. It was decided, at this time, that the nurses would be retained under the classification of RN, but that no longer would such a professional qualification be a standard hiring qualification.

In this year, (1975), the Commission reported that the plans for both the China Creek centre and the Pender Street centre had been continually delayed because of contractual difficulties, so that the detoxification services continued to be located in the unattractive skid row site. In the meantime, the numbers of intoxicated persons being handled by the city jail were steadily increasing and there were also more requests being received for detox beds for female clients. The number of admissions to the Cordova detox for the year, 1975, rose to approximately 3,000, and the operating budget rose to $299,987.

In 1976, March 18, the long-awaited move to Pender Street took place. This newly renovated premise provided a supportive environment for twenty-two clients, fourteen for men, and eight for women.

The Pender Street Detox, upon opening, served the Lower Mainland as well as the Greater Vancouver district. In addition, it received

the occasional referral from other parts of the province. St. Paul's Hospital provided the emergency medical back-up service while the Vancouver General Hospital provided any necessary psychiatric service.

During this year, 1976, all new personnel were hired under the classification of Orderly I, and the more senior male orderlies were made Orderly II's. A salary differential continued to exist between them and the RN's.

This Pender Street Detox was the only direct-service detox operated by the Commission at this time. The other detox units which had been set up in Victoria, Prince George, and Merritt during the years 1974-76 had a different organizational structure. They had been formed under the direction of non-profit society boards of local community members. They were, thus, removed from direct government control. Their funding remained 100% from the government by way of grants from the Commission. The policies of the units were congruent with those outlined by the Commission for its directly funded agencies, but the boards retained considerable autonomy in the interpretation of these directives. A most significant difference was, and is, that the employees are not government employees, so are not members of the BCGEU. This fact allows greater flexibility in staff hiring and in allocations of duties. These detoxification centres have as their treatment focus the non-medical model, but some of them go beyond the giving of crisis-oriented care with a short stay characteristic, and offer the client the possibility of a stay longer than the recommended 72 hours.

In the fall of 1976, the Salvation Army reopened its Cordova Street premises which had been vacated by the new Pender Street unit. They offered a detoxification service principally to the "chronic alcoholic", usually from the adjacent skid row area. The administrative control was under the Salvation Army Harbour Lights complex, and most of the funding came from this organization. They did receive partial funding from the Commission and they participated in the data collecting for the monitoring system.

The Client Monitoring System of the Commission had become operational in April, 1975, when it became obvious that information would be needed for the evaluation and description of the alcohol services which were being set up throughout the province. Marcus J. Hollander was ap-

pointed as the Director of this service and he outlined its purpose as follows:

> The primary purpose of the Client Monitoring System was to provide the Commission with data about the number of clients in treatment, their characteristics and their movement through the system of care. In addition, the Monitoring System was to provide information relevant to the treatment agencies themselves, as well as to researchers, government bodies and the public. The first version of the Monitoring System was designed to collect sufficient data to monitor agencies; however, it was felt that future versions should be designed to provide progressively more date related to treatment evaluation. (Client Monitoring System Report, 1977).

In the year 1977, the Alcohol and Drug Commission was returned to the direction of the Ministry of Health. The number of the Commissioners had been reduced to three, with Mr. Bert Hoskins appointed as Chairman, and Mr. John Russell and Dr. Christine Rogers, the other two members. During the previous year, following the Social Credit Government's taking office, the administrative offices of the Commission had been moved to the premises at 805 West Broadway, which had previously been occupied by the British Columbia Medical Services. This return to the Ministry of Health from the Department of Human Resources did not change the preferred treatment emphasis on non-medical for the detoxification services.

In the Pender Detox, a significant change occured with the reclassification of the staff members as "Health Care Workers" with two categories, HCW III, and HCW II. Under this classification, all staff members with the exception of the supervisor, now became members of the BCGEU. The salary level for the HCW III, to which group the RN's were now assigned, was comparable to that which they had received as RN's. In the job descriptions for the HCW III positions, the health care training requirement was that of specific training such as RN, RPN, or Certified Orderly, or Industrial First Aid, plus relevant detox experience. Personal experience with alcohol problems was held to be a valuable adjunct.

In December of 1977, the Alcohol and Drug Commission opened its second direct detoxification service at Maple Cottage in the grounds of Woodlands School. The catchment area was perceived to be that of the Lower Fraser Valley, New Westminster and adjacent suburbs of Vancouver. These geographical boundaries are not rigid and clients are ac-

cepted from all areas. The treatment follows that of the Pender Detox with an even more stringently applied policy of minimum medications. The unit is to start a study of the effects of such a policy commencing in September of the current year, 1978. Other policies that will be examined will be those of the "open-door admission" and the minimal use of physicians and hospitals.

CHAPTER SEVEN

IMPLICATIONS OF THE NON-INSTITUTIONAL DETOXIFICATION FACILITY

FOR THE CLIENT

It is the hope that by setting up the detoxification facility as a social model, the client will be encouraged to see himself as an independent person seeking assistance for a problem which he has recognized as being unwanted. In our units, this has led to our insistance that the person requesting admission must be coming voluntarily, that he is knowingly asking for the assistance we are able to give to him. The detoxification centre is not a rehabilitative treatment centre, but it is an entry point into the system of care established for the alcohol dependent person of our community. Therefore, it is important that the philosophy of treatment which will be espoused in the detoxification centres be congruent with that of the rest of the system. Not only for those clients who go on to further treatment is this important, but also, for those persons for whom this may be the only contact with the system. The detoxification centres recognize that the immediate presenting problem of the client which must be dealt with is that of managing the reduction of the acute intoxication of the client. This condition is usually reduced within twelve hours so that the client may by then have recovered some of his or her senses. It is usually possible after this length of time to conduct rational conversations. Despite feelings of physical and emotional weakness, the client can begin to think upon his life situation. Every effort is made to support the client's appreciation of himself as a person of worth. Therefore, the staff strive to convey, by their actions and their conversation, their very real interest in each client, and their view of each client as in independent human being. The client is encouraged to restrict his demands for sedatives to reduce "the miseries". The desire for pills to alleviate the distressful symptoms of withdrawal is natural, but the use of these agents only prolongs

the process of reducing the dependency, Within our detoxification units where we practice minimal administration of drugs, there is no suggestion that the "cold turkey" route is being used as a punishment. For some clients the distress of severe tremors is too acute to leave untreated, so that relief is given to enable the client to settle down sufficiently for communication to be established. During the past two months, the Maple Cottage Detox has witnessed an amazing reduction in the amount of medications distributed to clients. Our average use of the mild tranquilizer, Librium 10 mg., had been three capsules per client stay of an average of 60 hours. In addition, most clients had received Chloral Hydrate 500 mgm. at bedtime for an average of two nights. Such dosages are small when viewed against other medical practices, but we have reduced the level even further. Currently, our clients are usually receiving no sedatives during their stay which has lengthened to approximately 72-80 hours. Most of our clients have responded well to this new regime and have not seemed to be any more uncomfortable. Accompanying this reduction of sedatives, interaction with the clients has been increased and physical techniques such as bathing, walking and talking have been encouraged to relieve stress symptoms.

The client is encouraged to see himself as his own agent of control, so that he is enroled as an active participant in all facets of his treatment program. He is encouraged to see the detox staff as resource facilitators who will work with him for his recovery of sobriety.

FOR MANAGEMENT

When the non-medical model of detoxofication therapy is adopted for use, the principal agent in the therapeutic process is the health care worker. The personality characteristics and attitudes of the staff members are the most significant variables relevant to this therapeutic change desired. Carkuff, 1969, discusses the problems inherent in assessing desirable "helper" characteristics and evaluating individual effectiveness by outcomes, in the fields of the selection of counsellors for persons with emotional problems. His remarks are singularly relevant for those persons who seek to work with the alcohol dependent person. It has become evident that efforts to rehabilitate these persons are dependent upon motiva-

ting them to behaviour change. Therefore, the role of the worker is that of a helper or facilitator, "a change agent". Each staff person, as soon as he is cast in to a helper's role, must understand the implied proposition that his level of personal functioning is higher than that of the person applying for help. How is this level of functioning to be measured? How can management measure the maturity and humanity of the potential staff member? Carkuff suggests that ideally a helper offers perceptive understanding, warmth of acceptance, accompanied by active, assertive offerings, involving direction, confrontation, and more action-oriented activities. While the detoxification service as outlined is a short crisis-oriented therapy, it must initiate helping processes which are congruent with following rehabilitative therapy. It is desirable that the staff members, therefore, exhibit many of the characteristics which are looked for in the rehabilitative counsellors. It has been demonstrated that these characteristics are not easily quantified, and are not necessarily the result of formal training. Indeed, Carkuff quotes a number of researchers who have explored the advisability of using lay workers in helping roles, and concludes that there is extensive evidence which indicates that lay persons can be trained to function effectively for constructive client change. Training programs can be of relatively short duration. The ensuing successful trainee growth seems to be related more to personality attributes than to professional or intellectual qualifications. Carkuff further suggests that the success of lay trainees who are of lower socio-economic levels than many of the graduates of professional programs, may be rooted in their reasons for entering the helper field. He says that persons may be motivated to help by their simpler, more directly humanistic, motives than the professionals whose needs in adopting a helper role may stem from desires for status, prestige, money or "certification". Furthermore, where the client population has a preponderance of persons from a lower socio-economic or educational level, then a lay group who more nearly matches these class levels, finds empathy and problem identification much easier.

This principle of congruity of life experience has been used for the selection of many staff workers in the alcohol rehabilitation field, with much success. In many treatment centres personal experience of alcohol addiction and recovery, and /or membership in Alcoholics Anonymous, is a primary qualification for personnel hiring. In detoxification

centres of the non-medical model, there can be the tendency for this attribute to outweigh the other more formally acquired health care training of other potential staff members. It is unfortunate to over-value such experiential learning because it is not universally available. Staff members who are not alcohol dependent may become quite cynical upon repeated assertions of, "If you've never been there, you cannot understand it." Appreciation of past life misery may well heighten an understanding of the depths of despair and guilt being felt by an addicted client, but the rehabilitative behaviour required is future oriented. Sympathetic understanding is expected from all staff members with a demonstrated acceptance of all persons as human beings of worth. Administrators and managers of detoxification services can examine their units to assess from a functional point of view, what competencies are required of their staff. The goals of the service are to supervise the detoxification process to ensure client safety, and to promote rehabilitative treatment through referral to community agencies.

Anderson, et al., (1977), in discussing the increased use of paraprofessionals in human service programs, state that a most important step to take is to get away from the credentialism that tends to mark public employment. They say that the controversy surrounding professional or non-professional staff can blur the important issue of getting the most appropriate staff to reach the service goal. They suggest that the approach to take is to identify as specifically as possible the concrete tasks that will be performed; the skills, knowledge and abilities these tasks will require, and the population groups and individuals most likely to possess these skills. Such observations lead us to conclude that a balance must be reached whereby recognition of the value of experiential knowledge and empathetic indentification is weighed beside more formally acquired technical and didactic knowledge.

Another concern for the directors of programs, is that with the acceptance of paraprofessionals as peer members of the staff, there will evolve the necessity to provide a career design for such workers. It is usually not satisfactory merely to provide employment within the service field for empathetic persons, but there must evolve a means of career advancement to higher or different levels of related work. This is not to suggest that all workers will seek to advance, but if no such "career

ladder" is developed, then the paraprofessionals may perceive their jobs as being "dead-ended". If this perception exists then staff motivation is difficult to maintain. However, a model whereby the subprofessional work levels are defined and keyed to specific instructional units which, in turn, lead to wider career tracks, is difficult to design because of the complexities of traditional occupational training and entry requirements for future professional credentialing. Lynton, in reporting of workshops in 1969, considering first this question, observes that the health care field may be successful in such developments because occupations within it are in a continual process of evolution and there is a constant role-blurring in response to shifting patterns of responsibility. Within our health care system, a definite core of basic knowledge could be developed which could be utilized by any of the paraprofessionals to be used in human service fields. Currently, the Vancouver City College has been studying the education of Homemakers who are being used extensively for the care of the chronic and geriatric persons in the community. The curriculum committees have identified four areas for basic instruction: (1) human functioning, (2) communication, involving human interactional techniques, and record-keeping, (3) protection, involving human and environmental safety control, and (4) personal and vocational development. If such basic instruction were to be developed on an interdisciplinary concept, it would be feasible to access such courses for potential health care workers. The techniques and specific knowledges desirable for service to alcohol and drug dependent persons could be added at an in-service level.

For the manager of a detox unit where male and female staff are required, the choosing of male staff poses the greater problem. In answer to job competitions, there are many female applicants who possess highly satisfactory health care educational qualifications. Such applicants range from registered nurses through the ranks of licensed practical nurses, psychiatric aids and child care counsellors. The male applicants, however, are seldom as well qualified in specific health care training. Human service has traditionally been viewed as a field of female endeavour. The few males who do qualify themselves in the area are in great demand. In order to have a standard of subprofessional competence for applicants who lacked the more traditional qualifications, the Public Service Commission has accepted the St. John's Industrial First Aid Certification as an accept-

able substitute. This certificate involves 60 hours of instruction and practice, and each candidate must pass strict examinations. The advantage of this course is that it is readily available and has a health care content. For detox workers, the emphasis upon the treatment of accident victims lacks some relevance. However, since no other short courses are available, its validity stands. It has become apparent to me during these months of staff selection and training that the lack of standards for determining subprofessional competence other than the conventional certification process is a crucial problem.

Many of the male applicants in recent job competitions have been recovered alcoholics, for whom provision of appropriate educational opportunities would be most advantageous. Enabling them to begin a process of career development will protect their sense of personal worth. The recruitment of more men into the health care services is dependent upon the establishment of a career program within the industry which will provide both lateral and vertical job mobility.

Recommendations which were made by the 1969 workshop on Subprofessional Employment are relevant to our discussion and are a useful summary. (Lynton, 1967, p. 56-58).

1. Entry jobs must be discrete work levels designed as part of staff development.

2. Career ladders must provide sequences and gradations of skill and responsibility that allow for worker mobility.

3. Differentiation between levels and categories of work must be based on standards of output.

4. Recruitment must reach the desired manpower supply. Selection criteria must be relevant to subprofessional performance.

5. Training, education, and on-the-job supervision need to be synthesized into a flexible instrument for continuous development.

6. Changes required by the model in existing personnel systems or alternates to that system must be established.

7. All experience with differential use of varying categories of staff must be collected, analyzed, and evaluated.

8. New research is needed to develop the knowledge for designing subprofessional careers.

9. Technical assistance must be provided to employers in the human services to enable them to improve current operations or implement new models.

10. Ample opportunities must be provided to test and evaluate new models within the service delivery system for which they are intended.

FOR STAFF

The staff of a social model of a detoxification unit, as discussed in the preceding section, have to adapt themselves to a change of role. The emphasis upon behaviour management and increased skills of interpersonal communication will replace the medically oriented tasks of the administration of medications. The staff chosen from subprofessional categories are of a vocational level in keeping with that of most of the clients. (Table III). However, this Table also shows that the clients are from other educational and occupational strata as well, so that it is desirable to have such a mix within the personnel. If the trend to increased usage by the total community continues, then the staff composition would need to be flexible enough to match any such change. It is obvious that for female clients, female staff are needed. For clients whose education and occupation are of higher levels, staff need to be able to converse and interact suitably. A socially acceptable level of language and behaviour is necessary if clients are to feel comfortable.

CHAPTER EIGHT

STAFF SELECTION

The social model of detox service leads to a hiring policy which de-emphasizes professional health care training and recognizes the suitability of accepting workers who have minimal formal training but may have adequate experientially gained knowledge. A review of the applicants for the positions for Maple Cottage Detox in the fall of 1977, reveals the selection problem. There were 13 positions in all; five for HCW III, and eight for HCW II. The staff to be hired were to be balanced as to males and females.

The distribution of applications as to gender were:

	HCW III		HCW II	
	M	F	M	F
Applications	8	32	8	23
Interviewed	5	10	6	10
Accepted	2	3	4	4

All of the prospective staff had acceptable service experience, either in a detox unit or in psychiatric or emergency departments of hospitals. However, their formalized health care training varied considerably as may be seen from the following table. I have indicated three levels of health care training:

Level I - experiential training only

Level II - paraprofessional training such as Licensed Practical Nurses, Certified Orderlies, Psychiatric Aides

Level III - Registered Nurses, Registered Psychiatric Nurses

TABLE IV : STAFF ANALYSIS

PERFORMANCE LEVEL	UNACCEPTABLE	ACCEPTABLE	SATISFACTORY	NUMBER
AGE -35		2	5	7
36-45	2	3	6	11
46-55		3	4	7
56-65		1	3	4
Totals:	2	9	18	29
MARITAL STATUS:				
Couple		5	10	15
Single	2	4	8	14
Totals:	2	9	18	29
ALCOHOL HISTORY:				
Yes	1	7	7	15
No	1	2	11	14
Totals:	2	9	18	29
EDUCATION:				
Primary	1	1	5	7
High School	1	8	11	20
Post-Graduate			2	2
Totals:	2	9	18	29
HEALTH CARE EDUCATION:				
I. 0-3 mos.	1	4	10	15
II. 4-12 mos.		3	3	6
III. 12+ mos. (Prof.)	1	2	5	8
Totals:	2	9	18	29

From a reading of Table IV it may be seen that all of the female staff members (7) had Level II and Level III qualifications, with only one having an alcohol dependency history. The male members (6), however, were evenly divided between Levels I and II, for specific health care training, and with a single exception, had had a personal experience of alcohol dependency. From my subsequent acquaintance with these men I learned that for the five "ex-alcoholics", this occupation of health service was a re-tracking. Originally, they had been in very different fields, from an executive in the pulp industry, a salesman for an equipment manufacturer, to men who had never had a job or specific expertise. The women, in contrast, were seeking employment in their vocation of first choice. One only, a nurse, whose registration had been withheld because of her problem with alcohol abuse, could view employment in the detox service as a position of less than desired job status.

The disparity in educational background has led to difficulties in the development of peer relationships which are essential for successful team practice. The experiential knowledge of alcohol dependency is a qualification which is difficult to equate to more formalized learning, yet it proved to be a deciding factor in the selection of the male applicants.

As mentioned previously, the Public Service Commission has listed the Industrial First Aid Certificate as a desirable credentialing. While the knowledge gained from this course is pertinent for a first aid official in an industrial setting, it lacks the specifics relevant to detox care. The Pender Detox staff, during the past $2\frac{1}{2}$ years, have not had to use emergency practices as detailed by this course. The Coronary Pulmonary-Resusitation (CPR) component of the course has been criticized by some staff members as being notably difficult to achieve. It is not the acquiring of the theoretical knowledge of this course which poses the problem, but rather, the intense physical effort required to inflate the practice rubber dummy! Within my own experience of three years detox service, no occasion has arisen which required the application of these restorative measures to a client. The detox units are equipped with oxygen cylinders for use in cases of respiratory distress, yet even this equipment is seldom used (once in Maple Cottage Detox, of 700 admissions).

The health care knowledge which is necessary for practice in the detox unit centres upon the recognition of the signs of the presence of

life-threatening conditions. These conditions are those of cardiac distress, respiratory difficulty, severe dehydration, malnutrition, abnormal levels of consciousness and head injury sustained prior to admission. The detection of these critical states is dependent upon knowledgeable observation of physical signs. Training to develop these observational skills can be a definite part of an in-service program.

The most frequently occurring complication is that of alcoholic seizures during the withdrawal. This condition requires prompt and efficient care. Staff members are required to know how to protect clients during the convulsion and to refer him to the emergency ward immediately. Direct experience with the handling of such behaviour is not common among health care workers in general, so it is mandatory within detox units to give such instruction to all staff members.

In addition to these specific knowledges, detox workers need to possess or to develop interpersonal skills to handle interviewing for history and referral information, and to enable them to participate in group discussions. Record-keeping skill is a further requirement which must be of an acceptable standard.

The personality characteristics of empathy, kindness and acceptance of others as equals, are highly desirable attributes of a potential detox worker. With such a personality profile, many men and women with little or no formal health care training could be prepared to practice successfully in the field of detox service. Short courses of both generic and specific emphasis could be developed and made available either through the training department of the Alcohol and Drug Commission, or by way of junior colleges. Present staff members who lack adequate formal training could be assisted to attend such courses, by being allowed paid time for them. Upon completion of these courses, credit units, or some form of diploma recognition could be designed to give the worker-student a valid record of his achievements. It could become a hiring policy of the detox staff selection committee that all workers be required to acquire this specially designed package of learning materials or their deemed equivalent.

By means of these specific learning modules, all detox workers could acquire a standardized educational base. The men and women so prepared would have no reason to feel inferior to any of their team mates

who might have health care training of a more professional level. The possession of additional health care knowledge could then be viewed as any other personal characteristic, and would not imbue the holder with any increased status. The task of selecting candidates for detox staff would be greatly facilitated if such educational resources could be made available.

CHAPTER NINE

CONCLUSION AND RECOMMENDATIONS

CONCLUSION

The detoxification services which have been set up in Greater Vancouver and other centres in the province of British Columbia have been established in response to a need experienced by the citizens. These services are a part of a program of services which encompass educational and rehabilitative components. They form a system of care which is in a developmental stage. Philosophical beliefs and attitudes have been stated by the Commission which provide the rationale for a humanitarian approach to the provision of care for alcoholics. These beliefs are translated into policies for practice which encompass the principles of equity of admission, and client safety while in treatment. A further principle of responsible delivery is supported by the policy directives to monitor the effectiveness of the service in terms of prevention of over-use of the service benefits.

Need for Alcohol Service

It has been suggested that large numbers of the population of British Columbia are affected by their having developed a dependency upon alcohol. This affected population is likely to increase in size because of the increasing number of persons who adopt heavy drinking practices. The cultural patterns of our society are not likely to change. Therefore, there will be increasing numbers of people who will expose themselves to the risk of alcohol addiction. The trend of recent years for women to move out of the home to enter the business and professional world, coupled with the increasing acceptance of public drinking by women, is an example of one of the specific groups at risk. Another group of persons among whose ranks problem drinking is becoming more visible is that of the retired or senior citizens.

The total population profile is projected to be that of a gradually aging group as the "baby boom" of the fifties matures to adulthood. It is in the adult age group that the problem of alcohol dependency usually appears. Therefore, as the population of adults increases proportionally, so does the probability of the need for alcohol treatment services.

Demand for Alcohol Service

The demand for services for alcohol dependent persons does not parallel the need in the community. Reluctance to admit to the existence of the dependency and feelings of shame and fear of social disdain have kept many alcoholics from accessing the alcohol services. However, as public education brings greater recognition of the treatability of the condition, and insofar as it thereby reduces the stigma, then the demands for the services will become more in line with the needs of the community.

Alcohol Treatment Resource: Detoxification Centre

Detoxification centres which have been developed and those which are yet in the planning stages are being designed for delivery at many communities throughout the province. These centres serve as important entry points for further rehabilitative treatment programs and may be the initial service developed as the beginning of a wider system of care for a district.

Model of a Detoxification Care

The medical care of persons in acute stages of alcohol intoxification and withdrawal has proven to be less in demand than the psychosocial needs for their rehabilitation. Therefore, the social or psychosocial model for detoxification care is currently the one being practised in most of the detoxification centres in B. C. Even though this care is for short length of stay episodes, so that it may be viewed as crisis intervention, yet it addresses those aspects of rehabilitative care which emphasize the clients' needs to gain new insights into their life skills and functionings, as well as making positive efforts towards assisting them to solve their social problems of possible employment and family loss.

Staffing

The concept of teamwork is supported by the directors of the detoxification services. For this reason, distinctions of job assignment are minimized and equality of team membership in decision making functions is encouraged. It has been observed that to be accepted as peers, the staff members need to have, or be able to acquire, similar preparation for practice.

RECOMMENDATIONS

Recommendation I:

That directives or guidelines for the delivery of detoxification services should be developed from observed practices and that they will be expected to change over time.

From the practices observed in the detoxification centres in Greater Vancouver, the following recommendations are made:

Recommendation II:

That a humanistic philosophy be supported to provide a detoxification service which is available to all citizens.

Recommendation III:

That a psychosocial model as contrasted to the medical model for detoxification service delivery be adopted.

Recommendation IV:

That the use of paraprofessionals be encouraged for the staffing personnel of detoxification centres as much as is consistent with the preservation of client safety.

Recommendation V:

That the competencies required for detoxification care be defined and complementary courses be designed to enable existing or potential employees to qualify themselves.

Recommendation VI:

That a means of improving feed-back information of client's progression through the system of care and eventual experience in the community be studied.

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APPENDIX I

Alcohol and Drug Commission Act

British Columbia, 1973

Alcohol and Drug Commission Act

Interpretation.

1. In this Act, unless the context otherwise requires,

"alcoholic" means a person who suffers from the illness of alcoholism;

"alcoholism" means any dependent condition produced by the action of alcohol upon the human system;

"commission" means the Alcohol and Drug Commission established under section 3;

"drug abuse" means

(i) addiction to a substance other than alcohol; or

(ii) the use, whether habitual or not, of a substance other than alcohol that is capable of inducing euphoria, hallucinations, or intoxication in the human body;

"drug user" means a person who

(i) is addicted to the use of a substance other than alcohol; or

(ii) uses, whether habitually or not, a substance other than alcohol for the purpose of inducing euphoria, hallucinations, or intoxication. 1973, c. 3, s. 1.

Commission.

2. (1) There is hereby established a corporation to be known as the Alcohol and Drug Commission consisting of not less than five members appointed by the Lieutenant-Governor in Council to hold office during his pleasure.

(2) Each member shall be reimbursed for reasonable travelling or out-of-pocket expenses necessarily incurred by him in discharging his duties, and, in addition, may be paid such remuneration for his services as the Lieutenant-Governor in Council may determine.

(3) A majority of the members, present at any meeting of the commission, constitutes a quorum. 1973, c. 3, s. 2.

Chairman.

3. The Lieutenant-Governor in Council shall designate one of the members as chairman and one other member as vice-chairman. 1973, c. 3, s. 3.

Agent of Crown.

4. (1) The commission is, for all purposes, an agent of the Crown in right of the Province.

(2) The commission may, on behalf of the Crown in right of the Province, carry out its powers and duties under this Act in its own name and may, with the consent of the Lieutenant-Governor in Council, hold in its own name any land or other real or personal property, and likewise may dispose of, mortgage, hypothecate, pledge, and assign any such property. 1973, c. 3, s. 4.

Manager and employees.

5. (1) A manager of the commission, and such other employees as are required to carry out the proper business of the commission, may be appointed pursuant to the *Civil Service Act*.

(2) The commission may, subject to the *Civil Service Act*, designate the title, office and responsibilities of any employee of the commission.

(3) The Lieutenant-Governor in Council may, by order, declare that the *Public Service Superannuation Act* applies to the manager and employees of the commission.

(4) The commission may, with the approval of the minister, engage and retain such persons as it considers necessary as consultants, experts, or specialists, and may fix their remuneration. 1973, c. 3, s. 5.

Application of *Companies Act*.

6. Except as provided in this Act, the *Companies Act* does not apply to the commission, but the Lieutenant-Governor in Council may, by order, direct that the *Companies Act* or any provision thereof applies to the commission and, thereupon, that provision applies to the commission. 1973, c. 3, s. 6.

Members not personally liable.

7. No member or employee of the commission, and no person acting under the authority of this Act or the commission, is personally liable for any loss or damage suffered by any person by reason of anything in good faith done or omitted to be done in the exercise or purported exercise of any powers given by this Act. 1973, c. 3, s. 7.

Secrecy of information.

8. (1) Except as otherwise provided in this section

(*a*) no person who is or has been a member or employee of the commission or is or has been employed or engaged in the administration of this Act shall disclose, or be compelled to disclose, any information obtained by him that pertains to a drug user or to an alcoholic; and

(*b*) no file, record, document, or paper in the custody of the commission that pertains to a drug user or to an alcoholic shall be disclosed to any person or be admitted in evidence in any proceedings.

(2) Subsection (1) does not apply

(*a*) where the disclosure is necessarily made in administering the business and affairs of the commission or in administering this Act; or

(*b*) where the disclosure is made at the request of or with the consent of the drug user or alcoholic concerned, his personal representative or the committee of his estate; or

(*c*) in any special case where permission is given by an order of the Lieutenant-Governor in Council.

(3) Information in the custody of the commission pertaining to drug users and alcoholics, and the treatment, care and services provided to them, may be published by or with the consent of the commission in

statistical form if the individual names of drug users and alcoholics are not revealed or made identifiable.

(4) Every person who contravenes a provision of this section is guilty of an offence and liable on summary conviction. 1973, c. 3, s. 8.

Agreements.

9. For the purposes of this Act, the commission may, subject to the approval of the Lieutenant-Governor in Council, enter into such agreements as the commission considers advisable with

(*a*) the Government of Canada;

(*b*) a municipality;

(*c*) a regional district;

(*d*) an agent of the Crown in right of the Province or the Dominion;

(*e*) any department of a Provincial or the Dominion Government. 1973, c. 3, s. 9.

Programmes.

10. The commission may, subject to the approval of the Lieutenant-Governor in Council

(*a*) operate programmes, or enter into agreements with any department of Government, hospital, agency, university, or person to operate programmes, for studying, researching, diagnosing, treating, rehabilitating, counselling, following-up, caring, or providing other services for alcoholics or drug users;

(*b*) provide financial or other assistance to any person or organization mentioned in clause (*a*);

(*c*) conduct, or arrange and fund, programmes for the dissemination of information about alcoholism and drug abuse. 1973, c. 3, s. 10.

Reports.

11. The commission shall submit annually to the Minister of Human Resources

(*a*) a report respecting the operation of the commission for the immediately preceding fiscal year; and

(*b*) a financial statement showing the business of the commission for that fiscal year;

and the report and financial statement shall be laid before the Legislature if it is then in session; otherwise the report and financial statement shall be laid before the Legislature within fifteen days after the opening of the next ensuing session. 1973, c. 3, s. 11.

Expenses of administration.

12. All moneys required to be expended for the purposes of this Act shall be paid out of the Consolidated Revenue Fund with moneys authorized by an Act of the Legislature to be so paid and applied, and, for the fiscal year 1973/74, shall be paid out of the Consolidated Revenue Fund. 1973, c. 3, s. 12.

Commencement.

13. (1) This Act, excepting this section, comes into force on a date to be fixed by the Lieutenant-Governor by his Proclamation, and he may fix different dates for the coming into force of the several provisions.

(2) This section comes into force on Royal Assent. 1973, c. 3, s. 13.

[NOTE.—Act proclaimed in force June 5, 1973, Part II Gazette Vol. 16, p. 244.]

Printed by K. M. MACDONALD, Printer to the Queen's Most Excellent Majesty
in right of the Province of British Columbia.
1974

800-374-3653

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APPENDIX II

Task Force II Report on the Operation and Effectiveness of the Ontario Detoxication System (1976)

TASK FORCE II REPORT ON THE OPERATION AND EFFECTIVENESS OF THE ONTARIO DETOXICATION SYSTEM (1976)

CONCLUSIONS:

1. The system was planned and built to serve the needs of the chronic drunkenness offender or police arrestee. It was not meant to provide facilities for the detoxication and rehabilitation of all types of alcoholics or intoxicated person.

2. The key features of the detox-based system have been in operation long enough to establish their contribution to the rehabilitation of the chronic police arrestee.

3. Upward of 50% of detox admissions have not been arrested for drunkenness in the past year, and many admissions have stable accommodation and family ties. (NOTE: Stable accomodation and family ties are typically not found among chronic police arrestees.)

4. There is a great variability among detoxication centres in mean length of stay of residents (range 1.8 days to 4.8 days). In some centres, only a small minority of admissions stay less than 24 hours, whereas in other centres, over half of all admissions are discharged within 24 hours.

5. A large proportion of the population periodically establishes contact with other longer-term health facilities. Only about 10% of detox admissions are successfully referred to such facilities on discharges from detox. The referral rate on second and subsequent admissions decreases.

6. Persons admitted to post-detoxication facilities do not have lower rates of detox readmission and drunkenness arrests than those who are not admitted.

7. Premature termination of treatment is the norm for half-way house populations and for detox referrals to both out-patient and residential facilities of all kinds.

8. There is little evidence of positive effects of detox on the clients' post-detox drinking behavior. On the average, arrests after detox admission do not decline. Readmission rates are as high as 70% over two years.

9. Drunkenness arrests showed inconsistent changes after the introduction of the system. Such changes could be as much due to modifications in police and court policies and attitudes as to some specific effect of the detox half-way house system on the chronic police arrestee.

10. In at least half of communities with detoxication centres most persons arrested for drunkenness are not taken to the detox but continue to be processed only through the criminal justice system. In average,

in the designated areas throughout the province, only 25% of police arrestees for drunkenness are taken to detoxes.

11. In most detoxication centres considerably less than 50% admissions are referred by police, and in five of nine communities, 31% or less were police referrals in 1975. The substantial proportion of self admissions and admission from other social health agencies is not in keeping with the original aims of the system.

12. Accounts by skid row inebriates, as well as by policemen and administrators of skid row services, suggest that there has been a deterioration in the physical health of the public inebriate. One possible explanation is that the perceived changes are related to leniency in enforcement and judicial practices together with the limited application of apulic health approach. In short, the skid row inebriates have more time at large to drink and fewer interruptions of drinking sprees.

13. Attitudes of current skid row alcoholics suggest that detoxication centres are seen primarily as drying-out and care-taking agencies rather than as gateways to rehabilitation. Detoxication centres do not appear to have played a significant role in changing the life-styles of most men on skid row.

APPENDIX III

Treatment Agencies Funded by
The Alcohol and Drug Commission
Ministry of Health, Province of British Columbia